**SUMMARY PLAN DESCRIPTION**

**FOR**

# Employer Solutions Group LLC


# GROUP MAJOR MEDICAL EXPENSE BENEFITS PLAN

**Effective: January 1, 2024**

**Caution:** This document, together with the certificate of insurance booklets issued by BCS Insurance Company is your Summary Plan Description. If the certificate of insurance booklet is not attached, then this Summary Plan Description is not complete and you should contact Planned Administrators, Inc. (PAI), whose contact information is on page ii, for a complete copy.

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## ADMINISTRATIVE INFORMATION

| | |
|---|---|
| Name of Plan | Essential StaffCARE Group Major Medical Expense Benefit Plan |
| Employer / Plan Sponsor | Employer Solutions Group LLC<br>7201 Metro Blvd., Suite 900<br>Edina, MN 55439 |
| Plan Sponsor's Employer Identification Number | 20-2301006 |
| Plan Number | 510 |
| Group Number | Z2193000 |
| Type of Plan | A welfare benefit plan providing group major medical expense health benefits. |
| Type of Plan Administration | This plan is fully insured. Benefits are provided under group insurance contracts entered into between **Employer Solutions Group LLC** and BCS Insurance Company. |
| Plan Administrator/ Named Fiduciary/ Insurance Companies | BCS Insurance Company<br>2 Mid America Plaza, Suite 200<br>Oakbrook Terrace, IL 60181<br>1(630)472-7700 |
| Third Party Administrator (TPA): | Planned Administrators, Inc. (PAI)<br>P.O. Box 6702<br>Columbia, SC 29260<br>1(866)798-0803 (Toll Free)<br>8:30 a.m. – 8:00 p.m. Eastern Standard Time(EST) |
| Plan Year/Policy Year: | Begins January 1st of each year and continues for 12 consecutive months, ending on December 31st of the same year. |

### DISCLAIMER

**Benefits under the Plan are provided pursuant to insurance contracts between the Employer/Plan Sponsor and the Insurance Company. If the terms of this SPD conflict with the terms of the Plan or the insurance contracts, the terms of the Plan and the insurance contract will control, unless superseded by applicable law.**

### CONFORMITY WITH THE LAW

**If any provision of this Plan is contrary to any law to which it is subject, such provision is hereby amended to conform thereto. Nothing in this Plan is intended to replace or affect any requirements for coverage by workers' compensation insurance.**

# **NOTICES TO EMPLOYEES**

## NOTICE: Preferred Provider Organization (PPO)

- Medical – **First Health Network**

As a selective consumer concerned with health care costs, it would benefit you through added discounts to visit providers who **participate within the First Health Network for medical services**. However, in order to realize these potential discounts, before you receive services or supplies, you should verify whether or not your provider is participating by:

**ALWAYS** asking the provider the following question:

- **"Do you participate within the First Health Network PPO?"**

## Prior Authorization

For **Prior Authorization** for **Covered Services Listed Below**, please call **1-844-213-6893**:

- Inpatient Confinement
- Inpatient & Outpatient Surgery
- Chemotherapy
- Diagnostic Services (CAT scan, MRI, PET scan)
- Mental Health Disorders or Substance Abuse Programs
- Pediatric Orthodontic Dental Services
- Rehabilitative & Transplant Services

## NOTICE: Prescription Drug Network

Your health plan has chosen the OptumRx network of pharmacies to serve you. OptumRx is an independent company that also provides pharmacy benefits on behalf of your plan.

For inquiries regarding your prescription drug benefits, please call PAI toll-free at **1-866-798-0803**.

To find a network location near you visit www.paisc.com, log in with your group number (on your ID card), then click on the OptumRx link. You may also call PAI at 1(866) 798-0803.

***To use the OptumRx Prescription Drug Discount, visit or call a participating network location.***

## INTRODUCTION, GROUP MAJOR MEDICAL EXPENSE PLAN, Essential StaffCARE

**Employer Solutions Group LLC** (the "Employer") is pleased to sponsor a welfare benefit plan (the "Plan") for you and your fellow eligible employees. References to "you" and "your" throughout this SPD refer to you as the employee who may be entitled to benefits under the Plan.

**The Plan provides the following benefits:**

Medical (including prescription drugs).

### Summary Plan Description

This document is a summary plan description ("SPD"). It provides a summary of the major provisions and benefits of the Plan. It is also intended to inform you of some of the Plan's limitations and exclusions and your rights as a participant. Because this is only a summary, it has not been written with all of the technical words and legal phrases used in the official Plan documents, insurance contracts and other Plan materials. For full details about the Plan and any of the insurance contracts that provide benefits under the Plan, please consult your human resource representative, the Plan Administrator or Planned Administrators, Inc. (PAI).

### Employee Welfare Benefit Plan

The Plan is intended to be a program of benefits constituting an "Employee Welfare Benefit Plan" under the Employee Retirement Income Security Act of 1974 (ERISA) and any amendments thereto.

### Use of Third Party Administration

Your Employer has selected group major medical expense coverage underwritten by BCS Insurance Company and administered by Planned Administrators, Incorporated (PAI) - experienced in processing and paying medical claims and providing consulting services in connection with the operation of these benefits. Your Third Party Administrator (TPA), PAI, is located in Columbia, South Carolina. PAI is a TPA who provides record keeping and claims processing services for BCS Insurance Company. As a TPA, PAI has no discretionary powers under the Plan and, in particular, has no discretionary power in the paying or denying of claims.

**PAI is committed to helping you understand your coverage and obtain maximum benefits on your claims. If you have questions about your coverage, you may call between 8:30 a.m. and 8:00 p.m. Eastern Standard Time (EST) or write PAI at the following:**

**Planned Administrators, Inc.**
**Attn: Claims**
**P.O. Box 6702**
**Columbia, SC 29260**
**1(866)798-0803**
**www.paisc.com**

## MAKING CHANGES TO HEALTH INSURANCE BENEFITS

Please read the information below carefully to determine when and how you may make changes to your pre-tax insurance benefits. If you enrolled in pre-tax benefits when you completed an application for employment but did not have an assignment, you have up to thirty (30) days from the first date of your first assignment to make changes. If you did not have an assignment in the first thirty (30) days of employment, then you have an additional thirty (30) days from the date of your first paycheck to make changes.

As you are enrolled in a pre-tax plan, once your coverage begins you will only be able to make coverage changes during the plan year due to a qualifying life event or you may wait until a subsequent open enrollment period.

The following are considered qualifying life events for changes in coverage:

- Your current health care coverage will no longer be offered;
- You move to a new area that offers you different plans, or isn't covered by your current network;
- You get married, legally separated or divorced;
- You have or adopt a child;
- You lose other health coverage due to job loss, a decrease in work hours, end of COBRA coverage or other reasons;
- You become a U.S. citizen;
- Your income changes, or some other event changes your income or household status; or
- You are no longer covered on a family member's policy because you turned 26 or the policy holder has passed away.

In addition, you may request a special enrollment (for yourself and/or eligible dependents) within sixty (60) days (1) of termination of coverage under Medicaid or a State Children's Health Insurance Program (SCHIP), or (2) upon becoming eligible for SCHIP premium assistance this medical benefit. You are required to provide supporting documentation to your employer for their review and approval for QLEs.

You can make changes by contacting customer service at **(866) 798-0803**.

## PLAN ADMINISTRATION

### Plan Funding/Administration

All Plan benefits are provided on a fully insured basis through a group insurance contract between BCS Insurance Company and the Plan Sponsor (identified under **Administrative Information**). Participants are responsible for all required premiums. BCS Insurance Company is the insurance underwriter of the Group Major Medical Expense Plan.

Claims for benefits are sent to Planned Administrators, Incorporated in accordance with the Plan's claims procedures. BCS Insurance Company is responsible for paying claims, not the Employer. BCS Insurance Company is responsible for determining eligibility for and the amount of benefits payable under the Plan and for prescribing, implementing and complying with claims procedures established to determine benefits under the Plan.

If you have any questions regarding eligibility or benefits provided under the insurance contract, please contact Planned Administrators, Inc.

### Contributions to the Plan

Contributions to the Plan will be either:

- Contributory - the Employer pays 100% of the cost of coverage in excess of the calculated safe harbor.
- Non-contributory - all premiums are paid by the insured.

Please contact the Essential StaffCare customer service center at **866-798-0803** if you have questions regarding your premium payment.

## ELIGIBILITY AND PARTICIPATION IN THE PLAN

All active regular full-time employees who are 18 years of age or older with a valid Social Security Number (SSN) are eligible for medical benefits as defined by the Employer. Please see Certificate for details.

There are certain exceptions to the annual enrollment requirement. If you declined coverage (for yourself, and/or eligible dependents) at a time of eligibility due to the fact that you, and/or eligible dependents were covered under another plan, and that health coverage is terminated as a result of loss of eligibility for the coverage (including as a result of legal separation, divorce, death, termination of employment, or reduction in the number of hours of employment) or employer contributions towards such coverage were terminated, you can request a special enrollment within 31 days of the loss of coverage. In addition, you may request a special enrollment (for yourself, and/or eligible dependents) within 60 days (1) of termination of coverage under Medicaid or a State Children's Health Insurance Program (SCHIP), or (2) upon becoming eligible for SCHIP premium assistance under this medical benefit. Please consult with your human resource personnel, the Plan Administrator, or Third Party Administrator (PAI) if you are interested in obtaining medical benefits and think one of these situations may apply to you.

**If you have questions concerning eligibility for benefits, please contact your human resource personnel or PAI.**

## TERMINATION OF COVERAGE

Your benefits will terminate, except for COBRA continuation coverage, as described below. In addition, benefits will also terminate the date the employee becomes eligible for another group health benefit program sponsored by the Employer, other than the Plan, regardless of whether the employee participates in such program.

Your eligible dependents' coverage will terminate, except for any COBRA continuation coverage, as described below. In addition, benefits will terminate the date your eligible dependents become eligible as a covered employee for another group health benefit program.

Except for those benefits that provide COBRA continuation coverage referenced within this SPD:

**A. Your coverage will terminate:**

- on the last day for which premium payment is made following termination of employment or you otherwise cease to be eligible for coverage;
- on the last day for which a premium payment was made if you fail to remit, when due, the required premium payment for your coverage;
- on the termination date of the benefit;
- on the date that you enter into an armed service on full-time active duty. For information on continuing benefits after entering into an armed service on active duty, refer to the Uniformed Services Employment and Re-Employment Rights Act (USERRA) on the following page; or
- for any other reason as set forth in the benefit summaries, insurance contracts or other governing documents for each applicable benefit.

**B. Coverage for your covered Dependents will also terminate on the day:**

- on which your coverage is terminated;
- following the last day for which required premium payments are made for Dependent coverage;
- that you cease to be in a class eligible for Dependent coverage;
- that a covered Dependent ceases to meet the definition of a Dependent;
- coverage for your Dependents is discontinued under the Plan;
- the termination date of the benefit; or
- for any other reason as set forth in the benefit summaries, insurance contracts or other governing documents for each applicable benefit.

In no case will Dependent coverage terminate later than the coverage of the employee.

Certain requirements must be met to continue coverage beyond the age limit for a child. Please consult your human resource representative or PAI for more information concerning these requirements.

### Extension of Coverage, Other than COBRA

In some limited circumstances, and as governed by state law, you may be entitled to extended coverage if you lose your coverage and do not elect COBRA (or when your COBRA continuation ends). At such time, you should contact the ERISA Plan Administrator to determine what rights, if any, you might have.

### Uniformed Services Employment and Re-Employment Rights Act (USERRA)

USERRA requires employers to offer continuation of coverage for Plan participants when called to serve in the military. If you are called to military duty for more than thirty (30) days, you may elect to continue Employer-sponsored health care for yourself and your eligible dependents for up to twenty-four (24) months, but you may be required to pay up to 102% of the applicable premium. The Employer shall be required to provide coverage for you as though you had remained on the job if you are out on military service for less than thirty-one (31) days. In this case, you will be charged only your share of the premium. Upon your return to work, you will be reinstated with no new waiting periods. However, pre-existing condition waiting periods can be imposed for any condition that occurred as a direct result of the military service.

## EMPLOYMENT RETIREMENT INCOME SECURITY ACT OF 1974 (ERISA)

As a Participant in the Plan, you are entitled to certain rights and protections under the Employment Retirement Income Security Act (ERISA) of 1974.

ERISA provides that all Plan participants shall be entitled to:

a) Examine, without charge at the Plan Administrator's office, all Plan documents and copies of all documents filed by the Plan with the U.S. Department of Labor and available at the Public Disclosure Room of the Employee Benefits Security Administration (EBSA).

b) Obtain copies of all Plan documents and other Plan information upon written request to the Plan Administrator. The Plan Administrator may make a reasonable charge for the copies.

c) Receive a summary of the Plan's annual financial reports. The Plan Administrator is required by law to furnish each participant with a copy of this Summary Annual Report.

In addition to creating rights for Plan participants, ERISA imposes duties upon the people who are responsible for the operations of the employee benefit plan. The people who operate your Plan, called "fiduciaries" of the Plan, have a duty to do so prudently and in the interest of you and other Plan participants and beneficiaries. No one, including your Employer, or any other person, may fire you or otherwise discriminate against you in any way to prevent you from obtaining a welfare benefit or exercising your rights under ERISA.

If your claim for a welfare benefit is denied in whole or in part, you have a right to know why this was done. You have the right to obtain copies of documents relating to the decision without charge. You have the right to have the Plan review and reconsider your claim. Certain time schedules apply to these decisions.

Under ERISA, there are steps you can take to enforce the above rights. For instance, if you request materials from the Plan and do not receive them within 30 days, you may file suit in a Federal court. In such a case, the court may require the Plan Administrator to provide the materials and pay you up to $110 a day until you receive the materials unless the materials were not sent because of reasons beyond the control of the Plan Administrator. If you have a claim for benefits, which is denied or ignored, in whole or in part, you may file suit in a State or Federal court so long as you have exhausted the Plans claims procedures. No such action can be brought against the Employer more than three years after it receives a claim. In addition, if you disagree with the Plan's decision or lack thereof concerning the qualified status of a medical child support order, you may file suit in Federal court. If it should happen that Plan fiduciaries misuse the Plan's money, or if you are discriminated against for asserting your rights, you may seek assistance from the U.S. Department of Labor or you may file suit in a Federal court. The court will decide who should pay court costs and legal fees. If you are successful, the court may order the person you have sued to pay these costs and fees. If you lose, the court may order you to pay these costs and fees; for example, if it finds your claim is frivolous.

You may be eligible to continue health coverage for yourself or eligible dependents if there is a loss of coverage under the Plan as a result of a qualifying event. You and your dependents may have to pay for such coverage. Review this SPD and the documents governing the Plan on the rules governing your COBRA continuation coverage rights.

You may be eligible to reduce or eliminate exclusionary periods of coverage for pre-existing conditions under your group health plan if you have had creditable coverage under a previous plan. A certificate of creditable coverage should be provided to you, free of charge, from your group health plan or health insurance issuer when you lose coverage under the Plan, when you become entitled to elect COBRA continuation coverage, when your COBRA continuation coverage ceases, if you request it before losing coverage, or if you request it up to 24 months after losing coverage.

If you have any questions about your Plan, you should contact the Plan Administrator or PAI. If you have any questions about this statement or about your rights under ERISA, you should contact the nearest office of the Employee Benefits Security Administration, U.S. Department of Labor, listed in your telephone directory or the Division of Technical Assistance and Inquiries, Employee Benefits Security Administration, U.S. Department of Labor, 200 Constitution Avenue N.W., Washington D.C. 20210. You may also obtain certain publications about your rights and responsibilities under ERISA by calling the publications hotline of the Employee Benefits Security Administration.

## OTHER PROVISIONS

### Employment Rights

Under no circumstances does the maintenance of the Plan, the provision of benefits under the Plan or under any insurance contract or agreement, or this SPD constitute a contract of employment or modify, alter or affect the terms of employment of any participant or employee of the Employer. In addition, the provisions of this SPD do not constitute a contractual agreement as to the terms and conditions of your employment.

### Plan Amendment or Termination

Although it is the intent of the Employer to continue the Plan indefinitely, the Employer reserves the right to modify, amend or terminate the Plan or any benefit programs or coverage under the Plan, any group insurance contract, and/or any other agreement or contract associated with the Plan at any time.

### Misstatement of Age

If age is a factor in determining eligibility or amount of coverage and there has been a misstatement of age, the coverage or amount of benefits, or both, for which the person is covered shall be adjusted in accordance with the covered individual's true age. Any such misstatement of age shall neither continue coverage otherwise validly terminated nor terminate coverage otherwise validly in force. Contributions and benefits will be adjusted on the contribution due date next following the date of the discovery of such misstatement.

### Women's Health And Cancer Rights Act Of 1998

The Plan provides, in the case of a participant or covered Dependent who is receiving benefits in connection with a mastectomy, and who elects breast reconstruction in connection with such mastectomy, coverage for:

A. Reconstruction of the breast on which the mastectomy has been performed;
B. Surgery and reconstruction of the other breast to produce a symmetrical appearance; and
C. Prosthesis and treatment for physical complications at all stages of mastectomy, including lymphedemas.

The Plan's Benefit Limitations as outlined in the benefit summaries will apply to these benefits.

### Newborns' and Mothers' Health Protection Act of 1996

Group health plans and health 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 section. However, Federal law generally does not prohibit the mother's or newborn's attending provider, after consulting with the mother, from discharging the mother or her newborn earlier than 48 hours (or 96 hours as applicable). In any case, the Plan and the insurance company may not, under Federal law, require that a provider obtain authorization from the Plan or the insurance company for prescribing a length of stay not in excess of 48 hours (or 96 hours).

### Qualified Medical Child Support Order (QMCSO)

The term Medical Child Support Order means any judgment, decree or order (including approval of a settlement agreement) issued by a court of competent jurisdiction which:

A. Provides for child support with respect to a child of a participant under the Plan or provides for health benefits coverage to such a child, is made pursuant to a State domestic relations law (including a community property law), and relates to benefits under the Plan, or
B. Enforces a law relating to medical child support described in section 1908 of the Social Security Act (as added by section 13822 of the Omnibus Budget Reconciliation Act of 1993) with respect to a group health plan.

For further information on QMCSOs please contact Essential StaffCARE at 1(866)798-0803 between 8:30 a.m. and 8:00 p.m. EST. A copy of the QMCSO procedures for the Plan is available without charge from the Plan Administrator.

## Genetic Information Nondiscrimination Act of 2008 (GINA)

Under GINA, an insurance provider or your employer may not discriminate against you on the basis of genetic information, including by adjusting premiums and contribution amounts.

## Mental Health Parity and Addiction Equity Act of 2008 (MHPAEA)

If the Plan (1) provides for both medical and surgical mental health or substance use disorder benefits and (2) is not subject to an increased cost exemption (within the meaning of the MHPAEA):

- The health insurance option may not apply annual or lifetime limits for mental health or substance use disorders that are lower than those for medical and surgical benefits.
- The medical insurance option may not apply more restrictive financial requirements or treatment limitations to mental health or substance use disorder benefits in any classification than the predominant limitations applied to substantially all of the medical and surgical benefits in any classification.
- The criteria for medical necessity determinations made under any health insurance option with respect to mental health or substance use disorder benefits shall be made available by the Plan Administrator (in accordance with the MHPAEA) to any current or potential participant upon request.
- The reason for any denial under the Plan or reimbursement or payment for services with respect to mental health or substance use disorder benefits in the case of any participant shall, on request or as otherwise required under the MHPAEA, be made available by the Plan Administrator to the participant in accordance with the claims procedures applicable to the group medical coverage feature.
- The Plan shall be operated and construed in all respects in compliance with the MHPAEA.

“Mental health benefits” and “substance use disorder benefits” is defined in the medical benefit contract of the Plan, pursuant to applicable state and federal law, and consistent with generally recognized standards of current medical practice.

## 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're eligible for health coverage from your employer, your state may have a premium assistance program that can help pay for coverage, using funds from their Medicaid or CHIP programs. If you or your children aren't eligible for Medicaid or CHIP, you won't be eligible for these premium assistance programs but you may be able to buy individual insurance coverage through the Health Insurance Marketplace. For more information, visit **www.healthcare.gov**.

If you or your dependents are already enrolled in Medicaid or CHIP and you live in a State listed below, 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, 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, ask your state if it has a program that might help you pay the premiums for an employer-sponsored plan.

If you or your dependents are eligible for premium assistance under Medicaid or CHIP, as well as eligible under your employer plan, your employer must allow you to enroll in your employer plan if you aren't 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, contact the Department of Labor at **www.askebsa.dol.gov** or call **1-866-444-EBSA (3272)**.

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**If you live in one of the following states, you may be eligible for assistance paying your employer health plan premiums. The following list of states is current as of July 31, 2019. Contact your State for more information on eligibility –**

| ALABAMA – Medicaid | FLORIDA – Medicaid |
|---|---|
| Website: http://myalhipp.com/<br>Phone: 1-855-692-5447 | Website: http://flmedicaidtplrecovery.com/hipp/<br>Phone: 1-877-357-3268 |
| **ALASKA – Medicaid** | **GEORGIA – Medicaid** |
| The AK Health Insurance Premium Payment Program<br>Website: http://myakhipp.com/<br>Phone: 1-866-251-4861<br>Email: CustomerService@MyAKHIPP.com<br>Medicaid Eligibility:<br>http://dhss.alaska.gov/dpa/Pages/medicaid/default.aspx | Website: https://medicaid.georgia.gov/health-insurance-premium-payment-program-hipp<br>Phone: 678-564-1162 ext 2131 |
| **ARKANSAS – Medicaid** | **INDIANA – Medicaid** |
| Website: http://myarhipp.com/<br>Phone: 1-855-MyARHIPP (855-692-7447) | Healthy Indiana Plan for low-income adults 19-64<br>Website: http://www.in.gov/fssa/hip/<br>Phone: 1-877-438-4479<br>All other Medicaid<br>Website: http://www.indianamedicaid.com<br>Phone 1-800-403-0864 |
| **COLORADO – Health First Colorado (Colorado's Medicaid Program) & Child Health Plan Plus (CHP+)** | **IOWA – Medicaid** |
| Health First Colorado Website:<br>https://www.healthfirstcolorado.com/<br>Health First Colorado Member Contact Center:<br>1-800-221-3943/ State Relay 711<br>CHP+: https://www.colorado.gov/pacific/hcpf/child-health-plan-plus<br>CHP+ Customer Service: 1-800-359-1991/ State Relay 711 | Website:<br>http://dhs.iowa.gov/Hawki<br>Phone: 1-800-257-8563 |

| KANSAS – Medicaid | NEW HAMPSHIRE – Medicaid |
|---|---|
| Website: http://www.kdheks.gov/hcf/<br>Phone: 1-785-296-3512 | Website: https://www.dhhs.nh.gov/oii/hipp.htm<br>Phone: 603-271-5218<br>Toll free number for the HIPP program: 1-800-852-3345, ext 5218 |
| **KENTUCKY – Medicaid** | **NEW JERSEY – Medicaid and CHIP** |
| Website: https://chfs.ky.gov<br>Phone: 1-800-635-2570 | Medicaid Website:<br>http://www.state.nj.us/humanservices/dmahs/clients/medicaid/<br>Medicaid Phone: 609-631-2392<br>CHIP Website:<br>http://www.njfamilycare.org/index.html<br>CHIP Phone: 1-800-701-0710 |
| **LOUISIANA – Medicaid** | **NEW YORK – Medicaid** |
| Website:<br>http://dhh.louisiana.gov/index.cfm/subhome/1/n/331<br>Phone: 1-888-695-2447 | Website:<br>https://www.health.ny.gov/health_care/medicaid/<br>Phone: 1-800-541-2831 |
| **MAINE – Medicaid** | **NORTH CAROLINA – Medicaid** |
| Website: http://www.maine.gov/dhhs/ofi/public-assistance/index.html<br>Phone: 1-800-442-6003<br>TTY: Maine relay 711 | Website: https://medicaid.ncdhhs.gov/<br>Phone: 919-855-4100 |
| **MASSACHUSETTS – Medicaid and CHIP** | **NORTH DAKOTA – Medicaid** |
| Website:<br>http://www.mass.gov/eohhs/gov/departments/masshealth/<br>Phone: 1-800-862-4840 | Website:<br>http://www.nd.gov/dhs/services/medicalserv/medicaid/<br>Phone: 1-844-854-4825 |
| **MINNESOTA – Medicaid** | **OKLAHOMA – Medicaid and CHIP** |
| Website:<br>https://mn.gov/dhs/people-we-serve/seniors/health-care/health-care-programs/programs-and-services/other-insurance.jsp<br>Phone: 1-800-657-3739 | Website: http://www.insureoklahoma.org<br>Phone: 1-888-365-3742 |
| **MISSOURI – Medicaid** | **OREGON – Medicaid** |
| Website:<br>http://www.dss.mo.gov/mhd/participants/pages/hipp.htm<br>Phone: 573-751-2005 | Website:<br>http://healthcare.oregon.gov/Pages/index.aspx<br>http://www.oregonhealthcare.gov/index-es.html<br>Phone: 1-800-699-9075 |
| **MONTANA – Medicaid** | **PENNSYLVANIA – Medicaid** |
| Website:<br>http://dphhs.mt.gov/MontanaHealthcarePrograms/HIPP<br>Phone: 1-800-694-3084 | Website:<br>http://www.dhs.pa.gov/provider/medicalassistance/healthinsurancepremiumpaymenthippprogram/index.htm<br>Phone: 1-800-692-7462 |
| **NEBRASKA – Medicaid** | **RHODE ISLAND – Medicaid and CHIP** |
| Website: http://www.ACCESSNebraska.ne.gov<br>Phone: (855) 632-7633<br>Lincoln: (402) 473-7000<br>Omaha: (402) 595-1178 | Website: http://www.eohhs.ri.gov/<br>Phone: 855-697-4347, or 401-462-0311 (Direct RIte Share Line) |

| NEVADA – Medicaid | SOUTH CAROLINA – Medicaid |
|---|---|
| Medicaid Website: https://dhcfp.nv.gov<br>Medicaid Phone: 1-800-992-0900 | Website: https://www.scdhhs.gov<br>Phone: 1-888-549-0820 |
| **SOUTH DAKOTA - Medicaid** | **WASHINGTON – Medicaid** |
| Website: http://dss.sd.gov<br>Phone: 1-888-828-0059 | Website: https://www.hca.wa.gov/<br>Phone: 1-800-562-3022 ext. 15473 |
| **TEXAS – Medicaid** | **WEST VIRGINIA – Medicaid** |
| Website: http://gethipptexas.com/<br>Phone: 1-800-440-0493 | Website: http://mywvhipp.com/<br>Toll-free phone: 1-855-MyWVHIPP (1-855-699-8447) |
| **UTAH – Medicaid and CHIP** | **WISCONSIN – Medicaid and CHIP** |
| Medicaid Website: https://medicaid.utah.gov/<br>CHIP Website: http://health.utah.gov/chip<br>Phone: 1-877-543-7669 | Website: https://www.dhs.wisconsin.gov/publications/p1/p10095.pdf<br>Phone: 1-800-362-3002 |
| **VERMONT– Medicaid** | **WYOMING – Medicaid** |
| Website: http://www.greenmountaincare.org/<br>Phone: 1-800-250-8427 | Website: https://wyequalitycare.acs-inc.com/<br>Phone: 307-777-7531 |
| **VIRGINIA – Medicaid and CHIP** | |
| Medicaid Website: http://www.coverva.org/programs_premium_assistance.cfm<br>Medicaid Phone: 1-800-432-5924<br>CHIP Website: http://www.coverva.org/programs_premium_assistance.cfm<br>CHIP Phone: 1-855-242-8282 | |

To see if any other states have added a premium assistance program since July 31, 2019, or for more information on special enrollment rights, contact either:

U.S. Department of Labor
Employee Benefits Security Administration
**www.dol.gov/agencies/ebsa**
1-866-444-EBSA (3272)

U.S. Department of Health and Human Services
Centers for Medicare & Medicaid Services
**www.cms.hhs.gov**
1-877-267-2323, Menu Option 4, Ext. 61565

## Paperwork Reduction Act Statement

According to the Paperwork Reduction Act of 1995 (Pub. L. 104-13) (PRA), no persons are required to respond to a collection of information unless such collection displays a valid Office of Management and Budget (OMB) control number. The Department notes that a Federal agency cannot conduct or sponsor a collection of information unless it is approved by OMB under the PRA, and displays a currently valid OMB control number, and the public is not required to respond to a collection of information unless it displays a currently valid OMB control number. See 44 U.S.C. 3507. Also, notwithstanding any other provisions of law, no person shall be subject to penalty for failing to comply with a collection of information if the collection of information does not display a currently valid OMB control number. See 44 U.S.C. 3512.

The public reporting burden for this collection of information is estimated to average approximately seven minutes per respondent. Interested parties are encouraged to send comments regarding the burden estimate or any other aspect of this collection of information, including suggestions for reducing this burden, to the U.S. Department of Labor, Employee Benefits Security Administration, Office of Policy and Research, Attention: PRA Clearance Officer, 200 Constitution Avenue, N.W., Room N-5718, Washington, DC 20210 or email ebsa.opr@dol.gov and reference the OMB Control Number 1210-0137.

## PREFERRED PROVIDER ORGANIZATION (PPO)

The Preferred Provider Organization (PPO) for the participants with medical benefits under the Plan is:

- **First Health Network**

PPO Providers are hospitals, skilled nursing facilities, home health agencies, hospice, doctors and other providers of medical services and supplies who have a written agreement with the above referenced network.

**The PPO Providers will file all claims for covered services or supplies with PAI for you.**

You will receive discounted rates when you use PPO Providers for services. **You will pay more if you do not use PPO Providers.** You will receive Non-PPO rates for providers (such as the radiologist, anesthesiologist, etc.) who are not in the preferred network, even if the hospital is a preferred provider. It is in your best interest for you to make sure that all of your providers are participating providers within the appropriate PPO Network referenced by state above. The **NOTICE** on Page 1 has additional information on how to find out if your provider is a PPO Provider.

**Non-PPO Providers can bill you their total charge. They may ask you to pay the total amount of their charges at the time you receive services or supplies and you will have to file your own claims.**

## CLAIM FILING PROCEDURES

### How to file your claims

- If you receive healthcare or supplies from a PPO Provider, the Provider will file your claims for you.
- If you receive healthcare services or supplies from a Non-Network Provider, you will have to file your own claims using the Medical Claim Form.
- If you receive outpatient prescription drug benefits, please refer to Part III, Description of Covered Services, Outpatient Prescription Drug Benefit section in the attached certificate.

Please follow the instructions below when you have claims for expenses. When filing your own claims, here are some things you will need:

1. Medical Claim Form for each patient. You can get these forms from your Employer's benefits department, in the FORMS section attached at the end of this SPD, or you may print them from the Essential StaffCARE website at www.paisc.com.
2. Itemized bills from the providers. These bills should include:
   A. Provider's name and address and Tax Identification number;
   B. Patient's name and date of birth;
   C. Your ID number;
   D. Description (applicable CPT, dental, vision or NDC drug procedure code) and charge/cost for each service;
   E. Date that each service took place; and
   F. Description of the illness or injury (ICD-9 diagnosis code).

Complete the front of each claim form and attach the itemized bills to it.

Before you submit your claims, we suggest you make copies of all claim forms and itemized bills for your records since we cannot return them to you. Send your claims to PAI at the address found on the bottom of the claim form.

## Authorized Representative

Unless expressly permitted under the protection of the ERISA regulations and the Health Insurance Portability and Accountability Act of 1996 (HIPAA), your protected health information (PHI) cannot be released to an individual without your consent. There are instances when a family member or representative needs to discuss your protected health information or receive an explanation of benefits to help manage your care. In order to comply with these regulations and to protect your privacy, a written authorization or a completed Authorized Representative Form is required. Please visit the Essential StaffCARE website at www.paisc.com and click FORMS on the left. You can print this form and mail to the PAI address. You can also call 1(866)798-0803 for a form to complete.

## Time Limits to File a Claim

Claims must be filed no later than ninety (90) days from the incurred date of service you and/or eligible dependents receive services or supplies. We will not deny nor reduce any claim if it was not reasonably possible to give proof of loss in the time required. In any event, proof must be given within one (1) year after it is due, unless you are legally incapable of doing so.

## Denial of Claims

If we deny any part or all of a claim, you will receive an adverse benefit determination notice known as an explanation of benefits (EOB) explaining the reasons for the claim denial.

If you do not understand why we denied your claim, you can:

- Read the information in this SPD. It outlines the terms and conditions of your health coverage; and
- Contact PAI at 1(866)798-0803 between 8:30 a.m. and 8:00 p.m. Eastern Standard Time (EST).

**Appeal Procedures**

If you wish to file a formal appeal, you must write to:

**Essential StaffCARE**
**Attention: Claims Appeal**
**P.O. Box 6702**
**Columbia, SC 29260**

The letter must state that a formal appeal has been requested and all pertinent information regarding the claim in question must also be included in the letter.

# PRIVACY NOTICE

This notice describes BCS Insurance Company's privacy practices in compliance with the Health Insurance Portability and Accountability Act of 1996 (HIPAA) and the regulations that implement HIPAA.

## Our Legal Duty

HIPAA requires us to maintain the privacy of information we use and maintain about you (your medical information). We are required to give you this notice about our privacy practices, our legal duties, and your rights concerning your medical information. We also must inform you of a breach involving your unsecured medical information. We must follow the privacy practices that are described in this notice while it is in effect. This notice takes effect **July 1, 2013**, and will remain in effect until we replace it.

We reserve the right to change our privacy practices and the terms of this notice at any time. Any new terms will be effective for all medical information that we maintain, including medical information we create or receive before we make the changes. Before we make a significant change in our privacy practices, we will change this notice and post our new notice on our website. We will provide information about changes to the notice and how to obtain the notice in our next annual mailing to our health plan subscribers at the time of the change.

You may request a copy of our notice at any time. For more information about our privacy practices, or for additional copies of this notice, please contact us using the information listed at the end of this notice.

### Uses and Disclosures of Medical Information

We use and disclose medical information about you for the following purposes:

**Treatment:** We may use and disclose your medical information for treatment. For example, we may disclose your medical information to a physician or other health care provider who is providing treatment to you.

**Payment:** We may use and disclose your medical information to pay for benefits or to obtain premiums. For example, we pay claims to physicians, hospitals and other providers for services delivered to you that are covered by your health plan. We also use and disclose your medical information to establish your eligibility for benefits, to determine medical necessity, and to issue explanations of benefits. We may disclose your medical information to a health care provider or entity subject to HIPAA so they can engage in these type of payment activities.

**Health Care Operations:** We may use and disclose your medical information in connection with our everyday work activities (health care operations). These operations include, for example, customer service, resolution of grievances, quality assessment and improvement activities, and fraud and abuse detection and compliance. They also include underwriting, enrollment, and other activities related to creating, renewing, or replacing a benefits plan. We may not, however, use or disclose genetic information for underwriting purposes. In limited circumstances, we may disclose your medical information to another entity subject to HIPAA so they can engage in their own health care operations.

**Required or Permitted by Law:** We may use or disclose your medical information when required by law, such as in response to a court order or for government health oversight activities (*i.e.*, inquiries from a State Department of Insurance). In limited circumstances, we may also give out medical information as permitted by law, such as for public health purposes (*i.e.*, reporting disease outbreaks), law enforcement purposes, research studies, to avoid a serious and imminent threat to health or safety, to create de-identified information, and for emergencies.

**To You or Others Involved In Your Care:** We may use or disclose your medical information to provide information to you or to a family member, friend or other person to help with your health care or with payment for your health care. Before we disclose your medical information to a family member, friend or other person, we will provide you with an opportunity to object to the use or disclosure. If you are not present, or in the event of your incapacity or an emergency, we will disclose your medical information based on our professional judgment of whether the disclosure is in your best interest.

**Plan Sponsors:** If you are a participant in a group health plan, we may disclose summary information about the enrollees in your plan to the employer (or other organization that sponsors your plan) to use to obtain premium bids for the health insurance coverage offered through your plan or to decide whether to modify, amend or terminate your plan. Summary information is partially de-identified information about claims history, claims expenses, or types of claims experienced by plan enrollees. If the employer (or other plan sponsor) takes appropriate steps to comply with HIPAA, we may disclose medical information of individuals enrolled in your plan to the plan sponsor to permit the plan sponsor to perform plan administration functions. If this is the case, your group health plan will publish its own notice describing how it uses and disclosures your medical information.

**Situations Other Than Those Above:** Except as described in this notice, we may not use or disclose your medical information without your written authorization. You may give us written authorization to use your medical information or to disclose it to anyone for any purpose. If you give us written authorization, you may revoke it at any time by notifying us of your revocation in writing. Your revocation will not affect any use or disclosure permitted by the authorization while it was in effect. We need your written authorization to use or disclose psychotherapy notes, except in limited circumstances such as when the disclosure is required by law. We also must obtain your written authorization to sell information about you to a third party or, in most circumstances, to use or disclose your medical information to send you communications about products and services. We do not need your written authorization, however, to send you communications about health related products or services, as long as the products or services are associated with your coverage or are offered by us.

## Individual Rights

In most cases, you have the right to look at or get a copy of the medical information that we use to make decisions about you. If you request copies, we may charge you a reasonable, cost-based fee for the copies. You also have the right to receive a list of instances in which we have disclosed health information about you for reasons other than treatment, payment, health care operations, and certain other purposes. If you believe the records we maintain about you are incorrect or are missing important information, you have the right to request that we correct our records.

If you believe that you would be in danger if we send your medical information to the address we have for you in our records, you have the right to request that we communicate with you using alternative means or an alternative location. We will accommodate your request if the request (a) states that our communications could put you in danger, (b) is reasonable, (c) specifies the alternative means or location for communicating with you, and (d) permits us to continue collecting premiums and paying claims under your health plan.

Finally, you may request that we place additional restrictions on how we use or disclose your medical information. We will consider your request but are not legally required to agree to it.

All requests to exercise these rights must be made in writing by you and directed to the contact person named below.

## Your California Privacy Rights

If you are a California resident, California law may provide you with additional rights regarding our use of your personal information. To learn more about your California privacy rights, email privacyofficer@bcsigroup.com.

## Questions and Complaints

If you want more information about our privacy practices or have questions or concerns, please contact us using the information listed at the end of this notice. If you are concerned that we may have violated your privacy rights, you may complain to us using the contact information listed at the end of this notice. You may also submit a complaint to the U.S. Department of Health and Human Services. We will provide you with their address upon request. We will not retaliate in any way if you choose to file a complaint with us or with the U.S. Department of Health and Human Services. Privacy Officer at BCS Insurance Company 2 Mid America Plaza, Suite 200, Oakbrook Terrace, IL 60181 By phone: 833-227-4512, fax: 630-472-7822 or email: privacyofficer@bcsf.com.

**If you have a question, a general complaint or concern unrelated to your privacy (for example, to request information about your plan or to request an ID card) please contact PAI's Customer Service Team toll-free at 866-798-0803 by mail - PAI P.O. Box 6927 Columbia, SC 29260 or by Email at** paicomplianceteam@paisc.com.

# COBRA NOTICE

**IMPORTANT INFORMATION- PLEASE READ AND KEEP FOR YOUR RECORDS.**

**COBRA NOTICE **CONTINUATION COVERAGE RIGHTS UNDER COBRA****

**This notice describes how/when your coverage can be continued after a coverage loss and also provides additional information about other coverage options available to you. Please read it carefully.**

**There may be more affordable options available to you through the Health Insurance Marketplace, Medicaid or other group health plan coverage (such as a spouse's employer-sponsored plan). Be sure to compare all your options to COBRA continuation & select what's best for you/your family.**

**Visit/call the Health Insurance Marketplace at:** www.HealthCare.gov **/ 1-800-318-2596.**

**COBRA Continuation Introduction**

You are receiving this notice because you recently become covered under a Health Benefit Plan. This notice contains important information about your right to COBRA continuation coverage, a temporary extension of coverage under the Plan. The right to COBRA continuation coverage is created by federal law, called the Consolidated Omnibus Budget Reconciliation Act of 1985 (COBRA). COBRA continuation coverage becomes available to you & members of your family covered under the Plan when you otherwise lose health coverage.

**This notice summarizes COBRA continuation coverage, when it may become available to you, your family, & what to do to protect the rights.**

For more information about your rights, obligations under the Plan & under federal law, you should contact PAI at:

**PAI**
**P.O. Box 6839 Columbia, SC 29260**
**or call Toll-Free: 866-798-0803, 8:30 a.m. - 8:00 p.m. EST.**

**COBRA Continuation Coverage**

COBRA continuation coverage is a continuation of coverage when coverage otherwise ends because of a life event known as a "qualifying event" (specific qualifying events are listed below). COBRA continuation coverage is offered to each "qualified beneficiary", someone who loses coverage under the Plan because of a qualifying event. Depending on the type of qualifying event, employees, spouses of employees, & dependent children of employees may be a qualified beneficiary. Qualified beneficiaries who elect COBRA continuation coverage must pay the premium for it. If you are an employee, you become a qualified beneficiary if you lose coverage under the Plan due to one of the following qualifying events:

1) Your hours of employment are reduced, or
2) Your employment ends for any reason other than your gross misconduct.

A spouse of an employee is a qualified beneficiary if they lose coverage under the Plan because of any the following qualifying events:

1) The employee-spouse dies;
2) The spouse's hours of employment are reduced;
3) The spouse's employment ends for any reason other than his or her gross misconduct;
4) Your spouse becomes enrolled in Medicare (Part A, Part B, or both); or
5) You become divorced or legally separated from your spouse.

Your dependent children become qualified beneficiaries if they lose coverage under the Plan because any of the following qualifying events:

1) The parent-employee dies;
2) The parent-employee's hours of employment are reduced;
3) The parent-employee's employment ends for any reason other than his or her gross misconduct;
4) The parent-employee becomes enrolled in Medicare (Part A, Part B, or both);
5) The parents become divorced or legally separated; or
6) The child stops being eligible for coverage under the plan as a "dependent child."

Sometimes filing a proceeding in bankruptcy under Title 11 of the United States Code is a qualifying event. If a proceeding in bankruptcy is filed, with respect to your employer and bankruptcy results in the loss of coverage of any retired employee covered under the Plan, the retired employee is a qualified beneficiary with respect to the bankruptcy. The retired employee's spouse, surviving spouse, & dependent children are also qualified beneficiaries in this case.

The Plan offers COBRA continuation to qualified beneficiaries only after PAI is notified of the occurrence of a qualifying event. When the qualifying event is the end of employment or reduction of hours of employment, death of the employee, or enrollment of the employee in Medicare (Part A, Part B, or both), the employer must notify PAI of the qualifying event. In addition, if the Plan provides retiree health coverage, then commencement of a proceeding in a bankruptcy with respect to the employer is also a qualifying event where the employer must notify PAI of the qualifying event.

**For other qualifying events including divorce, legal separation of employee & spouse or dependent child's loss of eligibility as a dependent, *you* must notify PAI within 60 days after the qualifying event occurs. You must send this notice to:**

**PAI Attn: COBRA**
**P.O. Box 6839**
**Columbia, SC 29260.**

Upon notice a qualifying event, COBRA continuation coverage will be offered to each of the qualified beneficiaries. For each qualified beneficiary who elects COBRA continuation coverage, COBRA continuation coverage will begin either (1) on the date of the qualifying event or (2) on the date that Plan coverage would otherwise have been lost, depending on the nature of the Plan.

COBRA continuation coverage is a temporary continuation of coverage. When the qualifying event is the death of the employee, enrollment of the employee in Medicare (Part A, Part B, or both), your divorce or legal separation, or a dependent child losing eligibility as a dependent child, COBRA continuation coverage lasts for up to 36 months.

When the qualifying event is the end of employment or reduction of the employee's hours of employment, COBRA continuation coverage lasts for up to 18 months. There are two ways in which this 18-month period of COBRA continuation coverage can be extended.

**Disability extension of 18-month period of continuation coverage**

**If you or your family member covered under the Plan is determined by the Social Security Administration to be disabled at any time during the first 60 days of COBRA continuation coverage & you notify PAI in a timely fashion, you & your entire family can receive up to an additional 11 months of COBRA continuation coverage, for a total maximum of 29 months. You must make sure that PAI is notified of the determination before the end of the 18-month period of COBRA continuation coverage.**

**This notice should be sent to:**

**PAI, Attn: COBRA**
**P.O. Box 6839**
**Columbia, SC 29260**

**Second qualifying event extension of 18-month period of continuation coverage**

If your family experiences another qualifying event while receiving COBRA continuation coverage, the spouse & dependent children in your family can get additional months of COBRA continuation coverage, up to a maximum of 36 months. This extension is available to the spouse & dependent children if the former employee dies, enrolls in Medicare (Part A, Part B, or both), gets divorced or legally separated.

The extension is also available to a dependent child when the child stops being eligible under the Plan as a dependent**. In all of these cases, you must make sure that PAI is notified of the second qualifying event within 60 days of the second qualifying event. This notice must be sent to:**

**PAI, Attn: COBRA**
**P.O. Box 6839**
**Columbia, SC 29260**

**Trade Act of 2002**
If you qualify for Trade Adjustment Assistance (TAA) as defined by the Trade Act of 2002, then you will be provided with an additional 60-day enrollment period, with continuation coverage beginning on the date of such TAA approval.

**If You Have Questions**
If you have questions about your COBRA continuation coverage, you should contact PAI's COBRA Unit or you may contact the nearest Regional or District Office of the U.S Department of Labor's Employee Benefits Security Administration (EBSA). Addresses and phone numbers of Regional and District EBSA Offices are available through EBSA's website at www.dol.gov/ebsa.

**Keep Your Plan Informed of Address Changes**
In order to protect your family's rights, you should keep the Plan informed of any family member address changes. You should also keep a copy of any notices you send to the Plan.

**HIPAA/COBRA RIGHTS**
The Health Insurance Portability and Accountability Act of 1996 (HIPAA) includes some provisions that may affect decisions you make about your participation in the Group Health Plan under the Consolidated Omnibus Budget Reconciliation Act of 1985 (COBRA). These provisions are as follows:

1. Under COBRA, if the qualifying event is a termination or reduction in hours of employment, affected qualified beneficiaries are entitled to continue coverage for up to 18 months after the qualifying event, subject to various requirements. Before HIPAA, this 18-month period could be extended for up to 11 months (for a total COBRA coverage period of up to 29 months from the initial qualifying event) if an individual was determined by the Social Security Administration, under the Social Security Act, to have been disabled at the time of the qualifying event and if the plan administrator was notified of that disability determination within 60 days of the determination and before the end of the original 18-month period.

Under HIPAA, if a qualified beneficiary is determined by the Social Security Administration to be disabled under the Social Security Act at any time during the first 60 days of COBRA coverage, the 11-month extension is available to all individuals who are qualified beneficiaries due to the termination or reduction in hours of employment. The disabled individual can be a covered employee or any other qualified beneficiary. However, to be eligible for the 11-month extension, affected individuals must still comply with the notification requirements in a timely fashion.

2. A child that is born to or placed for adoption with the covered employee during a period of COBRA coverage will be eligible to become a qualified beneficiary. In accordance with the terms of the employer's group health plan(s) and the requirements of Federal law, these qualified beneficiaries can be added to COBRA coverage upon proper notification to the Plan Administrator of the birth or adoption.

3. HIPAA restricts the extent to which group health plans may impose pre-existing condition limitations. Under COBRA, your right to continuation coverage terminates if you become covered by another employer's group health plan that does not limit or exclude coverage for your pre-existing conditions. If you become covered by another group health plan and that plan contains a pre-existing condition limitation that affects you, your COBRA continuation coverage cannot be immediately terminated. However, if the other plan's pre-existing condition rule does not apply to you by reason of HIPAA's restrictions on pre-existing condition clauses, the employer's group health plan(s) may terminate your COBRA coverage.

Essential StaffCARE

# Medical Claim Form

**Send Medical Claims to:**
**PAI**
**Attn: Claims**
**P.O. Box 6702**
**Columbia, SC 29260-6702**

## HOW TO FILE A MEDICAL CLAIM

**Claim payment may be delayed if information is incomplete or missing.**

Please note that HCFA and UB claim forms are available upon request from your provider.

_____**Part One – Attach itemized bills.**

Itemized bills are not balance due statements or Explanation of Benefits.

**Checklist to make sure all information required has been enclosed:**

- _____ **Doctor's name and address**
- _____ **Doctor's tax ID number**
- _____ **Patient's name**
- _____ **Diagnosis Code(s) ICD-9**
- _____ **Date of service**
- _____ **Charges/Cost of each treatment**
- _____ **Procedure Code(s) CPT-4**
- _____ **Place of service code**

_____**Part Two (Page 2) – to be complete signed and dated.**

To be completed by the Employee. Please note that employee signature, social security number, and authorization are required.

_____**Part Three – Keep a copy for your records.**

Mail your Medical claim form and itemized bills to:

**PAI, P.O. Box 6702 Columbia, South Carolina 29260**

**Questions?** Call Essential StaffCARE's toll-free Customer Service Line, 1-866-798-0803, Monday through Friday, 8:30 a.m. to 8:00 p.m. Eastern Time. A language line is available for translation for most languages.



Underwritten by BCS Insurance Company
Oakbrook Terrace, IL

Administered by Planned Administrators Inc.
Columbia, South Carolina

Form 1.620.20220427

# Medical Claim Form

**Send Medical Claims to:**
**PAI**
**Attn: Claims**
**P.O. Box 6702**
**Columbia, SC 29260-6702**

**Attach itemized bills providing complete information on:**

- Doctor's name and address • Doctor's tax identification number • Patient's name • Diagnosis Code ICD-9 • Date of service
- Charges/Cost of each treatment • Procedure Codes CPT-4 • Place of service code

**Note:** Itemized bills are not balance due statements or Explanation of Benefits.

**Please note: Incomplete forms and the absence of itemized bills may delay the processing of your claim**

## Section 1: Employee Information

Employee's Name: _____ SSN: _____
Last First Middle

Address: _____
Street City State ZIP

Telephone: _____ Employer Name: _____ Group No. ( from ID card): _____

## Section 2: Patient Information

Patient's Name: _____
Last First Middle

SSN: _____ Birth Date: _____ Sex ☐ Male ☐ Female

Relationship to Employee: ☐ Self ☐ Spouse ☐ Daughter ☐ Son ☐ Other: (specify): _____

If the patient is your child and over 25, is he or she dependent upon you for support? ☐ Yes ☐ No

## Section 3: Claim Information

Is the claim for an ☐ accident ☐ illness Is treatment a result of occupational illness or injury? ☐ Yes ☐ No

When did the accident or illness occur? _____ First date consulted for the diagnosis? _____

Please explain what you were treated for, and if it was an accident, provide details on how, when, and where it happened. (Attach a separate sheet of paper to to this form if necessary.) _____

## Section 4: Authorization

**Instructions:** The authorization should be completed and signed by the insured. If the insured in unable to sign, the authorization should be completed and signed by the legal guardian or next-of-kin.

To healthcare providers:

You are authorized to permit Planned Administrators, Inc., its Third Party Administrators, and any authorized representative to view and obtain copies of all records related to health care services rendered, health care advice, treatment or supplies provided to the patient including information related to mental illness, drug or alcohol treatment, HIV or AIDS. The information provided will only be used as it relates to the evaluation of claims for benefit payment.

I understand the information obtained will only be used by Planned Administrators, Inc. to determine eligibility for insurance and benefits claimed under the policy. I consent to disclosure of such information to reinsuring companies, the Medical Information Bureau and such other persons or organization performing business or legal services in connection with my claim, or as may be otherwise lawfully required. Such information will not be given, sold, transferred, or relayed to any other person not specified in this form without my consent. I understand this authorization may be revoked by written notice to Planned Administrators, Inc. but this revocation will not apply to information already released. If not revoked, this authorization will be valid while the claim is pending but not to exceed a maximum of two years from the date below. I know I may request to receive a copy of this authorization. I also agree that a photographic copy of this authorization shall be as valid as the original.

_____ _____ _____
**Signed** **Date** **Relationship to insured if signed by other than insured**

(If signed by other than the Insured, please print name and address, and include guardianship papers or other evidence of legal representation.)

_____ _____
**Name** **Address**

**Questions?** Call Essential StaffCARE's toll-free Customer Service Line, 1-866-798-0803, Monday through Friday, 8:30 a.m. to 8:00 p.m. Eastern Time. A language line is available for translation for most languages.



Underwritten by BCS Insurance Company
Oakbrook Terrace, IL

Administered by Planned Administrators Inc.
Columbia, South Carolina

Form 1.620.20220427

# Medical Claim Form

**Send Medical Claims to:**
**PAI**
**Attn: Claims**
**P.O. Box 6702**
**Columbia, SC 29260-6702**

## Fraud Notices

**Alabama**: Any person who knowingly presents a false or fraudulent claim for payment of a loss or benefit or who knowingly presents false information in an application for insurance is guilty of a crime and may be subject to restitution fines or confinement in prison, or any combination thereof.

**Alaska**: ALASKA LAW REQUIRES US TO NOTIFY YOU OF THE FOLLOWING: Any person who knowingly and with intent to injure, defraud, or receive an insurance company files a claim containing false, incomplete, or misleading information may be prosecuted under state law.

**Arizona:** For your protection **Arizona** law requires the following statement to appear on this form: Any person who knowingly presents a false or **fraudulent** claim for payment of a loss is subject to criminal and civil penalties. Penalties may include imprisonment, fines, denials of **insurance** and civil damages.

**California**: For your protection, California law requires the following to appear on this form. Any person who knowingly presents a false or fraudulent claim for the payment of a loss is guilty of a crime and may be subject to fines and confinement in state prison.

**Colorado:** It is unlawful to knowingly provide false, incomplete, or misleading facts or information to an insurance company for the purpose of defrauding or attempting to defraud the company. Penalties may include imprisonment, fines, denial of insurance, and civil damages. Any insurance company or agent of an insurance company who knowingly provides false, incomplete, or misleading facts or information to a policyholder or claimant for the purpose of defrauding or attempting to defraud the policyholder or claimant with regard to a settlement or award payable from insurance proceeds shall be reported to the Colorado Division of Insurance within the Department of Regulatory Agencies.

**Delaware, Idaho, Indiana and Oklahoma**: Any person who knowingly, and with intent to injure, defraud or deceive any insurer, files a statement of claim containing any false, incomplete or misleading information is guilty of a felony.

**District of Columbia**: **WARNING**: It is a crime to provide false or misleading information to an insurer for the purpose of defrauding the insurer or any other person. Penalties include imprisonment and/or fines. In addition, an insurer may deny insurance benefits, if false information materially related to a claim was provided by the applicant.

**Florida:** Any person who knowingly and with intent to injure, defraud, or deceive any insurer files a statement of claim containing any false, incomplete, or misleading information is guilty of a felony of the third degree.

**Kansas:** Any person who knowingly and with intent to defraud any insurance company or other person by presenting any written statement as part of an application for insurance, the rating of an insurance policy, or statement of claim containing any materially false information, or conceals for the purpose of misleading information concerning any fact material thereto has committed a fraudulent insurance act.

**Kentucky:** Any person who knowingly and with intent to defraud any insurance company or other person files a statement of claim containing any materially false information or conceals, for the purpose of misleading, information concerning any fact material thereto commits a fraudulent insurance act, which is a crime.

**Maine:** It is a crime to knowingly provide false, incomplete or misleading information to an insurance company for the purpose of defrauding the company. Penalties may include imprisonment, fines or a denial of insurance benefits.

**Minnesota:** A person who files a claim with intent to defraud or helps commit a fraud against an insurer is guilty of a crime.

**New Hampshire**: Any person who, with a purpose to injure, defraud or deceive any insurance company, files a statement of claim containing any false, incomplete or misleading information is subject to prosecution and punishment for insurance fraud, as provided in RSA 638:20.

**New Jersey**: Any person who knowingly files a statement of claim containing any false or misleading information is subject to criminal and civil penalties.

**New Mexico**: Any person who knowingly presents a false or fraudulent claim for payment of a loss or benefit or knowingly presents false information in an application for insurance is guilty of a crime and may be subject to civil fines and criminal penalties.

**New York**: Any person who knowingly and with intent to defraud any insurance company or other person files an application for insurance or statement of claim containing any materially false information, or conceals for the purpose of misleading, information concerning any fact material thereto, commits a fraudulent insurance act, which is a crime, and shall also be subject to a civil penalty not to exceed five thousand dollars and the stated value of the claim for each such violation.

**Oregon:** Any person who, with an intent to knowingly defraud or knowingly facilitate a fraud against an insurer, submits an application or files a claim containing a false or deceptive statement or a material fact, may be guilty of insurance fraud.

**Pennsylvania**: Any person who knowingly and with intent to defraud any insurance company or other person files an application for insurance or statement of claim containing any materially false information or conceals for the purpose of misleading, information concerning any fact material thereto commits a fraudulent insurance act, which is a crime and subjects such person to criminal and civil penalties.

**Puerto Rico:** Any person who knowingly and with the intention to defraud includes false information in an application for insurance or file, assist or abet in the filing of a fraudulent claim to obtain payment of a loss or other benefit, or files more than one claim for the same loss or damage, commits a felony and if found guilty shall be punished for each violation with a fine of no less than five thousand dollars ($5,000), not to exceed ten thousand dollars ($10,000); or imprisoned for a fixed term of three (3) years, or both. If aggravating circumstances exist, the fixed jail term may be increased to a maximum of five (5) years; and if mitigating circumstances are present, the jail term may be reduced to a minimum of two (2) years.

**Tennessee, Virginia and Washington**: It is a crime to knowingly provide false, incomplete, or misleading information to an insurance company for the purpose of defrauding the company. Penalties include imprisonment, fines, and denial of insurance benefits.

**All Other States Not Listed Separately:** Any person who knowingly presents a false or fraudulent claim for payment of a loss or benefit or knowingly presents false information in an application for insurance is guilty of a crime and may be subject to fines and confinement in prison.

**Questions?** Call Essential StaffCARE's toll-free Customer Service Line, 1-866-798-0803, Monday through Friday, 8:30 a.m. to 8:00 p.m. Eastern Time. A language line is available for translation for most languages.



Underwritten by BCS Insurance Company
Oakbrook Terrace, IL

Administered by Planned Administrators Inc.
Columbia, South Carolina

Form 1.620.20220427

# BCS Insurance Company
## 2 Mid America Plaza
## Oakbrook Terrace, Illinois 60181

# GROUP MAJOR MEDICAL EXPENSE INSURANCE

### THIS IS A NON-QUALIFIED HEALTH PLAN

# CERTIFICATE OF COVERAGE

Group Policy No. **PAI-Z2193000** ("the Policy"), has been issued to **Employer Solutions Group LLC**, which we refer to as "the Policyholder". We refer to BCS Insurance Company as "we", "us" or "our".

The Policy is administered on our behalf by "the Administrator": Planned Administrators, Inc.

The Policy was delivered in **Minnesota** and is governed by its laws and, to the extent applicable, the Employee Retirement Income Security Act of 1974 (ERISA) and any of its amendments.

This certificate of insurance is evidence of the Insured's coverage under the Policy and of its benefits. Everything contained in this certificate is subject to the provisions, definitions and exceptions in the Policy. The Policy is on file with the Policyholder and may be examined at any reasonable time. Only one of our executive officers may authorize a change to the Policy.

This certificate replaces all certificates and certificate riders, if any, previously issued to the Insured under the Policy.

IN WITNESS WHEREOF, we have signed the Policy at Oakbrook Terrace, Illinois.

PRESIDENT

SECRETARY

This is a Participating Provider Plan. There are differences in benefits provided under the Plan when a Covered Person receives Covered Services from a Participating Provider (In-Network) or Non-Participating Providers (Out-of-Network). We pay Covered Services at the In-Network or Out-of-Network benefit level shown in the Schedule of Benefits. Services or supplies from a Non-Participating Provider may be significantly higher than those same services or supplies received from a Participating Provider. However, if a Covered Person uses a Non-Participating Provider solely because he or she receives Medically Necessary Emergency Medical Care, then the benefits will be paid for Covered Services on the same basis as if the Covered Person had used the services of a Participating Provider, subject to the same In-Network Provider Cost-Sharing requirements.

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## PART I - GENERAL DEFINITIONS

Throughout this certificate, many words are used which have a specific meaning when applied to your health care coverage. These terms will always begin with a capital letter. Wherever used in this certificate:

**Accident** means a sudden, unforeseeable event that causes Injury to one or more Covered Persons.

**Alcoholism** means a disorder characterized by a pathological pattern of alcohol use that causes a serious impairment in social or occupational functioning, also termed alcohol abuse or, if tolerance or withdrawal is present, alcohol dependence.

**Ambulatory/Outpatient Surgical Facility** means a facility (other than a Hospital) whose primary function is the provision of surgical procedures on an ambulatory basis and which is duly licensed by the appropriate state and local authority to provide such services.

**Anesthesia Services** means the administration of anesthesia and the performance of related procedures by a Physician or a certified registered nurse anesthetist that may be legally rendered by them respectively.

A **Calendar Year** is a 12-month period beginning each January 1 at 12:01 a.m. Standard Time.

**Claim** means notification in a form acceptable to us that a service has been rendered or furnished to a Covered Person. This notification must include full details of the service received, including name, age, sex, identification number, the name and address of the Provider, an itemized statement of the service rendered or furnished, the date of service, the diagnosis, the Claim Charge, and any other information which we may request in connection with services rendered to a Covered Person.

**Claim Charge** means the amount which appears on a Claim as the Provider's charge for service rendered to a Covered Person.

**Claim Payment** means the benefit payment calculated by us, after submission of a Claim, in accordance with the benefits described in this certificate. All Claim Payments will be calculated on the basis of the Eligible Charge for Covered Services rendered to a Covered Person.

**COBRA** means the Consolidated Omnibus Budget Reconciliation Act of 1985 (P.L. 99-272), or as later amended.

**Coinsurance** is the percentage of Covered Expenses the Covered Person is responsible for paying (after the applicable Deductible is satisfied and/or Copayment paid). **Coinsurance does not include charges for services that are not Covered Services or charges in excess of the Eligible Charge. These charges are the Covered Person's responsibility and are not included in the Coinsurance calculation.**

**Coinsurance Maximum** is the amount of Coinsurance each Covered Person incurs for Covered Expenses in a Coverage Year. The Coinsurance **does not** include any amounts in excess of the Eligible Charge, the Deductible and/or any Copayments, any penalties, or any amounts in excess of other benefit limits of this Plan.

**Coinsurance Percentage** is the percentage of Covered Expenses we will pay after the applicable deductible amount(s) or copayment amount(s) for a service or supply that:

a) qualifies as a Covered Expense under one or more benefit provisions; and
b) is received while the Covered Person's insurance is in force under the Policy if the charge for the service or supply qualifies as a Covered Expense.

**Confined/Confinement** means being registered as an Inpatient in a Hospital or other Health Care Facility, on the order of a Physician, for Medically Necessary treatment.

**Copayment** is the fixed dollar amount of Covered Expenses the Covered Person is responsible for paying a Provider at the time of service in connection with specific Covered Services. **Copayment does not include charges for services that are not Covered Services or charges in excess of the Eligible Charge.**

**Cosmetic and Reconstructive Surgery**. **Cosmetic Surgery** is performed to change the appearance of otherwise normal looking characteristics or features of the patient's body. A physical feature or characteristic is normal looking when the average person would consider that feature or characteristic to be within the range of usual variations of normal human appearance. **Reconstructive Surgery** is surgery to correct the appearance of abnormal looking features or characteristics of the body caused by birth defects, Injury, tumors, or infection. A feature or characteristic of the body is abnormal looking when an average person would consider it to be outside the range of general variations of normal human appearance. **Note: Cosmetic Surgery does not become Reconstructive Surgery because of psychological or psychiatric reasons.**

**Course of Treatment** is a planned, structured, and organized sequence of treatment procedures based on an individualized evaluation to restore or improve health function, or to promote chemical free status. A Course of Treatment is complete when the patient has finished a series of treatments without a lapse in treatment or has been medically discharged. If the Covered Person begins a series of treatments, it will count as one course of treatment, reducing the available benefits, even if the patient fails to comply with the treatment program for a period of thirty (30) days.

**Coverage Year** begins on the Policy Effective Date shown in the Schedule of Benefits and continues for the next 12 consecutive month period.

**Covered Expenses** are the expenses incurred for Covered Services. Covered Expenses for Covered Services received from Participating Providers will not exceed the Negotiated Rate. Covered Expenses for Covered Services received from Non-Participating Providers will not exceed the Eligible Charge. In addition, Covered Expenses may be limited by other specific maximums described in this Policy under Part III DESCRIPTION OF COVERED SERVICES or in the Schedule of Benefits. Covered Expenses are subject to applicable Deductibles, penalties and other benefit limits. **An expense is incurred on the date the Covered Person receives the service or supply.**

**Covered Person** means any person for whom coverage is in effect under the Policy.

**Covered Services** are Medically Necessary services or supplies that are listed in Part III THE DESCRIPTION OF COVERED SERVICES section of this Plan, and for which a Covered Person is entitled to receive benefits.

**Custodial Care Service** means those services that do not require the technical skills or professional training of medical and/or nursing personnel in order to be safely and effectively performed. Examples of Custodial Care Service are: assistance with activities of daily living, administration of oral medications, assistance in walking, turning and positioning in bed, and acting as a companion or sitter. Custodial Care Service also means providing Inpatient service and supplies to you if you are not receiving Skilled Nursing Service on a continuous basis and/or you are not under a specific therapeutic program which has a reasonable expectancy of improving your condition within a reasonable period of time and which can only be safely and effectively administered to you as an Inpatient in the Health Care Facility involved.

**Deductible** means the amount of Covered Expenses specified in the Schedule of Benefits each Covered Person must pay for Covered Services before benefits are payable under this Plan. The **Family Deductible** means the amount of Deductibles specified in the Schedule of Benefits that must be met by all Covered Persons during the Coverage Year before no further Deductibles are required to be satisfied. Deductible does not include any copayment amount or charges in excess of the Eligible Charge.

**Doctor** (See Physician).

**Diagnostic Services** means tests rendered for the diagnosis of your symptoms and which are directed toward evaluation or progress of a condition, disease or Injury. Such tests include, but are not limited to,

x-ray, pathology services, clinical laboratory tests, pulmonary function studies, electrocardiograms, electroencephalograms, radioisotope tests, and electromyograms.

**Durable Medical Equipment** means items that are used to serve a specific diagnostic or therapeutic purpose in the treatment of an Injury or Sickness, are Medically Necessary and prescribed by a Doctor, can withstand repeated use, generally not useful to a person in the absence of Injury or Sickness and are appropriate for use in the patient's home.

The **Effective Date of the Policy** is the date that the Policy became active with us.

The **Effective Date of Coverage** is the date on which coverage under this Policy begins for the Insured and any other Covered Person. Refer to Effective Date under Part II INDIVIDUAL INSURING PROVISIONS.

**Eligible Charge** means the amount we will consider a Covered Expense with respect to charges made by a Provider for Covered Services. In the case of a Provider which has a written agreement with us and/or our authorized Administrator to provide care to a Covered Person at the time Covered Services are rendered, such Provider's Claim Charge for Covered Services. In the case of a Provider who does not have a written agreement with us and/or our authorized Administrator to provide care to a Covered Person at the time Covered Services are rendered, the lesser of either of the following charges for Covered Services:

a) the charge which the particular Hospital or Health Care Facility usually charges its patients for Covered Services, or
b) the charge which is within the range of charges other similar Hospitals, Health Care Facilities or other Providers in similar geographic areas charge their patients for the same or similar services.

**Eligible Dependent** See Eligibility under Part II INDIVIDUAL INSURING PROVISIONS.

**Eligible Employee** means an individual who is:

a) employed by the Policyholder and working full-time according to state guidelines or at least 30 hours per week;
b) receiving monetary compensation from the Policyholder that is subject to FICA and federal income tax withholding by the Policyholder;
c) not a seasonal or temporary employee and is scheduled to work at least nine (9) months per Calendar Year; and
d) a partner or proprietor actively engaged in the business of the Policyholder on a full-time basis.

An individual who is laid off, retired, a consultant or on the board of directors will not be considered an Eligible Employee.

**Emergency or Emergency Medical Care** means services provided for the initial Outpatient treatment, including related Diagnostic Services, of an Illness or Injury displaying itself by acute symptoms of sufficient severity (including severe pain) such that a prudent layperson, which possesses an average knowledge of health and medicine, could reasonably expect that the absence of immediate medical attention could result in:

a) placing the health of the Covered Person (or, with respect to a pregnant woman, the health of the woman or her unborn child) in serious jeopardy;
b) serious impairment to bodily functions;
c) serious dysfunction of any bodily organ or part; or
d) serious disfigurement of the Covered Person.

**Experimental or Investigational Medical Treatment, Procedure or Drugs.** A treatment, medication, drug, device, procedure, supply or service and related services (or any portion thereof, including the form, administration or dosage) for a particular diagnosis or condition when any one of the following exists: (1) It cannot be legally marketed without the approval of the United States Food and Drug

Administration (FDA) and such approval has not been granted at the time of its proposed use; (2) It is not yet recognized as acceptable medical practice throughout the United States to treat that Sickness or Injury; or (3) It does not have the positive endorsement of national medical bodies or panels, such as the American Cancer Society. A treatment, drug, device, procedure, supply or service may be Experimental or Investigational based on the following evaluations: (1) Reports in peer review medical literature published in the English language as of the date of service; (2) Scientific evaluations published by organizations that conduct health care research such as the Agency for Health Care Policy and Research, the National Institutes of Health, the American Medical Association, and the American College of Physicians; (3) Opinions of independent medical consultants; (4) Listings in drug correspondence, including the American Medical Association's Drug Evaluations, the American Hospital Formulary Service Drug Information, and the United States Pharmacopoeia Drug Information; (5) Use of a written informed consent addressing the Experimental or Investigational nature of the service or supply. This applies whether consent is used by the Insured Person's Physician or by any other Physician studying the same or similar service or supply; (6) Any requirement that the use of the service or supply be subject to Institutional Review Board ("IRB") approval; (7) Written protocols used by the health care Provider.

**Group Policy or Policy** means the agreement between us and the Policyholder, any riders, this certificate, the Schedule of Benefits, the application and any employee application form of the persons covered under the Policy.

**Habilitation Services** means ongoing, Medically Necessary, therapies provided to persons with developmental disabilities and similar conditions who need habilitation therapies to achieve functions and skills never before acquired, including services and devices that improve, maintain, and lessen the deterioration of a person's functional status over a lifetime and on a treatment continuum.

**Health Care Facility** means an institution providing health care services or a health care setting, including but not limited to Hospitals and other licensed inpatient facilities, Ambulatory/Surgical Facility, urgent care centers, Skilled Nursing Facility, residential treatment centers, diagnostic, laboratory and imaging centers, and rehabilitation and other therapeutic health care settings

**Home Health Care Agency** is a Provider of home health care that is licensed according to state and local laws to provide skilled nursing and other services on a visiting basis in the Covered Person's home. They must be approved as home health care providers under Medicare and the Joint Commission on Accreditation of Health Care Organizations.

**Hospice Care Program** means a coordinated, interdisciplinary program prescribed and supervised by a Physician to meet the special physical, psychological, and social needs of a terminally ill Covered Person and those of his or her Immediate Family.

**Hospices** are Providers that are licensed according to state and local laws to provide skilled nursing and other services to support and care for persons experiencing the final phases of terminal Illness. They must be approved as a hospice Provider under Medicare and the Joint Commission on Accreditation of Health Care Organizations.

**Hospital** means an institution that:

a) is operated pursuant to law for the care and treatment of injured or sick persons on an inpatient basis;
b) has organized facilities for diagnosis and treatment of acute medical, surgical, or mental conditions either on its premises or has a contract with another hospital for these services;
c) has staff of one or more Physicians available at all times; and
d) has 24-hour a day nursing service by Registered Nurses (R.N.).

Hospital excludes any institution that is primarily a long term care, extended care facility rest home, nursing home, convalescent home, a home for the aged, an alcoholism or a drug addiction treatment facility or a facility for treatment of mental disorders.

**Illness (See Sickness)**

**Immediate Family** means the parents, spouse, children or siblings of any Covered Person or any person residing with the Covered Person.

**Infertility** means the condition of an otherwise presumably healthy married individual who is unable to conceive or produce conception during a period of one (1) year.

**Infusion Therapy** is the administration of Drugs (prescription substances), by the intravenous (into a vein), intramuscular (into a muscle), subcutaneous (under the skin), and intrathecal (into the spinal canal) routes. For the purpose of this Plan, it shall also include drugs administered by aerosol (into the lungs) and by feeding tube.

**Injury** means an accidental bodily injury of a Covered Person, which is the direct cause of a Loss independent of disease, bodily infirmity or any other cause.

**In-Network/In-Network Provider(s)** means a Hospital, Physician, Pharmacy or any other health services Provider which has signed an agreement affiliating with a Network Provider Organization to provide services and supplies at a predetermined rate. We or our subcontractor vendor selects In-Network Providers to make their services and supplies available to specific geographic areas at benefit levels as shown in the Schedule of Benefits. Your Network Provider Organization is identified on your insurance I.D. card. An In-Network Provider is a Preferred Provider.

**Inpatient** means that you are a registered bed patient and are treated as such in a Hospital or other Health Care Facility.

**Insured/Insured Person** means an employee for whom coverage is in effect under the Policy.

**Investigative Procedures** (See Experimental/Investigational)

**Investigational or Investigational Services and Supplies** means procedures, drugs, devices, services and/or supplies which (1) are provided or performed in special settings for research purposes or under a controlled environment and which are being studied for safety, efficiency and effectiveness, and/or (2) are awaiting endorsement by the appropriate government agency for general use by the medical community at the time they are rendered to you, and (3) specifically with regard to drugs, combination of drugs and/or devices, are not finally approved by the appropriate government agency at the time used or administered to you.

**Loss** means an event for which benefits are payable under this Plan. A Loss must occur while the Covered Person is insured under this Policy.

**Manipulative Therapy** means treatment applied to the spine or joint structures to correct vertebral or joint malposition and to eliminate or alleviate somatic dysfunction including, but not limited to, manipulation, myofacial release or soft tissue mobilization. Treatment must demonstrate pain relief and continued improvement in range of motion and function and cannot be performed for maintenance care only. Manipulative therapy is not limited to treatment by manual means.

**Maternity Service** means the services rendered for normal pregnancy. A normal pregnancy means an intrauterine pregnancy that, through vaginal delivery, results in an infant, who weighs *5* pounds or more.

**Medical Care** means the diagnosis, care, mitigation, treatment or prevention of disease.

**Medically Necessary** means the care, service or supply is:

a) prescribed by a Doctor for the diagnosis or treatment of an Injury or Sickness; and
b) appropriate, according to conventional medical practice for the Injury or Sickness in the locality in which the care or service is given.

**Medicare** means Title XVIII of the United States Social Security Act of 1965, as then constituted or as later amended.

**Mental Health Disorders** means a mental or emotional disease classified as disorders in the Diagnostic and Statistical Manual of Mental Disorders published by the American Psychiatric Association that is current as of the date services are rendered to a patient.

**Negotiated Rate** is the rate of payment that we have negotiated with a Participating Provider for Covered Services.

**Network** means the group of Participating Providers providing services who have contracts that include an agreed upon price for health care expenses.

**Network Provider Organization** (Preferred Provider Organization) means a vendor under contract with us or our authorized Administrator to provide Covered Services within a service area. The vendor will enter into separate and distinct contracts with In-Network Providers to provide services covered by the Policy at a reduced predetermined rate.

**Non-Participating Hospital** (Out of Network) is a Hospital that has not entered into a Participating Hospital agreement with the Network Provider Organization at the time services are rendered.

**Non-Participating Physician** (Out of Network) is a Physician who does not have a Participating Provider agreement in effect with the Network Provider Organization at the time services are rendered.

**Non-Participating Pharmacy** (Out of Network) is a Pharmacy that has not entered into a Participating Pharmaceutical agreement with the Network Provider Organization at the time services are rendered.

**Non-Participating Provider** (Out of Network) is a Provider who does not have a Participating Provider agreement in effect with the Network Provider Organization at the time services are rendered.

**Occupational Therapy** means constructive therapeutic activity designed and adapted to promote the restoration of useful physical function. Occupational Therapy does not include educational training or services designed and adapted to develop a physical function.

**Office Visit** means a visit by the Covered Person, who is the patient, to the office of a Physician during which one or more of only the following three specific services are provided:

a) History (gathering of information on a Sickness or Injury);
b) Examination; or
c) Medical decision making (the Physician's diagnosis and Course of Treatment).

This does not include other services (e.g. X-rays or lab services) even if performed on the same day.

**Out-of-Network/Out-of-Network Provider** means a Hospital, Physician, Pharmacy or any other Provider who does not have an agreement with a Network Provider Organization to provide services and supplies at a predetermined rate at the time services are rendered.

**Out-of-Pocket Maximum** means those Covered Expenses that a Covered Person is required to pay that:

a) qualify as Covered Expenses; and
b) are not paid or payable if a claim were made under any Other Plan.

When the Out-of-Pocket Maximum has been met, additional Covered Expenses will be payable at 100%. The amount payable will be subject to any specific benefit limits stated in the Policy, a determination of eligible Covered Expenses and any reduction for a Covered Expense incurred at a Non-Participating Provider. The Out-of-Pocket Maximum includes the Deductible, Coinsurance and any Copayments the Covered Person is responsible for paying.

**Outpatient** means a person who incurs medical expenses at Doctors' offices, an Ambulatory/Outpatient Surgical Facility or other Health Care Facility while not an Inpatient. Services considered Outpatient, include, but are not limited to, services in a Hospital emergency room regardless of whether you are subsequently registered as an Inpatient.

**Partial Hospitalization Treatment Program** means a planned program of a Hospital or Substance Abuse Treatment Facility for the treatment of Mental Sickness or Substance Abuse Rehabilitation Treatment in which patients spend days or nights.

**Participating Hospital** (In Network) is a Hospital that has a Participating Hospital agreement in effect with us or our authorized Network Provider Organization at the time services are rendered. Participating Hospitals agree to accept the Negotiated Rate as payment in full for Covered Expenses.

**Participating Physician** (In Network) is a Physician who has a Participating Physician agreement in effect with us or our authorized Network Provider Organization at the time services are rendered. Participating Physicians agree to accept the Negotiated Rate as payment in full for Covered Expenses.

**Participating Provider** (In Network) is a Participating Physician, Hospital, or other health care Provider that has a Participating Provider agreement in effect with us or our authorized Network Provider Organization at the time services are rendered. Participating Providers agree to accept the Negotiated Rate as payment in full for Covered Expenses.

**Pediatric Preventative Care** means those services recommended by the Committee on Practice and Ambulatory Medicine of the American Academy of Pediatrics when delivered, supervised, prescribed, or recommended by a Physician and rendered to a child.

**Physical Therapy** means the treatment of a disease, injury or condition by physical means by a Physician or a registered professional physical therapist under the supervision of a Physician and which is designed and adapted to promote the restoration of a useful physical function. Physical Therapy does not include educational training or services designed and adapted to develop a physical function.

**Physician or Doctor** means any duly licensed medical practitioner of a healing art who is recognized by the law of the state in which treatment is received as qualified to perform the service for which Claim is made.

**Plan** is the set of benefits described in the certificate of coverage. This Plan is subject to the terms and conditions of the Policy we issued to the Policyholder. If changes are made to the Policy or Plan, an amendment or revised certificate will be issued to the Policyholder for distribution to each Insured affected by the change.

**Policy** is the Group Policy we have issued to the Policyholder.

**Prior Authorization** means that you must contact our authorized Administrator to obtain authorization to receive a Covered Service. Although you can go to the Hospital or Provider of your choice, your benefits will be greater when you use the services of the Hospital or Provider approved by our authorized Administrator. If you do not obtain Prior Authorization, benefits will be paid at the portion of the Eligible Charge as shown in the Schedule of Benefits under Prior Authorization.

**Private Duty Nursing Service** means Skilled Nursing Service provided on a one-to-one basis by an actively practicing registered nurse or licensed practical nurse that is not providing this service as an employee or agent of a Hospital or other Health Care Facility. Private Duty Nursing Service does not include Custodial Care Service.

**Provider** means any Health Care Facility (for example, a Hospital) or person (for example, a Physician, dentist or other health care provider) or entity duly licensed to render Covered Services to a Covered Person.

**Reconstructive Surgery** (See Cosmetic and Reconstructive Surgery)

**Rehabilitation Medical Practitione**r means a Physician, physical therapist, speech therapist, occupational therapist, or respiratory therapist. A Rehabilitation Medical Practitioner must be licensed or certified by the state in which care is rendered and performing services within the scope of that license or certification.

**Rehabilitative Services** means health care services that help a Covered Person keep, get back or improve skills and functioning for daily living that have been lost or impaired because the Covered Person was sick, hurt or disabled. These services consist of Physical Therapy, Occupational Therapy and Speech Therapy in an Inpatient and/or Outpatient setting.

**Serious Mental Illness** means the following biologically-based mental disorders as classified in the current Diagnostic and Statistical Manual published by the American Psychiatric Association:

a) schizophrenia;
b) bipolar disorder;
c) obsessive-compulsive disorder;
d) major depressive disorder;
e) panic disorder;
f) anorexia nervosa;
g) bulimia nervosa;
h) schizo-affective disorder; and
i) delusional disorder.

**Sickness** means a sickness, disease, Complication of Pregnancy, Mental Health Disorder or Substance Abuse of a Covered Person treated by a Doctor that causes Loss while a Covered Person's coverage is in force under the Policy. Sickness does not include learning disabilities, attitudinal disorders or disciplinary problems.

**Skilled Nursing/Rehabilitation Facility** means an institution or a distinct part of an institution which is primarily engaged in providing comprehensive skilled services and rehabilitative Inpatient care and is duly licensed by the appropriate governmental authority to provide such services. This definition **excludes** any home, facility or part thereof used primarily for rest; a home or facility primarily for the aged or for the care of drug addicts or alcoholics; a home or facility primarily used for the care and treatment of tuberculosis, mental diseases or disorders or custodial or education care.

**Skilled Nursing Service** means those services provided by a registered nurse (R.N.) or licensed practical nurse (L.P.N.) which require the technical skills and professional training of an R.N. or L.P.N. and which cannot be reasonably taught to a person who does not have specialized skill and professional training.

**Speech Therapy** means the treatment for the correction of a speech impairment resulting from disease, trauma, congenital anomalies, previous therapeutic processes, psycho-social speech delay, behavioral problems, attention disorder, conceptual disability or mental retardation and which is designed and adapted to promote the restoration of a useful physical function.

**Substance Abuse** means the uncontrollable or excessive abuse of addictive substances consisting of alcohol, morphine, cocaine, heroin, opium, cannabis, and other barbiturates, amphetamines, tranquilizers and/or hallucinogens, and the resultant physiological and/or psychological dependency that develops with continued use of such addictive substances requiring Medical Care as determined by a Physician or psychologist.

**Substance Abuse Rehabilitation Treatment** means an organized, intensive, structured, rehabilitative treatment program of either a Hospital or Substance Abuse Treatment Facility. It does not include programs consisting primarily of counseling by individuals other than a Physician, Psychologist, or Clinical Professional Counselor, court ordered evaluations, programs which are primarily for diagnostic

evaluations, mental retardation or learning disabilities, care in lieu of detention or correctional placement or family retreats.

**Substance Abuse Treatment Facility** means a facility (other than a Hospital) whose primary function is the treatment of Substance Abuse and is licensed by the appropriate state and local authority to provide such service. It does not include half-way houses, boarding houses or other facilities that provide primarily a supportive environment.

**Surgery** means the performance of any medically recognized, non-investigational surgical procedure including specialized instrumentation and the correction of fractures or complete dislocations and any other procedures as reasonably approved by our authorized Administrator.

**Totally Disabled** means:

a) with respect to the Insured Person, the inability by reason of Sickness or Injury to perform the duties of his or her regular occupation or employment within the first two (2) years of such disability; and
b) after the first two (2) years of such disability, the inability of the Insured Person to engage in any paid employment or work for which the Insured may, by education or training, including rehabilitative training be or reasonably become qualified; or
c) with respect to a Covered Person other than the Insured, the inability by reason of Sickness or Injury to engage in the normal activities of a person of the same age and sex who is in good health.

**Waiting Period** means the length of time that an Eligible Employee must continuously work before the Eligible Employee is covered under the terms of the Policy. The Waiting Period is determined by the Policyholder on the application for coverage under the Policy.

## PART II - INDIVIDUAL INSURING PROVISIONS

**Eligibility**:

**Insured -** Each person, as described in the Schedule of Benefits, is eligible for coverage under the Policy as an Insured.

**Eligible Dependents -** Coverage under the Policy may also be extended to include the Insured's children who are less than age 26.

Dependent children may include stepchildren, foster children, legally adopted children, children of adopting parents pending finalization of adoption procedures and children for whom coverage has been court-ordered.

**Effective Date**:

**Insured: Contributory** - Individual insurance becomes effective on the latest of:

a) the Policyholder's effective date if the person is eligible for coverage on that date and his or her enrollment and premium have been received on or before that date;

b) the date the person enrolls if: 1) he or she becomes eligible after the Policyholder's effective date, provided the person has satisfied any Waiting Period; and 2) the person's enrollment and premium are received within 31 days after the date the person becomes eligible; or

c) as provided in the Schedule of Benefits.

An eligible person may enroll only within 31 days after becoming eligible or acquiring a new dependent or during an open enrollment period. Open enrollment period means a pre-determined term during which any eligible person who previously did not enroll for coverage under the Policy, may enroll for coverage.

**Dependents** - Dependent insurance becomes effective on the latest of:

a) the Insured's effective date if the dependent is eligible for coverage as of that date and the Insured enrolls and pays premium for the dependent on or before that date;

b) the date the Insured enrolls a dependent if the dependent becomes eligible after the Insured's effective date and the enrollment and premium are received within 31 days after the date the dependent becomes eligible; or

c) as provided in the Schedule of Benefits.

In no case will coverage for eligible dependents take effect before the Insured's. No dependent will be covered, unless application has been made and the correct premium has been paid.

**Newborn Child Coverage:** A newborn child (including grandchildren who are financially dependent upon and reside with a covered grandparent from birth) of an Insured born while his or her coverage under the Policy is in force is covered from the moment of birth for Injury and Sickness. We request that you provide written notice of the birth of the child within 31 days from the date of birth and the required payment of the appropriate premium, from the date of birth. If we are not notified, payment of any benefits may be withheld until the premium owed is received as if we had been informed of the additional dependent immediately upon birth. Necessary care and treatment of congenital defects, birth abnormality and premature birth, as well as routine newborn care, are covered the same as Sickness.

**Adopted Children Coverage:** A minor child who comes under the charge, care and control of the Insured while his or her coverage under the Policy is in force is covered for an initial thirty-one (31) days for Injury and Sickness following the date of the final decree of adoption or placement in the home for the purpose of adoption, whichever is earlier. We request that you provide written notice of the placement of the child within 31 days from the date of placement and the required payment of the appropriate premium, from the date of placement. If we are not notified, payment of any benefits may be withheld until the premium owed is received as if we had been informed of the additional dependent immediately upon placement. Necessary care and treatment of congenital defects, birth abnormality and premature birth, as well as routine newborn care, are covered the same as Sickness. Coverage for the minor child continues, unless the petition for adoption is dismissed or denied.

**Alternate Enrollment Periods for Loss of Other Coverage** - an eligible person may elect coverage under the Policy at any time (including coverage for Eligible Dependents) if:

a) the person or dependent was previously covered by another plan when coverage under the Policy was originally offered;

b) the person or dependent stated in writing that coverage was declined because of the Other Coverage, if the person or dependent was notified that such a statement was required;

c) the person exhausted COBRA benefits or lost eligibility or employer's subsidy for some other coverage; and

d) the person requests enrollment in writing within thirty-one (31) days of loss of coverage.

**Termination**:

**Insured** - Coverage for an Insured ends on the earliest of:

a) the date the Insured is no longer eligible, unless contributions for coverage were made in advance, in which case coverage terminates at the end of the period for which premiums have been paid;
b) any premium due date, if full payment for the Insured's coverage is not made within thirty (31) days following the premium due date;
c) the date the Policy terminates; or
d) the date the Insured enters an armed service on full-time active duty. Premium will be returned on a pro-rata basis if the Policyholder notifies us in writing.

**Dependents** - Coverage for dependents ends on the earlier of:

a) the Insured's termination date; or
b) the date the dependent is no longer eligible, unless contributions for coverage were made in advance, in which case coverage terminates at the end of the period for which premiums have been paid.

Coverage continues for any child who reaches the age limit and is both:

a) totally incapable of self-sustaining employment by reason of developmental disability, mental illness or disorder or physical disability; and

b) chiefly dependent on the Insured for support and maintenance.

The Insured must give us proof of the child's incapacity and dependency within thirty-one (31) days of the child's reaching the age limit. We may require proof again from time to time, but not more often than once a year after the two (2) years that follow the child's reaching the age limit.

In no case will coverage end later than the Insured's.

Termination will not affect a Claim for benefits for covered services received while the person was covered by the Policy.

**Extension of Benefits**:

If coverage under the Policy ends while the Covered Person is Totally Disabled due to Injury or Sickness, we will pay benefits for Covered Services received after the date coverage under the Policy ends if they meet the following requirements:

a) the Covered Service must be rendered due to the same Injury or Sickness causing the Covered Person to be Totally Disabled on the date coverage ends;

b) the Covered Service must occur within 90 after the date the Covered Person's coverage under the Policy ends; and

c) coverage must not have ended as a result of the Covered Person's or, in the case of a dependent child, the child's parent's voluntary termination of coverage.

This extension of benefits terminates on the first of the following to occur:

a) The date the Insured ceases to be Totally Disabled; or

b) at the end of the period stated in b) above.

This Extension of Benefits is not applicable if the Policy is replaced by another health plan providing substantially equivalent or greater benefits.

## PART III - DESCRIPTION OF COVERED SERVICES

**Note:** This is a Participating Provider Plan. There are differences in benefits provided under the plan when a Covered Person receives Covered Services from a Participating Provider (In-Network) or Non-Participating Provider (Out-of-Network). We pay Covered Services at the In-Network or Out-of-Network benefit level shown in your Schedule of Benefits. Charges you receive for services or supplies from a Non-Participating Provider may be significantly higher than those same services or supplies received from a Participating Provider. In addition to the Deductible amount, Copayment amount, and Coinsurance you are responsible for the difference between the Eligible Charge and the amount the Non-Participating Provider bills you for the services or supplies. Any amount you are obligated to pay to the Provider in excess of the Eligible Charge will not apply to your Deductible or Out-of-Pocket Maximum.

**Specialty Care Providers** – You do not need a referral in order to receive Covered Services from a Participating Provider who is a specialist. This includes Covered Services for obstetrical services or pediatric services. Refer to the Schedule of Benefits section for benefit limitations and out-of-pocket costs applicable to your plan.

**Information Regarding the Provider Network and Plan –** To view a list of the names and locations of all affiliated providers go to:

www.firsthealth.com

Such list may be printed directly from the website. You may also contact First Health at: 1 800 226-5116.

### MEDICAL EXPENSE BENEFITS

#### Ambulance Service Benefit

Covered Expenses by a licensed ambulance service will include Medically Necessary ambulance services for local transportation:

a) To the nearest Hospital that can provide services appropriate to the Covered Person's Sickness or Injury; or
b) To the nearest neonatal special care unit for newborn infants for treatment of Sickness, Injury, congenital birth defects, or complications of premature birth that require that level of care.

Benefits for air ambulance services are limited to:

a) Services requested by police or medical authorities at the site of an Emergency; or
b) Those situations in which the Covered Person is in a location that cannot be reached by ground ambulance.

**Non Covered Services -** No benefits will be paid for:

a) Ambulance Services that are not for Emergency Medical Care;
b) Ambulance Services provided for a Covered Person’s comfort or convenience;
c) Expenses incurred for ambulance services covered by a local governmental or municipal body, unless otherwise required by law; or
d) Air ambulance:
    1) Outside of the fifty (50) United States and the District of Columbia;
    2) From a country or territory outside of the United States to a location within the fifty (50) United States or the District of Columbia;
    3) From a location within the fifty (50) United States or the District of Columbia to a country or territory outside of the United States.

**Habilitation and Rehabilitation Care Facility Benefit**

Covered Expenses include expenses incurred for Habilitation or Rehabilitation services or confinement in a Skilled Nursing/Rehabilitation Facility, subject to the following limitations:

a) Covered Expenses available to a Covered Person while Confined primarily to receive Habilitation or Rehabilitation are limited to those specified in this provision.
b) Rehabilitation services or confinement in a Skilled Nursing/Rehabilitation Facility must begin within fourteen (14) days of a Hospital stay of at least three (3) consecutive days and be for treatment of, or Rehabilitation related to, the same Sickness or Injury that resulted in the Hospital stay. Covered Expenses for Skilled Nursing/Rehabilitation Facility services are limited to charges made by a Hospital or Skilled Nursing/Rehabilitation Facility for:
    1) Daily room and board and nursing services;
    2) Diagnostic testing;
    3) Drugs and medicines that are prescribed by a Physician, must be filled by a licensed pharmacist, and are approved by the U.S. Food and Drug Administration.

Covered Expenses for non-provider facility services are limited to charges incurred for the professional services of Rehabilitation Medical Practitioners.

See the Schedule of Benefits for benefit levels or additional limits.

Care ceases to be Rehabilitation upon our determination of any of the following:

a) The Covered Person has reached maximum therapeutic benefit;
b) Further treatment cannot restore bodily function beyond the level the Covered Person already possesses;
c) There is no measurable progress toward documented goals; or
d) Care is primarily Custodial Care;

**Non Covered Services**
No benefits will be paid under these Habilitation and Rehabilitation Facility Expense Benefits for charges for services or Confinement related to treatment or therapy for Mental Health Disorders or Substance Abuse.

**Home Health Care Benefit**

Covered Expenses for home health care are limited to the following charges:
a) Home health aide services;
b) Services of a private duty registered nurse rendered on an Outpatient basis;
c) Professional fees of a licensed respiratory, physical, occupational, or speech therapist required for home health care;
d) I.V. medication and pain medication;
e) Hemodialysis, and for the processing and administration of blood or blood components;
f) Necessary medical supplies;
g) Rental of the durable medical equipment set forth below:
    1) I.V. stand and I.V. tubing;
    2) Infusion pump or cassette;
    3) Portable commode;
    4) Patient lift;
    5) Bili-lights;
    6) Suction machine and suction catheters.

Charges under b) include coverage for up to 120 hours of services provided by a private duty nurse or personal care assistant to the ventilator-dependent person during the time the ventilator-dependent person is in a hospital licensed under chapter 144. The personal care assistant or private duty nurse shall perform only the services of communicator or interpreter for the ventilator-dependent patient during

a transition period of up to 120 hours to assure adequate training of the hospital staff to communicate with the patient and to understand the unique comfort, safety, and personal care needs of the patient.

Charges under c) and f) are Covered Expenses to the extent they would have been Covered Expenses during an Inpatient Hospital stay.

At our option, we may authorize the purchase of the equipment in lieu of its rental if the rental price is projected to exceed the equipment purchase price, but only from a Provider we authorize before the purchase.

An agency that is approved to provide home health care to those receiving Medicare benefits will be deemed to be a Home Health Care Agency.

**Limitations:**
Each 4-hour period of home health aide services will be counted as one visit.

Covered Expenses for Outpatient Private Duty Nurse Services will be limited to $75 per visit and up to the maximum number of visits shown in the Schedule of Benefits.

**Non Covered Services**
No benefits will be payable for charges related to respite care, Custodial Care, or educational care.

**Hospice Care Benefit**

This provision only applies to a terminally ill Covered Person receiving Medically Necessary care under a Hospice Care Program. The Covered Person must have a life expectancy of six (6) months or less, as confirmed by the attending Physician. Covered Services will continue if the Covered Person lives longer than six (6) months.

Covered Expenses include:

a) Room and board in a Hospice while the Covered Person is an Inpatient;
b) Occupational therapy;
c) Speech-language therapy;
d) The rental of medical equipment while the terminally ill Covered Person is in a Hospice Care Program to the extent that these items would have been covered under the Policy if the Covered Person had been confined in a Hospital;
e) Medical, palliative, and supportive care, and the procedures necessary for pain control and acute and chronic symptom management;
f) Counseling the Covered Person regarding his or her terminal sickness;
g) Terminal sickness counseling of members of the Covered Person's Immediate Family; and
h) Bereavement counseling.

**Mental Health Disorder and Serious Mental Illness Medical Expense Benefit**

Covered Expenses for Inpatient and Outpatient treatment of Mental Health Disorders identified in the most recent edition of the Diagnostic and Statistical Manual and Serious Mental Illness are covered the same as any other Illness, including Autism. Before a Covered Person may qualify to receive benefits, a Physician, psychologist, advanced practice Registered Nurse, or social worker must certify that the Covered Person has a Mental Health Disorder or Serious Mental Illness and prescribe appropriate treatment, which may include referral to other treatment Providers. For the purpose of this benefit, the following definition applies: **Autism** means a developmental neurological disorder, usually appearing in the first three years of life, which affects normal brain functions and is manifested by compulsive, ritualistic behavior and severely impaired social interaction and communication skills.

Coverage for the diagnosis, evaluation, multidisciplinary assessment which includes the child’s developmental skills, functional behavior, needs and capacities, and medically necessary care of children under 18 with autism spectrum disorders, including but not limited to the following:

1. Early intensive behavioral and developmental therapy based in behavioral and developmental science, including, but not limited to, all types of applied behavior analysis, intensive early intervention behavior therapy, and intensive behavior intervention;
2. Neurodevelopmental and behavioral health treatments and management;
3. Speech therapy;
4. Occupational therapy;
5. Physical therapy; and
6. Medications.

Treatment includes individualized treatment plans prescribed by the Covered Person's treating physician or mental health professional.

We may request an updated treatment plan only once every sex month, unless we and the treating physician or mental health professional agree that a more frequent review is necessary due to emerging circumstances.

An independent progress evaluation conducted by a mental health professional with expertise and training in autism spectrum disorder and child development must be completed to determine if progress toward function and generalizable gains, as determined in the treatment plan, is being made.

Coverage for mental health services ordered by a court of competent jurisdiction under a court order which includes a diagnosis and individual treatment plan for the most appropriate care.

**Miscellaneous Medical Expense Benefits**

Covered Expenses for medical expense benefits are limited to charges:

a) Made by a Hospital for:

   1. Daily room and board and nursing services, not to exceed the Hospital's most common semi-private room rate;
   2. Daily room and board and nursing services while confined in an intensive care unit;
   3. Inpatient use of an operating, treatment, or recovery room;
   4. Outpatient use of an operating, treatment, or recovery room for Surgery;
   5. Services and supplies, including drugs and medicines, that are routinely provided by the Hospital to persons for use only while they are an Inpatient;
   6. Emergency treatment of an Injury or Sickness, even if Confinement is not required.

   Health care treatment or surgery performed on an outpatient basis at a facility equipped to perform these services, whether or not the facility is part of a hospital, will be covered on an inpatient basis, provided that such treatment is medically necessary, and provided by a health care provider who services would be covered under the policy if the treatment were performed in a hospital.

b) For Surgery in a Physician's office or at an Ambulatory/Outpatient Surgical Facility, including services and supplies;

c) Made by a Physician for professional services, including Surgery;

d) Anesthesia services if administered at the same time as a covered Surgery in a Hospital or Ambulatory/Outpatient Surgical Facility;

e) For anesthesia and hospital charges for dental care when provided to a child under age 5 or for someone who is severely disabled or has a medical condition and requires hospitalization or general anesthesia for dental care treatment. This covered service includes general anesthesia and treatment rendered by a dentist regardless of whether the services are provided in a hospital.

f) Made by an assistant surgeon, limited to 20 percent of the Eligible Charge for the covered Surgery;

g) For dressings, crutches, orthopedic splints, braces, casts, or other necessary medical supplies;

h) For Diagnostic Testing using radiologic, ultrasonographic, or laboratory services (psychometric, behavioral and educational testing are not included);

i) For chemotherapy and radiation therapy or treatment;

j) For hemodialysis, and the charges by a Hospital for processing and administration of blood or blood components;

k) For oxygen and its administration;

l) For dental expenses when a Covered Person suffers an Injury, after the Covered Person's Effective Date of Coverage, that results in:
   1) Damage to his or her natural teeth; and
   2) Expenses are incurred within six (6) months of the Accident or as part of a treatment plan that was prescribed by a Physician and began within six months of the Accident. Injury to the natural teeth will not include any injury as a result of chewing.

m) For a mastectomy as a result of breast cancer diagnosis. Coverage includes a minimum of forty-eight (48) hours Inpatient care following a mastectomy and twenty-four (24) hours Inpatient care following a lymph node dissection for the treatment of breast cancer;

n) Reconstructive breast surgery charges as a result of a partial or total mastectomy for breast cancer. Coverage includes surgery and reconstruction of the diseased and non-diseased breast and prosthetic devices necessary to restore a symmetrical appearance and treatment in connection with other physical complications resulting from the mastectomy including lymphedemas;

o) For charges made for services related to the diagnosis of infertility;

p) For Medically Necessary services and supplies used in the treatment of diabetes provided these services are rendered by a Physician or duly certified, registered or licensed health care professional with expertise in diabetes management. Covered Expenses include, but are not limited to, exams including podiatric exams; routine foot care such as trimming of nails and corns; laboratory and radiological Diagnostic Testing; self-management equipment and supplies such as urine and/or ketone strips, blood glucose monitor supplies (glucose strips) for the device, and syringes or needles; orthotics and diabetic shoes; urinary protein/microalbumin and lipid profiles; educational health and nutritional counseling for self-management, eye examinations, and prescription medication;

q) For Medically Necessary Manipulative Therapy treatment on an Outpatient basis only. See the Schedule of Benefits for benefit levels or additional limits. Covered Expenses are subject to all other terms and conditions of the Policy, including deductible and coinsurance percentage provisions;

r) For Maternity and Newborn Infant Care: Outpatient and Inpatient pre and post-partum care including exams, laboratory and radiology diagnostic testing, health education, nutritional counseling, risk assessment and childbirth classes. An Inpatient stay is covered for at least forty-eight (48) hours following an uncomplicated vaginal delivery, and for at least ninety-six (96) hours following an uncomplicated caesarean delivery. If the mother and newborn child have a shorter hospital stay than that provided above, coverage under this benefit shall include one home visit by a registered nurse. Services provided by the registered nurse include, but are not limited to, parent education, assistance and training in breast and bottle feeding, and conducting any

necessary and appropriate clinical tests. The home visit must be conducted within four (4) days following Hospital discharge of the mother and newborn child. Covered Expenses for a newborn child, including nursery charges, are subject to a separate Deductible and Coinsurance than Covered Expenses for the mother.

s) For the following types of human organ transplants:

1) Allogeneic and autologous bone marrow transplant/stem cell rescue;
2) Cornea;
3) Heart;
4) Kidney;
5) Liver;
6) Lung(s);
7) Pancreas;
8) Small intestine (small bowel);
9) Simultaneous heart/lung;
10) Simultaneous kidney/pancreas;
11) Any other transplants authorized by us.

All Covered Expenses for specified human organ transplant services, except anti-rejection drugs and other transplant-related prescription drugs, must be provided during the benefit period that begins five days before, and ends one year after, the organ transplant.

t) For health service benefits to any Covered Person on the same basis as other benefits under the Plan, for the treatment of emotionally disabled children in a residential treatment facility licensed by the commissioner of human services. For purposes of this benefit "emotionally disabled child" shall have the meaning set forth by the commissioner of human services in the rules relating to residential treatment facilities;

u) For inpatient or outpatient expenses arising from medical and dental treatment up to the limiting age for coverage of the dependent child, including orthodontic and oral surgery treatment, involved in the management of birth defects known as cleft lip and cleft palate. Benefits for individuals age 19 up to the limiting age for coverage of the dependent are limited to inpatient or outpatient expenses arising from medical and dental treatment that was scheduled or initiated prior to the dependent turning age 19. If orthodontic services are eligible for coverage under a dental insurance plan and another policy or contract, the dental plan shall be primary and the other policy or contract shall be secondary. Payment for dental or orthodontic treatment not related to the management of the congenital condition of cleft lip and cleft palate shall not be covered under this provision;

v) For surgical and nonsurgical treatment of temporomandibular joint disorder and craniomandibular disorder;

w) For low protein food products and amino acid modified preparations for the treatment of inherited metabolic diseases, if the low protein food products and the amino acid modified preparations are Medically Necessary and recommended by a physician. Inherited Diseases shall mean a disease caused by the inherited abnormality of body chemistry, including phenylketonuria;

x) For the treatment of Lyme disease;

y) For elimination or maximum feasible treatment of port-wine stains;

z) For routine patient costs associated with approved clinical trials.

**Miscellaneous Outpatient Medical Services and Supplies Benefit**

Covered Expenses for miscellaneous Outpatient medical services and supplies are limited to charges:

a) For artificial eyes or larynx, breast prosthesis, or basic artificial limbs (but not the replacement thereof, unless required by a physical change in the Covered Person and the item cannot be modified). If more than one prosthetic device can meet a Covered Person's functional needs, only the charge for the most cost effective prosthetic device will be considered a Covered Expense;

b) For one hearing aid for each ear, every three (3) years for a Covered Person 18 years of age or younger;

c) For Medically Necessary genetic blood tests;

d) For Medically Necessary immunizations to prevent respiratory syncytial virus (RSV);

e) For two mastectomy bras per year if the Covered Person has undergone a covered mastectomy;

f) For rental of a standard hospital bed, a standard walker, a standard non-motorized wheelchair, a wheelchair cushion, and a ventilator;

g) For the cost of one continuous passive motion (CPM) machine per Covered Person following a covered joint Surgery;

h) For the cost of one wig per Covered Person necessitated by hair loss due to cancer treatments or traumatic burns. See the Schedule of Benefits for benefit levels or additional limits;

i) For one scalp hair prostheses per benefit year that is worn for hair loss suffered as a result of alopecia ariata;

j) For one pair of eyeglasses or contact lenses per Covered Person following a covered cataract surgery. See the Schedule of Benefits for benefit levels or additional limits.

**Outpatient Prescription Drug Benefit**

Covered Expenses for Outpatient Prescription Drugs are limited to charges from a licensed pharmacy for a Prescription Drug if the Prescription Drug is:

a) approved by the United States Federal Drug Administration (FDA) not including medically necessary drugs used for the treatment of cancer if it is recognized for treatment of cancer in one of the standard reference compendia or in one article in the medical literature;
b) legally obtainable from only a licensed pharmacist and only upon written prescription from a Physician;
c) prescribed while the Covered Person is not Confined as an Inpatient; and
d) dispensed while such person is covered under this Policy.

**Definitions:** For purposes of this benefit subsection the following definitions apply:

a) Drugs (Prescription Drugs) mean Prescription Drugs approved by state law or the Federal Food and Drug Administration for general use by the public. For purposes of this benefit, insulin is considered a Prescription Drug.
b) Generic Prescription Drug is a pharmaceutical equivalent of one or more Brand Name Drugs and must be approved by the Food and Drug Administration as meeting the same standards of safety, purity, strength and effectiveness as the Brand Name Drug. These Prescription Drugs are generally less costly than their Brand-Name Drug.

c) Preferred Brand Name Prescription Drug is a Prescription Drug that has been patented and is only produced by one manufacturer and has been determined to be superior or equal to brand Non-Preferred Prescription Drugs and generally more cost effective.
d) Non-Preferred Brand Name Prescription Drug is a Prescription Drug that has a more cost effective therapeutic alternative.
e) Specialty Drug is a Prescription Drug that is used to treat rare and chronic diseases. Some Specialty Drugs are oral medications, but the majority of Specialty Drugs may require injection, infusion or inhalation. They may be administered by a Physician as an Outpatient or self-administered in a home setting and are listed on the Specialty Drug List maintained by us or our authorized designee as revised from time-to-time. Specialty Drugs require Prior Authorization before a Covered Person receives them.

The appropriate Drug choice for a Covered Person is a determination that is best made by the Covered Person and his or her Physician. Covered Expenses are payable after satisfaction of the Deductible or Copayment, if applicable, and subject to the Coinsurance shown in the Schedule of Benefits. The Coinsurance varies by the type of drug being dispensed.

Covered Expenses include prescribed orally administered anti-cancer medications on a basis no less favorable than intravenously administered or injected cancer medications.

Covered Expenses include antipsychotic drugs prescribed to treat emotional disturbance or mental illness.

**Participating Pharmacy**
Present the identification (ID) card to the Participating Pharmacy to obtain benefits. The following cost sharing provisions apply to covered Outpatient Prescription Drugs purchased at a Participating Pharmacy when the ID card is used to obtain benefits:

a) When a covered Generic Prescription Drug is available and that Generic Drug is received, the Covered Person pays the Plan Deductible and Plan Coinsurance for that Generic Prescription Drug as shown in the Schedule of Benefits.

b) When a Generic Drug is not available and a Brand Name (either Preferred or Non-Preferred) Prescription Drug is received, the Covered Person pays the Plan Deductible and Plan Coinsurance for that Brand Name Prescription Drug as shown in the Schedule of Benefits.

c) If a Preferred or Non-Preferred Brand Name Prescription Drug is received when a Generic Prescription Drug is available, the Covered Person pays the Plan Deductible and Plan Coinsurance for that Preferred or Non-Preferred Brand Name Prescription Drug, plus the difference in the charge between the cost of the Brand Name Drug and the Generic Drug. This cost will not be reimbursed by us nor does it count toward satisfying any Coinsurance, Deductible or other Out-of-Pocket Maximum.

If the Covered Person does not use the ID card to obtain Prescription Drugs at a Participating Pharmacy, the Covered Person must pay for the Prescription Drugs in full at the Participating Pharmacy. To receive reimbursement for Covered Expenses, the Covered Person must file a Claim with us. The Covered Person will be reimbursed at the Negotiated Rate that would have been paid to a Participating Pharmacy for the cost of the covered Prescription Drug.

**Non-Participating Pharmacy**
When the Covered Person has a Prescription Drug filled at a Non-Participating Pharmacy, the Covered Person must pay for the Prescription Drug in full at the Non-Participating Pharmacy. To receive reimbursement for Covered Expenses, the Covered Person must file a Claim with us. The Covered Person will be reimbursed subject to the Out of Network Plan Deductible and Plan Coinsurance shown in the Schedule of Benefits.

**Designated Specialty Pharmacy Providers**

A Covered Person must obtain Prior Authorization from us before a Specialty Drug is considered for possible coverage. Please refer to Part IV Prior Authorization section. If the Specialty Drug is authorized, we will advise the Covered Person how the Specialty Drug can be obtained from a Designated Specialty Pharmacy Provider and how to file a Claim with us.

**Non Covered Services**

The following are not Covered Expenses under this subsection:

a) Self-administered injectable drugs, except insulin;
b) Charges for more than a thirty-four (34) day supply when dispensed in any one prescription or refill or any refill dispensed after twelve (12) months from the date of the Physician's original order;
c) Drugs and medications used to induce non-spontaneous abortions;
d) Drugs for the treatment of erectile dysfunction or to assist in or enhance sexual performance;
e) Dietary supplements; vitamins (except pre-natal vitamins), mineral, herb or botanical product which is believed to have health benefits, but does not have Food and Drug Administration (FDA) approved indication to treat, diagnose or cure a medical condition;
f) Drugs taken while a Covered Person is an Inpatient in a Health Care Facility;
g) Any Drug labeled "Caution, limited by federal law to investigational use" or Non-FDA approved investigational Drugs;
h) Syringes and/or needles, except those dispensed for use with insulin;
i) Immunizing agents, biological sera, blood, blood products or blood plasma;
j) Professional charges in connection with administering, injecting or dispensing of Drugs;
k) Drugs and medications dispensed or administered in an Outpatient setting, including but not limited to Outpatient Hospital facilities and Doctor's offices;
l) Drugs used for cosmetic purposes;
m) Drugs used for the primary purpose of treating infertility;
n) Anorexiants or Drugs associated with weight loss;
o) Drugs obtained outside the United States;
p) Drugs for treatment of a condition, Sickness or Injury for which benefits are excluded or limited by other contract limitation;
q) Growth Hormone Treatment;
r) Over the counter medications and Prescription Drugs with a non-prescription (over the counter) chemical and dose equivalent, except as specified in the Preventive Care Services and Supplies Benefit under Part III DESCRIPTION OF COVERED SERVICES.

**Preventive Care Services and Supplies Benefit**

This benefit describes Covered Expenses provided to a Covered Person while they are well. Benefits for preventive care services and supplies listed in this provision are exempt from any Deductibles, Coinsurance and Copayment amounts under the Policy when the services are provided by an In-Network provider. Covered Expenses are subject to the applicable Deductible and Coinsurance requirements applicable to Out-of-Network Providers shown in the Schedule of Benefits.

As new recommendations and guidelines are issued, those services will be considered Covered Expenses when required by the United States Secretary of Health and Human Services, but not earlier than one year after the recommendation or guideline is issued.

Benefits include the charges incurred by a Covered Person for the following preventive health services if appropriate for that Covered Person in accordance with the following recommendations and guidelines:

A. 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) including but not limited to:

1. Routine screening procedures for cancer and the office or facility visit, including mammogram, surveillance tests for ovarian cancer for women who are at risk for ovarian cancer, pap smears, and colorectal screening tests for men and women when ordered or provided by a physician in accordance with the standard practice of medicine;

2. Colorectal Cancer Screening and Examination in accordance with standard, accepted published medical practice guidelines for colorectal cancer screening for Covered Persons age fifty (50) and older or for those Covered Persons under age fifty (50) who are at high risk for colorectal cancer include:
   a) Fecal occult blood test annually;
   b) Flexible Sigmoidoscopy every three (3) years;
   c) Colonoscopy every ten (10) years for low to moderate risk and every five (5) years for high risk persons.

3. Mammography
   a) A baseline mammogram for an asymptomatic women at least thirty-five (35) years of age; and
   b) An annual mammogram for an asymptomatic women age forty (40) and over after a baseline mammogram.

   Benefits will be provided for any woman when a Physician's evaluation of a woman's physical condition, symptoms or risk factors indicates a probability of breast cancer higher than the general population.

4. Prostate Cancer Screening - an annual screening for early detection of prostate cancer for men age forty (40) and older, consisting of a minimum of a prostate-specific antigen blood test and a digital rectal examination.

B. Immunizations for routine use in children, adolescents and adults that have in effect a recommendation from the Advisory Committee on Immunization Practices of the Centers for Disease Control and Prevention, including but not limited to (a) diphtheria, (b) hepatitis B, (c) measles, (d) mumps, (e) pertussis, (f) polio, (g) rubella, (h) tetanus, (i) varicella, (j) haemophilus influenza type B, and (k) hepatitis A, or any other immunization subsequently required for children by the State Board of Health, in effect for at least one year prior to the Effective Date of this Policy. Recommended doses and ages may vary by population.

C. With respect to Covered Persons who are infants, children and adolescents, evidence-informed preventive care and screenings provided for in comprehensive guidelines supported by the Health Resources and Services Administration include but are not limited to: for newborns: phenylketonuria (PKU) screening; screening for hearing loss; gonorrhea preventive medication for the eyes; hypothyroidism screening; and sickle cell screening; lead screening; iron supplementation for those children at risk of anemia; oral fluoride supplementation for children whose water supply is without fluoride; Child Health Supervision services from the moment of birth through the age of eighteen years at the following age intervals: birth, 2 months, 4 months, 6 months, 9 months, 12 months, 18 months, 2 years, 3 years, 4 years, 5 years, 6 years, 8 years, 10 years, 12 years, 14 years, 16 years and 18 years; Autism screening for children at 18 and 24 months; and for adolescents: alcohol and drug use assessments; depression screening; HIV screening; and sexually transmitted infection (STI) prevention and counseling.

D. With respect to Covered Persons who are adults, subject to specified age guidelines, additional preventive care services and screenings to the extent not included in A. above, evidence-informed preventive care and screenings provided for in comprehensive guidelines supported by the Health Resources and Services Administration include: abdominal aortic aneurysm one-time screening for men who have ever smoked; alcohol misuse screening and counseling; aspirin use to prevent cardiovascular disease; blood pressure screening; cholesterol screening; depression screening; diabetes (type 2) screening; diet counseling; HIV screening; lung cancer screening; obesity screening and counseling; sexually transmitted infection (STI) prevention and counseling; syphilis screening and tobacco use screenings and up to two (2) cessation interventions per Coverage Year for tobacco users.

E. With respect to Covered Persons who are women, additional preventive care and screening to the extent not included in A or D. above, evidence-informed preventive care and screenings provided for in accordance with comprehensive guidelines supported by the Health Resources and Services Administration include but are not limited to:

1. One well women preventive care visit per Coverage Year; for an adult woman to obtain the recommended preventive screening services that are age appropriate and developmentally appropriate;
2. One screening for gestational diabetes for pregnant women between 24-28 weeks of gestation and at the first prenatal visit for pregnant women identified to be high risk for diabetes;
3. High risk human papillomavirus DNA testing in women with normal cytology results. One screening is covered for females thirty (30) years of age and over and will be covered no more frequently than once every three (3) years;
4. Breast Cancer Genetic Test Counseling (BRCA) for women at higher risk for breast cancer;
5. Breast Cancer Chemoprevention counseling for women at higher risk;
6. Chlamydia infection screening for women under age twenty-nine (29) or other women at high risk;
7. One counseling session per Coverage Year for counseling on sexually transmitted infections for all sexually active women;
8. Gonorrhea screening for all women at higher risk;
9. One counseling session per Coverage Year for human immune-deficiency virus infection for all sexually active women;
10. All Food and Drug Administration approved contraceptive methods, sterilization procedures, and patient education and counseling for all women with reproductive capacity. This benefit does not include coverage for abortifacient drugs;
11. One screening and counseling for interpersonal and domestic violence per Coverage Year;
12. Folic Acid supplements for women who may become pregnant;
13. Anemia screening on a routine basis for pregnant women;
14. Syphilis screening for all pregnant women or other women at increased risk;
15. Hepatitis B screening for pregnant women at the first prenatal visit;
16. RH Incompatibility screening for all pregnant women and follow-up testing for women at higher risk;
17. Prenatal care services which includes medical and psychosocial support provided throughout the pregnancy, including risk assessment, serial surveillance, prenatal education, and use of specialized skills and technology, when needed, as defined by Standards for Obstetric-Gynecologic Services issued by the American College of Obstetricians and Gynecologists;

18. Breastfeeding support, supplies and counseling in conjunction with each birth. Comprehensive lactation support and counseling in conjunction with each birth and/or in the postpartum period. Coverage includes the costs for renting or purchase of one breast pump per pregnancy for the duration of the breast feeding;
19. Osteoporosis screening for women over age forty-five (45) depending on risk factors, for a medically accepted bone mass measurement. A qualified woman is a Covered Person who; (i) has an estrogen deficiency with vertebral abnormalities, primary hyperparathyroidism or a history of fragility bone fracture; or (ii) is receiving long term glucocorticoid or (iii) is currently under treatment for osteoporosis.

**Substance Abuse Benefit**

Covered Expenses for Inpatient and Outpatient treatment of Substance Abuse Disorders are covered the same as any other Illness. Prior Authorization is required before a Covered Person may qualify to receive benefits.

**Transplant Covered Expenses**

If we determine that a Covered Person is an appropriate candidate for a listed transplant, Covered Expenses will be provided for:

a) Pre-transplant evaluation;
b) Pre-transplant harvesting;
c) Pre-transplant stabilization, meaning an Inpatient stay to medically stabilize a Covered Person to prepare for a later transplant, whether or not the transplant occurs;
d) High dose chemotherapy;
e) Peripheral stem cell collection;
f) The transplant itself, not including the acquisition cost for the organ or bone marrow;
g) Post-transplant follow-up to 365 days after the transplant Surgery, or a lesser period not to exceed the termination date of this Policy.

We will cover the medical expenses incurred by a live donor as if they were medical expenses of the Covered Person if:

a) They would otherwise be considered Covered Expenses under the Policy, but will be limited by any payment which might be made under any other hospitalization coverage plan*;*
b) The Covered Person received an organ or bone marrow of the live donor; (i.e. donation made to a Covered Person);
c) The transplant was a listed transplant.

A Covered Person may obtain services in connection with a listed transplant from any Provider of such services. However, if services are received from a Participating Provider Covered Expenses for the listed transplant will include:

a) the acquisition cost of the organ or bone marrow;
b) We will pay a maximum of $10,000 per lifetime for the following services:
    1) Transportation for the Covered Person*,* any live donor, and the Immediate Family to accompany the Covered Person;
    2) Lodging at or near the Participating Hospital for any live donor and the Immediate Family accompanying the Covered Person while the Covered Person is Confined in the Participating Hospital.

We will pay the costs directly for transportation and lodging, however, you must make the arrangements.

**Non Covered Services**

Covered Expenses under these Transplant Expense Benefits do not include charges:

a) For search and testing in order to locate a suitable donor;
b) For a prophylactic bone marrow harvest or peripheral blood stem cell collection when no listed transplant occurs;
c) related to animal to human transplants;
d) For artificial or mechanical devices designed to replace a human organ temporarily or permanently;
e) For procurement or transportation of the organ or tissue, unless expressly provided for in this provision;
f) To keep a donor alive for the transplant operation;
g) For a live donor where the live donor is receiving a transplanted organ to replace the donated organ;
h) Related to transplants not included as a listed transplant;
i) For a listed transplant under study in an ongoing phase I or II clinical trial as set forth in the United States Food and Drug Administration ("USFDA") regulation, regardless of whether the trial is subject to USFDA oversight.

**Limitations on Transplant Expense Benefits**

In addition to the exclusions and limitations specified elsewhere in this section:
a) Covered Expenses for listed transplants will be limited to two (2) transplants during any ten (10) year period for each Covered Person.
b) If a Participating Provider is not used, Covered Expenses for a listed transplant will be limited to a maximum for all expenses associated with the transplant. See the Schedule of Benefits for benefit levels or additional limits.
c) If a Participating Provider is not used, the acquisition cost for the organ or bone marrow is not covered.

## PART IV - PRIOR AUTHORIZATION

**Prior Authorization Required:** Some Covered Expenses require Prior Authorization. In general, Participating Providers must obtain authorization from us or our designee prior to providing a Covered Service or supply to a Covered Person. However, there are some Covered Expenses for which a Covered Person must obtain the Prior Authorization.

In general, for services or supplies that require Prior Authorization, as shown in the Schedule of Benefits, the Covered Person must obtain authorization from us if:

a) Receiving a service or supply from a Non-Participating Provider;

b) Admitted into a Network facility by a Non-Participating Provider; or

c) Receiving a service or supply from a Participating Provider to which the Covered Person was referred by a Non-Participating Provider.

**How to Obtain Prior Authorization**
To obtain Prior Authorization or to confirm that a Participating Provider has obtained Prior Authorization, contact us by telephone at the telephone number listed on the health insurance identification card before the service or supply is provided to the Covered Person.

**Failure to Obtain Prior Authorization**
Failure to comply with the Prior Authorization requirements will result in benefits being reduced. Please see the Schedule of Benefits for specific details.

Participating Providers cannot bill you for services for which they fail to obtain Prior Authorization as required.

Benefits will not be reduced for failure to comply with Prior Authorization requirements prior to an Emergency. However, you must contact us as soon as reasonably possible after the Emergency occurs.

**Prior Authorization Does Not Guarantee Benefits**
Prior Authorization does not guarantee either payment of benefits or the amount of benefits. Eligibility for, and payment of, benefits are subject to all terms and conditions of the Policy.

**Requests for Predeterminations**
You may request a predetermination of coverage. We will provide one if circumstances allow us to do so. However, we are not required to make a predetermination of either coverage or benefits for any particular treatment or medical expense. Any predetermination we may make will be reviewed after the medical expense is incurred and a Claim is filed. A review that shows one or more of the following may cause us to reverse the predetermination:

a) The predetermination was based on incomplete or inaccurate information initially received by us.

b) The medical expense has already been paid by someone else.

c) Another party is responsible for payment of the medical expense.

We will make all benefit determinations after a Loss in good faith. All benefit determinations are subject to our receipt of proper proof of loss.

## PART V - EXCLUSIONS AND LIMITATIONS

The Policy contains certain exclusions and limitations. Charges for any treatment, services, or supplies as described below will not be considered as Covered Expenses under the Policy and no benefits will be payable for such charges. The Policy does not provide any benefits for:

1. Any treatment, service or supply which is not due to a Sickness or Injury, except for Preventive Care as specified in Part III Description of Covered Services; or
2. Any treatment, service or supply unless administered or ordered by a Physician and is Medically Necessary to the diagnosis or treatment of an Injury or Sickness; or
3. Services or supplies received during an Inpatient stay when the stay is primarily related to behavioral, social maladjustment, lack of discipline or other antisocial actions that are not specifically the result of a Mental Health Disorder; or
4. Inpatient personal convenience items such as radio and television, massages, telephone charges, take home supplies and guest meals; or
5. Treatment, services or supplies for which you are not required to make payment or would have no legal obligation to pay if you did not have this or similar coverage; or
6. Treatment, services or supplies that are furnished to you by the local, state or federal government and for any services or supplies to the extent payment or benefits are provided or available from the local, state or federal government when payment or benefits are received; or
7. Hospital and Physician Charges for weekend Hospital admissions for non-Emergency procedures, unless Medically Necessary or unless Surgery is scheduled for the next day; or
8. Treatment, services or supplies for any Illness or Injury arising out of or in the course of employment for which benefits are available under any Workers' Compensation Law or other similar laws whether or not you make a claim for such compensation or receive such benefits; or
9. Physical or psychological examinations or Diagnostic Services required by any third party, such as by a court or for employment, premarital examinations, licensing, insurance, school, sports or recreational purposes and the completion of any forms for such examinations; or
10. Treatment, services or supplies for any Injury or Sickness resulting from war or any act of war, declared or undeclared, while serving in the military or an auxiliary unit attached to the military or working in an area of war whether voluntarily or as required by an Employer; or
11. Treatment, services or supplies for any Injury or Sickness incurred during the commission or attempted commission of a crime or felony or while engaged in any illegal occupation; or
12. Treatment, services or supplies for any Injury or Sickness for Loss incurred as a result of a Covered Person operating a motor vehicle while intoxicated, or being under the influence of any narcotic, barbiturate, or hallucinatory, unless administered by a Physician; or
13. Treatment of malocclusions; or
14. Treatment, services or supplies due to complications of a non-covered service; or
15. Cosmetic or plastic Surgery, or the complications of any such Surgery, except for Reconstructive Surgery that is incidental to or follows Surgery or an Injury that was covered under the Policy or is performed to correct a birth defect in a child who has been a Covered Person from birth until the date of Surgery; or
16. Breast augmentation or reduction; the removal of breast implants unless Medically Necessary and related to Surgery performed as Reconstructive Surgery due to a Sickness; and breast reduction Surgery unless Medically Necessary due to a Sickness. This exclusion does not apply to complications caused by a breast implant; or
17. Surgery to correct refractive errors, such as radial keratotomy or radial keratectomy; or

18. Routine eye exams, eye glasses, visual therapy, or contact lenses, or
19. Routine hearing exams except as specified in the Preventive Care Services and Supplies Benefit under Part III DESCRIPTION OF COVERED SERVICES; or
20. Assessment of the need for, or change to, hearing aids; and the purchase, fittings or adjustments of hearing aids except as specified in the Miscellaneous Outpatient Medical Services and Supplies Benefit under Part III DESCRIPTION OF COVERED SERVICES; or
21. Dental treatment, surgery, dental prostheses and orthodontic treatment except for dental care or services necessary due to congenital disease or anomaly; or
22. Penile implants; fertility and sterility studies; any treatment, services or supplies to restore or enhance fertility; or
23. Vasectomies and reversal of sterilization; or
24. Impregnation techniques such as: (a) artificial insemination; or (b) in vitro fertilization; including: in vitro zygote and intra-fallopian transfers, gamete intra-fallopian transfer, genetic counseling, and all Charges related to such in vitro fertilization; or
25. Injury or Sickness that is intentionally self-inflicted while sane, except that this exclusion does not apply to any self-inflicted Injury or Sickness that is the result of a medical condition; or
26. The voluntary taking of poison; or the voluntary inhaling of gas; or
27. Marriage or family counseling, recreational therapy, equine therapy, educational therapy, social therapy, or sex therapy; or
28. Services rendered to a surrogate mother who is not a Covered Person; or
29. Sexual reassignments or sexual dysfunctions or inadequacies; or
30. Alternative treatments as defined by the Office of Alternative Medicine of the National Institutes of Health including but not limited to: acupressure, acupuncture, aroma therapy, hypnotism, and massage therapy; or
31. Routine foot care, except for Covered Persons diagnosed with diabetes, including the cutting or removal of corns, calluses or bunions, the trimming of nails, routine hygienic care and any service rendered in the absence of localized Illness, Injury or symptoms involving the feet; or
32. Treatment of flat foot conditions and the prescription of supportive devices for such conditions and the treatment of subluxations of the foot; or
33. Orthotics – specially fitted inserts to a shoe; or
34. Obesity, extreme obesity, morbid obesity or weight reduction, unless specified in the Preventive Care Services and Supplies Benefit under Part III DESCRIPTION OF COVERED SERVICES, including wiring of the teeth and all forms of surgery including bariatric surgery, intestinal bypass surgery and complications resulting from such surgery; or
35. Any services performed by a member of a Covered Person's Immediate Family; or
36. Experimental or Investigational treatment, services and supplies (including Prescription Drugs or medications) and all related services and supplies; or
37. Any surgical removal of an organ or tissue unless Medically Necessary; or
38. Any over-the-counter medication or medication that may be obtained without a prescription unless specified in the Preventive Care Services and Supplies Benefit under Part III DESCRIPTION OF COVERED SERVICES; or
39. Blood derivatives that are not classified as drugs in the official formularies; or
40. Custodial Care, regardless of who prescribes or renders such care; or
41. Treatment, services or supplies received or purchased outside the United States, except for an Emergency, while traveling for up to a maximum of ninety (90) consecutive days. If travel extends beyond ninety (90) consecutive days, no coverage is provided for Emergency Medical Care for

the entire period of travel including the first ninety (90) days; or

42. Any education or training materials including, programs or materials for management of pain, asthma and heart disorders; or

43. Equipment, other than Durable Medical Equipment, including, modifications to motor vehicles or motor homes; wheelchair lifts or ramps; water therapy devices, such as Jacuzzis or hot tubs; and exercise equipment or comfort and convenience items commonly used for other than medical purposes such as air conditioners, humidifiers, physical fitness equipment, television and telephones; or

44. flying as a pilot or crew member of any aircraft or travel or flight, including boarding or alighting, in any vehicle or device while being used for any test or experimental purposes or while being operated by, for or under the direction of any military authority other than the Military Airlift Command (MAC) of the United States or similar air transport service of any other country; or

45. An Injury sustained during or due to participating, instructing, demonstrating, guiding, or accompanying others in any of the following: operating or riding on a motorcycle; professional or semi-professional sports; intercollegiate sports (not including intramural sports); parachute jumping; hang-gliding; racing or speed testing any motorized vehicle or conveyance; racing or speed testing any non-motorized vehicle or conveyance (if the Covered Person is paid to participate or to instruct); scuba/skin diving (when diving 60 or more feet in depth); skydiving; bungee jumping; rodeo sports; horseback riding (if the Covered Person is paid to participate or to instruct); rock or mountain climbing (if the Covered Person is paid to participate or to instruct); or skiing (if the Covered Person is paid to participate or to instruct); or

46. Telephone and electronic consultations, appointment fees for failing to keep a scheduled visit, fees for completing claim forms, fees related to obtaining Prior Authorization, and fees related to the provision of medical records; or

47. Any treatment, services or supplies not identified or included as a Covered Expense under the Policy. You will be fully responsible for payment for any services that are not Covered Expenses; or

48. Treatment services or supplies that are provided prior to the Effective Date or after the termination date of this Policy, except as provided for under the Extension of Benefits provision; or

49. Treatment, services and supplies related to an abortion; except if the life of the mother would be in danger if the fetus were carried to term.

## PART VI - COORDINATION OF BENEFITS (COB)

If the Covered Person is covered by more than one group medical plan, the Covered Person's benefits under This Plan will be coordinated with the benefits of those Other Plans, as shown below. These coordination provisions apply separately to each Covered Person, per Coverage Year, and are largely determined by law. Benefits from This Plan and any Other Plan are limited to the actual charges incurred. Any coverage the Covered Person has for medical benefits will be coordinated as shown below.

**Definitions**
The meanings of key terms used in this Part VI are shown below. Whenever any of the key terms shown below appear in these provisions, the first letter of each word will be capitalized. When the Insured sees these capitalized words, then he/she should refer to this Definitions provision.

**Allowable Expense** the portion of a Covered Expense used in determining the benefits This Plan pays when it is the Secondary Plan. The Allowable Expense is the lesser of:

a) The charge used by the Primary Plan in determining the benefits it pays;
b) The charge that would be used by This Plan in determining the benefits it would pay if it were the Primary Plan, and
c) The amount of the Covered Expense.

**Insured Dependent** is a member of the Insured's family who is eligible for and has coverage under This Plan.

**Other Plan** is any of the following:

a) Group, blanket or franchise insurance coverage, except blanket student accident coverage;
b) Group service plan contract, group practice, group individual practice and other group prepayment coverages;
c) Group coverage under labor management trustee plans, union benefit organization plans, employer organization plans, employee benefit organization plans, or self-insured employee benefit plans.

The term "Other Plan" refers separately to each agreement, policy, contract, or other arrangement for services and benefits, and only to that portion of such agreement, policy, contract, or arrangement, which reserves the right to take the services or benefits of other plans into consideration in determining benefits.

**Primary Plan** is that plan which will have its benefits determined first.

**Secondary Plan** is the plan, which will have its benefits determined after the Primary Plan.

**This Plan** is that portion of this Plan, which provides benefits subject to this provision.

**Order of Benefits Determination**
The following rules determine the order in which benefits are payable:

a) A plan, which has no Coordination of Benefits provision, pays before a plan, which has a Coordination of Benefits provision.
b) A plan which covers the Covered Person as an Eligible Employee pays before a plan that covers the Covered Person as an Eligible Dependent.
c) For a dependent child covered under plans of two parents, the plan of the parent whose birthday falls earlier in the Calendar Year pays before the plan of the parent whose birthday falls later in the Calendar Year. But if one plan does not have a birthday rule provision, the provisions of that plan determine the order of benefits.

**Exception to** c) **above:** For a dependent child of parents who are divorced or separated, the following rules will be used in place of c):

1) If the parent with custody of that child for whom a Claim has been made has not remarried, then the plan of the parent with custody that covers that child as an insured dependent pays first.

2) If the parent with custody of the child for whom a Claim has been made has remarried, then the order in which benefits are paid will be as follows:
    a. The plan which covers the child as an insured dependent of the parent with custody.
    b. The plan which covers the child as an insured dependent of the stepparent (married to the parent with custody).
    c. The plan which covered the child as an insured dependent of the parent without custody.
    d. The plan which covers the child as an insured dependent of the stepparent (married to the parent without custody).
3) Regardless of 1) and 2) above, if there is a court decree which establishes a parent's financial responsibility for that child's health care coverage, a plan which covers that child as an insured dependent of that parent pays first.

d) The plan covering the Insured as a laid-off or retired employee or as an Eligible Dependent of a laid-off or retired Insured pays after a plan covering the Insured as other than a laid-off or retired employee or the Eligible Dependent of such a person. But if either plan does not have a provision regarding laid-off or retired participant, Rule f) applies.
e) If a Covered Person whose coverage is provided under a right of continuation pursuant to federal or state law is also covered under another plan, the following shall be the order of benefit determination:
    1) First the benefits of a plan covering the Insured as an Eligible Employee (or as that person's Eligible Dependent).
    2) Second the benefits under the continuation coverage.
f) When the above rules do not establish the order of payment, the plan which the Covered Person has been enrolled the longest pays first.

**Effect on the Benefits Payable:** If This Plan is the Primary Plan, according to the Order of Benefits Determination provision above, the amount This Plan pays for a Covered Expense will be determined without regard to the benefits payable under any Other Plan.

If This Plan is Secondary, according to the Order of Benefits Determination provision above, the amount this Plan pays for a Covered Expense is the Allowable Expense less the amount payable by the Primary Plan during a claim determination period.

When we are the Secondary Plan, the benefits payable under This Plan will be reduced to the extent necessary so that when our benefit payments are added to the benefits payable under all Other Plans, all benefit payments do not exceed the total Allowable Expense for any services or supplies.

**Right to Receive and Release Needed Information**: Certain facts are needed to apply these COB rules. We may get material facts from each person claiming benefits and also gather material facts from or give them to any other insurance company or group health benefit plan administrator with whom we coordinate benefits.

**Responsibility for Timely Notice:** We are not responsible for coordination of benefits unless timely information has been provided by the requesting party regarding the application of this provision.

**Reasonable Cash Value:** If any Other Plan provides benefits in the form of services rather than cash payment, the reasonable cash value of services provided will be considered the Allowable Expense. The reasonable cash value of such service will be considered a benefit paid, and our liability reduced accordingly.

**Facility of Payment:** If payments which should have been made under This Plan have been made under any Other Plan, we have the right to pay that Other Plan any amount we determine to be warranted to satisfy the intent of this provision. Any such amount will be considered a benefit paid under This Plan, and such payment will fully satisfy our liability under this provision.

**Right of Recovery:** If payments made under This Plan exceed the maximum payment necessary to satisfy the intent of this provision, we have the right to recover that excess amount from any persons or organizations to or for whom those payments were made, or from any insurance company or service plan.

## PART VII - CONTINUATION OF COVERAGE

Coverage for Covered Services incurred as a result of Injury or Sickness may be continued under certain circumstances.

Evidence of insurability is not required for this provision. If a Covered Person exercises this provision, it will be in lieu of any continuation rights granted under the Consolidated Omnibus Budget Reconciliation Act of 1985 ("COBRA").

**Eligibility**:

**Insured -** Insureds may elect to continue coverage for themselves and their covered dependents . Coverage may be continued for eighteen (18) months if one of the following events occurs:

a) an Insured's employment is terminated for any reason other than gross misconduct; or

b) a change in eligible class or a reduction in an Insured's hours results in the loss of coverage.

**Disabled Insured -** Insureds who are determined to be disabled under the Social Security Act within sixty (60) days of the date they become eligible for continuation under this provision may continue coverage for themselves and their covered dependents for up to twenty-nine (29) months.

**Dependents -** A covered dependent may elect to continue coverage for a period of thirty-six (36) months if one of the following occurs:

a) a dependent child is no longer a dependent child for the purposes of the plan; or

b) the Insured becomes entitled to Medicare benefits.

**Coverage**:

If a Covered Person exercises this provision, coverage will be identical in scope to the coverage provided in the Policy.

**Premiums**:

The Covered Person will pay premiums directly to the Policyholder with the option of paying in monthly installments. The premiums will not exceed 102 percent of the applicable premium for such period.

**Notice Requirements**:

The Policyholder must notify us in writing within thirty-one (31) days after the date:

a) the Insured dies;

b) the Insured's employment is terminated, the Insured's hours are reduced or the Insured fails to remain in an eligible class; or

c) the Insured becomes entitled to Medicare benefits.

Each covered dependent who wishes to continue coverage must notify us in writing within sixty (60) days after the date a dependent child is no longer a dependent child for the purposes of the plan.

Upon our receipt of any such notice, we must give written notice of the right to continue coverage to the Covered Person(s) within fourteen (14) days.

Covered Persons who wish to continue coverage must notify us in writing within sixty (60) days after the date they receive notice of their right to continue coverage.

**Termination**:

Covered Persons who exercise this provision will not have their coverage interrupted or canceled or otherwise terminated until the date on which:

a) they fail to make a premium payment in the time required to make that payment;

b) they become eligible for substantially similar coverage under another health insurance policy, hospital or medical service subscriber contract, medical practice or other prepayment plan, or any other plan or program (including Medicare);

c) the required period for continued coverage ends; or

a) the Policy is terminated.

**Continuation of Coverage for Survivors:**

If the Insured dies, the surviving dependents may choose to continue coverage under the Policy while this Policy remains in force, until the earlier of the following dates:

a) the date the surviving spouse becomes covered under another group health plan; or

b) the date coverage would have terminated under the Policy, had the Insured lived.

If the dependent(s) elect to continue coverage, the dependent(s) must pay, on a monthly basis, the entire cost of the continued coverage. In no event shall the amount of premium charged exceed 102% of the cost to the Plan for such period of coverage for other similarly situated spouses and dependent children who are not the survivors of a deceased Insured, without regard to whether such cost is paid by the employer or employee.

Failure of the survivor to make premium payments within 90 days after notice of the requirement to pay the premiums shall be a basis for the termination of the coverage without written consent. In event of termination by reason of the survivor's failure to make required premium contributions, written notice of cancellation will be mailed to the survivor's last known address at least 30 days before the cancellation. Any required premium contributions for the coverage shall be paid by the survivor to the Policyholder for remittance to the Insurer.

**Continuation of Coverage for Former Spouse and Children:**
If there is a break in the marital relationship, the Insured’s former spouse and children may choose to continue coverage under the Policy while this Policy remains in force, until the earlier of the following dates:

a) the date the former spouse becomes covered under another group health plan; or

b) the date coverage would otherwise terminate under the Policy.

If the former spouse elects to continue coverage, the former spouse must pay, on a monthly basis, the entire cost of the continued coverage. In no event shall the amount of premium charged exceed 102% of the cost to the Plan for such period of coverage for other similarly situated spouses and dependent children with respect to whom the marital relationship has not dissolved, without regard to whether such cost is paid by the employer or employee.

## PART VIII - PREMIUMS

Premiums are shown in the Schedule of Benefits. The premium must be remitted to us not more than 31days after the effective date of the eligible person's coverage. A person's coverage is not affected by the Policyholder's failure, due to clerical error, to remit premiums to us on time.

Rates are provided on a group basis. Premiums may be changed on any premium due date, on or after the first anniversary of the Policy, with thirty-one (31) days advance notice in writing to the Policyholder.

**Grace Period:** The Policyholder has a thirty-one (31) day grace period after each premium due date after the first premium. If a subsequent premium is not paid by the end of the grace period, coverage ends as of the premium due date. If this happens, the Policyholder owes us all premiums then due, including any premium due for the grace period or for any part of the grace period.

**Reinstatement:** If any renewal premium be not paid within the grace period, a subsequent acceptance of premium by the insurer or by any agent duly authorized by the insurer to accept such premium, without requiring in connection therewith an application for reinstatement, shall reinstate the policy. If the insurer or such agent requires an application for reinstatement and issues a conditional receipt for the premium tendered, the policy will be reinstated upon approval of such application by the insurer or, lacking such approval, upon the forty-fifth day following the date of such conditional receipt unless the insurer has previously notified the insured in writing of its disapproval of such application. The insurer will accept payment of a renewal premium and reinstate the policy, if the policyholder applies for reinstatement no later than 60 days after the due date for the premium payment, unless: (a) the policyholder has in the interim left the state or the insurer's service are; or (b) the policyholder has applied for reinstatement on two or more prior occasions.

The reinstated policy shall cover only loss resulting from such accidental injury as may be sustained after the date of reinstatement and loss due to such sickness as may begin more than ten days after such date. In all other respects the insured and insurer shall have the same rights thereunder as they had under the policy immediately before the due date of the defaulted premium, subject to any provision endorsed hereon or attached hereto in connection with the reinstatement. Any premium accepted in connection with a reinstatement shall be applied to a period for which premium has not been previously paid, but not to any period more than 60 days prior to the date of reinstatement.

## PART IX - CLAIM PROVISIONS

**Notice of Claim:** Written notice of Claim must be given within twenty (20) days after a covered Loss starts or as soon as is reasonably possible. The notice must be given to the Administrator named on the face page of this certificate. Notice should include information that identifies the claimant and the Policy.

**Claim Forms:** When the Administrator receives notice of Claim, forms for filing proof of loss will be sent to the claimant. If these forms are not sent within fifteen (15) days, the claimant will meet the proof of loss requirements if the Administrator named on the face page of this certificate is given, within the time fixed in the Policy for filing proofs of loss, written proof of the nature and extent of the Loss for which Claim is made.

**Proof of Loss:** Written proof of loss must be given to the Administrator named on the face page of this certificate within ninety (90) days after the Loss starts. We will not deny or reduce any Claim if it was not reasonably possible to give proof of loss in the time required. In any event, proof must be given to the Administrator within one year after it is due, unless the Insured is legally incapable of doing so.

**Time of Payment of Claim:** Benefits for Loss covered by the Policy will be paid immediately upon receipt of proper written proof of the loss. A clean claim must be paid or denied within 30 calendar days after the date upon which we have received the claim. If the claim is not paid or denied within that time frame, we will pay 1.5% interest per month or any part of the month on the claim for the period beginning on the day after the required payment date and ending on the date on which we make payment or deny the claim. A "clean claim" means a claim that has no defect or impropriety, including any lack of any required substantiation documentation, including, but not limited to, coordination of benefits information, or

particular circumstance requiring special treatment that prevents timely payment from being made on a claim.

**Payment of Claims:** All benefits will be paid to the Insured, if living, or to the beneficiary. If a beneficiary has not been designated, then benefits will be paid to the Insured's estate.

If any benefit of this Policy is payable to the estate of the Insured, or to an Insured or beneficiary who is a minor or otherwise not competent to give a valid release, we may pay such benefit, up to an amount not to exceed $1,000, to any relative by blood or connection by marriage of the Insured or beneficiary who is deemed by us to be equitably entitled to such payment. Any payment made by us in good faith pursuant to this provision fully releases us to the extent of the payment.

**Change of Beneficiary:** The beneficiary is the last person named in writing by the Covered Person and recorded by or on the Insurer's behalf. The beneficiary can be changed at any time by sending a written notice to the Insurer or to its Administrator. The beneficiary's consent is not required for this or any other change in the Plan unless the designation of the beneficiary is irrevocable.

**Physical Examination:** At our expense, we may have a person claiming benefits examined as often as reasonably necessary while the Claim is pending.

**Legal Action:** No legal action may be brought to recover on the Policy before sixty (60) days after written proof of loss has been furnished as required by the Policy. No action may be brought after three (3) years from the time written proof of loss is required to be furnished.

## PART X - GRIEVANCE AND APPEAL PROCEDURES

In response to Health Care Reform, State Law provides for an internal and independent external review of grievances. . You have the right to file a Grievance on any matter pertaining to Your contractual relationship with Us.

As used in this notice, the terms "You" and "Yours" means the insured or covered person. The terms "We", "Us" and "Our" refer to BCS Insurance Company (BCSI).

No covered person who exercises the right to file a Grievance or Appeal shall be subject to disenrollment or otherwise penalized due to the filing of a grievance or appeal.

All complaint procedures are voluntary and at any time, You, Your health care provider or Your authorized representative, may seek the assistance of the Minnesota Department of Commerce, by writing to or calling at the following address:

Mail: External Review Process
State of Minnesota
Department of Commerce
85 7th Place East
St. Paul, MN 55101

Phone: 1-800-657-3602 or (651) 296-2488 (Option #1)
Fax: (651) 296-4328

Upon request, We may provide this notice to You in a culturally and linguistically appropriate manner consistent with the requirements of the Federal Affordable Care Act.

**Level 1: Internal Review (Grievance)**
If a claim is denied either in whole or in part, You, Your treating physician or authorized representative, may file a Grievance either orally (by telephone or in person) or in writing within 180 days of receiving a denial in Your claim.

If Your claim was denied due to missing or incomplete information, You, Your treating physician or

authorized representative, may resubmit the claim to Us with the necessary information to complete the claim.

You, Your treating physician or authorized representative, have the right to complain about any decision We make that denies payment on the claim for coverage of a health care service or treatment.

You, Your treating physician or authorized representative, may request more explanation when Your claim for coverage of a health care service or treatment is denied or was no fully covered.

Contact us when You:

- Do not understand the reason for the denial;
- Do not understand why the health care service or treatment was not fully covered;
- Cannot find the applicable provision in Your Benefit Plan Document; or
- Disagree with the denial or the amount not covered and You want to appeal.

Your request should contain an explanation of all pertinent issues. To contact Us, You may:

- Sending an email to: bcsassist@bcsf.com
- Calling Us at Our toll free number: (877) 777-3092
- Writing Us at the following address:

  Essential StaffCARE
  Attention: Claims Appeal
  P.O. Box 6702
  Columbia, SC 29260

If Your claim was denied due to missing or incomplete information, You, treating physician or authorized representative, may resubmit the claim to Us with the necessary information to complete the claim.

Within 5 business days of receipt of Your request, You will receive a letter from Us confirming the receipt of Your grievance with the name, address and telephone number of the person who will be reviewing Your grievance. If all required information is complete, Your grievance will be resolved within 30 days of receipt. If additional information is required, We will send You a letter requesting the information. Your grievance will then be resolved within 20 days of receipt of all requested information.

**Level 2: Internal Review (Appeal):**

If You are not satisfied with Our decision on Your grievance, You, Your treating physician or authorized representative, have the right to appeal Our determination to confirm the denial of payment on Your claim for coverage of a health care service or treatment within 180 days of Your receipt of notice of Our Adverse Decision.

**Adverse Decision** means a determination by Us or a designee review agency, that an admission, availability of care, continued stay or other health care service that is a covered benefit has been reviewed, and based upon the information provided, does not meet the requirements for medical necessity, appropriateness, health care setting, level of care or effectiveness of the health care service or treatment rendered and the payment for the service is therefore denied, reduced or terminated.

You may submit any comments, documents, records or other information without regard to whether those materials were considered in the initial grievance review.

You, Your treating Physician or authorized representative, may contact Us by:

- Sending an email to: bcsassist@bcsf.com
- Calling Us at Our toll free number: (877) 777-3092
- Writing Us at the following address:

  Essential StaffCARE
  Attention: Claims Appeal
  P.O. Box 6702
  Columbia, SC 29260

All internal appeals must be sent to Us within 180 days of the date You received Our Adverse Decision. We will provide a fair and full review of Your claim by individuals associated with Us but who were not involved in making the initial denial of Your claim.

You, Your treating physician or authorized representative, may provide Us with additional information that relates to Your claim or may request copies of information that We have that pertains to Your claim. We will notify You, Your treating physician or authorized representative of Our decision in writing within 30 days of receiving Your request for appeal. If You do not receive Our decision within 30 days of receiving Your request for an appeal, You, Your treating physician or authorized representative, may be entitled to file a request for independent external review.

**Expedited Internal Review:**

If You have a medical condition that would seriously jeopardize Your ability to regain maximum function if treatment is delayed, You may be entitled to request an expedited internal review of Our denial either orally or in writing and at the same time, request an expedited external review. A decision will be made as expeditiously as possible but no more than 72 hours after Your request was received.

If given information is insufficient, You, Your treating physician or authorized representative, will be notified of information needed as soon as possible, and no later than 24 hours after receipt. You will be given no less than 48 hours to submit the specified information.

You, Your treating physician or authorized representative, will be notified of Our decision no later than 48 hours after (1) the receipt of the submitted information; or (2) the end of the 48 hour period given to provide the information, whichever is earlier.

However, an expedited internal review may not be provided for retrospective review decisions.

**Independent External Review:**

When We have denied Your request for internal appeal, failed to respond to your internal appeal within the specified time or if You are not satisfied with the Final Adverse Decision, You may have the right to have Our decision reviewed by Maximus, an independent company hired by the State to review independent external appeals within 4 months after the receipt of the Final Adverse notice. Maximus, its employees and physicians are impartial, separate from and has no affiliations with any health plan.

You need to complete an application form and attach the $25 filing fee made payable to the Maximus/Minnesota Appeal and submitting it to the Minnesota Department of Commerce at:

Mail: External Review Process
State of Minnesota
Department of Commerce
85 7th Place East
St. Paul, MN 55101

Phone: 1-800-657-3602 or (651) 296-2488 (Option #1)
Fax: (651) 296-4328

You must exhaust the internal complaint review process to submit a request for independent external review. The process is exhausted when:

- We have denied Your request for Internal appeal;
- You have completed Our internal appeals process;
- You do not receive a timely decision from Us on Your appeal and You have not requested or agreed to the delay;
- Expedited internal appeal is requested, therefore You can request an expedited external review at the same time; or
- We have waived the exhaustion requirement.

For standard external review, a decision will be made within 40 days of receiving Your request. If You have a medical condition that would seriously jeopardize Your ability to regain maximum function if treatment is delayed, You may be entitled to request an expedited external review of Our denial. However, an expedited external review may not be provided for retrospective review decisions.

If Our denial to provide or pay for the health care services or course of treatment is based on a determination that the service or treatment is experimental or investigational, You also may be entitled to file a request for external review of Our denial. For more details, please review Your Benefit Plan Document, contact Us or Your state insurance department at the addresses provided above.

You, Your treating physician or authorized representative may, provide additional information that relates to Your claim or may request copies of information that We have that pertains to Your claim. You may be required to provide written consent authorizing Maximus to obtain all necessary medical records from both the provider(s) and Us. You are not legally required to provide any private or confidential data to Maximus or the Department of Commerce and You may refuse to provide any data. However, failure to provide the requested data could affect the decision of Your appeal. If the Department of Commerce identifies the need to conduct its own investigation of Your complaint, They will contact You directly to discuss the investigation and obtain the necessary information.

You, Your treating physician or authorized representative will be notified of the decision in writing within 40 days of receiving Your request.

The ruling provided by the Commissioner of Insurance from an independent external review will be in writing and will be nonbinding on You but binding on BCSI. If You lose, You have the right to appeal the decision in court. If BCSI loses, it cannot appeal the decision.

**Reconsideration of Our Decision:**

If, at any time during the review process, You, Your treating physician or authorized representative, submits information to Us relevant to Our resolution of Your request for review and for which We had not originally considered, We may reconsider our determination.

If Your request has already been submitted for independent external review and We choose to reconsider Our decision, the independent review organization will suspend its review process until Our reconsideration process is completed. In such case, We will notify You of Our decision within 15 days of receiving the new information.

If we decide not to reconsider Our determination upon review of the new information, We will forward that new information to the independent review organization not more than 2 business days of receiving it.

## PART XI - GENERAL PROVISIONS

**Examination of the Policy:** The Group Policy will be available for inspection at the Policyholder's office during regular business hours.

**Not in Lieu of Workers' Compensation:** The Policy is not in lieu of, and does not affect requirements for, coverage under Workers' Compensation laws.

**Misstatement of Age**: If the age of a Covered Person has been misstated, we will adjust premiums based on the Covered Person's true age. If age is a factor in determining eligibility or amount of insurance and there has been a misstatement of age, we will adjust the insurance coverages or amounts of benefits, or both, in accordance with the Covered Person's true age. The misstatement of age neither continues insurance otherwise validly terminated nor terminates insurance otherwise validly in force.

**Subrogation:** If the Covered Person suffers an Injury or Sickness through the act or omission of another person, and if benefits are paid under the Plan due to that Injury or Sickness, then to the extent the Covered Person obtains a full recovery for the same Injury or Sickness from a third party, its insurer, or the Covered Person's uninsured motorist insurance, we will be entitled to a refund of all benefits we have paid from such recovery less the Insurer's pro-rata share of attorney fees, disbursements and costs directly related to the recovery. Further, we have the right to offset subsequent benefits payable to the Covered Person under the Policy against such recovery.

We may file a lien in a Covered Person's action against the third party and have a lien upon a full recovery that the Covered Person receives whether by settlement, judgment, or otherwise, and regardless of how such funds are designated. We shall have a right to recovery of the full amount of benefits paid under the Plan for the Injury or Sickness, and that amount shall be deducted first from a full recovery made by the Covered Person. We will not be responsible for the Insurer's pro-rata share of attorneys' fees disbursements and costs directly related to the recovery.

Upon request, the Covered Person must complete the required forms and return them to us or to the Administrator. The Covered Person must cooperate fully with us in asserting his/her right to recover. The Covered Person will be personally liable for reimbursement to us to the extent of any recovery obtained by the Covered Person from any third party. If it is necessary for us to institute legal action against the Covered Person for failure to repay us the Covered Person will be personally liable for all costs of collection, including reasonable attorneys' fees.

**Right of Recovery:** Whenever we have made payments with respect to benefits payable under the Plan in excess of the amount necessary, we shall have the right to recover such payments. We shall notify the Covered Person of such overpayment and request reimbursement from the Covered Person. However, should the Covered Person not provide such reimbursement, we have the right to offset such overpayment against any other benefits payable to the Covered Person under the Policy to the extent of the overpayment.

## PART XII - SCHEDULE OF BENEFITS

1. POLICYHOLDER INFORMATION:

   Name: Employer Solutions Group LLC

   Policy Number: PAI-Z2193000

   Policy Effective Date: January 1, 2024

   Policy Anniversary Date: January 1st

   COVERAGE YEAR:

   Starts on January 1, 2024 through December 31, 2024.

2. ELIGIBILITY:* All active regular full-time employees who are 18 years of age or older with a valid Social Security Number (SSN) are eligible for medical benefits as defined by the Employer.

   Dependent Coverage:* ☑Yes ☐No

   * In no case will any person be covered unless application has been made and the correct premium has been paid.

3. CERTIFICATE HOLDER INFORMATION: ON FILE

4. COVERAGE AND BENEFIT AMOUNTS:

   This is a Participating Provider Plan. The Network Provider Organization must be utilized to receive the maximum benefits available under this Policy. Services or supplies from a Non-Participating Provider may be significantly higher than those same services or supplies received from a Participating Provider. In addition to the Deductible amount, Copayment and Coinsurance you are responsible for the difference between the Eligible Charge and the amount the Non-Participating Provider bills you for the services or supplies. Any amount you are obligated to pay to the Provider in excess of the Eligible Charge will not apply to your Deductible or Out-of-Pocket Maximum. The Policy provides coverage for benefits in the amounts and up to the limits as shown below. Benefits will be paid for Covered Expenses incurred while coverage is in force. Benefits are subject to the provisions, definitions and exclusions and limitations in the Policy. Benefits listed in this Schedule are for each Covered Person unless otherwise indicated.

| **PLAN DEDUCTIBLES** | | |
|---|---|---|
| | In-Network | Out-of-Network |
| Individual Deductible each Coverage Year | $5,500 | $11,000 |
| Family Deductible each Coverage Year | $11,000 | $22,000 |
| In-Network Deductibles are distinct from Out-of-Network Deductibles. Charges that accrue to one Deductible do not accrue to another. | | |
| Once 2 or more Covered Persons have collectively met the maximum Family Deductible, no additional Deductible will be taken during the Coverage Year | | |
| **ADDITIONAL DEDUCTIBLE:**<br>Failure to obtain Prior Authorization $2,000<br>Failure to obtain Prior Authorization for Specialty Drugs no coverage for the specified drug<br>Prior Authorization is required for the following Covered Services: Inpatient Confinement; Inpatient and Outpatient Surgery; Chemotherapy; Diagnostic Services: i) Cat Scan, ii) MRI; iii) Pet Scan, Mental Health Disorders or Substance Abuse programs; Pediatric Orthodontic Dental Services; Rehabilitative Services and Transplant Services.<br>The additional deductible for failure to obtain Prior Authorization does not go towards satisfying the Plan Deductibles or Out-of-Pocket Maximum. | | |

| **PLAN COINSURANCE AND OUT-OF-POCKET MAXIMUM**<br>The Coinsurance is listed below unless specified elsewhere in the Schedule of Benefits. | | |
|---|---|---|
| Once the Out-of-Pocket Maximum limit is met the Plan pays 100% of Covered Expenses unless otherwise specified. | | |
| Charges for Specialty Pharmaceuticals obtained from a provider other than a Designated Specialty Pharmacy Provider are not covered | | |
| | In-Network | Out-of-Network |
| Coinsurance<br>(Percentage of Covered Expenses the Covered Person must pay.) | 20% until the Out-of-Pocket Maximum is satisfied | 40% until the Out-of-Pocket Maximum is satisfied |
| Individual Out-of-Pocket Maximum each Coverage Year(includes Deductible, Coinsurance and any Copayments) | $6,350 | $12,700 - unlimited |
| Family Out-of-Pocket Maximum each Coverage Year (includes Deductible, Coinsurance and any Copayments) | $12,700 | $25,400 - unlimited |

**Inpatient Hospitalization Services**

| | In-Network | Out-of-Network |
|---|---|---|
| Semi-Private Room, Inpatient Physician Care, General Nursing Care, Hospital Services & Supplies | 20% after Deductible | 40% after Deductible |
| Inpatient Medical Care | 20% after Deductible | 40% after Deductible |

**Alternatives to Inpatient Hospital Care**

| | | |
|---|---|---|
| Ambulatory Surgical Facility or other Health Care Facility | 20% after Deductible | 40% after Deductible |
| Home Health Care – limited to 30 visits per Coverage Year | 20% after Deductible | 40% after Deductible |
| Hospice Care | 20% after Deductible | 40% after Deductible |
| Skilled Nursing/Rehabilitation Facility – up to 30 days per Coverage Year | 20% after Deductible | 40% after Deductible |

**Diagnostic Services**

| | | |
|---|---|---|
| Diagnostic mammogram, MRI, MRS, PET and CAT Scans & Nuclear Medicine | 20% after Deductible | 40% after Deductible |
| Other Diagnostic Tests, X-rays, Laboratory & Pathology | 20% after Deductible | 40% after Deductible |
| Radiation Therapy | 20% after Deductible | 40% after Deductible |
| Osteoporosis Screening | 20% after Deductible | 40% after Deductible |

**Emergency Medical Care**

| | | |
|---|---|---|
| Hospital Emergency Room Emergency or Emergency Medical Care | 20% after Deductible | 20% after Deductible |
| Ambulance Services – Medically Necessary transport for Emergency Medical Care. | 20% after Deductible | 40% after Deductible |

**Human Organ Transplants**

| Transplant Donor Expenses will be covered up to a maximum of $10,000 per transplant. Transplant travel expenses will be covered up to a maximum of $10,000 per transplant provided a Covered Person obtains services in connection with a listed transplant from a Participating Provider as described in Part III The Description of Covered Services Section. | | |
|---|---|---|
| | In-Network | Out-of-Network |
| Specified Organ Transplants – when coordinated through a Participating Provider – no maximum benefit limit. | 20% after Deductible | 40% after Deductible. Covered Expenses are limited to a maximum of $100,000 for all expenses per transplant and 2 transplants per lifetime. |

**Maternity Services Provided by a Physician**

| | In Network | Out of Network |
|---|---|---|
| Pre-Natal and Post-Natal Care | 20% after Deductible | 40% after Deductible |
| Delivery and Nursery Care | 20% after Deductible | 40% after Deductible |

**Mental Health and Substance Abuse Services**

| | | |
|---|---|---|
| Inpatient Mental Health | 20% after Deductible | 40% after Deductible |
| Outpatient Mental Health | 20% after Deductible | 40% after Deductible |
| Inpatient Substance Abuse | 20% after Deductible | 40% after Deductible |
| Outpatient Substance Abuse | 20% after Deductible | 40% after Deductible |

**Other Services**

| | | |
|---|---|---|
| | | |
| Habilitative Services | 20% after Deductible | 40% after Deductible |
| Manipulative Therapy applies to the office visit exam and/or spinal manipulation and all services performed during the visit (e.g., X-ray, physical therapy, etc.) –limited to 30 visits per Coverage Year | 20% after Deductible | 40% after Deductible |
| Outpatient Physical, Speech and Occupational Therapy limited to 30 visits for each therapy per Coverage Year | 20% after Deductible | 40% after Deductible |
| Durable Medical Equipment/Medical Supplies<br><br>For questions regarding this coverage contact us at our customer service number 1-800-768-4375 or by writing to us at the following address:<br><br>BCS Insurance Company<br>2 Mid America Plaza<br>Oakbrook Terrace, IL | 20% after Deductible | 40% after Deductible |
| Wigs/Scalp Prosthesis | 20% after Deductible | 40% after deductible |
| Prosthetic and Orthotic Appliances | 20% after Deductible | 40% after Deductible |
| Private Duty Nursing limited to 30 visits per Coverage Year | 20% after Deductible | 40% after Deductible |

**Outpatient Prescription Drugs**

| | | |
|---|---|---|
| Generic | 20% after Deductible | 40% after Deductible |
| Preferred Brand | 30% after Deductible | 50% after Deductible |
| Non-Preferred Brand | 40% after Deductible | 50% after Deductible |
| Specialty | 50% after Deductible | Not Covered |

**Outpatient Services**

| | | |
|---|---|---|
| Surgery – includes related surgical services | 20% after Deductible | 40% after Deductible |
| Chemotherapy | 20% after Deductible | 40% after Deductible |

**Physician Office Visit**

| | | |
|---|---|---|
| Office Visits include:<br>• Primary care and specialist Physicians<br>• Pre-surgical consultations | 20% after Deductible | 40% after Deductible |

**Preventive Care Screening and Immunizations**

| Listed in the recommendations of USPSTF A & B and HRSA Women's Preventive Services include: | In-Network | Out-of-Network |
|---|---|---|
| Annual Health Maintenance Exam – beginning age 19, includes related X-rays, EKG, lab procedures, and routine screening tests performed as part of the physical exam – one per Coverage Year | Deductible waived<br>0% Coinsurance | Deductible applies –40% after Deductible |

| | | |
|---|---|---|
| Annual Well Woman Exam – includes pelvic exam and breast exam – one per Coverage Year | Deductible waived<br>0% Coinsurance | Deductible applies – 40% after Deductible |
| Pap Smear Screening – laboratory services only – one per Coverage Year | Deductible waived<br>0% Coinsurance | Deductible applies – 40% after Deductible |
| Well-Baby and Child Care – through age 18 | Deductible waived<br>0% Coinsurance | Deductible applies – 40% after Deductible |
| Hearing Exams (newborn) performed by the examining Physician | Deductible waived<br>0% Coinsurance | Deductible applies – 40% after Deductible |
| Immunizations – child and adult | Deductible waived<br>0% Coinsurance | Deductible applies – 40% after Deductible |
| Mammography Screening – one baseline at age 35 and one per Coverage Year for women age 40 and older. | Deductible waived<br>0% Coinsurance | Deductible applies – 40% after Deductible |
| Prostate Specific Antigen (PSA) Screening – one per Coverage Year for men age 40 and older | Deductible waived<br>0% Coinsurance | Deductible applies – 40% after Deductible |

5. EFFECTIVE DATE:

   If selected, the following will apply to Eligible Employees of the Policyholder and their eligible dependents in addition to the Effective Date provision: ☑ Yes ☐ No

   Coverage will become effective the first of the month following completion of the waiting period and receipt of total premium by the carrier.

6. Waiting Period: 60 Days

7. PREMIUM PAYABLE: ☑Monthly ☐Annual

8. PREMIUMS:

   ☑Employee Only $1,750.32

   ☑Employee and children $3,096.95

# BCS Insurance Company
## Oakbrook Terrace, Illinois

NOTICE CONCERNING POLICYHOLDER RIGHTS IN AN
INSOLVENCY UNDER THE MINNESOTA LIFE AND HEALTH
INSURANCE GUARANTY ASSOCIATION LAW

If the insurer that issued your life, annuity, or health insurance policy becomes impaired or insolvent, you are entitled to compensation for your policy from the assets of that insurer. The amount you recover will depend on the financial condition of the insurer.

In addition, residents of Minnesota who purchase life insurance, annuities, or health insurance from insurance companies authorized to do business in Minnesota are protected, SUBJECT TO LIMITS AND EXCLUSIONS, in the event the insurer becomes financially impaired or insolvent. This protection is provided by the Minnesota Life and Health Insurance Guaranty Association.

Minnesota Life and Health Insurance Guaranty Association

4760 White Bear Parkway Suite 101
White Bear Lake, MN 55110

The maximum amount the guaranty association will pay for all policies issued on one life by the same insurer is limited to $500,000. Subject to this $500,000 limit, the guaranty association will pay up to $500,000 in life insurance death benefits, $130,000 in net cash surrender and net cash withdrawal values for life insurance, $500,000 in health insurance benefits, including any net cash surrender and net cash withdrawal values, $250,000 in annuity net cash surrender and net cash withdrawal values, $410,000 in present value of annuity benefits for annuities which are part of a structured settlement or for annuities in regard to which periodic annuity benefits, for a period of not less than the annuitant's lifetime or for a period certain of not less than ten years, have begun to be paid on or before the date of impairment or insolvency, or if no coverage limit has been specified for a covered policy or benefit, the coverage limit shall be $500,000 in present value. Unallocated annuity contracts issued to retirement plans, other than defined benefit plans, established under section 401, 403(b), or 457 of the Internal Revenue Code of 1986, as amended through December 31, 1992, are covered up to $250,000 in net cash surrender and net cash withdrawal values, for Minnesota residents covered by the plan provided, however, that the association shall not be responsible for more than $10,000,000 in claims from all Minnesota residents covered by the plan. If total claims exceed $10,000,000, the $10,000,000 shall be prorated among all claimants. These are the maximum claim amounts. Coverage by the guaranty association is also subject to other substantial limitations and exclusions and requires continued residency in Minnesota. If your claim exceeds the guaranty association's limits, you may still recover a part or all of that amount from the proceeds of the liquidation of the insolvent insurer, if any exist. Funds to pay claims may not be immediately available. The guaranty association assesses insurers licensed to sell life and health insurance in Minnesota after the insolvency occurs. Claims are paid from this assessment.

THE COVERAGE PROVIDED BY THE GUARANTY ASSOCIATION IS NOT A SUBSTITUTE FOR USING CARE IN SELECTING INSURANCE COMPANIES THAT ARE WELL MANAGED AND FINANCIALLY STABLE. IN SELECTING AN INSURANCE COMPANY OR POLICY, YOU SHOULD NOT RELY ON COVERAGE BY THE GUARANTY ASSOCIATION.

THIS NOTICE IS REQUIRED BY MINNESOTA STATE LAW TO ADVISE POLICYHOLDERS OF LIFE, ANNUITY, OR HEALTH INSURANCE POLICIES OF THEIR RIGHTS IN THE EVENT THEIR INSURANCE CARRIER BECOMES FINANCIALLY INSOLVENT. THIS NOTICE IN NO WAY IMPLIES THAT THE COMPANY CURRENTLY HAS ANY TYPE OF FINANCIAL PROBLEMS. ALL LIFE, ANNUITY, AND HEALTH INSURANCE POLICIES ARE REQUIRED TO PROVIDE THIS NOTICE."