network health

BENEFIT BOOKLET

3738-01-1021

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In your Member Portal you will find a link to the Preventive Services Guide which informs you of the preventive services covered at no member cost share. You will also find the How to Use Your Health Plan participant guide to help you navigate your health plan.

Please review all these materials carefully to best understand your health benefits and how to utilize them. Should you have any questions, you may contact our Member Experience team at the number found on the back of your ID card.

Assure Level-Funded Plan

Summary of Participant Responsibility

This is a summary of what you'll pay for covered medical services and prescription drugs. It is not a complete list of services or costs.

Please reference your Summary Plan Description for detailed benefits information, eligible services and coverage guidelines for this self-funded plan. All benefits are subject to the terms, limitations and exclusions of your Summary Plan Description.

Benefits begin on your effective date and accumulate on a calendar year basis of January 1 – December 31		**You Pay**
Annual Deductible *This is the amount of money you must pay before your plan begins paying for Covered Services.*	**Per Participant**	**$7,000**
	Per Family	**$14,000**
Coinsurance (after Deductible) *This is the percent of the cost you'll pay after you've met your Deductible.*		**0%**
Annual Out-of-Pocket Maximum *This is the maximum amount you'll pay for covered services and prescription drugs during a plan year. Once this limit is reached, your plan pays 100 percent for all Covered Services.*	**Per Participant**	**$7,000**
	Per Family	**$14,000**

Applicable medical and prescription drug Copayments, Deductible and Coinsurance costs apply toward your Annual Out-of-Pocket Maximum when the services are provided by a Participating Provider. When medical services are **not** provided by a Participating Provider, they will not be covered unless it is for specified emergency services. Any applicable medical and prescription drug Copayments and Coinsurance do not apply toward your Deductible. Any non-covered services and denied benefits will not apply toward your Deductible or Out-of-Pocket Maximum. The plan's coverage complies with applicable Federal regulations.

You can search for Participating Providers at **networkhealth.com**.
For help understanding your benefits, call Network Health's Member Experience Team at 844-300-5537.

Medical Benefits at a Glance

Medical Benefit	What You Pay
Preventive Health (Eligible for one annual preventive health visit per service, unless otherwise deemed Medically Necessary by the Plan)	
Preventive Services *Refer to your Summary Plan Description for a complete list of services*	$0
Routine Vision Exam	$0
Primary Doctor and Specialist Services	
Primary Care Physician Home and Office Visits *Including Behavioral Health and Substance Abuse* (Excluding Preventive Services)	Deductible
FastCare® clinic visit (Services must be provided at an approved, designated, clinic site as indicated in the rider.)	Deductible
Specialist Home and Office Visits	Deductible
Virtual Visits	Deductible
Primary Care Provider Inpatient Visits	Deductible
Specialist Inpatient Visits	Deductible
All other outpatient services/procedures performed in a provider's office not otherwise listed on this table	Deductible
Maternity Care	Deductible
Chiropractic Office Visits and Manipulations	Deductible
Medications administered in a provider's office	Refer to your Pharmacy Benefits at a Glance table that follows
Chemotherapy Medication	
Administered in a Provider's office, outpatient facility or in your home	Refer to your Pharmacy Benefits at a Glance table that follows
Infusion Services	
Pharmacy charge for medication (See Pharmacy Summary of Member Responsibility)	Based on formulary and benefit for tier.
Professional (Administration)Fees, facility charge, supplies and any other charges	Deductible
Diagnostic Services	
Lab, Pathology *Office visit or outpatient service*	Deductible
Lab tests for condition management of chronic diseases	Deductible
X-Ray and Diagnostic Imaging Practitioner's office or Outpatient	Deductible
PET Scans, MRIs, MRAs, CT Scans	Deductible

Medical Benefit	What You Pay
Stress Tests	Deductible
Ultrasounds/Echocardiograms	Deductible
Hospital Services	
Inpatient Services *Including Behavioral Health and Substance Abuse*	Deductible
Outpatient Services or Procedures *Including Cardiac Rehabilitation, Radiation Therapy, Dialysis, Behavioral Health and Substance Abuse*	Deductible
Ambulatory Surgical Center	Deductible
Rehabilitation Services	
Therapy – Physical/Occupational/Speech	Deductible
Home Health Care	
	Deductible
Hospice Care	
	Deductible
Medical Supplies and Equipment	
Durable Medical Equipment	Deductible
Medical Supplies *Including insulin pump supplies*	Deductible
Ambulance Services	
Emergency Ambulance Transport *Land and Air*	Deductible
Emergency and Urgent Care	
Emergency Room Services	Deductible
Urgent Care	Deductible

Applicable copayments will apply to your deductible and/or out-of-pocket maximum. Participants must use a participating pharmacy for drugs to be covered.

Pharmacy Benefit	What You Pay
30-Day Supply *Administered in a provider's office, outpatient facility or in your home.*	
Smart Choice Drugs	$0 copayment per prescription or refill after deductible
Preventive Drugs Tier 0	$0 per prescription or refill
Generic Prescription Drugs Tier 1	$0 copayment per prescription or refill after deductible
Preferred Prescription Drugs Tier 2	$0 copayment per prescription or refill after deductible
Non-Preferred Prescription Drugs Tier 3	$0 copayment per prescription or refill after deductible
Preferred Specialty Prescription Drugs Tier 4 *Must be provided through a plan participating specialty pharmacy*	0% per prescription or refill after deductible
Non-Preferred Specialty Prescription Drugs Tier 5 *Must be provided through a plan participating specialty pharmacy*	0% per prescription or refill after deductible
SaveOnSP Specialty Products	Enrolled Participants will have no cost share applied to these prescriptions. Non-enrolled Participants will pay the entire Copayment for the drug which may be found at (networkhealth.com/saveon-drug-list)
Mail Order 90-Day Supply	
Smart Choice Drugs	$0 copayment per prescription or refill after deductible
Preventive Drugs Tier 0	$0 per prescription or refill
Generic Prescription Drugs Tier 1	$0 copayment per prescription or refill after deductible
Preferred Prescription Drugs Tier 2	$0 copayment per prescription or refill after deductible

Pharmacy Benefit	What You Pay
Non-Preferred Prescription Drugs Tier 3	$0 copayment per prescription or refill after deductible
Preferred Specialty Prescription Drugs Tier 4	No mail order
Non-Preferred Specialty Prescription Drugs Tier 5	No mail order

Coverage for certain specialty pharmacy drugs that are considered non-essential health benefits are not subject to the out-of-pocket limits set under the Affordable Care Act. That means your cost share amount is not limited in the manner described in the tiers under this Rider, and the cost share amounts do not apply toward your out-of-pocket maximum. The SaveOnSP Program is a voluntary program. The SaveOnSP Program provides participants who choose to enroll the opportunity to get certain specialty pharmacy drugs that are not covered as an essential health benefit at no additional out-of-pocket cost. If You are prescribed a drug covered under the SaveonSP program, You will be contacted to enroll in the program. If you choose to enroll in the SaveOnSP program, You will incur no cost for these drugs and the cost share will not be applied towards satisfying the Out-of-Pocket Limit. Participants who decline to enroll will be responsible for the entire cost share, which will not be applied to the Out-of-Pocket Limit. A listing of the cost share amounts may be found at **networkhealth.com/saveon-drug-list**.

Any monetary amount of the Prescription Drug Product covered by a Copay Assistance Card will not apply towards the Deductible and Out-of-Pocket Limit.

network health **LFS22HSAE7000_0**

Coverage for: Individual or Individual + Family | **Plan Type:** LF_LLC

The Summary of Benefits and Coverage (SBC) document will help you choose a health plan. The SBC shows you how you and the plan would share the cost for covered health care services. NOTE: Information about the cost of this plan (called the premium) will be provided separately. This is only a summary. For more information about your coverage, or to get a copy of the complete terms of coverage, call 1-844-300-5537 or visit www.networkhealth.com. For general definitions of common terms, such as allowed amount, balance billing, coinsurance, copayment, deductible, provider, or other underlined terms see the Glossary. You can view the Glossary at www.networkhealth.com or call 1-844-300-5537 to request a copy.

Important Questions	Answers	Why This Matters:
What is the overall deductible?	**$7,000** per Participant **/ $14,000** per Family	Generally, you must pay all of the costs from providers up to the Deductible amount before this plan begins to pay. If you have other family members on the plan, each family member must meet their own individual Deductible until the total amount of Deductible expenses paid by all family members meets the overall family Deductible.
Are there services covered before you meet your deductible?	Yes. Preventive care is covered before you meet your Deductible.	This plan covers some items and services even if you haven't yet met the deductible amount. But a copayment or coinsurance may apply. For example, this plan covers certain preventive services without cost sharing and before you meet your deductible. See a list of covered preventive services at https://www.healthcare.gov/coverage/preventive-care-benefits/.
Are there other deductibles for specific services?	No.	You don't have to meet deductibles for specific services.
What is the out-of-pocket limit for this plan?	For network providers **$7,000** per Participant **/ $14,000** per Family.	The out-of-pocket limit is the most you could pay during a coverage period (usually one year) for your share of the costs of covered services. This limit helps you plan for health care expenses.
What is not included in the out-of-pocket limit?	Non-covered services, denied benefits, and the benefit reduction amount when prior authorization is not obtained. Certain specialty drugs that are considered non-essential health benefits.	Even though you pay these expenses, they don't count toward the out of pocket limit. Certain specialty drugs that are considered non essential will be reimbursed by the manufacturer at no cost to you.
Will you pay less if you use a network provider?	Yes. See www.networkhealth.com or call Network Health Customer Service at 1-844-300-5537 for a listing of participating providers.	This plan uses a provider network. You will pay less if you use a provider in the plan's network. You will pay the most if you use an Out-of-network provider, and you might receive a bill from a provider for the difference between the provider's charge and what your plan pays (balance billing). Be aware your network provider might use an Out-of-network provider for some services (such as lab work). Check with your provider before you get services.
Do you need a referral to see a specialist?	No.	You can see the specialist you choose without a referral.

(DT - OMB control number: 1545-0047/Expiration DATE: 12/31/2019)(DOL - OMB control number: 1210-0147/Expiration DATE: 5/31/2022)
(HHS - OMB control number: 0938-1146/Expiration DATE: 10/31/2022)

All copayment and coinsurance costs shown in this chart are after your deductible has been met, if a deductible applies.

Common Medical Event	Services You May Need	What You Will Pay		Limitations, Exceptions, & Other Important Information
		Network Provider (You will pay the least)	Out-of-Network Provider (You will pay the most)	
If you visit a health care provider's office or clinic	Primary care visit to treat an injury or illness	0% Coinsurance	Not Covered	----------None----------
	Specialist visit	0% Coinsurance	Not Covered	----------None----------
	Preventive care/screening/ immunization	No Charge	Not Covered	Ask your provider if the services needed are preventive.
If you have a test	Diagnostic test (x-ray, blood work)	0% Coinsurance	Not Covered	----------None----------
	Imaging (CT/PET scans, MRIs)	0% Coinsurance	Not Covered	----------None----------
If you need drugs to treat your illness or condition More information about prescription drug coverage is available at www.networkhealth.com	Generic drugs (Tier 1)	0% Coinsurance per prescription or refill for retail and mail order	Not Covered	Covers up to a 30-90 day supply, per 30-day supply (retail prescription); 30-90 day supply (mail order prescription).
	Preferred brand drugs (Tier 2)	0% Coinsurance per prescription or refill for retail and mail order	Not Covered	Covers up to a 30-90 day supply, per 30-day supply (retail prescription); 30-90 day supply (mail order prescription).
	Non-preferred brand drugs (Tier 3)	0% Coinsurance per prescription or refill for retail and mail order	Not Covered	Covers up to a 30-90 day supply, per 30-day supply (retail prescription); 30-90 day supply (mail order prescription).
	Preferred Specialty drugs (Tier 4)	0% Coinsurance per prescription or refill at specialty pharmacy and no mail order	Not Covered	Covers up to a 30-day supply (specialty pharmacy); No mail order Please see "Important questions" regarding the plan's out of pocket limit
	Non-preferred Specialty drugs (Tier 5)	0% Coinsurance per prescription or refill at specialty pharmacy and no mail order	Not Covered	Covers up to a 30-day supply (specialty pharmacy); No mail order Please see "Important questions" regarding the plan's out of pocket limit
If you have outpatient surgery	Facility fee (e.g., ambulatory surgery center)	0% Coinsurance	Not Covered	----------None----------
	Physician/surgeon fees	0% Coinsurance	Not Covered	----------None----------

Common Medical Event	Services You May Need	What You Will Pay		Limitations, Exceptions, & Other Important Information
		Network Provider (You will pay the least)	Out-of-Network Provider (You will pay the most)	
If you need immediate medical attention	Emergency room care	0% Coinsurance	0% Coinsurance	----------None----------
	Emergency medical transportation	0% Coinsurance	0% Coinsurance	----------None----------
	Urgent care	0% Coinsurance	Not Covered	----------None----------
If you have a hospital stay	Facility fee (e.g., hospital room)	0% Coinsurance	Not Covered	Preauthorization is required.
	Physician/surgeon fees	0% Coinsurance	Not Covered	----------None----------
If you need mental health, behavioral health, or substance abuse services	Outpatient services	0% Coinsurance	Not Covered	----------None----------
	Inpatient services	0% Coinsurance	Not Covered	Preauthorization is required.
If you are pregnant	Office visits	0% Coinsurance	Not Covered	----------None----------
	Childbirth/delivery professional services	0% Coinsurance	Not Covered	----------None----------
	Childbirth/delivery facility services	0% Coinsurance	Not Covered	----------None----------
If you need help recovering or have other special health needs	Home health care	0% Coinsurance	Not Covered	Limited to 50 Visits per 12 month period; Preauthorization is required.
	Rehabilitation services	0% Coinsurance	Not Covered	Limited to 60 total combined visits per Calendar Year for Physical/Occupational/Speech Therapy.
	Habilitation services	Not Covered	Not Covered	Not Covered
	Skilled nursing care	0% Coinsurance	Not Covered	Limited to 60 days per confinement period; Preauthorization is required
	Durable medical equipment	0% Coinsurance	Not Covered	----------None----------
	Hospice services	0% Coinsurance	Not Covered	Preauthorization is required.
If your child needs dental or eye care	Children's eye exam	No Charge	Not Covered	Limited to one Routine Eye exam per 12 months.
	Children's glasses	Not Covered	Not Covered	----------None----------
	Children's dental check-up	Not Covered	Not Covered	----------None----------

Excluded Services & Other Covered Services:

Services Your Plan Generally Does NOT Cover (Check your policy or plan document for more information and a list of any other excluded services.)		
• Abortion (Excluded service)	• Dental Care (Adult)	• Oral Surgery (Dental)
• Accidental Dental	• Hearing Aids	• Private-Duty Nursing
• Acupuncture	• Infertility Treatment	• Routine Foot Care
• Bariatric Surgery	• Long-Term Care	• Weight Loss Programs
• Cosmetic Surgery	• Non-Emergency Care When Traveling Outside the Country	
Other Covered Services (Limitations may apply to these services. This isn't a complete list. Please see your plan document.)		
• Chiropractic Care	• Routine Eye Care (Adult)	

Your Rights to Continue Coverage: There are agencies that can help if you want to continue your coverage after it ends. The contact information for those agencies is: Department of Labor's Employee Benefits Security Administration at 1-866-444-EBSA (3272) or www.dol.gov/ebsa/healthreform, Department of Health and Human Services Center for Consumer Information and Insurance Oversight, at 1-877-267-2323 x61565 or www.cciio.cms.gov, or you may contact Network Health Member Experience Team at 1-844-300-5537 for more information. Other coverage options may be available to you too, including buying individual insurance coverage through the Health Insurance Marketplace. For more information about the Marketplace, visit www.HealthCare.gov or call 1-800-318-2596.

Your Grievance and Appeals Rights: There are agencies that can help if you have a complaint against your plan for a denial of a claim. This complaint is called a grievance or appeal. For more information about your rights, look at the explanation of benefits you will receive for that medical claim. Your plan documents also provide complete information on how to submit a claim, appeal, or a grievance for any reason to your plan. For more information about your rights, this notice, or assistance, contact: Department of Labor's Employee Benefits Security Administration at 1-866-444-EBSA (3272) or www.dol.gov/ebsa/healthreform, or you may contact Network Health Member Experience Team at 1-844-300-5537 for more information.

Does this plan provide Minimum Essential Coverage? **Yes.**
Minimum essential coverage generally includes plans, health insurance available through the Marketplace or other individual market policies, Medicare, Medicaid,CHIP, TRICARE, and certain other coverage. If you are eligible for certain types of Minimum essential coverage, you may not be eligible for the premium tax credit.

Does this plan meet Minimum Value Standards? **Yes.**
If your plan doesn't meet the Minimum value standard, you may be eligible for a Premium tax credit to help you pay for a plan through the Marketplace.

To see examples of how this plan might cover costs for a sample medical situation, see the next section.

About these Coverage Examples:

This is not a cost estimator. Treatments shown are just examples of how this plan might cover medical care. Your actual costs will be different depending on the actual care you receive, the prices your providers charge, and many other factors. Focus on the cost sharing amounts (deductibles, copayments and coinsurance) and excluded services under the plan. Use this information to compare the portion of costs you might pay under different health plans. Please note these coverage examples are based on self-only coverage.

Peg is Having a Baby
(9 months of in-network pre-natal care and a hospital delivery)

The plan's overall Deductible	$7,000
Specialist Coinsurance	0%
Hospital (facility) Coinsurance	0%
Other Coinsurance	0%

This EXAMPLE event includes services like:
Specialist office visits (*prenatal care*)
Childbirth/Delivery Professional Services
Childbirth/Delivery Facility Services
Diagnostic tests (*ultrasounds and blood work*)
Specialist visit (*anesthesia*)

Total Example Cost	**$12,700**

In this example, Peg would pay:

Cost Sharing	
Deductibles	$7,000
Copayments	$0
Coinsurance	$0
What isn't covered	
Limits or exclusions	$60
The total Peg would pay is	**$7,060**

Managing Joe's type 2 Diabetes
(a year of routine in-network care of a well-controlled condition)

The plan's overall Deductible	$7,000
Specialist Coinsurance	0%
Hospital (facility) Coinsurance	0%
Other Coinsurance	0%

This EXAMPLE event includes services like:
Primary care physician office visits (*including disease education*)
Diagnostic tests (*blood work*)
Prescription drugs
Durable medical equipment (*glucose meter*)

Total Example Cost	**$5,600**

In this example, Joe would pay:

Cost Sharing	
Deductibles	$5,310
Copayments	$0
Coinsurance	$0
What isn't covered	
Limits or exclusions	$60
The total Joe would pay is	**$5,370**

Mia's Simple Fracture
(in-network emergency room visit and follow up care)

The plan's overall Deductible	$7,000
Specialist Coinsurance	0%
Hospital (facility) Coinsurance	0%
Other Coinsurance	0%

This EXAMPLE event includes services like:
Emergency room care (*including medical supplies*)
Diagnostic test (*x-ray*)
Durable medical equipment (*crutches*)
Rehabilitation services (*physical therapy*)

Total Example Cost	**$2,800**

In this example, Mia would pay:

Cost Sharing	
Deductibles	$2,800
Copayments	$0
Coinsurance	$0
What isn't covered	
Limits or exclusions	$0
The total Mia would pay is	**$2,800**

Note: These numbers assume the patient does not participate in the plan's wellness program. If you participate in the plan's wellness program, you may be able to reduce your costs. For more information about the wellness program, please contact: 1-855-275-1400.

The **plan** would be responsible for the other costs of these EXAMPLE covered services.

HOUSE OF HOPE GREEN BAY INC LF
HEALTH PLAN DOCUMENT

Group Plan Effective Date: 01/01/2022

This Plan Document is composed of the following documents:

- General Plan Information
- Summary Plan Description
- Summary of Participant Responsibility - Medical
- Summary of Participant Responsibility – Pharmacy

This Plan Document amends, replaces, and supersedes any prior plans, policies, or descriptions related to the medical and pharmacy benefits through HOUSE OF HOPE GREEN BAY INC LF.

GENERAL PLAN INFORMATION

Name of Plan:	HOUSE OF HOPE GREEN BAY INC LF
Plan Sponsor/Employer:	HOUSE OF HOPE GREEN BAY INC LF 1660 CHRISTIANA STREET GREEN BAY, WI 54303
Plan Administrator:	HOUSE OF HOPE GREEN BAY INC LF (Named Fiduciary) 1660 CHRISTIANA STREET GREEN BAY, WI 54303 920-884-6740
Employer Identification Number: (EIN):	39-1708805
Source of Funding:	Employer and Employee contributions for the Self-Insured Plan.
Plan Year:	The initial Plan Year starts on the Plan Effective Date and goes through December of that year. Thereafter, the Plan Year is January 1 through December 31.
Plan Number:	501
Plan Type:	Medical and Prescription Drug
Third Party Administrator for Medical Plan:	Network Health Administrative Services LLC. 1570 Midway Place Menasha, WI 54952 Phone: Refer to phone number on your Participant ID card.
Pharmacy Benefits Administrator:	Express Scripts/ESI 1 Express Way Saint Louis, MO 63121 Phone: 1-800-282-2881 Website: www.express-scripts.com
Eligible for Continuation:	Yes
Continuation Administrator:	,
Agent for Service of Legal Process:	Plan Administrator
Provider Networks available:	Assure

Eligibility requirement:

An employee needs to regularly work 30 hours per week to be eligible for the plan.

Waiting period & Effective Date of Coverage

- The Waiting Period for an eligible Employee is: 60 days from the date of hire or date of becoming eligible under the Plan.

- The Effective Date of coverage for the eligible Employee and eligible Dependents is first of the month following completion of the waiting period, provided that application is made in accordance with the Initial Enrollment Procedures stated above.

- Employees who are rehired within 30 days from terminating employment with the Plan Sponsor will not be treated as a new employee and will not be subject to the waiting period.

Plan Document and Summary Plan Description

Assure Self-Insured Plan
Administered by Network Health Administrative Services (NHAS), LLC

Assure ERISA with and without COBRA eff 012022

Self-insured plans administered by Network Health Administrative Services, LLC.

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SECTION 1 ~ ESTABLISHMENT, ADOPTION AND PURPOSE OF THE PLAN

THIS PLAN DOCUMENT AND SUMMARY PLAN DESCRIPTION (Plan Document), hereby sets forth the provisions of the Plan Sponsor's self-insured Employee Health Care Plan (the Plan). This Plan Document amends, replaces and supersedes any prior plans, policies or descriptions related to the medical and pharmacy Benefits through the Plan Sponsor. The "Plan Sponsor" is the entity listed on the General Plan Information page of this Plan Document.

The purpose of this document is to provide eligible Employees and Dependents with information related to medical and pharmacy Benefits under this Plan, along with information on Other Plan-related details that You need to have. This Plan is established to protect eligible Employees and their Dependents against certain catastrophic health expenses and to help cover the costs arising from Injury or Illness.

The Plan Sponsor, as the settlor of the Plan, hereby adopts this Plan Document as the written description of the Plan, to set forth the terms and provisions of the Plan that provide for the payment or reimbursement of all or a portion of certain expenses for eligible Benefits. This document represents both the Plan Document and the Summary Plan Description.

By adopting this Plan Document, the Plan Sponsor certifies that the Plan Document incorporates the provisions required by the Health Information Portability and Accountability Act (HIPAA) Privacy and Security Standards for disclosure of protected health information. The Plan Sponsor also certifies the Plan will not use such information for any employment-related action or decision.

The Plan Sponsor maintains this Plan Document and it may be reviewed any time during normal working hours by any Participant.

To give You information about the document that will help You understand this Plan Document, certain capitalized words have special meanings. These words are defined in SECTION 22 ~ DEFINED TERMS. You can refer to SECTION 22 ~ DEFINED TERMS as You read this document to have a clearer understanding of Your Plan Document.
NHAS is used in place of Network Health Administrative Services (NHAS) who is the third-party administrator of the Plan. When the words "You" and "Your" are used, it is referring to people who are Participants under the Plan.

Have Questions?

Soon after You enroll in this Plan, You will receive a Participant Identification Card (ID Card). ID cards are for identification purposes only. An individual must be a plan Participant to receive services or Benefits. Your coverage may be revoked for allowing unauthorized use of Your ID card. The ID Card provides specific phone numbers to call if You have questions about Your medical or pharmacy Benefits. In addition, the ID Card contains phone numbers for Prior Authorization requests. To contact the NHAS Member Experience Team, call the telephone

number listed on the back of Your Participant ID card. If You prefer, You may send a secure message through the Member portal at **login.networkhealth.com**.

Care Management Assistance

The Plan contracts with NHAS to provide certain care and condition management services for Participants who have acute, chronic, terminal, catastrophic or complex medical conditions. For example, if You have a condition such as heart failure or heart disease, need for organ transplant, diabetes, asthma, chronic obstructive pulmonary disease (COPD), cancer or mental health or chemical dependency issues, You may be eligible for these services. NHAS's care management staff may contact You if You are eligible for a program, but You may also contact NHAS if You feel You may benefit from participation in a program. Your participation is completely voluntary. Please contact NHAS at the phone number listed on the back of Your ID Card.

SECTION 2 ~ HELPFUL INFORMATION FOR PARTICIPANTS

This Plan Document contains important information You need to understand so when You need medical care or prescription medication, You will know what this Plan covers and Your obligations and rights. Please review this document as soon as possible after enrolling in the Plan so You make the best decisions possible when medical care is needed.

Here are some of the key provisions in this Plan Document that You may find helpful, however the entire document describes Your Benefits under this Plan. Remember, for coverage all services must be Medically Necessary. The fact that a service is performed, prescribed or approved by a Provider does not mean it is Medically Necessary.

a) **Claims and Appeals**: This Plan Document explains the process for how Claims are submitted to the Plan for review and processing, timelines for processing Claims and the process to Appeal a Claim that was fully or partially denied.
b) **Cost of Plan Coverage**: This Plan is paid for through a mix of Employer and Employee contributions. The Employer will provide eligible Employees with information related to the Employee's cost for individual or family coverage under this Plan. Employees who submit the enrollment form for coverage under this Plan are also authorizing the Employer to deduct the applicable costs for the coverage selected from Your paycheck. If an Employee enrolls a new Dependent in accordance with the Special Enrollment provision contained in this Plan Document, a contribution will be charged to the Employee from the first day of coverage for that Dependent, unless family coverage is already in effect and no additional contribution is needed. If Participants under the Plan are eligible for COBRA continuation, they are responsible for paying the full cost of coverage as discussed later in this Plan Document. Please see the General Plan Information page in your plan documents which will indicate if COBRA is available.
c) **Cost Sharing Information**: The Summary of Participant Responsibility (SOPR) document that is part of this Plan Document tells You how much Your cost share responsibility is for medical and pharmacy services You receive. Generally, this Plan only pays toward the cost of Covered Services after a Participant has met the Deductible. After Your Deductible has been met, You are responsible for any applicable Coinsurance percentage. Some plans have fixed amounts, called Copayments, that the Participant must pay. Copayments may be required instead of the Deductible or after meeting it, so it is important to review and understand Your cost sharing obligations. The maximum total You may pay for Deductible, Coinsurance and Copayments in a year is the Out-of-Pocket Limit.

   In addition, You are responsible for paying any Balance Billing that may occur from Non-Participating Providers or for non-Covered Services.

   NOTE: The following will not be used to meet the Deductible or Annual Out-Of-Pocket Maximum.

i. The Employee's contribution deducted from Your paycheck to participate in the Plan;
ii. Monthly payments for COBRA if the Plan is eligible. Please see the General Plan Information page in your plan documents which will indicate if COBRA is available;
iii. Expenses for excluded services;
iv. Any charges above the maximum limits specified in this document:
v. Any amount in excess of the Allowed Amount that a Participant must pay to a Non-Participating Provider (Balance Billing);
vi. Penalties for services that did not receive Prior Authorization as required in this Plan Document;
vii. Payments by the Participant for services for which Prior Authorization was denied if the decision is made to still receive those services;
viii. The pharmacy Ancillary Fee that is charged if the Participant or Provider requests a brand name medication when a generic medication is available.

If the Plan initially becomes effective on a date other than January 1, a Participant will be given credit for Deductibles paid under the Plan Sponsor's previous health plan. Proper documentation must be submitted within 90 Days of the date this Plan Document became effective. Acceptable documentation includes a Deductible report for the previous insurer, or an explanation of benefits from the Participant, showing the amount of the Deductible that was satisfied under the prior carrier.

d) **Covered Medical Benefits**: This Plan Document and Summary Plan Description (SPD) describes the medical services, procedures and pharmacy Benefits covered under this Plan, along with any applicable conditions or limitations.
e) **Eligibility, Enrollment, Termination and Continuation of Coverage**: The General Plan Information page and additional provisions in this Plan Document describe which Employees and their Dependents are eligible for coverage under this Plan, how to enroll and what the timelines are for enrolling, a description of Special Enrollment Rights, and annual open enrollment opportunities. This document describes when coverage for You and Your Dependents will end, as well as what rights You may have to continue coverage.
f) **Exclusions and Limitations**: This Plan Document lists the items not covered (not paid for) by this Plan. If You receive services or treatment for something that is listed as excluded or that has limitations that have been exceeded, You will be responsible for paying the entire bill to the Provider.
g) **Participating Provider**: A "Participating Provider" is a medical Provider, medical facility, or supplier who has contracted with NHAS to provide Covered Services to Participants under the Plan for discounted fees. Because of the discounted fees, it is more cost-effective for You to get services and treatment from a Participating Provider whenever possible.
h) **Non-Participating Provider**: A Non-Participating Provider is a medical Provider, medical facility, or supplier that <u>does not have</u> a contract with NHAS to provide Covered Services to Participants under the Plan for discounted fees. Only Participants having a

Point of Service (POS) plan have out-of-network coverage for non-Emergency services, but at a greater cost share. Generally, Non-Participating Providers can also Balance Bill You for any amount that is over the Allowed Amount and the Balance Bill amount is Your financial responsibility.

i) **Out-of-Network Services:** If You obtain services or supplies from any medical Provider, medical facility, or supplier who is not a Participating Provider (or who is not part of the NHAS designated out-of-area network, if You are eligible for and elect Network Extend), those services will be considered "out-of-network." If Your Summary of Participant Responsibility indicates that You have out-of-network coverage, the out-of-network Deductibles, Copayments, and Coinsurance will apply to those services and supplies. If Your Summary of Participant Responsibility does not show that You have out-of-network coverage and/or indicates that You are participating in an "Exclusive Provider Organization," the Plan will not cover any out-of-network services or supplies except for Emergency Services.

j) **Participating Provider Not Available:** Despite the above-mentioned, if there is no in-network Participating Provider for a particular service or supply and NHAS's utilization management team determines the service or supply is Medically Necessary and would have been considered a Covered Service if an in-network Provider had been available, the Plan may cover such service or supply at in-network rates and cost sharing if the Participant obtains Prior Authorization. You will receive written notification of our utilization management team's determination letting You know if the service is approved or denied.

k) **Primary Care Practitioner:** It is highly recommended that Participants select a Primary Care Practitioner (PCP) to serve as Your main Provider and help You with Prior Authorization requirements. Participants can designate any Participating Provider as the Primary Care Physician if the Provider is in Family Practice, General Practice, Internal Medicine, Obstetrics/Gynecology or Pediatrics and is available to accept the Participant. For additional information please see the Patient Protection Notice within this document.

l) **Preventive Services Benefits**: Preventive Services can lead to the early detection of diseases, so a medical problem has a better chance of being treated early or prevented. Discuss with Your medical Provider which Preventive Services he or she recommends for You and then obtain those services. Many Preventive Services are covered by the Plan at 100 percent (no Deductible or Coinsurance) if these services are provided by a Participating Provider and appropriately billed by the Provider as a preventive service. A list of covered Preventive Services is included in the Preventive Services Guide. **Prior Authorization Requirements**: Certain non-Emergency services or procedures require NHAS approval (Prior Authorization) before You receive the services. Failure to obtain Prior Authorization as required may result in You being partially or fully responsible for the cost of the medical care received. See Section 6, Prior Authorization Requirements and Procedures, for more information.

These are only some of the important details contained in this Plan Document, so please take time to review this document.

SECTION 3 ~ PLAN ADMINISTRATION

The Plan Sponsor will appoint an individual, committee or entity to be Plan Administrator and serve at the convenience of the Plan Sponsor. The Plan Sponsor may appoint a new Plan Administrator at any time.

Plan Administrator

The Plan Administrator shall administer the Plan in accordance with its terms and for the exclusive benefit of persons entitled to participate in the Plan. The Plan Administrator may delegate to one or more individuals or entities part or all of its authority under the Plan, provided that the Plan Administrator puts any such delegation in writing. The Plan Administrator has retained the services of NHAS as the Third-Party Administrator and has delegated to them responsibility for certain Claims processing and other technical services.

The Plan Administrator shall establish and maintain 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 all interpretive and factual determinations as to whether any individual is eligible and entitled to receive any Benefit under the terms of this Plan, to decide disputes that may arise with respect to a Participant's rights and to decide questions of Plan interpretation and those of fact relating to the Plan. To the extent that the Plan Sponsor or Plan Administrator appoints a Third-Party Administrator to process Claims and make Claims determinations under the Plan, such Third-Party Administrator shall have the same discretionary authority as the Plan Administrator to:

a) Construe and interpret the terms and provisions of the Plan
b) Make all interpretive and factual determinations as to whether any individual is eligible and entitled to receive any Benefit under the terms of this Plan
c) Decide disputes that may arise with respect to a Participant's rights
d) Decide questions of Plan interpretation and those of fact relating to the Plan

The decisions of the Plan Administrator (or Third-Party Administrator, if applicable) will be final and binding on all interested parties. Benefits will be paid under this Plan only if the Plan Administrator (or Third-Party Administrator, if applicable), in its discretion, determines that the Participant is entitled to them.

If, due to errors in drafting, any Plan provision does not accurately reflect its intended meaning, as demonstrated by prior interpretations or other evidence of intent, or as determined by the Plan Administrator or Third Party Administrator in its sole and exclusive judgment, the provision will be considered ambiguous and will be interpreted by the Plan Administrator or Third Party Administrator in a fashion consistent with the intent of the Plan, as determined by the Plan Administrator or Third-Party Administrator. The Plan may be amended retroactively to cure any such ambiguity, notwithstanding anything in the Plan to the contrary.

No provision of the Plan may be invoked by any person to require the Plan to be interpreted in a manner that is inconsistent with the Plan Administrator's or Third-Party Administrator's interpretations of the Plan. All actions taken and all determinations by the Plan Administrator or Third-Party Administrator will be final and binding upon all persons claiming any interest under the Plan subject only to the Claims Appeal procedures of the Plan. Any review of a final decision or action of the Plan Administrator or Third-Party Administrator will be based only on such evidence presented to or considered by the Plan Administrator or Third-Party Administrator at the time it made the decision that is the subject of review.

Duties of the Plan Administrator

The duties of the Plan Administrator include the following:

a) Administer the Plan according to its terms;
b) Determine all questions of eligibility and coverage under the Plan;
c) Interpret the Plan, including the authority to construe possible ambiguities, inconsistencies, omissions and disputed terms;
d) Make factual findings;
e) Decide disputes that may arise relative to a Participant's rights or the availability of benefits;
f) Prescribe procedures for filing a Claim for benefits, review Claim denials and Appeals relating to them and to uphold or reverse such denials;
g) Keep and maintain the Plan documents and all other records pertaining to the Plan;
h) Appoint and supervise a Third-Party Administrator to process Claims;
i) Perform all necessary reporting;
j) Establish and communicate procedures to determine whether a Medical Child Support Order is a QMCSO;
k) Delegate to any person or entity such powers, duties and responsibilities as it deems appropriate; and
l) Perform each and every function necessary for or related to the Plan's administration.

Amending and Terminating the Plan

This Plan was established for the exclusive benefit of the Employees. As the settlor of the Plan, however, the Plan Sponsor may at any time, through its directors and officers and in its sole discretion, amend, suspend or terminate the Plan in whole or in part. This includes amending the benefits under the Plan or the trust agreement (if any). All Amendments to this Plan will become effective as of a date established by the Plan Sponsor.

The Plan Sponsor's directors and officers if it is incorporated (in compliance with its articles of incorporation or bylaws and if these provisions are deemed applicable), or the sole proprietor in his or her own discretion if the Plan Sponsor is a sole proprietorship, will determine the process by which the Plan may be amended, suspended, or terminated in accordance with applicable federal and state law, including applicable notification rules.

If the Plan is terminated, the rights of the Plan Participants are limited to expenses Incurred before termination. In connection with the termination, the Plan Sponsor may establish a deadline by which all Claims must be submitted for consideration. Benefits will be paid only for Covered Expenses Incurred prior to the termination date and submitted in accordance with the rules established by the Plan Sponsor. Upon termination, any Plan assets will be used to pay outstanding Claims and expenses of Plan termination. To the extent that any Plan assets remain, they will be used for the benefit of covered Participants.

Summary of Material Reduction (SMR)

A material reduction means any modification to the Plan that the average Participant would consider to be an important reduction in Covered Services or benefits. Examples include reductions in benefits or increases in Deductibles or Copayments.

The Plan Administrator shall notify all eligible Employees of any plan Amendment considered a material reduction as soon as administratively feasible after its adoption, but no later than 60 Days after the date of adoption of the reduction. Any changes so made will be binding on each Participant. Eligible Employees and beneficiaries must be furnished a summary of such reductions. The 60-Day period for furnishing a summary of material reduction does not apply to any Employee covered by the Plan who would reasonably expect to receive a summary through other means within the next 90 Days.

Material reduction disclosure provisions are subject to the requirements of the Health Insurance Portability and Accountability Act of 1996 (HIPAA) and any related Amendments.

Summary of Material Modification (SMM)

A Summary of Material Modifications reports changes in the information provided within the Plan Document. Examples include a change to Deductibles, eligibility or the addition or deletion of coverage. The Plan Administrator shall notify all covered Employees of any plan Amendment considered a Summary of Material Modifications as soon as administratively feasible after its adoption, but no later than within 210 Days after the close of the Plan Year in which the changes became effective.

Distribution of Assets Upon Termination of Plan

Post tax contributions paid by COBRA beneficiaries and/or retirees, if applicable, will be used for the exclusive purpose of providing benefits and defraying reasonable expenses related to Plan administration and will not inure to the benefit of the Employer.

Applicable Law

This is a self-insured Benefit plan coming within the purview of the Employee Retirement Income Security Act of 1974 (ERISA) and the laws of the State of Wisconsin to the extent not pre-empted by federal law and jurisdiction.

Clerical Error/Delay/Overpayments

Any clerical error by the Plan Administrator or an agent of the Plan Administrator in keeping pertinent records or a delay in making any changes to such records will not invalidate coverage otherwise validly in force or continue coverage validly terminated. Contributions made in error by Participants due to such clerical error will be returned to the Participant; coverage will not be inappropriately extended.

Contributions that were due but not made, in error and due to such clerical error will be owed immediately upon identification of said clerical error. Failure to so remedy amounts owed may result in termination of coverage. effective dates, Waiting Periods, deadlines, rules and other matters will be established based upon the terms of the Plan, as if no clerical error had occurred. An equitable adjustment of contributions will be made when the error or delay is discovered. If, an overpayment occurs in a Plan reimbursement amount, the Plan retains a contractual right to the overpayment. The person or Institution receiving the overpayment will be required to return the incorrect amount of money. In the case of a Plan Participant, the amount of overpayment may be deducted from future benefits payable

Fraud

Under this Plan, coverage may be retroactively canceled or terminated (rescinded) if a Participant acts fraudulently or intentionally makes material misrepresentations of fact. It is a Participant's responsibility to provide accurate information and to make accurate and truthful statements, including information and statements regarding family status, age, relationships, etc. It is also a Participant's responsibility to update previously provided information and statements. Failure to do so may result in coverage of Participants being canceled and such cancellation may be retroactive.

If a Participant, or any other entity, submits or attempts to submit a Claim for or on behalf of a person who is not a Participant of the Plan; submits a Claim for services or supplies not provided; provides false or misleading information relating to enrollment in the Plan; or provides any false or misleading information to the Plan regarding any element of its administration; that will be deemed as fraud. If a Participant is aware of any instance of fraud and does not provide that information to the Plan Administrator's attention, that will also be deemed as fraud. Fraud will result in immediate termination of all coverage under this Plan for the Participant and his or her Dependents.

A determination by the Plan that a rescission is warranted will be considered an Adverse Benefit Determination for purposes of review and Appeal. A Participant whose coverage is being rescinded will be provided a 30-Day notice period as described under The Patient Protection and Affordable Care Act (PPACA) and regulatory guidance. Claims Incurred after the retroactive date of termination shall not be further processed and/or paid under the Plan. Claims Incurred after the retroactive date of termination that were paid under the Plan will be treated as erroneously paid Claims under this Plan.

Headings
The headings used in this Plan Document are used for convenience of reference only. Participants are advised not to rely on any provision because of the heading.

No Waiver or Estoppel
All parts, portions, provisions, conditions and/or other items addressed by this Plan shall be deemed to be in full force and effect and not waived, absent an explicit written instrument expressing otherwise; executed by the Plan Administrator. Absent such explicit waiver, there shall be no estoppel against the enforcement of any provision of this Plan. Failure by any applicable entity to enforce any part of the Plan shall not constitute a waiver, either as it specifically applies to a particular circumstance, or as it applies to the Plan's general administration. If an explicit written waiver is executed, that waiver shall only apply to the matter addressed therein and shall be interpreted in the narrowest fashion possible.

Plan Contributions
The Plan Administrator shall, from time to time, evaluate the funding method of the Plan and determine the amount to be contributed by each Participant.

The Plan Sponsor will fund the Plan in a manner consistent with the provisions of the Internal Revenue Code and other applicable laws and regulations.

Notwithstanding any other provision of the Plan, the Plan Administrator's obligation to pay Claims otherwise allowable under the terms of the Plan shall be limited to its obligation to make contributions to the Plan as set forth in the preceding paragraph. Payment of said Claims in accordance with these procedures shall discharge completely the Employer's obligation with respect to such payments.

In the event that the Plan Sponsor terminates the Plan, then as of the effective date of termination, the Employer and eligible Employees shall have no further obligation to make additional contributions to the Plan and the Plan shall have no obligation to pay Claims Incurred after the termination date of the Plan.

Right to Receive and Release Information
The Plan Administrator may, without notice to or consent of any person, release to or obtain any information from any insurance company or other organization or person regarding coverage, expenses and benefits which the Plan Administrator, at its sole discretion, considers necessary to determine and apply the provisions and benefits of this Plan. In so acting, the Plan Administrator shall be free from any liability that may arise with regard to such action. Any Participant claiming benefits under this Plan shall furnish to the Plan Administrator such information as requested and as may be necessary to implement this provision.

Written Notice
Any written notice required under this Plan which, as of the effective date, is in conflict with the law of any governmental body or agency which has jurisdiction over this Plan shall be interpreted to conform to the minimum requirements of such law.

Right of Recovery
In accordance with the Recovery of Payments provision, whenever payments have been made by this Plan in a total amount, at any time, in excess of the Covered Expenses payable under this Plan, the Plan shall have the right to recover such excess payments, from any one or more of the following as this Plan shall determine: any person to or with respect to whom such payments were made, or such person's legal representative, any insurance companies, or any other individuals or organizations which the Plan determines are responsible for payment of such amount and any future benefits payable to the Participant or his or her Dependents. See the Recovery of Payments provision for full details.

Statements
All statements made by a Participant will, in the absence of fraud, be considered representations and not warranties. No statements made for the purpose of obtaining benefits under this document will be used in any contest to avoid or reduce the benefits provided by the document unless contained in a written application for benefits and a copy of the instrument containing such representation is or has been furnished to the Participant.

Any Participant who knowingly and with intent to defraud the Plan, files a statement of Claim containing any materially false information, or intentionally conceals information concerning any material fact, commits a Fraudulent act. The Participant may be subject to prosecution by the United States Department of Labor. Fraudulently claiming benefits may be punishable by a substantial fine, imprisonment, or both.

Protection Against Creditors
No Benefit payment under this Plan shall be subject in any way to alienation, sale, transfer, pledge, attachment, garnishment, execution or encumbrance of any kind and any attempt to accomplish the same shall be void. If the Plan Administrator shall find that such an attempt has been made with respect to any payment due or to become due to any Participant, the Plan Administrator in its sole discretion may terminate the interest of such Participant or former Participant in such payment. In such case the Plan Administrator shall apply the amount of such payment to or for the benefit of such Participant or former Participant, his/her spouse, parent, adult Child, guardian of a minor Child, brother or sister or other relative of a Dependent of such Participant or former Participant, as the Plan Administrator may determine and any such application shall be a complete discharge of all liability with respect to such Benefit payment. However, Benefit payments may be assigned to health care Providers in accordance with the Assignment of Benefits provisions of the Plan; however, no such Assignment of Benefits shall be construed as an assignment of any legal or equitable right to institute any court proceeding.

Unclaimed Self-Insured Plan Funds (Uncashed Checks)

In the event a benefits check issued by the Third-Party Administrator for this self-insured Plan is not cashed within one year of the date of issue, the check will be voided and the funds will be returned to this Plan and applied to the payment of current benefits and administrative fees under this Plan. In the event a Participant subsequently requests payment with respect to the voided check, the Third-Party Administrator for the self-insured Plan shall make such payment under the terms and provisions of the Plan as in effect when the Claim was originally processed. Unclaimed self-insured Plan funds may be applied only to the payment of benefits (including administrative fees) under the Plan.

Not a Contract

This Plan Document and any Amendments constitute the terms and provisions of coverage under this Plan. The Plan Document is not to be construed as an employment contract of any type between the Employer and any Participant or to be consideration for, or an inducement or condition of, the employment of any Employee. Nothing in this Plan Document shall be deemed to give any Employee the right to be retained in the service of the Employer or to interfere with the right of the Employer to discharge any Employee at any time

SECTION 4 ~ PROVIDER NETWORK

Knowing which medical Providers and facilities are considered Participating Providers will help You determine Your cost sharing obligations to pay for certain services. To receive the best financial benefits under this Plan, Participants must see a Participating Practitioner or Participating Provider for medical care, except in the case of an Emergency medical condition. Of course, You always have the right to receive medical services from any Provider at Your own expense.

Participating Practitioners and Participating Providers have a contract with NHAS to provide Covered Services at a discounted fee. Because of these discounted fees, it is more cost-effective for You to get services and treatment from a Participating Provider whenever possible. Participating Practitioners or Participating Providers will also obtain Prior Authorization from NHAS for Covered Services requiring it. If you are enrolled in an EPO plan, no Out-of-Network benefit will be listed on the Summary of Participant Responsibility and non-Emergency services are covered only when provided by a Participating Practitioner or Provider.

Non-Participating Providers do not have a contract with NHAS to provide Covered Services at a discounted fee. If You are enrolled in a POS plan and decide to get care from a Non-Participating Practitioner or Non-Participating Provider in a non-Emergency situation, You will pay more of the bill since Your Deductible and Coinsurance are significantly higher. If You are enrolled in a POS plan, Your Summary of Participant Responsibility will indicate Out-of-Network Benefits. Non-Participating Providers can also Balance Bill You for any amount that is over the Allowed Amount and the Balance Bill amount is Your financial responsibility. In addition, when Providers are Non-Participating, NHAS is unable to oversee the services they provide which limits its ability to ensure You receive quality care. If there is no In-Network Participating Provider for a particular service or supply and NHAS's utilization management determines that the service or supply is Medically Necessary, the Plan may cover the service or supply at In-Network rates and cost sharing if the Participant obtains Prior Authorization approval.

> ***IMPORTANT:*** *In receiving services from a Participating Practitioner or Participating Provider, a Non-Participating Provider may be utilized without Your knowledge. This sometime occurs for certain services such as laboratory, radiology, pathology or other ancillary services. In this situation, the Non-Participating Provider charges may be denied for being Out-of-Network. When this occurs, You may contact NHAS's Member Experience to indicate the Non-Participating Provider services were performed at an In-Network facility under direction of a Participating Practitioner.*

How Do Participants Find Out Which Providers are Participating Providers?

Employees Who Live Within NHAS's Service Area

Practitioners, Providers and facilities that are part of **NHAS's Provider network** are considered Participating Providers. NHAS has contracted with various Practitioners, Providers and facilities within its service area.

To learn if a specific Practitioner, Provider or facility is In-Network, go to **networkhealth.com**, click **Find a Doctor** and enter Your information. Under **Choose a Plan**, select **I get coverage through my employer**. You can also call the Member Experience phone number on the back of Your Participant ID card to get assistance with selecting a Participating Provider or request a paper copy of the directory.

Employees Who Live Outside NHAS's Service Area Enrolled in Network Extend

For covered Employees who live outside NHAS's Employer Service Area (**networkhealth.com/about/service-area** – Employer Service Area), this Plan provides Network Extend. This extended network is provided through a contract with a designated out-of-area network and allows these Participants to receive benefits under the Participating Practitioner or Provider In-Network cost sharing Benefit level. If You are enrolled in Network Extend, information is included in this packet to explain how to access this network.

Continuity of Care

There are certain situations where the Plan will protect the continuity of care You receive from Your Participating Provider if that Provider terminates from NHAS's Provider Network for reasons other than professional misconduct, as long as the Provider still practices in NHAS's service area.

a) **Primary Care Practitioner (PCP):** If the Practitioner is Your PCP and Your PCP's relationship with NHAS's Provider network ends, the Plan will treat Your PCP as a Participating Practitioner for the lesser of 90 Days after the PCP is no longer in NHAS's Provider network or end of the Plan Year.

b) **Specialty Care Physician (SCP)**
   If You are undergoing a current course of treatment with an SCP and Your SCP's relationship with NHAS ends, the Plan will treat Your SCP as a Participating Practitioner for the remainder of the course of treatment or 90 Days, whichever is shorter. A course of treatment could include, but is not limited to, the following.
   i. A doctor visit or hospital stay with documented changes in a therapeutic regimen for an acute illness. This is within 21 Days prior to the member's plan effective date or the health care provider's termination date
   ii. Recent major surgeries still in the follow-up period, that is generally six to eight weeks
   iii. Transplant candidates, unstable recipients or recipients in need of ongoing care due to complications associated with a transplant
   iv. Trauma
   v. Newly diagnosed or relapsed cancer in the midst of chemotherapy, radiation therapy or reconstruction
   vi. Pregnancy is considered "high risk" if mother's age is 35 years or older, or patient has or had;
      1. Early delivery (three weeks) in previous pregnancy
      2. Gestational diabetes – pregnancy induced hypertension

3. Multiple inpatient admissions during this pregnancy

vii. Pregnancy induced hypertension

c) **Maternity Care Practitioner**

If You are pregnant in Your second or third trimester and Your Maternity Care Practitioner's relationship with NHAS ends, the Plan will treat Your Maternity Care Practitioner as a Participating Provider for 90 Days after they are no longer in NHAS's Provider network. If You wish to see this Provider for **more than** 90 Days for Your obstetric and post-partum care, please contact NHAS utilization management department using the number on Your ID card to see if approval will be provided.

SECTION 5 ~ BENEFIT PROVISIONS

The Plan will cover health products and services set forth in this Section and any applicable Amendments. The Plan's coverage is subject to Participant cost sharing set forth in the Summary of Participant Responsibility Table/Summary of Benefits and Coverage.

> ***IMPORTANT:*** *Coverage for all health products and services are subject to the exclusions and limitations of this Plan.*

GENERAL BENEFIT PROVISIONS

The Plan will cover Medically Necessary health services for the prevention, Diagnosis, or treatment of a bodily Injury or Illness. The Plan will only cover services as set forth in the Plan Document that are Medically Necessary subject to the exclusions and limitations of this Plan. NHAS will use its normal Claims processing procedures to determine how each Claim will be processed and which Cost Sharing category the service falls under.

If services with a Participating Practitioner or Provider require Prior Authorization by NHAS, Your Practitioner or an authorized Provider is responsible for requesting a Prior Authorization for those services. However, You are responsible to verify that Prior Authorization is obtained when receiving services requiring Prior Authorization. You are responsible for requesting Prior Authorization for services with Non-Participating Practitioners and Non-Participating Providers.

You will receive a written notification as to whether Your Prior Authorization request is approved or denied. If you choose to proceed with services before you are notified of the authorization decision you may be financially liable for those services.

Your Practitioner, or PCP, is responsible for Your care.

> ***IMPORTANT:*** *NHAS must receive and approve all non-urgent, non-emergent Authorization requests prior to the services being furnished.*

> ***IMPORTANT:*** *The fact that the Plan covers evaluation for diagnosis does not imply coverage for resulting care or treatment. Benefit limitations and exclusions will apply.*

> ***IMPORTANT:*** *The fact that a Practitioner refers You or a covered Dependent for services or treatment does not mean or imply that the Plan will cover the services or treatment.*

AMBULANCE SERVICES

Emergency Transportation (No Prior Authorization Needed)

The Plan will cover ground or air ambulance transport for Emergency conditions by a licensed ambulance service. The Plan will pay for transport to the nearest facility that can furnish

Emergency Health Services. The Plan will cover non-Emergency transfer ambulance service that NHAS initiates without Participant cost sharing.

The Plan requires Prior Authorization of non-emergent facility-to-facility transfers by a licensed ambulance service (either ground or air ambulance). Approval may be determined appropriate by NHAS in advance when the transport is for any of the following.

a) From a Non-Participating Hospital to a Participating Hospital.
b) To a Hospital that provides a higher level of care that was not available at the original Hospital.
c) To a more cost-effective acute care facility.
d) From an acute facility to a sub-acute setting.

IMPORTANT: *Emergency Services provided by an ambulance service to a Participant is also covered, even if the unit does not provide transportation.*

Non-Emergency Transportation (Prior Authorization Required)

a) **Transportation From Non-Participating Hospital to Participating Hospital once patient is stabilized (non-Emergency):** If a Participant is admitted to a Non-Participating Hospital immediately after Emergency Services are received, the Plan will cover non-Emergency air or ground ambulance services to transport the Participant from the Non-Participating Hospital to the closest Participating Hospital that can provide the needed treatment once the patient's condition has been stabilized as certified by the patient's attending physician. The Plan may communicate with the facility to initiate the transfer. Prior Authorization is required.

b) **Facility to Facility Transfers (non-Emergency):** The Plan will cover air or ground ambulance services only to transport the Participant to or from a Hospital or between Hospitals for required treatment that is not available at the initial Hospital when such transportation is certified by the attending physician as Medically Necessary and the Plan Prior Authorizes the service. Such transportation is covered only from the initial Hospital to the nearest Participating Hospital qualified to render the special treatment when there is a receiving Participating Hospital within a reasonable distance from the initial Hospital. If not within a reasonable distance, the Plan will cover transportation from the initial Hospital to the nearest Nonparticipating Hospital. NHAS will determine what is reasonable.

IMPORTANT: *If You are admitted to a Non-Participating Hospital following an Emergency department visit as part of the review of the admission, NHAS's Utilization Management Department in collaboration with the attending physician will determine if You are medically stable, and if so, may arrange for Your mandatory transfer to a Participating Provider. Failure to agree to transfer to a Participating Hospital as required above will result in You being financially responsible for that portion of the charges of the Non-Participating Facility after the date transfer was supposed to occur. If You have Exclusive Provider Organization (EPO) coverage, You may be responsible for all charges after that date. If You have Point of*

Service (POS) coverage, Your out-of-network benefits may be applied to dates after the date transfer was to occur.

AUTISM SERVICES

The Plan will cover the treatment for the primary, verified Diagnosis of autism spectrum disorder if the treatment is evidence-based, prescribed and rendered by a Practitioner who is qualified to provide intensive-level or non-intensive-level services.

IMPORTANT: *Prescription medications and Durable Medical Equipment (DME) will not count toward the coverage limits noted below.*

IMPORTANT: *NHAS may require a second opinion of the Diagnosis triggering the autism treatment.*

Intensive-level Services

The Plan will provide coverage for evidence-based behavioral intensive-level services per Participant per year, with the Participant receiving at least 20 hours of therapy per week over a continuous six-month period of time for up to forty-eight (48) months. The forty-eight (48) months of intensive-level treatment will be treated as a cumulative amount. For example, a child who received twenty-four (24) months of intensive-level treatment under another health plan or the Medicaid waiver program would be entitled to another twenty-four (24) months of treatment under the Plan.

IMPORTANT: *The intensive-level services must begin after a Participant is two (2) years of age and before the Participant is nine (9) years of age.*

Non-Intensive-Level Services

The Plan will provide coverage for evidence-based behavioral non-intensive-level services for Participants not receiving intensive-level services.

IMPORTANT: *Non-intensive-level services must sustain and maximize gains made during intensive-level treatment or improve the Participant's condition.*

BREAST RECONSTRUCTION

The Plan will cover breast reconstruction related to a covered mastectomy. The Plan will pay for:

a) Reconstruction of the breast on which the mastectomy was performed.
b) Surgery and reconstruction of the other breast to produce an even appearance.
c) Prosthesis and treatment of physical complications at all stages of the mastectomy.

CANCER CLINICAL TRIAL

Routine Patient Care provided to a Participant during the course of treatment in a cancer clinical trial that are consistent with the usual and customary standard of care are covered by the Plan.

Coverage of Routine Patient Care during the course of treatment in a cancer clinical trial is limited to cancer clinical trials meeting all the following criteria.

a) A purpose of the trial is to test whether the intervention potentially improves the trial participant's health outcomes.
b) The treatment provided as a part of the trial is given with the intention of improving the trial participant's health outcomes.
c) The trial has therapeutic intent and is not designed exclusively to test toxicity or disease pathology.
d) The trial does one of the following:
    i. Tests how to administer a health care service, item or Drug for the treatment of cancer;
    ii. Tests responses to a health care service, item or Drug for the treatment of cancer;
    iii. Compares the effectiveness of health care services, items or Drugs for the treatment of cancer;
    iv. Studies new uses of health care services, items or Drugs for the treatment of cancer.
e) The trial is approved by one of the following:
    i. National Institute of Health, or one of its cooperative groups or centers, under the Federal Department of Health and Human Services;
    ii. Food and Drug Administration (FDA);
    iii. Federal Department of Defense;
    iv. Federal Department of Veteran Affairs.

CARDIAC REHABILITATION SERVICES

The Plan will cover Stage 1 (inpatient) and Stage 2 (outpatient monitored) cardiac Rehabilitation Services.

CHEMOTHERAPY

The Plan will cover chemotherapy administered orally, intravenously or by injection. Oral chemotherapy will not require a higher Copayment, Deductible or Coinsurance than is required for injected or intravenous chemotherapy.

CHIROPRACTIC SERVICES

The Plan will cover spinal adjustment and manipulation, x-rays for manipulation and adjustment and other modalities performed by a Provider.

Maximum Benefits: Benefits are limited to 20 visits per Participant per Plan Year.

COLORECTAL CANCER SCREENING

The Plan will cover colorectal cancer screening without cost sharing for a Participant following the USPSTF guidelines. Cost sharing will apply for Participants outside of the recommended age range and/or for services beyond the USPSTF guidelines.

> ***IMPORTANT:*** *Please refer to Your Preventive Services Guide for a listing of covered preventive colorectal cancer screening services.*

CONTRACEPTIVES

Benefits for contraceptive coverage and family planning include the following:

a) Voluntary sterilization procedures which include tubal ligations and vasectomies.
b) Food and Drug Administration approved contraceptives including over-the-counter (OTC) products, self-administered contraceptive medications and devices when listed in the Preferred Drug List and purchased from a Participating pharmacy with a valid prescription are covered at no cost.
c) The administration of approved female contraceptives in the Practitioner's office. The administration, insertion and removal of approved contraceptive devices, such as an intrauterine device (IUD) is covered at no cost.

Covered female contraceptive services will be provided at no Participant cost only if provided by a Participating Practitioner or Participating Provider. Vasectomies will be subject to cost share as outlined in the Summary of Participant Responsibility Table/Summary of Benefits and Coverage.

DENTAL CARE - HOSPITAL OR AMBULATORY SURGICAL CENTER

The Plan will cover Hospital or Ambulatory Surgical Center services, including anesthetics, for dental care furnished in the facility, if any of the following applies:

a) The Participant is a Child under the age of five;
b) The Participant has a chronic disability as defined by applicable state law;
c) The Participant has a medical condition that requires hospitalization or general anesthesia for dental care.

IMPORTANT: *The Plan does not cover dentist or oral surgeon charges for care provided under this section.*

DIABETES TREATMENT, EQUIPMENT AND SUPPLIES

The Plan covers diabetic equipment and supplies under;

- The medical benefit when furnished by Practitioners or Providers
- The prescription Drug benefit when purchased at an In-Network pharmacy

Coverage includes:

a) Equipment, such as glucometers
b) Continuous glucose monitors and supplies
c) The installation and use of insulin infusion pumps
d) Batteries to operate such equipment
e) Supplies, including insulin, syringes, test strips, alcohol and lancets

Diabetes outpatient self-management training, education and medical nutrition therapy services must be ordered by a Practitioner and provided by appropriately licensed or registered health care professionals.

IMPORTANT: *Benefits under this section also include medical eye examinations (dilated retinal examinations) and preventive foot care for Participants with diabetes.*

DIAGNOSTIC SERVICES

Coverage for Diagnostic Services includes, but is not limited to:

a) Bone density study (DEXA scan);
b) Cardiographic (EKG) and encephalographic (EEG);
c) CT (CAT) scan;
d) Diagnostic Tests as an evaluation to determine the need for a covered transplant procedure;
e) Echocardiogram;
f) Laboratory and pathology services;
g) Positron emission tomography (PET scan);
h) Radioisotope tests (nuclear cardiology imaging study);
i) Magnetic Resonance Angiography (MRA) and Magnetic Resonance Imaging (MRI);
j) Muscle and Neurological testing (EMG);
k) Sleep study;
l) Ultrasound/Doppler Ultrasound study; and
m) X-ray and other radiology services.

Certain laboratory tests for condition management of chronic diseases may be covered at a lower cost share. If applicable, this will be indicated in Your Summary of Participant Responsibility Table/Summary of Benefits and Coverage and applies to the following tests.

a) Hemoglobin A1C, urine microalbumin to creatinine ratio, basic metabolic panel;
b) Fasting lipid panel for diabetes mellitus type 1 or 2, Coronary artery disease, Cerebrovascular disease, hyperlipidemia/dyslipidemia/hypertriglyceridemia;
c) Basic metabolic panel for hypertension.

DURABLE MEDICAL EQUIPMENT (DME) AND DISPOSABLE MEDICAL SUPPLIES

The Plan will cover certain DME and disposable medical supplies. The Plan will cover these only when ordered by a Practitioner and purchased from a Provider in the NHAS Network unless the Participant is enrolled in a POS plan. The Plan will only cover DME rental costs up to the purchase price.

The Plan will only cover DME that meets all of the following criteria:

a) Able to withstand repeated use;
b) Ordered by a Practitioner for outpatient use primarily in a home setting;
c) Primarily and customarily used to serve a medical purpose rather than being primarily for comfort or convenience;
d) Generally, not useful to the Participant in the absence of a bodily Injury or Illness;

e) Appropriate for home use;
f) Appropriate for treatment of Your bodily Injury or Illness;
g) Provided in the most cost-effective manner required by Your condition, including, at the Plan's discretion, rental or purchase.

If more than one piece of Durable Medical Equipment can meet Your functional needs, Benefits are available only for the equipment that meets the minimum specifications for Your needs.

Covered DME and Disposable Medical Supplies

The Plan will cover DME in accordance with the requirements set out in the Plan Document. The Plan's coverage includes, but is not limited to, the following types of DME.

a) Apnea monitors;
b) Bone growth stimulator;
c) Burn garments;
d) Crutches and wheelchairs;
e) Delivery pumps for tube feedings (including tubing and connectors);
f) Electronic breast pumps – basic model only generally will apply to preventive Benefit;
g) External cochlear devices and systems. Benefits for cochlear implantation are provided under the Hearing Devices section of this SPD;
h) Home uterine monitors;
i) Insulin pumps and all related necessary supplies as described under the Diabetes Treatment, Equipment and Supplies section;
j) Lift mechanism only for chair lift;
k) Lymphedema (compression) stockings;
l) Mastectomy bras;
m) Mechanical equipment necessary for the treatment of chronic or acute respiratory failure;
n) Orthotic devices, including but not limited to:
    i. Back braces;
    ii. Custom made ankle and foot orthosis;
    iii. Thoracic lumbar orthosis;
o) Oxygen and oxygen related supplies and equipment;
p) Standard Hospital-type bed.

Benefits under this section also include speech aid devices and tracheo-esophageal voice devices required for treatment of severe speech impediment or lack of speech directly attributed to an Illness or Accident/Injury. Insulin infusion pumps are limited to one pump in a calendar year, and You must use the pump for thirty (30) Days before purchase.

Benefits under this section do not include any device, appliance, pump (excluding an insulin pump), machine, stimulator or monitor that is fully implanted into the body.

Benefits are available for repairs and replacement, except that:

a) Benefits for repair and replacement do not apply to damage due to misuse, malicious breakage or gross neglect.
b) Benefits are not available to replace lost or stolen items.

IMPORTANT: *Other than insulin infusion pumps as noted above, the Plan will cover DME repairs and replacement based on the average life of the product, as determined by NHAS.*

IMPORTANT: *To verify whether NHAS will cover a specific DME item or disposable medical supply, please contact Member Experience at the number located on the back of Your Participant ID card.*

EMERGENCY HEALTH SERVICES

The Plan will cover Emergency Health Services with Participating and Non-Participating Providers and Practitioners if rendered in an Emergency room. Benefits under this section include the facility charge, supplies and all professional services required to stabilize Your condition and/or initiate treatment.

IMPORTANT: *The Plan will not pay for care furnished outside the NHAS Service Area for the Participant's convenience unless Participant has POS coverage. This includes, for example, non-Emergency, non-Urgent Care for Participants who live outside the Service Area. Reference the Urgent Care Services provisions within this SPD for Benefits.*

IMPORTANT: *NHAS requires authorization if Your Emergency medical condition at a Non-Participating facility following Emergency Health Services requires You to transfer to an observation or inpatient bed. You are required to notify NHAS within forty-eight (48) hours or the next business day after Your transfer. Reference the In-patient Services - Hospital/Rehabilitation Facility provisions within this SPD for Benefits.*

IMPORTANT: *Follow-Up Care following Emergency Services once the patient has been stabilized and is no longer experiencing an Emergency medical condition, any future medical care needed related to this Emergency will be subject to the applicable cost-sharing obligations of the Participant, based on whether follow-up care is provided by a Participating or Non- Participating Provider. Follow-up care includes all services that are delivered after You are discharged from the Emergency department.*

FASTCARE® CLINIC BENEFIT
PREFERRED CLINIC BENEFITS

Covered Services

The following primary care services will be provided at lower cost share as indicated on the Summary of Participant Responsibility (SOPR) when received at a Froedtert FastCare® Clinic location.

- Annual wellness visit
- Allergies
- Bladder infections (females 12 years and older)

- Bronchitis
- Chronic disease management
- Cold and flu symptoms
- Cold sores
- Ear infection
- Electronic prescriptions and refills
- Headache
- Immunizations
- Impetigo
- Insect bites
- Laryngitis
- Migraine
- Minor burns
- Minor cuts
- Mononucleosis
- Musculoskeletal aches and strains
- Nebulizer treatments (Albuterol)
- Physicals (camp, school, sport)
- Pink eye
- Poison ivy
- Rashes
- Respiratory infections
- Ringworm
- Sinus infections
- Sore throat
- Sprains
- Sports physical
- Sunburn
- Swimmer's ear
- TB skin testing
- Upper respiratory infections
- Urinary tract infection
- Wart removal
- Yeast infection

Designated laboratory tests performed at these preferred clinics will be covered as part of the Office Visit with no additional cost share applied. These include CPT codes 88000-88749 when done in connection with a preventive visit. CPT codes 81002 – 87880 are covered for the following laboratory services.

- Mononucleosis test
- Pregnancy test

- Rapid influenza
- Rapid strep
- Urinalysis

GYNECOLOGICAL CARE

The Plan will cover gynecological services without a referral, including annual exams.

HEARING DEVICES

The Plan covers the cost of Diagnoses, procedures, surgery and therapy related to cochlear implants or hearing aidsfor a covered Participant who is under 18 years of age and certified as deaf or hearing impaired by a Practitioner or audiologist, during the time they are covered under this Plan.

Benefits are provided for covered hearing devices and charges for associated fitting and testing. The Plan covers the cost of basic hearing aids limited to one hearing device per ear, including repair or replacement, once every three years up to age 18. The Plan covers the cost of one bone anchored hearing aid per Participant who meets the following requirements:

a) For Participants with craniofacial anomalies whose abnormal or absent ear canals preclude the use of a wearable hearing aid.
b) For Participants with hearing loss of sufficient severity that it would not be adequately remedied by a wearable hearing aid.

HOME HEALTH CARE SERVICES

The Plan covers Home Health Care services only when each of the following applies:

a. A licensed home care program furnishes the services in Your home.
b. The services provided are skilled nursing or Rehabilitation Services.
c. A Practitioner orders, supervises and reviews the care every two (2) months. The Practitioner may determine that a longer period between reviews is sufficient.

The Plan will cover up to 50 visits in a Benefit Year. Each consecutive four (4) hour period that a home health aide provides services is one (1) visit. A Practitioner in NHAS's network must order the services unless you have coverage under a POS plan.

IMPORTANT: *Physical, occupational and speech therapy rendered in the home will apply to the Home Health Care visit maximum.*

IMPORTANT: *Nursing or Rehabilitation Services may be Palliative Care as long as the services are not Custodial. You do not have to be home-bound to receive services.*

IMPORTANT: *Nursing services for the administration of injectable medications, including infusions, given in the home are not counted toward the home health visit limit.*

IMPORTANT: *A service will not be determined to be "skilled" nursing or rehabilitation simply because there is not an available caregiver.*

HOME INFUSION SERVICES

The Plan covers home infusion services only when a licensed home care or home infusion program furnishes the services in Your home or at their infusion center.

HOSPICE CARE

The Plan covers Hospice care if:

a) Your Practitioner certifies You or Your covered Dependent's life expectancy is about six months; and
b) The care is Palliative;
c) The Hospice Care is received from a licensed Hospice agency; and
d) Hospice Care Services are provided according to a written care delivery plan developed by a Hospice care Provider and by the recipient of the Hospice Care services.

Hospice care services include but are not limited to:

a) Practitioner services;
b) Nursing care;
c) Respite care,
d) Medical and social work services;
e) Counseling services;
f) Nutritional counseling;
g) Pain and symptom management;
h) Medical supplies and Durable Medical Equipment;
i) Occupational, physical or speech therapies;
j) Volunteer services;
k) Home Health Care services;
l) Bereavement services.

IMPORTANT: *Respite care can be provided only on an occasional basis (once per 60 Days) and will not be reimbursed for more than five (5) consecutive Days at a time.*

IMPORTANT: *Services may be furnished in a Hospice facility housed in a Hospital, a separate Hospice unit or in Your home. A Hospice facility housed in a Hospital must be in a separate and distinct area.*

INPATIENT SERVICES – HOSPITAL/REHABILITATION FACILITY

The Plan covers inpatient services and supplies furnished in a licensed Hospital or rehabilitation facility. NHAS must receive all details concerning Your care and proposed plan of care. The Plan will cover the cost of a Semi-Private room. The Plan will cover care in a private room or intensive or coronary care facility only if Medically Necessary.

You are responsible to obtain Prior Authorization when receiving services from a Non-Participating Provider. You must notify NHAS within forty-eight (48) hours or the next business day of any inpatient admissions following an Emergency department visit. If You are unable to notify NHAS within this time period because You are incapacitated, You are required to notify NHAS within forty-eight (48) hours or the next business day upon being capable of such notification. NHAS's Utilization Management Department will review the admission within two business days of notice. NHAS will notify You and Your treating Practitioner and/or Provider of authorization approval or authorization denial of any continued stay.

The Plan covers prescription Drugs furnished by a Provider during an Inpatient Stay. Any prescription Drugs taken home or needed following release from confinement will be subject to the terms and cost sharing of Your pharmacy Benefits described later in this document and on the Summary of Participant Responsibility document.

IMPORTANT: *In addition to the notification requirement and Prior Authorization process described above, if You are admitted to a Non-Participating Hospital following an Urgent Care or Emergency department visit and have an EPO plan, as part of the review of the admission, NHAS's Utilization Management Department in collaboration with the attending physician will determine if You are medically stable, and if so, may arrange for Your mandatory transfer to a Participating Provider.* ***Failure to agree to transfer or failure to notify NHAS of your admission to a Non-Participating Hospital as required above will result in You being financially responsible for that portion of the charges of the Non-Participating Facility attributable to the delay. Because there is no contract between the Non-Participating Facility and NHAS, that amount could be significant.***

IMPORTANT: *If Your Effective Date of coverage under the Plan occurs during a hospitalization, the prior carrier is responsible for covered facility charges if billed as a bundled charge called a Diagnosis Related Group (DRG). However, if the facility charges are not submitted as a DRG claim or the prior carrier declines to pay it as such, the Plan will only be responsible for charges incurred while You were a Participant under the Plan. If Your coverage under the Plan terminates during a hospitalization, the Plan is responsible for covered facility charges through discharge if billed as a DRG. The Plan is only responsible for non-facility charges that are Covered Services during the actual time You are a Participant under the Plan.*

KIDNEY DISEASE SERVICES

The Plan will cover chronic renal failure. Coverage includes

a. Dialysis;
b. Transplantation (see Organ and Tissue Transplant Services below in this section); and Services related to donation when the recipient is a Plan Participant.

MAMMOGRAPHY SERVICES

The Plan will cover low dose screening mammography exams, including 3D mammograms, administered by a Provider. Mammograms can fall under the Preventive Services category for

routine mammograms, or mammograms can be diagnostic in nature in which case cost sharing applies.

MATERNITY AND NEWBORN CARE

Maternity Care

The Plan covers routine maternity care. Routine services covered include:

a. Monthly visits up to twenty-eight (28) weeks gestation;
b. Biweekly visits from twenty-nine (29) to thirty-six (36) weeks gestation;
c. Weekly visits after thirty-six (36) weeks until delivery;
d. Delivery in a Hospital;
e. Post-Partum care. Such care includes Hospital and office visits.

The Plan will pay Benefits for an Inpatient Stay of at least:

a. Forty-eight (48) hours for the mother and newborn child following a normal vaginal delivery;
b. Ninety-six (96) hours for the mother and newborn child following a cesarean section delivery.

If the mother agrees, the attending Practitioner may discharge the mother and/or the newborn child earlier than these minimum time frames.

IMPORTANT: *Participant cost sharing may apply to office visits for services provided in a complicated pregnancy. See Your Summary of Participant Responsibility Table/Summary of Benefits and Coverage.*

IMPORTANT*: The initial office visit is generally considered to be a Diagnostic Service and not maternity care. Therefore, it may be billed as a diagnostic office visit, separate from other maternity care and Your applicable plan provisions and cost sharing will apply.*

IMPORTANT: *Please notify NHAS's Care Management Department of Your pregnancy during Your first trimester.*

IMPORTANT: *For continuity of their care, Participants new to the plan and in their third trimester of Pregnancy (the third trimester starts at 26 weeks gestation) may continue to receive obstetric care from their Non-Participating Practitioner and/or a Non-Participating Provider if the care is Prior Authorized. Participants in their first or second trimester (starting at conception through 25 completed weeks gestation) upon initial enrollment must transition to a Participating Practitioner and/or Provider if enrolled in an EPO plan. Prior Authorization of Non-Participating obstetrical services does not extend to care for the infant.*

Newborn Care

The Plan will cover newborn expenses as follows if the newborn is properly enrolled in this Plan within thirty-one (31) Days of birth as stated in the Special Enrollment provision in this Plan Document.

Covered Expenses include:

a) Initial examination of a newborn by the delivery physician.
b) Care for routine nursery charges for a newborn Child while the mother is confined in the Hospital.
c) If the enrolled newborn needs to stay in the Hospital after the mother is released from the Hospital, the mother or Provider must call NHAS to get Prior Authorization for the newborn's Hospital stay.
d) Circumcisions.

IMPORTANT: *Remember to enroll Your newborn in this Plan within thirty-one (31) Days of birth if the baby needs to be covered under this Plan*

IMPORTANT: *If the newborn is not enrolled in this Plan within the timelines allowed in the Special Enrollment provision, then the parents will be financially responsible for all costs for the newborn.*

MENTAL HEALTH AND SUBSTANCE ABUSE SERVICES

The Plan will cover services for Mental Health Disorders and Substance Abuse Disorders. The Plan's coverage includes care related to mental health, alcoholism, chemical dependency or Drug addiction.

Outpatient Benefits

The Plan covers office, clinic, intensive outpatient therapy and outpatient Hospital visits. If necessary, for the Participant's treatment, the Employee and his/her Dependents covered under the Plan may obtain these outpatient benefits.

Inpatient Benefits

The Plan will cover inpatient Mental Health Disorder and Substance Abuse Disorder services furnished in appropriately licensed facility such as a Hospital, Rehabilitation Facility or other licensed facility. The Plan will cover the cost of a Semi-Private room. NHAS must receive all details concerning the Participant care and proposed plan of care.

You are responsible to obtain Prior Authorization when receiving services from a Non-Participating Provider. You must notify NHAS within forty-eight (48) hours or the next business day of any inpatient admissions following an Emergency department visit. If You are unable to notify NHAS within this time period because You are incapacitated, You are required to notify NHAS within forty-eight (48) hours or the next business day upon being capable of such notification. NHAS's Utilization Management Department will review the admission within two (2) business days of notice. NHAS will notify You and Your treating Practitioner and/or Provider of authorization approval or authorization denial of any continued stay.

IMPORTANT: *In addition to the notification requirement and Prior Authorization process described above, if You are admitted to a Non-Participating Hospital following an Urgent Care or Emergency department visit, as part of the review of the admission, NHAS's Utilization Management Department in collaboration with the attending physician will determine if You are medically stable, and if so, may arrange for Your mandatory transfer to a Participating Provider.* ***Failure to agree to transfer or failure to notify NHAS of Your admission to a Non-Participating Hospital as required above will result in You being financially responsible for that portion of the charges of the Non-Participating Facility attributable to the delay. Because there is no contract between the Non-Participating Facility and NHAS, that amount could be significant.***

IMPORTANT: *If Your Effective Date of coverage under the Plan occurs during a hospitalization, the prior carrier is responsible for covered facility charges if billed as a bundled charge called a Diagnosis Related Group (DRG). However, if the facility charges are not submitted as a DRG claim or the prior carrier declines to pay it as such, the Plan will only be responsible for charges incurred while You were a Participant under the Plan. If Your coverage under the Plan terminates during a hospitalization, the Plan is responsible for covered facility charges through discharge if billed as a DRG. The Plan is only responsible for non-facility charges that are Covered Services during the actual time You are a Participant under the Plan.*

The Plan will cover court-ordered services for Mental Health Disorders and Substance Abuse Disorders. If a Non-Participating Practitioner or a Non-Participating Provider furnishes these Emergency court-ordered services, the Provider, Participant or Participant's representative must notify NHAS within forty-eight (48) hours or next business day after services begin. The Plan will not cover the services without notice.

IMPORTANT: *The Plan covers services for Emergency Mental Health Disorders and Substance Abuse Disorders regardless of where the crisis occurs. The Plan covers services for persons experiencing a mental health crisis or in a situation that, if left untreated, would likely become a crisis without proper support.*

Transitional Care

The Plan covers Transitional Care services for Mental Health Disorders and Substance Abuse Disorders including treatment in a Residential Treatment Facility and intensive outpatient therapy. The Plan will cover Transitional Care in a Residential Treatment Facility as an inpatient Benefit (as described above). The Plan will cover Transitional Care furnished as intensive outpatient therapy as an outpatient Benefit (as described above).

OBESITY TREATMENT

The Plan will cover diet counseling for Obesity, which is a Body Mass Index (BMI) of thirty (30) or higher.

ORAL SURGERY

The Plan will cover oral Surgery for medical conditions such as the following.

a) Excision of tumors and cysts of the jaws, cheeks, lips, tongues, roof and floor of the mouth;
b) Surgery needed to correct Accidental Injuries to the jaws, cheeks, lips, tongue, floor and roof of the mouth;
c) Excision of benign bony growths of the jaw and hard palate;
d) External incision and drainage of cellulites;
e) Functional osteotomies;
f) Alveolectomy or alveoplasty for treatment related to an Illness or Injury;
g) Frenectomy (incision of the membrane connecting the lip to the jaw or the tongue to the floor of the mouth); and
h) Incision of sensory sinuses, salivary glands or ducts.

ORGAN AND TISSUE TRANSPLANT SERVICES

The Plan covers the following organ and tissue transplant services: medical, surgical and Hospital services and costs related to obtaining organs. This includes services required to perform the following human organ or tissue transplants.

a) Heart
b) Liver
c) Liver/Intestine
d) Pancreas
e) Bone marrow (autologous self to self or allogenic other to self)
f) Kidney
g) Heart/Lung
h) Single lung
i) Bilateral sequential lung
j) Corneal
k) Kidney/Pancreas
l) Intestinal
m) Re-transplantation for the treatment of bone marrow or kidney disease.
n) Immuno-suppressive or anti-rejection medications. These Drugs must be for an approved transplant.
o) Health services for a Participant's organ donor including, but not limited to, compatibility testing for live donors. Donor costs directly related to organ removal are Covered Services for which Benefits are payable through the organ recipient's coverage under this Plan. These costs are subject to the Coordination of Benefits provision in this document.

OSTOMY SUPPLIES

Benefits for ostomy supplies are limited to the following:

a) Pouches, face plates and belts.
b) Irrigation sleeves, bags and ostomy irrigation catheters.
c) Skin barriers.

OUTPATIENT HOSPITAL OR AMBULATORY SURGICAL SERVICES

The Plan covers outpatient Hospital services such as cardiac rehabilitation, radiation therapy, dialysis, behavioral health and substance abuse. The Plan also covers surgical procedures at an outpatient Hospital or Ambulatory Surgical Center.

PRESCRIPTION DRUG BENEFITS

Participating Pharmacies:

Express Scripts® Inc. (ESI) is the Pharmacy Benefit Manager. To find out which pharmacies are considered Participating pharmacies with ESI, go to **networkhealth.com** and click on **Find a Pharmacy**. This will allow You to look up a pharmacy by pharmacy name, city/state or zip code. Only Participating pharmacies will be shown.

Specific Covered Services

Covered prescription Drug Benefits provided under this Plan include Food and Drug Administration (FDA) approved prescription Drugs dispensed under the guidelines in NHAS's Preferred Drug List (PDL) as applicable, and are:

a) Dispensed according to the prescription written by an appropriately licensed Practitioner;
b) Prescription Drugs not designated as Specialty Products filled at or administered by a Participating pharmacy, Practitioner's office, home infusion in the home, infusion center, outpatient facility or Participating Mail Order Pharmacy Program that is appropriately licensed to dispense prescription Drugs in the United States by the Federal Drug Enforcement Agency and the state;
c) Designated as a Specialty Product and dispensed at a Participating Specialty pharmacy or administered by a participating pharmacy, Practitioner's office, home infusion, in the home, infusion center or outpatient facility;
d) Received in full compliance with the provisions of this Plan document;
e) Medically Necessary and appropriate.

Prescription drugs, including Specialty Products which are subject to a Participant Copayment or Coinsurance and subject to Deductible and/or Out-of-Pocket as specified in your Summary of Participant Responsibility document, shall be covered under this Plan.
In addition:

a) **Retail pharmacy:** Prescription Drugs, contraceptives, insulin, diabetic supplies, therapeutic vaccines, immunotherapy and chemotherapy prescribed by a NHAS Participating or Non-Participating Provider and dispensed through a NHAS Participating retail pharmacy or administered in the outpatient or home setting. All prescriptions or

refills can be dispensed in quantities up to a 90-Day supply. Copayment is required for each 30-Day supply. Contraceptives including over-the-counter (OTC) products listed in the Preferred Drug List can be filled at no cost; and contraceptives administered in the office for contraceptive purposes are covered at no cost.

b) **Express Scripts® Inc. (ESI) Mail Order Pharmacy:** Prescription Drugs, contraceptives, insulin, diabetic supplies, therapeutic vaccines, immunotherapy and chemotherapy prescribed by a NHAS Participating or Non-Participating Provider and dispensed through ESI's mail-order pharmacy in quantities up to a 90-Day supply. Contraceptives including over-the-counter (OTC) products listed in the Preferred Drug List can be filled at no cost. Note that Preferred Specialty Products and Non-Preferred Specialty Products are not available through the mail-order pharmacy.
c) **Specialty** prescriptions or refills can be dispensed through a NHAS Participating specialty pharmacy in quantities up to a 30-Day supply

Limitations

Prescription Drug Benefits are subject to the following limitations.

a) Initial prescriptions or prescription refills obtained from a Participating Retail pharmacy, Participating Specialty pharmacy or Participating Mail Order pharmacy will be covered up to the limits outlined in the Summary of Participant Responsibility in accordance with directions from the prescribing Practitioner.
b) If the practitioner indicates "Dispense as Written" or if the Participant requests a brand name product for the prescription Drug when an NHAS approved generic is available, the Participant must pay the applicable Copayment or Coinsurance plus the Ancillary Fee. The Ancillary Fee is the cost difference between the brand name product and the generic product up to a maximum of $200 per one-month supply. The Ancillary Fee will not count towards the combined medical and pharmacy Deductible and/or Out-of-Pocket Limit. When generic substitution conflicts with state regulations or restrictions the pharmacist must gain approval from the prescribing Practitioner to use the generic equivalent.
c) Any monetary amount of the Prescription Drug Product covered by Copay Assistance Card will not apply towards the Deductible and/or Out-of-Pocket Limit.
d) Prescription refills are covered only after seventy-five percent (75%) of the previously dispensed amount is used.
e) In Emergency conditions, prescription Drugs may be dispensed by a Non-Participating pharmacy. You may be required to pay the difference between what You pay for the prescription Drug at the Non-Participating pharmacy and the cost that would be covered at a participating pharmacy.
f) Prescription Drugs for the treatment of HIV will be covered if they are prescribed by an appropriately licensed Practitioner and, either

i. Approved by the FDA; or
ii. In or have completed Phase 3 of the FDA's clinical evaluation and are administered under a protocol approved by the FDA.

g) Certain prescription Drugs (agents, medications, components) are determined and listed by NHAS's Pharmacy and Therapeutics (P&T) Committee to have an increased potential for improper use, misuse, or abuse. These prescription Drugs require Prior Authorization by NHAS. A listing of the prescription Drugs is provided to NHAS Participating Practitioners. Participants can access the listing of prescription drugs on **networkhealth.com**. Prior Authorization must be requested by the Participant or his/her treating Practitioner before the prescription Drugs will be considered covered under this Plan. Prescription Drugs may be removed from the list and other prescription Drugs may be added at any time based on the decisions of the P&T Committee.
h) Prescription Drugs categorized as self-administered injectables may be authorized for a one-time teaching dose in a participating prescriber's office. Future fills may be required to be obtained at a participating pharmacy.
i) Products designated as Specialty Products on NHAS's Preferred Drug List will be covered subject to the terms and limitations specified in Your Summary of Participant Responsibility document.
j) Prescription Drugs given during a Hospital stay or outpatient visit will be an Eligible Expense under the inpatient or outpatient Benefit.
k) Medications that can be self-administered, such as certain injections, will require the prescription Drug be obtained through the pharmacy Benefit and will not be covered under the medical Benefit. Exceptions to this coverage rule will require supporting documentation from the Provider.
l) SaveOn SP products will not count toward Deductible and Out-of-Pocket Limit.

Definitions

a) **Specialty Product:** NHAS's P&T Committee may designate pharmaceutical products as Preferred Specialty or Non-preferred Specialty Products. These products will be covered as set forth in the Summary of Participant Responsibility/Summary of Benefits and Coverage. Pharmaceutical products that have been designated as Specialty Products will be indicated on the PDL that Participants can receive upon request.
b) **Over-the-Counter Drugs:** An over-the-counter Drug is a product with ingredient(s) that are available without a prescription.
c) **Smart Choice:** Limited to specific prescription Drugs to treat certain conditions. Pharmaceutical products that have been designated as Smart Choice prescription Drugs will be listed in your Summary of Participant Responsibility/Summary of Benefits and Coverage.

d) **Drug Tiers:** Classification relating to Participant cost for a group of prescription Drugs based on their cost and effectiveness. Tiers and the corresponding cost to the Participant are covered as set forth in Summary of Participant Responsibility/Summary of Benefits and Coverage .
    i. TIER 0 DRUGS: Preventive and Smart Choice Drugs if available on plan. (Smart Choice will be indicated as Tier 0 on the pharmacy benefits Summary of Participant Responsibility document)
    ii. TIER 1 DRUGS: Prescription Drug consisting primarily of generic prescription Drugs based on their effectiveness and cost.
    iii. TIER 2 DRUGS: Prescription Drugs consisting of preferred prescription Drugs based on their effectiveness and cost.
    iv. TIER 3 DRUGS: Prescription Drugs consisting of non-preferred prescription Drugs based on their effectiveness and cost.
    v. TIER 4 DRUGS: Prescription Drugs consisting of preferred specialty prescription Drugs based on their effectiveness and cost.
    vi. TIER 5 DRUGS: Prescription Drugs consisting primarily of non-preferred specialty prescription Drug products.
e) **Preventive Drugs:** Prescription Drugs and over-the-counter Drugs that are used for the prevention of certain medical conditions.
f) **Participating Retail Pharmacy, Participating Mail Order Pharmacy, and Participating Specialty Pharmacy:** A pharmacy that has a contract to provide Benefits to You or Your covered Dependents under this Plan.
g) **SaveOnSP Program*:*** Coverage for certain specialty pharmacy Drugs considered non-Essential Health Benefits are not subject to the Out-of-Pocket Limits set under the Affordable Care Act. That means your cost share amount is not limited in the manner described in the Tiers under this Plan document, and the cost share amounts do not apply toward your Out-of-Pocket Limit. The SaveOn Program is a voluntary program. The SaveOn Program provides Participants who choose to enroll the opportunity to get certain specialty pharmacy Drugs that are not covered as an Essential Health Benefit at no additional Out-of-Pocket cost. If You are prescribed a Drug covered under the SaveonSP program, You will be contacted to enroll in the program. If You choose to enroll in the SaveOn program, You will incur no cost for these Drugs and the cost share will not be applied towards satisfying the Out-of-Pocket Limit. Participants who decline to enroll will be responsible for the entire cost share, which will not be applied to the Out-of-Pocket Limit. A listing of the cost share amounts may be found at **networkhealth.com/saveon-drug-list.**
h) **Self-Administered Injectable:** An injectable prescription Drug that can be administered in a home setting.

Notes

a) Prescriptions dispensed through a Non-Participating pharmacy are **not covered**, unless otherwise approved by the Plan for a Participant's Emergency medical condition.

Prior Authorization Requirements on Prescription Drugs

Certain Drugs (agents, prescription Drug, components) are determined and listed by the Pharmacy and Therapeutics Committee to have an increased potential for improper use, misuse or abuse. Listings of these Drugs are provided to Participants upon request by calling the Member Experience Team phone number on the back of Your ID card. Prior Authorization must be requested by the Participant or their treating Provider before the Drugs will be considered for coverage under the Plan. Drugs may be deleted from the list and other Drugs may be added at any time based on the decisions of the Pharmacy & Therapeutics Committee.

PREVENTIVE SERVICES

The Plan will cover routine evaluation and management of Your health including routine immunizations. A Practitioner in NHAS's network must furnish these services to be covered at no Participant cost share.

The Plan pays for:

a) Evidence-based items or services that the United States Preventive Services Task Force recommends as a grade "A" or "B" in the current recommendations;
b) Routine Immunizations as recommended and determined to be routine for use by the Centers for Disease Control and Prevention (CDC) Advisory Committee on Immunization Practices (ACIP);
c) Preventive services including routine screenings for infants, children and adolescents as recommended by the comprehensive guidelines supported by the Health Resources and Services Administration;
d) Well visit for adults and preventive childcare exams for school, camp and sports when done as part of the annual wellness visit.
e) Preventive Services for women as provided for in the comprehensive guidelines supported by the Health Resources and Services Administration. Benefits defined by the Health Resources and Services Administration include comprehensive lactation support and counseling by a trained Provider during pregnancy and/or in the postpartum period. Coverage includes the costs for the rental of breastfeeding equipment. This Benefit does not include coverage for routine pregnancy, delivery and newborn charges.

For a list of covered preventive services, log in to Your NHAS account at **login.networkhealth.com** and click on **My Materials** to find a link to the Preventive Services Guide. Please refer to this website often, as We have full discretionary authority to change it from time to time without notice to You.

PROSTHETIC DEVICES

The Plan covers prosthetic devices that replace a limb or a body part each Benefit Year, limited to:

a) Artificial arms, legs, feet and hands;
b) Artificial face, eyes, ears and nose;
c) Breast prosthesis.

If more than one prosthetic device can meet Your functional needs, Benefits are available only for the prosthetic device that meets the minimum specifications for Your needs. The prosthetic device must be ordered or provided by, or under the direction of a Practitioner.

PROVIDER AND PRACTITIONER SERVICES

The Plan will cover Provider and Practitioner services for the prevention, Diagnosis or treatment of a bodily Injury or Illness. For example, the Plan will cover the following types of services.

a) Physical exams, office visits and procedures, Hospital and home visits;
b) Administration of Drugs, immunizations, allergy testing and injections
c) Surgery
d) Hearing acuity testing
e) Lead poisoning screenings
f) Skilled Nursing Facility and residential visits;
g) Anesthesiology services;
h) Laboratory, radiology and other Diagnostic Services and testing
i) Chemo and radiation therapy;
j) Foot care limited to metabolic or peripheral disease or if skin or tissue is infected;
k) Palliative Care services
l) Inpatient rehabilitation facility or Alternate Facility;
m) Scopic procedures including arthroscopy, laparoscopy, bronchoscopy and hysteroscopy
n) Tests to determine the existence of a gender-linked genetic disorder
o) Covered Services include medical education services provided in a Practitioner's office by appropriately licensed or registered healthcare professionals when both of the following are true:
    i. Education is required for a disease in which self-management is an important component of treatment.
    ii. There exists a knowledge deficit regarding the disease which requires the intervention of a trained health professional.

IMPORTANT: *All services are subject to any terms, conditions, limitations, restrictions and exclusions in this Certificate/Policy.*

RECONSTRUCTIVE PROCEDURES

The Plan will cover Reconstructive Procedures and related Covered Services as necessary.

a) To treat a bodily Injury or Illness or a congenital disease or anomaly that causes a functional bodily impairment.

b) To improve or repair an abnormal condition of a body part that is the result of, or incidental to, a Surgery done on that part. This applies only if the initial Surgery was for the Diagnosis or treatment of a Covered Service.
c) For breast reconstruction due to a Mastectomy as stated above.

REHABILITATION SERVICES - OUTPATIENT

The Plan will cover a total of 60 outpatient visits from any combination of the following categories per Benefit Year:

a) Occupational therapy
b) Speech therapy
c) Physical therapy
d) Pulmonary rehabilitation therapy

The Plan will only pay for such services if they:

a) Significantly restore function lost due to a covered Illness or bodily Injury;
b) Provide either
    i. Training in the use of covered prosthetic or orthopedic devices; or
    The ability to care for oneself while restoring the function lost under a) above. This includes feeding, toilet activities and ambulation.

Rehabilitation Services must be performed by a Practitioner or by a licensed therapy Provider. Benefits under this provision include Rehabilitation Services provided in a Practitioner's office or on an outpatient basis at a Hospital or Alternate Facility.

Services may not be covered if the Participant is no longer making progress in meeting therapeutic goals or whose treatment goals have been met.

Please note that the Plan will pay Benefits for speech therapy for the treatment of disorders of speech, language, voice, communication and auditory processing only when the disorder results from Injury, stroke, cancer, or Congenital Anomaly. For speech therapy with relation to autism spectrum disorders, please refer to the services described under provision "Autism Services."

ROUTINE PATIENT CARE FOR APPROVED CLINICAL TRIAL

"Approved Clinical Trial" means a study conducted by a Participating Provider, Practitioner or Hospital that is performed to determine if a treatment, procedure, Drug (or combinations of Drugs), or device which might be considered Unproven, Experimental, Investigational, or for Research Purposes or not Medically Necessary may be considered clinically safe and effective to treat the life-threatening disease or condition of the Qualified Member. Only studies approved or funded by the federal governmental agencies listed below will be considered an "Approved Clinical Trial":

a) National Institutes of Health (NIH) Centers for Disease Control and Prevention
b) Agency for Health Care Research and Quality
c) Centers for Medicare and Medicaid Services
d) U.S. Department of Defense

e) U.S. Department of Veterans Affairs
f) U.S. Department of Energy

In addition to the above, a study conducted under an investigational new Drug application reviewed by the Food and Drug Administration (FDA) may also be considered an Approved Clinical Trial, as well as a study or investigation of a drug trial that is exempt from having such an investigational new drug application.

"Qualified Member" means a Member who:
a) Is eligible for coverage and enrolled in this Policy;
b) Has been diagnosed with cancer or another life-threatening disease or condition;
c) Is accepted into an Approved Clinical Trial; and
d) Has received Prior Authorization to participate in the Approved Clinical Trial from Network Health Plan.

In general, We do not cover medical or surgical procedures or devices that are not Medically Necessary or considered Unproven, Experimental, Investigational or for Research Purposes. However, You may ask for Prior Authorization to be part of Experimental or Investigational care. NHP may cover certain routine medical costs for qualified Members who participate in Approved Clinical Trials.

We do not have an obligation to cover certain items and services that are not Routine Patient Care, as determined by the Affordable Care Act, even when You incur these costs while in an Approved Clinical Trial. Costs excluded from coverage under Your Policy include:
a) The treatment, procedure, Drug (or combinations of Drugs), or device which is being tested if We consider it to be Unproven, Experimental, Investigational, or for Research Purposes or not Medically Necessary;
b) Items and services solely for purposes of data collection and analysis and not for direct clinical treatment or management of the patient;
c) Any service that is clearly inconsistent with widely accepted and established standards of care for a particular Diagnosis.

For Covered Services related to an Approved Clinical Trial, cost sharing will apply the same as if the service were not specifically related to an Approved Clinical Trial.

Second Opinion

The Plan will cover a second opinion from a board-certified specialist in the medical field relating to the treatment being proposed for You. The physician giving the second opinion must be a Participating Provider but not be affiliated in any way with the Provider who rendered the first opinion and may not furnish care or perform any procedure at the time of the evaluation.

SKILLED NURSING FACILITY (SNF) SERVICES

Services and supplies provided during an Inpatient Stay in a licensed Skilled Nursing Facility (SNF). Benefits are available for:

a) Supplies and non-Practitioner services received during the Inpatient Stay;
b) Daily (or swing bed) room and board in a Semi-Private Room.

Skilled Care is skilled nursing, skilled teaching and skilled Rehabilitation Services when all of the following are met:

a) It must be delivered or supervised by licensed technical or professional medical personnel in order to obtain the specified medical outcome, and provide for the safety of the Participant;
b) It is ordered by a Practitioner;
c) It is not delivered for the purpose of assisting with Activities of Daily Living, including but not limited to, dressing, feeding, bathing or transferring from a bed to a chair;
d) It requires clinical training in order to be delivered safely and effectively;
e) The Participant entered the Skilled Nursing Facility within 24 hours of discharge from a covered
f) Hospital Confinement.

NHAS will determine if Benefits are available by reviewing both the skilled nature of the service and the need for Practitioner-directed medical management. A service will not be determined to be "skilled" simply because there is not an available caregiver.

Benefits can be denied or shortened for Participants who are not progressing in goal-directed Rehabilitation Services or if discharge rehabilitation goals have previously been met.

IMPORTANT: *The Plan will not pay for more than 60 Days per Confinement.*

IMPORTANT: *The Plan will not cover inpatient services without Prior Authorization. You are responsible to obtain Authorization when receiving services from a Non-Participating Provider within forty-eight (48) hours or the next business day after admission.*

For Skilled Nursing Facilities, an Inpatient Stay begins on the day of admission into a Skilled Nursing Facility. The sixty- (60) Day Skilled Nursing Facility Benefit renews when You haven't received any inpatient Hospital care or skilled care in a Skilled Nursing Facility for the same or a similar diagnosis for sixty (60) consecutive Days. If You go into a Hospital or a Skilled Nursing Facility after one Skilled Nursing Facility Benefit period has ended, a new Benefit period begins. However, an additional sixty (60) Days is not available until skilled care has not been required for at least sixty (60) consecutive Days.

TELEHEALTH SERVICES

Some Practitioner services may be performed as a Telehealth Service. We will cover these services under the following conditions.

a) Services performed by a Participating Practitioner.
b) Performed through an interactive telecommunications equipment that includes audio and/or video.
c) Telehealth is an appropriate way to access services and an in-person visit is not required.

d) Participant cost share will be applied the same as indicated on the Summary of Participant Responsibility Table/Summary of Benefits and Coverage for that Covered Service.

Telehealth Services are different than Virtual Visits which have a different Member cost share and use a defined virtual network.

TEMPOROMANDIBULAR DISORDERS (TMD)

The Plan will cover diagnostic procedures and surgical or non-surgical treatment (including prescribed intraoral splint therapy devices) for the correction of TMD if **all** the following apply:

a) The condition is caused by congenital, Developmental or acquired deformity, disease or Injury.
b) The services are reasonable and appropriate for the Diagnosis or treatment of TMD. NHAS will use the accepted standards of the profession of the treating Practitioner to decide if services are reasonable and appropriate.
c) The service controls or eliminates
    i. Infection;
    ii. Pain;
    iii. Disease; or
    iv. Dysfunction.

IMPORTANT: *The Plan limits coverage for diagnostic procedures and non-surgical treatment for TMD to ten (10) services and/or devices per Benefit Year. Non-surgical services include prescribed intraoral splint therapy devices.*

TOBACCO COUNSELING

The Plan will cover the cost of one (1) annual screening and two (2) tobacco-quitting attempts per year. Each attempt includes coverage for up to four (4) tobacco-counseling sessions of at least ten (10) minutes each (including telephone, group and individual counseling) for a maximum of eight (8) tobacco-counseling sessions per year.

IMPORTANT: *The Plan covers specified smoking cessation pharmacy products.*

TRANSGENDER AND GENDER DYSPHORIA SERVICES

The Plan will cover Medically Necessary and appropriate non-surgical and surgical treatment for Transgender and Gender Dysphoria conditions. Coverage will be made available on the same terms and conditions for all Participants who are enrolled in this Plan, regardless of sex assigned at birth, Gender Identity or recorded gender.

URGENT CARE SERVICES

In the Service Area

The Plan will only cover Urgent Care furnished by a Provider or Urgent Care Facility that is in NHAS's network unless enrolled in a POS plan.

Outside the Service Area

The Plan will cover Urgent Care Services provided by a Non-Participating Urgent Care Facility subject to the same cost-sharing requirements that would have applied had such services been provided by a Participating Urgent Care Facility **only if:**

a) The Urgent Care Services are provided by the Emergency department of a Hospital or a Hospital-based Urgent Care Facility; or
b) The Urgent Care Services are provided by a non-Hospital-based Urgent Care Facility and the Participant provides NHAS with notification of the Urgent Care Services within one business day of receiving such services.

If You receive Urgent Care Services from a Non-Participating Provider or facility that does not meet the above criteria, then Your cost sharing obligations for Non-Participating Providers will apply.

***IMPORTANT**: The Plan will not pay for out-of-area services for the Participant's convenience under an EPO plan.*

***IMPORTANT**: A Participating Practitioner must furnish care following an Urgent Care visit if enrolled in an EPO plan. The Plan will not cover Out-of-Network care following an Urgent Care visit that has not been Prior Authorized by NHAS unless enrolled in a POS plan.*

VIRTUAL VISITS

Covered Telemedicine services that include the Diagnosis and treatment of specified medical and behavioral health conditions through electronic means. Benefits are available only when services are delivered through NHAS's defined virtual care contracted Provider network, which is indicated on the back of Your ID card. Any prescriptions the health Practitioner deems appropriate will be covered under the pharmacy Benefit of the Plan when filled at a participating pharmacy.

VISION CARE SERVICES

The Plan will cover routine vision exams. The exam may screen for eye disorders and assess the need for prescription corrective or contact lenses. The Plan will cover one (1) routine vision exam with an eye refraction for each Participant in a Benefit Year.

There is also a discount program available for the purchase of eye hardware and contacts with no payment from the Plan.

IMPORTANT: *The Plan will cover one (1) basic pair of eyeglasses following cataract Surgery The amount the Plan will cover for eyeglasses will not exceed $160 per lifetime. This does not include such items as blended, no-line progressive lenses; polycarbonate lenses; anti-reflective, scratch resistant and ultraviolet (UV) protection; any coating or lamination applied to lenses; tinting; and sunglasses.*

SECTION 6 ~ PRIOR AUTHORIZATION REQUIREMENTS AND PENALTIES

NHAS, directly or through a vendor, reviews certain services and treatment plans to ensure they are Medically Necessary and appropriate. If You are receiving services from a Participating Practitioner or Participating Provider, they will obtain from NHAS, or its vendor, Prior Authorization or pre-admission review to receive coverage for these services. However, if You are being treated by a Non-Participating Practitioner, You are responsible to verify that Prior Authorization is obtained when receiving services that require Prior Authorization.

IMPORTANT: *Examples of health services that require prior NHAS review are:*

a) *Entering a Hospital as a scheduled (non-Emergent) inpatient.*
b) *Obtaining non-emergent, non-Urgent services from a Non-Participating Practitioner or Provider.*
c) *Certain services received from a Specialty Care Practitioner (SCP), such as medical oncology, radiation therapy and genetic laboratory testing.*

The Plan provides coverage for Medically Necessary Emergency Health Services and Urgent Care services. For certain services, including non-emergent and non-urgent services from a Non-Participating Provider or a Non-Participating Practitioner, You are required to obtain Prior Authorization (approval) from NHAS **before** receiving the services or they may not be covered. In some situations, such as receiving Emergency services from a Non-Participating Practitioner and/or Non-Participating Provider, this authorization may be obtained after services are received. The Participant or Authorized Representative should notify NHAS of the situation no later than one (1) business day after receiving the services and being stabilized.

NHAS's Utilization Management Department, NHAS's Medical Director, or NHAS's delegate shall determine the Medical Necessity and appropriateness of these services. For a list of services that require Prior Authorization, log in to Your NHAS account at **login.networkhealth.com** and click **My Materials** to find a link to **Services Requiring Prior Authorization**. Please refer to this website often, as NHAS has full discretionary authority to change it from time to time without notice to You. The services will be denied if Prior Authorization approval is not given.

Procedure for Requesting Prior Authorization for Non-Emergency Situations

The Participant or the Participant's Provider should contact NHAS on behalf of the Plan at the Prior Authorization phone number listed on the Participant's Identification Card. A request for Prior Authorization should be made at least fourteen (14) business days prior to rendering a non-emergent service. NHAS will review the request and determine whether the service is a Covered Expense. NHAS will furnish written or verbal notice of its decision to the Participant and/or Provider as appropriate, as soon as reasonably possible given the medical circumstances. If You do not know the decision before You get the service, You should call NHAS at the number on the back of Your ID card.

What If Prior Authorization Is Not Obtained When Required?

a) Services received from a Participating Provider that NHAS contracts with requires that the Participating Provider obtain the Prior Authorization. If the Participating Provider does not get the authorization, the Participating Practitioner or Provider is financially responsible for the services provided and will not Balance Bill the Participant. If, however, the Prior Authorization is submitted but the authorization request is denied, then the Participant is financially responsible for the services if the decision is made to still receive those services. Payments by the Participant for such services do not apply to Your Deductible or Out-Of-Pocket maximum.
b) For services that are received from a Non-Participating Practitioner or Provider, the Participant is responsible for obtaining the Prior Authorization from NHAS. If Prior Authorization is not requested and received, then services will be denied for payment and the Participant will be responsible for paying the entire cost of the Claim to the Non-Participating Provider.
c) The Participant will also be financially responsible for the entire amount of the Claim if services are provided that are not considered Medically Necessary, or if the service is not covered by this Plan, or if Prior Authorization is requested but the authorization request is denied. The amount of the Claim will **not** be counted toward Your Deductible or Out-Of-Pocket Maximum.

IMPORTANT: *It is Your responsibility to obtain NHAS's Prior Authorization when required, before receiving health care services from Non-Participating Practitioners or Providers.*

IMPORTANT: *For non-emergent services with Non-Participating Practitioners or Providers, You must notify NHAS prior to receiving the service unless you have a POS plan.*

IMPORTANT: *You and Your treating Practitioner and/or Provider will receive written notification from NHAS either approving or denying services with Non-Participating Practitioners and Providers. If you do not receive approval from NHAS, You will be held financially responsible for the cost of those services.*

IMPORTANT: *NHAS's Prior Authorization does not mean the Plan will cover a health service or item. All other provisions in this Plan Document, including the Exclusions and Limitations and applicable Amendments, will also affect whether the Plan covers a health service or item.*

IMPORTANT: *NHAS cannot review or authorize coverage outside the current Benefit Year.*

IMPORTANT: *Prior Authorization does not verify eligibility for benefits nor guarantee Benefit payments under the Plan. It is the Participant's responsibility to verify that applicable services have been granted Prior Authorization before the services are provided.*

IMPORTANT: *The Plan reserves the right to approve alternate treatments for a Participant's bodily Injury or Illness that can be provided in the most cost-effective manner required for the Participant's medical condition.*

SECTION 7 ~ ELIGIBILITY AND ENROLLMENT

ELIGIBILITY

An eligible Employee is a person who is classified by the Employer on both personnel records and payroll as a full-time Employee who is scheduled to and regularly works the number of hours required for eligibility as listed on the **General Plan Information** page that is incorporated into this Plan Document. For purposes of coverage under this Plan, it does not include the following classifications of workers.

a) Temporary or leased employees.
b) An independent contractor who signs an agreement with the Employer as an independent contractor.
c) A consultant who is paid on other than a regular wage or salary by the Employer.
d) A member of the Employer's Board of Directors, an owner, partner, or officer, unless engaged in the conduct of the business on a full-time basis.

The specified eligibility requirements are used to determine an Employee's initial eligibility for coverage under this Plan as well as the requirements to retain eligibility for Plan coverage. An Employee may also retain eligibility for coverage under this Plan if the Employee is temporarily absent on an approved Leave of Absence, with the expectation of returning to work following the approved leave as determined by the Employer's leave policy, provided that contributions continue to be paid on a timely basis. The Employer's classification of an individual is conclusive and binding for purposes of determining eligibility under this Plan. No reclassification of a person's status, for any reason, by a third party, whether by a court, governmental agency or otherwise, without regard to whether or not the Employer agrees to such reclassification, shall change a person's eligibility for benefits.

Dependents: If the Employee is covered under this Plan, then the following Dependents can also be enrolled in the Plan.

a) The Employee's legal spouse, as defined by the state in which You reside, provided that the spouse is not covered as an Employee under this Plan.
b) A Dependent Child, married or unmarried, until the end of the month that the Child turns 26 years old, provided that the Child is not covered as a Dependent of another Employee at this company. The term "Child" includes the following Dependents regardless of the Child's eligibility for other insurance coverage and even if the Child no longer lives with his or her parents, is not a Dependent on a parent's tax return and is no longer a student:
    i. A natural Child
    ii. A step Child
    iii. A legally adopted Child or a Child legally placed for adoption as granted by action of a federal state or local governmental agency responsible for adoption administration or a court of law if the Child has not attained age 26 as of the date of such placement

iv. A Child who is considered an Alternate Recipient under a Qualified Medical Child Support Order
v. A Child for whom a court order requires the Employee to provide health coverage
vi. A Child for whom legal guardianship has been awarded to the Plan Participant or the Plan Participant's spouse
vii. A Child of a covered Dependent Child (grandchild) until the covered Dependent Child, who is the parent, turns 18

DISABLED DEPENDENT CHILD

A Child, who is either mentally or physically disabled, may be eligible for extended Dependent coverage under this Plan beyond the age of 26 if deemed Totally Disabled. In order to be deemed Totally Disabled, the following minimum requirements must be met:

a) The child is unable to hold a self-sustaining job due to intellectual disability or physical handicap;
b) The Child is chiefly dependent on You for support and maintenance;
c) The Child's incapacity existed before he or she reached age 26;
d) Your family coverage remains in force under this Plan; and
e) The child is unmarried.

Before any determination is made regarding coverage, a questionnaire must be completed by Your Dependent's physician. The Participant must submit a completed questionnaire within 31 Days after the day coverage for the Dependent would normally end. A review will be done by NHAS's Utilization Management team to determine eligibility. The Plan may, for two years, ask for additional proof at any time, after which NHAS can ask for proof not more than once per year. You must notify NHAS immediately of an end to the incapacity or dependency.

HOW TO ENROLL: INITIAL ENROLLMENT PROCEDURES

Enrollment in this Plan is not automatic. The eligible Employee who wants coverage is responsible for enrolling Yourself and Your eligible Dependents in this Plan within thirty-one (31) Days following Your hire date and in the manner and form prescribed by Your Employer. The Plan's eligibility and enrollment procedures include administrative safeguards and processes designed to ensure and verify that eligibility and enrollment determinations are made in accordance with the Plan. The Plan may request documentation from the Employee or Your Dependents in order to make these determinations.

Eligible Employees and Dependents who decline to enroll in this Plan when initially eligible, must state so in writing; however, failure to decline enrollment in writing will not result in enrollment.

WAITING PERIOD

If eligible for the Plan as described above, the Employee must complete any applicable Waiting Period as stated on the General Plan Information page of this Plan Document before coverage

becomes effective for You and Your eligible Dependents. The General Plan Information page will also indicate if a Waiting Period will be applied for Employees who have been rehired.

EFFECTIVE DATE OF COVERAGE

a) If the eligible Employee or eligible Dependent enrolls in the Plan in accordance with the Special Enrollment provision described below, coverage will become effective on the date set forth under the Special Enrollment provision if application is made within the timelines allowed in that provision.
b) Coverage for a Dependent who becomes eligible due to a Qualified Medical Child Support Order shall be effective on the later of the date specified in a Qualified Medical Child Support Order or the date the Plan Administrator determines that the order is a QMSCO.
c) Eligible Employees and Dependents who do not enroll in the Plan when initially allowed to enroll, or as part of Special Enrollment, will be considered a Late Enrollee. Late Enrollees can apply for coverage under the Plan during the annual Open Enrollment Period. Coverage under the Plan will then become effective the first day of the new Plan Year following Open Enrollment.

ANNUAL OPEN ENROLLMENT PERIOD

Eligible Employees who didn't previously enroll in the Plan will be able to enroll themselves and eligible Dependents (Late Enrollees) for coverage under this Plan during the annual Open Enrollment Period. Employees who enrolled in the Plan when initially eligible also have the right to make a change in coverage for themselves and their eligible Dependents during the annual Open Enrollment Period. The Employer will give Employees and other eligible individuals written notice prior to the start of an annual Open Enrollment Period regarding dates and procedures for open enrollment. Coverage under the Plan will become effective the first day of the new Plan Year following Open Enrollment if application for enrollment is properly made within the allowed timelines for the annual Open Enrollment Period.

VERIFYING ELIGIBILITY

Employees have an affirmative obligation to notify the Employer as soon as reasonably possible of circumstances that affect a Dependent's continued eligibility for this Plan, such as divorce, or a Child ceasing to meet the criteria listed above for Dependent Children.

This Plan reserves the right to require supporting documentation that demonstrates a Dependent's initial and/or ongoing eligibility for coverage.

SECTION 8 ~ SPECIAL ENROLLMENT RIGHTS

This Plan provides Special Enrollment rights to eligible Employees and Dependents if there is a loss of other health coverage or a change in family status as described below.

LOSS OF OTHER COVERAGE (EXCEPT UNDER MEDICAID OR A STATE CHILDREN'S HEALTH INSURANCE PROGRAM)

Eligible Employees and eligible Dependents who did not enroll when first eligible may enroll for coverage under the Plan during a special enrollment period. Each of the following conditions must be met and enrollment made no later than thirty-one (31) Days following loss of coverage.

a) The eligible Employee or Dependent who is seeking special enrollment was covered under another group health plan or had other health insurance coverage at the time coverage under this Plan was originally offered and
b) The eligible Employee or Dependent lost other coverage pursuant to one of the following events:
    i. The eligible Employee or Dependent was under COBRA or state continuation and that coverage was exhausted; or
    ii. The eligible Employee or Dependent's other coverage was terminated as a result of loss of eligibility (including as a result of Legal Separation, divorce, loss of dependent status, death of an Employee, termination of employment, or reduction in the number of hours worked);
    iii. The plan they were covered underis no longer being offered and no substitute is available; or
    iv. The Employer contributions were terminated and they would be required to pay the full cost of their coverage.

LOSS OF ELIGIBILITY UNDER MEDICAID OR A STATE CHILDREN'S HEALTH INSURANCE PROGRAM

If You (the Employee) decline enrollment for Yourself or for an eligible Dependent including Your spouse while Medicaid coverage or coverage under a state children's health insurance program is in effect, You may be able to enroll Yourself and Your eligible Dependents on this Plan if You or Your Dependents lose eligibility for the Medicaid or State children's health insurance program. You must request enrollment in this Plan within **sixty (60) Days** after coverage ends under Medicaid or a state children's health insurance program for You or Your Dependents.

Note that loss of eligibility does not include a loss resulting from the failure of the Employee or Dependent to pay premiums on a timely basis or a termination of coverage for cause (such as making a Fraudulent Claim or an intentional misrepresentation of a material fact in connection with the Plan).

CHANGE IN FAMILY STATUS

Current Employees, Dependents and COBRA Qualified Beneficiaries have a special opportunity to enroll for coverage under this Plan if there is a change in family status. If a person becomes an eligible Dependent through marriage, birth, adoption or placement for adoption, the Employee, spouse and newly acquired Dependent(s) who are not already enrolled, may enroll for health coverage under this Plan during a special enrollment period. The Employee must request and enroll for coverage no later than **thirty-one (31) Days** following Your marriage, or the birth, adoption or placement for adoption of Dependent Children.

ELIGIBILITY FOR STATE PREMIUM ASSISTANCE

If the Employee or Your Dependents including Your spouse become eligible for a state premium assistance subsidy from Medicaid or a state's Children's Health Insurance Program (CHIP) with respect to coverage under this Plan, You may be able to enroll Yourself and Your eligible Dependents in this Plan. The Employee must, however, request enrollment under this Plan within **sixty (60) Days** after the date the Employee and/or Dependent is determined to be eligible for such assistance, following enrollment procedures designated by Your Employer.

EFFECTIVE DATE OF COVERAGE UNDER SPECIAL ENROLLMENT PROVISION

If You properly apply for coverage during this Special Enrollment period as described in this document, the coverage will become effective as follows.

a) In the case of marriage, on either the date of the marriage or on the first of the month following marriage, based on the effective date that the Participant selects on the Assure Self-insured Application and Change Form); or
b) In the case of a Dependent's birth, on the date of such birth; or
c) In the case of a Dependent's adoption or placement for adoption, the earlier of date of such adoption or placement for adoption; or
d) In the case of eligibility for premium assistance under a state's Medicaid plan or state's Children's Health Insurance Program, on the date the approved request for coverage is received by the Plan; or
e) In the case of loss of coverage, on the date following loss of coverage.

SECTION 9 ~ TERMINATION OF COVERAGE

EMPLOYEE COVERAGE ENDS

The Employee's coverage under this Plan will end on the earliest of:

a) The last day of the month in which You are no longer a member of a covered class due to a reduction in work hours or change in employment as determined by the Employer, except if You are temporarily absent from work due to active military duty or Family and Medical Leave Act; or
b) The last day of the month in which Your employment ends; or
c) The end of the period for which Your last contribution is made, if You fail to make any required contribution towards the cost of coverage when due; or
d) The date this Plan is terminated; or
e) The last day of the month in which You tell the Plan to cancel Your coverage if You are voluntarily canceling it while remaining eligible; or
f) The date the Employee dies.
g) The date that the Employer stops funding the Plan

YOUR DEPENDENT'S COVERAGE ENDS

Coverage for Your Dependent will end on the earliest of the following:

a) The end of the period for which the Employee's last contribution is made, if the Employee fails to make any required contribution toward the cost of Your Dependent's coverage when due; or
b) The last day of the month in which the Employee's coverage ends; or
c) The last day of the month in which Your Dependent is no longer Your legal spouse due to divorce, as determined by the law of the state where the Employee resides; or
d) The last day of the month in which Your Dependent Child attains the limiting age listed under the Eligibility section, unless the Child qualifies for Extended Dependent Coverage; or
e) If Your Dependent Child qualifies for Extended Dependent Coverage as Totally Disabled, the last day of the month in which Your Dependent Child is no longer deemed Totally Disabled under the terms of the Plan; or
f) For a Dependent Child whose coverage is required pursuant to a QMCSO, the last day of the month as of which coverage is no longer required under the terms of the Order.
g) The date Dependent coverage is no longer offered under this Plan; or
h) The last day of the month in which the Employee tells the Plan to cancel Your Dependent's coverage if You are voluntarily canceling the Dependent's coverage while remaining eligible; or
i) The last day of the month in which the Dependent becomes covered as an Employee under this Plan; or

j) The date this Plan is terminated; or
k) The date the Dependent dies.
l) The date that the Employer stops funding the Plan

TERMINATION OF COVERAGE FOR CAUSE (RESCISSION)

Coverage under the Plan may be rescinded for any Participant (Employee or Dependent under family coverage) who engages in fraud or who makes a material misrepresentation of fact relating to the coverage. Rescission is a legal remedy which allows for the cancellation of coverage back to the point before the fraud or material misrepresentation occurred.

Example 1: Participant knowingly files a Claim for benefits for medical services or supplies that were not actually provided, which would be considered fraud. Coverage could be cancelled back to a date before the Fraudulent act occurred.

Example 2: An Employee signs an enrollment form indicating that an individual is eligible for coverage as a Dependent at a time when the Employee knows that the individual does not qualify as the Employee's Dependent. This would be a material misrepresentation and could lead to coverage terminated retroactively to the Effective Date.

REINSTATEMENT OF COVERAGE

If the Employee's coverage ends due to termination of employment, reduction of hours or lay-off and You qualify for eligibility under this Plan again at a later date, You must meet all requirements of an applicable Waiting Period unless You become eligible within the rehired days indicated on the General Plan Information page. If Your coverage ends due to a leave, refer to the information on Family and Medical Leave Act or Uniformed Services Employment and Reemployment Rights Act for possible exceptions, or contact Your benefits department.

PLEASE REFER TO THE COBRA SECTION OF THIS PLAN DOCUMENT FOR QUESTIONS REGARDING CONTINUATION OF COVERAGE. IF YOU ARE UNSURE IF THIS PLAN INCLUDES COBRA, PLEASE SEE THE GENERAL PLAN INFORMATION PAGE IN YOUR PLAN DOCUMENTS WHICH WILL INDICATE IF COBRA IS AVAILABLE.

SECTION 10 ~ COBRA CONTINUATION OF COVERAGE

Group health plans sponsored by employers with twenty (20) or more employees in the previous year are generally required to offer COBRA continuation to employees and their families. The General Plan Information page will indicate "Yes" for "Eligible for Continuation". It will also then list the Continuation administrator on the General Plan Information page in this Plan Document. If your General Plan Information page indicates "No" for Eligible for Continuation" this section does not apply to You. NHAS does not administer COBRA.

This Section has important information about rights that Participants have to COBRA continuation coverage, which is a temporary extension of coverage under the Plan. This notice explains COBRA continuation coverage, when it may become available to a Participant and what a Participant needs to do to protect Your right to get it. When a Participant becomes eligible for COBRA, that Participant may also become eligible for other coverage options that may cost less than COBRA continuation coverage.
The right to COBRA continuation coverage was created by a federal law, the Consolidated Omnibus Budget Reconciliation Act of 1985 (COBRA). COBRA continuation coverage can become available to Participants when group health coverage would otherwise end.

Qualified Beneficiaries that elect COBRA Continuation Coverage must pay the entire cost of the coverage, including a reasonable administration fee as allowed by law. There are several ways COBRA coverage will terminate, including the failure of the Participant or their covered Dependents to make timely payment of contributions.

WHAT IS COBRA CONTINUATION COVERAGE?

COBRA continuation coverage is a continuation of Plan coverage when it would otherwise end because of a life event. This is also called a "qualifying event." Specific qualifying events are listed later in this Section. After a qualifying event, COBRA continuation coverage must be offered to each person who is a Qualified Beneficiary. You, Your spouse and Your Dependent Children could become Qualified Beneficiaries if coverage under the Plan is lost because of the qualifying event. Under the Plan, Qualified Beneficiaries who elect COBRA continuation coverage must pay the full cost for that continuation coverage.

If You are an Employee covered under this Plan, You will become a Qualified Beneficiary if You lose Your coverage under the Plan because of the following qualifying events.

a) Your hours of employment are reduced, or
b) Your employment ends for any reason other than Your gross misconduct.

If You are the spouse of an Employee, You will become a Qualified Beneficiary if You lose Your coverage under the Plan because of the following qualifying events.

a) Your spouse dies;
b) Your spouse's hours of employment are reduced;
c) Your spouse's employment ends for any reason other than his or her gross misconduct;

d) Your spouse becomes entitled to Medicare benefits (under Part A, Part B, or both); or
e) You become divorced or legally separated from Your spouse.

Your Dependent Children will become Qualified Beneficiaries if they lose coverage under the Plan because of the following qualifying events.

a) The parent-Employee dies;
b) The parent-Employee's hours of employment are reduced;
c) The parent-Employee's employment ends for any reason other than his or her gross misconduct;
d) The parent-Employee becomes entitled to Medicare benefits (Part A, Part B, or both);
e) The parents become divorced or legally separated; or
f) The Child stops being eligible for coverage under the Plan as a "Dependent Child."

WHEN IS COBRA CONTINUATION COVERAGE AVAILABLE?

The Plan will offer COBRA continuation coverage to Qualified Beneficiaries only after the Plan Administrator has been notified that a qualifying event has occurred. The Employer must notify the Plan Administrator of the following qualifying events.

a) The end of employment or reduction of hours of employment;
b) Death of the Employee;
c) Commencement of a proceeding in bankruptcy with respect to the Employer if that Employer provides early retiree health coverage; or
d) The Employee is becoming entitled to Medicare benefits (under Part A, Part B, or both).

For all other qualifying events (divorce or Legal Separation of the Employee and spouse or a Dependent Child's losing eligibility for coverage as a Dependent Child), You must notify the Plan Administrator within sixty (60) Days after the qualifying event occurs.

HOW IS COBRA CONTINUATION COVERAGE PROVIDED AND FOR HOW LONG?

Once the COBRA Administrator receives notice that a qualifying event has occurred, COBRA continuation coverage will be offered to each of the Qualified Beneficiaries. Each Qualified Beneficiary will have an independent right to elect COBRA continuation coverage. Covered Employees may elect COBRA continuation coverage on behalf of their spouses and parents may elect COBRA continuation coverage on behalf of their Children.

COBRA continuation coverage is a temporary continuation of coverage that generally lasts for 18 months due to employment termination or reduction of hours of work. Certain qualifying events, or a second qualifying event during the initial period of coverage, may permit a beneficiary to receive a maximum of thirty-six (36) months of coverage.

There are also ways in which this 18-month period of COBRA continuation coverage can be extended as described below:

a) **Disability extension** of 18-month period of COBRA continuation coverage: If You or anyone in Your family covered under the Plan is determined by Social Security to be disabled and You notify the Plan Administrator in a timely fashion, You and Your entire family may be entitled to get up to an additional eleven (11) months of COBRA continuation coverage, for a maximum of twenty-nine (29) months. The disability must have started ***before*** the 60th Day of COBRA continuation coverage and must last at least until the end of the 18-month period of COBRA continuation coverage.

b) **Second** qualifying event extension of 18-month period of continuation coverage: If Your family experiences another qualifying event during the eighteen (18) months of COBRA continuation coverage, the spouse and Dependent Children in Your family can get up to 18 additional months of COBRA continuation coverage, for a maximum of 36 months, if the Plan is properly notified about the second qualifying event. This extension may be available to the spouse and any Dependent Children getting COBRA continuation coverage if the Employee or former Employee dies; becomes entitled to Medicare benefits (under Part A, Part B, or both); gets divorced or legally separated; or if the Dependent Child stops being eligible under the Plan as a Dependent Child. This extension is only available if the second qualifying event would have caused the spouse or Dependent Child to lose coverage under the Plan had the first qualifying event not occurred.

EARLY TERMINATION OF COBRA

COBRA continuation coverage may terminate before the end of the above maximum coverage periods for any of the following reasons.

a) The Employer ceases to maintain a group health plan for any Employee.
b) The required COBRA contribution (payment) is not paid on time by the Qualified Beneficiaries.
c) After electing COBRA continuation coverage, the Qualified Beneficiary becomes covered under another group health plan (but only after any pre-existing condition exclusions of that Other Plan for a pre-existing condition of the Qualified Beneficiary have been exhausted or satisfied).
d) After electing COBRA continuation coverage, the Qualified Beneficiary becomes entitled to Medicare.
e) The Qualified Beneficiary is found not to be disabled during the disability extension. The Plan will terminate the Qualified Beneficiary's COBRA continuation coverage one month after the Social Security Administration makes a determination that the Qualified Beneficiary is no longer disabled.
f) Termination for cause, such as submitting Fraudulent Claims.

ARE THERE OTHER COVERAGE OPTIONS BESIDES COBRA CONTINUATION COVERAGE?

Yes. Instead of enrolling in COBRA continuation coverage, there may be other coverage options for You and Your family through the Health Insurance Marketplace, Medicaid, or other group health plan coverage options (such as a spouse's plan) through what is called a "special enrollment period." Some of these options may cost less than COBRA continuation coverage. You can learn more about many of these options at healthcare.gov.

QUESTIONS?

Questions concerning Your Plan or Your COBRA continuation coverage rights should be addressed to the contact or contacts identified below. For more information about Your rights under the Employee Retirement Income Security Act (ERISA), including COBRA, the Patient Protection and Affordable Care Act and other laws affecting group health plans, contact the nearest Regional or District Office of the U.S. Department of Labor's Employee Benefits Security Administration (EBSA) in Your area or visit www.dol.gov/agencies/ebsa. (Addresses and phone numbers of Regional and District EBSA Offices are available through EBSA's website.) For more information about the Marketplace, visit healthcare.gov.

KEEP YOUR PLAN INFORMED OF ADDRESS CHANGES

To protect Your family's rights, let the Plan Administrator know about any changes in the addresses of family members. You should also keep a copy, for Your records, of any notices You send to the Plan Administrator.

SECTION 11 ~ OTHER CONTINUATION RIGHTS

UNIFORMED SERVICES EMPLOYMENT AND REEMPLOYMENT RIGHTS ACT OF 1994 (USERRA)

If You leave Your job to perform a Uniformed Service in the military, You have the right to elect to continue Your existing employer-based health plan coverage for You and Your Dependents for up to twenty-four (24) months while performing Uniformed Service. Even if You don't elect to continue coverage during Your Uniformed Service, You have the right to be reinstated in Your Employer's health plan when You are reemployed, generally without any Waiting Periods except for service-connected Illnesses or injuries Under USERRA, an Employee is entitled to reemployment rights and maintenance of employment benefits only if the person returning from Uniformed Service meets five eligibility criteria.

a) The person must have held a civilian job with the Employer;
b) The person must have given advance notice to the Employer that he or she was leaving the job for Uniformed Service;
c) The period of Uniformed Service must not have exceeded five (5) years;
d) The person must have been released from Uniformed Service under honorable conditions; and
e) The person must have reported back to the civilian job in a timely manner or have submitted a timely application for reemployment.

Similar to COBRA rights, USERRA also provides that service members who are on military duty for more than thirty (30) Days may elect to continue employer-sponsored health care for themselves and their families for up to twenty-four (24) months, but they may be required to pay up to 102 percent of the total monthly rate. Service members who are on military duty less than thirty-one (31) Days shall be provided health care coverage by the Employer as if the Employee out on Uniformed Service had remained employed.

Upon an Employee returning from Uniformed Service, the Employer must reinstate health insurance coverage without any Waiting Period or exclusion for preexisting conditions, other than Waiting Periods or exclusions that would have applied even if there had been no absence for Uniformed Service. However, this rule will not apply to the coverage of any Illness or Injury determined by the Secretary of Veterans Affairs to have been Incurred in or aggravated during the Employee's performance of military duty.

SECTION 12 ~ CLAIMS PROCEDURES

REASONABLE AND CONSISTENT CLAIMS PROCEDURES

The Plan's Claims procedures are designed to ensure and verify that Claim determinations are made in accordance with this Plan Document and that provisions will be applied consistently. Claims and Appeal procedures are in place to ensure the independence and impartiality of the individuals who are involved in making decisions about Claims and Appeals.

PROOF OF LOSS PERIOD

Participants are responsible for making sure that complete Claims are submitted to the Third-Party Administrator as soon as possible after services are received, but no later than ninety (90) Days after the date of service (the Proof of Loss Period). Claims received after the Proof of Loss Period will not be covered by this Plan and the Participant will be responsible for paying the full cost of services provided. (In the event a Claim is denied by worker's compensation, it would then be eligible for consideration under the medical Plan and not subject to the Proof of Loss Period.)

AUTHORIZED REPRESENTATIVE

Authorized Representative means a person who can contact the Plan on the Participant's behalf to help with Claims, Appeals, or other Benefit issues related to this Plan.

No person will be recognized as an Authorized Representative until the Plan receives an Appointment of Authorized Representative form signed by the Participant. Minor Dependents must have the signature of a parent or legal guardian in order to appoint someone other than a parent or legal guardian as an Authorized Representative. The Appointment of Authorized Representative form needs to include the following: The name of the Authorized Representative, the date and duration of the appointment and any other pertinent information on the form. In addition, the Participant must agree to grant the Authorized Representative access to his or her Protected Health Information. Once an Authorized Representative is appointed, the Plan will direct all information regarding the Claim or Appeal to the Authorized Representative. The Participant will be copied on all notifications regarding decisions, unless the Participant provides specific written direction telling the Plan not to copy the Participant in.

Health care professionals (Providers) are not considered to be Authorized Representatives merely because they submit Claims to the Plan on behalf of the Participant. Providers also are not considered Authorized Representatives by virtue of having the Participant sign an Assignment of Benefits document so that the Provider receives payment for services.

However, in situations where a Participant has an Emergency medical condition where You cannot act on Your own behalf, the medical Provider who has knowledge of Your medical condition will be considered an Authorized Representative for purposes of discussing Claims and Benefit issues with the Plan.

TYPE OF CLAIMS

There are different rules and procedures related to how Claims and Appeals are handled, based on the type of Claim as defined below.

a) **Pre-Service Claim:** A Claim is considered to be a Pre-Service Claim if this Plan Document specifically requires **You to obtain Prior Authorization before receiving the service**.

b) **Post-Service Claim** means a Claim that involves payment for the cost of health care that has already been provided.

c) **Concurrent Care Claim** means that an ongoing course of treatment for a Covered Service to be provided over a period of time or for a specified number of treatments has been approved by the Plan. Any reduction or termination of the approved course of treatment before the end of the treatment will be considered an Adverse Benefit Determination, unless the Plan is formally amended or terminated. In addition, a request by a Participant or Authorized Representative to extend the period or number of treatments will be treated as a Claim for benefits.

PROCEDURES FOR SUBMITTING CLAIMS

Pre-Service Claims

Participating Practitioners and Providers will contact NHAS on Your behalf to request Prior Authorization for the service being requested. You are responsible for having Non-Participating Practitioners and Providers contact NHAS to request Prior Authorization. Before You actually receive a non-Emergency Service that requires Prior Authorization, You are responsible to make sure that Your Provider has obtained the needed Prior Authorization before the service is provided. The Prior Authorization phone number is on the back of Your Participant Identification Card.

Post-Service Claims

Most Providers will send a Claim for services directly to the Plan on Your behalf. If the Provider will not bill the Plan, then the Participant will need to pay the Provider directly and send the Claim and proof of payment to the Plan within the timelines discussed below in order to receive reimbursement. The address for submitting medical Claims is on the back of Your Participant Identification Card.

Emergency and Urgent Care Services received outside the United States

Participants who receive Emergency Services or Urgent Care Services outside the United States are responsible for ensuring that the Provider is paid. If the Provider will not bill the Plan directly with the Claim in English, then the Participant will need to pay the Claim up front and then submit the Claim in English and converted to United States currency along with proof of payment to the Plan for reimbursement. The Plan will reimburse Participants for any Covered

Expenses in U.S. currency, based on the U.S. equivalency rate that is in effect on the date the Participant paid the Claim or on the date of service if paid date is not known.

WHAT IS A COMPLETE CLAIM?

A complete Claim must be submitted in writing and should include the following information.

a) Participant/patient ID number, name, sex, date of birth, address and relationship to Employee
b) Authorized signature from the Participant
c) Diagnosis
d) Date of service
e) Place of service
f) Procedures, services or supplies (narrative description)
g) Charges for each listed service
h) Number of days or units
i) Patient account number (if applicable)
j) Total billed charges
k) Provider billing name, address, telephone number
l) Provider Taxpayer Identification Number (TIN)
m) Signature of Provider
n) Billing Provider
o) Any information on other insurance (if applicable)
p) Whether the patient's condition is related to employment, auto accident or other Accident (if applicable)
q) Assignment of Benefits (if applicable)

RECEIPT OF INCOMPLETE CLAIM

If the Plan receives a Claim that is missing required information, the Plan can deny the Claim and the Participant would have the right to go through the Appeal process discussed below. If, however, the Plan puts the Claim on hold instead of denying it up front, then the Plan will send the Participant a written notice explaining what information or documentation is missing. You will have forty-five (45) Days from the date of receipt of this notice to provide all required information to the Plan. While the Plan is waiting to receive the missing information, the Claim will be on hold. Once the Plan receives all needed information, the Claim will be processed. If all needed information is not received within forty-five (45) Days, then the Claim will be denied. In the event that the Claim is missing so many details that it is impossible for the Plan to identify who the Claim is for; the Plan will send the Claim back to the Provider for investigation and resubmission if appropriate.

INCORRECTLY FILED CLAIMS (APPLIES TO PRE-SERVICE CLAIMS ONLY)

If a Participant or Authorized Representative attempts to, but does not properly follow the Plan's procedures for requesting Prior Authorization, the Plan will notify the person to explain proper procedures within five (5) Days following receipt of a Pre-Service Claim request. The Plan's notice of an incorrectly filed Claim will usually be oral, unless written notice is requested by the Participant or Authorized Representative.

HOW MEDICAL BENEFITS ARE CALCULATED

When NHAS receives a Claim for services that have been provided to a Participant, it will determine if the service is a Covered Service under this group health Plan.

If the Claim is not for a Covered Service, the Claim will be denied and the Participant will be responsible for paying the Provider the full cost of services. Remember that You have the right to Appeal the Plan's decision to deny the Claim. Please refer to the Appeal Procedures provision in this Plan Document for more details on Your Appeal rights.

If, however, the Claim is for a Covered Service, NHAS will establish an Allowed Amount for that service in accordance with the following: When a Provider network contract is in place with a Participating Provider, that contract determines the Plan's Allowed Amount for a particular Covered Service. Non-Participating Providers, however, generally are paid the lesser of the billed amount or a contracted rate that a secondary network, designated by NHAS, has negotiated for Covered Service. The Allowed Amount is then used to determine the cost sharing obligations for both the Plan and the Participant, so Your Deductible and Coinsurance will be calculated on the Allowed Amount rather than being calculated on the amount billed by the Provider in most cases. This normally will reduce the cost that You and the Plan need to pay for Covered Services, however remember that Non-Participating Providers (except those who are eligible for and participating in Network Extend) have the right to Balance Bill You for costs over and above the Allowed Amount. You will be responsible for the cost of the Non-Participating Provider's charge for such services. Because NHAS does not have an agreement with Non-Participating Providers, and there is no limit on what a Non-Participating Provider may charge, this cost may be significant.

The Plan will normally send payment for Covered Services directly to the Participant's Provider. If the Participant has already paid the Provider for all costs, then the Participant will need to submit verification of the paid Claim to NHAS for reimbursement of Allowed Amounts under this Plan.

The Third-Party Administrator will use its normal Claims processing procedures when determining how each Claim will be processed and what Cost Sharing category the service falls under. If You have questions, please call Member Experience at the phone number on the back of Your Participant Identification Card.

TIMELINES FOR MAKING INITIAL MEDICAL BENEFIT DETERMINATION

NHAS, on behalf of the Plan, will process Claims within the following timelines, although the Participant may voluntarily extend these timelines:

Pre-Service Claim: A decision will be made within a reasonable time appropriate to the medical circumstances, but no later than fifteen (15) Days following receipt of the Pre-Service request. However, the Plan can, have an extra 15-Day extension when necessary for reasons beyond the control of the Plan, if written notice explaining why is given to the Participant within the original 15-Day period.

Post-Service Claims: Claims will be processed within a reasonable time but no later than thirty (30) Days following receipt of the Claim. The Plan can, however, have an additional 15-Day extension when necessary for reasons beyond the control of the Plan, if written notice explaining why is provided to the Participant within the original 30-Day period.

Concurrent Care Claims: A decision by the Plan to reduce or terminate an initially approved course of treatment is an Adverse Benefit Determination that may be appealed by the Participant. The Plan will notify the Participant sufficiently in advance of the reduction or termination of a previously approved course of treatment to allow the Participant to Appeal the adverse decision. If the Participant does file an Appeal within the timelines listed under the Appeals Procedures in this Plan Document, then the course of treatment will not be reduced or terminated until the Participant has received a decision on the Appeal.

A medical Claim is considered to be filed when the Claim for benefits has been received by NHAS for formal consideration under the terms of this Plan.

NOTIFICATION OF ADVERSE BENEFIT DETERMINATION

For Pre-Service Claims: The Plan will provide the Participant and Provider with a notification to explain whether the Pre-Service Claim request is being approved or denied. Sufficient information will be provided to inform the Participant and Provider of the Plan's decision, explanation of what is being authorized, if any; and any conditions such as a limit on the number of treatments, or whether a particular Provider needs to be used. If a Pre-Service Claim is denied, additional information on the rationale will be provided along with Appeal rights information.

For Post-Service Claims: If a Claim is being denied in whole or in part and the Participant will owe any amount to the Provider because of cost sharing obligations or other reasons, the Participant will receive an initial Claim denial notice in writing or electronically, usually referred to as an Explanation of Benefits (EOB), within the timelines described above. The Explanation of Benefits will provide sufficient information so that You can identify the Claim, including the date of service, the Provider's name and the Claim amount. The Provider will receive a similar form on each Claim that is submitted. Please check the information on each EOB to make sure the services charged were actually received from the Provider and that the information appears correct. For any questions or concerns about the EOB, call NHAS at the number listed on the EOB or on the back of Your Participant identification card.

In addition to the information above, the EOB will also:

a) Explain the specific reasons for the Adverse Benefit Determination.
b) Provide a specific reference to pertinent Plan provisions on which the Adverse Benefit Determination was based.
c) Provide a description of any material or information that is necessary for the Participant to complete the Claim, along with an explanation of why such material or information is necessary, if applicable.
d) Let You know that upon request to the Plan, You can receive the Diagnosis code, treatment code and the meanings of those codes. The Plan will not consider this request to be a request for an internal Appeal or external review.
e) Provide appropriate information as to the steps the Participant can take to submit the Claim for Appeal (review).

If an internal rule or guideline was relied upon, or if the Adverse Benefit Determination was based on Medical Necessity or Experimental or Investigational treatment, the Plan will notify the Participant of that fact. The Participant has the right to request a copy of the rule/guideline or clinical criteria that was relied upon and such information will be provided free of charge.

CIRCUMSTANCES CAUSING LOSS OR DENIAL OF PLAN BENEFITS

Claims can be denied in whole or in part for any of the following reasons:

a) Participant is no longer eligible for coverage under this Plan.
b) Charges Incurred prior to the Participant's effective date or following termination of coverage.
c) Amendment or Termination of this Plan.
d) Incomplete or inaccurate Claim submission.
e) Employee, Dependent or Provider did not respond to a request for additional information needed to process the Claim or Appeal.
f) Application of Coordination of Benefits.
g) Enforcement of subrogation, including You and/or Your Dependent’s refusal to sign an agreement acknowledging the Plan’s subrogation rights.
h) Services are not a Covered Service under this Plan.
i) Services are not considered Medically Necessary.
j) Failure to comply with Prior Authorization requirements before receiving services.
k) Misuse of the Plan identification card or other fraud.
l) Failure of the Employer to fully fund the Plan.
m) Employee or Dependent is responsible for charges due to Deductible, Copayment and Coinsurance obligations.
n) Application of the Usual and Customary fee limits, fee schedule or negotiated rates.
o) Other reasons as stated elsewhere in this Plan Document.

RIGHT TO REQUEST OVERPAYMENTS

The Plan reserves the right to recover any payments from Participants or any other party on the Participant's behalf when payments by the Plan were:

a) Made in error; or
b) Made after the date the person should have been terminated under this Plan; or
c) Made to any Participant or any party on a Participant's behalf where the Plan Sponsor determines the payment to the Participant or any party is greater than the amount payable under this Plan.

SECTION 13 ~ COMPLAINT AND APPEAL RESOLUTION

This Complaint and Appeal Resolution process is designed to protect the rights of You and Your covered Dependents.

If You have a question or Complaint about any decision NHAS makes, including a Coverage Denial Determination, or if You have any other question or concern about NHAS's administration of this Plan, contact an NHAS Member Experience Representative. The Member Experience Representative will try to answer Your question or resolve Your concern. If You are not satisfied, You may file an Appeal.

Appeals received are handled by NHAS's Appeals and Grievance Department.

INTERNAL AND EXTERNAL PROCEDURES

If You disagree with an Adverse Benefit Determination, You or Your Authorized Representative can request that the Plan review its initial determination of a Claim by submitting a written Appeal to the Plan as described in this Section.

FULL AND FAIR REVIEW

The Plan has procedures in place to ensure the individuals involved in making the decision about Your Appeal will do so in an impartial, consistent and independent manner. In addition, You will have the right to present evidence and testimony as part of the internal Appeals process. You or Your Authorized Representative will, upon request and at no charge, be given reasonable access to and copies of all documents, records and other information relevant to the Your Claim for benefits. A document, record, or other information will be considered "relevant" to a Claim if the Plan relied on it or considered it in making the initial Benefit determination, or it demonstrates compliance with the Plan's administrative processes and consistency safeguards.

TYPES OF APPEALS

An **Internal Appeal** is a review by the Plan of an Adverse Benefit Determination. NHAS (or another vendor for the Plan) may also review appealed Claims as described below.

An **External Review** for purposes of Appeals means a review of an Adverse Benefit Determination by an independent party. Only certain types of Appeals are eligible for an External Review, as described in the External Review provision below.

IMPORTANT: *Participants must exhaust the mandatory Internal Appeal procedures before an External Review is requested or other action is taken, except in the following cases.*

a) *Participants who are appealing an Adverse Benefit Determination related Emergency Services Claims may proceed with an Expedited External Review at the same time as the Internal Appeal process.*
b) *Participants who are appealing a reduction or termination of a previously approved Concurrent Care Claim may proceed with an Expedited External Review at the same time as the Internal Appeal process.*

c) *Participants who are not required to exhaust the Internal Appeal procedures pursuant to 29 C.F.R. § 2590.715-2719(b)(2)(ii)(F) for ERISA Plans; or pursuant to 45 C.F.R. § 147.136(b)(2)(ii)(F) for non-federal governmental plans.*

HOW MANY INTERNAL APPEAL LEVELS DOES THIS PLAN OFFER?

This Plan has one mandatory Internal Appeal level. When an Internal Appeal level is "**mandatory**", it means that You must normally complete the Appeal procedures listed below before You would have the right to request an External Review of Your Appeal under state or federal external review procedures, as applicable, or before You can pursue other legal remedies available under ERISA or under state law, as applicable.

HOW TO FILE AN INTERNAL APPEAL

If You want to have an Adverse Benefit Determination reviewed, such as a denied Claim, you can send a written Appeal request to the Plan within the Appeal timelines listed below. You or Your Authorized Representative may submit written comments, documents, records and other information relating to the Claim to explain why You believe the Adverse Benefit Determination should be overturned. This information should be submitted at the same time the written request for a review is submitted.

You also have the right to submit evidence that Your Claim is due to the existence of a physical or mental medical condition or domestic violence, under applicable federal nondiscrimination rules. In addition, You or Your Authorized Representative have the right to present evidence and testimony as part of the Appeals process. If You are (or Your authorized representative is) unable to attend, You (or Your authorized representative) may attend telephonically. You (or Your authorized representative) may ask questions of Appeal committee members at that time.

TIMELINES FOR PARTICIPANTS (OR AUTHORIZED REPRESENTATIVES) TO FILE AN INTERNAL APPEAL

a) **For all Claims other than Concurrent Care Claims:** You must file an Appeal with the Plan no later than **180 Days** after the date You received the Explanation of Benefits (EOB) from the Plan showing that the Claim was denied in whole or in part. The Plan will assume that You received the EOB or notification within five (5) days after the Plan mailed the EOB.

b) **For Concurrent Care Claims:** A Participant must file an Appeal with the Plan no later than the later of the following dates: (1) **thirty (30)** Days after the date You received notification of the Plan's decision to reduce or terminate a previously-approved course of treatment; or (2) **thirty (30)** Days before the end of Your previously-approved course of treatment., This will provide the Participant sufficient time to file the Appeal and obtain a decision on the Appeal before any reduction or termination of previously-approved services takes place.

TIMELINES FOR THE PLAN TO RESPOND TO AN INTERNAL APPEAL

After reviewing a Claim that has been appealed, the Plan will notify You or Your Authorized Representative of its decision within the timelines listed below, although You may voluntarily extend these timelines. In addition, if any new or additional evidence is relied upon or generated during the determination of the Appeal, the Plan will provide it to You free of charge and sufficiently in advance of the due date of the response to the Adverse Benefit Determination.

a) **Pre-Service Claim:** Within a reasonable time period appropriate to the medical circumstances but no later than thirty (30) Days after the Plan receives the request for review.

b) **Post-Service Claim:** Within a reasonable time period but no later than sixty (60) Days after the Plan receives the request for review.

c) **Concurrent Care Claims:** Before previously-approved treatment ends or is reduced.

HOW THE INTERNAL APPEAL WILL BE DECIDED

The review of Your Appeal will consider all comments, documents, records and other information submitted that are relevant to the Claim without regard to whether the information was received or considered in the prior Benefit determination. The review will not give deference to the initial Adverse Benefit Determination. It will be conducted by individuals who were not involved in the original Adverse Benefit Determination.

If the Adverse Benefit Determination was based in whole or in part on a medical judgment, the Plan will consult with a health care professional with appropriate training and experience in the field of medicine related to the medical judgment. This independent health care professional will not have been involved in the original Adverse Benefit Determination. If the Plan has obtained medical, or vocational experts relating to the Claim, they will be identified upon the Participant's request, regardless of whether the Plan relies on their advice in making any Benefit determinations.

Before making a final decision on Appeal that is based on a rationale that was not included in the initial determination, the Plan will provide You, free of charge, with the rationale as soon as possible and sufficiently in advance of the final Internal Appeal decision to give You a reasonable opportunity to respond.

NOTIFICATION OF DECISION ON INTERNAL APPEAL

After the Internal Appeal has been reviewed, You will receive written notification within the timelines listed above, letting You know if the appealed Claim is being approved or denied. The notification will provide the following information:

a) If the Internal Appeal is approved, You will be notified in writing of this fact and the Claim will be reprocessed.
b) If the Internal Appeal is denied, You will receive a written or electronic notice of the denial. The notice will explain the specific reasons for the denial of the Appeal; provide a specific reference to pertinent Plan provisions on which the denial of the Appeal was

based; include a statement disclosing any internal rule, guideline, protocol, scientific or clinical judgment or similar criteria that was relied on in making the adverse decision; and provide a statement that You may receive, upon request and free of charge, reasonable access to, and copies of, all documents, records and other information relevant to Your Claim including applicable internal rules, guidelines, scientific or clinical judgment or protocols that were relied upon.

The notification will also contain a statement regarding the Participant's right to bring an action in federal court if applicable to Your Plan.

Send Medical and Pharmacy Appeals to:

Network Health Administrative Services
Commercial Appeal Team
P.O. Box 120
Menasha, WI 54952

If applicable, send Appeals regarding COBRA eligibility or termination to the Continuation Administrator listed on the General Plan Information page of this Plan Document.

STANDARD EXTERNAL REVIEW AND EXPEDITED EXTERNAL REVIEW

When Can an External Review Be Requested?

You may request an External Review of an Adverse Benefit Determination if You have exhausted the Plan's mandatory Internal Appeal procedures as described above and the Claim that is being appealed meets one of the following criteria.

a) The Claim that was appealed involved **medical judgment** as determined by the external reviewer. Medical judgment includes but is 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 Expense, or if a treatment is Experimental or Investigational; or
b) The Claim that was appealed involved a **rescission of coverage** for the Plan (whether or not the rescission has any effect on any particular Benefit at that time).

The Participant's External Review request would either fall under the **Standard External Review** process, or under the **Expedited External Review** process, depending on the situation.

A Claim is **not** eligible for federal External Review if the Participant is or was not covered under the Plan at the time the health care item or service was requested; and the process does not apply to a denial, reduction, termination or a failure to provide payment for a Benefit based on a determination that the Participant does not meet the requirements for eligibility under the terms of a group health Plan.

Request for Standard External Review and Timeline

This type of review would be followed in most cases. To request a standard External Review, You must send Your written request within four (4) months after the date You receive notice of an Adverse Benefit Determination or Final Internal Adverse Benefit Determination. If there is no corresponding date four months after the date of receipt of such a notice, then the request must be filed by the first day of the fifth (5^{th}) month following the receipt of the notice. For example, if the date of receipt of the notice is October 30, because there is no February 30, the request must be filed by March 1. If the last filing date would fall on a Saturday, Sunday or federal holiday, the last filing date is extended to the next business day.

Preliminary Review

Within five (5) business days following the date of receipt of the External Review request, the Plan will complete a preliminary review of the request to determine whether:

a) The Participant is or was covered under the Plan at the time the health care item or service was requested or, in the case of a retrospective review, was covered under the Plan at the time the health care item or service was provided;
b) The Adverse Benefit Determination or the Final Adverse Benefit Determination does not relate to the Participant's failure to meet the requirements for eligibility under the terms of the Plan (e.g., worker classification or similar determination);
c) The Participant has exhausted the Plan's mandatory Internal Appeal procedures;
d) The Participant has provided all the information and forms required to process an external review.

Within one business day after completion of the preliminary review, the Plan will notify you of its determination. If Your request is not eligible for External Review, Your notification will include the reasons for its ineligibility and contact information for the Employee Benefits Security Administration (toll-free number 866-444-EBSA (3272)). If the request is not complete, Your notification will describe the information or materials needed to make the request complete and You will be allowed to complete the request for External Review within the four-month filing period or within the 48-hour period following the receipt of the notification, whichever is later.

Referral to Independent Review Organization

The Plan will assign an independent review organization (IRO) that is accredited by the Utilization Review Accreditation Commission (URAC) or by a similar nationally recognized accrediting organization to conduct the External Review. The Plan will contract with at least three IROs for assignments under the Plan and rotate Claims assignments among them (or incorporate other independent unbiased method for selection of IROs, such as random selection). In addition, the IRO is not eligible for any financial incentives based on the likelihood that the IRO will support the denial of benefits. In reaching a decision, the assigned IRO will review the Claim de novo and is not bound by any decisions or conclusions reached during the Plan's internal Claims and Appeals process.

Reversal of Plan's Adverse Benefit Decision

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

EXPEDITED EXTERNAL REVIEW PROCEDURES

Request for Expedited External Review

The Plan will allow a Participant to make a request for an expedited External Review with the Plan at the time the Participant receives the following.

a) An Adverse Benefit Determination involving a medical condition of the Participant for which the timeframe for completion of a standard Internal Appeal would seriously jeopardize the life or health of the Participant or the Participant's ability to regain maximum function, or in the opinion of a Provider with knowledge of the Participant's medical condition could subject the Participant to severe pain that cannot be adequately managed if there is a delay in care and the Participant has filed a request for an expedited Internal Appeal; or

b) A Final Internal Adverse Benefit Determination if the Participant has a medical condition where the timeframe for completion of a standard External Review would seriously jeopardize the life or health of the Participant or would jeopardize the Participant's ability to regain maximum function or in the opinion of a Provider with knowledge of the Participant's medical condition could subject the Participant to severe pain that cannot be adequately managed if there is a delay in care); or

c) A Final Internal Adverse Benefit Determination concerning a reduction or termination of a previously approved Concurrent Care Claim.

Preliminary Review of Expedited External Review Request

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

Referral to Independent Review Organization (Expedited External Review)

Upon a determination that a request is eligible for expedited External Review following the preliminary review, the Plan will assign an IRO pursuant to the requirements set forth above for standard External Review. The Plan will provide or transmit all necessary documents and information considered in making the Adverse Benefit Determination or Final Internal Adverse Benefit Determination to the assigned IRO electronically or by telephone or facsimile or any other available expeditious method. The assigned IRO, to the extent the information or documents are available and the IRO considers them appropriate, will consider the information or documents described above under the procedures for standard External Review. In reaching a

decision, the assigned IRO will review the Claim de novo and is not bound by any decisions or conclusions reached during the Plan's internal Claims and Appeals process.

Notice of Final External Review Decision

NHAS's contract with the assigned IRO will require the IRO to provide notice of the final External Review decision, in accordance with the requirements set forth above, as expeditiously as the Participant's medical condition or circumstances require, but in no event more than seventy-two (72) hours after the IRO receives the request for an expedited External Review. If the notice is not in writing, within forty-eight (48) hours after the date of providing that notice, the assigned IRO will provide written confirmation of the decision to the Participant and the Plan.

LEGAL ACTIONS FOLLOWING APPEALS

No legal action for benefits may be filed against the Plan after one year from the date the Plan gives the Participant a final determination on their Appeal. Prior to bringing any legal action against the Plan, Participants must exhaust mandatory Internal Appeal procedures that are discussed in this Plan Document or be deemed to have exhausted all remedies under this Plan.

SECTION 14 ~ COORDINATION OF BENEFITS

The Plan will coordinate Benefit payments with other health care coverage You may have, as set forth below. The purpose of this provision is to ensure You receive the Benefits to which You are entitled without providing more Benefits than the total cost of care received.

APPLICABILITY

a) This Coordination of Benefits (COB) provision applies to This Plan when a covered Dependent has health care coverage under more than one Plan. "Plan" and "This Plan" are defined below.
b) If this COB provision applies, the order of Benefit determination rules shall be looked at first. The rules determine whether the Benefits of This Plan are determined before or after those of another Plan. The Benefits of This Plan:
    i. Shall not be reduced when, under the order of Benefit determination rules, This Plan determines its Benefits before another Plan; but
    ii. May be reduced when, under the order of Benefit determination rules, another Plan determines its Benefits first.

DEFINITIONS SPECIFIC TO COORDINATION OF BENEFITS

a) "Allowable Expense" means a necessary, reasonable and customary item of expense for health care, when the item of expense is covered at least in part by one or more Plans covering the person for whom the Claim is made.
b) "Claim Determination Period" means a calendar year. However, it does not include any part of a year during which a person has no coverage under This Plan or any part of a year before the date this COB provision or a similar provision takes effect.
c) "Plan" means any of the following which provides Benefits or services for, or because of, medical or dental care or treatment:
    i. Group insurance or group-type coverage, whether insured or self-funded, that includes continuous 24-hour coverage. This includes prepayment, group practice or individual practice coverage. It also includes coverage other than school accident-type coverage.
    ii. Coverage under a governmental plan or coverage that is required or provided by law. This does not include a state plan under Medicaid (Title XIX, Grants to States for Medical Assistance Programs, of the United States Social Security Act as amended from time to time). It also does not include any Plan whose benefits, by law, are excess to those of any private insurance program or other non-governmental program. Each contract or other arrangement for coverage under (i) or (ii) is a separate Plan. If an arrangement has two parts and COB rules apply only to one of the two, each of the parts is a separate Plan.
    iii. Individual policies sold on and off the Federally Facilitated Exchange, grandfathered individual plans and transitional (aka grandmothered) individual plans.

d) "Primary Plan"/"Secondary Plan". The order of Benefit determination rules state whether This Plan is a Primary Plan or Secondary Plan as to another Plan covering the person.
    i. When This Plan is a Secondary Plan, its Benefits are determined after those of the other Plan and may be reduced because of the other Plan's benefits.
    ii. When This Plan is a Primary Plan, its Benefits are determined before those of the other Plan and without considering the other Plan's benefits.
    iii. When there are more than two Plans covering the person, This Plan may be a Primary Plan as to one or more other Plans and may be a Secondary Plan as to a different Plan or Plans.

ORDER OF DETERMINATION

The rules below determine which health plan is primary and which health plan is secondary.

a) No COB provision: If the Participant's other health plan does not have a COB provision, that Plan will be primary.
b) Non-Dependent/Dependent: An Empolyee's Plan will be primary over a Plan that covers that Employee as a Dependent.
c) Dependent children: The "Birthday Rule" will determine which Plan is primary for a Dependent child with coverage under both parents' Plans.

Birthday Rule

The Plan of the parent whose birth date occurs first in a calendar year is primary. If both parents have the same birth date, the Plan that has covered the parent for a longer period of time is primary.

Dependent Children with Unmarried, Separated or Divorced Parents

The rules below determine which health plan is primary for a child for whom a court order awards custody to one parent.

a) The Plan of the parent with custody of the child is primary.
b) If the custodial parent has no Plan, the Plan of the custodial parent's spouse is primary.
c) If neither the custodial parent nor his/her new spouse has a Plan, the Plan of the parent who does not have custody of the child, or their spouse is considered primary.

If the specific terms of a court decree state that the parents have joint custody and do not specify which parent is responsible for health care expenses, the Birthday Rule will apply.

If a court decree orders that one parent is responsible for health care expenses, the Plan of that parent will be primary.

> ***IMPORTANT:*** *These rules for Dependent children of divorced or separated parents only apply after NHAS has been informed of the court ordered terms.*

ACTIVE/INACTIVE EMPLOYEE

If a spouse is laid off or retired, a Plan that covers an actively at work spouse is primary for the inactive spouse and their Dependents.

CONTINUATION OF COVERAGE
The Plan that covers a Participant as an actively at work employee or Dependent is primary over any continuation of coverage Plan.

LONGER/SHORTER LENGTH OF COVERAGE
If none of the above rules determines the order of Benefits, the Plan that has covered the person for a longer period of time will be primary.

EFFECT ON BENEFITS WHEN THIS PLAN IS SECONDARY
The Plan will apply these provisions to Allowable Expenses payable under both this Plan and any other Plan. To be eligible, You must incur the Allowable Expenses while You are a Plan Participant and Claims must be submitted to Us within ninety (90) Days of receipt of the primary health plan's Explanation of Benefits. These provisions apply only when the sum of the amount the Plan covers for Allowable Expenses under the Plan and the amount of Allowable Expense any other Plan covers, in the absence of this COB section or any similar provision in the other Plan, exceed the amount of Allowable Expenses.

The Plan will cover Allowable Expenses incurred by You while You are a Plan Participant as follows:

a) If the Plan is primary, Benefits will be paid without regard to any other Plan;
b) If another Plan is primary, Benefits will be reduced so that total Benefits payable by all Plans will not exceed the total of Allowable Expenses.

COB WITH MEDICARE
The section above "EFFECT ON BENEFITS WHEN THIS PLAN IS SECONDARY" notwithstanding, when Medicare is primary, total Benefits payable by NHP shall not exceed the Member's Out-of-Pocket liability under Medicare or this NHP Plan, whichever is lesser. COB with Medicare will conform to federal statutes and regulations.

RIGHT TO NECESSARY INFORMATION
The Plan Administrator may need information to determine proper payment. The Plan Administrator may obtain that information from any organization or person without Your consent but will do so only as needed to apply these COB rules. The Plan Administrator may give necessary information to another organization or person in order to coordinate Benefits. Medical records remain confidential as provided by state law. Each person claiming Benefits under This Plan must give the Plan Administrator any facts it needs to pay the Claim.

> ***IMPORTANT:*** *NHAS uses and discloses confidential medical and patient information only as state and federal law allows.*

FACILITY OF PAYMENT

The Plan Administrator may directly pay another Plan that pays an amount that should have paid under This Plan. That amount will then be treated as though it were a Benefit paid under This Plan. The Plan Administrator will not have to pay that amount again. The term "payment made" means reasonable cash value of the Benefits provided in the form of services.

RIGHT TO RECOVERY

The Plan may recover payments it makes that are in excess of the amount owed. The Participant grants the Plan a lien against any amounts paid to You or to a third party on Your behalf and the Plan Administrator will recover from You or such third party an amount equal to the excess payment made under this Article.

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SECTION 15 ~ SUBROGATION AND REIMBURSEMENT

The Plan has a right to subrogation and reimbursement. References to "You" or "Your" in this provision shall include You as the Participant, Your estate and Your heirs and beneficiaries unless otherwise stated.

Subrogation applies when the Plan has paid benefits on Your behalf for an Illness or Injury for which a third party is considered responsible. The right to subrogation means this Plan is substituted to and shall succeed to any and all legal Claims You may be entitled to pursue against any third party for the benefits the Plan has paid that are related to the Illness or Injury for which a third party is considered responsible.

The right to reimbursement occurs when a third party causes or is alleged to have caused an Illness or Injury for which You receive a full or partial settlement, judgment or other recovery from any third party. Once you are fully compensated or made whole, You must then use remaining proceeds to return to this Plan 100 percent of any Benefits You received for that Illness or Injury, with such proceeds available for collection to include any and all amounts payed as non-economic damage judgment or settlement. The right of reimbursement shall apply to any benefits received at any time until the rights are extinguished, resolved or waived in writing.

The following persons and entities are considered third parties.

a) A person or entity alleged to have caused You to suffer an Illness, Injury or damages, or who is legally responsible for the Illness, Injury or damages.
b) Any insurer or other indemnifier of any person or entity alleged to have caused or who caused the Illness, Injury or damages.
c) The Plan Sponsor in a workers' compensation case or other matter alleging liability.
d) Any person or entity who is or may be obligated to provide benefits or payments to You, including benefits or payments for underinsured or uninsured motorist protection, no-fault or traditional auto insurance, medical payment coverage (auto, homeowners or otherwise), workers' compensation coverage, other insurance carriers or third-party administrators.
e) Any person or entity liable for payment to You on any equitable or legal liability theory.

You agree as follows:

a) You will cooperate with the Plan in protecting its legal and equitable rights to subrogation and reimbursement in a timely manner, including, but not limited to:
    i. Notifying the Plan, in writing, of any potential legal claim(s) You may have against any third party for acts which caused Benefits to be paid or become payable.

ii. Providing any relevant information requested by the Plan.
iii. Signing and/or delivering such documents as the Plan or its agents reasonably request to secure the subrogation and reimbursement Claim.
iv. Responding to requests for information about any Accident or injuries.
v. Making court appearances.
vi. Obtaining the Plan's consent or it's agents' consent before releasing any party from liability or payment of medical expenses.

Complying with the terms of this Article:

a) The Plan may at its option, take necessary and appropriate action to preserve its rights under these subrogation provisions, including but not limited to, providing or exchanging medical payment information with an insurer, the insurer's legal representative or other third party, filing an ERISA or other reimbursement lawsuit to recover the full amount of medical benefits You receive for the Illness or Injury out of any settlement, judgment or other recovery from any third party considered responsible; and filing suit in Your name or Your estate's name, which does not obligate this Plan in any way to pay You part of any recovery NHAS obtains. Any ERISA or other reimbursement lawsuit stemming from a refusal to refund benefits as required under the terms of the Plan is governed by a six-year statute of limitations.
b) You may not accept any settlement that does not fully reimburse the Plan, without its written approval.
c) The Plan has the authority and discretion to resolve all disputes regarding the interpretation of the language stated herein.
d) In the case of Your wrongful death or survival claim, the provisions of this Article apply to Your estate, the personal representative of Your estate and Your heirs or beneficiaries. In the case of Your death, the Plan's right of reimbursement and right of subrogation shall apply if a Claim can be brought on behalf of You or Your estate that can include a Claim for past medical expenses or damages. The obligation to reimburse the Plan is not extinguished by a release of claims or settlement agreement of any kind.
e) Your failure to cooperate with the Plan is considered a breach of contract. As such, it has the right to:
    i. Terminate Your Benefits;
    ii. Deny future Benefits;
    iii. Take legal action against You; and/or
    iv. Offset from any future Benefits the value of Benefits the Plan has paid relating to any Illness or Injury alleged to have been caused or caused by any third party to the extent not recovered by the Plan.
    v. Recover any attorneys' fees and costs incurred by the Plan in order to collect third-party settlement funds held by You or Your representative. You may also be required to pay interest on any amounts You hold which should have been returned to the Plan.

f) No allocation of damages, settlement funds or any other recovery, by You, Your estate, the personal representative of Your estate, Your heirs, Your beneficiaries or any other person or party, shall be valid if it does not reimburse the Plan for 100 percent of its interest unless the Plan provides written consent to the allocation.
g) The provisions of this Section apply to the parents, guardian or other representative of a Dependent child who incurs an Illness or Injury caused by a third party. If a parent or guardian brings a claim for damages arising out of a minor's Illness or Injury, the terms of this subrogation and reimbursement clause shall apply to that claim.
h) If a third party causes or is alleged to have caused You to suffer an Illness or Injury while You are covered under this Plan, the provisions of this Article continue to apply, even after You are no longer covered.
i) The Plan has a first priority right to receive payment on any claim against a third party before You receive payment from that third party. Further, the Plan's first priority right to payment is superior to any and all claims, debts or liens asserted by any medical Providers, including but not limited to, Hospitals or Emergency treatment facilities, that assert a right to payment from funds payable from or recovered from an allegedly responsible third party and/or insurance carrier.
j) The Plan and all Administrators administering the terms and conditions of the Plan's subrogation and reimbursement rights have such powers and duties as are necessary to discharge its duties and functions, including the exercise of its discretionary authority to (1) construe and enforce the terms of the Plan's subrogation and reimbursement rights and (2) make determinations with respect to the subrogation amounts and reimbursements owed to the Plan.
k) The Plan's subrogation and reimbursement rights apply to full and partial settlements, judgments or other recoveries paid or payable to You or Your representative, Your heirs and beneficiaries no matter how those proceeds are captioned or characterized. Payments include, but are not limited to, economic, non-economic and punitive damages. The Plan is not required to help You to pursue Your claim for damages or personal injuries and no amount of associated costs, including attorneys' fees, shall be deducted from NHAS's recovery without the Plan's express written consent. No so-called "Fund Doctrine" or "Common Fund Doctrine" or "Attorney's Fund Doctrine" shall defeat this right.
l) The Plan may collect from You the proceeds of any full or partial recovery You or Your legal representative obtain, whether in the form of a settlement (either before or after any determination of liability) or judgment, no matter how those proceeds are captioned or characterized. Proceeds from which the Plan may collect include, but are not limited to, economic, non-economic, and punitive damages. No "collateral source""" rule, any "Made-Whole Doctrine" or "Make-Whole Doctrine," claim of unjust enrichment, nor any other equitable limitation shall limit the Plan's subrogation and reimbursement rights.
m) If You receive any payment from any party as a result of Illness or Injury, and the Plan alleges some or all of those funds are due and owed to the Plan, You shall hold those funds in trust, either in a separate bank account in Your name or in Your attorney's trust account. You agree that You will serve as a trustee over those funds to the extent of the Benefits the Plan has paid.

n) The Plan's rights to recovery will not be reduced due to Your own negligence.
o) Upon the Plan's request, You will assign to the Plan all rights of recovery against third parties, to the extent of the Benefits We have paid for the Illness or Injury.
p) Benefits paid by this Plan may also be considered to be benefits advanced.

By participating in and accepting benefits from this Plan, You agree that (i) any amounts recovered by You from any third party shall constitute Plan assets (to the extent of the amount of Plan benefits provided on behalf of the covered Participant), (ii) You and Your representative shall be fiduciaries of the Plan (within the meaning of ERISA) with respect to such amounts and (iii) You shall be liable for and agree to pay any costs and fees (including reasonable attorney fees) Incurred by this Plan to enforce its reimbursement rights.

SECTION 16 ~ PRIVACY AND SECURITY OF PERSONAL INFORMATION

The Plan is a "group health plan" funded by the Plan Sponsor. The Plan Sponsor helps to administer the Plan by conducting "plan administration functions," including conducting "payment" activities and "health care operations" (as each of those terms is defined in the Privacy Standards). The Plan Sponsor must use, disclose and maintain "protected health information" (that is, personally identifiable health information about Participants) to perform these functions. Under the Privacy Standards, the Plan may disclose protected health information about Participants to the Plan Sponsor only upon receipt of a certification by the Plan Sponsor that the Plan has been amended to include certain conditions to the Plan Sponsor's receipt of protected health information about Participants and that Plan Sponsor agrees to those conditions. By adopting this Plan Document, Plan Sponsor certifies that the Plan has been amended as required by the Privacy Standards and that it agrees to the below conditions, thereby allowing the Plan to disclose protected health information about Participants to the Plan Sponsor.

THE PLAN SPONSOR WILL:

a) Use and disclose protected health information to the extent of and in accordance with the uses and disclosures permitted by HIPAA. For example, Plan Sponsor may use and disclose protected health information for Plan payment and administration purposes and in accordance with the HIPAA minimum necessary standard. Notwithstanding the foregoing, Plan Sponsor shall not use or disclose protected health information, except as permitted or required by the Plan Document, as required by law, or as authorized by Participants;
b) Implement administrative, physical, and technical safeguards that reasonably and appropriately protect the confidentiality, integrity and availability of protected health information;
c) Ensure that any agents to which it provides protected health information agree to the same restrictions and conditions that apply to the Plan Sponsor with respect to such information, including (but not limited to) reasonable and appropriate safeguarding measures;
d) Not use or disclose the information for employment-related actions and decisions or in connection with any other Benefit or employee Benefit plan of Plan Sponsor;
e) Report to the Plan any non-permitted use or disclosure of the information and any security incident of which the Plan Sponsor becomes aware;
f) Make available protected health information in accordance with the Privacy Standards' "access" requirements;
g) Make available protected health information for Amendment and incorporate any Amendments to protected health information in accordance with the Privacy Standards' "Amendment" requirements;
h) Make available information necessary for the Plan to provide an accounting of disclosures in accordance with the Privacy Standards' "disclosure accounting" requirements;

i) Make its internal practices, books and records relating to the use and disclosure of protected health information available to the Secretary of the U.S. Department of Health and Human Services for purposes of determining the Plan's compliance with the Privacy Standards;
j) If feasible, return or destroy all protected health information received from the Plan that the Plan Sponsor maintains in any form (and retain no copies of such information) when the information is no longer needed for plan administration functions. If return or destruction is not feasible, Plan Sponsor will limit further uses and disclosures of the information to those purposes that make the return or destruction infeasible;
k) Ensure that adequate separation is established and maintained. Plan Sponsor will establish and maintain systems and procedures to limit access to protected health information to those persons who must have access to the information for the performance of plan administration functions.
l) Limit access to protected health information to conduct plan administration functions in the ordinary course of business to those Employees (or classes of Employees), consultants, or other vendors under the control of Plan Sponsor identified as Authorized Individuals; and prohibit these Authorized Individuals from accessing, using or disclosing protected health information for any purpose other than plan administration functions;
m) Adopt reasonable and appropriate mechanisms to permit only Authorized Individuals to access protected health information; and impose disciplinary actions on any Authorized Individual that fails to comply with these restrictions.

SECTION 17 ~ EXCLUSIONS AND LIMITATIONS

Coverage is not available from the Plan for charges arising from the following care, supplies, treatment and/or services, including complications from the following.

IMPORTANT: *The Plan will not pay for services or supplies that are excluded even if:*

a) A Practitioner prescribes, recommends or approves the service or supply.

b) The listed exclusion is Medically Necessary.

SERVICES, TREATMENT, EQUIPMENT AND SUPPLIES NOT COVERED

1. Abortions, the directly intended termination of a pregnancy and all related charges and complications.
2. Acupuncture, acupressure and similar services, including dry needling.
3. Alternative medicine, including but not limited to:
    a) Aroma therapy;
    b) BEST or AIT therapy;
    c) Colonic irrigation;
    d) Contact reflex analysis;
    e) Electromagnetic therapy;
    f) Herbal therapy;
    g) Holistic medicine;
    h) Homeopathy;
    i) Hypnosis:
    j) Iridology;
    k) Magnetic innervation therapy;
    l) Music therapy, unless performed in a behavioral health setting by a licensed mental health professional; and
    m) Naturopathy;
    n) Neurofeedback.
    o) Orthomolecular therapy;
    p) Reike therapy;
    q) Thermography;
    r) Vitamins or dietary products;

4. Ambulance Services that the Plan does not cover include:
    a) Non-Emergency transport, unless initiated or approved by NHAS.
    b) Services or supplies that are not Medically Necessary, even if furnished while in transport.
5. Animal-based therapy including equine therapy or hippotherapy.
6. Any services or supplies for bodily Injuries sustained while the Participant is committing or attempting to commit a crime punishable as a felony. Any services or supplies arising from the Participant engaging in an illegal occupation or commission or attempted commission on an assault or other illegal act if the Participant is convicted of a crime on account of such illegal assault or other act.
7. Any service or expense You incur:

a) Before Your Effective Date of coverage,
b) After the date Your coverage under this Plan terminates or
c) After You are disenrolled from the Plan. If a Participant is inpatient on the Effective Date of Coverage, the Plan will only pay for the portion of expenses incurred on and after the Effective Date.

8. Any supplies or services furnished for the protection or convenience of or to meet a requirement of third parties. This includes medical, physical, mental health and substance abuse services or examinations. Third parties include, but are not limited to, attorneys, school systems, employers and insurers. This exclusion extends to court ordered commitments including sex offender treatment programs and screening interviews or treatment programs related to driving under the influence of alcohol or drugs, mandated AA and NA meetings and anger management. The Plan does not cover health services mandated by a court as a stipulation of parole, probation, sentencing or any other reason, unless Medically Necessary.
9. Any service provided by a school system.
10. Any treatment that is habilitative in nature, such as therapy or treatment for Developmental or Learning Disability or Delays. This applies to any procedure, service, device, supply or drug. It also applies to Durable Medical Equipment, prosthetic devices and technology.
11. Any treatment that is not Medically Necessary and appropriate. This applies to any procedure, service, site of care, device, supply or Drug. It also applies to Durable Medical Equipment, prosthetic devices and technology.
12. Any treatment that is not medical in nature or that is solely for the purpose of athletic performance and/or participation. This applies to any procedure, service, device, supply or Drug. It also applies to Durable Medical Equipment, prosthetic devices and technology.
13. Any treatment that is provided mainly for the Participant's vocation, comfort, safety, personal hygiene, convenience, exercise, physical fitness or recreation. Any treatment that is provided mainly as an adaptation of the Participant's environment such as ramps, grab bars or that is a common household item such as air-conditioners, humidifiers, dehumidifiers, air purifiers and filters. This applies to any procedure, service, device, supply or Drug. It also applies to Durable Medical Equipment, prosthetic devices and technology.
14. Any treatment provided in the absence of a bodily Injury or Illness. This applies to any procedure, service, device, supply or Drug. It also applies to Durable Medical Equipment, prosthetic devices and technology.
15. Any treatment furnished or ordered for a Participant themself, by a Family Member or any person residing with the Participant. This includes prescriptions, services or supplies. Family Members include Your lawful spouse, child, parent, grandparent, brother, sister or any person related in the same way to Your covered Dependent.
16. Augmentative and alternative communication aids, such as talk boards. The Plan does not cover the fitting of such items.
17. Autism Services the Plan does not cover include:
    a) Acupuncture

b) Animal-based therapy including hippotherapy;
c) Auditory integration training
d) Care provided in a Residential Treatment Facility, inpatient treatment or day treatment facility
e) Chelation therapy
f) Childcare fees
g) Cranial sacral therapy
h) Custodial care
i) Facility or location or the use of a facility or location when treatment, therapy or services are provided outside of a Participant's home
j) Hyperbaric oxygen therapy
k) Respite care
l) Services rendered by any Practitioner who is not qualified to provide intensive-level services or non-intensive level services
m) Special diets or supplements
n) Travel time for Qualified Providers, supervising Providers, professionals, therapists or paraprofessionals
o) Treatments in a school facility that are not related to the goals of the treatment plan or duplicate services that are required to be provided by a school
p) Treatment rendered by parents or legal guardians who are otherwise Qualified Providers to their own Children

18. Autopsy
19. Batteries and battery chargers, except for diabetic equipment, covered wheelchairs, and implanted devices
20. Cardiac Rehabilitation Services that the Plan does not cover are:
    a) Stage 3 rehabilitation (Supervised Therapy)
    b) Stage 4 rehabilitation (Maintenance/Follow-Up Therapy)
21. Charges in excess of the Maximum Allowable Fee.
22. Chelation Therapy for autism, Alzheimer's and atherosclerosis..
23. Chiropractic Care the Plan does not cover includes:
    a) Maintenance Therapy
    b) Massage Therapy
    c) Self-help, educational or vocational training treatment, services or supplies
    d) Any services outlined in alternative medicine exclusions listed above
24. Cold laser therapy (also known as low-level light therapy) and similar services. Cold laser therapy is excluded except for the treatment of temporomandibular joint disorders (TMD) dysfunction, rheumatoid arthritis, carpal tunnel syndrome and lateral epicondylitis.
25. Coma stimulation.
26. Complications resulting from a Participant leaving a Hospital or other facility or discontinuing treatment against a Practitioner's written orders.
27. Continuous Passive Motion devices and associated items such as sheepskin pads and water circulating pumps.

28. Cost of a standby Practitioner.
29. Cost of missed appointments.
30. Cost of release and review of medical records, including copy costs, postage, shipping or handling charges, except when requested by NHAS.
31. The cost of communications, lodging and transport or travel time for the Participant or their Family Member(s).
32. Cryopreservation (freezing) of body fluids or tissues.
33. Custodial Care, services of personal care attendants or maintenance care.
34. Dental care for Accidents that the Plan does not cover includes:
    a) Services rendered more than twelve (12) months after the date of the Injury;
    b) Orthodontia treatment;
    c) Orthognathic surgery;
    d) Osteotomy;
    e) Dentures, implants, bridges and services for the preparation thereof;
    f) Restoration of cracked or broken teeth caused by biting or chewing;
    g) Teeth whitening or bleaching.
35. Dental care or treatment except as outlined under Benefit Provisions. Dental damage that occurs as a result of normal Activities of Daily Living or extraordinary use of the teeth is not considered having occurred as an Accident or Injury. Benefits are not available for repairs to teeth that are damaged as a result of such activities. This exclusion applies to
    a) Periodontic care
    b) Dentures
    c) Mouth guards
    d) Osteotomy
    e) Teeth whitening and bleaching
    f) Treatment of congenitally missing, malpositioned or supernumerary teeth, even if part of a Congenital Anomaly, unless functional repair or restoration is necessary to achieve normal body functioning for newborn infants
36. Dental implants.
37. Durable Medical Equipment (DME) and Disposable Medical Supplies that the Plan does not cover includes:
    a) Cords for hearing aids.
    b) DME with features that provide more functions than are Medically Necessary for the Member. The Plan will cover the standard DME model, as determined by NHAS.
    c) Medical supplies or DME used for habilitative needs or services.
    d) Motor vehicles or vehicle adaptations, including, but not limited to, lifts for wheelchairs and scooters.
    e) Repairs or replacements of DME, orthotics or prosthetics due to Accidental loss, theft or negligent misuse.
    f) Self-help devices that are not primarily medical in nature.

g) Services, supplies, equipment, accessories or other items which are purchased at retail establishments (including on-line) or over the counter.
h) Shoes, orthopedic shoes, shoe orthotics, diabetic shoes, arch supports or shoe inserts, except when custom made.

IMPORTANT: *To verify whether the Plan will cover a specific DME item or disposable medical supply, please contact the NHAS Member Experience Team at the number on the back of your Participant ID card.*

38. Enteral feedings, even if the sole source of nutrition.
39. Expenses incurred by a non-Participant except for covered services relating to live donor transplants to a Plan Participant.
40. Health Club Memberships, costs of fitness programs, exercise programs and equipment.
41. Health services for disabilities or conditions resulting from military service, including participation in the National Guard and Civilian auxiliary forces. This applies only if the Participant is legally entitled to services provided by a government agency. Government facilities must be reasonably available to the Participant. NHAS will determine whether services are reasonably available. This exclusion may be limited by federal law.
42. Health services for job, employment or work-related bodily Injuries or Illnesses for which coverage is:
    a) Required under any Workers' Compensation Act or Law;
    b) Required under any Occupational Disease Act or Law;
    c) Provided under a Workers' Compensation policy.
43. Health services provided by Non-Participating Providers and Non-Participating Practitioners under an EPO plan. This includes:
    a) Ambulatory non-emergent, non-urgent follow-up care furnished by a Non-Participating Provider or Non-Participating Practitioner after an Emergency, unless NHAS Prior Authorizes the care;
    b) Acute Hospital (inpatient or observation) follow-up care furnished by a Non-Participating Provider or Non-Participating Practitioner after an Emergency, unless NHAS Prior Authorizes the care;
    c) Non-Emergency, non-Urgent Care, except as this Plan document specifically allows;
    d) Urgent Care Services or treatment furnished by a Non-Participating Provider or a Non-Participating Practitioner that is in NHAS's Service Area.

    This does not apply to:
    a) Services provided with NHAS's Prior Authorization;
    b) Emergency Health Services provided in an Emergency room or Hospital-based Urgent Care Facility when, due to the Participant's location when care became necessary, a Participating Provider or Practitioner could not practically furnish the care;

c) Urgent Care provided in an Emergency room or Hospital-based Urgent Care Facility outside NHAS's Service Area.

44. Human Chorionic Gonadotropin injections if used to treat a non-Covered Service such as Infertility.
45. Immunizations, exams, prescriptions and health services required solely for purposes of school, sports, camp, travel, licensing, employment, recreation, higher education and insurance, marriage or adoption purposes.
46. Inpatient Hospital services that NHAS or its designee does not certify as being Medically Necessary and appropriate care. Inpatient Hospital services for days that NHAS does not Authorize.
47. Infertility services, artificial conception procedures, supplies and prescriptions which are not for treatment of Illness or Injury (i.e., that are for the purpose of achieving pregnancy). The diagnosis of Infertility alone does not constitute an Illness.

This includes, but is not limited to:

a) Prescriptions
b) Lab and diagnostic procedures;
c) In-vitro fertilization;
d) Artificial insemination;
e) Intrauterine insemination;
f) Micromanipulation procedures of sperm such as intracytoplasmic sperm injection (ICSI);
g) Sperm penetration and movement studies;
h) Sperm banking;
i) Freezing (cryopreservation) of sperm, oocytes or embryos;
j) Advanced reproductive technologies. These include in-vitro fertilization (IVF), zygote intra-fallopian transfer (ZIFT) and gamete intra-fallopian transfer (GIFT) whose primary purpose is to achieve pregnancy;
k) Procedures related to infertility problems that are considered Unproven, Experimental and Investigational or for Research Purposes.
l) Reversal of voluntarily sterilization or any related services or complications.

48. Kidney disease services for which the Participant is eligible for reimbursement by Medicare are not covered.
49. Learning, motor skills and primary communication disorders as defined in the current edition of the Diagnostic and Statistical Manual of the American Psychiatric Association
50. Maintenance Therapy of any kind. This includes, but is not limited to, acupuncture, chiropractic, physical, speech and occupational therapy.
51. Marriage Counseling.
52. Massage Therapy.
53. Maternity care that the Plan does not cover.
    a) Diagnostic tests solely to determine the gender of a fetus. The Plan will cover tests to determine the existence of a gender-linked genetic disorder;

b) Births at stand-alone birth centers, home births and all related services.
c) Childbirth preparation classes including, but not limited to, Lamaze, hypnobirthing and baby care.
d) Maternity expenses for a non-Participant acting as a surrogate.

54. Mental Health Services as treatments for V-code conditions or services performed in connection with conditions not classified within the current edition of the Diagnostic and Statistical Manual of the American Psychiatric Association. These include, but are not limited to:
    a) Abuse and neglect
    b) Circumstances of personal history
    c) Crime and legal system
    d) Educational and occupational
    e) Housing and economic
    f) Other health service encounters
    g) Other psychosocial, personal and environmental circumstances
    h) Relational
    i) Social environment
55. Mental Health Services as treatments for Z-code conditions or services performed in connection with conditions not classified within the current edition of the Diagnostic and Statistical Manual of the American Psychiatric Association. These include, but are not limited to:
    a) Education and literacy
    b) Employment and unemployment
    c) Housing and economic
    d) Negative life events in childhood
    e) Problems related to upbringing
    f) Problems related to primary support
    g) Psychosocial circumstances
    h) Other Psychosocial circumstances
    i) Social environment
56. Neuropsychological testing for Attention Deficit Disorder and Attention Deficit Hyperactivity Disorder.
57. Oral surgery. This includes:
    a) Jaw adjustments to correct malocclusion;
    b) Surgical removal of impacted or infected teeth and surgical or non-surgical removal of third molars;
    c) Surgical removal of teeth due to anomalies of tooth position of fully erupted teeth;
    d) Alveolectomy or alveoplasty unrelated to an illness or injury such as preparation for dentures;
    e) Apicoectomy (excision of apex of tooth root);
    f) Treatment of periodontitis and gingivitis;
    g) Osteotomy surgery; and
    h) Reconstructive orthognathic surgery.
58. Organ and Tissue Transplant Services that We do not cover include:

a) Any organ or tissue re-transplantation except for kidney re-transplantation for the treatment of kidney disease or bone marrow re-transplantation.
b) Services for which Medicare will pay.

59. Orthodontic services and surgery except for the treatment of TMD.
60. Ostomy supply Benefits are not available for deodorants, filters, lubricants, tape, appliance cleaners, adhesive, adhesive remover or other items not listed in the Benefits Provisions section.
61. Payment for services not billed in accordance with Our payment policies, which are based on Current Procedural Terminology (CPT®*) billing requirements, regulations promulgated by Center for Medicare and Medicaid Services (CMS) or other coding guidelines. Our payment policies take into consideration factors such as coding practices, industry-standard reimbursement logic and applicable legal requirements.
62. Prayer or Spiritual Healing.
63. Prescription Drug Benefits not covered under this Plan are:
    a) Over-the-counter Drugs and supplies with or without a prescription, unless specifically listed in the most recent edition of the Preferred Drug List (PDL); prescription Drugs that are comprised of components that are available in over-the-counter form or equivalent unless specifically listed in the most recent edition of the PDL; certain prescription Drug products that have been determined to be therapeutically equivalent to an over-the-counter Drug;
    b) Prescription Drugs prescribed for treatment of Infertility;
    c) Experimental or other FDA approved prescription Drugs including compounded prescription Drugs to be used for experimental purposes or unapproved routes of administration. This excludes prescription Drugs for the treatment of HIV that are;
        i. Prescribed by a Practitioner and, either
        ii. Approved by the Food and Drug Administration (FDA); or
        iii. In or have completed Phase 3 of the FDA's clinical evaluation and are administered under a protocol approved by the FDA.
    d) Prescriptions or refills required by a Participant because of theft, damage or loss of the prescription;
    e) Prescriptions or refills exceeding dispensing limitations, for vacation, travel or other periods of extended duration, unless Prior Authorization is given by NHAS;
    f) Prescription Drugs for home use dispensed prior to your release by Home Health Care Services, inpatient services, Skilled Nursing Facilities or Practitioner's office are not covered. Prescription Drugs a Participant receives while an inpatient, or as part of an authorized Home Health Care program, or while a resident in a Skilled Nursing Facility will be eligible for coverage under the Plan's medical Benefit;
    g) Prescription Drugs dispensed outside the United States, except when required for Emergency treatment;

h) Prescription Drugs received from the local, state or federal government. In addition, prescription Drugs where payment or benefits are provided at the local, state or federal government level (e.g., Veterans Affairs benefits) except as otherwise mandated by law;
i) Prescription Drugs for a condition, Injury, sickness or mental Illness related to any workers' compensation law or other similar laws, if a claim for such benefits is made;
j) Any product dispensed for appetite suppression or weight loss;
k) Durable Medical Equipment with or without a prescription other than items specifically stated as covered in the PDL;
l) Vitamins, except prescription items and over-the-counter products covered by the Affordable Care Act, such as prenatal vitamins, vitamins with fluoride and certain single-entity vitamins;
m) Unit dose packaging of prescription Drugs;
n) Prescription Drugs used for cosmetic purposes;
o) Bulk Powders;
p) Any prescription Drug purchased from the original Drug manufacturer and placed into different containers. These are commonly referred to as "repackaged Drugs";
q) New prescription Drugs and/or new dosage forms until the date they are assigned to a Tier by the P&T Committee;
r) Prescription compounded Drugs that do not contain at least one ingredient that has been approved by the FDA and not otherwise excluded from coverage by the Plan as experimental. Compounded Drugs that are available as a comparable commercially available prescription Drug;
s) Growth hormone for children with familial short stature (short stature based upon heredity and not caused by a diagnosed medical condition);
t) Any product for which the primary use is a source of nutrition or dietary management of disease. These products include nutritional supplements and prescription medicinal food products, even when used for the treatment of Sickness or Injury;
u) Prescription Drugs for sexual dysfunction;
v) A prescription Drug or dosage form that NHAS determines does not meet the definition of a Covered Service. This may include Drugs that are therapeutically equivalent or have modified versions of a prescription Drug. These determinations may be made by the P&T Committee. NHAS may decide at any time to reinstate Benefits for a prescription Drug previously excluded under this provision;
w) Prescription Drugs that have not received FDA approval may not be covered as determined by the P&T Committee. These prescription Drugs may also be known as Non-FDA approved Drugs or DESI Drugs (Drug Efficacy Study Implementation);

x) Prescription Drugs for the desensitization of environmental and food allergies (e.g., Palforzia).]

64. Private Duty Nursing.
65. Private Room Charges unless no semi-private room is available.
66. Routine foot care. This includes, but is not limited to, trimming corns and calluses; hypertrophy or hyperplasia of the skin and subcutaneous tissue of the feet and nails. This also includes other hygienic and preventive maintenance care, such as cleaning and soaking the foot, use of skin creams to maintain Member's skin tone and any other service performed in the absence of localized Illness, Injury, or symptoms involving the foot. The Plan does cover services for a metabolic or peripheral disease or if skin or tissue is infected.
67. Self-help, educational or vocational training, treatment, services or supplies.
68. Services and supplies for which You have no legal obligation to pay, no charge is made or for which You would not be required to pay if You did not have this coverage.
69. Services done solely for gender determination of a fetus.
70. Services for hair analysis, hair removal, hair loss and all forms of alopecia. This applies to any such treatment procedure, service, device, supply or Drug including Durable Medical Equipment, prosthetic devices and technology. The Plan does not cover hair replacements, wigs, toupees and hair replacement therapies.
71. Services or supplies the Participant receives, which are paid, may be paid, are provided or may be provided at no cost to the Participant through any program or agency. It also includes care provided at government expense under any program for which the Participant is eligible. Examples of these types of services include, but are not limited to:
    a) Provided under a Workers' Compensation policy.
    b) Received as a veteran in a Veteran Administration facility.
    c) Provided by a university student health center.

    This Exclusion does not apply when otherwise prohibited by law, including laws applicable to Medicaid and Medicare.
72. Services performed by a Provider enrolled in an education or training program when such services are related to the education or training program, except as specifically provided in the Plan.
73. Services solely to improve the Participant's appearance. The Plan will not pay for services that are not for the correction of a functional defect caused by a bodily Injury or Illness. This includes reconstructive, plastic, cosmetic surgery or any other service or supply which is primarily used to improve, alter or enhance appearance, whether or not for psychological or emotional reasons, except to the extent where it is needed for:
    a) Repair or alleviation of damage resulting from an Accident;
    b) Because of infection or Illness;
    c) Due to congenital disease, Developmental condition or anomaly of a covered Dependent child which has resulted in a functional defect; or
    d) Breast reconstruction as allowed under the Women's Health and Cancer Rights Act.

    Psychological impact is not a functional defect caused by a bodily Injury or Illness. The fact that a Participant may suffer psychological consequences or socially avoidant

behavior as a result of an Injury, Sickness or Congenital Anomaly does not classify surgery (or other procedures done to relieve such consequences or behavior) as a Reconstructive Procedure.

74. Services, supplies, equipment, accessories or other items which can be purchased at retail establishments (including on-line) or over the counter.
75. Services that are not Medically Necessary, including services that are Fraudulent, Wasteful or Abusive Practices.
76. Skilled Nursing Facility services that can be provided at an ambulatory or home care level.
77. Sublingual (under the tongue) allergy testing and treatment.
78. The following services related to the treatment of Temporomandibular (TMD) Disorders.
    a) Periodontic care;
    b) General dental care; or
    c) Any procedure, device or treatment for plastic or Cosmetic Services or to improve the Participant's appearance.
79. Transgender and Gender Dysphoria Exclusions include, but are not limited to:
    a) Procurement, cryopreservation or storage of embryo, sperm or oocytes as part of gender reassignment Surgery.
    b) Treatment or Surgery received outside the United States.
    c) The reversal of any transgender or gender dysphoria surgery.
    d) Examples of treatments that are considered to be Cosmetic in nature and not Medically Necessary as treatments of Gender Dysphoria, include, but are not limited to: Abdominoplasty, blepharoplasty, breast augmentation, brow lift, calf implants, collagen injections, dermabrasion/chemical peels, electrolysis, face lift, facial bone reconstruction, facial implants, gluteal augmentation, hair removal/hairplasty, jaw reduction (jaw contouring), lip reduction/enhancement, lip filling/collagen injections, liposuction, nose implants, pectoral implants, penile implants (inflatable and non-inflatable), rhinoplasty, thyroid cartilage reduction (chondroplasty), voice modification Surgery and voice therapy.
80. Treatment and services for Rett's Disorder and sensory integration or defensiveness.
81. Treatment and/or services related to a non-covered Benefit, including complications from treatment of a non-covered Benefit.
82. Treatment for gambling addiction.
83. Treatment for obesity including, but not limited to, weight loss or weight management programs and bariatric procedures such as ileal bypass, gastric bypass or stapling and complications from such procedures.
84. Treatment of flat feet and treatment of subluxation of the foot.
85. Treatment of sexual or erectile dysfunction (including impotence). This includes any procedure, service, supply, Drug, device or technology used to treat these conditions.
86. Treatment or services furnished and/or billed by an adult or child daycare organization.
87. Treatment or services which are not furnished or supplied by a Provider under the direction of a Practitioner.
88. Tuition for or services that are school based for children and adolescents under the Individuals with Disabilities Education Act.

89. Drugs, Medical or surgical procedures that are considered Unproven, Experimental, Investigational or for Research Purposes. This includes service levels that are not appropriate to the procedure or services, based on national standards. This applies to complications from such procedures. NHAS's Medical Director will make such determinations. NHAS will base its decisions on generally accepted standards of the U.S. medical community.

IMPORTANT: *A service, supply, treatment or facility may be considered Unproven, Experimental or Investigational or for Research Purposes even if the Practitioner has performed, prescribed, recommended, ordered or approved it, or if it is the only available procedure or treatment for the condition.*

90. Upper and lower jawbone surgery except as required for direct treatment of acute traumatic Injury, dislocation, tumors, cancer or temporomandibular joint disorder (TMD). Orthognathic surgery jaw alignment, except as treatment of obstructive sleep apnea.
91. Vision services not covered under this Plan:
    a) Glasses or contact lenses or their measurement, fitting and adjustment
    b) Vision therapy, including eye exercises
    c) Orthoptic pleoptic training aids
    d) Surgery to correct vision. This includes, but is not limited to:
        i. Radial Keratotomy (RK);
        ii. Astigmatic Keratotomy (AK);
        iii. Automated Lamellar Keratoplasty (ALK);
        iv. Excimer Laser;
        v. Photorefractive Keratotomy (PRK);
        vi. Phototherapeutic Keratotomy (PTK);
        vii. Laser Assisted In Situ Keratomileusis (LASIK);
        viii. Corneal modulation; and
        ix. Refraction Keratoplasty.

92. War/Riot. That Incurred as a result of war or any act of war, whether declared or undeclared, or any act of aggression by any country, including rebellion or riot, when the Participant is a member of the armed forces of any country, or during service by a Participant in the armed forces of any country, or voluntary participation in a riot. This Exclusion does not apply to any Participant who is not a member of the armed forces and does not apply to victims of any act of war or aggression.
93. Work Hardening Services, which are a Rehabilitation Services program designed to restore functional and work capacities to the injured worker through application of graded work simulation.

With respect to any Injury that is otherwise covered by the Plan, the Plan will not deny benefits otherwise provided for treatment of the Injury if the Injury results from being the victim of an act of domestic violence.

SECTION 18 ~ DEFINED TERMS

The following words and phrases shall have the meanings stated below when used in this Plan Document. The following definitions are not an indication that charges for care, supplies or services are eligible for payment under the Plan. In fact, they may be used to identify ineligible expenses. Please refer to the appropriate sections of the Plan Document for information regarding coverage and exclusions.

1. ABORTION

An operation or other procedure, including but not limited to induction, to terminate pregnancy before the fetus is viable; or an operation or other procedure to terminate pregnancy after the fetus is viable when the operation or procedure is not performed with the intent to treat a pregnant Participant's or fetus' functional defect caused by bodily Injury or Illness. Psychological impact is not a functional defect caused by a bodily Injury or Illness.

2. ABUSIVE PRACTICES

Practices that, either directly or indirectly, result in unnecessary costs to the Plan. Abuse includes any practice inconsistent with providing patients with Medically Necessary services meeting professionally recognized standards. Examples of abuse include:

a) Billing for unnecessary medical services
b) Charging excessively for services or supplies
c) Misusing codes on a Claim, such as upcoding or unbundling

3. ACCIDENT (ACCIDENTAL)

An occurrence which is:

a) Unforeseen; and,
b) Is not due to, or contributed to by, a Sickness or disease of any kind; and,
c) Causes Injury.

4. ACTIVITIES OF DAILY LIVING

Basic self-care tasks an individual does on a day-to-day basis, which are fundamental in caring for oneself and maintaining independence. These include, but are not limited to:

a) Bathing;
b) Dressing;
c) Toileting;
d) Transferring, which is move out of bed, chair, wheelchair, tub or shower;
e) Mobility;
f) Eating;
g) Continence, which is voluntary maintaining control of bowel or bladder; in the event of incontinence, maintaining a reasonable level of personal hygiene.

5. ADVERSE BENEFIT DETERMINATION

Any of the following:

a) Denial, reduction or termination of Benefits;

b) Limitation of a Covered Service
c) Failure to provide or make payment (in whole or in part) for a Benefit based on a determination of a person's eligibility to participate in the Plan.
d) Reduction or denial of a Claim based on utilization review, experimental or investigational treatments and Medical Necessity or appropriateness.
e) A rescission of coverage.

6. ALLOWABLE EXPENSE

Amounts paid for Covered Services which meet all requirements for coverage under the Plan, including that it be reasonable, usual and customary and Medically Necessary. All Allowable Expenses are subject to Benefit maximums, cost sharing, limitations and exclusions provided in the Plan documents.

7. ALLOWED AMOUNT

Maximum amount on which payment is based for covered health care services. If Your Practitioner and/or Provider charges more than the Allowed Amount, You may have to pay the difference. (See Balance Billing.) For Out-Of-Network charges refer to Maximum Out-of-Network Allowed Fee.

8. ALTERNATE FACILITY

A health care facility that is not a Hospital and that provides one or more of the following services on an outpatient basis, as permitted by law:

a) Surgical services.
b) Emergency Health Services.
c) Rehabilitative, laboratory, diagnostic or therapeutic services.

An Alternate Facility may also provide Mental Health Services or services for Substance Abuse Disorders on an outpatient or inpatient basis.

9. ALTERNATE RECIPIENT

Any Child of a Participant who is recognized under a Medical Child Support Order as having a right to enrollment under this Plan as the Participant's eligible Dependent. For purposes of the benefits provided under this Plan, an Alternate Recipient shall be treated as an eligible Dependent.

10. AMBULATORY SURGICAL CENTER

Any public or private state licensed establishment that operates exclusively for the purpose of providing surgery to patients not requiring hospitalization. The patient is admitted to and discharged from the facility within the same working day as the facility does not provide overnight services and accommodations.

11. AMENDMENT
Any attached written description of additional or alternative provisions to the Plan documents. Amendments are subject to all conditions, limitations and exclusions of the Plan documents, except for those specifically amended.

12. ANCILLARY FEE
An additional amount, not to exceed $200 for a month supply, that You are charged to fill a prescription when You substitute a brand-name Drug for an available generic Drug. When generic substitution conflicts with state regulations or restrictions the pharmacist must gain approval from the prescriber to use the generic equivalent.

13. APPEAL
A request for an Adverse Benefit Determination or Coverage Denial Determination to be reviewed again.

14. ASSIGNMENT OF BENEFITS
An arrangement whereby the Participant assigns their right to seek and receive payment of Eligible Expenses, (less Participant cost share) directly to a Provider. If the Provider accepts the arrangement, the Provider's rights to receive payment are equal to the benefits available to the Participant and are limited by the terms of this Plan Document. The Plan Administrator may revoke or disregard an Assignment of Benefits at its discretion and continue to treat the Participant as the sole beneficiary. In no event shall an Assignment of Benefits be construed as an assignment of any legal or equitable right to institute any court proceeding.

A Claimant may not assign his/her Claim under the Plan to a Nonparticipating Provider without the Plan's express written consent. Regardless of this prohibition on assignment, the Plan may, in its sole discretion, pay a Nonparticipating Provider directly for Covered Expenses rendered to a Claimant. Payment to a Nonparticipating Provider does not constitute a waiver, and the Plan retains a full reservation of all rights and defenses.

15. AUTHORIZED REPRESENTATIVE
A person who can contact the Plan on the Participant's behalf to help with Claims, Appeals, or other Benefit issues related to this Plan.

16. BALANCE BILLING
When a Practitioner or Provider bills You for the difference between the charged and the Allowed Amount. For example, if the Practitioner's or Provider's charge is $100 and the Allowed Amount is $70, the Practitioner or Provider may bill You for the remaining $30. A Participating Provider may not Balance Bill You.

17. BENEFIT YEAR
The 12-month period during which yearly plan design features, such as the Deductible, Out-of-Pocket Limit and specific Benefit maximums, accumulate. May follow a calendar year (January 1 – December 31) or plan year (Example: July 1 – June 30).

18. BENEFIT(S)
Your right to payment for Covered Services that are available under the Policy. Your right to Benefits is subject to the terms, conditions, limitations and exclusions of the Plan Document, the Summary of Member Responsibility Table/Summary of Benefits and Coverage, and any attached Amendments.

19. CHELATION THERAPY
A treatment that uses special Drugs that bind to heavy metals, like lead or mercury, in Your blood, and remove them through Your urine.

20. CLAIM
A request for payment or reimbursement for health care services made by a Participant or a Participant's Provider in accordance with NHAS's procedures for filing Claims.

21. COBRA
The Consolidated Omnibus Budget Reconciliation Act of 1985, as amended. Provides Participants and their Dependents who lose coverage under the Plan the right to choose to continue group health benefits for limited periods of time under certain circumstances such as voluntary or involuntary job loss, reduction in the hours worked, transition between jobs, death, divorce and other life events.

22. COINSURANCE
A percentage of the Allowed Amount You must pay for Covered Services after the Deductible is met, if applicable. The Plan pays the rest of the Allowed Amount. The Summary of Participant Responsibility Table/Summary of Benefits and Coverage sets out what, if any, Coinsurance You must pay.

23. COMPLAINT
A verbal expression by or on behalf of the Participant of any dissatisfaction with NHAS or its contracted providers.

24. CONFINEMENT
An admission as an inpatient or outpatient to a Hospital, Residential Treatment Facility, Skilled Nursing Facility or licensed Ambulatory Surgical Center on the advice of Your Practitioner; or the time spent receiving Emergency Health Services for Illness or Injury in a Hospital. Hospital swing bed and Hospital sub-acute Confinement is considered the same as Confinement in a Skilled Nursing Facility. If the Participant is transferred or discharged to another facility for continued treatment of the same or related condition, it is one Confinement.

25. CONGENITAL ANOMALY
A physical Developmental defect that is present at the time of birth.

26. COPAYMENT
A charge, stated as a set dollar amount, You are required to pay directly to the Provider for certain Covered Services. The Summary of Participant Responsibility Table/Summary of Benefits and Coverage sets out what, if any, Copayment You must pay. The Summary of Participant Responsibility Table/Summary of Benefits and Coverage will also indicate if the Copayment would apply to the plan Deductible and/or Out-Of-Pocket Limits.

27. 18. COSMETIC PROCEDURES
Any surgery or medical treatment undertaken to change or improve the Participant's appearance or self-esteem, without significantly improving physiological function as determined by NHAS such as plastic surgery to enhance Your appearance. Cosmetic Procedures do not treat a bodily Injury, Illness or functional bodily impairment.

28. COVERED SERVICE(S)
A Medically Necessary service, treatment or supply, meant to improve a condition or Participant's health, which is eligible for coverage under this Plan. When more than one treatment option is available, and one option is no more effective than another, the Covered Service is the least costly option that is no less effective than any other option.

29. CUSTODIAL CARE
The provision of room and board, nursing care, personal care or other care designed to assist the Participant in the Activities of Daily Living. Custodial Care is not likely to improve a Participant's medical condition. Care provided to a Participant who has reached the maximum level of recovery is Custodial Care. Such care is custodial even if the level of maintenance care requires services of some skilled health professionals. Custodial Care also includes rest cures, respite care and home care provided by Family Members. NHAS's Medical Director will determine whether care qualifies as Custodial Care.

30. DAYS
Any reference to "Days" means calendar days, unless otherwise noted.

31. DEDUCTIBLE
The amount stated in the Summary of Participant Responsibility Table/Summary of Benefits and Coverage that each Participant or between all Participants of a family is required to pay each Benefit Year before any payment for expenses is made by the Plan. NHAS will calculate the Deductible based upon the total amount of Allowable Expenses incurred during a Benefit Year. The Deductible does not include any amount that exceeds Eligible Expenses. Only charges for Covered Services satisfy the Deductible.

32. DEPENDENT(S)
The Participant's legal spouse and/or child or the child of the Participant's spouse. The individual must also be a citizen of the United States or a resident legal alien.

The term child includes any of the following:

a) A natural child;

b) A stepchild;
c) A legally adopted child or a child legally placed for adoption as granted by action of a federal state or local governmental agency responsible for adoption administration or a court of law if the child has not attained age 26 as of the date of such placement;
d) A child who is considered an Alternate Recipient under a Qualified Medical Child Support Order;
e) A child for whom a court order requires the Employee to provide health coverage;
f) A child for whom legal guardianship has been awarded to the Plan Participant or the Plan Participant's spouse;
g) A child of a covered Dependent child (grandchild) until the covered Dependent child who is the parent turns 18.

A Child listed above must be under 26 years of age.

A Dependent will also include a child age 26 or older who meets the following criteria:
a) The child is unable to hold a self-sustaining job due to intellectual disability or physical handicap;
b) The child is chiefly dependent on You for support and maintenance;
c) The child's incapacity existed before he or she reached age 26;
d) Your family coverage remains in force under this Plan; and
e) The child is unmarried.

Written proof of the child's incapacity and dependency must be furnished to Plan Administrator within thirty-one (31) Days of the child attaining age 26, and at any time thereafter, but no more frequently than annually after the initial two-year period following the attainment of age 26. You must notify NHAS immediately of an end to the incapacity or dependency.

A Dependent also includes an adult child who meets all of the following:
a) The child is a Full-Time Student, regardless of age, attending an accredited vocational, technical or adult education school, or an accredited college or university; and
b) The child was under age 27 and called to federal active duty in the National Guard or in a reserve component of the U.S. Armed Forces while attending, on a full-time basis, an institution of higher education.

A Dependent who is on active duty with the military service, including the National Guard or Reserves, for more than thirty (30) Days is not an eligible Dependent. NHAS may require proof of the adult child's Full-Time Student enrollment on an as-needed basis.

33. DEVELOPMENTAL OR LEARNING DISABILITY OR DELAY

Any condition that interrupts or delays the sequence and rate of normal growth, development and maturation. The condition may be due to:

a) Congenital abnormality;
b) Trauma;
c) Deprivation; or
d) Disease.

34. DIAGNOSIS
The act or process of identifying or determining the nature and cause of an Illness or Injury through evaluation of patient history, examination and review of laboratory test result data.

35. DIAGNOSTIC SERVICE
An examination, test, or procedure performed for specified symptoms to obtain information to aid in the assessment of the nature and severity of a medical condition or the identification of an Illness or Injury. The Diagnostic Service must be ordered by a Provider.

36. DRUG
An FDA approved prescription medicine, preventive medicine or medicine covered under the Affordable Care Act, intended for human use in the Diagnosis, cure, alleviation, treatment or prevention of disease, that is listed with approval in the United States Pharmacopeia, National Formulary, American Hospital Formulary Service, Micromedex or National Comprehensive Cancer Network. It must be legally obtained and only dispensed by a licensed Provider. These products are approved under a New Drug Application, Amended New Drug Application, Biological License Application or under Biosimilar regulations. It does not include medicinal foods, devices, components, parts or accessories of devices.

37. DURABLE MEDICAL EQUIPMENT (DME)
Equipment that meets all of the following criteria:
a) Can withstand repeated use;
b) Is not disposable
c) Is used to serve a medical purpose with respect to treatment of a Sickness, bodily Injury or their symptoms rather than being primarily for comfort or convenience;
d) Is generally not useful to a Participant in the absence of an Illness, Injury or their symptoms; and
e) Is not implantable within the body.

38. EFFECTIVE DATE
The date that a Participant, or any qualified Dependent, becomes enrolled and entitled to the Benefits specified in this Plan, as shown in the records of NHAS.

39. ELIGIBLE EXPENSES
Expenses that may be considered for processing toward Deductible or payment if the services meet all of the following:
a) Are Medically Necessary and not Experimental/Investigational (except as described in the Routine Patient Care for Approved Clinical Trial section).

b) Received while the Plan is in effect.
c) The person who receives Covered Services meets all eligibility requirements specified in the Plan.
d) Appropriate Proof of Loss was submitted timely.

40. EMERGENCY

A medical condition which may manifest itself by acute symptoms of sufficient severity, including severe pain, that leads a prudent layperson, who possesses an average knowledge of health and medicine, to reasonably conclude that a lack of immediate medical attention will likely result in any of the following:

a) Serious jeopardy to the person's health or, with respect to a pregnant woman, serious jeopardy to the health of the woman or her unborn child; or
b) Serious impairment to the person's bodily functions; or
c) Serious dysfunction of one or more of the person's body organs or parts.

An Emergency includes, but is not limited to, severe chest pain, poisoning, unconsciousness and hemorrhage.

41. EMERGENCY HEALTH SERVICES

Services and supplies necessary for the treatment of an Emergency including:

a) A medical screening examination (as required under section 1867 of the Social Security Act, 42 U.S.C. 1395dd) that is within the capability of the Emergency department of a Hospital, including ancillary services routinely available to the Emergency department to evaluate such Emergency medical condition; and
b) Such further medical examination and treatment, to the extent they are within the capabilities of the staff and facilities available at the Hospital, as are required under section 1867 of the Social Security Act (42 U.S.C. 1395dd) to stabilize the patient.

42. EMPLOYEE

An Employee who is eligible for coverage under this Plan by virtue of meeting the criteria listed in the Eligibility provision and the General Plan Information page in this Plan Document.

43. EMPLOYER

The "Employer" identified on the General Plan Information page in this Plan Document.

44. ERISA

The Employee Retirement Income Security Act of 1974, as amended. A federal law that sets minimum standards for most voluntarily established health plans in private industry to provide protection for individuals in these plans.

45. ESSENTIAL HEALTH BENEFITS (EHB)

A set of 10 categories health insurance plans must cover under the Affordable Care Act (ACA). These include doctors' services, inpatient and outpatient hospital care, prescription drug coverage, pregnancy and childbirth, Mental Health Services, and more. Not all services under

these categories are considered an EHB, which vary by state. Only charges for EHB Covered Services are required under the ACA to apply toward the Deductible and Out-of-Pocket Limit.

46. EXCLUSIVE PROVIDER ORGANIZATION (EPO)

Coverage that only provides benefits when utilizing a Participating Provider and which has no benefit for using a Non-Participating Provider when receiving non-emergent services.

47. EXPERIMENTAL TREATMENT DETERMINATION

NHAS's determination that each of the following applies:

a) A proposed treatment has been reviewed by or on behalf of the Plan;
b) The treatment was determined to be Experimental;
c) NHAS denied the treatment or payment for the treatment.

48. EXTEND EXCLUSIVE PROVIDER ORGANIZATION (EPO)

Coverage provided to Participants under the Plan residing out of the NHAS Service Area, that limits coverage to Participating Providers through the First Health network. Your ID card will have the First Health logo on the back if You are enrolled in an Assure Extend plan.

49. EXTEND POINT OF SERVICE (POS)

Coverage provided to Participants under the Plan residing out of the NHAS Service Area, which offers coverage with Participating Practitioners and Providers and Non- Participating Practitioners and Providers. Participants pay less cost sharing by using Participating Practitioners and Providers in the First Health network. Participants using Non-Participating Practitioners and Providers will have a considerably higher cost share. Your ID card will have the First Health logo on the back if You are enrolled in an Assure Extend plan.

50. FAMILY MEMBER

A person who is related to the Participant as a spouse, parent, grandparent, stepparent, step grandparent, siblings, step siblings, children, step children and grandchildren, whether the relationship exists by virtue of blood or in law.

51. FINAL INTERNAL ADVERSE BENEFIT DETERMINATION

An Adverse Benefit Determination that has been upheld by the Plan at the conclusion of the Internal Appeal process, or an Adverse Benefit Determination with respect to which the Internal Appeal process has been deemed exhausted.

52. FRAUDULENT

Fraudulent services typically include knowingly submitting, or causing to be submitted, false Claims or making misrepresentations of fact to obtain a health care payment for which a Provider would otherwise not be entitled. Examples of fraud include:

a) Billing for appointments the patient failed to keep;
b) Knowingly billing for services at a level of complexity higher than services actually provided or documented in the file;

c) Knowingly billing for services not furnished, supplies not provided, or both, including falsifying records to show delivery of such items;
d) Misrepresenting who provided the services, altering Claim forms, electronic Claim records or medical documentation.

53. FULL-TIME STUDENT

A Dependent who is enrolled in at least twelve (12) credits per semester, or as defined by the institution the student is attending.

54. GENDER DYSPHORIA

Refers to the significant distress that is caused by a discrepancy between a persons' Gender Identity and that person's biological sex assigned at birth.

55. GENDER IDENTITY

Refers to an individual's internal sense of gender, which may be male, female, neither, or a combination of male and female and which may be different from an individual's sex assigned at birth.

56. HABILITATIVE SERVICES

Educational and therapeutic services meant to increase the functional skills of individuals with Developmental delays, disabilities and other conditions. Examples include therapy for a child who isn't walking or talking at the expected age. These services may include physical and occupational therapy, speech-language pathology and other services for people with disabilities in a variety of inpatient and/or outpatient settings.

57. HIPAA

The Health Insurance Portability and Accountability Act of 1996, as amended, is a federal law that required the creation of national standards to protect sensitive patient health information from being disclosed without the patient's consent or knowledge.

58. HOME HEALTH AGENCY

An agency or organization which provides a program of Home Health Care and which:

a) Is a federally certified Home Health Agency and approved as such under Medicare;
b) Meets the established standards and is operated pursuant to applicable laws in the jurisdiction in which it is located and, is licensed and approved by the regulatory authority having the responsibility for licensing, where licensing is required; or
c) Meets all of the following requirements:
    i. It is an agency which holds itself forth to the public as having the primary purpose of providing a Home Health Care delivery system bringing supportive services to the home;
    ii. It has a full-time administrator;
    iii. It maintains written records of services provided to the patient;

iv. Its staff includes at least one Registered Nurse (R.N.) or it has nursing care by a Registered Nurse (R.N.) available; and
v. Its employees are bonded and it provides malpractice insurance.

59. HOME HEALTH CARE

Care and treatment the Participant needs, but that the Participant's immediate family is not able to provide or may only provide with undue hardship. Your immediate family includes other persons who reside with You. A state licensed or Medicare certified Home Health Agency or certified rehabilitation agency must manage the care. Home Health Care consists of one or more of the following:

a) Part-time or intermittent nursing care;
b) Physical, respiratory, speech, occupational therapy;
c) Nutritional counseling;
d) Part-time or intermittent home health aide services;
e) Medical supplies, Drugs;
f) Laboratory services;
g) Evaluation of the need for and the development of a plan for home health services.

60. HOSPICE

Services within an integrated program, the primary purpose of which is to provide comfort and support to the terminally ill and their families on a 24 hour a day, seven-days a week basis. Services include physical, psychological, social and spiritual care for the terminally ill person and short-term grief counseling for immediate Family Members while the Participant is receiving Hospice care. The Provider may also offer skilled nursing services, dietary counseling, physician services, physical or occupational therapist, home health aid services, pharmacy services and Durable Medical Equipment.

A licensed public agency or private entity must provide the services. Services may be furnished in a Hospice facility housed in a Hospital, a separate Hospice unit or in the patient's home. A Hospice facility housed in a Hospital must be in a separate and distinct area.

61. HOSPITAL

A facility that is appropriately licensed and operated as required by law and that meets the following:

a) Primarily engaged in providing health services, on an inpatient basis, for the acute care and treatment of injured or sick individuals.
b) Care is provided through medical, Diagnostic Service and surgical facilities, by or under the supervision of a staff of Practitioners.
c) 24-hour a day nursing services are provided by licensed nurses.

A Hospital is not a state tax supported Institution, primarily a place for rest, Custodial Care or care of the aged and is not a nursing home, convalescent home or similar institution.

62. ILLNESS
A disruption in function or structure of the Participant's body that causes physical signs or symptoms. An Illness, if left untreated, will cause the health of the Participant's body structure or system to deteriorate. Pregnancy is included in this definition.

63. INFERTILITY
The failure of a couple to conceive a pregnancy after trying to do so for at least one full year.

64. INJURY
Bodily damage, other than Sickness, including all related conditions and recurrent symptoms resulting from an Accident.

65. IN-NETWORK
The Practitioners and Providers NHAS has contracted with to provide Covered Services.

66. INPATIENT REHABILITATION FACILITY
A Hospital (or a special unit of a Hospital that is designated as an Inpatient Rehabilitation Facility) that provides rehabilitation health services (physical therapy, occupational therapy and/or speech therapy) on an inpatient basis, as licensed by law.

67. INPATIENT STAY
Care for a Participant as part of an admission to a Hospital, Skilled Nursing Facility or Inpatient Rehabilitation Facility. Observation status is not considered Inpatient.

68. INSTITUTION
A facility created and/or maintained for the purpose of practicing medicine and providing organized health care and treatment to individuals, operating within the scope of its license, such as a Hospital, Ambulatory Surgical Center, Psychiatric Hospital, community mental health center, residential treatment facility, psychiatric treatment facility, Substance Abuse Treatment Center, alternative birthing center, Home Health Care Agency, or any other such facility that the Plan approves.

69. LATE ENROLLEE
Eligible employees and Dependents who did not enroll when initially eligible for coverage and who are not eligible under the special enrollment period, are considered "late enrollees."

70. LEAVE OF ABSENCE
A period of time during which an Employee is away from his/her primary job with Employer, while maintaining their status of Employee. A Leave of Absence requested by an Employee must be approved by the Employer under the Employer's rules, policies, procedures and practices to qualify as a Leave of Absence under the Plan.

71. LEGAL SEPARATION
An arrangement to remain married but live apart, following a court order.

72. LIFE THREATENING
A disease or condition likely to result in death unless it is remedied.

73. MAINTENANCE THERAPY
Ongoing therapy for which only minimal rehabilitative gains can be shown. Such therapy is furnished after the acute phase of a bodily Injury or Illness has passed. Therapy furnished after a patient's recovery reaches a plateau or slows or ceases entirely. NHAS determines that therapy is Maintenance Therapy by reviewing a Participant's case history or the treatment plan the Provider submits.

74. MATERNITY CARE PRACTITIONER
A duly licensed obstetrician and gynecologist or other maternity care Providers who are licensed, registered or certified to perform maternity care in accordance with state law.

75. MAXIMUM ALLOWABLE FEE
The maximum amount allowed for charges for Covered Services based upon:

a) NHAS's methodology guidelines;
b) Pricing guidelines of any third party that is responsible for repricing a Claim;
c) The negotiated rate determined by NHAS in accordance with the applicable contract between NHAS and a health care Provider or Practitioner; or
d) Maximum Out-of-Network Allowable Fee.

The Maximum Allowable Fee may be less than the amount billed.

Upon written or oral request from You for the NHAS Maximum Allowable Fee for a health care service and if You provide NHAS with the appropriate billing code that identifies the health care service (e.g., CPT codes, ICD-9 or ICD-10 codes, or Hospital revenue codes) and the heath care Provider's or Practitioner's estimated fee for that health care service, NHAS will provide You with any of the following:

a) A description of NHAS's specific methodology including, but not limited to, the following:
    i. The source of the data used, such as Claims experience, an expert panel of Providers or Practitioners, or other sources;
    ii. The frequency of updating such data;
    iii. The geographical area used;
    iv. If applicable, the percentile used in determining the Maximum Allowable Fee; and
    v. Any supplemental information used in determining the Maximum Allowable Fee.
b) The Maximum Allowable Fee determined under NHAS guidelines for a specific health care service provided to You. That may be in the form of a range of payments or maximum payment.

76. MAXIMUM OUT-OF-NETWORK ALLOWABLE FEE

The maximum amount that the Plan will reimburse for Covered Services provided by a Non-Participating Provider, or a Non-Participating Practitioner, and incurred while the Plan is in effect.

77. MEDICAL DIRECTOR

The physician, licensed to practice medicine in the State of Wisconsin, who is employed either directly or by contract with NHAS. The Medical Director makes authorization decisions including the determinations of not medically necessary and experimental/investigational. The Medical Director is also involved in the development, participation and oversight of NHAS's population health clinical and quality programs.

78. MEDICALLY NECESSARY (MEDICAL NECESSITY)

Health care services or supplies that meet all of the following:

a) Are appropriate and necessary to identify, diagnose or treat a bodily Injury or Illness;
b) Are appropriate for and consistent with the Participant's Diagnosis in accord with generally accepted standards of the medical community;
c) Are not primarily Custodial Care, Maintenance Therapy or Habilitative Services;
d) Are provided in the least intense, most cost-effective setting or manner needed for the Participant's bodily Injury or Illness;
e) Are provided in an institution and could not have been furnished at a lower level of care;
f) Are not primarily educational in nature;
g) Are not for the Participant's vocation, comfort, convenience, exercise, physical fitness or recreation;
h) Are not to improve the appearance of the Participant or for the convenience of the Provider.

79. MEDICARE

Title XVIII (Health Insurance Act for the Aged) of the U.S. Social Security Act, as amended. A health insurance program for people:

a) Age 65 or older.
b) Under age 65 with certain disabilities.
c) Of all ages with End-Stage Renal Disease (permanent kidney failure requiring dialysis or a kidney transplant).

80. MENTAL HEALTH DISORDER

A mental or emotional disease or disorder to such an extent that a Participant so afflicted requires care and treatment for his or her own welfare, or the welfare of others, or the community. Mental disorder includes psychiatric illnesses classified as a Mental Health Disorder in the current edition of International Classification of Diseases, listed in the current edition of the Diagnostic and Statistical Manual for Mental Disorders of the American Psychiatric Association.

Mental Health Disorder does not include autism spectrum disorder.

81. MENTAL HEALTH SERVICES
Covered Services for the Diagnosis and treatment of Mental Health Disorders. The fact that a condition is listed in the current Diagnostic and Statistical Manual of the American Psychiatric Association does not mean that treatment for the condition is a Covered Service.

82. NHAS
Network Health Administrative Services, the Third-Party Administrator for the Plan.

83. NO-LOSS, NO-GAIN
The Deductible will be considered on a No-Loss, No-Gain basis for Participants covered under the employer's prior Group plan on the date that plan was replaced by this Plan. In this replacement situation, charges applied toward satisfaction of the prior plan Deductible for the then current Benefit Year will "roll over" or be credited toward satisfaction of the Plan's Annual Deductible.

84. NON-PARTICIPATING PROVIDER, PRACTITIONER, FACILITY OR HOSPITAL
Facilities, Providers and suppliers who do not have a contract with NHAS to provide Covered Services to Participants under this Plan.

85. OPEN ENROLLMENT PERIOD
The time period in which Participants can make benefit changes.

86. OUT-OF-NETWORK
Practitioners or Providers who have not contracted with NHAS for reimbursement at a negotiated rate.

87. OUT-OF-POCKET LIMIT
The maximum amount stated in the Summary of Participant Responsibility Table/Summary of Benefits and Coverage, which can be paid by one Participant or between all Participants of a family, each Benefit Year, including annual Deductible, Coinsurance amounts, Copayments and Ancillary Fees for prescription Drugs. Once the Out-of-Pocket Limit is reached, the covered percentage will increase to 100 percent of the Allowable Expense (unless specifically stated otherwise in the Summary of Member Responsibility Table/Summary of Benefits and Coverage) for the rest of that Benefit Year. Expenses incurred for health care services not covered by the Plan, any funding contribution by the Participant, or expenses over and above the Maximum Allowable Fee (Balance-Billed charges) do not count towards the Participant's Out-of- Pocket Limit.

88. PALLIATIVE CARE
Services focused on preventing or relieving pain and suffering. The goal is to improve comfort and quality of life for people with a life-threatening or life-limiting Illness whether or not they are receiving active treatment. Palliative Care may include, but is not limited to, services for pain, fatigue, anxiety, difficulty breathing and nausea.

89. PARTICIPANT
Any Employee or Dependent who is eligible and enrolled for benefits under the Plan as defined in the Eligibility provision of this document.

90. PARTICIPATING PROVIDER, PRACTITIONER, FACILITY OR HOSPITAL
Practitioners, facilities, Providers and suppliers who have a contract with NHAS to provide Covered Services to Participants under this Plan for discounted fees which they have agreed to accept as payment in full.

91. PLAN ADMINISTRATOR
The individual, committee, or entity appointed by the Plan Sponsor, who is responsible for administering the Plan. The "Plan Administrator" is identified on the General Plan Information page in this Plan Document.

92. PLAN YEAR
The initial Plan Year starts on the Plan effective date and goes through December of that year as stated on the General Plan Information page in this Plan Document. Thereafter, the Plan Year is January 1 through December 31.

93. POINT OF SERVICE
A type of plan that offers coverage with Participating Practitioners and Providers and Non-Participating Practitioners and Providers. Participants pay less cost sharing when using Participating Practitioners and Providers. When Participants use Non-Participating Practitioners and Providers, they will have considerably higher cost share. POS plans are only available to Participants who have enrolled in a POS plan.

94. POST-SERVICE CLAIM
A Claim for Covered Services that have been furnished.

95. PRACTITIONER
An individual licensed by the state in which he/she practices within the scope of his/her license to furnish health care. A Practitioner may be a Doctor of Medicine (MD), Doctor of Osteopathic Medicine (DO), Podiatrist, Audiologist, Physician Assistant, Registered Nurse Midwife, Nurse Practitioner or Chiropractor.

96. PRE-SERVICE CLAIM
A request for a Prior Authorization to cover all or part of the services to be furnished.

97. PREVENTIVE SERVICES
Certain services required to be offered by the Plan in accordance with the Patient Protection and Affordable Care Act (PPACA), without cost sharing when a Participant receives these services from a Participating Provider.

98. PRIMARY CARE PRACTITIONER (PCP)
A Practitioner specializing in internal medicine, general practice, family practice, obstetrics/gynecology, pediatrics or other health care Provider designated by NHAS, who has been selected by a Participant to provide and coordinate their health care services.

99. PRIOR AUTHORIZATION
The process of obtaining NHAS's approval for health care services or supplies for a Participant that are Medically Necessary and appropriate. Generally, authorization is required to be obtained **before** health care services are rendered. In some situations, such as a Hospital admission following Emergency Health Services provided by a Non-Participating Practitioner or Non-Participating Provider, the authorization may be obtained after services were received.

100. PRIVACY STANDARDS
The standards of the privacy of individually identifiable health information, as pursuant to HIPAA.

101. PRIVATE DUTY NURSING
Nursing care provided on a one-to-one basis by licensed nurses in an inpatient or home setting when any of the following are true.

a) No skilled services are identified.
b) Skilled nursing resources are available in the facility.
c) The skilled care can be provided by a Home Health Agency on a per visit basis for a specific purpose.

The service is provided to a Participant by an independent nurse who is hired directly by the Participant or his/her family. This includes nursing services provided on an inpatient or home-care basis, whether the service is skilled or non-skilled independent nursing.

102. PROVIDER
Any Practitioner, facility, Skilled Nursing Facility, Home Health Agency or other duly licensed institution or health professional who is licensed, registered or certified by the state in which they practice; or health care entity, regardless of whether or not they are contracted with NHAS to provide Covered Services to Participants.

103. QUALIFIED BENEFICIARY
An individual who is entitled to COBRA continuation coverage because he or she was covered by a group health plan on the day before a "qualifying event."

104. QUALIFIED MEDICAL CHILD SUPPORT ORDER (QMCSO)
A Medical Child Support Order, in accordance with applicable law and which creates or recognizes the existence of an Alternate Recipient's right to, or assigns to an Alternate Recipient the right to, receive benefits for which a Participant or eligible Dependent is entitled under this Plan. A QMSCO must contain the content described herein, under the applicable Section titled Qualified Medical Child Support Orders.

105. REASONABLE

Fees for services or supplies that in the Plan's discretion, are necessary for the care and treatment of Illness or Injury. To be Reasonable, service(s) and/or fee(s) must also follow generally accepted billing practices for unbundling or multiple procedures. The Plan Administrator retains discretionary authority to determine whether service(s) and/or fee(s) are Reasonable based upon information presented to the Plan. The Plan Administrator reserves for itself and parties acting on its behalf the right to review charges processed and/or paid by the Plan, to identify charge(s) and/or service(s) that are not Reasonable and therefore not eligible for payment.

106. RECONSTRUCTIVE PROCEDURES

A procedure to improve or repair an abnormal condition of a body part.

107. REHABILITATION SERVICES

Health care services that help a person keep, get back or improve skills and functioning for daily living that have been lost or impaired because a person was sick, hurt or disabled. These services may include physical and occupational therapy, speech-language pathology and psychiatric Rehabilitation Services in a variety of outpatient settings.

108. RESIDENTIAL TREATMENT FACILITY

A facility which provides a program of effective Mental Health and Substance Abuse Services treatment and which meets all of the following requirements:

a) It is established and operated in accordance with applicable state law for residential treatment programs.
b) It provides a program of treatment under the active participation and direction of a Practitioner.
c) It has or maintains a written, specific and detailed treatment program requiring full-time residence and full-time participation by the Member.
d) It provides at least the following basic services in a 24-hour per day, structured milieu:
    i. Room and Board.
    ii. Evaluation and Diagnosis.
    iii. Counseling.
    iv. Referral and orientation to specialized community resources.

A Residential Treatment Facility that qualifies as a Hospital is considered a Hospital.

109. ROOM AND BOARD

A Hospital's charge for: room and complete linen service; dietary service, including all meals, special diets and dietary consultation; all general nursing services; and other conditions of occupancy which are Medically Necessary.

110. ROUTINE FOOT CARE

Routine foot care includes:

a) Cutting or removing corns and calluses.
b) Trimming, cutting, or clipping nails.
c) Hygienic or other preventive maintenance, like cleaning and soaking your feet

111. ROUTINE PATIENT CARE

All health care services, items and Drugs that are typically provided in health care, including those provided to a Participant during the course of treatment in a cancer trial (all phases) for a condition or any of its complications and those services are consistent with the usual and customary standard of care including the type and frequency of any diagnostic modality.

Routine Patient Care does not include:

a) The health care service, item or investigational Drug that is the subject of the cancer clinical trial;
b) Any health care service, item or Drug provided solely to satisfy data collection and analysis needs that are not used in the direct clinical management of the Participant;
c) Investigational Drugs or devices that have not been approved for market by the FDA;
d) Transportation, lodging, food or other expenses for the Participant or a family member or companion of the Participant that are associated with travel to or from a facility providing the cancer clinical trial;
e) Any services, items or Drugs provided by the cancer clinical trial sponsors free of charge;
f) Any services, items or Drugs eligible for reimbursement by a party other than the Participant.

112. SEMI-PRIVATE ROOM

A room with two or more beds. When an Inpatient Stay is a Covered Service, the Benefit is for the cost of a Semi-private Room and a private room is a Benefit only when Medically Necessary, or when a Semi-private Room is not available.

113. SERVICE AREA

The geographic area where NHAS provides third-party administrative services to employers and where NHAS has contracted with Participating Providers and Practitioners. Contact Member Experience or visit **networkhealth.com/about/service-area** to see the exact geographic area NHAS serves. The Service Area may change from time to time.

114. SICKNESS

A physical Illness or disease. The term Sickness as used in this plan document includes Mental Health and Substance Abuse Disorders.

115. SKILLED NURSING FACILITY

A facility that:

a) Is primarily engaged in providing skilled nursing care and related services on a twenty-four (24) hour a day basis to inpatients requiring medical or skilled nursing care; and,
b) Is qualified to participate under Medicare; and,
c) Is properly licensed.

116. SPECIALTY CARE PRACTITIONER (SPECIALIST)
A Practitioner who has a majority of his or her practice in areas other than general pediatrics, internal medicine, family practice or general medicine.

117. SUBSTANCE ABUSE DISORDER
Alcohol, drug and chemical abuse, overuse or dependency disorders listed in the current Diagnostic and Statistical Manual of the American Psychiatric Association, unless those services or disorders are specifically excluded. The fact that a disorder is listed in the Diagnostic and Statistical Manual of the American Psychiatric Association does not mean that treatment of the disorder is a Covered Service.

118. SUMMARY OF PARTICIPANT RESPONSIBILITY TABLE/SUMMARY OF BENEFITS AND COVERAGE
The documents outlining the Participant's cost-sharing terms and other terms of the medical and pharmacy Benefits under this plan.

119. TELEMEDICINE
Medical services provided using two-way, real time interactive communication between the Participant and the Provider at a remote site. This electronic communication means the use of interactive telecommunications equipment that includes audio and/or video. Telemedicine does not include email messages, text messages, fax or mail.

120. THIRD-PARTY ADMINISTRATOR
The Claims administrator which provides customer service and Claims payment services only and does not assume any financial risk or obligation with respect to those Claims.

121. TRANSGENDER
A term for people whose Gender Identity, expression or behavior is different from those typically associated with their assigned sex at birth.

122. TRANSITIONAL CARE
Mental Health and Substance Abuse Disorders provided in a less restrictive manner than inpatient Hospital services but more intensive than outpatient services. This includes residential treatment programs for alcohol and drug dependence in addition to adult, child and adolescent day treatment.

123. UNPROVEN, EXPERIMENTAL, INVESTIGATIONAL OR FOR RESEARCH PURPOSES
Treatments, procedures, services, supplies, drugs, devices or technologies ("Treatments") that are not known to be safe or effective or that are used in a way that deviates from generally accepted standards of the U.S. medical community. NHAS's Medical Director or designee will determine, in its sole discretion, if a Treatment qualifies.

124. URGENT CARE
Care for the sudden onset of bodily Injury or Illness that does not qualify as an Emergency. Services for care that You need before You can set up a routine doctor visit are Urgent Care. Examples of Urgent Care situations are closed fractures, non-severe bleeding, minor cuts and burns.

125. URGENT CARE FACILITY
A facility that provides for the delivery of Urgent Care Services. An Urgent Care Facility generally provides unscheduled, walk-in care. An Urgent Care Facility may be Hospital-based or non-Hospital-based.

126. VIRTUAL VISITS
Use of interactive secure audio and video telecommunications systems that permit real-time communication between a patient, who is not physically in a facility, clinic or Hospital, and a Provider who can report evaluation and management services. Virtual Visits allow Providers to diagnose symptoms, prescribe medication and send prescriptions for non-Emergency medical conditions. NHAS has partnered with a Provider of online visit care to offer services 24 hours a day, seven days a week, 365 days a year.

127. WAITING PERIOD
The interval of time that must pass before an Employee or Dependent is eligible for coverage under the Plan. The Waiting Period is listed on the General Plan Information page of this Plan Document.

128. WASTEFUL
The use, consumption or overutilization of services or other practices that, directly or indirectly, result in unnecessary costs. Waste is generally not considered to be caused by criminally negligent actions, but rather the misuse of resources. Examples of waste include:

a) Billing or dosage errors
b) Incorrect bundling of charges
c) Unnecessary or duplicative services
d) Excessive units

SECTION 19 ~ DISCLOSURE NOTICES

Women's Health and Cancer Rights Act Notice

The Federal Women's Health and Cancer Rights Act of 1998, contains coverage requirements for breast cancer patients who elect reconstruction in connection with a Mastectomy. Federal law requires group health plans that provide Mastectomy coverage to also cover breast reconstruction Surgery and prostheses following Mastectomy.

As required by law, You are being provided this notice to inform You about these provisions. The law mandates that individuals receiving benefits for a Medically Necessary Mastectomy will also receive coverage for: Reconstruction of the breast on which the Mastectomy has been performed, including nipple and areola reconstruction and re-pigmentation to restore the breast's physical appearance; surgery and reconstruction of the other breast to produce a symmetrical appearance; and prostheses and treatment of physical complications of all stages of Mastectomy, including lymphedemas.

Newborns' and Mothers' Health Protection Act of 1996: Maternity Stay Notice

Group health plans and health insurance issuers generally may not, under federal law, restrict benefits for any Hospital length of stay in connection with childbirth for the mother or newborn Child to less than forty-eight (48) hours following a vaginal delivery, or less than ninety-six (96) hours following a cesarean section. However, federal law generally does not prohibit the mother's or newborn's attending Provider, after consulting with the mother, from discharging the mother or her newborn earlier than forty-eight (48) hours (or ninety-six (96) hours as applicable). In any case, plans and issuers may not, under federal law, require that a Provider obtain Prior Authorization from the plan or the issuer for prescribing a length of stay less than forty-eight (48) hours (or ninety-six (96) hours).

Qualified Medical Child Support Order (QMSCO) Notice

The Plan extends medical benefits to an Employee's non-custodial child, as required by any Qualified Medical Child Support Order (QMCSO), under ERISA § 609(a). The Plan has procedures for determining whether an order qualifies as a QMSCO. Participants and beneficiaries can obtain, without charge, a copy of such procedures from the Plan Sponsor.

Genetic Information Nondiscrimination Act (GINA) Notice

GINA prohibits group health plans, issuers of individual health care policies and Employers from discriminating on the basis of genetic information.

The term genetic information means, with respect to any individual, information about:

a) Such individual's genetic tests;
b) The genetic tests of family members of such individual;
c) The manifestation of a disease or disorder in family members of such individual; and

d) The genetic information of a fetus carried by an individual or by a pregnant woman who is a family member of the individual and the genetic information of any embryo legally held by the individual or family member using an assisted reproductive technology.

The term genetic information includes participating in clinical research involving genetic services. Genetic tests would include analysis of human DNA, RNA, chromosomes, proteins, or metabolite that detect genotypes, mutations, or chromosomal changes. Genetic information is a form of Protected Health Information (PHI) as defined by and in accordance with the Health Insurance Portability and Accountability Act of 1996 (HIPAA) and is subject to applicable Privacy and Security Standards.

Family members as it relates to GINA include Dependents, plus all relatives to the fourth degree, without regard to whether they are related by blood, marriage, or adoption. Underwriting as it relates to GINA includes any rules for determining eligibility, computing premiums or contributions and applying preexisting conditions. Offering reduced premiums or other rewards for providing genetic information would be impermissible underwriting.

GINA will not prohibit a health care Provider who is treating an individual from requesting that the patient undergo genetic testing. The rules permit the Plan to obtain genetic test results and use them to make Claims payment determinations when it is necessary to do so to determine whether the treatment provided to the patient was medically advisable and/or necessary.

The Plan may request, but not require, genetic testing in certain very limited circumstances involving research, so long as the results are not used for underwriting and then only with written notice to the individual that participation is voluntary and will not affect eligibility for benefits, premiums or contributions. In addition, the Plan will notify and describe its activity to the Health and Human Services secretary of its activities falling within this exception.

While the Plan may collect genetic information after initial enrollment, it may not do so in connection with any annual renewal process where the collection of information affects subsequent enrollment. The Plan will not adjust premiums or increase group contributions based upon genetic information, request or require genetic testing or collect genetic information either prior to or relating to enrollment or for underwriting purposes.

Patient Protection

This plan allows the designation of a Primary Care Practitioner (PCP). You have the right to designate any PCP who participates in the NHAS network and who is available to accept You or Your family members. For information on how to select a PCP, and for a list of the participating PCPs, contact NHAS at the phone number on Your ID card. For Children, You may designate a pediatrician as the PCP.

You do not need Prior Authorization from the plan or from any other person (including a PCP) in order to obtain access to obstetrical or gynecological care from a health care professional in the NHAS network who specializes in obstetrics or gynecology. The health care professional,

however, may be required to comply with certain procedures, including obtaining Prior Authorization for certain services, following a pre-approved treatment plan or procedures for making referrals. For a list of participating health care professionals who specialize in obstetrics or gynecology, You may access the online Provider directory through the member portal or contact the NHAS.

Wellness Program

The Plan includes a voluntary wellness program administered by NHAS. You may view Your benefits under this program by logging into the member portal and clicking the **My Wellness** icon and then clicking the **Wellness Program Notice** link at the bottom of the webpage.

SECTION 20 ~ STATEMENT OF ERISA RIGHTS

As a Participant in the Plan, You are entitled to certain rights and protections under ERISA. ERISA provides that all Participants are entitled to the following.

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, collective bargaining agreements (if any), and copies of the latest annual report (Form 5500 Series) filed by the Plan with the U.S. Department of Labor if applicable 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 and collective bargaining agreements (if any), and copies of the latest annual report (Form 5500 Series) and updated summary plan 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 Participant 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 Plan Document and the documents governing the Plan on the rules regulating COBRA Continuation Coverage rights if these are applicable to this Plan as indicated on the General Plan Information page.

Prudent Actions by Plan Fiduciaries

In addition to creating rights for Participants, 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 Plan Participants and beneficiaries. No one, including Your Employer, or any other person, may fire You or otherwise discriminate against You in any way to prevent You from obtaining a Benefit or exercising Your rights under ERISA.

Enforce Your Rights

If Your Claim for a Plan Benefit is denied or ignored, in whole or in part, You have a right to know why, 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 thrity (30) Days, You may file suit in a federal court. In such a case, the court may require the Plan Administrator to provide the materials and pay You up to $110 a day until You

receive the materials, unless the materials were not sent because of reasons beyond the control of the Plan Administrator. If You have a Claim for benefits which is denied or ignored, in whole or in part and You have exhausted the mandatory Appeal procedures available to You and described in this Plan Document, 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 or a Medical Child Support Order, You may file suit in federal court. If the 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 (e.g., the court 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.

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