Nemours Foundation Employee Welfare Benefit Plan

Group No.: 20356

Benefits Description

Originally Effective: January 1, 2018

Amended and Restated Effective: January 1, 2024

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ESTABLISHMENT OF THE PLAN

The Nemours Foundation (the "Employer" or the "Plan Sponsor") has adopted this amended and restated Benefits Description effective as of January 1, 2024, for the Nemours Foundation Employee Welfare Benefit Plan (hereinafter referred to as the "Plan"), as set forth herein for the exclusive benefit of its Employees and their eligible Dependents. The Plan was originally adopted by the Employer effective as of January 1, 2018.

Purpose of the Plan
The Plan Sponsor has established the Plan for your benefit and for the benefit of your eligible Dependents, on the terms and conditions described herein. The Plan Sponsor's purpose in establishing the Plan is to help to protect you and your family by offsetting some of the financial problems that may arise from an Injury or Illness. To accomplish this purpose, the Plan Sponsor must attempt to control health care costs through effective plan design and the Plan Administrator must abide by the terms of the Plan Document to allow the Plan Sponsor to allocate the resources available to help those individuals participating in the Plan to manage their healthcare costs.

The Plan is not a contract of employment between you and your Employer and does not give you the right to be retained in the service of your Employer.

The purpose of this Plan is to set forth the terms and provisions of the Plan that provide for the payment or reimbursement of all or a portion of certain health care expenses. This Plan is maintained by the Plan Administrator and may be inspected at any time during normal working hours by you or your eligible Dependents.

Adoption of this Plan Document and Benefits Description
The Plan Sponsor, as the settlor of the Plan, hereby adopts this Benefits Description as the written description of the Plan, which is required by the Employee Retirement Income Security Act of 1974, as amended from time to time. This Benefits Description amends and replaces any prior statement of the health care coverage contained in the Plan or any predecessor to the Plan.

IN WITNESS WHEREOF, the Plan Sponsor has caused this Benefits Description to be executed as of the date set forth below.

The Nemours Foundation

Dated: 7/2/2024

By: DocuSigned by: AACA6F39489D4BE...

Name: Lisa Meddock

Title: Senior Director Total Rewards

GENERAL OVERVIEW OF THE PLAN

The Plan Administrator has entered into an agreement that provides access to one or more networks of Participating Providers called “Networks”. Available Networks are identified on the Employee identification card. These Networks offer your health care services at discounted rates. Using a Network provider will normally result in a lower cost to the Plan as well as a lower cost to you.

If you are enrolled in the Red Plan, Red HRA Plan, White Plan, White HRA Plan or Green Plan, there is no requirement for anyone to seek care from a provider who participates in the Network. The choice of provider is entirely up to you.

However, If you are enrolled in the Blue Plan or Blue HRA Plan you and your Dependents must seek care within the Network for expenses to be considered by the Plan. Expenses Incurred outside the Network will be denied, except as specified below.

You are also not required to designate a Primary Care Physician (PCP), but the Plan encourages you to designate a PCP to help manage your care.

Non-Participating Provider Exceptions
Unless otherwise described herein, covered services rendered by a Non-Participating Provider will be paid at the Participating Provider level subject to the Usual and Customary provision of the Plan when a:

(1) Covered Person has no choice of a Participating Provider.

(2) Covered Person has an Emergency Medical Condition requiring immediate care.*

(3) Covered Person receives services by a Non-Participating Provider who is under agreement with a Network facility.*

(4) Participating Provider submits a specimen to a Non-Participating Provider laboratory.

(5) Covered Person receives services from a Network surgeon who uses a non-Network Assistant Surgeon.

(6) Covered Person receives lactation consultations from a Non-Participating Provider.

(7) Participating Provider is not available within a 45-mile radius of the Covered Person’s residence.

***NOTE:** In the case of a Surprise Bill for covered services from a Non-Participating Provider who is under agreement with a Network facility and the Covered Person had no control of the Non-Participating Providers participation in their care or when a Covered Person seeks Emergency Services for an Emergency Medical Condition from a Non-Participating Provider, the cost share will be based on the median contract rate.

Not all providers based in Network Hospitals or medical facilities are Participating Providers. It is important when you enter a Hospital or medical facility that you request that ALL Physician services be performed by Participating Providers. By doing this, you will always receive the greater Participating Provider level of benefits.

A current list of Participating Providers is available, without charge, through the Third Party Administrator at benefits4nemours.com. If you do not have access to a computer at your home, you may contact your Employer or the Network at the phone number on the Employee identification card.

You have a free choice of any provider and you, together with your provider, are ultimately responsible for determining the appropriate course of medical treatment, regardless of whether the Plan will pay for all or a portion of the cost of such care. Participating Providers are independent contractors; neither the Plan nor the Plan Administrator makes any warranty as to the quality of care that may be rendered by any Participating Provider.

Transitional Care
Certain Covered Expenses may be paid at the applicable Participating Provider benefit level subject to the Usual and Customary provision of the Plan if the Covered Person is currently under a treatment plan by a Physician or other health care provider or facility that was a member of this Plan's previous Network but who is not a member of this Plan's current Network. In order to ensure continuity of care for certain medical conditions already under treatment, the Participating Provider benefit level may continue for 180 days for conditions approved as transitional care. Examples of medical conditions appropriate for consideration for transitional care include, but are not limited to:

(1) Cancer if under active treatment with chemotherapy and/or radiation therapy.

(2) Organ transplant patients if under active treatment (seeing a Physician on a regular basis, on a transplant waiting list, ready at any time for transplant).

(3) If the Covered Person is Inpatient in a Hospital on the effective date.

(4) Post-acute Injury or Surgery within the past 3 months.

(5) Pregnancy in the second or third trimester and up to 8 weeks postpartum.

(6) Behavioral Health – any previous treatment.

You or your Dependent must call the Plan Administrator prior to the effective date or within 4 weeks after the effective date to see if you or your Dependents are eligible for this benefit.

Routine procedures, treatment for stable chronic conditions, minor Illnesses and elective Surgical Procedures will not be covered by transitional level benefits.

Continuity of Care (Keeping a provider you go to now)
You may have to find a new provider when:

(1) The Plan's Network changes and the provider you have now is not in the new Network; or

(2) You are already enrolled in the Plan and your provider stops participating in the Plan's Network.

However, in some cases, you may be able to keep going to your current provider to complete a treatment or to have treatment that was already scheduled. This is called continuity of care. If you are pregnant and have entered your second trimester, this will include the time required for postpartum care directly related to the delivery. Routine procedures, minor Illnesses and elective Surgical Procedures generally are not covered under this provision.

Contact the phone number on the back of your identification card to obtain further information on how to submit a request for continuity of care. If your request is approved to keep going to your current provider, you will be informed how long you can continue to see the provider. Reimbursement for approved continuity of care will be at the applicable Participating Provider benefit level subject to the Usual and Customary provision of the Plan.

Costs
You must pay for a certain portion of the cost of Covered Expenses under the Plan, including (as applicable) any Copay, Deductible and Coinsurance percentage that is not paid by the Plan, up to the Out-of-Pocket Maximum set by the Plan.

Coinsurance
Coinsurance is the percentage of eligible expenses the Plan and the Covered Person are required to pay. The amount of Coinsurance a Covered Person is required to pay is the difference from what the Plan pays as shown in the Medical Schedule of Benefits.

There may be differences in the Coinsurance percentage payable by the Plan depending upon whether you are using a Participating Provider or a Non-Participating Provider. These payment levels are also shown in the Medical Schedule of Benefits.

Copay
A Copay is the portion of the medical expense that is your responsibility, as shown in the Medical Schedule of Benefits. A Copay is applied for each occurrence of such covered medical service and is not applied toward satisfaction of the Deductible.

Deductible
Blue Plan, Blue HRA Plan, Red Plan, Red HRA Plan, White Plan and White HRA Plan: A Deductible is the total amount of eligible expenses as shown in the Schedule of Benefits, which must be Incurred by you during any Calendar Year before Covered Expenses are payable under the Plan. The family Deductible maximum, as shown in the Schedule of Benefits, is the maximum amount which must be Incurred by the covered family members during a Calendar Year. However, each individual in a family is not required to contribute more than one individual Deductible amount to a family Deductible.

Green Plan: A Deductible is the total amount of eligible expenses as shown in the Schedule of Benefits, which must be Incurred by you during any Calendar Year before Covered Expenses are payable under the Plan, except as otherwise shown in the Schedule of Benefits. The family Deductible maximum, as shown in the Schedule of Benefits, is the maximum amount which must be Incurred by covered family members during a Calendar Year. When selecting family coverage, the entire family Deductible must be satisfied by one individual or collectively before benefits will be paid at the Coinsurance rate.

Out-of-Pocket Maximum
An Out-of-Pocket Maximum is the maximum amount you and/or all of your family members will pay for eligible expenses Incurred during a Calendar Year before the percentage payable under the Plan increases to 100%.

> **Blue Plan, Blue HRA Plan, Red Plan, Red HRA Plan, White Plan and White HRA Plan:** The single Out-of-Pocket Maximum applies to a Covered Person with single coverage. When a Covered Person reaches his or her Out-of-Pocket Maximum, the Plan will pay 100% of additional eligible expenses for that individual during the remainder of that Calendar Year.
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> The family Out-of-Pocket Maximum applies collectively to all Covered Persons in the same family. The family Out-of-Pocket Maximum is the maximum amount that must be satisfied by covered family members during a Calendar Year. The entire family Out-of-Pocket Maximum must be satisfied; however, each individual in a family is not required to contribute more than the single Out-of-Pocket amount to the family Out-of-Pocket Maximum before the Plan will pay 100% of Covered Expenses for any Covered Person in the family during the remainder of that Calendar Year.
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> **Green Plan:** The single Out-of-Pocket Maximum applies to a Covered Person with single coverage. When a Covered Person reaches his or her Out-of-Pocket Maximum, the Plan will pay 100% of additional eligible expenses for that individual during the remainder of that Calendar Year.
>
> The family Out-of-Pocket Maximum applies collectively to all Covered Persons in the same family. The family Out-of-Pocket Maximum is the maximum amount that must be satisfied by covered family members during a Calendar Year. The entire family Out-of-Pocket Maximum must be satisfied, by one individual or collectively, before the Plan will pay 100% of Covered Expenses for any Covered Person in the family during the remainder of that Calendar Year.

Your Out-of-Pocket Maximum may be higher for Non-Participating Providers than for Participating Providers. Please note, however, that not all Covered Expenses are eligible to accumulate toward your Out-of-Pocket Maximum. The types of expenses, which are not eligible to accumulate toward your Out-of-Pocket Maximum, ("non-accumulating expenses") include:

(1) Charges over Usual and Customary Charges for Non-Participating Providers.

(2) Charges this Plan does not cover.

Reimbursement for any eligible non-accumulating expenses will continue at the percentage payable shown in the Medical Schedule of Benefits, subject to the Plan maximums.

The Plan will not reimburse any expense that is not a Covered Expense. In addition, you must pay any expenses that are in excess of the Usual and Customary Charges for Non-Participating Providers. This could result in you having to pay a significant portion of your claim. None of these amounts will accumulate toward your Out-of-Pocket Maximum.

Once you have paid the Out-of-Pocket Maximum for eligible expenses Incurred during a Calendar Year, the Plan will reimburse additional eligible expenses Incurred during that year at 100%.

If you have any questions about whether an expense is a Covered Expense or whether it is eligible for accumulation toward your Out-of-Pocket Maximum, please contact your Plan Administrator for assistance.

Integration of Deductibles and Out-of-Pocket Maximums
NOTE: This provision only applies to the Red Plan, Red HRA Plan, White Plan, White HRA Plan or Green Plan option.

If you use a combination of Participating Providers and Non-Participating Providers, your total Deductible amount and Out-of-Pocket Maximum amount required to be paid will not exceed the amount shown for Non-Participating Providers. In other words, the amount of the Deductible expense and Out-of-Pocket Maximum you pay for both Participating Providers and Non-Participating Providers will be combined, and the total will not exceed the amount shown for Non-Participating Providers during a single Calendar Year.

All other maximum amounts (e.g., Calendar Year or Lifetime) are combined.

QUANTUM HEALTH'S CARE COORDINATION PROCESS

Introduction
The Plan incorporates a "Care Coordination" process by Quantum Health which leverages resources including but not limited to your Employer, the Plan and the Third Party Administrator, your provider, and your community to help you best navigate the healthcare system. This process includes a staff of Care Coordinators who receive notifications regarding most healthcare services sought by Covered Persons, and coordinate activities and information flow between the providers.

Care Coordination is intended to help Covered Persons obtain quality healthcare and services in the most appropriate setting, help reduce unnecessary medical costs, and ensure early identification of Covered Persons with complex medical conditions. The Care Coordinators are available to Covered Persons and their providers for information, assistance, and guidance, and can be reached toll-free by calling:

Care Coordinators: (844) 460-2817

It is important to note that clinical reviews are done to determine Plan coverage and are conducted by the clinical staff of Quantum Health.

Care Coordination Requirements
In order to receive the highest benefits available in the Plan, Covered Persons must follow the Care Coordination process outlined in this section, as well as other provisions in the Plan. In some cases, failure to follow this process can result in significant benefit reductions, penalties or even loss of benefits for specific services.

The Care Coordination process generally includes:

(1) Use of In-Network Providers

(2) Designating a Coordinating Provider (PCP)

(3) The Care Coordination Process and Utilization Management:

  (a) Preauthorization and Clinical Review

  (b) Concurrent Utilization Review

  (c) Personal Care Guide Management

Use of In-Network Providers
The Plan offers a broad network of providers and provides the highest level of benefits when Covered Persons utilize "In-Network" providers. These Networks will be indicated on your Plan identification card. **Services provided by Out-of-Network providers will not be eligible for the highest benefits**. Specific benefit levels are shown in the Medical Schedule of Benefits.

Designated Coordinating Provider
All Covered Persons are asked to designate a coordinating Primary Care Provider (PCP) for each Covered Person of their family. While such designation is not mandatory, it is strongly recommended. **To ensure highest level of benefits, and the best coordination of your care, all Covered Persons are encouraged to designate an In-Network Primary Care Provider (PCP) to be their coordinating Provider.** The Care Coordination process generally begins with the coordinating provider who maintains a relationship with the Covered Person, provides general healthcare evaluation, guidance, and management.

Covered Persons are encouraged to begin all healthcare events or inquiries with a call or visit to their designated PCP who will guide Covered Persons as appropriate. In addition to providing Care Coordination and submitting preauthorization requests, the PCP may also receive notices regarding healthcare services that their designated patients receive under the Plan. This allows the PCP to provide ongoing healthcare guidance.

If you have trouble obtaining access to a PCP, the Care Coordinators will be able to assist you by providing a list of In-Network PCPs. Please contact the Care Coordinators by calling:

Care Coordinators: (844) 460-2817

Utilization Management

Preauthorization and Clinical Review
To be covered at the highest level of benefit and to ensure complete Care Coordination, the Plan requires that certain care, services, and procedures be preauthorized before they are provided. Preauthorization requests are submitted to the Care Coordinators by a designated PCP, other PCP, specialty provider or other healthcare provider. Your Plan identification card includes instructions and the phone number for them to call. Depending on the request, the Care Coordinators may contact the requesting provider to obtain additional clinical information to support the request for the preauthorization and to ensure that the care, service and/or procedure meet Plan and nationally accepted medical criteria. If a preauthorization request does not meet Plan and nationally accepted medical criteria, the Covered Person and healthcare provider will be notified, and the Care Coordinators will assist in redirecting care if appropriate.

The following care, services and procedures are subject to preauthorization:

(1) ABA Therapy

(2) Dialysis

(3) Durable Medical Equipment - all rentals and any purchase over $1,500

(4) Inpatient and Skilled Nursing Facility admissions (hospitalizations to include acute care, skilled nursing, skilled rehabilitation, and treatment for Mental Disorders and Substance Use Disorders)

(5) Fixed Wing Aircraft Transportation

(6) Genetic Testing

(7) Home Health Care

(8) Hospice Care

(9) MRI/MRA and PET scans

(10) Oncology Care and Services (chemotherapy, radiation therapy, clinical trials)

(11) Organ, Tissue, and Bone Marrow Transplants

(12) Outpatient Surgeries

(13) Partial Hospitalization and Intensive Outpatient for Mental Health/Substance Use Disorders

(14) TMS (Transcranial Magnetic Stimulation)

All preauthorizations and clinical review services are conducted by Quantum Health. Care Coordinators will assist Covered Persons in understanding what services require preauthorization.

For preauthorization, Providers should call the number listed on the Plan identification card.

Concurrent Utilization Review
Quantum Health will regularly monitor an Inpatient Hospital stay, other institutional admission, or ongoing course of care for any Covered Person, and evaluate the appropriateness of the level of care and if the stay is meeting Medical Necessity. If necessary, they will examine the possible use of alternate levels of care or facilities. Quantum Health will communicate regularly with attending providers, the utilization management staff and/or discharge planners of such facilities, and the Covered Person and/or family to monitor the Covered Person's progress and anticipate and initiate planning for discharge needs. Such concurrent review, and authorization for Plan coverage of Inpatient days, is conducted in accordance with the utilization criteria adopted by the Plan, Quantum Health, and nationally accepted medical criteria.

Personal Care Guide Management
Quantum Health utilizes a primary nurse model for chronic condition as well as acute condition management. This enhanced approach provides one nurse to address clinical needs for all chronic and acute issues. The Personal Care Guide (PCG) nurse will consult with the Covered Person, their family (if requested), the attending Physician, and other members of the Covered Person's treatment team to assist in facilitating/implementing proactive plans of care which provide the most appropriate health care and services in a timely, efficient, and cost-effective manner. They assist with benefits, incidental health care issues, becoming healthier, finding resources or an unexpected healthcare journey.

During outreach, the Personal Care Guide will touch on the Covered Person's treatment and perform a physical assessment, perform a medication reconciliation to ensure there are no duplications or interactions, perform a depression screening with subsequent referrals to EAP or In-Network Providers, as well as focus on the physical and emotional needs of the Covered Person.

The Personal Care Guide will look at the Covered Person's psychosocial needs and social determinants of health. In addition to the depression screening, they will evaluate the Covered Person's financial issues, knowledge deficits, as well as any cultural barriers that may exist. Conversations with the Covered Person would occur at least monthly, if not more frequently, and continue until the Covered Person's health goals and needs are met.

The primary Personal Care Guide nurse will align with the Covered Person and be the single point of contact them, and their family and caregivers, and providers.

The primary Personal Care Guide nurse will:

(1) Provide comprehensive benefit education/utilization support;

(2) Drive PCP designation and steerage to In-Network Providers;

(3) Encourage provider involvement;

(4) Deliver precertification assistance;

(5) Perform pre-admission, pre-discharge, and post-discharge engagement;

(6) Coordinate for utilization review and discharge planning;

(7) Identify gaps in care and alleviate clinical, financial, and humanistic barriers;

(8) Coordinate second opinions, drive utilization to other third-party vendor tools, and introduce community resources;

(9) Perform behavioral health screening.

Our primary nurse model has 3 foundational drivers for the changes:

(1) Humanistic: to help Covered Persons with acute and chronic needs by assigning a single nurse to the Covered Person and their family as well as a heightened attention to psychosocial issues that can negatively affect health, quality of life and financial outcomes.

(2) Clinical: identify and prioritize Covered Persons in need of clinical outreach. Improve adherence to quality measures for preventive health and management of chronic conditions.

(3) Financial: identify and outreach to Covered Persons at risk for future high costs while encouraging preventive care and chronic condition management to improve health and reduce costs.

General Provisions for Care Coordination

Authorized Representative
The Covered Person is ultimately responsible for ensuring that all preauthorizations are approved and in place prior to the time of service to receive the highest level of benefits. However, in most cases, the actual preauthorization process will be executed by the Covered Person's Primary Care Provider or other providers. By subscribing to this Plan, the Covered Person authorizes the Plan and its designated service providers (including Quantum Health and the Third Party Administrator, and others) to accept healthcare providers or those providers who otherwise have knowledge of the Covered Person's medical condition, as their authorized representative in matters of Care Coordination, including preauthorization requests. Communications with and notifications to such healthcare providers shall be considered as notification to the Covered Person.

Time of Notice
The preauthorization request should be made to the Care Coordinators within the following timeframe:

(1) At least **3 business days,** before a scheduled (elective) Inpatient admission;

(2) By the next business day after, an emergency Hospital admission;

(3) Upon being identified as a potential organ or tissue transplant recipient;

(4) At least **3 business days** before receiving any other services requiring preauthorization.

For preauthorization, Providers should call the number listed on the Plan identification card.

Special Note: The Covered Person will not be penalized for failure to obtain preauthorization if a prudent layperson, who possesses an average knowledge of health and medicine, could reasonably expect that the absence of immediate medical attention would jeopardize the life or long-term health of the individual. However, Covered Persons who receive care on this basis must contact the Care Coordinators as soon as possible within 24 hours of the first business day after receiving care or Hospital admittance. Care Coordinators will then coordinate with Quantum Health Utilization Management to review services provided within 48 hours of being contacted.

"Emergency" Admissions and Procedures
Any Inpatient admission or Outpatient procedure that has not been previously scheduled and cannot be delayed without harming the Covered Person's health is considered an emergency for purposes of the Utilization Management notification.

Maternity Admissions
A notice regarding admissions for childbirth should be submitted to the Care Coordinators in advance, preferably 30 days prior to expected delivery. The Plan and the Care Coordination process complies with all state and federal regulations regarding Utilization Management for maternity admissions. The Plan will not restrict benefits for any hospital stay in connection with childbirth for the mother or newborn child to less than 48 hours following a normal vaginal delivery, or less than 96 hours following a cesarean section, or require preauthorization or authorization for prescribing a length of stay not in excess of these periods. If the mother's or newborn's attending provider, after

consulting with the mother, discharges the mother or her newborn earlier than the applicable 48 or 96 hours, the Plan will only consider benefits for the actual length of the stay. The Plan will not set benefit levels or out-of-pocket costs so that any later portion of the 48 or 96-hour stay is treated in a manner less favorable to the mother or newborn than any earlier portion of the stay.

Care Coordination is Not a Guarantee of Payment of Benefits
The Care Coordination process does not provide a guarantee of payment of benefits. Approvals of preauthorizations for procedures, hospitalizations and other services indicate that the medical condition, services, and care settings meet the utilization criteria established by the Plan. The Care Coordination approvals do not indicate that the service is a covered benefit, that the Covered Person is eligible for such benefits, or that other benefit conditions such as Copay, Deductible, Coinsurance, or maximums have been satisfied. Final determinations regarding coverage and eligibility for benefits are made by the Plan.

Appeal of Care Coordination Determinations
Covered Persons have certain appeal rights regarding adverse determinations in the Care Coordination process, including reduction of benefits and penalties. The Appeal Process is detailed in the Claims Procedures section within this document.

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HEALTH REIMBURSEMENT ARRANGEMENT

The Employer provides a Health Reimbursement Arrangement (HRA) to eligible Employees for reimbursement of certain Covered Expenses under the medical benefit component of the Plan. This HRA intends to meet the requirements of IRS Notice 2002-45. Notwithstanding anything in the Plan to the contrary, the HRA is not intended to be an Internal Revenue Code section 125 “cafeteria plan” and any reimbursements paid under the HRA are provided solely by the Employer and not pursuant to any salary reduction elections. Any provision of this Plan that would cause the HRA to fail to qualify as an employer-provided health reimbursement arrangement described in IRS Notice 2002-45 or that would cause the HRA to violate any applicable nondiscrimination requirements or other applicable legal requirement will be ineffective.

Eligibility
If you and your Dependents meet the general eligibility requirements of the Plan you will also be eligible for benefits under the HRA provided you have elected coverage under one of the HRA options available under the Plan.

HRA Fund Amount

Single:	$1,000
Employee + 1:	$2,000
Family:	$2,000

Reimbursement Provisions

(1) The HRA cannot be used to pay an Employee’s premium contributions under the Plan.

(2) The HRA will be used to pay amounts that qualify as:

  (a) Copays

  (b) Deductibles

  (c) Coinsurance

(3) The HRA may not be used to reimburse:

  (a) Any amount paid as a penalty

  (b) Medical expenses (as defined in Section 213(d) of the Code) that are not otherwise eligible for coverage under the Plan but that are eligible for reimbursement from an HRA

(4) Only those eligible expenses that are Incurred by you or your eligible Dependents can be reimbursed.

  A medical expense is Incurred at the time the medical care or service is furnished and not when the Covered Person is billed for, is charged for, or pays for the medical care.

  A medical expense that otherwise meets the requirements described in this section is eligible for HRA reimbursement provided that the expense was Incurred while you and/or your Dependent were covered under the HRA during the applicable Calendar Year. Medical expenses can be reimbursed only to the extent that the person incurring the expense is not reimbursed (or eligible for reimbursement) for the expense through other insurance or any other accident or health plan and only if the expense is not taken as a deduction from income on such person’s federal income tax return in any tax year. If only a portion of a medical expense has been reimbursed elsewhere, the HRA can reimburse the remaining portion of such expense if it meets the HRA requirements.

(5) The Employer funds the full amount of the HRA. There are no participant contributions for benefits under the HRA.

(6) Your HRA account will be credited upon the first day of the Calendar Year. If you become eligible for benefits under the Plan after the beginning of the Calendar Year your entire HRA fund amount will be available once you have satisfied the eligibility requirements under this section.

(7) Rollover. If any balance remains in your HRA account after all reimbursements have been made for the Calendar Year, such balance will NOT rollover to a subsequent Calendar Year.

(8) Only those medical expenses which are Incurred during the same Calendar Year of the HRA will be debited from the account balance.

(9) Written notice of a claim and all information needed to process the claim must be given to the Third Party Administrator as soon as reasonably possible in accordance with the Claims Procedures section of the Plan and in no event, later than 12 months following the date services were Incurred.

Termination of Coverage

(1) If you lose coverage during the Calendar Year due to termination of employment, any fund balance that is remaining at termination may be used for any claims that were Incurred prior to the date of termination and would have been eligible for reimbursement while you were covered under the Plan. The HRA amount will not be pro-rated based on the termination date; however, any unused account balance that remains after eligible claims are paid will be forfeited, unless coverage under COBRA is elected. Upon termination eligible Employees may spend down their HRA balance on eligible medical expenses (except as limited in #2 above under Reimbursement Provisions) until the fund is depleted.

(2) If you choose coverage under COBRA, the fund balance will remain active until you are no longer eligible for coverage under COBRA.

(3) Should the Plan Sponsor choose to terminate this Plan, your rights are limited to reimbursement for any claims Incurred prior to the date of termination.

EMPLOYEE ASSISTANCE PROGRAM

The Employee Assistance Program (EAP") is a program separate and independent from the Plan. The Plan Sponsor pays a fee to the EAP vendor to make its EAP services available to employees and their dependents.

The EAP provides short-term counseling and consultations services to assist employees and dependents with personal problems, including, but not limited to:

- Family problems
- Marital problems
- Emotional difficulties
- Stress and anxiety
- Alcoholism
- Drug abuse
- Legal problems
- Financial problems

The number of sessions offered for these services through the EAP will be determined by the program elected by the Employer. See your Employer for details. Some sessions may be offered virtually.

The benefits provided through the EAP are fully paid for by your Employer and cover the employee as well as their dependents. For detailed information with respect to the actual benefits provided under the EAP and any conditions, limitations and exclusions that may apply to those benefits, please refer to the EAP materials distributed to you by your Employer and/or the EAP Administrator. If you do not have a copy of these materials, please contact your Employer or the EAP Administrator. Your personal information will be kept strictly confidential by the EAP Program Administrator.

If you do not have a copy of these materials, please contact your Employer or the EAP Administrator, identified on the General Plan Information page for additional information. Any login information may be customized per the Employer.

MEDICAL SCHEDULE OF BENEFITS: BLUE PLAN

BENEFIT DESCRIPTION	PARTICIPATING PROVIDERS ONLY
LIFETIME MAXIMUM BENEFIT	Unlimited
CALENDAR YEAR MAXIMUM BENEFIT	Unlimited
CALENDAR YEAR DEDUCTIBLE	
Single	$600
Family	$1,200
CALENDAR YEAR OUT-OF-POCKET MAXIMUM (includes medical Deductible, medical Coinsurance and Medical Copays)	
Single	$4,000
Family	$8,000
MEDICAL BENEFITS	
Acupuncture	$40 Copay then 100%; Deductible waived
Calendar Year Maximum Benefit	10 visits
Ambulance Services	$50 Copay per trip then 100%; Deductible waived
NOTE: Emergency ambulance services by Non-Participating Providers will be paid at the Participating Provider level of benefits. Fixed wing aircraft ambulance services by Non-Participating Providers will be paid at the Participating Provider level of benefits subject to preauthorization.	
Ambulatory Surgical Center	80% after Deductible
Cardiac Rehab (Outpatient)	Paid based on place of service
Carrum Health	100%; Deductible waived
NOTE: Carrum Health is a Surgery and medical program sponsored by The Nemours Foundation. Carrum Health partners with top Hospitals or Centers of Excellence (COE) providers to give Covered Persons access to high-quality providers and lower their cost of care. Some care available through Carrum Health is orthopedic (outpatient orthopedic MSK, total joint replacement, spine), bariatric, cardiac, including travel costs as determined eligible by the program. For more information on this program you may call Carrum Health at (888) 855-7806 or visit their website at carrum.me/nemours.	
Chemotherapy (Outpatient – includes all related charges)	Paid based on place of service
Chiropractic Care/Spinal Manipulation	$50 Copay then 100%; Deductible waived
Calendar Year Maximum Benefit	30 visits
Cognitive Therapy (Outpatient)	Paid based on place of service
Delaware School-Based Health Centers (SBHCs) TINs: 51-0064318, 52-2011066, 51-0103684, 14-1850828, 45-2755081, 51-0069243, 59-0634433, 86-1127196	100%; Deductible waived

BENEFIT DESCRIPTION	PARTICIPATING PROVIDERS ONLY
Diagnostic Testing, X-Ray, and Lab Services (Outpatient)	80% after Deductible
Mammogram	100%; Deductible waived
Advanced Imaging (MRI, MRA, CT and PET Scans, Bone Density, Scintimammography, Capsule Endoscopy, Nuclear Medicine)	80% after Deductible
Durable Medical Equipment (DME)	80% after Deductible
Emergency Services/Emergency Room Services	$250 Copay then 100%; Deductible waived
NOTE: The Copay will be waived if the person is admitted directly as an Inpatient to the Hospital.	
NOTE: Non-emergency Emergency Room Services by Non-Participating Providers will not be covered.	
Fertility	
Basic Fertility Expenses	Paid based on place of service
Comprehensive Fertility Services (Progyny Only – TIN 27-2220139)	80% after Deductible
NOTE: Includes any item or service not otherwise covered under the preventive services provision.	
Gene Therapy	Paid based on place of service
Hearing Aids (up to age 20)	80% after Deductible
Maximum Benefit	1 hearing aid per ear every 36 months
Hearing Exams (non-routine)	Paid based on place of service
Maximum Benefit Per 24-Month Period	1 exam
Home Health Care	80% after Deductible
Calendar Year Maximum Benefit	100 visits
NOTE: Expenses for certain Specialty Drugs or injectable specialty medications will not be considered eligible under the medical Plan unless administered in an Inpatient (e.g., overnight) setting, in an emergency room, or are transplant-related Specialty Drug. Administration costs of all Prescription Drugs including these excluded drugs are covered under the Plan. Please contact the Plan Administrator for additional information.	
Hospice Care	80% after Deductible
Hospital Expenses or Long-Term Acute Care Facility/Hospital (facility charges)	
Inpatient	80% after Deductible
Room and Board Allowance*	*Semi-Private Room Rate
Intensive Care Unit	ICU/CCU Room Rate
Miscellaneous Service and Supplies	80% after Deductible
Outpatient	80% after Deductible
* A private room will be considered eligible when Medically Necessary. Charges made by a Hospital having only single or private rooms will be considered at the least expensive rate for a single or private room.	
Infusion Therapy (Outpatient)	80% after Deductible
NOTE: Expenses for certain Specialty Drugs or injectable specialty medications will not be considered eligible under the medical Plan unless administered in an Inpatient (e.g., overnight) setting, in an emergency room, or are transplant-related Specialty Drug. Administration costs of all Prescription Drugs including these excluded drugs are covered under the Plan. Please contact the Plan Administrator for additional information.	

BENEFIT DESCRIPTION	PARTICIPATING PROVIDERS ONLY
Maternity (non-facility charges)*	
Preventive Prenatal and Breastfeeding Support (other than lactation consultations)	100%; Deductible waived
Lactation Consultations	100%; Deductible waived
All Other Prenatal and Postnatal Care	$50 Copay then 100%; Deductible waived
Delivery	80% after Deductible
* See Preventive Services under Eligible Medical Expenses for limitations.	
Mental Disorders and Substance Use Disorders	
Inpatient	80% after Deductible
Outpatient:	
Office Visits	$40 Copay then 100%; Deductible waived
Intensive Outpatient Therapy/Partial Hospitalization	80% after Deductible
All Other Outpatient Care	80% after Deductible
NOTE: Emergency care (ambulance and Emergency Services/Room) will be paid the same as the benefits for ambulance services and Emergency Services/Room listed above in the Medical Schedule of Benefits, however, the Participating Provider level of benefits will always apply regardless of the provider utilized.	
NOTE: Certain Covered Expenses require precertification. Contact with Care Coordinators by Quantum Health should be made prior to receiving services. See the Care Coordination Process section of the Plan.	
Morbid Obesity/Obesity	80% after Deductible
Occupational Therapy (OT) (Outpatient)	$50 Copay then 100%; Deductible waived
Calendar Year Maximum Benefit	50 visits
Physical Therapy (PT) (Outpatient)	$50 Copay then 100%; Deductible waived
Calendar Year Maximum Benefit	50 visits
Physician's Services	
Inpatient/Outpatient Services	80% after Deductible
Office Visits:	
Primary Care Physician (PCP)	$40 Copay* then 100%; Deductible waived
Specialist	$50 Copay* then 100%; Deductible waived
Physician Office Surgery:	
Primary Care Physician (PCP)	$40 Copay* then 100%; Deductible waived
Specialist	$50 Copay* then 100%; Deductible waived
*Copay applies per visit regardless of what services are rendered.	

BENEFIT DESCRIPTION	PARTICIPATING PROVIDERS ONLY
Preventive Services and Routine Care	
Preventive Services (includes the office visit and any other eligible item received at the same time as the preventive service, whether billed at the same time or separately)	100%; Deductible waived
Routine Care (includes any routine care item or service not otherwise covered under the preventive service provision above)	100%; Deductible waived
Routine Colonoscopy	100%; Deductible waived
NOTE: Routine colonoscopy includes the consultation, removal of polyps, anesthesia and any pathology services.	
Routine Eye Exam (including refractions and glaucoma testing)	100%; Deductible waived
Maximum Benefit Per 12-Month Period	1 exam
Private Duty Nursing (Outpatient)	80% after Deductible
Calendar Year Maximum Benefit	30 eight hour shifts
Radiation Therapy (Outpatient – includes all related charges)	Paid based on place of service
Respiratory/Pulmonary Therapy (Outpatient)	Paid based on place of service
Skilled Nursing Facility and Rehabilitation Facility	80% after Deductible
Combined Calendar Year Maximum Benefit	120 days
Speech/Hearing Therapy (ST/HT) (Outpatient)	$50 Copay then 100%; Deductible waived
Calendar Year Maximum Benefit	50 visits
Telemedicine	
Mental Disorders & Substance Use Disorders	Paid same as office visit benefit for Mental Disorders and Substance Use Disorders
All Other Provider Services	Paid based on provider billing for telemedicine (subject to any applicable maximums and exclusions for the services provided)
Telemedicine by Amwell	
Behavioral Health Consultations	$40 Copay then 100%; Deductible waived
Urgent Care	$35 Copay then 100%; Deductible waived
Transplants	80% after Deductible (Aetna IOE program)* Not Covered (All Other Network Providers)
* Please refer to the Aetna Institute of Excellence (IOE) Program section of this Plan for a more detailed description of this benefit, including travel and lodging maximums. Travel and lodging will be paid at 100% with no Deductible.	
NOTE: Cornea transplants performed by any provider are covered under the Plan as a separate benefit and paid the same as any other Illness.	

BENEFIT DESCRIPTION	PARTICIPATING PROVIDERS ONLY
Urgent Care Facility	$50 Copay* then 100%; Deductible waived
*Copay applies per visit regardless of what services are rendered.	
Walk-In Clinic	$40 Copay then 100%; Deductible waived
Wig (see Eligible Medical Expenses)	80% after Deductible
All Other Eligible Medical Expenses	80% after Deductible

MEDICAL SCHEDULE OF BENEFITS: BLUE HRA PLAN

BENEFIT DESCRIPTION	PARTICIPATING PROVIDERS ONLY
LIFETIME MAXIMUM BENEFIT	Unlimited
CALENDAR YEAR MAXIMUM BENEFIT	Unlimited
CALENDAR YEAR DEDUCTIBLE	
Single	$600
Family	$1,200
CALENDAR YEAR OUT-OF-POCKET MAXIMUM (includes medical Deductible, medical Coinsurance and medical Copays)	
Single	$4,000
Family	$8,000
MEDICAL BENEFITS	
Acupuncture	$40 Copay then 100%; Deductible waived
Calendar Year Maximum Benefit	10 visits
Ambulance Services	$50 Copay per trip then 100%; Deductible waived
NOTE: Emergency ambulance services by Non-Participating Providers will be paid at the Participating Provider level of benefits. Fixed wing aircraft ambulance services by Non-Participating Providers will be paid at the Participating Provider level of benefits subject to preauthorization..	
Ambulatory Surgical Center	80% after Deductible
Cardiac Rehab (Outpatient)	Paid based on place of service
Carrum Health	100%; Deductible waived
NOTE: Carrum Health is a Surgery and medical program sponsored by The Nemours Foundation. Carrum Health partners with top Hospitals or Centers of Excellence (COE) providers to give Covered Persons access to high-quality providers and lower their cost of care. Some care available through Carrum Health is orthopedic (outpatient orthopedic MSK, total joint replacement, spine), bariatric, cardiac, including travel costs as determined eligible by the program. For more information on this program you may call Carrum Health at (888) 855-7806 or visit their website at carrum.me/nemours.	
Chemotherapy (Outpatient – includes all related charges)	Paid based on place of service
Chiropractic Care/Spinal Manipulation	$50 Copay then 100%; Deductible waived
Calendar Year Maximum Benefit	30 visits
Cognitive Therapy (Outpatient)	Paid based on place of service
Delaware School-Based Health Centers (SBHCs) TINs: 51-0064318, 52-2011066, 51-0103684, 14-1850828, 45-2755081, 51-0069243, 59-0634433, 86-1127196)	100%; Deductible waived

BENEFIT DESCRIPTION	PARTICIPATING PROVIDERS ONLY
Diagnostic Testing, X-Ray, and Lab Services (Outpatient)	80% after Deductible
Mammogram	100%; Deductible waived
Advanced Imaging (MRI, MRA, CT and PET Scans, Bone Density, Scintimammography, Capsule Endoscopy, Nuclear Medicine)	80% after Deductible
Durable Medical Equipment (DME)	80% after Deductible
Emergency Services/Emergency Room Services	$250 Copay then 100%; Deductible waived
NOTE: The Copay will be waived if the person is admitted directly as an Inpatient to the Hospital.	
NOTE: Non-Emergency Emergency Room Services by Non-Participating Providers will not be covered.	
Fertility	
Basic Fertility Expenses	Paid based on place of service
Comprehensive Fertility Services (Progyny Only – TIN 27-2220139)	80% after Deductible
NOTE: Includes any item or service not otherwise covered under the preventive services provision.	
Gene Therapy	Paid based on place of service
Hearing Aids (up to age 20)	80% after Deductible
Maximum Benefit	1 hearing aid per ear every 36 months
Hearing Exams (non-routine)	Paid based on place of service
Maximum Benefit Per 24-Month Period	1 exam
Home Health Care	80% after Deductible
Calendar Year Maximum Benefit	100 visits
NOTE: Expenses for certain Specialty Drugs or injectable specialty medications will not be considered eligible under the medical Plan unless administered in an Inpatient (e.g., overnight) setting, in an emergency room, or are transplant-related Specialty Drug. Administration costs of all Prescription Drugs including these excluded drugs are covered under the Plan. Please contact the Plan Administrator for additional information.	
Hospice Care	80% after Deductible
Hospital Expenses or Long-Term Acute Care Facility/Hospital (facility charges)	
Inpatient	80% after Deductible
Room and Board Allowance*	*Semi-Private Room Rate
Intensive Care Unit	ICU/CCU Room Rate
Miscellaneous Service and Supplies	80% after Deductible
Outpatient	80% after Deductible
* A private room will be considered eligible when Medically Necessary. Charges made by a Hospital having only single or private rooms will be considered at the least expensive rate for a single or private room.	
Infusion Therapy (Outpatient)	80% after Deductible
NOTE: Expenses for certain Specialty Drugs or injectable specialty medications will not be considered eligible under the medical Plan unless administered in an Inpatient (e.g., overnight) setting, in an emergency room, or are transplant-related Specialty Drug. Administration costs of all Prescription Drugs including these excluded drugs are covered under the Plan. Please contact the Plan Administrator for additional information.	

BENEFIT DESCRIPTION	PARTICIPATING PROVIDERS ONLY
Maternity (non-facility charges)*	
Preventive Prenatal and Breastfeeding Support (other than lactation consultations)	100%; Deductible waived
Lactation Consultations	100%; Deductible waived
All Other Prenatal and Postnatal Care	$50 Copay then 100%; Deductible waived
Delivery	80% after Deductible
* See Preventive Services under Eligible Medical Expenses for limitations.	
Mental Disorders and Substance Use Disorders	
Inpatient	80% after Deductible
Outpatient:	
Office Visits	$40 Copay then 100%; Deductible waived
Intensive Outpatient Therapy/Partial Hospitalization	80% after Deductible
All Other Outpatient Care	80% after Deductible
NOTE: Emergency care (ambulance and Emergency Services/Room) will be paid the same as the benefits for ambulance services and Emergency Services/Room listed above in the Medical Schedule of Benefits, however, the Participating Provider level of benefits will always apply regardless of the provider utilized.	
NOTE: Certain Covered Expenses require precertification. Contact with Care Coordinators by Quantum Health should be made prior to receiving services. See the Care Coordination Process section of the Plan.	
Morbid Obesity/Obesity	80% after Deductible
Occupational Therapy (OT) (Outpatient)	$50 Copay then 100%; Deductible waived
Calendar Year Maximum Benefit	50 visits
Physical Therapy (PT) (Outpatient)	$50 Copay then 100%; Deductible waived
Calendar Year Maximum Benefit	50 visits
Physician's Services	
Inpatient/Outpatient Services	80% after Deductible
Office Visits:	
Primary Care Physician (PCP)	$40 Copay* then 100%; Deductible waived
Specialist	$50 Copay* then 100%; Deductible waived
Physician Office Surgery:	
Primary Care Physician (PCP)	$40 Copay* then 100%; Deductible waived
Specialist	$50 Copay* then 100%; Deductible waived
*Copay applies per visit regardless of what services are rendered.	

BENEFIT DESCRIPTION	PARTICIPATING PROVIDERS ONLY
Preventive Services and Routine Care	
Preventive Services (includes the office visit and any other eligible item received at the same time as the preventive service, whether billed at the same time or separately)	100%; Deductible waived
Routine Care (includes any routine care item or service not otherwise covered under the preventive service provision above)	100%; Deductible waived
Routine Colonoscopy	100%; Deductible waived
NOTE: Routine colonoscopy includes the consultation, removal of polyps, anesthesia and any pathology services.	
Routine Eye Exam (including refractions and glaucoma testing)	100%; Deductible waived
Maximum Benefit Per 12-Month Period	1 exam
Private Duty Nursing (Outpatient)	80% after Deductible
Calendar Year Maximum Benefit	30 eight hour shifts
Radiation Therapy (Outpatient – includes all related charges)	Paid based on place of service
Respiratory/Pulmonary Therapy (Outpatient)	Paid based on place of service
Skilled Nursing Facility and Rehabilitation Facility	80% after Deductible
Combined Calendar Year Maximum Benefit	120 days
Speech/Hearing Therapy (ST/HT) (Outpatient)	$50 Copay then 100%; Deductible waived
Calendar Year Maximum Benefit	50 visits
Telemedicine	
Mental Disorders & Substance Use Disorders	Paid same as office visit benefit for Mental Disorders and Substance Use Disorders
All Other Provider Services	Paid based on provider billing for telemedicine (subject to any applicable maximums and exclusions for the services provided)
Telemedicine by Amwell	
Behavioral Health Consultations	$40 Copay then 100%; Deductible waived
Urgent Care	$35 Copay then 100%; Deductible waived
Transplants	80% after Deductible (Aetna IOE program)* Not Covered (All Other Network Providers)
* Please refer to the Aetna Institute of Excellence (IOE) Program section of this Plan for a more detailed description of this benefit, including travel and lodging maximums. Travel and lodging will be paid at 100% with no Deductible.	
NOTE: Cornea transplants performed by any provider are covered under the Plan as a separate benefit and paid the same as any other Illness.	

BENEFIT DESCRIPTION	PARTICIPATING PROVIDERS ONLY
Urgent Care Facility	$50 Copay* then 100%; Deductible waived
*Copay applies per visit regardless of what services are rendered.	
Walk-In Clinic	$40 Copay then 100%; Deductible waived
Wig (see Eligible Medical Expenses)	80% after Deductible
All Other Eligible Medical Expenses	80% after Deductible

MEDICAL SCHEDULE OF BENEFITS: RED PLAN

RED PLAN	PARTICIPATING PROVIDERS	NON-PARTICIPATING PROVIDERS (Subject to Usual and Customary Charges)
LIFETIME MAXIMUM BENEFIT	Unlimited	
CALENDAR YEAR MAXIMUM BENEFIT	Unlimited	
CALENDAR YEAR DEDUCTIBLE		
Single	$500	$1,000
Family	$1,000	$2,000
CALENDAR YEAR OUT-OF-POCKET MAXIMUM (includes medical Deductible, medical Coinsurance and medical Copays)		
Single	$4,000	$8,000
Family	$8,000	$16,000
MEDICAL BENEFITS		
Acupuncture	$30 Copay then 100%; Deducible waived	60% after Deductible
Calendar Year Maximum Benefit	10 visits	
Ambulance Services	$50 Copay per trip then 100%; Deductible waived	Paid at the Participating Provider level of benefits
NOTE: Fixed wing aircraft ambulance services by Non-Participating Providers will be paid at the Participating Provider level of benefits subject to preauthorization.		
Ambulatory Surgical Center	80% after Deductible	60% after Deductible
Cardiac Rehab (Outpatient)	Paid based on place of service	Paid based on place of service
Carrum Health	100%; Deductible waived	Not Applicable
NOTE: Carrum Health is a Surgery and medical program sponsored by The Nemours Foundation. Carrum Health partners with top Hospitals or Centers of Excellence (COE) providers to give Covered Persons access to high-quality providers and lower their cost of care. Some care available through Carrum Health is orthopedic (outpatient orthopedic MSK, total joint replacement, spine), bariatric, cardiac, including travel costs as determined eligible by the program. For more information on this program you may call Carrum Health at (888) 855-7806 or visit their website at carrum.me/nemours.		
Chemotherapy (Outpatient – includes all related charges)	Paid based on place of service	Paid based on place of service
Chiropractic Care/Spinal Manipulation	$40 Copay then 100%; Deductible waived	60% after Deductible
Calendar Year Maximum Benefit	30 visits	

RED PLAN	PARTICIPATING PROVIDERS	NON-PARTICIPATING PROVIDERS (Subject to Usual and Customary Charges)
Cognitive Therapy (Outpatient)	Paid based on place of service	Paid based on place of service
Delaware School-Based Health Centers (SBHCs) TINs: 51-0064318, 52-2011066, 51-0103684, 14-1850828, 45-2755081, 51-0069243, 59-0634433, 86-1127196)	100%; Deductible waived	100%; Deductible waived
Diagnostic Testing, X-Ray, and Lab Services (Outpatient)	80% after Deductible	60% after Deductible
Mammogram	100%; Deductible waived	60% after Deductible
Advanced Imaging (MRI, MRA, CT and PET Scans, Bone Density, Scintimammography, Capsule Endoscopy, Nuclear Medicine)	80% after Deductible	60% after Deductible
Durable Medical Equipment (DME)	80% after Deductible	60% after Deductible
Emergency Services – Emergency Medical Condition	$250 Copay then 100%; Deductible waived	$250 Copay then 100%; Deductible waived
Emergency Room – Non-Emergency Medical Condition	$250 Copay then 100%; Deductible waived	$250 Copay then 100%; Deductible waived
NOTE: The Copay will be waived if the person is admitted directly as an Inpatient to the Hospital.		
Fertility		
Basic Fertility Expenses	Paid based on place of service	Paid based on place of service
Comprehensive Fertility Services (Progyny Only – TIN 27-2220139)	80% after Deductible	Not Applicable
NOTE: Includes any item or service not otherwise covered under the preventive services provision.		
Gene Therapy	Paid based on place of service	Not Covered
Hearing Aids (up to age 20)	80% after Deductible	60% after Deductible
Maximum Benefit	1 hearing aid per ear every 36 months	
Hearing Exams (non-routine)	Paid based on place of service	Paid based on place of service
Maximum Benefit Per 24 -Month Period	1 exam	
Home Health Care	80% after Deductible	60% after Deductible
Calendar Year Maximum Benefit	100 visits	
NOTE: Expenses for certain Specialty Drugs or injectable specialty medications will not be considered eligible under the medical Plan unless administered in an Inpatient (e.g., overnight) setting, in an emergency room, or are transplant-related Specialty Drug. Administration costs of all Prescription Drugs including these excluded drugs are covered under the Plan. Please contact the Plan Administrator for additional information.		
Hospice Care	80% after Deductible	60% after Deductible

RED PLAN	PARTICIPATING PROVIDERS	NON-PARTICIPATING PROVIDERS (Subject to Usual and Customary Charges)
Hospital Expenses or Long-Term Acute Care Facility/Hospital (facility charges)		
Inpatient	80% after Deductible	60% after Deductible
Room and Board Allowance*	Semi-Private Room Rate*	Semi-Private Room Rate*
Intensive Care Unit	ICU/CCU Room Rate	ICU/CCU Room Rate
Miscellaneous Services & Supplies	80% after Deductible	60% after Deductible
Outpatient	80% after Deductible	60% after Deductible
* A private room will be considered eligible when Medically Necessary. Charges made by a Hospital having only single or private rooms will be considered at the least expensive rate for a single or private room.		
Infusion Therapy (Outpatient)	80% after Deductible	60% after Deductible
NOTE: Expenses for certain Specialty Drugs or injectable specialty medications will not be considered eligible under the medical Plan unless administered in an Inpatient (e.g., overnight) setting, in an emergency room, or are transplant-related Specialty Drug. Administration costs of all Prescription Drugs including these excluded drugs are covered under the Plan. Please contact the Plan Administrator for additional information.		
Maternity (non-facility charges)*		
Preventive Prenatal and Breastfeeding Support (other than lactation consultations)	100%; Deductible waived	60% after Deductible
Lactation Consultations	100%; Deductible waived	100%; Deductible waived
All Other Prenatal and Postnatal Care	$40 Copay then 100%; Deductible waived	60% after Deductible
Delivery	80% after Deductible	60% after Deductible
* See Preventive Services under Eligible Medical Expenses for limitations.		
Mental Disorders and Substance Use Disorders		
Inpatient	80% after Deductible	60% after Deductible
Outpatient		
Office Visits	$30 Copay then 100%; Deductible waived	60% after Deductible
Intensive Outpatient Therapy/Partial Hospitalization	80% after Deductible	60% after Deductible
All Other Outpatient Care	80% after Deductible	60% after Deductible
NOTE: Emergency care (ambulance and Emergency Services/Room) will be paid the same as the benefits for ambulance services and Emergency Services/Room listed above in the Medical Schedule of Benefits, however, the Participating Provider level of benefits will always apply regardless of the provider utilized.		
NOTE: Certain Covered Expenses require precertification. Contact with Care Coordinators by Quantum Health should be made prior to receiving services. See the Care Coordination Process section of the Plan.		
Morbid Obesity/Obesity	80% after Deductible	60% after Deductible
Occupational Therapy (OT) (Outpatient)	$40 Copay then 100%; Deductible waived	60% after Deductible
Calendar Year Maximum Benefit	50 visits	

RED PLAN	PARTICIPATING PROVIDERS	NON-PARTICIPATING PROVIDERS (Subject to Usual and Customary Charges)
Physical Therapy (PT) (Outpatient)	$40 Copay then 100%; Deductible waived	60% after Deductible
Calendar Year Maximum Benefit	50 visits	
Physician's Services		
Inpatient/Outpatient Services	80% after Deductible	60% after Deductible
Office Visits:		
Primary Care Physician (PCP)	$30 Copay* then 100%; Deductible waived	60% after Deductible
Specialist	$40 Copay* then 100%; Deductible waived	60% after Deductible
Physician Office Surgery:		
Primary Care Physician (PCP)	$30 Copay* then 100%; Deductible waived	60% after Deductible
Specialist	$40 Copay* then 100%; Deductible waived	60% after Deductible
*Copay applies per visit regardless of what services are rendered.		
Preventive Services and Routine Care		
Preventive Services (includes the office visit and any other eligible item or service received at the same time, whether billed at the same time or separately)	100%; Deductible waived	60% after Deductible
Routine Care (includes any routine care item or service not otherwise covered under the preventive services provision above)	100%; Deductible waived	60% after Deductible
Routine Colonoscopy	100%; Deductible waived	60% after Deductible
NOTE: Routine colonoscopy includes the consultation, removal of polyps, anesthesia and any pathology services.		
Routine Eye Exam (including refractions and glaucoma testing)	100%; Deductible waived	60% after Deductible
Maximum Benefit Per 12-Month Period	1 exam	
Private Duty Nursing (Outpatient)	80% after Deductible	60% after Deductible
Calendar Year Maximum Benefit	30 eight hour shifts	
Radiation Therapy (Outpatient – includes all related charges)	Paid based on place of service	Paid based on place of service
Respiratory/Pulmonary Therapy (Outpatient)	Paid based on place of service	Paid based on place of service
Skilled Nursing Facility and Rehabilitation Facility	80% after Deductible	60% after Deductible
Combined Calendar Year Maximum Benefit	120 days	
Speech/Hearing Therapy (ST/HT) (Outpatient)	$40 Copay then 100%; Deductible waived	60% after Deductible
Calendar Year Maximum Benefit	50 visits	

RED PLAN	PARTICIPATING PROVIDERS	NON-PARTICIPATING PROVIDERS (Subject to Usual and Customary Charges)
Telemedicine		
Mental Disorders & Substance Use Disorders	Paid same as office visit benefit for Mental Disorders and Substance Use Disorders	Paid same as office visit benefit for Mental Disorders and Substance Use Disorders
All Other Provider Services	Paid based on provider billing for telemedicine (subject to any applicable maximums and exclusions for the services provided)	Paid based on provider billing for telemedicine (subject to any applicable maximums and exclusions for the services provided)
Telemedicine by Amwell		
Behavioral Health Consultations	$30 Copay, then 100%; Deductible waived	Not Applicable
Urgent Care	$25 Copay, then 100%; Deductible waived	Not Applicable
Transplants	80% after Deductible (Aetna IOE Program)* 60% after Deductible (All Other Network Providers)	60% after Deductible
* Please refer to the Aetna Institute of Excellence (IOE) Program section of this Plan for a more detailed description of this benefit, including travel and lodging maximums. Travel and lodging will be paid at 100% with no Deductible.		
NOTE: Cornea transplants performed by any provider are covered under the Plan as a separate benefit and paid the same as any other Illness.		
Urgent Care Facility	$50 Copay* then 100%; Deductible waived	$50 Copay* then 100%; Deductible waived
*Copay applies per visit regardless of what services are rendered.		
Wig (see Eligible Medical Expenses)	80% after Deductible	60% after Deductible
All Other Eligible Medical Expenses	80% after Deductible	60% after Deductible

MEDICAL SCHEDULE OF BENEFITS: RED HRA PLAN

RED HRA PLAN	PARTICIPATING PROVIDERS	NON-PARTICIPATING PROVIDERS (Subject to Usual and Customary Charges)
LIFETIME MAXIMUM BENEFIT	Unlimited	
CALENDAR YEAR MAXIMUM BENEFIT	Unlimited	
CALENDAR YEAR DEDUCTIBLE		
Single	$500	$1,000
Family	$1,000	$2,000
CALENDAR YEAR OUT-OF-POCKET MAXIMUM (includes medical Deductible, medical Coinsurance and medical Copays)		
Single	$4,000	$8,000
Family	$8,000	$16,000
MEDICAL BENEFITS		
Acupuncture	$30 Copay then 100%; Deducible waived	60% after Deductible
Calendar Year Maximum Benefit	10 visits	
Ambulance Services	$50 Copay per trip then 100%; Deductible waived	Paid at the Participating Provider level of benefits
NOTE: Fixed wing aircraft ambulance services by Non-Participating Providers will be paid at the Participating Provider level of benefits subject to preauthorization.		
Ambulatory Surgical Center	80% after Deductible	60% after Deductible
Cardiac Rehab (Outpatient)	Paid based on place of service	Paid based on place of service
Carrum Health	100%; Deductible waived	Not Applicable
NOTE: Carrum Health is a Surgery and medical program sponsored by The Nemours Foundation. Carrum Health partners with top Hospitals or Centers of Excellence (COE) providers to give Covered Persons access to high-quality providers and lower their cost of care. Some care available through Carrum Health is orthopedic (outpatient orthopedic MSK, total joint replacement, spine), bariatric, cardiac, including travel costs as determined eligible by the program. For more information on this program you may call Carrum Health at (888) 855-7806 or visit their website at carrum.me/nemours.		
Chemotherapy (Outpatient – includes all related charges)	Paid based on place of service	Paid based on place of service
Chiropractic Care/Spinal Manipulation	$40 Copay then 100%; Deductible waived	60% after Deductible
Calendar Year Maximum Benefit	30 visits	

RED HRA PLAN	PARTICIPATING PROVIDERS	NON-PARTICIPATING PROVIDERS (Subject to Usual and Customary Charges)
Cognitive Therapy (Outpatient)	Paid based on place of service	Paid based on place of service
Delaware School-Based Health Centers (SBHCs) TINs: 51-0064318, 52-2011066, 51-0103684, 14-1850828, 45-2755081, 51-0069243, 59-0634433, 86-1127196)	100%; Deductible waived	100%; Deductible waived
Diagnostic Testing, X-Ray, and Lab Services (Outpatient)	80% after Deductible	60% after Deductible
Mammogram	100%; Deductible waived	60% after Deductible
Advanced Imaging (MRI, MRA, CT and PET Scans, Bone Density, Scintimammography, Capsule Endoscopy, Nuclear Medicine)	80% after Deductible	60% after Deductible
Durable Medical Equipment (DME)	80% after Deductible	60% after Deductible
Emergency Services – Emergency Medical Condition	$250 Copay then 100%; Deductible waived	$250 Copay then 100%; Deductible waived
Emergency Room – Non-Emergency Medical Condition	$250 Copay then 100%; Deductible waived	$250 Copay then 100%; Deductible waived
NOTE: The Copay will be waived if the person is admitted directly as an Inpatient to the Hospital.		
Fertility		
Basic Fertility Expenses	Paid based on place of service	Paid based on place of service
Comprehensive Fertility Services (Progyny Only – TIN 27-2220139)	80% after Deductible	Not Applicable
NOTE: Includes any item or service not otherwise covered under the preventive services provision.		
Gene Therapy	Paid based on place of service	Not Covered
Hearing Aids (up to age 20)	80% after Deductible	60% after Deductible
Maximum Benefit	1 hearing aid per ear every 36 months	
Hearing Exams (non-routine)	Paid based on place of service	Paid based on place of service
Maximum Benefit Per 24 -Month Period	1 exam	
Home Health Care	80% after Deductible	60% after Deductible
Calendar Year Maximum Benefit	100 visits	
NOTE: Expenses for certain Specialty Drugs or injectable specialty medications will not be considered eligible under the medical Plan unless administered in an Inpatient (e.g., overnight) setting, in an emergency room, or are transplant-related Specialty Drug. Administration costs of all Prescription Drugs including these excluded drugs are covered under the Plan. Please contact the Plan Administrator for additional information.		
Hospice Care	80% after Deductible	60% after Deductible

RED HRA PLAN	PARTICIPATING PROVIDERS	NON-PARTICIPATING PROVIDERS (Subject to Usual and Customary Charges)
Hospital Expenses or Long-Term Acute Care Facility/Hospital (facility charges)		
Inpatient	80% after Deductible	60% after Deductible
Room and Board Allowance*	Semi-Private Room Rate*	Semi-Private Room Rate*
Intensive Care Unit	ICU/CCU Room Rate	ICU/CCU Room Rate
Miscellaneous Services & Supplies	80% after Deductible	60% after Deductible
Outpatient	80% after Deductible	60% after Deductible
* A private room will be considered eligible when Medically Necessary. Charges made by a Hospital having only single or private rooms will be considered at the least expensive rate for a single or private room.		
Infusion Therapy (Outpatient)	80% after Deductible	60% after Deductible
NOTE: Expenses for certain Specialty Drugs or injectable specialty medications will not be considered eligible under the medical Plan unless administered in an Inpatient (e.g., overnight) setting, in an emergency room, or are transplant-related Specialty Drug. Administration costs of all Prescription Drugs including these excluded drugs are covered under the Plan. Please contact the Plan Administrator for additional information.		
Maternity (non-facility charges)*		
Preventive Prenatal and Breastfeeding Support (other than lactation consultations)	100%; Deductible waived	60% after Deductible
Lactation Consultations	100%; Deductible waived	100%; Deductible waived
All Other Prenatal and Postnatal Care	$40 Copay then 100%; Deductible waived	60% after Deductible
Delivery	80% after Deductible	60% after Deductible
* See Preventive Services under Eligible Medical Expenses for limitations.		
Mental Disorders and Substance Use Disorders		
Inpatient	80% after Deductible	60% after Deductible
Outpatient		
Office Visits	$30 Copay then 100%; Deductible waived	60% after Deductible
Intensive Outpatient Therapy/Partial Hospitalization	80% after Deductible	60% after Deductible
All Other Outpatient Care	80% after Deductible	60% after Deductible
NOTE: Emergency care (ambulance and Emergency Services/Room) will be paid the same as the benefits for ambulance services and Emergency Services/Room listed above in the Medical Schedule of Benefits, however, the Participating Provider level of benefits will always apply regardless of the provider utilized.		
NOTE: Certain Covered Expenses require precertification. Contact with Care Coordinators by Quantum Health should be made prior to receiving services. See the Care Coordination Process section of the Plan.		
Morbid Obesity/Obesity	80% after Deductible	60% after Deductible
Occupational Therapy (OT) (Outpatient)	$40 Copay then 100%; Deductible waived	60% after Deductible
Calendar Year Maximum Benefit	50 visits	

RED HRA PLAN	PARTICIPATING PROVIDERS	NON-PARTICIPATING PROVIDERS (Subject to Usual and Customary Charges)
Physical Therapy (PT) (Outpatient)	$40 Copay then 100%; Deductible waived	60% after Deductible
Calendar Year Maximum Benefit	50 visits	
Physician's Services		
Inpatient/Outpatient Services	80% after Deductible	60% after Deductible
Office Visits:		
Primary Care Physician (PCP)	$30 Copay* then 100%; Deductible waived	60% after Deductible
Specialist	$40 Copay* then 100%; Deductible waived	60% after Deductible
Physician Office Surgery:		
Primary Care Physician (PCP)	$30 Copay* then 100%; Deductible waived	60% after Deductible
Specialist	$40 Copay* then 100%; Deductible waived	60% after Deductible
*Copay applies per visit regardless of what services are rendered.		
Preventive Services and Routine Care		
Preventive Services (includes the office visit and any other eligible item or service received at the same time, whether billed at the same time or separately)	100%; Deductible waived	60% after Deductible
Routine Care (includes any routine care item or service not otherwise covered under the preventive services provision above)	100%; Deductible waived	60% after Deductible
Routine Colonoscopy	100%; Deductible waived	60% after Deductible
NOTE: Routine colonoscopy includes the consultation, removal of polyps, anesthesia and any pathology services.		
Routine Eye Exam (including refractions and glaucoma testing)	100%; Deductible waived	60% after Deductible
Maximum Benefit Per 12-Month Period	1 exam	
Private Duty Nursing (Outpatient)	80% after Deductible	60% after Deductible
Calendar Year Maximum Benefit	30 eight hour shifts	
Radiation Therapy (Outpatient – includes all related charges)	Paid based on place of service	Paid based on place of service
Respiratory/Pulmonary Therapy (Outpatient)	Paid based on place of service	Paid based on place of service
Skilled Nursing Facility and Rehabilitation Facility	80% after Deductible	60% after Deductible
Combined Calendar Year Maximum Benefit	120 days	
Speech/Hearing Therapy (ST/HT) (Outpatient)	$40 Copay then 100%; Deductible waived	60% after Deductible
Calendar Year Maximum Benefit	50 visits	

RED HRA PLAN	PARTICIPATING PROVIDERS	NON-PARTICIPATING PROVIDERS (Subject to Usual and Customary Charges)
Telemedicine		
Mental Disorders & Substance Use Disorders	Paid same as office visit benefit for Mental Disorders and Substance Use Disorders	Paid same as office visit benefit for Mental Disorders and Substance Use Disorders
All Other Provider Services	Paid based on provider billing for telemedicine (subject to any applicable maximums and exclusions for the services provided)	Paid based on provider billing for telemedicine (subject to any applicable maximums and exclusions for the services provided)
Telemedicine by Amwell		
Behavioral Health Consultations	$30 Copay, then 100%; Deductible waived	Not Applicable
Urgent Care	$25 Copay, then 100%; Deductible waived	Not Applicable
Transplants	80% after Deductible (Aetna IOE Program)* 60% after Deductible (All Other Network Providers)	60% after Deductible
* Please refer to the Aetna Institute of Excellence (IOE) Program section of this Plan for a more detailed description of this benefit, including travel and lodging maximums. Travel and lodging will be paid at 100% with no Deductible.		
NOTE: Cornea transplants performed by any provider are covered under the Plan as a separate benefit and paid the same as any other Illness.		
Urgent Care Facility	$50 Copay* then 100%; Deductible waived	$50 Copay* then 100%; Deductible waived
*Copay applies per visit regardless of what services are rendered.		
Wig (see Eligible Medical Expenses)	80% after Deductible	60% after Deductible
All Other Eligible Medical Expenses	80% after Deductible	60% after Deductible

MEDICAL SCHEDULE OF BENEFITS: WHITE PLAN

WHITE PLAN	PARTICIPATING PROVIDERS	NON-PARTICIPATING PROVIDERS (Subject to Usual and Customary Charges)
LIFETIME MAXIMUM BENEFIT	Unlimited	
CALENDAR YEAR MAXIMUM BENEFIT	Unlimited	
CALENDAR YEAR DEDUCTIBLE		
Single	$1,200	$2,400
Family	$2,400	$4,800
CALENDAR YEAR OUT-OF-POCKET MAXIMUM (includes medical Deductible, medical Coinsurance and medical Copays)		
Single	$4,000	$8,000
Family	$8,000	$16,000
MEDICAL BENEFITS		
Acupuncture	$40 Copay then 100%; Deducible waived	50% after Deductible
Calendar Year Maximum Benefit	10 visits	
Ambulance Services	$50 Copay per trip then 100%; Deductible waived	Paid at the Participating Provider level of benefits
NOTE: Fixed wing aircraft ambulance services by Non-Participating Providers will be paid at the Participating Provider level of benefits subject to preauthorization.		
Ambulatory Surgical Center	70% after Deductible	50% after Deductible
Cardiac Rehab (Outpatient)	Paid based on place of service	Paid based on place of service
Carrum Health	100%; Deductible waived	Not Applicable
NOTE: Carrum Health is a Surgery and medical program sponsored by The Nemours Foundation. Carrum Health partners with top Hospitals or Centers of Excellence (COE) providers to give Covered Persons access to high-quality providers and lower their cost of care. Some care available through Carrum Health is orthopedic (outpatient orthopedic MSK, total joint replacement, spine), bariatric, cardiac, including travel costs as determined eligible by the program. For more information on this program you may call Carrum Health at (888) 855-7806 or visit their website at carrum.me/nemours.		
Chemotherapy (Outpatient – includes all related charges)	Paid based on place of service	Paid based on place of service
Chiropractic Care/Spinal Manipulation	$50 Copay then 100%; Deductible waived	50% after Deductible
Calendar Year Maximum Benefit	30 visits	

WHITE PLAN	PARTICIPATING PROVIDERS	NON-PARTICIPATING PROVIDERS (Subject to Usual and Customary Charges)
Cognitive Therapy (Outpatient)	Paid based on place of service	Paid based on place of service
Delaware School-Based Health Centers (SBHCs) TINs: 51-0064318, 52-2011066, 51-0103684, 14-1850828, 45-2755081, 51-0069243, 59-0634433, 86-1127196)	100%; Deductible waived	100%; Deductible waived
Diagnostic Testing, X-Ray, and Lab Services (Outpatient)	70% after Deductible	50% after Deductible
Mammogram	100%; Deductible waived	50% after Deductible
Advanced Imaging (MRI, MRA, CT and PET Scans, Bone Density, Scintimammography, Capsule Endoscopy, Nuclear Medicine)	70% after Deductible	50% after Deductible
Durable Medical Equipment (DME)	70% after Deductible	50% after Deductible
Emergency Services – Emergency Medical Condition	$250 Copay then 100%; Deductible waived	$250 Copay then 100%; Deductible waived
Emergency Room – Non-Emergency Medical Condition	$250 Copay then 100%; Deductible waived	$250 Copay then 100%; Deductible waived
NOTE: The Copay will be waived if the person is admitted directly as an Inpatient to the Hospital.		
Fertility		
Basic Fertility Expenses	Paid based on place of service	Paid based on place of service
Comprehensive Fertility Services (Progyny Only – TIN 27-2220139)	70% after Deductible	Not Applicable
NOTE: Includes any item or service not otherwise covered under the preventive services provision.		
Gene Therapy	Paid based on place of service	Not Covered
Hearing Aids (up to age 20)	70% after Deductible	50% after Deductible
Maximum Benefit	1 hearing aid per ear every 36 months	
Hearing Exams (non-routine)	Paid based on place of service	Paid based on place of service
Maximum Benefit Per 24 -Month Period	1 exam	
Home Health Care	70% after Deductible	50% after Deductible
Calendar Year Maximum Benefit	100 visits	
NOTE: Expenses for certain Specialty Drugs or injectable specialty medications will not be considered eligible under the medical Plan unless administered in an Inpatient (e.g., overnight) setting, in an emergency room, or are transplant-related Specialty Drug. Administration costs of all Prescription Drugs including these excluded drugs are covered under the Plan. Please contact the Plan Administrator for additional information.		
Hospice Care	70% after Deductible	50% after Deductible

WHITE PLAN	PARTICIPATING PROVIDERS	NON-PARTICIPATING PROVIDERS (Subject to Usual and Customary Charges)
Hospital Expenses or Long-Term Acute Care Facility/Hospital (facility charges)		
Inpatient	70% after Deductible	50% after Deductible
Room and Board Allowance*	Semi-Private Room Rate*	Semi-Private Room Rate*
Intensive Care Unit	ICU/CCU Room Rate	ICU/CCU Room Rate
Miscellaneous Services & Supplies	70% after Deductible	50% after Deductible
Outpatient	70% after Deductible	50% after Deductible
* A private room will be considered eligible when Medically Necessary. Charges made by a Hospital having only single or private rooms will be considered at the least expensive rate for a single or private room.		
Infusion Therapy (Outpatient)	70% after Deductible	50% after Deductible
NOTE: Expenses for certain Specialty Drugs or injectable specialty medications will not be considered eligible under the medical Plan unless administered in an Inpatient (e.g., overnight) setting, in an emergency room, or are transplant-related Specialty Drug. Administration costs of all Prescription Drugs including these excluded drugs are covered under the Plan. Please contact the Plan Administrator for additional information.		
Maternity (non-facility charges)*		
Preventive Prenatal and Breastfeeding Support (other than lactation consultations)	100%; Deductible waived	50% after Deductible
Lactation Consultations	100%; Deductible waived	100%; Deductible waived
All Other Prenatal and Postnatal Care	$50 Copay then 100%; Deductible waived	50% after Deductible
Delivery	70% after Deductible	50% after Deductible
* See Preventive Services under Eligible Medical Expenses for limitations.		
Mental Disorders and Substance Use Disorders		
Inpatient	70% after Deductible	50% after Deductible
Outpatient		
Office Visits	$40 Copay then 100%; Deductible waived	50% after Deductible
Intensive Outpatient Therapy/Partial Hospitalization	70% after Deductible	50% after Deductible
All Other Outpatient Care	70% after Deductible	50% after Deductible
NOTE: Emergency care (ambulance and Emergency Services/Room) will be paid the same as the benefits for ambulance services and Emergency Services/Room listed above in the Medical Schedule of Benefits, however, the Participating Provider level of benefits will always apply regardless of the provider utilized.		
NOTE: Certain Covered Expenses require precertification. Contact with Care Coordinators by Quantum Health should be made prior to receiving services. See the Care Coordination Process section of the Plan.		
Morbid Obesity/Obesity	70% after Deductible	50% after Deductible
Occupational Therapy (OT) (Outpatient)	$50 Copay then 100%; Deductible waived	50% after Deductible
Calendar Year Maximum Benefit	50 visits	

WHITE PLAN	PARTICIPATING PROVIDERS	NON-PARTICIPATING PROVIDERS (Subject to Usual and Customary Charges)
Physical Therapy (PT) (Outpatient)	$50 Copay then 100%; Deductible waived	50% after Deductible
Calendar Year Maximum Benefit	50 visits	
Physician's Services		
Inpatient/Outpatient Services	70% after Deductible	50% after Deductible
Office Visits:		
Primary Care Physician (PCP)	$40 Copay* then 100%; Deductible waived	50% after Deductible
Specialist	$50 Copay* then 100%; Deductible waived	50% after Deductible
Physician Office Surgery:		
Primary Care Physician (PCP)	$40 Copay* then 100%; Deductible waived	50% after Deductible
Specialist	$50 Copay* then 100%; Deductible waived	50% after Deductible
*Copay applies per visit regardless of what services are rendered.		
Preventive Services and Routine Care		
Preventive Services (includes the office visit and any other eligible item or service received at the same time, whether billed at the same time or separately)	100%; Deductible waived	50% after Deductible
Routine Care (includes any routine care item or service not otherwise covered under the preventive services provision above)	100%; Deductible waived	50% after Deductible
Routine Colonoscopy	100%; Deductible waived	50% after Deductible
NOTE: Routine colonoscopy includes the consultation, removal of polyps, anesthesia and any pathology services.		
Routine Eye Exam (including refractions and glaucoma testing)	100%; Deductible waived	50% after Deductible
Maximum Benefit Per 12-Month Period	1 exam	
Private Duty Nursing (Outpatient)	70% after Deductible	50% after Deductible
Calendar Year Maximum Benefit	30 eight hour shifts	
Radiation Therapy (Outpatient – includes all related charges)	Paid based on place of service	Paid based on place of service
Respiratory/Pulmonary Therapy (Outpatient)	Paid based on place of service	Paid based on place of service
Skilled Nursing Facility and Rehabilitation Facility	70% after Deductible	50% after Deductible
Combined Calendar Year Maximum Benefit	120 days	
Speech/Hearing Therapy (ST/HT) (Outpatient)	$50 Copay then 100%; Deductible waived	50% after Deductible
Calendar Year Maximum Benefit	50 visits	

WHITE PLAN	PARTICIPATING PROVIDERS	NON-PARTICIPATING PROVIDERS (Subject to Usual and Customary Charges)
Telemedicine		
Mental Disorders & Substance Use Disorders	Paid same as office visit benefit for Mental Disorders and Substance Use Disorders	Paid same as office visit benefit for Mental Disorders and Substance Use Disorders
All Other Provider Services	Paid based on provider billing for telemedicine (subject to any applicable maximums and exclusions for the services provided)	Paid based on provider billing for telemedicine (subject to any applicable maximums and exclusions for the services provided)
Telemedicine by Amwell		
Behavioral Health Consultations	$40 Copay, then 100%; Deductible waived	Not Applicable
Urgent Care	$35 Copay, then 100%; Deductible waived	Not Applicable
Transplants	70% after Deductible (Aetna IOE Program)* 50% after Deductible (All Other Network Providers)	50% after Deductible
* Please refer to the Aetna Institute of Excellence (IOE) Program section of this Plan for a more detailed description of this benefit, including travel and lodging maximums. Travel and lodging will be paid at 100% with no Deductible.		
NOTE: Cornea transplants performed by any provider are covered under the Plan as a separate benefit and paid the same as any other Illness.		
Urgent Care Facility	$50 Copay* then 100%; Deductible waived	$50 Copay* then 100%; Deductible waived
*Copay applies per visit regardless of what services are rendered.		
Wig (see Eligible Medical Expenses)	70% after Deductible	50% after Deductible
All Other Eligible Medical Expenses	70% after Deductible	50% after Deductible

MEDICAL SCHEDULE OF BENEFITS: WHITE HRA PLAN

WHITE HRA PLAN	PARTICIPATING PROVIDERS	NON-PARTICIPATING PROVIDERS (Subject to Usual and Customary Charges)
LIFETIME MAXIMUM BENEFIT	Unlimited	
CALENDAR YEAR MAXIMUM BENEFIT	Unlimited	
CALENDAR YEAR DEDUCTIBLE		
Single	$1,200	$2,400
Family	$2,400	$4,800
CALENDAR YEAR OUT-OF-POCKET MAXIMUM (includes medical Deductible, medical Coinsurance and medical Copays)		
Single	$4,000	$8,000
Family	$8,000	$16,000
MEDICAL BENEFITS		
Acupuncture	$40 Copay then 100%; Deducible waived	50% after Deductible
Calendar Year Maximum Benefit	10 visits	
Ambulance Services	$50 Copay per trip then 100%; Deductible waived	Paid at the Participating Provider level of benefits
NOTE: Fixed wing aircraft ambulance services by Non-Participating Providers will be paid at the Participating Provider level of benefits subject to preauthorization.		
Ambulatory Surgical Center	70% after Deductible	50% after Deductible
Cardiac Rehab (Outpatient)	Paid based on place of service	Paid based on place of service
Carrum Health	100%; Deductible waived	Not Applicable
NOTE: Carrum Health is a Surgery and medical program sponsored by The Nemours Foundation. Carrum Health partners with top Hospitals or Centers of Excellence (COE) providers to give Covered Persons access to high-quality providers and lower their cost of care. Some care available through Carrum Health is orthopedic (outpatient orthopedic MSK, total joint replacement, spine), bariatric, cardiac, including travel costs as determined eligible by the program. For more information on this program you may call Carrum Health at (888) 855-7806 or visit their website at carrum.me/nemours.		
Chemotherapy (Outpatient – includes all related charges)	Paid based on place of service	Paid based on place of service
Chiropractic Care/Spinal Manipulation	$50 Copay then 100%; Deductible waived	50% after Deductible
Calendar Year Maximum Benefit	30 visits	

WHITE HRA PLAN	PARTICIPATING PROVIDERS	NON-PARTICIPATING PROVIDERS (Subject to Usual and Customary Charges)
Cognitive Therapy (Outpatient)	Paid based on place of service	Paid based on place of service
Delaware School-Based Health Centers (SBHCs) TINs: 51-0064318, 52-2011066, 51-0103684, 14-1850828, 45-2755081, 51-0069243, 59-0634433, 86-1127196)	100%; Deductible waived	100%; Deductible waived
Diagnostic Testing, X-Ray, and Lab Services (Outpatient)	70% after Deductible	50% after Deductible
Mammogram	100%; Deductible waived	50% after Deductible
Advanced Imaging (MRI, MRA, CT and PET Scans, Bone Density, Scintimammography, Capsule Endoscopy, Nuclear Medicine)	70% after Deductible	50% after Deductible
Durable Medical Equipment (DME)	70% after Deductible	50% after Deductible
Emergency Services – Emergency Medical Condition	$250 Copay then 100%; Deductible waived	$250 Copay then 100%; Deductible waived
Emergency Room – Non-Emergency Medical Condition	$250 Copay then 100%; Deductible waived	$250 Copay then 100%; Deductible waived
NOTE: The Copay will be waived if the person is admitted directly as an Inpatient to the Hospital.		
Fertility		
Basic Fertility Expenses	Paid based on place of service	Paid based on place of service
Comprehensive Fertility Services (Progyny Only – TIN 27-2220139)	70% after Deductible	Not Applicable
NOTE: Includes any item or service not otherwise covered under the preventive services provision.		
Gene Therapy	Paid based on place of service	Not Covered
Hearing Aids (up to age 20)	70% after Deductible	50% after Deductible
Maximum Benefit	1 hearing aid per ear every 36 months	
Hearing Exams (non-routine)	Paid based on place of service	Paid based on place of service
Maximum Benefit Per 24 -Month Period	1 exam	
Home Health Care	70% after Deductible	50% after Deductible
Calendar Year Maximum Benefit	100 visits	
NOTE: Expenses for certain Specialty Drugs or injectable specialty medications will not be considered eligible under the medical Plan unless administered in an Inpatient (e.g., overnight) setting, in an emergency room, or are transplant-related Specialty Drug. Administration costs of all Prescription Drugs including these excluded drugs are covered under the Plan. Please contact the Plan Administrator for additional information.		
Hospice Care	70% after Deductible	50% after Deductible

WHITE HRA PLAN	PARTICIPATING PROVIDERS	NON-PARTICIPATING PROVIDERS (Subject to Usual and Customary Charges)
Hospital Expenses or Long-Term Acute Care Facility/Hospital (facility charges)		
Inpatient	70% after Deductible	50% after Deductible
Room and Board Allowance*	Semi-Private Room Rate*	Semi-Private Room Rate*
Intensive Care Unit	ICU/CCU Room Rate	ICU/CCU Room Rate
Miscellaneous Services & Supplies	70% after Deductible	50% after Deductible
Outpatient	70% after Deductible	50% after Deductible
* A private room will be considered eligible when Medically Necessary. Charges made by a Hospital having only single or private rooms will be considered at the least expensive rate for a single or private room.		
Infusion Therapy (Outpatient)	70% after Deductible	50% after Deductible
NOTE: Expenses for certain Specialty Drugs or injectable specialty medications will not be considered eligible under the medical Plan unless administered in an Inpatient (e.g., overnight) setting, in an emergency room, or are transplant-related Specialty Drug. Administration costs of all Prescription Drugs including these excluded drugs are covered under the Plan. Please contact the Plan Administrator for additional information.		
Maternity (non-facility charges)*		
Preventive Prenatal and Breastfeeding Support (other than lactation consultations)	100%; Deductible waived	50% after Deductible
Lactation Consultations	100%; Deductible waived	100%; Deductible waived
All Other Prenatal and Postnatal Care	$50 Copay then 100%; Deductible waived	50% after Deductible
Delivery	70% after Deductible	50% after Deductible
* See Preventive Services under Eligible Medical Expenses for limitations.		
Mental Disorders and Substance Use Disorders		
Inpatient	70% after Deductible	50% after Deductible
Outpatient		
Office Visits	$40 Copay then 100%; Deductible waived	50% after Deductible
Intensive Outpatient Therapy/Partial Hospitalization	70% after Deductible	50% after Deductible
All Other Outpatient Care	70% after Deductible	50% after Deductible
NOTE: Emergency care (ambulance and Emergency Services/Room) will be paid the same as the benefits for ambulance services and Emergency Services/Room listed above in the Medical Schedule of Benefits, however, the Participating Provider level of benefits will always apply regardless of the provider utilized.		
NOTE: Certain Covered Expenses require precertification. Contact with Care Coordinators by Quantum Health should be made prior to receiving services. See the Care Coordination Process section of the Plan.		
Morbid Obesity/Obesity	70% after Deductible	50% after Deductible
Occupational Therapy (OT) (Outpatient)	$50 Copay then 100%; Deductible waived	50% after Deductible
Calendar Year Maximum Benefit	50 visits	

WHITE HRA PLAN	PARTICIPATING PROVIDERS	NON-PARTICIPATING PROVIDERS (Subject to Usual and Customary Charges)
Physical Therapy (PT) (Outpatient)	$50 Copay then 100%; Deductible waived	50% after Deductible
Calendar Year Maximum Benefit	50 visits	
Physician's Services		
Inpatient/Outpatient Services	70% after Deductible	50% after Deductible
Office Visits:		
Primary Care Physician (PCP)	$40 Copay* then 100%; Deductible waived	50% after Deductible
Specialist	$50 Copay* then 100%; Deductible waived	50% after Deductible
Physician Office Surgery:		
Primary Care Physician (PCP)	$40 Copay* then 100%; Deductible waived	50% after Deductible
Specialist	$50 Copay* then 100%; Deductible waived	50% after Deductible
*Copay applies per visit regardless of what services are rendered.		
Preventive Services and Routine Care		
Preventive Services (includes the office visit and any other eligible item or service received at the same time, whether billed at the same time or separately)	100%; Deductible waived	50% after Deductible
Routine Care (includes any routine care item or service not otherwise covered under the preventive services provision above)	100%; Deductible waived	50% after Deductible
Routine Colonoscopy	100%; Deductible waived	50% after Deductible
NOTE: Routine colonoscopy includes the consultation, removal of polyps, anesthesia and any pathology services.		
Routine Eye Exam (including refractions and glaucoma testing)	100%; Deductible waived	50% after Deductible
Maximum Benefit Per 12-Month Period	1 exam	
Private Duty Nursing (Outpatient)	70% after Deductible	50% after Deductible
Calendar Year Maximum Benefit	30 eight hour shifts	
Radiation Therapy (Outpatient – includes all related charges)	Paid based on place of service	Paid based on place of service
Respiratory/Pulmonary Therapy (Outpatient)	Paid based on place of service	Paid based on place of service
Skilled Nursing Facility and Rehabilitation Facility	70% after Deductible	50% after Deductible
Combined Calendar Year Maximum Benefit	120 days	
Speech/Hearing Therapy (ST/HT) (Outpatient)	$50 Copay then 100%; Deductible waived	50% after Deductible
Calendar Year Maximum Benefit	50 visits	

WHITE HRA PLAN	PARTICIPATING PROVIDERS	NON-PARTICIPATING PROVIDERS (Subject to Usual and Customary Charges)
Telemedicine		
Mental Disorders & Substance Use Disorders	Paid same as office visit benefit for Mental Disorders and Substance Use Disorders	Paid same as office visit benefit for Mental Disorders and Substance Use Disorders
All Other Provider Services	Paid based on provider billing for telemedicine (subject to any applicable maximums and exclusions for the services provided)	Paid based on provider billing for telemedicine (subject to any applicable maximums and exclusions for the services provided)
Telemedicine by Amwell		
Behavioral Health Consultations	$40 Copay, then 100%; Deductible waived	Not Applicable
Urgent Care	$35 Copay, then 100%; Deductible waived	Not Applicable
Transplants	70% after Deductible (Aetna IOE Program)* 50% after Deductible (All Other Network Providers)	50% after Deductible
* Please refer to the Aetna Institute of Excellence (IOE) Program section of this Plan for a more detailed description of this benefit, including travel and lodging maximums. Travel and lodging will be paid at 100% with no Deductible.		
NOTE: Cornea transplants performed by any provider are covered under the Plan as a separate benefit and paid the same as any other Illness.		
Urgent Care Facility	$50 Copay* then 100%; Deductible waived	$50 Copay* then 100%; Deductible waived
*Copay applies per visit regardless of what services are rendered.		
Wig (see Eligible Medical Expenses)	70% after Deductible	50% after Deductible
All Other Eligible Medical Expenses	70% after Deductible	50% after Deductible

MEDICAL SCHEDULE OF BENEFITS: GREEN PLAN

GREEN PLAN	PARTICIPATING PROVIDERS	NON-PARTICIPATING PROVIDERS (Subject to Usual and Customary Charges)
LIFETIME MAXIMUM BENEFIT	Unlimited	
CALENDAR YEAR MAXIMUM BENEFIT	Unlimited	
CALENDAR YEAR DEDUCTIBLE (combined with Prescription Drugs under the standalone Prescription Drug plan)		
Single	$2,500	$5,000
Family	$5,000	$10,000
CALENDAR YEAR OUT-OF-POCKET MAXIMUM (includes medical Deductible, medical Coinsurance and medical Copays)		
Single	$5,000	$10,000
Family	$10,000	$20,000
MEDICAL BENEFITS		
Acupuncture	80% after Deductible	50% after Deductible
Calendar Year Maximum Benefit	10 visits	
Ambulance Services	80% after Deductible	Paid at the Participating Provider level of benefits
NOTE: Fixed wing aircraft ambulance services by Non-Participating Providers will be paid at the Participating Provider level of benefits subject to preauthorization.		
Ambulatory Surgical Center	80% after Deductible	50% after Deductible
Cardiac Rehab (Outpatient)	Paid based on place of service	Paid based on place of service
Carrum Health	100% after Deductible (must meet the IRS federal minimum Deductible)	Not Applicable
NOTE: Carrum Health is a Surgery and medical program sponsored by The Nemours Foundation. Carrum Health partners with top Hospitals or Centers of Excellence (COE) providers to give Covered Persons access to high-quality providers and lower their cost of care. Some care available through Carrum Health is orthopedic (outpatient orthopedic MSK, total joint replacement, spine), bariatric, cardiac, including travel costs as determined eligible by the program. For more information on this program you may call Carrum Health at (888) 855-7806 or visit their website at carrum.me/nemours.		
Chemotherapy (Outpatient – includes all related charges)	Paid based on place of service	Paid based on place of service
Chiropractic Care/Spinal Manipulation	80% after Deductible	50% after Deductible
Calendar Year Maximum Benefit	30 visits	
Cognitive Therapy (Outpatient)	Paid based on place of service	Paid based on place of service

GREEN PLAN	PARTICIPATING PROVIDERS	NON-PARTICIPATING PROVIDERS (Subject to Usual and Customary Charges)
Delaware School-Based Health Centers (SBHCs) TINs: 51-0064318, 52-2011066, 51-0103684, 14-1850828, 45-2755081, 51-0069243, 59-0634433, 86-1127196)		
Preventive Services (pursuant to the Affordable Care Act) and Routine Care	100%; Deductible waived	100%; Deductible waived
All Other Services (non-preventive)	100% after Deductible	100% after Deductible
NOTE: Includes any item or service not otherwise covered under the preventive services provision.		
Diagnostic Testing, X-Ray, and Lab Services (Outpatient)	80% after Deductible	50% after Deductible
Mammogram	100% after Deductible	50% after Deductible
Advanced Imaging (MRI, MRA, CT and PET Scans, Bone Density, Scintimammography, Capsule Endoscopy, Nuclear Medicine)	80% after Deductible	50% after Deductible
Durable Medical Equipment (DME)	80% after Deductible	50% after Deductible
Emergency Services – Emergency Medical Condition	80% after Deductible	Paid at the Participating Provider level of benefits
Emergency Room – Non-Emergency Medical Condition	80% after Deductible	80% after Deductible
Fertility		
Basic Fertility Expenses	Paid based on place of service	Paid based on place of service
Comprehensive Fertility Services (Progyny Only – TIN 27-2220139)	80% after Deductible	Not Applicable
NOTE: Includes any item or service not otherwise covered under the preventive services provision.		
Gene Therapy	Paid based on place of service	Not Covered
Hearing Aids (up to age 20)	80% after Deductible	50% after Deductible
Maximum Benefit	1 hearing aid per ear every 36 months	
Hearing Exams (non-routine)	Paid based on place of service	Paid based on place of service
Maximum Benefit Per 24-Month Period	1 exam	

GREEN PLAN	PARTICIPATING PROVIDERS	NON-PARTICIPATING PROVIDERS (Subject to Usual and Customary Charges)
Home Health Care	80% after Deductible	50% after Deductible
Calendar Year Maximum Benefit	100 visits	
NOTE: Expenses for certain Specialty Drugs or injectable specialty medications will not be considered eligible under the medical Plan unless administered in an Inpatient (e.g., overnight) setting, in an emergency room, or are transplant-related Specialty Drug. Administration costs of all Prescription Drugs including these excluded drugs are covered under the Plan. Please contact the Plan Administrator for additional information.		
Hospice Care	80% after Deductible	50% after Deductible
Hospital Expenses or Long-Term Acute Care Facility/Hospital (facility charges)		
Inpatient	80% after Deductible	50% after Deductible
Room and Board Allowance*	Semi-Private Room Rate*	Semi-Private Room Rate*
Intensive Care Unit	ICU/CCU Room Rate	ICU/CCU Room Rate
Miscellaneous Services & Supplies	80% after Deductible	50% after Deductible
Outpatient	80% after Deductible	50% after Deductible
* A private room will be considered eligible when Medically Necessary. Charges made by a Hospital having only single or private rooms will be considered at the least expensive rate for a single or private room.		
Infusion Therapy (Outpatient)	80% after Deductible	50% after Deductible
NOTE: Expenses for certain Specialty Drugs or injectable specialty medications will not be considered eligible under the medical Plan unless administered in an Inpatient (e.g., overnight) setting, in an emergency room, or are transplant-related Specialty Drug. Administration costs of all Prescription Drugs including these excluded drugs are covered under the Plan. Please contact the Plan Administrator for additional information.		
Maternity (non-facility charges)*		
Preventive Prenatal and Breastfeeding Support (other than lactation consultations)	100%; Deductible waived	50% after Deductible
Lactation Consultations	100%; Deductible waived	100%; Deductible waived
All Other Prenatal, Delivery and Postnatal Care	80% after Deductible	50% after Deductible
* See Preventive Services under Eligible Medical Expenses for limitations.		
Mental Disorders and Substance Use Disorders		
Inpatient	80% after Deductible	50% after Deductible
Outpatient	80% after Deductible	50% after Deductible
Intensive Outpatient Therapy/Partial Hospitalization	80% after Deductible	50% after Deductible
All Other Outpatient Care	80% after Deductible	50% after Deductible
NOTE: Emergency care (ambulance and Emergency Services/Room) will be paid the same as the benefits for ambulance services and Emergency Services/Room listed above in the Medical Schedule of Benefits, however, the Participating Provider level of benefits will always apply regardless of the provider utilized.		
NOTE: Certain Covered Expenses require precertification. Contact with Care Coordinators by Quantum Health should be made prior to receiving services. See the Care Coordination Process section of the Plan.		

GREEN PLAN	PARTICIPATING PROVIDERS	NON-PARTICIPATING PROVIDERS (Subject to Usual and Customary Charges)
Morbid Obesity/Obesity	80% after Deductible	50% after Deductible
Occupational Therapy (OT) (Outpatient)	80% after Deductible	50% after Deductible
Calendar Year Maximum Benefit	50 visits	
Physical Therapy (PT) (Outpatient)	80% after Deductible	50% after Deductible
Calendar Year Maximum Benefit	50 visits	
Physician's Services		
Inpatient/Outpatient Services	80% after Deductible	50% after Deductible
Office Visits:		
Primary Care Physician (PCP)	80% after Deductible	50% after Deductible
Specialist	80% after Deductible	50% after Deductible
Physician Office Surgery	80% after Deductible	50% after Deductible
Preventive Services and Routine Care		
Preventive Services (includes the office visit and any other eligible item or service received at the same time, whether billed at the same time or separately)	100%; Deductible waived	50% after Deductible
Routine Care (includes any routine care item or service not otherwise covered under the preventive services provision above)	100%; Deductible waived	50% after Deductible
Routine Colonoscopy	100%; Deductible waived	50% after Deductible
NOTE: Routine colonoscopy includes the consultation, removal of polyps, anesthesia and any pathology services.		
Routine Eye Exam (including refractions and glaucoma testing)	100%; Deductible waived	50% after Deductible
Maximum Benefit Per 12-Month Period	1 exam	
Private Duty Nursing (Outpatient)	80% after Deductible	50% after Deductible
Calendar Year Maximum Benefit	30 eight hours shifts	
Radiation Therapy (Outpatient – includes all related charges)	Paid based on place of service	Paid based on place of service
Respiratory/Pulmonary Therapy (Outpatient)	Paid based on place of service	Paid based on place of service
Skilled Nursing Facility and Rehabilitation Facility	80% after Deductible	50% after Deductible
Combined Calendar Year Maximum Benefit	120 days	
Speech/Hearing Therapy (ST/HT) (Outpatient)	80% after Deductible	50% after Deductible
Calendar Year Maximum Benefit	50 visits	

GREEN PLAN	PARTICIPATING PROVIDERS	NON-PARTICIPATING PROVIDERS (Subject to Usual and Customary Charges)
Telemedicine		
Mental Disorders & Substance Use Disorders	Paid same as office visit benefit for Mental Disorders and Substance Use Disorders	Paid same as office visit benefit for Mental Disorders and Substance Use Disorders
All Other Provider Services	Paid based on provider billing for telemedicine (subject to any applicable maximums and exclusions for the services provided)	Paid based on provider billing for telemedicine (subject to any applicable maximums and exclusions for the services provided)
Telemedicine by Amwell		
Behavioral Health Consultations	80% after Deductible	Not Applicable
Urgent Care	80% after Deductible	Not Applicable
Transplants	80% after Deductible (Aetna IOE Program)* 50% after Deductible (All Other Network Providers)	50% after Deductible
* Please refer to the Aetna Institute of Excellence (IOE) Program section of this Plan for a more detailed description of this benefit, including travel and lodging maximums. Travel and lodging will be paid at 100% after Deductible.		
NOTE: Cornea transplants performed by any provider are covered under the Plan as a separate benefit and paid the same as any other Illness.		
Urgent Care Facility	80% after Deductible	50% after Deductible
Walk-In Clinic	80% after Deductible	50% after Deductible
Wig (see Eligible Medical Expenses)	80% after Deductible	50% after Deductible
All Other Eligible Medical Expenses	80% after Deductible	50% after Deductible

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ELIGIBLE MEDICAL EXPENSES

Eligible expenses shall be the charges actually made for services provided to the Covered Person and will be considered eligible only if the expenses are:

(1) Routine care or preventive services provided such services are ordered and performed by a Physician and not otherwise excluded under the Plan; or

(2) Due to Illness or Injury provided such services are ordered and performed by a Physician, Medically Necessary and not otherwise excluded under the Plan.

Reimbursement for eligible expenses will be made directly to the provider of the service, unless a receipt showing payment is submitted. All eligible expenses Incurred at a Participating Provider will be reimbursed to the provider.

(1) **Acupuncture:** Services by a licensed Doctor of Medicine, Doctor of Osteopathic Medicine or Acupuncturist. Covered services include manual or electro acupuncture. Eligible expenses will be payable as shown in the Medical Schedule of Benefits.

(2) **Allergy Services:** Allergy testing, serum, and injections. Some allergy services may be payable under the Physician office visit benefit.

(3) **Ambulance Service:** Professional ambulance service to transport the Covered Person:

(a) To the nearest Hospital equipped to treat the specific Illness or Injury in an emergency situation; or

(b) To another Hospital in the area when the first Hospital did not have services required and/or facilities to treat the Covered Person; or

(c) To and from a Hospital during a period of Hospital confinement to another facility for special services which are not available at the first Hospital; or

(d) From the Hospital to the patient's home or to a Skilled Nursing Facility, Rehabilitation Facility, or any other type of convalescent facility nearest to the patient's home when there is documentation the patient required ambulance transportation.

Professional ambulance charges for convenience are not covered.

Eligible expenses will be payable as shown in the Medical Schedule of Benefits.

(4) **Ambulatory Surgical Center:** Services and supplies provided by an Ambulatory Surgical Center. Eligible expenses will be payable as shown in the Medical Schedule of Benefits.

(5) **Anesthetics:** Anesthetics and their professional administration.

(6) **Biofeedback:** Services and supplies related to biofeedback when Medically Necessary.

(7) **Bone-Anchored Hearing Aids (BAHAs):** Services and supplies related to bone-anchored hearing aids **(BAHAs)** when Medically Necessary.

(8) **Blood and Blood Derivatives:** Blood, blood plasma or blood components not donated or replaced. For autologous blood donations, only administration and processing expenses are covered.

(9) **Cardiac Rehabilitation:** Cardiac rehabilitation services which are rendered: (a) under the supervision of a Physician; and (b) in connection with a myocardial infarction, coronary occlusion or coronary bypass Surgery or any other medical condition if medically appropriate; and (c) initiated within 12 weeks after other treatment for the medical condition ends; and (d) in a medical care facility.

Expenses in connection with Phase III or Phase IV cardiac rehabilitation, including, but not limited to occupational therapy or work hardening programs will not be considered eligible. Phase III and Phase IV is defined as the general maintenance level of treatment, with no further medical improvements being made and exercise therapy that no longer requires the supervision of medical professionals.

Eligible expenses will be payable as shown in the Medical Schedule of Benefits.

(10) **Chemotherapy:** Services and supplies related to chemotherapy. Eligible expenses will be payable as shown in the Medical Schedule of Benefits.

(11) **Chiropractic Care/Spinal Manipulation:** Skeletal adjustments, manipulation, or other treatment in connection with the correction by manual or mechanical means of structural imbalance or subluxation in the human body, including x-rays. Eligible expenses will be payable as shown in the Medical Schedule of Benefits.

(12) **Circumcision:** Services and supplies related to circumcision. Circumcision performed while Hospital confined following birth will be considered as a newborn expense.

(13) **Cleft Palate and Cleft Lip:** Services and supplies related to cleft palate and cleft lip. Cleft palate is defined as a birth deformity in which the palate (the roof of the mouth) fails to close, and cleft lip is defined as a birth deformity in which the lip fails to close. Eligible expenses include the following when provided by a Physician, or other professional provider:

(a) Oral and facial Surgery, surgical management and follow-up care by plastic surgeons and oral surgeons.

(b) Habilitative speech therapy.

(c) Otolaryngology treatment.

(d) Audiological assessments and treatment.

(e) Orthodontic Treatment.

(f) Prosthodontic treatment.

(g) Prosthetic treatment such as obturators, speech appliances and feeding appliances.

(14) **Cochlear Implants:** Services and supplies related to cochlear implants when Medically Necessary, and the related maintenance and adjustments.

Benefits include post-cochlear implant aural therapy under the recommendation of a Physician.

(15) **Cognitive Therapy:** Restorative or rehabilitative cognitive therapy when the cognitive deficits have been acquired as a result of neurological impairment due to trauma, stroke, or encephalopathy, and when the therapy is part of a treatment plan intended to restore previous cognitive function under the recommendation of a Physician. Eligible expenses will be payable as shown in the Medical Schedule of Benefits.

(16) **Contraceptives:** Contraceptive procedures and medications other than those considered preventive services, including, but not limited to: orals, patches, injections, diaphragms, intrauterine devices (IUD), implants and any related office visit. Some contraceptives may be available under the standalone Prescription Drug plan. The Plan does not cover contraceptive supplies or devices available without a Physician’s prescription or contraceptives provided over-the-counter (unless the expense qualifies as a preventive service).

(17) **Cosmetic Procedures/Reconstructive Surgery:** Cosmetic procedures or Reconstructive Surgery will be considered eligible only under the following circumstances:

(a) For the correction of a Congenital Anomaly for a Dependent Child.

(b) Any other Medically Necessary Surgery related to an Illness or Injury.

(c) Charges for reconstructive breast Surgery following a mastectomy will be eligible as follows:

(i) Reconstruction of the breast on which the mastectomy has been performed;

(ii) Surgery and reconstruction of the other breast to produce symmetrical appearance; and

(iii) Coverage for prostheses and physical complications of all stages of mastectomy, including lymphedemas.

The manner in which breast reconstruction is performed will be determined in consultation with the attending Physician and the Covered Person.

(18) **Delaware School-Based Health Centers (SBHCs):** Public school-based wellness centers or student wellness centers, providing school-aged youths with comprehensive physical, behavioral, and preventive services delivered by qualified medical and mental health providers in school settings. Eligible expenses will be payable as shown in the Medical Schedule of Benefits.

(19) **Dental Care:** Dental services and x-rays rendered by Dentist or dental surgeon for:

(a) Excision of tumors and cysts of the jaws, cheeks, lips, tongue, roof, and floor of the mouth.

(b) Eligible health services also include the procedures or Surgery to sound natural teeth, injured due to an Accident and performed as soon as medically possible, when:

(i) The teeth were stable, functional, and free from decay or disease at the time of the Injury.

(ii) The Surgery or procedure returns the Injured teeth to how they functioned before the Accident.

These dental related services are limited to:

(i) The first placement of a permanent crown or cap to repair a broken tooth;

(ii) The first placement of dentures or bridgework to replace lost teeth;

(iii) Orthodontic therapy to pre-position teeth.

(c) Surgery needed to correct Accidental Injuries to the jaws, cheeks, lips, tongue, floor, and roof of the mouth.

(d) Excision of benign bony growths of the jaw and hard palate.

(e) External incision and drainage of cellulitis.

(f) Incision of sensory sinuses, salivary glands, or ducts.

(g) Removal of impacted teeth.

(h) Cutting out:

(i) Teeth partly or completely impacted in the bone of the jaw;

(ii) Teeth that will not erupt through the gum;

(iii) Other teeth that cannot be removed without cutting into bone;

(iv) The roots of a tooth without removing the entire tooth.

General anesthesia and Hospital expenses are covered for eligible dental care services that would require the service be performed in a Hospital to monitor the patient due to a serious underlying medical condition, such as heart condition, blood disorder, etc. or; is necessary due to Accidental Injury to sound natural teeth; or your Physician has certified the service cannot be performed in the Dentist's office due to age or condition of the Covered Person.

(20) **Developmental Delay:** Testing and Medically Necessary treatment of developmental delay, including therapy. Any developmental delays that meet the definition of a Mental Disorder or Substance Use Disorder are paid under the separate Mental Disorder and Substance Use disorder benefits.

(21) **Diabetic Education:** The following diabetic education and self-management programs: diabetes outpatient self-management training and education, including medical nutrition therapy that is provided by a certified, registered, or licensed healthcare professional working in a program consistent with the national standards of diabetes self-management education as established by the American Diabetes Association. Coverage is provided for individuals with diabetes.

(22) **Diabetic Supplies:** All Physician-prescribed medically appropriate and necessary equipment and supplies used in the management and treatment of diabetes that are not covered under the standalone Prescription Drug plan.

(23) **Diagnostic Testing, X-ray, and Laboratory Services:** Diagnostic testing, x-ray and laboratory services, and services of a professional radiologist or pathologist. Dental x-rays are not eligible expenses, except as specified under Dental Care. Eligible expenses will be payable as shown in the Medical Schedule of Benefits.

(24) **Dialysis:** Treatment of a kidney disorder by dialysis as an Inpatient in a Hospital or other facility or for expenses in an outpatient facility or in the Covered Person’s home, including the training of one attendant to perform kidney dialysis at home. The attendant may be a family member. When home care replaces Inpatient or outpatient dialysis treatments, the Plan will pay for rental of dialysis equipment and expendable medical supplies for use in the Covered Person’s home as shown under the Durable Medical Equipment benefit.

(25) **Durable Medical Equipment:** The rental of oxygen, wheelchairs, walkers, special Hospital beds, iron lungs and other Durable Medical Equipment subject to the following:

(a) The equipment must be prescribed by a Physician and Medically Necessary; and

(b) The equipment will be provided on a rental basis; however, such equipment may be purchased at the Plan's option. Any amount paid to rent the equipment will be applied towards the purchase price. In no case will the rental cost of Durable Medical Equipment exceed the purchase price of the item (oxygen equipment is not limited to the purchase price); and

(c) Benefits will be limited to standard models as determined by the Plan; and

(d) The Plan will pay benefits for only one of the following unless Medically Necessary due to growth of the Covered Person or if changes to the Covered Person's medical condition requires a different product, as determined by the Plan: a manual wheelchair, motorized wheelchair, or motorized scooter; and

(e) If the equipment is purchased, benefits will be payable for subsequent repairs, excluding batteries, necessary to restore the equipment to a serviceable condition. If such equipment cannot be restored to a serviceable condition, replacement will be considered eligible subject to prior approval by the Plan. In all cases, repairs, or replacement due to abuse or misuse, as determined by the Plan, are not covered; and

(f) Expenses for the rental or purchase of any type of air conditioner, air purifier, whirlpools, portable whirlpool pumps, massage table, sauna baths, message devices (personal voice recorder), over bed table, elevators, communication aids, vision aids, telephone alert systems or any other device or appliance will not be considered eligible.

Eligible expenses will be payable as shown in the Medical Schedule of Benefits.

(26) **Emergency Services/Emergency Room:** When you experience an Emergency Medical Condition, coverage for Emergency Services will continue until your condition is Stabilized and:

(a) Your attending Physician determines that you are medically able to travel or to be transported, by non-medical or non-emergency medical transportation, to another provider if you need more care; and

(b) You are in a condition to be able to receive from the Non-Participating Provider delivering services the notice and consent criteria with respect to the services; and

(c) Your Non-Participating Provider delivering the services meets the notice and consent criteria with respect to the services.

If you go to an emergency room for what is not an Emergency Medical Condition, the Plan may not cover your expenses. See the Medical Schedule of Benefits and the General Exclusions and Limitations for specific Plan details. If your Physician decides you need to stay in the Hospital (emergency admission) or receive follow-up care, these are not Emergency Services. Different benefits and requirements apply.

Eligible expenses will be payable as shown in the Medical Schedule of Benefits.

(27) **Fertility:**

Basic Fertility Expenses:

Diagnosis and testing for fertility performed by the Employee or Spouse's Primary Care Physician or OB/GYN, including any Surgical Procedure to correct the underlying medical cause of infertility.

Diagnosis and testing for fertility performed by any other fertility Specialist must be received by a Progyny in-network provider or will not be covered.

Comprehensive Fertility Services (Progyny Only)
Fertility benefits are provided through Progyny to provide additional levels of coverage for fertility treatments to assist an Employee or Spouse wishing to have a child. Progyny's program includes a credentialed provider network, and a personalized concierge-style member support team (Patient Care Advocates) who offer education, support, and coordinated care.

Progyny's program does not require a medical diagnosis of infertility in order to access fertility treatment services, which ensures that members of the LGBTQ+ community and single parents by choice receive equitable access to coverage. Progyny offers a full suite of fertility treatment options.

If you have any questions about your fertility benefit, please call your dedicated Progyny Patient Care Advocate, or you can call the Progyny General Enterprise line at (844) 930-3289.

(28) **Gender Reassignment Services:** Services and supplies provided in connection with gender transition when you have been diagnosed with gender identity disorder or gender dysphoria by a Physician. This coverage is provided according to the terms and conditions of the Plan that apply to all other covered medical conditions, including Medical Necessity requirements, Medical Management, Prescription Drug programs, and exclusions for Cosmetic services (except as allowed per guidelines). Additional guidelines or requirements may need to be satisfied before benefits are paid under the Plan. Coverage includes, but is not limited to, Medically Necessary services related to gender transition such as gender reassignment (sex change) Surgery, breast removal, gonadectomy, breast implants, hormone therapy, and psychotherapy.

Services that are excluded on the basis that they are Cosmetic include, but are not limited to: abdominoplasty; blepharoplasty; body contouring (liposuction of waist); brow lift; calf implants; cheek/malar implants; chin/nose implants; collagen injections; construction of a clitoral hood; drugs for hair loss or growth; face lifting; facial bone reduction; facial feminization and masculinization Surgery; feminization of torso; forehead lift; jaw reduction (jaw contouring); hair removal (e.g., electrolysis, laser hair removal; exception: a limited number of electrolysis or laser hair removal sessions are considered Medically Necessary for skin graft preparation for genital Surgery); hair transplantation; lip enhancement; lip reduction; liposuction; masculinization of torso; mastopexy; neck tightening; nipple reconstruction; nose implants; pectoral implants; pitch-raising Surgery; removal of redundant skin; rhinoplasty; skin resurfacing (dermabrasion/chemical peel); tracheal shave (reduction thyroid chondroplasty); voice modification Surgery (laryngoplasty, cricothyroid approximation or shortening of the vocal cords); and voice therapy/voice lessons.

(29) **Gene Therapy:** Gene-based, cellular, and innovative therapies as follows:

(a) Cellular immunotherapies;

(b) Genetically modified oncolytic viral therapy;

(c) Other types of cells and tissues from and for use by the same person (autologous) and cells and tissues from one person for use by another person (allogenic) for certain therapeutic conditions;

(d) All human gene therapy that seeks to change the function of a gene or alter the biologic properties of living cells for therapeutic use, examples include:

(i) Luxturna (Voretigene neparvovec);

(ii) Zolgensma (Onasemnogene abeparvoved-xioi); and

(iii) Spinraza (Nusinersen).

(e) Products derived from gene editing technologies, including CRISPR-Cas9;

(f) Oligonucleotide-based therapies, examples include:

(i) Antisense (Spinraza),

(ii) siRNA, mRNA; and

(iii) microRNA therapies.

(30) **Genetic Testing:** Diagnostic testing of Genetic Information and counseling when Medically Necessary. Genetic testing is covered in addition to and to the extent it is not otherwise included for coverage under the preventive services section of the Plan.

(31) **Hearing Aids:** Hearing aids (including the fitting thereof) and related supplies for Covered Persons up to age 20. Covered services include the following:

(a) Audiometric hearing visit and evaluation for a hearing aid prescription performed by:

(i) Physician certified as an otolaryngologist or otologist.

(ii) An audiologist who:

(A) Is legally qualified in audiology.

(B) Holds a certificate of Clinical Competence in Audiology from the American Speech and Hearing Association in the absence of any licensing requirements.

(C) Performs the exam at the written direction of a legally qualified otolaryngologist or otologist.

(b) Electronic hearing aids, installed in accordance with a prescription written during a covered hearing exam.

(c) Any other related services necessary to access, select, and adjust or fit a hearing aid.

The following are not covered services:

(a) Replacement of a hearing aid that is lost, stolen or broken.

(b) Replacement parts or repairs for a hearing aid.

(c) Batteries or cords.

(d) A hearing aid that does not meet the specifications prescribed for correction of hearing loss.

For purposes of this Plan, cochlear implants and bone-anchored hearing aids **(**BAHAs) are not considered a hearing aid and will be paid under the cochlear benefit or bone-anchored hearing aid benefit.

Coverage for hearing aids and supplies for you and your Dependents will continue for 30 days following your last day of active employment, if you are not totally disabled on the last day of active employment. Coverage will continue if:

(a) The prescription for the hearing aid is written during the 30 days before your coverage ends; or

(b) The hearing aid is ordered during the 30 days before your coverage ends.

Eligible expenses will be payable as shown in the Medical Schedule of Benefits.

(31) **Hearing Exams:** Services for non-routine hearing examinations performed for the evaluation and treatment of an Illness, Injury or hearing loss when performed by a hearing specialist. Hearing exams given during a stay in a Hospital or other facility are not covered, except those provided to newborns as part of the overall Hospital stay.

(32) **Home Health Care:** Services provided by a Home Health Care Agency to a Covered Person in the home. The following are considered eligible home health care services:

(a) Home nursing care;

(b) Services of a home health aide or licensed practical nurse (L.P.N.), under the supervision of a registered nurse (R. N.);

(c) Visits provided by a medical social worker (MSW);

(d) Physical, occupational, speech, or respiratory/pulmonary therapy if provided by the Home Health Care Agency;

(e) Medical supplies, drugs and medications prescribed by a Physician;

(f) Laboratory services; and

(g) Nutritional counseling by a licensed dietician.

For the purpose of determining the benefits for home health care available to a Covered Person, each visit by a member of a Home Health Care Agency shall be considered as one home health care visit and each 4 hours of home health aide services shall be considered as one home health care visit.

In no event will the services of a Close Relative, transportation services, housekeeping services and meals, etc., be considered an eligible expense.

Eligible expenses will be payable as shown in the Medical Schedule of Benefits.

NOTE: Expenses for certain Specialty Drugs or injectable specialty medications will not be considered eligible under the medical Plan unless administered in an Inpatient (e.g., overnight) setting, in an emergency room, or are transplant-related Specialty Drug. Administration costs of all Prescription Drugs including these excluded drugs are covered under the Plan. Please contact the Plan Administrator for additional information.

(33) **Hospice Care:** Hospice care on either an Inpatient or outpatient basis for a terminally ill person rendered under a Hospice treatment plan. The Hospice treatment plan must certify that the person is terminally ill with a life expectancy of 6 months or less.

Covered services include:

(a) Room and board charges by the Hospice.

(b) Other Medically Necessary services and supplies.

(c) Nursing care by or under the supervision of a registered nurse (R.N.).

(d) Home health care services furnished in the patient's home by a Home Health Care Agency for the following:

(i) health aide services consisting primarily of caring for the patient (excluding housekeeping, meals, etc.); and

(ii) physical and speech therapy.

(e) Counseling services by a licensed social worker for the patient's immediate family.

(f) Nutritional counseling by a licensed dietician.

(g) Respite care, except for adult (or child) day care or convalescent care.

(h) Bereavement counseling services by a licensed social worker for the patient's immediate family. For the purposes of bereavement counseling, the term "Patient's Immediate Family" means the patient's spouse, parents of a Dependent Child and/or Dependent Children who are covered under the Plan.

Eligible expenses will be payable as shown in the Medical Schedule of Benefits.

(34) **Hospital Services or Long-Term Acute Care Facility/Hospital:**

(a) Inpatient

Room and board, including all regular daily services in a Hospital or Long-Term Acute Care Facility/Hospital. Care provided in an Intensive Care Unit (including cardiac care (CCU) and burn units).

Miscellaneous services and supplies, including any additional Medically Necessary nursing services furnished while being treated on an Inpatient basis.

(b) Outpatient

Services and supplies furnished while being treated on an outpatient basis.

Eligible expenses will be payable as shown in the Medical Schedule of Benefits.

(35) **Infusion Therapy:** Services, supplies, and equipment necessary for infusion therapy provided:

(a) By a free-standing facility;

(b) By an outpatient department of a Hospital;

(c) By a Physician in his/her office; or

(d) In your home.

Infusion therapy is the intravenous or continuous administration of medications or solutions that are a part of your course of treatment. Charges for the following outpatient infusion therapy services and supplies are Covered Expenses:

(a) The pharmaceutical when administered in connection with infusion therapy and any medical supplies, equipment and nursing services required to support the infusion therapy;

(b) Professional services;

(c) Total parenteral nutrition (TPN);

(d) Chemotherapy;

(e) Drug therapy (includes antibiotic and antivirals);

(f) Pain management (narcotics); and

(g) Hydration therapy (includes fluids, electrolytes, and other additives).

Infusion therapy provided by a Home Health Care Agency will not be subject to the Home Health Care maximum benefit.

Eligible expenses will be payable as shown in the Medical Schedule of Benefits.

NOTE: Expenses for certain Specialty Drugs or injectable specialty medications will not be considered eligible under the medical Plan unless administered in an Inpatient (e.g., overnight) setting, in an emergency room, or are transplant-related Specialty Drug. Administration costs of all Prescription Drugs including these excluded drugs are covered under the Plan. Please contact the Plan Administrator for additional information.

(36) **Lenses:** Initial pair of eyeglasses, contact lenses or an intraocular lens following a Medically Necessary Surgical Procedure to the eye or for aphakic patients. Soft lenses or sclera shells intended for use as corneal bandages.

(37) **Mammograms:** Services related to routine and non-routine mammograms. Mammograms are covered in addition to and to the extent it is not otherwise included for coverage under the preventive services section of the Plan. Eligible expenses will be payable as shown in the Medical Schedule of Benefits.

(38) **Maternity:** Expenses Incurred by all Covered Persons for:

(a) Pregnancy.

(b) Preventive prenatal and breastfeeding support as identified under the preventive services section below.

(c) Services provided by a Birthing Center.

(d) Amniocentesis testing when Medically Necessary.

(e) Up to 2 ultrasounds per pregnancy (more than 2 only when it is determined to be Medically Necessary).

(f) When not prohibited by state or local laws, elective induced abortions.

Hospital stays in connection with childbirth for either the mother or newborn may not be limited to less than 48 hours following a vaginal delivery or 96 hours following a cesarean section. These requirements can only be waived by the attending Physician in consultation with the mother. The Covered Person or provider is not required to precertify the maternity admission unless the stay extends past the applicable 48 or 96 hour stay. A Hospital stay begins at the time of delivery or for deliveries outside the Hospital, the time the newborn or mother is admitted to a Hospital following birth, in connection with childbirth.

If the mother is discharged earlier, the Plan will pay for one home visit after delivery by a health care provider.

Eligible expenses will be payable as shown in the Medical Schedule of Benefits.

(39) **Medical and Surgical Supplies:** Crutches, ostomy supplies, prescribed compression garments, dressings and other Medically Necessary supplies ordered by a Physician.

The following outpatient disposable supply or device are not considered eligible. Examples of these include: sheaths; bags; elastic garments; support hose; bandages; bedpans; home test kits not related to diabetic testing; splints; neck braces; compresses; and other devices not intended for reuse by another patient.

(40) **Mental Disorders:** Care, supplies and treatment of a Mental Disorder including, but not limited to treatment for autism, ADD and ADHD and family counseling. Eligible expenses will be payable as shown in the Medical Schedule of Benefits.

NOTE: Certain Covered Expenses require precertification. Contact with Care Coordinators by Quantum Health should be made prior to receiving services. See the Care Coordination Process section of the Plan.

(41) **Morbid Obesity/Obesity:** Care and treatment of Obesity and/or Morbid Obesity (including surgical treatment). Weight loss medication will be considered under the standalone Prescription Drug Card Program. Surgical and non-surgical treatment of Obesity and Morbid Obesity includes office visits (including the initial medical history and physical exams) and diagnostic tests, x-rays and lab services.

Surgery performed if diagnosed as Morbidly Obese and for the purpose of losing weight. Your Physician will determine whether you qualify for Obesity Surgery.

Covered services include:

(a) A multi-stage procedure when planned and approved by the Plan; and

(b) Adjustments after an approved lap band procedure, including approved adjustments in an office or outpatient setting.

The following are not covered services:

(a) Weight management treatment;

(b) Drugs intended to decrease or increase body weight, control weight, or treat obesity;

(c) Stimulants, preparations, foods or diet supplements, dietary regimens and supplements, food supplements, appetite suppressants and other medications;

(d) Hypnosis, or other forms of therapy;

(e) Exercise programs, exercise equipment, membership to health or fitness clubs, recreational therapy or other forms of activity or activity enhancement.

Eligible expenses will be payable as shown in the Medical Schedule of Benefits.

(42) **Nutritional Counseling:** Services related to nutritional counseling for a covered medical condition. Nutritional counseling is covered in addition to and to the extent it is not otherwise included for coverage under the preventive services section of the Plan.

(43) **Nutritional Supplements:** Physician-prescribed nutritional supplements or other enteral supplementation necessary to sustain life for Covered Persons who are or will become malnourished or suffer from disorders, which left untreated will cause chronic disability or intellectual disability. Covered Expenses include rental or purchase of equipment used to administer nutritional supplements or other enteral supplementation, and special dietary treatment when prescribed by a Physician for Covered Persons with inherited metabolic diseases, such as phenylketonuria (PKU), branched-chain ketonuria, galactosemia and homocystinuria.

Over-the-counter nutritional supplements or infant formulas will not be considered eligible even if prescribed by a Physician.

(44) **Occupational Therapy:** Rehabilitative occupational therapy rendered by a qualified Physician or a licensed occupational therapist under the recommendation of a Physician. Expenses for Maintenance Therapy or therapy primarily for recreational or social interaction will not be considered eligible. Eligible expenses will be payable as shown in the Medical Schedule of Benefits.

(45) **Off-Label Drug Use:** Services and supplies related to Off-Label Drug Use (the use of a drug for a purpose other than that for which it was approved by the FDA) will be eligible for coverage when all of the following criteria have been satisfied:

(a) The named drug is not specifically excluded under the General Exclusions and Limitations section of the Plan; and

(b) The named drug has been approved by the FDA; and

(c) The Off-Label Drug Use is appropriate and generally accepted by the medical community for the condition being treated; and

(d) If the drug is used for the treatment of cancer, The American Hospital Formulary Service Drug Information or NCCN Drugs and Biologics Compendium recognize it as an appropriate treatment for that form of cancer.

NOTE: Expenses for certain Specialty Drugs or injectable specialty medications will not be considered eligible under the medical Plan unless administered in an Inpatient (e.g., overnight) setting, in an emergency room, or are transplant-related Specialty Drug. Administration costs of all Prescription Drugs including these excluded drugs are covered under the Plan. Please contact the Plan Administrator for additional information.

(46) **Orthotics:** Prescribed trusses, braces, and other medical orthotics ordered by a Physician. Benefits also include orthopedic shoes and therapeutic shoes when an integral part of a leg brace.

The purchase, fitting and repair of custom-fitted foot orthotics will be eligible for coverage when required for the treatment of or to prevent complications of diabetes.

(47) **Physical Therapy:** Physical therapy rendered by a qualified Physician or a licensed physical therapist under the recommendation of a Physician. This includes Medically Necessary aquatic therapy (hydrotherapy or pool therapy) for musculoskeletal conditions when provided by a physical therapist or other recognized, licensed provider. Eligible expenses include the professional charges for physical therapy modalities administered in a pool, which require direct one-on-one patient contact. Charges for aquatic exercise programs or separate charges for use of a pool are not covered. Maintenance Therapy will not be considered eligible. Eligible expenses will be payable as shown in the Medical Schedule of Benefits.

(48) **Physician's Services:** Services of a Physician for medical care or Surgery.

(a) Services performed in a Physician's office on the same day for the same or related diagnosis. Services include, but are not limited to: examinations, supplies, injections, x-ray, and laboratory tests (including the reading or processing of the tests), cast application and minor Surgery. If more than one Physician is seen in the same clinic on the same day, only one Copay will apply.

(b) For multiple or bilateral surgeries performed during the same operative session which are not incidental or not part of some other procedure and which add significant time or complexity (all as determined by the Plan) to the complete procedure, the charge considered will be: (i) 100% for the primary procedure; (ii) 50% for the secondary procedure, including any bilateral procedure; and (iii) 50% for each additional covered procedure. This applies to all Surgical Procedures, except as determined by the Plan.

(c) For surgical assistance by an Assistant Surgeon, the charge will be 25% of the corresponding Surgery.

Eligible expenses will be payable as shown in the Medical Schedule of Benefits.

(49) **Podiatry:** Treatment for the following foot conditions: (a) bunions when an open cutting operation is performed; (b) non-routine treatment of corns or calluses; (c) toenails when at least part of the nail root is removed or treatment of ingrown toenails; (d) any Medically Necessary Surgical Procedure required for a foot condition. For foot orthotics, refer to the Orthotics benefit.

(50) **Pre-Admission Testing:** Outpatient pre-admission testing performed prior to a scheduled Inpatient hospitalization or Surgery.

(51) **Prescription Drugs:** Drugs, medicines and injectables prescribed in writing by a Physician and dispensed by a licensed pharmacist, up to a 30 day supply, which are deemed necessary for treatment of an Illness or Injury, including insulin and oral contraceptives/patches (regardless of intended use). Benefits are not provided for over-the-counter drugs, vitamins and supplements, even if prescribed by a Physician, unless they are considered a Preventive Drug. Please refer to the preventive services section under Eligible Medical Expenses with respect to Preventive Drug coverage.

NOTE: Certain Specialty Drugs received on an outpatient basis are not covered under the medical Plan and MUST be obtained directly from the Specialty Pharmacy Program through the standalone Prescription Drug plan. These excluded Specialty Drugs or injectable specialty medications will not be considered eligible unless administered in an Inpatient (e.g., overnight) setting, in an emergency room, or are transplant-related Specialty Drug. Administration costs of all Prescription Drugs including these excluded drugs are covered under the Plan. Please contact the Plan Administrator for additional information for information regarding Prescription Drug coverage.

(52) **Preventive Services and Routine Care:** The following preventive services and routine care are paid as shown in the Medical Schedule of Benefits:

(a) Preventive Services

(i) Evidence-Based Preventive Services

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 (the "Task Force") with respect to the individual involved, except that with respect to breast cancer screening, mammography and prevention of breast cancer, the recommendations of the Task Force issued in 2016 will be considered the current recommendations until further guidance is issued by the Task Force or the Health Resources and Services Administration.

(ii) Routine Vaccines

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

(iii) Prevention for Children

With Respect to infants, children and adolescents, evidence-informed preventive care and screenings provided for in the comprehensive guidelines supported by the Health Resources and Services Administration.

(iv) Prevention for Women

With respect to women, such additional preventive care, and screenings, not otherwise addressed by the Task Force, as provided for in comprehensive guidelines supported by the Health Resources and Services Administration and published on August 1, 2011 (or any applicable subsequent guidelines or guidance requiring any additional women's preventive services). Those guidelines generally include the following:

(A) Well-woman visits. Well-woman preventive care visits annually for adult women to obtain the recommended preventive services that are age and developmentally appropriate, including preconception and prenatal care. The inclusion of a well-woman visit is not meant to limit the coverage for any other preventive service described elsewhere in this Plan document that might be administered as part of the well-woman visit.

Coverage for prenatal care is limited to pregnancy-related Physician office visits including the initial and subsequent history and physical exams of the pregnant woman. In the event a provider bills a "maternity global rate", the portion of the claim that will be considered for prenatal visits and therefore, preventive care, is 40% of the "maternity global rate". As a result, 60% of the "maternity global rate" will be considered for delivery and postnatal care and the normal cost-sharing provisions would apply. Items not considered preventive (and therefore subject to normal cost-sharing provisions) include Inpatient admissions, high risk specialist units, ultrasounds, amniocentesis, fetal stress tests, delivery including anesthesia and certain pregnancy diagnostic lab tests.

(B) Screening for gestational diabetes.

(C) Human papillomavirus (HPV) testing. High-risk HPV DNA testing in women with normal cytology results. Screening is limited to women age 30 or older and is limited to 1 screening every 3 Calendar Years.

(D) Counseling annually for sexually transmitted infections (including for the human immunodeficiency virus (HIV)) and screening annually for HIV for all sexually active women. Limited to 2 counseling sessions per Calendar Year.

(E) Screening and counseling annually for interpersonal and domestic violence.

(F) Contraceptive methods and counseling, as prescribed by your Physician. All FDA approved contraceptive methods (see Preventive Drugs section below), sterilization procedures and patient education and counseling for women with reproductive capacity. Contraceptive counseling is limited to 2 visits per 12-month period.

For purposes of the above, the sterilization procedures to be considered preventive include any FDA approved sterilization implants and surgical sterilization either abdominally, vaginally, or laparoscopically. Eligible charges for a sterilization procedure and all ancillary services will be covered when sterilization is the primary purpose of the services provided and/or if it is performed as a standalone procedure and billed as such. However, complications arising following a sterilization procedure are not covered as preventive services. Covered Expenses

do not include charges for a sterilization procedure to the extent the procedure was not billed separately by the provider or because it was not the primary purpose of the procedure. To the extent sterilization is part of another procedure and/or is not a separate line on the bill, the sterilization procedure is not a Covered Expense.

(G) Breastfeeding support, supplies, and counseling in conjunction with each birth, including the following:

(1) Comprehensive lactation support and counseling by a trained provider during pregnancy and/or in the postnatal period (60 days from baby's date of birth). Lactation consultation is limited to 6 cumulative visits per 12-month period.

(2) Breastfeeding equipment will be covered, subject to the following:

(i) Rental of a Hospital grade electric pump while the baby is Hospital confined; and

(ii) Purchase of a standard (non-Hospital grade) electric breast pump or manual breast pump if requested during pregnancy or during the duration of breastfeeding, provided the Covered Person remains continuously enrolled in the Plan.

(3) For women using a breast pump from a prior pregnancy, one new set of breast pump supplies will be covered at 100% with each subsequent pregnancy for initiation or continuation of breastfeeding.

For a detailed listing of women's preventive services, please visit the U.S. Department of Health and Human Services website at: https://www.hrsa.gov/womens-guidelines. For a paper copy, please contact the Plan Administrator. To the extent the above does not cover any preventive service required to be covered under the guidelines published by the Health Resources and Services Administration on August 1, 2011 (or any applicable subsequent guidelines or guidance requiring any additional women's preventive services), the above shall be deemed to be amended to cover such preventive services to the extent required by such guidelines.

(v) Preventive Drugs means items which have been identified by the U.S. Department of Health and Human Services (HHS) as a preventive service. You may view the guidelines established by HHS by visiting the following website:

https://www.healthcare.gov/what-are-my-preventive-care-benefits

For a list of Preventive Drugs, contact the Plan Administrator.

For a detailed listing of preventive services, please visit the U.S. Department of Health and Human Services website at: https://www.healthcare.gov/what-are-my-preventive-care-benefits. For a paper copy, please contact the Plan Administrator. To the extent the above does not cover any preventive service required to be covered by the U.S. Department of Health and Human Services (HHS) the above shall be deemed to be amended to cover such preventive service to the extent required by the HHS.

(b) Routine Care

Routine care including, but not limited to, the office visit, lab tests, x-rays, routine testing, vaccinations or immunizations (including flu vaccines), well child care, pap smears, mammograms, routine eye exams (including refraction and glaucoma testing), colon exams and PSA testing. If a diagnosis is indicated after a routine exam, the exam will still be payable under the routine care benefit, however, all charges related to the diagnosis (except the initial exam) will be payable as any other Illness.

The above routine care items are covered in addition to and to the extent they are not otherwise included for coverage under the Preventive Services section of the Plan.

(53) **Private Duty Nursing (Outpatient):** Outpatient private duty nursing care by a licensed nurse (R.N., L.P.N. or L.V.N.). Charges are covered only when care is Medically Necessary and not Custodial in nature. Charges covered for outpatient nursing care billed by a Home Health Care Agency are shown under Home Health Care Services and Supplies. Outpatient private duty nursing care not billed by a Home Health Care Agency must be supported by a certification and a treatment plan from the attending Physician.

Eligible expenses will be payable as shown in the Medical Schedule of Benefits.

(54) **Prosthetic Devices:** Artificial limbs, eyes, or other prosthetic devices when necessary due to an Illness or Injury. This benefit includes any necessary repairs to restore the prosthesis to a serviceable condition. If such prosthesis cannot be restored to a serviceable condition, replacement will be considered eligible, subject to prior approval by the Plan. In all cases, repairs, or replacement due to abuse or misuse, as determined by the Plan, are not covered.

(55) **Qualified Clinical Trial Expenses:** Expenses that are, except as excluded below, healthcare items and services for the treatment of cancer or any other life threatening condition for a qualifying individual enrolled in a Qualified Clinical Trial that are otherwise consistent with the terms of the Plan and would be covered if the Covered Person did not participate in the Qualified Clinical Trial.

For purposes of this section, a “life threatening condition” means any condition or disease from which the likelihood of death is probable unless the course of the disease or condition is interrupted; and a “qualifying individual” means any Covered Person who is eligible to participate in a Qualified Clinical Trial according to the trial protocol for treatment of cancer or any other life threatening condition that makes his or her participation in the program appropriate, as determined based on either (i) a conclusion of a referring health care professional or (ii) medical and scientific information provided by the Covered Person.

Notwithstanding the above, Qualified Clinical Trial expenses do not include any of the following:

(a) Costs associated with managing the research associated with the Qualified Clinical Trial; or

(b) Costs that would not be covered for non-Experimental and/or Investigational treatments; or

(c) Any item or service that is clearly inconsistent with widely accepted and established standards of care for a particular diagnosis.

(56) **Radiation Therapy:** Radium and radioactive isotope therapy treatment. Eligible expenses will be payable as shown in the Medical Schedule of Benefits.

(57) **Reconstructive Surgery:** See Cosmetic Procedures/Reconstructive Surgery.

(58) **Rehabilitation Facility:** Inpatient care in a Rehabilitation Facility provided such confinement: (a) is under the recommendation and general supervision of a Physician; (b) is for the purpose of receiving medical care necessary for convalescence from the conditions causing or contributing to the precedent Hospital or Skilled Nursing Facility confinement; and (c) is not for Custodial Care.

See the Skilled Nursing Facility benefit for services and supplies provided for confinements in a Skilled Nursing Facility.

Eligible expenses will be payable as shown in the Medical Schedule of Benefits.

(59) **Respiratory/Pulmonary Therapy:** Respiratory/pulmonary therapy under the recommendation of a Physician. Eligible expenses will be payable as shown in the Medical Schedule of Benefits.

(60) **Routine Newborn Care:** Routine newborn care including Hospital nursery expenses and routine pediatric care while confined following birth will be considered as part of the newborn's expense.

If the newborn is ill, suffers an Injury or requires care other than routine care, benefits will be provided on the same basis as any other eligible expense.

(61) **Second Surgical Opinion:** Voluntary second surgical opinions for elective, non-emergency Surgery when recommended for a Covered Person.

Benefits for the second opinion will be payable only if the opinion is given by a specialist who: (a) is certified in the field related to the proposed Surgery; and (b) is not affiliated in any way with the Physician recommending the Surgery.

If the second opinion conflicts with the first opinion, the Covered Person may obtain a third opinion, although this is not required.

(62) **Skilled Nursing Facility:** Skilled nursing care in a Skilled Nursing Facility provided such confinement: (a) is under the recommendation and general supervision of a Physician; (b) is for the purpose of receiving medical care necessary for convalescence from the conditions causing or contributing to the precedent Hospital or Rehabilitation Facility confinement; and (c) is not for Custodial Care.

See the Rehabilitation Facility benefit for services and supplies provided for confinements in a Rehabilitation Facility.

Eligible expenses will be payable as shown in the Medical Schedule of Benefits.

(63) **Sleep Disorders:** Sleep disorder treatment and sleep studies that are Medically Necessary.

(64) **Speech/Hearing Therapy:** Restorative or rehabilitative speech or hearing therapy rendered by a qualified Physician or a licensed speech or hearing therapist under the recommendation of a Physician, necessary because of loss or impairment due to an Illness, Injury or Surgery or therapy to correct a Congenital Anomaly. Eligible expenses will be payable as shown in the Medical Schedule of Benefits.

(65) **Sterilization:** Elective sterilization procedures (this does not include reversal of sterilization). Elective sterilization procedures are covered in addition to and to the extent they are not otherwise included for coverage under the preventive services section of the Plan.

(66) **Substance Use Disorders:** Care, supplies, and treatment of a Substance Use Disorder, including family counseling. Eligible expenses will be payable as shown in the Medical Schedule of Benefits.

NOTE: Certain Covered Expenses require precertification. Contact with Care Coordinators by Quantum Health should be made prior to receiving services. See the Care Coordination Process section of the Plan.

(67) **Telemedicine:** Services related to the delivery of clinical medicine via real-time telecommunications such as telephone, the Internet, or other communication networks or devices that do not involve direct patient contact by a covered provider. Eligible expenses will be payable as shown in the Medical Schedule of Benefits.

(68) **Telemedicine by Amwell:** Virtual care of clinical medicine via real-time telecommunications such as telephone, the Internet, or other communication networks or devices by a covered provider. Services eligible for virtual care will be determined on the available programs elected by the Employer. Download the app or visit online at: https://business.amwell.com. Eligible expenses will be payable as shown in the Medical Schedule of Benefits.

(69) **Temporomandibular Joint Dysfunction (TMJ):** Hospital and Surgery expenses related to a Surgical Procedure for the treatment of Temporomandibular Joint Dysfunction (TMJ). Services related to the initial diagnosis of Temporomandibular Joint Dysfunction (TMJ).

(70) **Transcranial Magnetic Stimulation** (**TMS**): Care and treatment related to transcranial magnetic stimulation (TMS).

(71) **Transplants (other than those received through the Aetna IOE Program) - Red Plan, Red HRA Plan, White Plan, White HRA Plan and Green Plan Only:** Services and supplies in connection with Medically Necessary non-Experimental and/or non-Investigational transplant procedures.

(a) If both the donor and the recipient are covered under this Plan, eligible expenses Incurred by each person will be treated separately for each person.

(b) If the recipient is covered under this Plan and the donor is not covered, eligible expenses Incurred by the donor will be considered eligible if not covered by the donor's plan.

(c) If the donor is covered under this Plan and the recipient is not covered, eligible expenses Incurred by the donor will not be covered.

(d) The Usual and Customary fee of securing an organ from the designated live donor, a cadaver or tissue bank, including the surgeon's fees, anesthesiology, radiology, and pathology fees for the removal of the organ and a Hospital's charge for storage or transportation of the organ.

See the Aetna Institute of Excellence (IOE) Program section of the Plan with respect to coverage for transplants received through the Aetna IOE Program.

Eligible expenses will be payable as shown in the Medical Schedule of Benefits.

Exclusions:

(a) Non-human and artificial organ transplants.

(b) The purchase price of bone marrow, any organ, tissue, or any similar items which are sold rather than donated.

(c) Transplants which are not medically recognized and are Experimental and/or Investigational in nature.

(d) Lodging expenses, including meals.

(e) Expenses related to the Covered Person’s travel.

(72) **Transplants (Cornea Only) - Blue Plan and Blue HRA Plan Only:** Services and supplies in connection with Medically Necessary non-Experimental and/or non-Investigational cornea transplant procedures.

(a) If both the donor and the recipient are covered under this Plan, eligible expenses Incurred by each person will be treated separately for each person.

(b) If the recipient is covered under this Plan and the donor is not covered, eligible expenses Incurred by the donor will be considered eligible if not covered by the donor's plan.

(c) If the donor is covered under this Plan and the recipient is not covered, eligible expenses Incurred by the donor will not be covered.

(d) The Usual and Customary fee of securing an organ from the designated live donor, a cadaver or tissue bank, including the surgeon's fees, anesthesiology, radiology, and pathology fees for the removal of the organ and a Hospital's charge for storage or transportation of the organ.

Exclusions:

(a) Non-human and artificial organ transplants.

(b) Lodging expenses, including meals.

(c) Expenses related to the Covered Person's travel.

(d) The purchase price of any organ, tissue or any similar items which are sold rather than donated.

(e) Transplants which are not medically recognized and are Experimental and/or Investigational in nature.

(73) **Urgent Care Facility:** Services and supplies provided by an Urgent Care Facility. Eligible expenses will be payable as shown in the Medical Schedule of Benefits.

(74) **Walk-In Clinic**: Services provided at a Walk-In Clinic for scheduled and unscheduled visits for Illnesses and Injuries, or preventive care administered within the scope of the clinic's license. Eligible expenses will be payable as shown in the Medical Schedule of Benefits.

(75) **Wigs:** Purchase of a scalp hair prosthesis when necessitated by hair loss and when prescribed by a Physician due to the following:

(a) Alopecia areata with near full or full cranial hair loss;

(b) Alopecia totalis;

(c) Alopecia universalis;

(d) Second degree burns (full thickness) and third degree burns with resulting permanent alopecia;

(e) Chemotherapy or radiation;

(f) Fungal infections not responsive to the right (typically 6 weeks) course of antifungal treatment resulting in near full or full cranial hair loss;

(g) Lupus;

(h) Hair loss due to Injury.

Eligible expenses will be payable as shown in the Medical Schedule of Benefits.

AETNA INSTITUTE OF EXCELLENCE (IOE) PROGRAM

The Institute of Excellence (IOE) is a facility that contracted with Aetna to furnish particular services and supplies to you in connection with one or more highly specialized medical procedures. The maximum charge made by the IOE for such services and supplies will be the amount agreed to between Aetna and the IOE.

Transplant Expenses
Once it has been determined that you or one of your eligible Dependents may require an organ transplant, you or your Physician must call Care Coordinators by Quantum Health to discuss coordination of your transplant care. Aetna will coordinate all transplant services. In addition, you must follow any precertification requirements. Organ means solid organ; stem cell; bone marrow and tissue.

Benefits may vary if an IOE facility or a non-IOE facility is used. In addition, some expenses listed below may only be payable only within the IOE network. The IOE facility must be specifically approved and designated by Aetna to perform the procedure you require. A transplant will be covered at the Participating Provider level only if performed in a facility that has been designated as an IOE facility. Any treatment or service related to transplants that are provided by a facility that is not specified as an IOE network facility (even if the facility is considered a network facility for other types of services), will be payable as shown in the Medical Schedule of Benefits. Please read each section below carefully.

Covered Transplant Expenses
Covered transplant expenses include the following:

(1) Charges for activating the donor search process with national registries.

(2) Compatibility testing of prospective organ donors that are immediate family members. For purposes of this section an “immediate” family member is defined as a first-degree biological relative. These are your biological parent, sibling, or child.

(3) Inpatient and outpatient expenses directly related to a transplant.

(4) Charges made by a Physician or a transplant team.

(5) Charges made by a Hospital, outpatient facility or Physician for the medical and surgical expenses of a live donor, but only to the extent not covered by another plan or program.

(6) Related supplies and services provided by the IOE facility during the transplant process. These services and supplies may include: physical, speech and occupational therapy; bio-medicals and immunosuppressants; home health care expenses and home infusion services.

Covered transplant services are typically Incurred during the 4 phases of transplant care described below. Expenses Incurred for one transplant during these 4 phases of care will be considered one transplant occurrence.

A transplant occurrence is considered to begin at the point of evaluation for a transplant and end either: (1) 180 days from the date of the transplant; or (2) upon the date the patient is discharged from the Hospital or outpatient facility for the admission or visits related to the transplant, whichever is later.

The 4 phases of one transplant occurrence and a summary of covered transplant expense during each phase are as follows:

(1) Pre-transplant evaluation/screening. Pre-transplant evaluation screening includes all transplant-related professional and technical components required for assessment, evaluation, and acceptance into a transplant facility’s transplant program.

(2) Pre-transplant candidacy screening. Pre-transplant candidacy screening includes Human Leukocyte Antigen (HLA) typing/compatibility testing of prospective organ donors that are immediate family members.

(3) Transplant event. A transplant event includes Inpatient and outpatient services for all covered transplant-related health services and supplies provided to you and a donor during the one or more Surgical Procedures or medical therapies for a transplant; Prescription Drugs provided during your Inpatient stay or outpatient visits, including bio-medical and immunosuppressant drugs; physical, speech or occupational therapy provided during your Inpatient stay or outpatient visits; cadaveric and live donor procurement.

(4) Follow-up care. Follow-up care includes all covered transplant expenses; home health care services; home infusion services and transplant-related outpatient services rendered within 180 days from the date of the transplant event.

One Transplant Occurrence
The following are considered one transplant occurrence:

(1) Heart.

(2) Lung.

(3) Heart/Lung.

(4) Simultaneous Pancreas Kidney (SPK).

(5) Pancreas.

(6) Kidney.

(7) Liver.

(8) Intestine.

(9) Bone marrow/stem cell transplant.

(10) Multiple organs replaced during one transplant Surgery.

(11) Tandem transplants (stem cell).

(12) Sequential transplants.

(13) Re-transplant of same organ type within 180 days of first transplant.

(14) Any other single organ transplant, unless otherwise excluded under the Plan.

More Than One Transplant Occurrence
The following are considered more than one transplant occurrence:

(1) Autologous blood/bone marrow transplant followed by allogeneic blood/bone marrow transplant (when not part of a tandem transplant).

(2) Allogeneic blood/bone marrow transplant followed by an autologous blood/bone marrow transplant (when not part of a tandem transplant).

(3) Re-transplant after 180 days of the first transplant.

(4) Pancreas transplant following a kidney transplant.

(5) A transplant necessitated by an additional organ failure during the original transplant Surgery/process.

(6) More than one transplant when not performed as part of a planned tandem or sequential transplant (i.e., a liver transplant with subsequent heart transplant).

(7) CAR-T and T Cell receptor therapy for FDA-approved treatments.

Limitations
Transplant coverage does not include charges for the following:

(1) Outpatient drugs, including bio-medicals and immunosuppressants not expressly related to an outpatient transplant occurrence.

(2) Services and supplies furnished to a donor when recipient is not a Covered Person.

(3) Home infusion therapy after the transplant occurrence.

(4) Harvesting or storage of organs without the expectation of immediate transplant for an existing Illness.

(5) Harvesting and/or storage of bone marrow, tissue, or stem cells without the expectation of transplantation within 12 months for an existing Illness.

(6) Cornea (corneal graft with amniotic membrane) or cartilage (autologous chondrocyte or autologous osteochondral mosaicplasty) transplants, unless otherwise authorized by the Plan.

Travel and Lodging Expenses
Travel and lodging expenses will be covered under the Plan subject to the conditions described below.

(1) Distance requirement. The IOE facility must be more than 100 miles away from the patient's residence.

(2) Travel allowances. Travel is reimbursed between the patient's home and the facility for round trip (air, train, or bus) transportation costs (coach class only). If traveling by auto to the facility, mileage, parking, and toll cost will be reimbursed per IRS guidelines.

(3) Lodging allowances. Reimbursement of expenses Incurred by the patient and any companion for hotel lodging away from home is reimbursed at a rate of $50 per night per person, to a maximum of $100 per night.

(4) Overall maximum. Travel and lodging reimbursements are limited to $10,000 for any one transplant or procedure type, including tandem transplants. This is a combined maximum for the patient, companion, and donor.

(5) Companions. One companion is permitted per adult and 2 parents or guardians are permitted per Child.

ALTERNATE BENEFITS

In addition to the benefits specified, the Plan may elect to offer benefits for services furnished by any provider pursuant to a Plan-approved alternate treatment plan, in which case those charges Incurred for services provided to a Covered Person under an alternate treatment plan to its end, will be more cost effective than those charges to be Incurred for services to be provided under the current treatment plan to its end.

The Plan shall provide such alternate benefits at its sole discretion and only when and for so long as it determines that alternate treatment plan is Medically Necessary and cost effective. If the Plan elects to provide alternate treatment plan benefits for a Covered Person in one instance, it shall not be obligated to provide the same or similar benefits for such Covered Person in any other instance or for other Covered Persons under this Plan in any other instance, nor shall it be construed as a waiver of the Plan Administrator's rights to administer this Plan thereafter in strict accordance with its express terms.

GENERAL EXCLUSIONS AND LIMITATIONS

No payment will be eligible under any portion of this Plan for expenses Incurred by a Covered Person for the expenses or circumstances listed below. If an expense is paid that is found to be excluded or limited as shown below, the Plan has the right to collect that amount from the payee, the Covered Person or from future benefits and any such payment does not waive the written exclusions, limitations, or other terms of the Plan.

(1) **Acupressure:** Expenses for acupressure will not be considered eligible.

(2) **Administrative Services:** Expenses for completion of claim forms and shipping and handling will not be considered eligible.

(3) **Adoption:** Expenses related to adoption will not be considered eligible.

(4) **After Termination Date:** Expenses which are Incurred after the termination date of your coverage under the Plan will not be considered eligible.

(5) **Cardiac Rehabilitation:** Expenses in connection with Phase III or Phase IV cardiac rehabilitation, including, but not limited to occupational therapy or work hardening programs will not be considered eligible. Phase III and Phase IV is defined as the general maintenance level of treatment, with no further medical improvements being made and exercise therapy that no longer requires the supervision of medical professionals.

(6) **Chelation Therapy:** Expenses for chelation therapy will not be considered eligible, unless due to heavy metal poisoning.

(7) **Close Relative:** Expenses for services, care or supplies provided by a person who normally resides in the Covered Person's home or by a Close Relative will not be considered eligible.

(8) **Complications:** Expenses for care, services or treatment required as a result of complications from a treatment or procedure not covered under the Plan will not be considered eligible, unless determined to be Medically Necessary.

(9) **Convenience Items:** Expenses for personal hygiene and convenience items will not be considered eligible.

(10) **Cosmetic Procedures:** Expenses for Cosmetic and reconstructive procedures will not be considered eligible, except as specified under Eligible Medical Expenses.

(11) **Counseling:** Expenses for religious, marital, or relationship counseling will not be considered eligible, except as specified under Eligible Medical Expenses.

(12) **Court Ordered:** Expenses for court ordered services and supplies, including those as a condition of parole, probation, release or because of any legal proceeding will not be considered eligible, unless they are considered a covered expense under the Plan.

(13) **Custodial Care:** Expenses for Custodial Care will not be considered eligible, except as specified under the Home Health Care and Hospice Care benefits.

(14) **Dental Care:** Expenses Incurred in connection with dental care, treatment, x-rays, implants, general anesthesia, or Hospital expenses will not be considered eligible, except as specified under Eligible Medical Expenses.

(15) **Exercise Programs:** Expenses for exercise programs for treatment of any condition will not be considered eligible, except for Physician-supervised cardiac rehabilitation and occupational or physical therapy covered by the Plan.

(16) **Experimental and/or Investigational:** Expenses for treatment, procedures, devices, drugs, or medicines which are determined to be Experimental and/or Investigational will not be considered eligible, except for Off-Label Drug Use or when such expenses are considered Qualified Clinical Trial Expenses.

(17) **Facility Charges:** Expenses for care, services or supplies provided in the following facilities will not be considered eligible:

(a) Rest homes.

(b) Similar institutions serving as a person's main residence or providing mainly custodial or rest care.

(c) Health resorts.

(d) Spas.

(e) Schools or camps.

(18) **Foot Care:** Expenses for routine foot care, treatment of weak, unstable, or flat feet will not be considered eligible, unless for metabolic or peripheral vascular disease.

(19) **Foot Orthotics:** Expenses for foot only orthotics, orthopedic shoes (except those that are an integral part of a leg brace), arch supports or for the exam, prescription or fitting thereof will not be considered eligible, except as specified under the Eligible Medical Expenses section of the Plan.

(20) **Governmental Agency:** Expenses for services and supplies which are provided by any governmental agency for which the Covered Person is not liable for payment will not be considered eligible. In the case of a state-sponsored medical assistance program, benefits payable under this Plan will be primary. Benefits payable under this Plan will also be primary for any Covered Person eligible under TRICARE (the government sponsored program for military dependents).

(21) **Growth/Height:** Expenses for treatment, device, drug, service, or supply to increase or decrease height or alter the rate of growth, including Surgical Procedures, devices, and growth hormones to stimulate growth will not be considered eligible, except as specified under the standalone Prescription Drug plan.

(22) **Hair Loss:** Expenses for hair loss, hair transplants, wigs or any drug that promises hair growth, whether or not prescribed by a Physician, will not be considered eligible, except as specified under Eligible Medical Expenses. This exclusion does not apply to the Medically Necessary treatment of alopecia areata.

(23) **Hearing Aids:** Expenses for hearing aids (including the fitting thereof) and supplies for Covered Persons age 20 and older will not be considered eligible. This exclusion does not apply to a cochlear implant or a bone-anchored hearing aid.

(24) **Hearing Exams:** Expenses for routine hearing examinations will not be considered eligible. This exclusion does not apply to any expenses otherwise covered as a preventive service under the Eligible Medical Expenses section of the Plan.

(25) **Home Births:** Expenses for services and supplies related to births occurring in the home or in a place not licensed to perform deliveries will not be considered eligible.

(26) **Homeopathic Treatment:** Expenses for naturopathic and homeopathic treatments, services and supplies will not be considered eligible.

(27) **Hypnotherapy:** Expenses for hypnosis and hypnotherapy will not be considered eligible.

(28) **Illegal Occupation/Felony:** Expenses for or in connection with an Injury or Illness arising out of an illegal occupation or commission of a felony will not be considered eligible. This exclusion will not apply to Injuries and/or Illnesses sustained due to a medical condition (physical or mental) or due to an act of domestic violence.

(29) **Immunizations:** Expenses for immunizations that are not considered preventive services, such as those required due to your employment or travel will not be considered eligible.

(30) **Maintenance Therapy:** Expenses for Maintenance Therapy of any type when the individual has reached the maximum level of improvement will not be considered eligible.

(31) **Massage Therapy:** Expenses for massage therapy or Rolfing will not be considered eligible, except when used as a physical therapy modality.

(32) **Medically Necessary:** Expenses which are determined not to be Medically Necessary will not be considered eligible.

(33) **Missed Appointments:** Expenses for missed appointments will not be considered eligible.

(34) **No Legal Obligation:** Expenses for services provided for which the Covered Person has no legal obligation to pay will not be considered eligible. This exclusion will not apply to eligible expenses that may be covered by state Medicaid coverage where federal law requires this Employer's Plan to be primary.

(35) **Non-Covered Procedures:** Expenses for services related to a non-covered Surgery or procedure will not be considered eligible regardless of when the Surgery or procedure was performed.

(36) **Non-Participating Provider Services:** Expenses for services received by a Non-Participating Provider will not be considered eligible, except as specified under the General Overview of the Plan section.

(37) **Not Performed Under the Direction of a Physician:** Expenses for services and supplies which are not prescribed or performed by or under the direction of a Physician will not be considered eligible.

(38) **Not Recommended by a Physician:** Expenses by a Hospital or covered residential treatment center if hospitalization is not recommended or approved by a legally qualified Physician will not be considered eligible.

(39) **Nutritional Supplements:** Expenses for nutritional supplements or other enteral supplementation will not be considered eligible, except as otherwise covered as a preventive service and as specified under the Eligible Medical Expenses section of the Plan. Over-the-counter nutritional supplements or infant formulas will not be considered eligible even if prescribed by a Physician.

(40) **Occupational Therapy:** Expenses for occupational therapy primarily for recreational or social interaction will not be considered eligible.

(41) **Operated by the Government:** Expenses for treatment at a facility owned or operated by the government will not be considered eligible unless the Covered Person is legally obligated to pay. This does not apply to Covered Expenses rendered by a Hospital owned or operated by the United States Veteran's Administration when services are provided to a Covered Person for a non-service related Illness or Injury.

(42) **Outside the United States (U.S.):** Expenses for services or supplies if the Covered Person leaves the U.S. or the U.S. Territories for the express purpose of receiving medical treatment will not be considered eligible.

(43) **Over-the-Counter (OTC) Medication:** Expenses for any over-the-counter medication will not be considered eligible. Expenses for drugs and medicines not requiring a prescription by a licensed Physician and not dispensed by a licensed pharmacist will not be considered eligible, except as otherwise covered as a preventive service under the Eligible Medical Expenses section of the Plan.

(44) **Plan Maximums:** Expenses for charges in excess of Plan maximums will not be considered eligible.

(45) **Prescription Drugs:** Expenses for outpatient Prescription Drugs purchased from a pharmacy will not be considered eligible, except as specified under Eligible Medical Expenses. Please contact the Plan Administrator for information regarding Prescription Drug coverage.

(46) **Prior to Effective Date:** Expenses which are Incurred prior to the effective date of your coverage under the Plan will not be considered eligible.

(47) **Private Duty Nursing:** Expenses for Inpatient private duty nursing will not be considered eligible.

(48) **Radioactive Contamination:** Expenses Incurred as the result of radioactive contamination or the hazardous properties of nuclear material will not be considered eligible.

(49) **Recreational and Educational Therapy:** Expenses for recreational and educational services; learning disabilities; behavior modification services; vocational testing or training; any form of non-medical self-care or self-help training, including any related diagnostic testing; music therapy; health club memberships; will not be considered eligible. Diabetic education is considered eligible as specified under Eligible Medical Expenses. This exclusion will not apply to expenses related to the diagnosis, testing and treatment of autism, ADD or ADHD.

(50) **Refractive Errors:** Expenses for radial keratotomy, Lasik Surgery, or any Surgical Procedure to correct refractive errors of the eye will not be considered eligible.

(51) **Required by Law:** In any case where an individual is required by law to maintain insurance coverage (or to maintain any other security or reserve amount in lieu of insurance coverage), expenses of a Covered Person that would be paid by such insurance coverage are not eligible expenses, regardless of whether the individual is in fact covered under such coverage. For purposes of any required automobile, motorcycle or other vehicle coverage, otherwise eligible expenses below the minimum required coverage or the actual coverage elected, whichever is higher, will be excluded from coverage under this Plan.

(52) **Riot/Revolt:** Expenses resulting from a Covered Person's participation in a riot or revolt will not be considered eligible. This exclusion will not apply to Injuries and/or Illnesses sustained due to a medical condition (physical or mental) or domestic violence.

(53) **School:** Expenses for educational services, schooling or any such related or similar program, including therapeutic programs within a school setting will not be considered eligible.

(54) **Services Not Permitted Under Applicable State or Local Laws:** Some state or local laws restrict the scope of health care services that a provider may render. In such cases, the Plan will not cover such health care services.

(55) **Sexual Deviations:** Expenses for sexual deviations will not be considered eligible, except for gender identity disorders.

(56) **Sexual Dysfunction/Impotence:** Expenses for services, supplies or drugs related to sexual dysfunction/ impotence not related to organic disease, including Surgery, drugs, implants, devices or preparations to correct or enhance erectile function, enhance sensitivity, or alter the shape of a sex organ will not be considered eligible, except as specified under the standalone Prescription Drug plan. Expenses for sex therapy will not be considered eligible.

(57) **Sign Language:** Expenses for services provided in an educational or training setting or to teach sign language will not be considered eligible.

(58) **Sleep Therapy:** Expenses for treatment, services and supplies for sleep therapy will not be considered eligible.

(59) **Smoking Cessation:** Expenses for smoking and tobacco cessation programs, including smoking/tobacco deterrents will not be considered eligible, unless otherwise covered as a preventive service under the Eligible Medical Expenses section of the Plan.

(60) **Specialty Drugs:** Expenses for certain Specialty Drugs or injectable specialty medications will not be considered eligible unless administered in an Inpatient (e.g., overnight) setting, in an emergency room, or are transplant-related. For additional information, please contact the Plan Administrator.

(61) **Stand-by Physician:** Expenses for technical medical assistance or stand-by Physician services will not be considered eligible.

(62) **Sterilization:** Expenses for the reversal of elective sterilization will not be considered eligible.

(63) **Strength and Performance**: Expenses for services, devices, and supplies such as drugs or preparations designed primarily for the purpose of enhancing your strength, physical condition, endurance, or physical performance will not be considered eligible.

(64) **Surrogate:** Expenses relating to a surrogate pregnancy of any person who is not covered under this Plan and for any Covered Person other than the Employee and Spouse will not be considered eligible, including but not limited to pre-pregnancy, conception, prenatal, childbirth and postnatal expenses. This exclusion does not apply to preventive services for any Covered Person as described under the Eligible Medical Expenses section of the Plan.

(65) **Temporomandibular Joint Dysfunction (TMJ):** Expenses related to non-surgical treatment of Temporomandibular Joint Dysfunction (TMJ) will not be considered, except the initial diagnosis.

(66) **Therapies and Tests**: Expenses for the following therapies and tests will not be considered eligible:

(a) Full body CT scans;

(b) Hair analysis; and

(c) Sensory or auditory integration therapy.

(67) **Third Party Exams:** Expenses for any health or dental examinations needed for the following will not be considered eligible except as otherwise covered as a preventive service under the Eligible Medical Expenses section of the Plan:

(a) Because a third party requires the exam (e.g. examinations to get or keep a job, and examinations required under a labor agreement or other contract);

(b) To buy insurance or to get or keep a license;

(c) To travel;

(d) To go to a school, camp, sporting event, or to join in a sport or other recreational activity.

(68) **Transplants:** Expenses for transplants performed outside the Aetna Institute of Excellence (IOE) Program will not be considered eligible, except for cornea transplants as specified under Eligible Medical Expenses. Please refer to the Aetna Institute of Excellence (IOE) Program section.

(69) **Travel:** Expenses for travel will not be considered eligible, except as specified under Eligible Medical Expenses.

(70) **Usual and Customary Charge:** Expenses in excess of the Usual and Customary Charge will not be considered eligible.

(71) **Vision Care:** Expenses for vision care, including professional services for the fitting and/or supply of lenses, frames, contact lenses and other fabricated optical devices will not be considered eligible, except routine eye exams as specified under Eligible Medical Expenses. However, benefits will be provided for the necessary initial placement of a pair of eyeglasses, contact lenses or an intraocular lens following a Medically Necessary Surgical Procedure to the eye. This exclusion does not apply to aphakic patient and soft lenses or sclera shells intended for use as corneal bandages.

(72) **War:** Expenses for the treatment of Illness or Injury resulting from actively participating in a war or any act of war or terrorism, whether declared or undeclared, civil war, hostilities, or invasion, or while in the armed forces of any country or international organization will not be considered eligible.

(73) **Weekend Admissions:** Expenses for care and treatment billed by a Hospital for non-Emergency Medical Condition admissions on a Friday, Saturday or Sunday will not be considered eligible, unless Surgery is scheduled within 24 hours.

(74) **Wilderness Treatment Programs:** Expenses for wilderness treatment programs will not be considered eligible.

(75) **Workers' Compensation:** Expenses for or in connection with any Injury or Illness which arises out of or in the course of any occupation for which the Covered Person would be entitled to compensation under any Workers' Compensation Law or occupational disease law or similar legislation will not be considered eligible.

Expenses for Injuries or Illness which were eligible for payment under Workers' Compensation or similar law and have reached the maximum reimbursement paid under Workers' Compensation or similar law will not be eligible for payment under this Plan.

CLAIM PROCEDURES

You will receive an Employee identification card which will contain important information, including claim filing directions and contact information.

At the time you receive treatment, show the Employee identification card to your provider of service. In most cases, your provider will file your claim for you. You may file the claim yourself by submitting the required information to:

Meritain Health, Inc.
P.O. Box 853921
Richardson, TX 75085-3921
(877) 404-9750

Most claims under the Plan will be “post service claims.” A “post service claim” is a claim for a benefit under the Plan after the services have been rendered. Post service claims must include the following information in order to be considered filed with the Plan:

(1) The date of service;

(2) The name, address, telephone number and tax identification number of the provider of the services or supplies;

(3) The place where the services were rendered;

(4) The diagnosis and procedure codes;

(5) The amount of charges (including Network repricing information);

(6) The name of the Plan;

(7) The name of the covered Employee; and

(8) The name of the patient.

A call from a provider who wants to know if an individual is covered under the Plan or if a certain procedure or treatment is a Covered Expense before the treatment is rendered, is not a “claim” since an actual written claim for benefits is not being filed with the Plan. Likewise, presentation of a prescription to a pharmacy does not constitute a claim.

Timely Filing
All claims must be filed with the Third Party Administrator within 12 months following the date services were Incurred. Please see the Health Reimbursement Arrangement section for information regarding the timely filing of HRA claims. Claims filed after this time period will be denied.

Procedures for all Claims
The Plan's claim procedures are intended to reflect the Department of Labor's claims procedures regulations and should be interpreted accordingly. In the event of any conflict between this Plan and those Regulations, those Regulations will control. In addition, any changes in those Regulations shall be deemed to amend this Plan automatically, effective as of the date of those changes.

To receive benefits under the Plan, the claimant (i.e., you and your covered Dependents) must follow the procedures outlined in this section. There are 4 different types of claims: (1) Urgent Care Claims; (2) Concurrent Care Claims; (3) Pre-Service Claims; and (4) Post-Service Claims. The procedures for each type of claim are more fully described below:

(1) **Urgent Care Claims.** If your claim is considered an urgent care claim, the Plan Administrator will notify you of the Plan's benefit determination (whether adverse or not) as soon as possible, taking into account the medical exigencies, but not later than 72 hours after the Plan receives the claim, unless you fail to provide sufficient information to determine whether or to what extent, benefits are covered or payable under the Plan. If you fail to provide sufficient information for the Plan to decide your claim, the Plan Administrator will notify you as soon as

possible, but not later than 24 hours after the Plan receives the claim, of the specific information necessary to complete the claim. The notification may be oral unless written notification is requested by you. You will be afforded a reasonable amount of time, taking into account the circumstances, but not less than 48 hours, to provide the specified information. The Plan Administrator will notify you of the Plan's determination as soon as possible, but in no case later than 48 hours after the earlier of (1) the Plan's receipt of the specified additional information or (2) the end of the period afforded the claimant to provide the specified additional information.

A claim for benefits is considered an urgent care claim if the application of the time periods for making non-urgent care determinations could seriously jeopardize your life or health or your ability to regain maximum function or, in the opinion of a Physician with knowledge of your medical condition, would subject you to severe pain that could not be adequately managed without the care or treatment which is the subject of the claim. In determining if the initial claim for benefits should be treated as an urgent care claim, the Plan will defer to a determination, if any, by an attending provider that the claim should be treated as an urgent care claim, if that determination is timely provided to the Plan.

(2) **Concurrent Care Claims.** If the Plan has approved an ongoing course of health care treatment to be provided over a period of time or number of treatments, any reduction or termination by the Plan of the previously approved course of treatment (other than by Plan amendment or termination) before the approved time period or number of treatments constitutes an adverse determination. In such a case, the Plan Administrator will notify you of the adverse determination at a time sufficiently in advance of the reduction or termination to allow you, the claimant, to appeal and obtain a determination on review of that adverse determination before reduction or termination of the benefit.

Any request by you to extend a previously approved course of urgent care treatment beyond the approved period of time or number of treatments shall be decided as soon as possible, taking into account the medical exigencies and the Plan Administrator will notify you of the benefit determination, whether adverse or not, within 24 hours after the Plan receives the claim provided that any such claim is made to the Plan at least 24 hours prior to the expiration of the prescribed period of time or number of treatments.

(3) **Pre-Service Claims.** For a pre-service claim, the Plan Administrator will notify you of the Plan's benefit determination (whether adverse or not) within a reasonable period of time appropriate to the medical circumstances, but not later than 15 days after the Plan receives the claim. If, due to matters beyond the control of the Plan, the Plan Administrator needs additional time to process a claim, the Plan Administrator may extend the time to notify you of the Plan's benefit determination for up to 15 days provided that the Plan Administrator notifies you within 15 days after the Plan receives the claim, of those special circumstances and of when the Plan Administrator expects to make its decision. However, if such an extension is necessary due to your failure to submit the information necessary to decide the claim, the notice of extension must specifically describe the required information and you will be afforded at least 45 days from receipt of the notice within which to provide the specified information.

A claim for benefits is considered a pre-service claim if the claim requires approval, in part or in whole, in advance of obtaining the health care in question.

(4) **Post-Service Claims.** For a post-service claim, the Plan Administrator will notify you of the Plan's adverse determination within a reasonable period of time, but not later than 30 days after receipt of the claim. If, due to special circumstances, the Plan Administrator needs additional time to process a claim, the Plan Administrator may extend the time for notifying you of the Plan's benefit determination on a one-time basis for up to 15 days provided that the Plan Administrator notifies you within 30 days after the Plan receives the claim, of those special circumstances and of the date by which the reviewer expects to make a decision. However, if such a decision is necessary due to your failure to submit the information necessary to decide the claim, the notice of extension will specifically describe the required information and you will be afforded at least 45 days from receipt of the notice within which to provide the specified information.

A claim for benefits is considered a post-service claim if it is a request for payment for services or other benefits that you have already received (or any other claim for health benefits that is not a pre-service claim or an urgent care claim).

Manner and Content of Notice of Initial Adverse Determination
If the Plan Administrator denies a claim, it must provide to you in writing or by electronic communication:

(1) An explanation of the specific reasons for the denial;

(2) A reference to the Plan provision or insurance contract provision upon which the denial is based;

(3) A description of any additional information or material that you must provide in order to perfect the claim;

(4) An explanation of why the additional material or information is necessary;

(5) Notice that you have the right to request a review of the claim denial and information on the steps to be taken if you wish to request a review of the claim denial along with the time limits applicable to a request for review;

(6) A statement describing your right to request an external review (or, if applicable, to request a second level appeal) or, if applicable, to bring an action under ERISA Section 502(a);

(7) A copy of any rule, guideline, protocol, or other similar criterion relied upon in making the adverse determination (or a statement that the same will be provided upon your request and without charge); and

(8) If the adverse determination is based on the Plan's Medical Necessity, Experimental treatment or similar exclusion or limit, either: (a) an explanation of the scientific or clinical judgment applying the exclusion or limit to your medical circumstances or (b) a statement that the same will be provided upon your request and without charge.

Any notice of adverse determination also will include the following information:

(1) Information sufficient to identify the claim involved, including the date of service, the health care provider, and the claim amount (if applicable);

(2) As part of the explanation of the determination, a discussion of the decision, as well as disclosure of any denial code used (and an explanation of its meaning) and a description of the Plan's standard, if any, that was used in denying the claim;

(3) A description of available internal appeals and external review processes, including information regarding how to initiate an appeal;

(4) Information (including contact information) about the availability of any applicable office of health insurance consumer assistance or ombudsmen established pursuant to the Patient Protection and Affordable Care Act (PPACA) to assist individuals with internal claims and appeals and external review processes; and

(5) A statement describing the availability, upon request, of any applicable diagnosis code (and an explanation of its meaning) and any applicable treatment code (and an explanation of its meaning).

For an adverse determination concerning an urgent care claim, the information described in this Section may be provided to you orally within the permitted time frame provided that a written or electronic notification in accordance with this section is furnished to you no later than 3 days after the oral notification.

Internal Review of Initial Adverse Benefit Determination
If you submit a claim for Plan benefits and it is initially denied under the procedures described above, you may request a review of that denial under the procedures described below.

You have 180 days after you receive notice of an initial adverse determination within which to request a review of the adverse determination. For a request for a second level appeal, you have 60 days after you receive notice of an adverse determination at the first level of appeal to request a second level appeal of the adverse determination.

If you request a review of an adverse determination within the applicable time period, the review will meet the following requirements:

(1) The Plan will provide a review that does not afford deference to the adverse determination that is being appealed and that is conducted by an appropriate named fiduciary of the Plan who did not make the adverse determination that is the subject of the appeal and who is not a subordinate of the individual who made that adverse determination.

(2) The appropriate named fiduciary of the Plan will consult with a health care professional who has appropriate training and experience in the field of medicine involved in the medical judgment before making a decision on review of any adverse determination based in whole or in part on a medical judgment, including determinations with regard to whether a particular treatment, drug or other item is Experimental and/or Investigational or not Medically Necessary or appropriate. The professional engaged for purposes of a consultation in the preceding sentence will be an individual who is neither an individual who was consulted in connection with the adverse determination that is the subject of the appeal, nor a subordinate of any such individual.

(3) The Plan will identify any medical or vocational experts whose advice is obtained on behalf of the Plan in connection with the Plan's review of an adverse determination, without regard to whether the advice is relied upon in making the adverse determination on review.

(4) For a requested review of an adverse determination involving an urgent care claim, the review process will meet the expedited deadlines described below. Your request for such an expedited review may be submitted orally or in writing and all necessary information, including the Plan's determination on review, will be transmitted between the Plan and you by telephone, facsimile, or other available similarly expeditious method.

(5) The reviewer will afford you an opportunity to review and receive, without charge, all relevant documents, information, and records relating to the claim and to submit issues and comments relating to the claim in writing to the Plan. The reviewer will take into account all comments, documents, records, and other information submitted by the claimant relating to the claim regardless of whether the information was submitted or considered in the initial benefit determination.

(6) You will be provided, free of charge, any new or additional evidence or rationale considered, relied upon, or generated by the Plan in connection with the claim. Such evidence or rationale will be provided as soon as possible and sufficiently in advance of the Plan's deadline for providing notice of its determination on review to give you a reasonable opportunity to respond prior to such determination.

(7) The Plan will ensure that all claims are adjudicated in a manner designed to ensure the independence and impartiality of the persons involved in making the decisions.

(8) The Plan will provide you with continued coverage pending the outcome of an internal appeal.

All requests for review of initial adverse benefit determinations (including all relevant information) must be submitted to the following address:

Quantum Health
Appeals Department
5240 Blazer Parkway
Dublin, OH 43017
Fax: (877) 498-3681

Requirements for Second Level Appeal
The Covered Person must file an appeal regarding a post-service claim and applicable Adverse Benefit Determination, in writing within 60 days following receipt of the notice of the first level Adverse Benefit Determination.

Two Levels of Appeal
This Plan requires 2 levels of appeal by a Covered Person before the Plan's internal appeals are exhausted. For each level of appeal, the Covered Person and the Plan are subject to the same procedures, rights, and responsibilities as stated within this Plan. Each level of appeal is subject to the same submission and response guidelines.

Once a Covered Person receives an Adverse Benefit Determination in response to an initial claim for benefits, the Covered Person may appeal that Adverse Benefit Determination, which will constitute the initial appeal. If the Covered Person receives an Adverse Benefit Determination in response to that initial appeal, the Covered Person may appeal that Adverse Benefit Determination as well, which will constitute the final internal appeal. If the Covered Person receives an Adverse Benefit Determination in response to the Covered Person's second appeal, such Adverse Benefit Determination will constitute the Final Internal Adverse Benefit Determination, and the Plan's internal appeals procedures will have been exhausted.

Deadline for Internal Review of Initial Adverse Benefit Determinations
(1) Urgent Care Claims. The Plan provides for 2 levels of appeal for urgent care claims. For each level of appeal, the reviewer will notify you of the Plan's determination on review as soon as possible, taking into account the medical exigencies, but not later than 36 hours after the Plan receives your request for review of the initial adverse determination (or of the first-level appeal adverse determination).

(2) Pre-Service Claims. The Plan provides for 2 levels of appeal for a pre-service claim. At each level of appeal, the reviewer will notify you of the Plan's determination on review within a reasonable period of time appropriate to the medical circumstances, but in no event later than 15 days after the Plan receives your request for review of the initial adverse determination (or of the first-level appeal adverse determination).

(3) Post-Service Claims. The Plan provides for 2 levels of appeal for a post-service claim. At each level of appeal, the reviewer will notify you of the Plan's determination on review within a reasonable period of time appropriate to the medical circumstances, but in no event later than 30 days after the Plan receives your request for review of the initial adverse determination (or of the first-level appeal adverse determination).

Manner and Content of Notice of Decision on Internal Review of Initial Adverse Benefit Determinations
Upon completion of its review of an initial adverse determination (or a first-level appeal adverse determination), the reviewer will give you, in writing or by electronic notification, a notice of its benefit determination. For an adverse determination, the notice will include:

(1) A description of the Plan's decision;

(2) The specific reasons for the decision;

(3) The relevant Plan provisions or insurance contract provisions on which its decision is based;

(4) A statement that you are entitled to receive, upon request and without charge, reasonable access to and copies of, all documents, records and other information in the Plan's files which is relevant to your claim for benefits;

(5) A statement describing your right to request an external review (or, if applicable, to request a second level appeal) or, if applicable, to bring an action under ERISA Section 502(a);

(6) A statement describing your right to request an external review (or, if applicable, to request a second level appeal),or, if applicable, to bring an action for judicial review;

(7) If an internal rule, guideline, protocol, or other similar criterion was relied upon in making the adverse determination on review, a statement that a copy of the rule, guideline, protocol, or other similar criterion will be provided without charge to you upon request;

(8) If the adverse determination on review is based on a Medical Necessity, Experimental treatment or similar exclusion or limit, either: (a) an explanation of the scientific or clinical judgment on which the determination was based, applying the terms of the Plan to the claimant's medical circumstances or (b) a statement that such an explanation will be provided without charge upon request; and

(9) The following statement: "You and your Plan may have other voluntary alternative dispute resolution options, such as mediation. One way to find out what may be available is to contact your local U.S. Department of Labor Office and, if your benefit is an insured benefit, your state insurance regulatory agency."

Any notice of adverse determination will include the following information:

(1) Information sufficient to identify the claim involved, including the date of service, the health care provider, and the claim amount (if applicable);

(2) As part of the explanation of the determination, a discussion of the decision, as well as disclosure of any denial code used (and an explanation of its meaning) and a description of the Plan's standard, if any, that was used in denying the claim;

(3) A description of available internal appeals and external review processes, including information regarding how to initiate an appeal;

(4) Information (including contact information) about the availability of any applicable office of health insurance consumer assistance or ombudsmen established pursuant to the Patient Protection and Affordable Care Act (PPACA) to assist individuals with internal claims and appeals and external review processes; and

(5) A statement describing the availability, upon request, of any applicable diagnosis code (and an explanation of its meaning) and any applicable treatment code (and an explanation of its meaning).

Final Internal Adverse Benefit Determination
Upon receipt, review, adjudication and conclusion of a Final Post-Service Appeal, if it is determined by the Plan fiduciary – either the Plan Administrator, Plan Sponsor, and/or other named fiduciary assigned authority and the duty to otherwise handle appeals, or the PACE – that benefits and/or coverage is not available from the Plan as it relates to claims for benefits submitted to the Plan; when such a final Adverse Benefit Determination is made, by either the Plan Administrator, Plan Sponsor, and/or other named fiduciary assigned authority and the duty to otherwise handle appeals, or the PACE, the determination will be final and binding on all interested parties.

Calculation of Time Periods
For purposes of the time periods described in the Plan's claim procedures, the period of time during which a benefit determination is required to be made begins at the time a claim (or a request for review of an adverse benefit determination) is filed in accordance with the Plan procedures without regard to whether all the information necessary to make a decision accompanies the request. If a period of time is extended due to your failure to submit all information necessary for a claim for non-urgent care benefits, the period for making the determination is "frozen" from the date the notification requesting the additional information is sent to you until the date you respond or, if earlier, until 45 days from the date you receive (or were reasonably expected to receive) the notice requesting additional information.

Plan's Failure to Follow Procedures
If the Plan fails to follow the claim procedures described above, you will be deemed to have exhausted the Plan internal claim procedures and you will be entitled to pursue any available remedy (including any available external review process) under state or federal law on the basis that the Plan has failed to provide a reasonable claims procedure that would yield a decision on the merits of the claim.

However, the Plan will not be treated as failing to follow its claim procedures and you will not be deemed to have exhausted the Plan's administrative remedies merely because of a failure by the Plan that would be considered (based on applicable regulations) a "*de minimis* violation" that does not cause and is not likely to cause prejudice or harm to you as long as the Plan can demonstrate that the violation was for good cause or due to matters beyond the control of the Plan and that the violation occurred in the context of an ongoing, good faith exchange of information between the Plan and you. You may request a written explanation of any violation by the Plan of these procedures. If you request such an explanation, the Plan will provide it within 10 days and, if applicable, the explanation will include a

specific description of the Plan's reasons for asserting that the violation does not cause the Plan's internal claim procedures to be exhausted. If a court or external review rejects your request for an immediate review (based on a claim that you should be deemed to have exhausted the Plan's internal claim procedures), because the court or external reviewer determines that the "*de minimis* violation" exception applies, the Plan will provide to you a notice of your right to resubmit your internal appeal with a reasonable time (no longer than 10 days) after the court or external reviewer makes such a determination. Any applicable time limit for you to re-file your claim will begin to run when you receive that notice from the Plan.

External Review of Adverse Benefit Determinations
If you have exhausted the Plan's internal appeal process (or if you are eligible to request an external review for any other reason under the above procedures), you may request an external review of the Plan's final adverse determination for certain health benefit claims.

The Plan will provide for an external review process in accordance with federal law.

Note that the federal external review process (including the expedited external review process described later in these procedures) is not available for review of all internal adverse determinations. Specifically, federal external review is not available for review of an internal adverse determination that is based on a determination that a claimant fails to meet the eligibility requirements under the terms of the Plan. Also, the federal external review process is available only for:

(1) An adverse determination that involves medical judgment (including, but not limited to determinations based on the Plan's requirements for Medical Necessity, appropriateness, health care setting, level of care or effectiveness of a covered benefit; or the Plan's determination that a treatment is Experimental or Investigational), as determined by the external reviewer; and

(2) A rescission of coverage; and

(3) An adverse determination for Surprise Bills (medical and air ambulance bills), including determination of whether an adverse determination is subject to Surprise Bill provisions.

For any adverse determination for which external review is available, the federal external review requirements are as follows:

(1) You have 4 months following the date you receive notice of the Plan’s final internal adverse determination within which to request an external review. The request for an external review must be submitted to the following address:

Quantum Health
Appeals Department
5240 Blazer Parkway
Dublin, OH 43017
Fax: (877) 498-3681

(2) Within 5 business days following the date the Plan receives your external review request the Plan will complete a preliminary review. The Plan will notify you in writing within one business day after it completes the preliminary review whether the claim is eligible for the external review process:

(a) If the request is complete, but the claim is not eligible for external review, the notice will describe the reasons it is not eligible and will provide contact information for the Employee Benefits Security Administration.

(b) If the request is not complete, the notice will describe information or materials needed to make the request complete. If the request is not complete and additional information or materials are needed to complete the preliminary review, you will have until the later of (i) 48 hours following the date of receipt of the notification or (ii) the end of the 4-month deadline described in (1) above to provide the necessary additional information or materials.

(3) Following the Plan's preliminary review, if the request is eligible for external review, the Plan will assign an independent review organization (IRO) (as soon as administratively feasible) to make a determination on the request for external review. Within 5 business days following assignment of the IRO, the Plan will forward to the IRO all information and materials relevant to the final internal adverse determination.

(4) The assigned IRO will notify you in writing (within a reasonable period of time) of the request's eligibility and acceptance for external review. The notice will include a statement regarding your right to submit any additional information, within 10 business days from the date of receipt of the notice, for the IRO to consider as part of the external review process. Any such additional information received by the IRO will be forwarded on and shared with the Plan. The Plan, based upon any new information received, may reconsider its final internal adverse determination. Reconsideration by the Plan will not delay the external review process. If the Plan does not reconsider its final internal adverse benefits determination, the IRO will continue to proceed with the external review process.

(5) Within 45 days after the IRO receives the external review request from the Plan, the IRO must provide written notice of its external review determination to you and the Plan. The IRO's notice is required to contain the following:

(a) A general description of the reason for the request for external review, including information sufficient to identify the claim, the diagnosis code and treatment code and the corresponding meaning for each and the reason for the previous denial;

(b) The date the IRO received the assignment to conduct the external review and the date of the IRO decision;

(c) References to the evidence or documentation, including the specific coverage provisions and evidence based standards, considered in reaching its decision;

(d) A discussion of the principal reason or reasons for its decision, including the rationale for its decision and any evidence-based standards that were relied on in making its decision;

(e) A statement that the determination is binding except to the extent that other remedies may be available under state or federal law to either the group health plan or to you;

(f) A statement that judicial review may be available to you; and

(g) Current contact information, including telephone number, for any applicable office of health insurance consumer assistance or ombudsman established under the Public Health Service Act Section 2793.

Expedited External Review
You may request an expedited external review if you have received:

(1) An initial internal adverse determination if the adverse determination involves a medical condition for which the time frame for completion of an expedited internal appeal under the Plan's internal claim procedures would seriously jeopardize your life or health or would jeopardize your ability to regain maximum function and you have filed a request for an expedited internal appeal; or

(2) A final internal adverse determination, if you have a medical condition where the timeframe for completion of a standard external review would seriously jeopardize your life or health or would jeopardize your ability to regain maximum function or if the final internal adverse determination concerns an admission, availability of care, continued stay or health care item or service for which you received Emergency Services but have not been discharged from a facility.

The following requirements apply to an expedited external review:

(1) Immediately following the date the Plan receives the external review request the Plan will complete a preliminary review. The Plan will notify you in writing immediately after completion of the preliminary review whether the request is eligible for the external review process.

(a) If the request is complete, but the claim is not eligible for external review, the notice will describe the reasons it is not eligible and will include contact information for the Employee Benefits Security Administration.

(b) If the request is not complete, the notice will describe any information or materials needed to make the request complete. If the request is not complete and additional information or materials is needed to complete the preliminary review, you will have until the later of (i) 48 hours following the date of receipt of the notification or (ii) the end of the 4-month deadline described in (1) above to provide the necessary additional information or materials.

(2) Following the Plan's preliminary review, if the request is eligible for external review, the Plan will assign an independent review organization (IRO) to make a determination on the request for external review. The Plan will promptly forward to the IRO, by any available expeditious method (e.g., telephone, facsimile, etc.), all information and materials relevant to the final internal adverse determination.

(3) The IRO must provide notice to the claimant and the Plan (either in writing or orally) as expeditiously as the claimant's medical condition or circumstance require and no later than 72 hours after it receives the expedited external review request from the Plan. If notice is not provided in writing, the IRO must provide written notice to you and the Plan as confirmation of the decision within 48 hours after the date of the notice. The IRO's notice is required to contain the following information:

(a) A general description of the reason for the request for external review, including information sufficient to identify the claim, the diagnosis code and treatment code and the corresponding meaning for each and the reason for the previous denial;

(b) The date the IRO received the assignment to conduct the external review and the date of the IRO decision;

(c) References to the evidence or documentation, including the specific coverage provisions and evidence based standards, considered in reaching its decision;

(d) A discussion of the principal reason or reasons for its decision, including the rationale for its decision and any evidence-based standards that were relied on in making its decision;

(e) A statement that the determination is binding except to the extent that other remedies may be available under state or federal law to either the group health plan or to you;

(f) A statement that judicial review may be available to you; and

(g) Current contact information, including telephone number, for any applicable office of health insurance consumer assistance or ombudsman established under the Public Health Service Act Section 2793.

Effect of External Review Determination
A determination on external review is binding on the Plan and the claimant, except to the extent that other remedies are available under applicable state or federal law. However, a decision by the external reviewer does not preclude the Plan from making payment or providing benefits on a claim at any time, including after a decision that denies the claim. When an external review decision requires the Plan to provide benefits or payment on a claim, the Plan will provide benefits or payment pursuant to the decision without unreasonable delay regardless of whether the Plan intends to seek judicial review of the decision, unless and until there is a judicial decision that provides otherwise.

Statute of Limitations for Plan Claims
Please note that no legal action may be commenced or maintained to recover benefits under the Plan more than 12 months after the final review/appeal decision by the Plan Administrator has been rendered (or deemed rendered).

Appointment of Authorized Representative
A Covered Person is permitted to appoint an authorized representative to act on his or her behalf with respect to a benefit claim or appeal of a denial. An assignment of benefits by a Covered Person to a provider will not constitute appointment of that provider as an authorized representative. To appoint such a representative, the Covered Person must complete a form which can be obtained from the Plan Administrator or the Third Party Administrator. However, in connection with a claim involving urgent care or services rendered by a Participating Provider, the Plan will permit a health care professional with knowledge of the Covered Person's medical condition to act as the Covered Person's authorized representative without completion of this form. In the event a Covered Person designates an authorized representative, all future communications from the Plan will be with the representative, rather than the Covered Person, unless the Covered Person directs the Plan Administrator, in writing, to the contrary.

Physical Examinations
The Plan reserves the right to have a Physician of its own choosing examine any Covered Person whose Illness or Injury is the basis of a claim. All such examinations will be at the expense of the Plan. This right may be exercised when and as often as the Plan Administrator may reasonably require during the pendency of a claim. The Covered Person must comply with this requirement as a necessary condition for coverage.

DEFINITIONS

In this section you will find the definitions for the capitalized words found throughout this Plan. There may be additional words or terms that have a meaning that pertains to a specific section and those definitions will be found in that section provided, however, that any such capitalized word shall have such meaning when used in any other section. These definitions are not an indication that charges for particular care, supplies or services are eligible for payment under the Plan. Please refer to the appropriate sections of this Plan for that information.

Accident means a non-occupational sudden and unforeseen event, definite as to time and place or a deliberate act resulting in unforeseen consequences.

Adverse Benefit Determination means any of the following:

(1) A denial in benefits.

(2) A reduction in benefits.

(3) A rescission of coverage, even if the rescission does not impact a current claim for benefits.

(4) Termination of benefits.

(5) Failure to provide or make payment (in whole or in part) for a benefit, including any such denial, reduction, termination, or failure to provide or make payment that is based on a determination of a Covered Person's eligibility to participate in the Plan.

(6) A denial, reduction, or termination of, or a failure to provide or make payment (in whole or in part) for, a benefit resulting from the application of the Medical Management Program.

(7) A failure to cover an item or service for which benefits are otherwise provided because it is determined to be Experimental and/or Investigational or not Medically Necessary or appropriate.

Ambulatory Surgical Center means a free-standing surgical center, which is not part of a Hospital and which: (1) has an organized medical staff of Physicians; (2) has permanent facilities that are equipped and operated primarily for the purpose of performing Surgical Procedures; (3) has continuous Physician's services and registered graduate nursing (R.N.) services whenever a patient is in the facility; (4) is licensed by the jurisdiction in which it is located; and (5) does not provide for overnight accommodations.

Assistant Surgeon means a Physician who actively assists the Physician in charge of a case in performing a Surgical Procedure. Depending on the type of Surgery to be performed, an operating surgeon may have one Assistant Surgeon, or 2 Assistant Surgeons if Medically Necessary. The technical aspects of the Surgery involved dictate the need for an Assistant Surgeon.

Birthing Center means a place licensed as such by an agency of the state. If the state does not have any licensing requirements, it must meet all of the following tests: (1) is primarily engaged in providing birthing services for low risk pregnancies; (2) is operated under the supervision of a Physician; (3) has at least one registered nurse (R.N.) certified as a nurse midwife in attendance at all times; (4) has a written agreement with a licensed ambulance for that service to provide immediate transportation of the Covered Person to a Hospital as defined herein if an emergency arises; and (5) has a written agreement with a Hospital located in the immediate geographical area of the Birthing Center to provide emergency admission of the Covered Person.

Calendar Year means January 1 – December 31.

Close Relative means a Covered Person's spouse, parent (including step-parents), sibling, child, grandparent, or in-law.

COBRA means the Consolidated Omnibus Budget Reconciliation Act of 1985, as may be amended from time to time.

Coinsurance has the same meaning as set forth in the section of this Plan entitled "General Overview of the Plan".

Congenital Anomaly means a physical developmental defect that is present at birth.

Copay has the same meaning as set forth in the section of this Plan entitled “General Overview of the Plan”.

Cosmetic means any procedure which is primarily directed at improving an individual's appearance and does not meaningfully promote the proper function of the body or prevent or treat Illness or disease.

Covered Expense means:

(1) An item or service listed in the Plan as an eligible medical expense for which the Plan provides coverage.

Covered Person means, individually, a covered Employee and each of his or her Dependents who are covered under the Plan.

Custodial Care means care, or confinement provided primarily for the maintenance of the Covered Person, essentially designed to assist the Covered Person, whether or not totally disabled, in the activities of daily living, which could be rendered at home or by persons without professional skills or training. This care is not reasonably expected to improve the underlying medical condition, even though it may relieve symptoms or pain. Such care includes, but is not limited to, bathing, dressing, feeding, preparation of special diets, assistance in walking or getting in and out of bed, supervision over medication which can normally be self-administered and all domestic activities.

Dentist means an individual who is duly licensed to practice dentistry or to perform oral surgery in the state where the service is performed and is operating within the scope of such license. A Physician will be considered a Dentist when performing any covered dental services allowed within such license.

Dependent is a Covered Person, other than the Employee**,** who is covered by the Plan who meets all eligibility requirements.

Durable Medical Equipment means equipment that:

(1) Can withstand repeated use;

(2) Is primarily and customarily used to serve a medical purpose;

(3) Generally is not useful to a person in the absence of an Illness or Injury; and

(4) Is appropriate for use in the home.

Emergency Medical Condition means a medical condition manifesting itself by acute symptoms of sufficient severity (including severe pain) so that a prudent layperson, who possesses an average knowledge of health and medicine, could reasonably expect the absence of immediate medical attention to result in:

(1) Placing the health of the individual (or, with respect to a pregnant woman, the health of the woman or her unborn child) in serious jeopardy;

(2) Serious impairment to bodily functions; or

(3) Serious dysfunction of any bodily organ or part.

Emergency Services means treatment given in a Hospital’s emergency room for an Emergency Medical Condition. This includes evaluation of, and treatment to Stabilize an Emergency Medical Condition.

Employee means a Full-Time or Part-Time Employee of the Employer who regularly works 30 or more Hours of Service per week.

Employer means The Nemours Foundation, or any successor thereto.

ERISA means the Employee Retirement Income Security Act of 1974, as may be amended from time to time.

Experimental and/or Investigational means services, supplies, care, and treatment which do not constitute accepted and appropriate medical practice considering the facts and circumstances of the case and by the generally accepted standards of a reasonably substantial, qualified, responsible, relevant segment of the appropriate medical community or government oversight agencies at the time services were rendered, as determined by the Plan Administrator as set forth below.

The Plan Administrator must make an independent evaluation of the Experimental or non-Experimental standings of specific technologies. The Plan Administrator shall be guided by a reasonable interpretation of Plan provisions. The decisions shall be made in good faith and rendered following a detailed factual background investigation of the claim and the proposed treatment. The decision of the Plan Administrator will be final and binding on the Plan. In addition to the above, the Plan Administrator will be guided by the following principles to determine whether a proposed treatment is deemed to be Experimental and/or Investigational:

(1) If the drug or device cannot be lawfully marketed without approval of the U.S. Food and Drug Administration (FDA) and approval for marketing has not been given at the time the drug or device is furnished, then it is deemed to be Experimental and/or Investigational; or

(2) If the drug, device, medical treatment or procedure or the patient informed consent document utilized with the drug, device, treatment, or procedure, was reviewed, and approved by the treating facility's Institutional Review Board or other body serving a similar function or if federal law requires such review or approval, then it is deemed to be Experimental and/or Investigational; or

(3) If Reliable Evidence shows that the drug, device, medical treatment or procedure is the subject of on-going Phase I or Phase II clinical trials or is the subject of the research, Experimental, study, Investigational or other arm of on-going Phase III clinical trials or is otherwise under study to determine its maximum tolerated dose, its toxicity, its safety, its efficacy or its efficacy as compared with a standard means of treatment or diagnosis, then it is deemed to be Experimental and/or Investigational; or

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

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

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

Expenses for drugs, devices, services, medical treatments, or procedures related to an Experimental and/or Investigational treatment (related services) and complications from an Experimental and/or Investigational treatment and their related services are excluded from coverage, even if such complications and related services would be covered in the absence of the Experimental and/or Investigational treatment.

Final determination of Experimental and/or Investigational, Medical Necessity and/or whether a proposed drug, device, medical treatment, or procedure is covered under the Plan will be made by and in the sole discretion of the Plan Administrator.

Final Internal Adverse Benefit Determination means an Adverse Benefit Determination that has been upheld by the Plan at the conclusion of the internal claims and appeals process, or an Adverse Benefit Determination with respect to which the internal claims and appeals process has been deemed exhausted.

Final Post-Service Appeal means a post-service appeal, which constitutes the last internal appeal available to the Covered Person to be filed with the Plan Administrator, Plan Sponsor, and/or other named fiduciary assigned authority and the duty to otherwise handle appeals. The term “Final Post-Service Appeal” shall only refer to such appeals if medical services and/or supplies have already been provided. Upon filing, adjudication and conclusion of this appeal, external review becomes available to the Covered Person; otherwise in accordance with applicable terms found within the Plan Document and applicable law. The Plan Administrator, Plan Sponsor, and/or other named fiduciary assigned authority and the duty to otherwise handle appeals, reserves the right to allocate certain discretionary authority as it applies to adjudication of Final Post-Service Appeals to the Plan Appointed Claim Evaluator or “PACE.”

FMLA means the Family and Medical Leave Act of 1993, as may be amended from time to time.

Genetic Information means information about genes, gene products and inherited characteristics that may derive from the individual or a family member. This includes information regarding carrier status and information derived from laboratory tests that identify mutations in specific genes or chromosomes, physical medical examinations, family histories and direct analysis of genes or chromosomes. Genetic Information will not be taken into account for purposes of (1) determining eligibility for benefits under the Plan (including initial enrollment and continued eligibility) and (2) establishing contribution or premium accounts for coverage under the Plan.

HIPAA means the Health Insurance Portability and Accountability Act of 1996 (HIPAA), as may be amended from time to time.

Home Health Care Agency means a public or private agency or organization that specializes in providing medical care and treatment in the home. Such a provider must meet all of the following conditions, it: (1) is duly licensed, if such licensing is required, by the appropriate licensing authority to provide skilled nursing services and other therapeutic services; (2) qualifies as a Home Health Care Agency under Medicare; (3) meets the standards of the area-wide healthcare planning agency; (4) provides skilled nursing services and other services on a visiting basis in the patient's home; (5) is responsible for administering a home health care program; and (6) supervises the delivery of a home health care program where the services are prescribed and approved in writing by the patient's attending Physician.

Hospice means an agency that provides counseling and incidental medical services and may provide room and board to terminally ill individuals and which meets all of the following requirements: (1) has obtained any required state or governmental Certificate of Need approval; (2) provides 24-hour-a-day, 7 days-a-week service; (3) is under the direct supervision of a duly qualified Physician; (4) has a nurse coordinator who is a registered nurse (R.N.) with 4 years of full-time clinical experience, at least 2 of which involved caring for terminally ill patients; (5) has a social-service coordinator who is licensed in the jurisdiction in which it is located; (6) is an agency that has as its primary purpose the provision of hospice services; (7) has a full-time administrator; (8) maintains written records of services provided to the patient; (9) the employees are bonded and it provides malpractice and malplacement insurance; (10) is established and operated in accordance with the applicable laws in the jurisdiction in which it is located and, where licensing is required, has been licensed and approved by the regulatory authority having responsibility for licensing under the law; (11) provides nursing care by a registered nurse (R.N.), a licensed practical nurse (L.P.N.), a licensed physical therapist, certified occupational therapist, American Speech Language and Hearing Association certified speech therapist or a certified respiratory therapist; and (12) provides a home health aide acting under the direct supervision of one of the above persons while performing services specifically ordered by a Physician.

Hospital means a facility which: (1) is licensed as a Hospital where licensing is required; (2) is open at all times; (3) is operated mainly to diagnose and treat Illnesses or Injuries on an Inpatient basis; (4) has a staff of one or more Physicians on call at all times; (5) has 24-hour-a-day nursing services by registered nurses (R.N.'s); and (6) has organized facilities for major Surgery.

However, an institution specializing in the care and treatment of Mental Disorders or Substance Use Disorders which would qualify as a Hospital, except that it lacks organized facilities on its premises for major Surgery, shall be deemed a Hospital.

In no event shall "Hospital" include an institution which is primarily a rest home, a nursing home, a clinic, a Skilled Nursing Facility, a convalescent home, or a similar institution.

Illness means a non-occupational bodily disorder, disease, physical sickness, pregnancy (including childbirth and miscarriage), Mental Disorder or Substance Use Disorder.

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

Injury means physical damage to the body, caused by an external force and which is due directly and independently of all other causes, to an Accident.

Inpatient means any person who, while confined to a Hospital, is assigned to a bed in any department of the Hospital other than its outpatient department and for whom a charge for room and board is made by the Hospital.

Intensive Care Unit means a separate, clearly designated service area, which is maintained within a Hospital solely for the care and treatment of patients who are critically ill. This also includes what is referred to as a “coronary care unit” or an “acute care unit.” It has: (1) facilities for special nursing care not available in regular rooms and wards of the Hospital; (2) special lifesaving equipment which is immediately available at all times; (3) at least 2 beds for the accommodation of the critically ill; and (4) at least one registered nurse (R.N.) in continuous and constant attendance 24 hours a day.

Lifetime Maximum means the maximum benefit payable during an individual's lifetime while covered under this Plan. Benefits are available only when an individual is eligible for coverage under this Plan. The Plan may provide for a Lifetime Maximum benefit for specific types of medical treatment. Any Lifetime Maximum will be shown in the applicable Schedule of Benefits.

Long-Term Acute Care Facility/Hospital (LTACH) means a facility that provides specialized acute care for medically complex patients who are critically ill; have multi-system complications and/or failures and require hospitalization in a facility offering specialized treatment programs and aggressive clinical and therapeutic intervention on a 24-hour-a-day, 7 days a week basis. The severity of the LTACH patient’s condition requires a Hospital stay that provides: (1) interactive Physician direction with daily on-site assessment; (2) significant ancillary services as dictated by complex, acute medical needs - such as full service and laboratory, radiology, respiratory care services, etc.; (3) a patient-centered outcome-focused, interdisciplinary approach requiring a Physician-directed professional team that includes intensive case management to move the patient efficiently through the continuum of care; (4) clinically competent care providers with advanced assessment and intervention skills; and (5) education for the patient and family to manage their present and future healthcare needs.

Maintenance Therapy means medical and non-medical health-related services that do not seek to cure or that are provided during periods when the medical condition of the patient is not changing or does not require continued administration by medical personnel.

Medically Necessary/Medical Necessity means treatment is generally accepted by medical professionals in the United States as proven, effective, and appropriate for the condition based on recognized standards of the health care specialty involved.

(1) "Proven" means the care is not considered Experimental and/or Investigational, meets a particular standard of care accepted by the medical community and is approved by the Food and Drug Administration (FDA) for general use.

(2) “Effective" means the treatments beneficial effects can be expected to outweigh any harmful effects. Effective care is treatment proven to have a positive effect on your health, while addressing particular problems caused by disease, Injury, Illness, or a clinical condition.

(3) "Appropriate" means the treatment's timing and setting are proper and cost effective.

Medical treatments which are not proven, effective and appropriate are not covered by the Plan.

All criteria must be satisfied. When a Physician recommends or approves certain care it does not mean that care is Medically Necessary.

Medicare means the program of health care for the aged established by Title XVIII of the Social Security Act of 1965, as amended.

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

Morbid Obesity/Obesity is defined as (1) a body mass index (BMI) of 40 or greater (or 37.5 or greater for persons of Asian ancestry) or (2) a BMI of 35 or greater (or 32.5 for persons of Asian ancestry) in conjunction with a severe co-morbidity, such as obesity hypoventilation, sleep apnea, diabetes, hypertension, cardiomyopathy, or musculoskeletal dysfunction.

Non-Participating Provider means a health care practitioner or health care facility that has not contracted directly with the Plan or an entity contracting on behalf of the Plan to provide health care services to Plan enrollees.

Ongoing Employee means a current Employee who has worked at least one Standard Measurement Period, as defined by this Plan.

Orthodontic Treatment means the corrective movement of teeth to treat a handicapping malocclusion of the mouth.

Out-of-Pocket Maximum has the same meaning as set forth in the section of this Plan entitled “General Overview of the Plan”.

Participating Provider means a health care practitioner or health care facility that has contracted directly with the Plan or an entity contracting on behalf of the Plan to provide health care services to Plan enrollees.

Physician means a legally licensed Physician who is acting within the scope of their license and any other licensed practitioner required to be recognized for benefit payment purposes under the laws of the state in which they practice and who is acting within the scope of their license. The definition of Physician includes but is not limited to: Doctor of Medicine (M.D.), Doctor of Osteopathy (D.O.), Chiropractor, Licensed Consulting Psychologist, Licensed Psychologist, Licensed Clinical Social Worker, Occupational Therapist, Optometrist, Ophthalmologist, Physical Therapist, Podiatrist, Registered Nurse (R.N.), Licensed Practical Nurse (L.P.N.), Nurse Practitioner, Physician’s Assistant, Speech Therapist, Speech Pathologist and Licensed Midwife (if covered by the Plan). An employee of a Physician who provides services under the direction and supervision of such Physician will also be deemed to be an eligible provider under the Plan.

Plan means the Nemours Foundation Employee Welfare Benefit Plan.

Plan Administrator means the administrator of the Plan in accordance with ERISA.

Plan Appointed Claim Evaluator or “PACE” means an entity appointed by the Plan Administrator, Plan Sponsor, and/or other named fiduciary assigned authority and the duty to otherwise handle appeals, with authority to make final, binding (insofar and to the same extent as a decision by the Plan Administrator, Plan Sponsor, and/or other named fiduciary assigned authority and the duty to otherwise handle appeals, would be deemed to be binding), claims processing decisions in response to Final Post-Service Appeals. In instances where the Plan Administrator, Plan Sponsor, and/or other named fiduciary assigned authority and the duty to otherwise handle appeals, delegates fiduciary authority to the PACE, the PACE may exercise the same level of discretionary authority as that which the Plan Administrator, Plan Sponsor, and/or other named fiduciary assigned authority and the duty to otherwise handle appeals, may otherwise exercise. The PACE’s fiduciary duties extend only to those determinations actually made by the PACE. The PACE may perform other tasks on behalf of, and in consultation with, the Plan Administrator, Plan Sponsor, and/or other named fiduciary assigned authority and the duty to otherwise handle appeals, but the PACE shall only be deemed to be a fiduciary when making final determinations regarding Plan coverage and claims examined via Final Post-Service Appeal. The PACE shall at all times strictly abide by, and make determination in accordance with, the terms of the Plan and applicable law, in light of the facts, law, medical records, and all other information submitted to the PACE.

Plan Sponsor means The Nemours Foundation or any successor thereto.

Plan Year means the period from January 1 - December 31 each year.

Prescription Drug means any of the following: (a) a Food and Drug Administration-approved drug or medicine, which, under federal law, is required to bear the legend, “Caution: federal law prohibits dispensing without prescription,” (b) injectable insulin; or (c) hypodermic needles or syringes, but only when dispensed upon a written prescription of a licensed Physician. Such drug must be Medically Necessary in the treatment of an Illness or Injury..

Primary Care Physician (PCP) means a licensed Physician practicing in one of the following fields: (1) family practice; (2) general practice; (3) internal medicine; or (4) pediatrics.

Qualified Clinical Trial means a Phase I, Phase II, Phase III or Phase IV clinical trial that is conducted in relation to the prevention, detection, or treatment of cancer or other life threatening condition and is described in (1), (2) or (3) below:

(1) The study or investigation is approved or funded (which may include funding through in-kind contributions) by one or more of the following:

   (a) The National Institutes of Health;

   (b) The Centers for Disease Control and Prevention;

   (c) The Agency for Health Care Research and Quality;

   (d) The Centers for Medicare & Medicaid Services;

   (e) A cooperative group or center of one of the entities described in (a) through (d) above;

   (f) A qualified non-governmental research entity identified in guidelines issued by the National Institutes of Health for center support grants; or

   (g) The Department of Veteran Affairs; the Department of Defense or the Department of Energy, if (i) the study or investigation has been reviewed and approved through a system of peer review that the Secretary determines to be comparable to the system of peer review of studies and investigations used by the National Institutes of Health; and (ii) assures unbiased review of the highest scientific standards by qualified individuals who have no interest in the outcome of the review.

(2) The study or investigation is conducted under an investigational new drug application reviewed by the Food and Drug Administration.

(3) The study or investigation is a drug trial that is exempt from having such an investigational new drug application.

Reconstructive Surgery means Surgery that is incidental to an Injury, Illness or Congenital Anomaly when the primary purpose is to improve physiological functioning of the involved part of the body. The fact that physical appearance may change or improve as a result of Reconstructive Surgery does not classify such Surgery as Cosmetic when a physical impairment exists, and the Surgery restores or improves function. Additionally, the fact that a Covered Person may suffer psychological consequences or socially avoidant behavior as a result of an Injury, Illness or Congenital Anomaly does not classify Surgery to relieve such consequences or behavior as Reconstructive Surgery.

Rehabilitation Facility means a facility must meet all of the following requirements: (1) must be for the treatment of acute Injury or Illness; (2) is licensed as an acute Rehabilitation Facility; (3) the care is under the direct supervision of a Physician; (4) services are Medically Necessary; (5) services are specific to an active written treatment plan; (6) the patient's condition requires skilled nursing care and interventions which cannot be achieved or managed at a lower level of care; (7) nursing services are available 24 hours a day; and (8) the confinement is not for Custodial Care or maintenance care.

Residential Treatment Facility means a facility that provides 24-hour treatment for Mental Disorders or Substance Use Disorders on an Inpatient basis. It must provide at least the following: room and board; medical services; nursing and dietary services; patient diagnosis, assessment, and treatment; individual, family and group counseling; and educational and support services. A Residential Treatment Facility is recognized if it is accredited for its stated purpose by the Joint Commission and carries out its stated purpose in compliance with all relevant state and local laws.

Security Standards mean the final rule implementing HIPAA's Security Standards for the Protection of Electronic PHI, as amended.

Semi-Private Room means a Hospital room shared by 2 or more patients.

Skilled Nursing Facility is a facility that meets all of the following requirements:

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

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

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

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

(5) It has an effective utilization review plan.

(6) It is not, other than incidentally, a place for rest, the aged, drug addicts, alcoholics, developmentally disabled, Custodial, or educational care or care of Mental Disorders.

(7) It is approved and licensed by Medicare.

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

Specialist means a licensed Physician that provides services to a Covered Person within the range of their specialty (e.g., cardiologist, neurologist, OB/GYN, etc.).

Specialty Drug means those Prescription Drugs, medicines, agents, substances, and other therapeutic products that include one or more of the following particular characteristics:

(1) Address complex, chronic diseases with many associated co-morbidities (e.g., cancer, rheumatoid arthritis, hemophilia, multiple sclerosis);

(2) Require a greater amount of pharmaceutical oversight and clinical monitoring for side effect management and to limit waste;

(3) Limited pharmaceutical supply chain distribution as determined by the applicable drug's manufacturer; and/or

(4) Relative expense.

Spouse means any person who is lawfully married to you under any state law.

Stabilize means, with respect to an Emergency Medical Condition, to provide such medical treatment for the condition as may be necessary to assure, within reasonable medical probability, that no material deterioration of the condition is likely to result from or occur during the transfer of the individual from a facility; or with respect to an Emergency Medical Condition of a pregnant woman who is having contractions (1) there is adequate time to effect a safe transfer to another Hospital before delivery; and (2) transfer will not pose a threat to the health or safety of the woman or her unborn child to deliver (including the placenta).

Substance Use Disorder means any disease or condition that is classified as a Substance Use Disorder in the current edition of the International Classification of Diseases published by the U.S. Department of Health and Human Services.

Surgery or **Surgical Procedure** means any of the following:

(1) The incision, excision, debridement or cauterization of any organ or part of the body and the suturing of a wound;

(2) The manipulative reduction of a fracture or dislocation or the manipulation of a joint including application of cast or traction;

(3) The removal by endoscopic means of a stone or other foreign object from any part of the body or the diagnostic examination by endoscopic means of any part of the body;

(4) The induction of artificial pneumothorax and the injection of sclerosing solutions;

(5) Arthrodesis, paracentesis, arthrocentesis and all injections into the joints or bursa;

(6) Obstetrical delivery and dilation and curettage; or

(7) Biopsy.

Surprise Bill/Surprise Billing happens when people unknowingly get care from providers that are outside of their health Plan's Network and can happen for both emergency and non-emergency care.

Third Party Administrator means Meritain Health, Inc., P.O. Box 853921, Richardson, TX 75085-3921.

Urgent Care Facility means a facility which is engaged primarily in providing minor emergency and episodic medical care to a Covered Person. A board-certified Physician, a registered nurse and a registered x-ray technician must be in attendance at all times that the facility is open. The facility must include x-ray and laboratory equipment and a life support system. For the purpose of this Plan, a facility meeting these requirements will be considered to be an Urgent Care Facility, by whatever actual name it may be called; however, an after-hours clinic shall be excluded from the terms of this definition.

USERRA means the Uniformed Services Employment and Reemployment Rights Act of 1994 (USERRA), as may be amended from time to time.

Usual and Customary Charge (U&C) means, with respect to Non-Participating Providers, charges made for medical or dental services or supplies essential to the care of the individual that will be subject to a Usual and Customary determination. Subject to the rest of this definition, the Usual and Customary Charge means the lesser of the charge by other providers in the same geographic area or billed charges for the same or comparable service or supply. From time to time, the Plan may enter into an agreement with a Non-Participating Provider (directly or indirectly through a third party) which sets the rate the Plan will pay for a service or supply. In these cases the Usual and Customary Charge will be the rate established in such agreement with the Non-Participating Provider.

The Plan may reduce the Usual and Customary Charge by applying reimbursement policies administered by the Plan’s Third Party Administrator. These reimbursement policies address the appropriate billing of services, taking into account factors that are relevant to the cost of the service such as:

(1) The duration and complexity of a service;

(2) Whether multiple procedures are billed at the same time, but no additional overhead is required;

(3) Whether an Assistant Surgeon is involved and necessary for the service;

(4) If follow up care is included;

(5) Whether there are any other characteristics that may modify or make a particular service unique; and

(6) When a charge includes more than one claim line, whether any services described by a claim line are part of or incidental to the primary service provided.

The reimbursement policies utilized are based on review of the policies developed for Medicare; the generally accepted standards of medical and dental practice, which are based on credible scientific evidence published in peer-reviewed literature generally recognized by the relevant medical or dental community or which are otherwise consistent with Physician or dental specialty society recommendations; and the views of Physicians and Dentists practicing in the relevant clinical areas.

The Usual and Customary Charge for covered services will be based on the median contract rate when a Covered Person had no control over the services performed by a Non-Participating Provider who is under agreement with a Network facility or when the Covered Person seeks Emergency Services for an Emergency Medical Condition from a Non-Participating Provider.

Walk-In Clinic: means a health care facility that provides limited medical care on a scheduled and unscheduled basis. A walk-in clinic may be located in, near or within a drug store, pharmacy, retail store, or supermarket.

The following are not considered a Walk-In Clinic: Ambulatory Surgical Center, emergency room, Hospital, outpatient department of a Hospital, Physician’s office, or Urgent Care Facility.

PLAN ADMINISTRATION

Delegation of Responsibility
The Plan Sponsor is a named fiduciary of the Plan with full discretionary authority for the control and management of the operation and administration of the Plan. The Plan Sponsor may delegate fiduciary and other responsibilities to any individual or entity. Any person to whom any responsibility is delegated may serve in more than one fiduciary capacity with respect to the Plan and may be a participant in the Plan.

Authority to Make Decisions
The Plan is administered by the Plan Administrator in accordance with ERISA. The Plan Administrator has retained the services of the Third Party Administrator to provide certain claims processing and other ministerial services. An individual or entity may be appointed by the Plan Sponsor to be Plan Administrator and serve at the convenience of the Plan Sponsor. If the Plan Administrator resigns, dies, is otherwise unable to perform, is dissolved or is removed from the position, the Plan Sponsor will appoint a new Plan Administrator as soon as reasonably possible.

The Plan Administrator will administer this Plan in accordance with its terms and establish its policies, interpretations, practices, and procedures. It is the express intent of this Plan that the Plan Administrator will have maximum legal discretionary authority to construe and interpret the terms and provisions of the Plan, to make determinations regarding issues which relate to eligibility for benefits (including the determination of what services, supplies, care and treatments are Experimental and/or Investigational), to decide disputes which may arise relative to you and/or your Dependent's rights and to decide questions of Plan interpretation and those of fact and law relating to the Plan. The decisions of the Plan Administrator as to the facts related to any claim for benefits and the meaning and intent of any provision of the Plan or its application to any claim, shall receive the maximum deference provided by law and will be final and binding on all interested parties. Benefits under this Plan will be paid only if the Plan Administrator decides, in its discretion, that you and/or your Dependent (as applicable) are entitled to them.

The duties of the Plan Administrator include the following:

(1) To administer the Plan in accordance with its terms;

(2) To determine all questions of eligibility, status, and coverage under the Plan;

(3) To interpret the Plan, including the authority to construe possible ambiguities, inconsistencies, omissions, and disputed terms;

(4) To make factual findings;

(5) To decide disputes which may arise relative to a Covered Person's rights;

(6) To prescribe procedures for filing a claim for benefits, to review claim denials and appeals relating to them and to uphold or reverse such denials; or, alternatively, to appoint a qualified administrator to carry out these functions on the Plan Administrator's behalf;

(7) To keep and maintain the Plan documents and all other records pertaining to the Plan;

(8) To appoint and supervise a Third Party Administrator to pay claims;

(9) To perform all necessary reporting as required by federal or state law;

(10) To establish and communicate procedures to determine whether a child support order or decree is a QMCSO;

(11) To delegate to any person or entity such powers, duties, and responsibilities as it deems appropriate; and

(12) To perform each and every function necessary for or related to the Plan's administration.

Discretionary Authority
The Plan is administered by the Plan Administrator (which may be the Plan Sponsor, or another entity appointed by the Plan Sponsor for this purpose) in accordance with the provisions of the Employee Retirement Income Security Act of 1974, as amended ("ERISA"). The Plan Administrator (or the PACE insofar as it relates to Final Post-Service Appeals) shall have sole, full and final discretionary authority to interpret all Plan provisions, including the right to remedy possible ambiguities, inconsistencies and/or omissions in the Plan and related documents; to make determinations in regards to issues relating to eligibility for benefits; to decide disputes that may arise relative to a Covered Person's rights; and to determine all questions of fact and law arising under the Plan. The Plan Administrator, Plan Sponsor, and/or any other fiduciary appointed by the Plan Sponsor for this purpose, reserves the right to allocate certain discretionary authority as it applies to assessment and final determinative authority on and regarding Final Post-Service Appeal[s], to the "PACE."

The PACE's fiduciary duties extend only to those determinations actually made by the PACE, and with which the Plan Administrator, Plan Sponsor and/or any other fiduciary appointed to act on behalf of the Plan complies. An entity that may perform services as the PACE may perform other tasks on behalf of, and in consultation with, the Plan Administrator and/or Plan Sponsor, but not as the PACE, and the PACE shall only be deemed to be a fiduciary when making final determinations regarding Plan coverage and claims examined via Final Post-Service Appeal. All other matters, including, but not limited to, other appeals that are "not" Final Post-Service Appeals, and matters the Plan Administrator, Plan Sponsor and/or any other fiduciary appointed to act on behalf of the Plan is prohibited from referring to the PACE in accordance with applicable law and/or pre-existing contract.

The PACE shall at all times strictly abide by, and make determination(s) in accordance with, the terms of the Plan and applicable law. In instances where the Plan Administrator, Plan Sponsor, and/or any other fiduciary appointed by the Plan Sponsor for this purpose, delegates fiduciary authority to the PACE to make a determination regarding a Final Post-Service Appeal, the PACE shall have discretion to interpret the terms of this Plan, and the PACE possesses all duties and rights otherwise ascribed to the Plan Administrator, Plan Sponsor, and/or any other fiduciary appointed by the Plan Sponsor for this purpose, in this limited scope only. In such instances, the PACE's determinations will be final and binding on all interested parties, and failure to comply with said determination by the Plan Administrator, Plan Sponsor and/or any other fiduciary appointed to act on behalf of the Plan, shall absolve the PACE of any and all fiduciary (and other) liability, responsibility, obligations, and/or duties.

Duties and Rights of the PACE
When the PACE is assigned by the Plan Administrator, Plan Sponsor and/or any other fiduciary appointed to act on behalf of the Plan, the task of making a determination regarding a Final Post-Service Appeal, the PACE shall possess the rights and exercise the duties otherwise ascribed to the Plan Administrator, Plan Sponsor, and/or other named fiduciary assigned authority and the duty to otherwise handle appeals, only insofar as it relates to said Final Post-Service Appeals. Assignment is achieved by and when the Plan Administrator, Plan Sponsor and/or any other fiduciary appointed to act on behalf of the Plan advances a request for a Final Post-Service Appeal, received by the Plan or its authorized agent(s), to the PACE with instructions to provide a directive regarding the Final Post-Service Appeal

Amendment or Termination of Plan
The Plan Sponsor expects to maintain this Plan indefinitely; however, the Plan Sponsor may, in its sole discretion, at any time, amend, suspend, or terminate the Plan in whole or in part.

Any such amendment, suspension or termination shall be taken and enacted in accordance with applicable federal and state law and any applicable governing documents.

If the Plan is terminated, the rights of Covered Persons are limited to expenses Incurred before termination. All amendments to this Plan shall become effective as of a date established by the Plan Sponsor.

MISCELLANEOUS INFORMATION

Assignment of Benefits
No benefit under the Plan shall be subject in any manner to anticipation, alienation, sale, transfer, assignment, pledge, encumbrance or charge and any attempt to do so shall be void. No benefit under the Plan shall in any manner be liable for or subject to the debts, contracts, liabilities, engagements, or torts of any person.

Notwithstanding the foregoing, the Plan will honor any Qualified Medical Child Support Order ("QMCSO") which provides for coverage under the Plan for an alternate recipient, in the manner described in ERISA Section 609(a) and in the Plan's QMCSO procedures.

Clerical Error
Clerical errors made on the records of the Plan and delays in making entries on such records shall not invalidate coverage nor cause coverage to be in force or to continue in force. Rather, the effective dates of coverage shall be determined solely in accordance with the provisions of this Plan regardless of whether any contributions with respect to you and/or your Dependents have been made or have failed to be made because of such errors or delays. Upon discovery of any such error or delay, an equitable adjustment of any such contributions will be made.

Conformity with Applicable Laws
This Plan shall be deemed automatically to be amended to conform as required by any applicable law, regulation or the order or judgment of a court of competent jurisdiction governing provisions of this Plan, including, but not limited to, stated maximums, exclusions, or limitations. In the event that any law, regulation or the order or judgment of a court of competent jurisdiction causes the Plan Administrator to pay claims that are otherwise limited or excluded under this Plan, such payments will be considered as being in accordance with the terms of Plan. It is intended that the Plan will conform to the requirements of any applicable federal or state law.

Cost of the Plan
The Plan Sponsor is responsible for funding the Plan and will do so as required by law. To the extent permitted by law, the Plan Sponsor is free to determine the manner and means of funding the Plan, including, but not limited to, payment of Plan expenses from the Employer’s general assets. If applicable, a biometric evaluation to determine health risk factors associated with a wellness program will be paid from the general assets of the Employer. The amount of contribution (if any) for your coverage or coverage for your Dependents will be determined from time to time by the Plan Sponsor, in its sole discretion.

Interpretation of this Document
The use of masculine pronouns in this Plan shall apply to persons of both sexes unless the context clearly indicates otherwise. The headings used in this Plan are used for convenience of reference only. You and your Dependents are advised not to rely on any provision because of the heading.

The use of the words, “you” and “your” throughout this Plan applies to eligible or covered Employees and, where appropriate in context, their covered Dependents.

Minimum Essential Coverage
Refer to the Employer’s Summary of Benefits and Coverage (SBC) for determination as to whether the Plan provides “minimum essential coverage” within the meaning of Code Section 5000A(f) and any accompanying regulations or guidance and whether it provides “minimum value” within the meaning of Code Section 36B(c)(2)(C)(ii) and any accompanying regulations or guidance (e.g., the Plan provides at least 60% actuarial value).

No Contract of Employment
This Plan and any amendments constitute the terms and provisions of coverage under this Plan. The Plan shall not be deemed to constitute a contract of any type between the Employer and any person or to be consideration for or an inducement or condition of the employment of any Employee. Nothing in this Plan shall be deemed to give any Employee the right to be retained in the service of the Employer or to interfere with the right of the Employer to discharge any Employee at any time.

Release of Information
For the purpose of determining the applicability of and implementing the terms of these benefits, the Plan Administrator may, without the consent of or notice to any person, release, or obtain any information necessary to determine the acceptability of any applicant or person covered for benefits under this Plan. In so acting, the Plan Administrator shall be free from any liability that may arise with regard to such action; however, the Plan Administrator at all times will comply with the applicable privacy standards. Any Covered Person claiming benefits under this Plan shall furnish to the Plan Administrator such information as may be necessary to implement this provision.

Workers' Compensation
This Plan excludes coverage for any Injury or Illness that is eligible for coverage under any Workers' Compensation policy or law regardless of the date of onset of such Injury or Illness. However, if benefits are paid by the Plan and it is later determined that you received or are eligible to receive Workers' Compensation coverage for the same Injury or Illness, the Plan is entitled to full recovery for the benefits it has paid. This exclusion applies to past and future expenses for the Injury or Illness regardless of the amount or terms of any settlement you receive from Workers' Compensation. The Plan will exercise its right to recover against you. The Plan reserves its right to exercise its rights under this section and the section entitled "Recovery of Payment" even though:

(1) The Workers' Compensation benefits are in dispute or are made by means of settlement or compromise;

(2) No final determination is made that the Injury or Illness was sustained in the course of or resulted from your employment;

(3) The amount of Workers' Compensation benefits due specifically to health care expense is not agreed upon or defined by you or the Workers' Compensation carrier; or

(4) The health care expense is specifically excluded from the Workers' Compensation settlement or compromise.

You are required to notify the Plan Administrator immediately when you file a claim for coverage under Workers' Compensation if a claim for the same Injury or Illness is or has been filed with this Plan. Failure to do so or to reimburse the Plan for any expenses it has paid for which coverage is available through Workers' Compensation, will be considered a fraudulent claim and you will be subject to any and all remedies available to the Plan for recovery and disciplinary action.

STATEMENT OF ERISA RIGHTS

As a Covered Person in the Plan, you and your Dependents are entitled to certain rights and protections under ERISA. ERISA provides that you and your eligible Dependents are entitled to:

Receive Information About Your Plan and Benefits
Examine, without charge, at the Plan Administrator's office and at other specified locations, such as worksites, all documents governing the Plan, including insurance contracts (if any) and copies of the latest annual report (Form 5500 Series) filed by the Plan with the U.S. Department of Labor and available at the Public Disclosure Room of the Employee Benefits Security Administration.

Obtain, upon written request to the Plan Administrator, copies of documents governing the operation of the Plan, including insurance contracts (if any) and copies of the latest annual report (Form 5500 Series) and updated Benefits Description. The Plan Administrator may make a reasonable charge for the copies.

Receive a summary of the Plan's annual financial report. The Plan Administrator is required by law to furnish each Covered Person with a copy of this summary annual report.

Continue Group Health Plan Coverage
Continue health care coverage for yourself, Spouse, or Dependents if there is a loss of coverage under the Plan as a result of a qualifying event. You or your Dependents may have to pay for such coverage. Review this Benefits Description and the documents governing the Plan on the rules governing your COBRA continuation coverage rights.

Prudent Actions by Plan Fiduciaries
In addition to creating rights for Covered Persons, ERISA imposes duties upon the people who are responsible for the operation of the 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 Covered Persons and beneficiaries. No one, including your Employer, 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.

Enforce Your Rights
If your claim for a welfare benefit is denied or ignored, in whole or in part, you have a right to know why this was done, to obtain copies of documents relating to the decision without charge and to appeal any denial, all within certain time schedules.

Under ERISA, there are steps you can take to enforce the above rights. For instance, if you request a copy of Plan documents or the latest annual report 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 a daily penalty up to the statutory maximum amount 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. In addition, if you disagree with the Plan's decision or lack thereof concerning the qualified status of a domestic relations order, a medical child support order or a national medical support notice, 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 would 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.

Assistance with Your Questions
If you have any questions about the Plan, you should contact the Plan Administrator. If you have any questions about this statement or about your rights under ERISA or if you need assistance in obtaining documents from the Plan Administrator, 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.

HIPAA PRIVACY PRACTICES

The following is a description of certain rules that apply to the Plan Sponsor regarding uses and disclosures of your health information.

Disclosure of Summary Health Information to the Plan Sponsor
In accordance with HIPAA's standards for privacy of individually identifiable health information (the "privacy standards"), the Plan may disclose summary health information to the Plan Sponsor, if the Plan Sponsor requests the summary health information for the purpose of:

(1) Obtaining premium bids from health plans for providing health insurance coverage under this Plan; or

(2) Modifying, amending, or terminating the Plan.

"Summary health information" is information, which may include individually identifiable health information, that summarizes the claims history, claims expenses or the type of claims experienced by individuals in the Plan, but that excludes all identifiers that must be removed for the information to be de-identified, except that it may contain geographic information to the extent that it is aggregated by 5-digit zip code.

Disclosure of Protected Health Information ("PHI") to the Plan Sponsor for Plan Administration Purposes
Except as described under "Disclosure of Summary Health Information to the Plan Sponsor" above or under "Disclosure of Certain Enrollment Information to the Plan Sponsor" below or under the terms of an applicable individual authorization, the Plan may disclose PHI to the Plan Sponsor and may permit the disclosure of PHI by a health insurance issuer or HMO with respect to the Plan to the Plan Sponsor only if the Plan Sponsor requires the PHI to administer the Plan. The Plan Sponsor by formally adopting this Plan document certifies that it agrees to:

(1) Not use or further disclose PHI other than as permitted or required by the Plan or as required by law;

(2) Ensure that any agents, to whom the Plan Sponsor provides PHI received from the Plan agree to the same restrictions and conditions that apply to the Plan Sponsor with respect to such PHI;

(3) Not use or disclose PHI for employment-related actions and decisions or in connection with any other benefit or employee benefit plan of the Plan Sponsor;

(4) Report to the Plan any PHI use or disclosure that is inconsistent with the uses or disclosures provided for of which the Plan Sponsor becomes aware;

(5) Make available PHI in accordance with section 164.524 of the privacy standards;

(6) Make available PHI for amendment and incorporate any amendments to PHI in accordance with section 164.526 of the privacy standards;

(7) Make available the information required to provide an accounting of disclosures in accordance with section 164.528 of the privacy standards;

(8) Make its internal practices, books and records relating to the use and disclosure of PHI received from the Plan available to the U.S. Department of Health and Human Services ("HHS"), for purposes of determining compliance by the Plan with part 164, subpart E, of the privacy standards;

(9) If feasible, return or destroy all PHI received from the Plan that the Plan Sponsor still maintains in any form and retain no copies of such PHI when no longer needed for the purpose for which disclosure was made, except that, if such return or destruction is not feasible, limit further uses and disclosures to those purposes that make the return or destruction of the PHI infeasible; and

(10) Ensure that adequate separation between the Plan and the Plan Sponsor, as required in section 164.504(f)(2)(iii) of the privacy standards, is established as follows:

(a) The Plan Sponsor shall only allow certain named employees or classes of employees or other persons under control of the Plan Sponsor who have been designated to carry out plan administration functions, access to PHI. The Plan Sponsor will maintain a list of those persons and that list is incorporated into this document by this reference. The access to and use of PHI by any such individuals shall be restricted to plan administration functions that the Plan Sponsor performs for the Plan.

(b) In the event any of the individuals described in (a) above do not comply with the provisions of the Plan documents relating to use and disclosure of PHI, the Plan Administrator shall impose reasonable sanctions as necessary, in its discretion. Such sanctions shall be imposed progressively (for example, an oral warning, a written warning, time off without pay and termination), if appropriate and shall be imposed so that they are commensurate with the severity of the violation.

“Plan administration” activities are limited to activities that would meet the definition of payment or health care operations, but do not include functions to modify, amend or terminate the Plan or solicit bids from prospective issuers. “Plan administration” functions include quality assurance, claims processing, auditing, monitoring, and management of carve-out plans, such as vision and dental. It does not include any employment-related functions or functions in connection with any other benefit or benefit plans.

The Plan shall disclose PHI to the Plan Sponsor only upon receipt of a certification by the Plan Sponsor that:

(1) The Plan documents have been amended to incorporate the above provisions; and

(2) The Plan Sponsor agrees to comply with such provisions.

Disclosure of Enrollment Information to the Plan Sponsor
Pursuant to section 164.504(f)(1)(iii) of the privacy standards, the Plan may disclose to the Plan Sponsor information on whether an individual is participating in the Plan or is enrolled in or has disenrolled from a health insurance issuer or health maintenance organization offered under the Plan.

Disclosure of PHI to Obtain Stop-loss or Excess Loss Coverage; Disclosures of Genetic Information
Except as otherwise provided below, the Plan Sponsor hereby authorizes and directs the Plan, through the Plan Administrator or the Third Party Administrator, to disclose PHI to stop-loss carriers, excess loss carriers or managing general underwriters (“MGUs”) for underwriting and other purposes in order to obtain and maintain stop-loss or excess loss coverage related to benefit claims under the Plan. Such disclosures shall be made in accordance with the privacy standards.

The Plan will not use or disclose Genetic Information, including information about genetic testing and family medical history, for underwriting purposes. The Plan may use or disclose PHI for underwriting purposes, assuming the use or disclosure is otherwise permitted under the privacy standards and other applicable law, but any PHI that is used or disclosed for underwriting purposes will not include Genetic Information.

“Underwriting purposes” is defined for this purpose under federal law and generally includes any Plan rules relating to (1) eligibility for benefits under the Plan (including changes in deductibles or other cost-sharing requirements in return for activities such as completing a health risk assessment or participating in a wellness program); (2) the computation of premium or contribution amounts under the Plan (including discounts or payments or differences in premiums based on activities such as completing a health risk assessment or participating in a wellness program); and (3) other activities related to the creation, renewal, or replacement of a contract for health insurance or health benefits. However, “underwriting purposes” does not include rules relating to the determination of whether a particular expense or claim is medically appropriate.

HIPAA SECURITY PRACTICES

Disclosure of Electronic Protected Health Information ("Electronic PHI") to the Plan Sponsor for Plan Administration Functions

In accordance with HIPAA's standards for security (the "Security Standards"), to enable the Plan Sponsor to receive and use Electronic PHI for Plan administration functions (as defined in 45 CFR § 164.504(a)), the Plan Sponsor agrees to:

(1) Implement and maintain administrative, physical, and technical safeguards that reasonably and appropriately protect the confidentiality, integrity, and availability of the Electronic PHI that it creates, receives, maintains, or transmits on behalf of the Plan.

(2) Ensure that adequate separation between the Plan and the Plan Sponsor, as required in 45 CFR § 164.504(f)(2)(iii), is supported by reasonable and appropriate security measures.

(3) Ensure that any agent, including any business associate or subcontractor, to whom the Plan Sponsor provides Electronic PHI created, received, maintained, or transmitted on behalf of the Plan, agrees to implement reasonable and appropriate security measures to protect the Electronic PHI.

(4) Report to the Plan any security incident of which it becomes aware.

(5) The Plan Sponsor will promptly report to the Plan any breach of unsecured Protected Health Information of which it becomes aware in a manner that will facilitate the Plan's compliance with the breach reporting requirements of the HITECH Act, based on regulations or other applicable guidance issued by the Department of Health and Human Services.

Any terms not otherwise defined in this section shall have the meanings set forth in the Security Standards.

GENERAL PLAN INFORMATION

Name of Plan:	Nemours Foundation Employee Welfare Benefit Plan
Plan Sponsor: **(Named Fiduciary)**	The Nemours Foundation 10140 Centurion Parkway N Jacksonville, FL 32256 (904) 697-4100
Plan Administrator:	The Nemours Foundation 10140 Centurion Parkway N Jacksonville, FL 32256 (904) 697-4100
Plan Sponsor EIN:	59-0634433
Plan Year:	January 1 - December 31
Plan Number:	513
Meritain Health, Inc. Group Number:	20356
Plan Type:	Welfare benefit plan providing medical benefits.
Plan Funding:	All benefits are paid from the general assets of the Employer.
Contributions:	The cost of coverage under the Plan is funded in part by Employer contributions and in part by Employee contributions.
Third Party Administrator:	Meritain Health, Inc. P.O. Box 853921 Richardson, TX 75085-3921 (877) 404-9750
Fiduciary for Second Level Appeal	The Phia Group, LLC
Care Coordination Administrator:	Quantum Health 5240 Blazer Parkway Dublin, OH 43017 (844) 460-2817 benefits4nemours.com
Employee Assistance Program (EAP) Administrator:	Aetna Resources for Living (855) 283-1917 www.resourcesforliving.com
Agent for Service of Legal Process:	The Nemours Foundation 10140 Centurion Parkway N Jacksonville, FL 32256 (904) 697-4100

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