First Choice Health

MONUMENT
HEALTH

Monument Health EPO Medical Plan

Plan Document and Summary Plan Description

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Important Information about this Plan

This Summary Plan Description provides you with important information about the Monument Health, Inc. Medical Plan benefits including your coverage, payment levels, how to use the benefits, administration, eligibility, enrollment, continuation of coverage, coordination of benefits, subrogation, claim and appeal procedures and other legally required material.

The Plan is a self-funded, unfunded arrangement. The Employer, Monument Health, Inc., funds benefits from its general assets, rather than through insurance contracts. This Plan does not discriminate on the basis of race, color, national origin, sex, age, or disability in the provision of benefits for employees and beneficiaries. This Plan complies with the Genetic Information Nondiscrimination Act (GINA), the Family and Medical Leave Act (FMLA), and the Uniformed Services Employment and Reemployment Rights Act (USERRA).

Monument Health, Inc., the employer, is also the Plan Sponsor and Plan Administrator of the Plan. Monument Health, Inc. delegates to First Choice Health (FCH - a division of First Choice Health Network, Inc.), a Third Party Administrator (TPA), to perform certain Plan services, such as claim administration services. Monument Health, Inc. has delegated fiduciary responsibility for claims administration and appeal decisions related to medical claims to First Choice Health (FCH) but otherwise retains at all times the ultimate fiduciary authority, responsibility and control over Plan assets, management and administration, including appeals related to eligibility status, change in status, special enrollment, termination and continuation of coverage, and qualified medical child support orders.

The Monument Health, Inc. Medical Plan will be referred to within this document as the Plan. Under the Plan, you only receive benefits when you see a Monument Health Network or certain Monument Health Independent Providers & Facilities within the Western Providers Network. There is no coverage for non-network providers, except for Emergency Services, services from a Recognized Provider.

Please review this booklet carefully and share it with your family. If you have questions, contact Monument Health Plan Administrators. If you have questions about whether a provider is considered in-network, contact the appropriate network listed under *How to Obtain Health Services*.

Coverage under this Plan will take effect for eligible employees and dependents when all eligibility requirements are satisfied. There are no “vested” benefits provided by this Plan. Monument Health, Inc. reserves the right to terminate, suspend, discontinue or amend the Plan at any time, for any reason. Changes in the Plan may occur in any or all parts of the Plan including benefit coverage, deductibles, maximums, copayments, exclusions, limitations, definitions, eligibility, etc.

The Plan will pay benefits only for expenses incurred while this coverage is in force. No benefits are payable for expenses incurred before coverage began or after it is terminated, even if the expenses resulted from an accident, injury or disease that occurred, began or existed while coverage was in force. An expense for a service or supply is incurred on the date the service or supply is furnished to a Plan participant or beneficiary. If the Plan terminates, the rights of participants and beneficiaries are limited to charges incurred before termination.

These materials do not create a contract of employment or any rights to continued employment with Monument Health, Inc.

Contacting First Choice Health

You may call FCH Customer Service directly whenever you have questions or concerns at the number printed on your ID card or contact FCH by mail, fax or Internet:

First Choice Health
Customer Service Department
PO Box 12659
Seattle, WA 98111-4659
(800) 305-0849
Local: (206) 268-2360
Fax: (888) 206-3092
Medical pre-authorization: (800) 808-0450
Mental health/chemical dependency pre-authorization: (800) 640-7682
TTY: (866) 876-5924
www.fchn.com

Spanish (Español): Para obtener asistencia en Español, llame al (800) 305-0849.

Tagalog (Tagalog): Kung kailangan ninyo ang tulong sa Tagalog tumawag sa (800) 305-0849.

Chinese（中文）：如果需要中文的帮助，请拨打这个号码(800) 305-0849.

Navajo (Dine): Dinek'ehgo shika at'ohwol ninisingo, kwiijigo holne' (800) 305-0849.

FCH's Customer Service Department business hours are Monday through Friday, 9:00 AM to 6:00 PM Mountain Standard Time (MST). The office is closed on New Year's Day, Memorial Day, Independence Day (4th of July), Labor Day, Thanksgiving, and the day after Thanksgiving, Christmas Eve and Christmas Day. FCH offices close at 3:00 PM on the day before Thanksgiving and on December 23rd (or on the Friday before if the 23rd falls on a weekend). If the holiday falls on a Saturday, the office is closed on Friday; if the holiday falls on Sunday, the office is closed Monday (the holiday is recognized during the same calendar week in which the holiday falls).

You can access benefit information or your specific claim and enrollment status anytime at www.fchn.com or by calling FCH Customer Service's automated voice response system at (800) 305-0849.

How to Obtain Health Services

Your ID Card

Your ID card identifies you as a Plan participant and contains important information about your coverage and benefits. Please present your ID card each time you receive care. If you lose your ID card, you may order a new one either through contacting FCH Customer Service at (800) 305-0849, or logging into www.fchn.com. Under no circumstances should you give your ID card to another person for their use.

Choosing a Provider

To receive benefit coverage, services must be obtained from Monument Health Providers and certain Monument Health Independent Providers and Facilities within the Western Providers Network provider. All other providers are considered out of network. The networks are described below:

Networks	State/Area	Phone	Website
Monument Health Providers	South Dakota and Wyoming	(605) 755-5510	Providers – Monument Health
Monument Health Independent Providers & Facilities within the Western Providers Network	South Dakota and Wyoming	N/A	www.fchn.com/providersearch or www.westernprovidersinc.com
Mayo Complex Care	Rochester, MN Phoenix, AZ Jacksonville, FL		www.westernprovidersinc.com
Out of Network	Any provider not participating in one of the above networks		

Mayo Clinic coverage is by referral only. Those members with approved referrals will have Monument Health Network benefits applied. There are no Mayo Clinic benefits for those who self-refer.

Contact the networks directly, either by phone or through the websites provided, for information on providers and/or provider directories.

Services Received Outside of the U.S.

If you are traveling outside of the United States and require treatment for an injury or medical emergency, any payments you make for medical treatment may be reimbursed, provided the following guidelines are met:

- Participants must pay for medical services at the time of service.

- Upon returning to the United States, Participants must submit an itemized statement of charges that includes diagnosis and all charges paid. The exchange rate for foreign currency must also be noted on submitted forms.
- Charges submitted must be for an Emergency or Urgent Care as defined in the Plan Summary Plan Description.
- Claims must be submitted in English.

Continuity of Care

When you are receiving certain types of in-network care and the treating in-network provider leaves the network, the Plan must provide 90 days of continued in-network coverage (or 90 days from the date that you are no longer a continuing care patient, whichever is earlier) and the provider cannot send you a balance bill. A continuity of care patient is a person who is: (1) undergoing a course of treatment for a serious and complex condition from the provider or facility; (2) undergoing a course of institutional or inpatient care from the provider or facility; (3) scheduled to undergo non-elective surgery from the provider; (4) pregnant and undergoing a course of treatment for pregnancy from the provider; or (5) determined to be terminally ill and receiving treatment for such illness from the provider or facility. This requirement does not apply to for-cause terminations of a provider.

Medical Management

Pre-authorization Requirements

All inpatient admissions and certain outpatient services and procedures **require FCH pre-authorization**, as also noted in the *Summary of Medical Benefits*. If pre-authorization is not obtained on the services noted below, your claim may be denied. Call (800) 808-0450 for pre-authorization on medical services or (800) 640-7682 for mental health or chemical dependency services. *Emergency Services* do not need to be pre-authorized.

- **Admissions**
  - Inpatient
    - Chemical dependency and mental health admissions
    - Inpatient hospital
    - Inpatient hospice
    - Medical/surgical admissions (excluding routine maternity deliveries)
    - Partial hospital program admissions for chemical dependency or mental health
  - Transitional Care
    - Home health care services (certain drugs may also require pre-authorization, see Medical Injectables)
    - Home health visits (for wound therapy only)
    - Hospice and respite care
    - Inpatient rehabilitation admissions
    - Long term acute care hospital (First Health Network facility only)
    - Skilled Nursing Facility
- **Ambulance Transport** - non-urgent transport
  - Air non-urgent transport
  - Ground non-emergent
- **Anesthesia for dental services**
- **Anti-reflux Surgery (i.e. LINX, Esophyx, etc.)**
- **Clinical Trials** (including all interventions/medications)
- **Dental Trauma Services** (follow-up services)
- **Dialysis**- all types (for chronic kidney disease)
- **Durable Medical Equipment, Medical Supplies and Prosthetics**
  - Bone growth and neuromuscular stimulators
  - Compression devices for home use
  - Cranial orthotic devices
  - Custom, power operated and manual wheelchairs and supplies
    - Standard, manual wheelchair rental for transition of care for up to 3 months does not require pre-authorization
  - Custom fabricated knee braces
  - Electrical stimulators- spinal- external
  - Oscillatory devices and cough stimulating devices
  - Prosthetics

- Myoelectric prosthetic components for the upper limb
    - Powered ankle-foot prosthesis, microprocessor-controlled ankle-foot prosthesis, and microprocessor-controlled knee prosthesis
  - Scooters
  - Speech generating devices
  - Tumor Treating Fields for Glioblastoma
  - Vacuum Assisted Wound Therapy
- **Enteral Formula, Medical Food and Associated Services**
- **Facet Joint Injections and Neurotomies** (any location)
- **Genetic Testing**
  - Over $500
- **Hyperbaric Oxygen Therapy**
- **Imaging**
  - Select MRI and CT Scans
- **Medical Injectables, Chemotherapy and Other Drugs over $5,000/annually** (Newly FDA approved medications may also require Pre-authorization. For questions, call FCH at the number above.)
  - Other medications, including:
  - Blood Clotting Factors, All types, All brands
  - Select Hormone Therapy
  - Intravenous Immunoglobulin Therapy- IVIG, All types, All brands
  - Botulinum Toxin, All types, All brands
- **Oral Appliances for Sleep Apnea Therapy**
- **Organ and Bone Marrow Transplants** (includes evaluation of services for recipient and donor, and travel and lodging expenses)
- **Peripheral Nerve Blocks**
- **Radiation Therapy**
  - Proton beam, neutron beam or helium ion radiation therapy
  - Stereotactic body radiation therapy (SBRT)
  - Stereotactic radiosurgery (Gamma Knife, Cyber Knife)
- **Surgery**
  - Abdominoplasty/panniculectomy
  - BAHA-bone anchored hearing aid (DME benefit applies)
  - Bariatric surgery
  - Breast surgeries- selected (Pre-authorization is not required for breast reconstruction and nipple/areola reconstruction following mastectomy for breast cancer)
    - Implant removal
    - Mastectomy for gynecomastia
    - Reduction mammoplasty
  - Cochlear implants (surgical benefit applies)
  - Cosmetic or reconstructive surgery (non-excluded)
  - Deep brain stimulation
  - Eyelid surgery (i.e. blepharoplasty)
  - Fetal/intrauterine surgery
  - Gender affirming surgery

- Implantable peripheral nerve and/or spinal cord stimulator placement (temporary and permanent) including electrodes and/or pulse generator/receiver
- Orthognathic surgery
- Ovarian, internal iliac and gonadal vein embolization, ablation and sclerotherapy
- Rhinoplasty
- Spinal surgery - selected
    - Artificial intervertebral disc
    - Cervical fusions
    - Lumbar fusions
    - Minimally invasive, percutaneous & endoscopic spine surgery
- Surgical interventions for sleep apnea
- TMJ surgery
- Vagus nerve stimulation
- Varicose vein procedures
- Ventricular assist devices and total heart replacement

- **Transcranial Magnetic Stimulation**

As noted above, if you neglect to obtain pre-authorization for services which require it, your claim may be denied. Claims denied due to lack of pre-authorization do **not** apply toward your Plan year deductible or out-of-pocket maximums. Your provider may submit an advance request to FCH Medical Management for benefit or medical necessity determinations. **Experimental and investigational services are not covered.** If a service could be considered experimental and investigational for a given condition, we recommend a benefit determination in advance.

Mayo Clinic Complex Care Program

Precertification and/or pre-authorization requirements are waived for Mayo Clinic when receiving care through the Mayo Clinic Complex Care Program. A review of medical documentation will occur post-care to determine coverage amounts and medical necessity. A service or supply that is not deemed a medical necessity may be denied in whole or in part. *Experimental and investigational services are not covered.*

Notification for Emergency Admissions

Admissions directly from the emergency department do not require pre-authorization. However, notification is required within 2 business days after the admission, or as soon as possible, unless there are extenuating circumstances (as determined by FCH). You, or your provider, may call FCH at the number on your ID card.

Concurrent Review and Discharge Coordination

Continued hospitalization is subject to periodic clinical review to ensure timely, quality care in the appropriate setting. Discharge coordination assists those transferring from the hospital to home or another facility.

Case Management

A catastrophic or chronic medical or behavioral health condition may lead to long-term, or perhaps lifetime, care involving extensive services in a facility or at home. With case

management, a clinician monitors plan members who need assistance and support while exploring coordination and /or alternative types of appropriate care.

Case management is a voluntary service. There are no reductions of benefits or penalties if the patient and family choose not to participate. Each treatment is individually tailored to a specific patient and should not be seen as appropriate or recommended for any other patient, even one with the same diagnosis. The final decision on the course of treatment rests with patients and their providers.

Payment Provisions – EPO Plan

Highlights of Plan Provisions

- You must receive services from a Monument Health Network provider or certain Monument Health Independent Providers & Facilities within the Western Providers Network provider.
- Benefit payment is based on the Allowed Amounts agreed upon by Monument Health Network providers or certain Monument Health Independent Providers & Facilities within the Western Providers Network providers.
- Out-of-network services are not covered on this plan **except** for the following circumstances: Services for Emergency Care and services from a Recognized Provider.
- For Recognized Providers, an Allowed Amount will be obtained through Usual, Customary and Reasonable data or a negotiated rate. If neither is available or appropriate, billed charges may be used as the Allowed Amount. You will be responsible for the difference (if any) between the Plan payment and the billed charges on Recognized Provider claims and this difference would not apply to your Out-of-Pocket (OOP) maximum as discussed below.
- There are no benefits for non-emergency services received from non-network providers (who are not covered under Recognized No Surprises Provider). If you receive non-emergency services from non-network providers (who are not covered under Recognized No Surprises Provider), you are responsible to pay the provider's actual charges.
- Services received from a Recognized No Surprises Provider (see *Plan Definitions* under Section II - Summary Plan Description) provided by out-of-network Emergency Departments and out-of-network providers, certain non-emergency services furnished by out-of-network providers at certain in-network facilities, and out-of-network air ambulances, the cost-sharing amount is determined by the Qualifying Payment Amount (see *Plan Definitions* under Section II - Summary Plan Description).
- When you receive services from an in-network hospital or ambulatory surgical center, certain providers there may be out-of-network. In these cases, the most that those providers may bill you is your Plan's lowest in-network cost-sharing amount. This applies to emergency services, anesthesia, pathology, radiology, laboratory, neonatology, assistant surgeon, hospitalist, or intensivist services. These providers cannot balance bill you and may not ask you to give up your protections. If you receive other services at these in-network facilities, out-of-network providers cannot balance bill you, unless you give written consent and give up your protections.
- Certain serious and complex care treatments may apply to the Continuity of Care section. See Continuity of Care under *How to Obtain Health Services* for care from a provider who leaves the network.
- Claims are processed according to the diagnoses and services billed by the provider(s). Billing disputes regarding services received should be addressed with the rendering provider.

Annual Deductible

The annual deductible is the amount you (or your family) must pay each Plan year before the Plan will pay for covered services (payment for non-covered services will not be applied to the deductible). Once the deductible is satisfied, coinsurance amounts as noted in the *Summary of Medical Benefits* will be applied. Until then, the amount due to a provider is your responsibility.

This Plan offers an Embedded Deductible, which means each individual will meet no more than the individual maximum, but the family will meet no more than the stated family maximum, regardless of family size. In this case, some individuals may meet less than the individual maximum amount if the family maximum is met. The Monument Health Providers and certain Monument Health Independent Providers & Facilities within the Western Providers Network providers deductibles are inclusive of each other.

The following benefits do **not** apply toward the annual deductible:

- Charges of non-covered services and treatment
- Charges for services that are denied as not medically necessary
- Charges for services that are denied as experimental and investigational
- Charges for claims denied for lack of pre-authorization
- Charges over Usual, Customary and Reasonable (UCR) for non-network services as determined by FCH
- Non-network services
- Charges that exceed any applicable benefit maximum
- Copayments
- Difference in price between a brand name and generic drug
- Preventive care paid by the Plan at 100%
- Pharmacy services

Annual Out-of-Pocket Maximum

The annual out-of-pocket maximum is the most you will need to pay in a Plan year for covered services. This Plan offers an Embedded Out-of-Pocket (OOP) Maximum, which means once each individual within a family meets the individual maximum, s/he will not be assessed further co-insurances or copayments. Also, the family will meet no more than the stated family maximum regardless of family size.

The following do not apply toward the annual out-of-pocket maximum:

- Charges of non-covered services and treatment
- Charges for services that are denied as not medically necessary
- Charges for services that are denied as experimental and investigational
- Charges for claims denied for lack of pre-authorization
- Charges over Usual, Customary and Reasonable (UCR) for non-network services as determined by FCH
- Non-network services
- Charges that exceed any applicable benefit maximum
- Charges for services paid by the Plan at 100%

- Difference in price between a brand name and generic drug
- Specialty Pharmacy Manufacturer assistance dollars will not accumulate toward out-of-pocket maximums

Benefit Maximums

Your annual Plan deductible and out-of-pocket maximum, as well as your Plan year benefit maximums are noted in the tables that follow:

Annual Deductible and Out-of-Pocket Maximums

Deductible and Out-of-Pocket Maximums	Monument Health Network
Annual Deductible (per Plan year)	
Employee only	$1,000
Family	$2,000
Annual Medical Out-of-Pocket Maximum (per Plan year)	
Employee only	$3,000
Family	$6,000
Annual Pharmacy Out-of-Pocket Maximum (per Plan year)	
Employee only	$2,600
Family	$5,200

Specialty Pharmacy Manufacturer assistance dollars will not accumulate toward deductible maximums.

Summary of Benefit Maximums

Lifetime Maximum Benefits	
Bariatric Surgery Services	1 operative procedure per lifetime
Hospice • Respite care	10 days
Temporomandibular Joint Syndrome (TMJ)	$1,500
Durable Medical Equipment • Vision Hardware after Cataract Surgery or Aphakic Patients Only	$250
Plan Year Maximums	
Chiropractic Care	16 visits per plan year
Mayo Clinic Complex Care Program • Travel expenses	$1,000 per plan year
Obesity Screening and Counseling	16 visits per plan year
Organ Transplants • Harvesting, Storage and Transportation of Organ • Transportation and Lodging	$20,000 per occurrence (harvesting, storage and transportation of organ) $150 per day for lodging, $10,000 per transplant for all transportation and lodging for donor and recipient combined.
Wheelchair (power/motorized)	1 every five years
Wigs (related to chemotherapy or burns)	$700 every three years

Summary of Medical Benefits – EPO Plan

Monument Health EPO Plan **Some out-of-network services are covered only with an approved Network Waiver.** **Please see *Highlights of Plan Provisions* for more information.**	
	Monument Health Network
Allergy Care	
• **Testing** (Facility & Professional)	90% after deductible
• **Injections** (Facility)	90% after deductible
• **Injections** (Professional)	90% after deductible
Alternative Care (Includes acupuncture and massage therapy)	Not Covered
Ambulance Services FCH pre-authorization required for non-emergent air ambulance and non-emergent ground ambulance, non-emergent benefits outside of Monument Health Network or certain Monument Health Independent Providers & Facilities within the Western Providers Network requires approved network waiver.	90% after deductible
• **First Responder User Fees**	90% after deductible
Anesthesia	90% after deductible
Applied Behavior Analysis (ABA) Therapy (Outpatient)	90% after deductible
Autologous Blood Donation/Blood Transfusion	90% after deductible
Bariatric Surgery Services 1 operative procedure lifetime maximum. FCH pre-authorization required.	This Benefit is available from Monument Health providers only for treatment of obesity (surgical, non-surgical or therapeutic) subject to the mandatory enrollment in the Weight Management Program offered by Monument Health. (See *Weight Management* for more details). Complications are covered up to 180 days following a covered operative procedure. (See *Bariatric Surgery* benefit for more details.)
– **Inpatient** (Facility)	$250 copay then 100% no deductible
– **Inpatient** (Professional)	100% no deductible
– **Outpatient** (Facility)	90% after deductible

Monument Health EPO Plan Some out-of-network services are covered only with an approved Network Waiver. Please see *Highlights of Plan Provisions* for more information.	
	Monument Health Network
– **Outpatient** (Professional)	90% after deductible
– **Bariatric Pre and Post-Operative visits** (Facility)	90% after deductible
– **Bariatric Pre and Post-Operative visits** (Professional)	90% after deductible
– **Lab/Pathology**	90% no deductible
– **Radiology and Diagnostic Services**	90% after deductible
• **Non-Surgical Weight Management and Therapeutic Services** (*See Weight Management*)	Not Covered
Biofeedback	Not Covered
Chemical Dependency FCH pre-authorization required for inpatient, residential and partial hospitalization.	
• **Inpatient** (Facility)	$250 copay then 100% no deductible
• **Inpatient** (Professional)	100% no deductible
• **Outpatient** (Facility and Professional)	90% after deductible
Chiropractic Care 16 visits per plan year.	90% after deductible
Clinical Trials	Benefits depend on place and type of service. Covered as specifically outlined under *Clinical Trials*.
Dental Trauma FCH pre-authorization required for follow-up services and anesthesia. All services related to the repair must be completed within 24 months of the trauma date.	
• **Inpatient** (Facility)	$250 copay then 100% no deductible
• **Inpatient** (Professional)	100% no deductible
• **Outpatient** (Facility)	90% after deductible
• **Outpatient** (Professional)	90% after deductible

Monument Health EPO Plan Some out-of-network services are covered only with an approved Network Waiver. Please see *Highlights of Plan Provisions* for more information.	
	Monument Health Network
Diabetic Education and Diabetic Nutrition Education The first 6 Diabetic Nutrition Education visits (includes Nutritional Counseling visits) per Plan year are considered preventive. This benefit applies after the first 6 visits per Plan year are exhausted. Visits 7 and beyond are covered under the medical benefit.	90% after deductible
Diagnostic Testing (lab and radiology services, non-routine, facility and professional services) FCH pre-authorization required for certain CTs and MRIs.	
• **Hospital Inpatient** (Facility)	$250 copay then 100% no deductible
• **Hospital Inpatient** (Professional)	100% no deductible
• **Hospital Outpatient – Lab/Pathology** (Facility and professional fees)	90% no deductible
• **Hospital Outpatient – Diagnostic Testing and Radiology –** Including CT, MRI and PET scans (Facility and professional fees)	90% after deductible
• **Independent Facility** (Lab/Pathology)	90% no deductible
• **Independent Facility** (Diagnostic testing and radiology)	90% after deductible
• **Doctor's Office** (Lab/pathology services provided as part of the office visit, and billed as part of the office visit.)	90% no deductible
• **Doctor's Office** (Office-based diagnostic testing and radiology services provided as part of the office visit, and billed as part of the office visit.)	90% after deductible
Dialysis (End Stage Renal Disease)	Coverage based on place of service.
Durable Medical Equipment and Supplies	
• **Breast Pumps** (1 per pregnancy)	100% no deductible
• **Durable Medical Equipment**	90% after deductible

Monument Health EPO Plan **Some out-of-network services are covered only with an approved Network Waiver.** **Please see *Highlights of Plan Provisions* for more information.**	
	Monument Health Network
• **Medical Supplies**	90% after deductible
• **Oral Appliances** (FCH pre-authorization required when related to sleep apnea) TMJ appliances are covered under the TMJ benefit.	90% after deductible
• **Orthopedic Appliances/Braces**	90% after deductible
• **Prosthetic Devices** (4 breast prosthesis and 6 brassieres per plan year)	90% after deductible
• **Vision Hardware after Cataract Surgery or Aphakic Patients Only** $250 lifetime maximum for frames following cataract surgery and for Aphakic patients.	90% after deductible
• **Wheelchair** (power/motorized) 1 chair every 5 years.	90% after deductible
Emergency Care Copay waived if admitted within 24 hours. Out-of-Network Emergency Care is covered at the same level as Monument Health Network.	
• **Emergency Department** (Facility)	$150 copay then 100% no deductible
• **Emergency Department** (Professional)	100% no deductible
• **Lab/Pathology** (Professional)	90% no deductible
• **Radiology, Diagnostic Testing, CT, and MRI scans** FCH pre-authorization required	90% after deductible
• **Urgent Care**	
– Facility	100% no deductible
– Professional (Except Lab and Diagnostic Testing)	$40 copay then 100% no deductible
– Lab/Pathology (Professional)	90% no deductible
– Radiology, Diagnostic Testing, CT, and MRI scans FCH pre-authorization required.	90% after deductible

Monument Health EPO Plan **Some out-of-network services are covered only with an approved Network Waiver.** **Please see *Highlights of Plan Provisions* for more information.**	
	Monument Health Network
– Family Medicine Residency Clinic Visit	$20 copay then 100% no deductible
Family Planning	
• **Female – Office Visits**	100% no deductible
• **Male – Office Visits**	
– Primary Care Provider	$20 copay then 100% no deductible
– Specialist	$35 copay then 100% no deductible
• **Female – Devices, Implants and Injections**	100% no deductible
• **Male – Devices, Implants and Injections**	90% after deductible
• **Female – Contraceptive Diagnostic Testing**	100% no deductible
• **Male – Contraceptive Diagnostic Testing**	90% after deductible
• **Female – Lab/pathology**	100% no deductible
• **Male – Lab/pathology**	90% no deductible
• **Female – Sterilizations** (Employee and all dependents. Reversals are not covered.)	100% no deductible
• **Male – Sterilizations** (Employee and all dependents. Reversals are not covered.)	
– **Outpatient** (Facility)	90% after deductible
– **Outpatient (**Professional)	90% after deductible
• **Termination of pregnancy** (Employee or his/her spouse or female dependent children) Limited benefit (See Family Planning)	
– Facility	90% after deductible
– Professional	90% after deductible
– Office Visit (Primary Care Provider)	$20 copay then 100% no deductible
– Office Visit (Specialist)	$35 copay then 100% no deductible
Foot Orthotics	90% after deductible

Monument Health EPO Plan **Some out-of-network services are covered only with an approved Network Waiver.** **Please see *Highlights of Plan Provisions* for more information.**	
	Monument Health Network
Gender Affirming Services FCH pre-authorization required. Limited benefit, see *Gender Affirming Services* for details.	Coverage based on place of service.
Genetic Services FCH pre-authorization required for genetic testing if over $500.	
• **BRCA Testing**	100% no deductible
• **Genetic Testing**	90% no deductible
• **Genetic Counseling** (Facility)	90% after deductible
• **Genetic Counseling** (Professional)	90% after deductible
Habilitative Services (Includes physical, speech, occupational and aural therapies) FCH pre-authorization required if inpatient.	
• **Inpatient** (Facility)	$250 copay then 100% no deductible
• **Inpatient** (Professional)	100% no deductible
• **Outpatient** (Facility and Professional) Monument Health Network: First 8 visits for physical therapy do not require a referral. 9th visit and beyond a physician referral is required. All other physical therapy providers: Referral is required for all visits.	90% after deductible
• **All Other Therapy** (Speech, Occupational and Aural) - Referral is required for all visits.	90% after deductible
Hearing	
• **Routine Hearing Exams**	Not Covered
• **Medically Necessary Hearing Exams**	90% after deductible
• **Hearing Aids/Appliances**	Not covered, unless loss of hearing was due to an accidental injury or illness or congenital permanent childhood hearing impairment.

Monumen Health EPO Plan Some out-of-network services are covered only with an approved Network Waiver. Please see *Highlights of Plan Provisions* for more information.	
	Monument Health Network
Home Health Care FCH pre-authorization required for wound therapy, enteral formula, medical food and associated services.	
• **Home Health Care**	90% after deductible
• **Phototherapy** (Home)	90% after deductible
Hospice FCH pre-authorization required for inpatient and home hospice.	
• **Hospice Care**	90% after deductible
• **Respite Care** 10 days lifetime maximum.	90% after deductible
Hospital Inpatient Medical and Surgical Care FCH pre-authorization required. Benefits outside of Monument Health Network or certain Monument Health Independent Providers & Facilities within the Western Providers Network require an approved network waiver.	
• **Hospital Inpatient** (Facility)	$250 copay then 100% no deductible
• **Hospital Inpatient** (Physician visit/ Consultations)	100% no deductible
• **Hospital Surgery Inpatient** (Surgeon/Assistant Surgeon)	100% no deductible
Hospital Outpatient Surgery and Services FCH pre-authorization required for certain outpatient services; see *Pre-authorization Requirements* for details. Benefits outside of Monument Health Network or certain Monument Health Independent Providers & Facilities within the Western Providers Network require an approved network waiver.	
• **Hospital Outpatient** (Facility)	90% after deductible
• **Hospital Outpatient** (Professional/ Surgeon/Assistant Surgeon)	90% after deductible
• **Ambulatory Surgery Center (ASC)** (Facility)	90% after deductible

Monument Health EPO Plan **Some out-of-network services are covered only with an approved Network Waiver. Please see *Highlights of Plan Provisions* for more information.**	
	Monument Health Network
• **Ambulatory Surgery Center (ASC)** (Professional/ Surgeon/Assistant Surgeon)	90% after deductible
Infertility Diagnostic Services Coverage for the initial evaluation and diagnosis of infertility only.	
• **Office Visit** (Specialties considered PCPs are based upon individual credentialing.)	$20 copay then 100% no deductible
• **Office Visit** (Family Medicine Residency Clinic Visit)	$20 copay then 100% no deductible
• **Office Visit** (Specialist/Specialty Clinic)	$35 copay then 100% no deductible
• **Office Visit** (Facility fees)	90% after deductible
• **Infertility Diagnostic Services** (Professional fees)	90% after deductible
• **Infertility Diagnostic Services** (Facility fees)	90% after deductible
• **Initial Laboratory Testing** (Professional & Facility)	90% no deductible
Infusion Therapy (Includes infusion therapy provided in the home) FCH pre-authorization required for certain infusion therapy drugs, see *Pre-Authorizations Requirements.*	90% after deductible
Injections (outside of allergy care) FCH pre-authorization required for certain injections	
• **Facility**	90% after deductible
• **Professional**	90% after deductible
Maternity and Newborn Care (Including birthing centers) 1 routine ultrasound per pregnancy	
• **Maternity Pre and Post Natal Visits** (Including Dependent Maternity)	100% no deductible
• **Maternity Physician Delivery Services** (Including Dependent Maternity)	100% no deductible

Monument Health EPO Plan **Some out-of-network services are covered only with an approved Network Waiver.** **Please see *Highlights of Plan Provisions* for more information.**	
	Monument Health Network
• **Maternity Facility Services** (Including Dependent Maternity)	$250 copay then 100% no deductible
• **Newborn Inpatient Services** (Facility) Eligible newborn must be enrolled within 60 days of birth.	$250 copay then 100% no deductible
• **Newborn Inpatient Services** (Professional) Newborn must be enrolled within 60 days of birth.	100% no deductible
Mayo Clinic Complex Care Program Travel and Lodging - $1,000 maximum (one (1) travel companion for an adult patient, or up to two (2) travel companions for a pediatric patient) unless prohibited by law.	Covered based on place of service when services are approved through the Mayo Clinic Complex Care Program. All services, except emergent services, received from a covered Mayo Clinic location are considered to be part of the Mayo Clinic Complex Care Program. Participation in the Mayo Clinic Complex Care Program is not a guarantee of coverage. See details under *Medical Benefits*.
Mental Health Care FCH pre-authorization required for inpatient, residential and partial hospitalization. A network waiver is not required if seeing a participating provider in Monument Health-approved networks.	
• **Inpatient** (Facility)	$250 copay then 100% no deductible
• **Inpatient** (Professional)	100% no deductible
• **Partial Day Treatment** (PDT) (Facility)	90% after deductible
• **Partial Day Treatment** (PDT) (Professional)	90% after deductible
• **Office Visit**	$20 copay then 100% no deductible
• **Outpatient** (Facility and Professional)	90% after deductible
Nutritional and Dietary Formulas (including PKU) FCH pre-authorization required.	90% after deductible

Monument Health EPO Plan Some out-of-network services are covered only with an approved Network Waiver. Please see *Highlights of Plan Provisions* for more information.		
	Monument Health Network	
Nutritional Counseling The first 6 Nutritional Counseling visits (includes Diabetic Nutrition Education visits) per Plan year are considered preventive. This benefit applies when the first 6 visits per Plan year are exhausted. Visits 7 and beyond are covered under the medical benefit.	90% after deductible	
Oral Surgery	Coverage based on place of service.	
Pharmacy		
Administered by ClearScript (Monument Health may require certain products to be dispensed by Monument Health pharmacies only.) **Generic 90-day maintenance prescriptions may utilize mail order.**		
Monument Health Preferred Pharmacy Network		
	30-day fill	**90-day fill**
• **Generic**	$12 copay	$30 copay
• **Formulary Brand-Name**	$40 copay	$120 copay
• **Non-Formulary Brand-Name**	$90 copay	$270 copay
• **Diabetic Supplies**	20% coinsurance up to a maximum of $150	20% coinsurance up to a maximum of $450
• **Specialty Formulary**	20% co-insurance up to a maximum of $500	20% co-insurance up to a maximum of $1,500
• **Specialty Non-Formulary** (Manufacturer assistance dollars will not accumulate toward out-of-pocket maximums)	20% co-insurance up to a maximum of $600	20% co-insurance up to a maximum of $1,800
• **PPACA-Mandated Contraceptives**	100%	100%
ClearScript Participating Pharmacies	**30-day fill**	
• **Generic**	$25 copay	
• **Formulary Brand-Name**	$70 copay	
• **Non-Formulary Brand-Name**	$100 copay	
• **Diabetic Supplies**	20%	
• **Specialty Formulary**	Not Covered	
• **Specialty Non-Formulary**	Not Covered	

Monument Health EPO Plan Some out-of-network services are covered only with an approved Network Waiver. Please see *Highlights of Plan Provisions* for more information.	
	Monument Health Network
Plastic and Reconstructive Services FCH pre-authorization required. Limited benefit, see *Plastic and Reconstructive Services* for details.	
• **Inpatient** (Facility)	$250 copay then 100% no deductible
• **Inpatient** (Professional)	100% no deductible
• **Outpatient** (Facility)	90% after deductible
• **Outpatient** (Professional)	90% after deductible
Podiatric Care See *Podiatric Care* for details on routine foot care.	
• **Routine Foot Care**	Not Covered
• **Diabetic Routine Foot Care** (covered for diabetes and peripheral vascular disease only) (Facility)	90% after deductible
• **Diabetic Routine Foot Care** (covered for diabetes and peripheral vascular disease only) (Professional)	90% after deductible
• **Non-Routine Foot Care** (Facility)	90% after deductible
• **Non-Routine Foot Care** (Professional)	90% after deductible
Preventive Care	
Immunizations Immunizations for children and adults are covered in accordance with the recommendations set forth by the Centers for Disease Control and Prevention. See *Preventive Care* for details. Shingles immunizations provided at a pharmacy are covered at the In Network benefit level based on billed charges. Travel immunizations are not covered.	100% no deductible
Periodic Exams (Adult and Child) 1 per Plan year	100% no deductible
Nutritional Counseling – The first 6 nutritional counseling visits per Plan year. For visits 7 and beyond, refer to *Nutritional Counseling.*	100% no deductible

Monument Health EPO Plan **Some out-of-network services are covered only with an approved Network Waiver.** **Please see *Highlights of Plan Provisions* for more information.**	
	Monument Health Network
Obesity Screening and Counseling 16 visits per plan year (inclusive of nutritional visits for obesity).	100% no deductible
Screening Tests Screening tests are covered in accordance with the recommendations set forth by the US Preventive Services Task Force (USPSTF) and the Health Resources and Services Administration (HRSA). Below is a summary of the most commonly obtained preventive screening services (this is not meant to be an all-inclusive list and is subject to change). See *Preventive Care* for more details.	
• **Bone Density Screening**	100% no deductible
• **Colonoscopy** The first colonoscopy per Plan year is covered under the Preventive Care benefit, regardless of diagnosis. Subsequent colonoscopies in the same Plan year are covered under the medical benefits, regardless of diagnosis.	100% no deductible
• **Fecal Occult Blood Test** The first fecal occult blood test per Plan year is covered under the Preventive Care benefit, regardless of diagnosis. Subsequent fecal occult blood tests in the same Plan year are covered under the medical benefits, regardless of diagnosis.	100% no deductible
• **FIT-Fecal DNA** 1 per plan year	100% no deductible
• **Preventive Mammogram** Diagnostic Mammograms fall to the Radiology benefit.	100% no deductible
• **Pap Test** 1 per plan year.	100% no deductible
• **Prostate Cancer Screening** (PSA)	100% no deductible
• **Sigmoidoscopy** The first sigmoidoscopy per Plan year is covered under the Preventive Care benefit, regardless of diagnosis. Subsequent sigmoidoscopies in the same Plan year are covered under the medical benefits, regardless of diagnosis.	100% no deductible

Monument Health EPO Plan Some out-of-network services are covered only with an approved Network Waiver. Please see *Highlights of Plan Provisions* for more information.	
	Monument Health Network
• **All Other Screening Tests**	100% no deductible
Professional/Physician Services (office visits, certain telemedicine visits and related services)	
• **Primary Care Provider - Office Visit** (Specialties considered PCPs are based upon individual credentialing.)	$20 copay then 100% no deductible
• **Office Visit** (Family Medicine Residency Clinic Visit)	$20 copay then 100% no deductible
• **Specialist/Specialty Clinic - Office Visit**	$35 copay then 100% no deductible
• **Lab/Pathology Services**	90% no deductible
• **Radiology and Diagnostic Testing**	90% after deductible
• **All Other Services** (except for lab/pathology or radiology and diagnostic testing services).	90% after deductible
Rehabilitation Therapy (Includes physical, speech, occupational, aural and cardiac therapies) FCH pre-authorization required if inpatient.	
• **Inpatient** (Facility)	$250 copay then 100% no deductible
• **Inpatient** (Professional)	100% no deductible
• **Outpatient** (Facility and Professional)	
– Physical Therapy Monument Health providers: First 8 visits for physical therapy do not require a referral. 9th visit and beyond a physician referral is required. All other physical therapy providers: Referral is required for all visits.	90% after deductible
– All Other Therapy (Speech, Occupational, Aural and Cardiac) - Referral is required for all visits.	90% after deductible
Skilled Nursing Facility FCH pre-authorization required.	90% after deductible

Monument Health EPO Plan Some out-of-network services are covered only with an approved Network Waiver. Please see *Highlights of Plan Provisions* for more information.	
	Monument Health Network
Temporomandibular Joint (TMJ) Disorder FCH pre-authorization required for Inpatient and TMJ Surgery. $1,500 lifetime maximum. For Oral Appliances related to TMJ, see *Oral Appliances.*	
• **Outpatient** (Facility)	90% after deductible
• **Outpatient** (Professional)	90% after deductible
Tobacco Cessation (See *Preventive Care*)	100% no deductible
Transplants (Organ and Bone Marrow) FCH pre-authorization required. $20,000 maximum for donor services per occurrence (harvesting, storage and transportation of organ).	
• **Donor Services** $20,000 per occurrence (harvesting, storage and transportation of organ)	
– **Inpatient** (Facility)	$250 copay then 100% no deductible
– **Inpatient** (Professional)	100% no deductible
– **Outpatient** (Facility)	90% after deductible
– **Outpatient** (Professional)	90% after deductible
• **Recipient Services**	
– **Inpatient** (Facility)	$250 copay then 100% no deductible
– **Inpatient** (Professional)	100% no deductible
– **Outpatient** (Facility)	90% after deductible
– **Outpatient** (Professional)	90% after deductible
• **Transportation and Lodging** $10,000 maximum per occurrence for donor and recipient combined. (Inclusive of $150 per day maximum for lodging for donor and recipient combined.)	100% after deductible
Vision Services	Covered through VSP
Wigs (Related to Chemotherapy or Burns) $700 every three years.	100% no deductible

Medical Benefits

FCH administers the benefits described in this section for the Plan participants. All benefits are subject to plan exclusions and limits. All coinsurance, deductibles and inpatient, outpatient or office visit copayments apply. See *Payment Provisions, Summary of Medical Benefits* and *Plan Exclusions and Limitations* for more details, as well as *Plan Definitions*.

Coverage is provided only when **all** these conditions are met:

- The service or supply is a listed covered benefit,
- Specific benefit limits or lifetime maximums are not exhausted,
- All pre-authorization and benefit requirements are met,
- The participant is eligible for coverage and enrolled in this plan at the time the service or supply is received, and
- The service or supply is considered Medically Necessary for a covered medical condition, as defined.

Allergy Care

Benefits include allergy tests, injections, and serums, though serum is covered only when received and administered within the provider's office. If received from a pharmacy, the serum may be covered under the pharmaceutical benefit.

Ambulance Services

The plan covers medically necessary licensed ambulance transportation when the following conditions apply:

- The transportation is to the nearest available health care facility where medically necessary services can be provided;
- Other forms of transportation would likely endanger the participant's health.

Air ambulance transport and ground transportation services require pre-authorization for non-urgent transport.

Note: Emergent Air Ambulance Transport will be reviewed retrospectively.

Transportation for personal or convenience reasons is deemed to be not medically necessary.

Anesthesia

Benefits for anesthesia are covered if and when required for certain procedures or surgeries. Anesthesia must be administered within a hospital or ambulatory surgical center.

General Anesthesia for Dental Care

Coverage is provided for general anesthesia and associated facility charges in conjunction with dental care provided to a participant if such participant is:

- Five years of age or younger and/or
- Is physically developmentally disabled, or
- Is an individual with a medical condition that his/her physician determines will place the person at undue risk if the procedure is performed in a dental office. The covered participant's physician must approve the procedure.

Applied Behavior Analysis (ABA)

This benefit will provide coverage for behavioral interventions based on the principles of Applied Behavior Analysis (ABA).

ABA therapy programs incorporate behavior modification, training and education.

This benefit will cover the five components of ABA:

- Initial assessment
- Direct clinical treatment
- Program development
- Treatment planning
- Supervision of the providers of direct service

Coverage will be provided for medically necessary services to develop, maintain, and/or restore the functioning of an individual. Duplicate services, provider training and group classes are not covered.

Covered Providers

For ABA:

ABA services are provided by a state certified behavior health facility that has ABA services overseen by a BCBA- BCBA-D or provided directly by them as independent practitioners. Qualified network providers can be located using the FCH provider search at www.fchn.com, by selecting "other facilities" and then "Applied Behavior Analysis Facility."

- **Board Certified Behavior Analyst® (BCBA® graduate level, BCBA-D™ doctoral level)** – The BCBA and BCBA-D are independent practitioners who also may work as employees or independent contractors for an organization. The BCBA conducts descriptive and systematic behavioral assessments, including functional analyses, and provides behavior analytic interpretations of the results. The BCBA designs and supervises behavior analytic interventions. The BCBA is able to effectively develop and implement appropriate assessment and intervention methods for use in unfamiliar situations and for a range of cases. The BCBA seeks the consultation of more experienced practitioners when necessary. The BCBA teaches others to carry out ethical and effective behavior analytic interventions based on published research and designs and delivers instruction in behavior analysis. BCBAs supervise the work of Board Certified Assistant Behavior Analysts and others who implement behavior analytic interventions.
- **Board Certified Assistant Behavior Analyst® (BCaBA®)** – The BCaBA conducts descriptive behavioral assessments and is able to interpret the results and design ethical and effective behavior analytic interventions for clients. The BCaBA designs and oversees interventions in familiar cases (e.g., similar to those encountered during

their training) that are consistent with the dimensions of applied behavior analysis. The BCaBA obtains technical direction from a BCBA for unfamiliar situations. The BCaBA is able to teach others to carry out interventions and supervise behavioral technicians once the BCaBA has demonstrated competency with the procedures involved under the direct supervision of a BCBA. The BCaBA may assist a BCBA with the design and delivery of introductory level instruction in behavior analysis. It is mandatory that each BCaBA practice under the supervision of a BCBA. Governmental entities, third-party insurance plans and others utilizing BCaBAs must require this supervision.

- **Registered Behavior Technician™ (RBT™) or Therapy Assistant (TA)** – The RBT/TA is a paraprofessional who practices under the close, ongoing supervision of a BCBA or BCaBA ("Designated therapy supervisor"). The RBT/TA is primarily responsible for the direct implementation of skill-acquisition and behavior-reduction plans developed by the supervisor. The RBT/TA may also collect data and conduct certain types of assessments (e.g., stimulus preference assessments). The RBT/TA does not design intervention or assessment plans. It is the responsibility of the therapy supervisor to determine which tasks an RBT/TA may perform as a function of his or her training, experience, and competence. The therapy supervisor is ultimately responsible for the work performed by the RBT/TA and bills for their services.

Bariatric Surgery

The Bariatric Surgery benefit has a "one (1) operative procedure lifetime" maximum. This benefit is available only to members who have not had any previous bariatric surgical procedures, regardless of whether the member was enrolled on the Plan at the time of the previous procedure. For members who have not previously had a bariatric surgical procedure, the Plan covers one (1) operative procedure per lifetime if performed at Monument Health or Western Providers facilities. If complications arise from a covered Bariatric procedure, a second Bariatric procedure will not be covered by the Plan.

Morbid Obesity: Care and treatment of Morbid Obesity (including surgical treatment). Weight loss medication will be considered under the Prescription Drug Card Program. Surgical treatment for Morbid Obesity will only be covered if all the following conditions are met:

- The Covered Person has either:
  - a body mass index (BMI) of 40 or greater; or
  - a BMI of 35 or greater in conjunction with two or more co-morbidities, such as obesity hypoventilation, sleep apnea, diabetes, hyperlipidemia, hypertension, cardiomyopathy, coronary artery disease, congestive heart failure, or degenerative joint disease.
- The Covered Person has at least a 12-month history of Morbid Obesity as documented in such person's medical records.
- The Covered Person does not have an underlying diagnosed medical condition that would cause Morbid Obesity (e.g., an endocrine disorder) that can be corrected by means other than surgical treatment.
- The Covered Person has completed full growth (18 years old or supporting documentation of complete bone growth).
- The Covered Person must actively participate in the Monument Health Plan Care Management program for no less than six 6 months prior to surgery and for three 3 months following the surgery.

- The Covered Person has failed to achieve and maintain significant weight loss and must provide proof of participation in a Lifestyle/Weight Loss nutrition and exercise program for at least four (4) months occurring within the 12-month period prior to the proposed surgical treatment and such participation is documented in his or her medical records or proof of participation in a pre-approved program is provided to the Monument Health Care Management team prior to surgery. This includes a minimum of four (4) monthly visits with a provider, six (6) visits with a registered dietician, and may include three (3) visits with mental health counseling.
- The Covered Person must be evaluated by a licensed psychologist or psychiatrist, or licensed clinical social worker or mental health counselor experienced in the evaluation and management of bariatric patients certifying the member's fitness for surgery, including the ability to comply with required lifestyle modification and treatment programs. Evaluation is to be completed within 12 months prior to the proposed surgical treatment. The evaluation should document the following:
  - that there is no significant psychological problem that would limit the ability of the Covered Person to understand the procedure and comply with any medical and/or surgical recommendations,
  - any psychological co-morbidities that may be contributing to the Covered Person's inability to lose weight or a diagnosed eating disorder; and
  - the Covered Person's willingness to comply with the preoperative and postoperative treatment plans.
- The Covered Person must have documented screening or evaluation for obstructive sleep apnea documented in their medical record.
- If the Covered Person is an active smoker, they must enroll in a smoking cessation program and stop smoking no later than six (6) weeks prior to surgery.

The Plan does not cover certain procedures, including experimental and/or investigational treatment of Morbid Obesity. This list includes, but is not limited to:

- Loop gastric bypass
- Gastroplasty, more commonly known as "stomach stapling" (not to be confused with vertical band gastroplasty)
- Mini gastric bypass
- Duodenal switch

Complications that arise within180 days after the procedure will be covered by the plan only if:

- the procedure was performed at a Monument Health facility; or
- the member is new to the Monument Health plan within 180 days of the surgery date; and
- the surgery was performed at an in-network location for the plan at the time of surgery, or at a Center of Excellence defined by the plan at the time of surgery.

All other complications will only be covered related to technical failure of the device to include removal of the device and repair of existing device. Examples of technical failure of the original bariatric surgical procedure include, but not limited to, pouch dilatation and laparoscopic band erosion. If a covered surgical procedure is being performed in the same operative session as a non-covered procedure, then the entire surgical session would not be covered.

Eligible expenses will be payable as shown in the Summary of Medical Benefit.

Blood Transfusions/Donation

Autologous blood donations are those in which the blood being transfused was donated by the patient during surgery. Blood transfusions are the replacement of blood or one of its components, depending on the condition being treated. Coverage for either is provided when ordered by your physician.

Chemical Dependency

All inpatient admissions and partial hospital programs **require FCH pre-authorization** by calling (800) 640-7682. The plan covers services provided to individuals requiring chemical dependency treatment for abuse of substances, (e.g. alcohol or other drugs). Care must be medically necessary and provided at the least restrictive level of care.

Care may be received at a hospital, a chemical dependency facility, and/or received through residential treatment programs, partial hospital programs and intensive outpatient programs or through group or individual outpatient services.

Chiropractic Care

Coverage includes chiropractic manipulation of the spine when performed within the scope of the provider's license.

Clinical Trials

This benefit covers routine patient costs for members who choose to participate in an approved clinical trial (as outlined below), and the member's participation in the clinical trial has been pre-authorized. Services such as those identified as Experimental and/or Investigational in the clinical trial are not covered. Refer to "Costs Not Covered" below for details.

An approved clinical trial is defined as follows:

- Pre-authorization for clinical trial participation has been granted as described below.
- The clinical trial is a phase I, phase II, phase III, or phase IV clinical trial that is conducted in connection with the prevention, detection, or treatment of disease known to adversely affect the member's quality of life.
- The principal purpose of the trial intervention must be the therapeutic intent to potentially improve health outcomes.
- The clinical trial intervention must be intended for a condition covered by the health plan.
- The approved clinical trial must be classed as one of the following:
  - A federally funded or federally approved trial.
  - A clinical trial conducted under a U.S. Food and Drug Administration (FDA) investigational new drug application.
  - A drug trial that is exempt from the requirement of an FDA investigational new drug application.
- The clinical trial must be conducted under a written research protocol approved by an appropriate Institutional Review Board (IRB). This protocol must demonstrate that the trial is in compliance with Federal regulations relating to the protection of human subjects.

- The clinical trial must provide a thorough informed consent document to the participating member, and this document must be signed by the member prior to member's participation in the clinical trial.
- Services must be obtained by an in-network provider and facility. There is no out-of-network coverage for this benefit.
- A "qualified member" is a Plan member or beneficiary who is eligible, according to the trial protocol, to participate in the approved clinical trial for the treatment of disease and either:
  - The referring health care professional is a participating provider and has concluded that the member's or beneficiary's participation in the clinical trial would be appropriate; or
  - The member or beneficiary provides medical and scientific information establishing that the individual's participation in the clinical trial would be appropriate.

Costs associated with clinical trial participation may be covered as follows:

Costs Covered:

- Routine Patient Costs defined as follows-
  - Items or services that are typically provided under the plan for a participant not enrolled in a clinical trial. (e.g., usual care/standard care.).
  - Items, services, or tests that are required to safely provide the investigational intervention to include clinically appropriate monitoring of the effects of the intervention.
  - Medically necessary diagnosis and treatment for conditions that are medical complications resulting from the member's participation in the clinical trial.

Costs Not Covered:

- Investigational items, services, tests, or devices that are the object of the clinical trial.
- Interventions, services, tests, or devices provided by the trial sponsor without charge.
- Data collection or record keeping costs that would not be required absent the clinical trial; this exclusion extends to any activity (e.g. imaging, lab tests, biopsies) necessary only to satisfy the data collection needs of the trial.
- Services or interventions clearly not consistent with widely accepted and established standards of care for the member's particular diagnosis.
- Interventions associated with treatment for conditions not covered by the Plan.

COVID-19

The plan covers medically necessary diagnostic and treatment services related to COVID-19.

Dental Trauma

Not intended as dental coverage, this benefit coverage is provided for repair of sound natural teeth and/or implants of sound natural teeth, and repair of the jawbone or supporting tissues, due to accidental injury. After the initial examination by your dentist, a pre-authorization for further services is required by FCH. All services related to the repair must be completed within 24 months of the date of the injury. Any services received after 24 months have elapsed, or after you become disenrolled from this Plan regardless of whether 24 months have elapsed or not, are not covered. Anesthesia related to the accidental injury is covered within 24 months.

Injury due to biting or chewing is not covered, and is not considered an accidental injury. For the purposes of this coverage, a “sound natural tooth” is a tooth that is (i) free of active or chronic clinical decay, (ii) contains at least fifty percent (50%) bony structure, (iii) is functional in the arch, and (iv) has not been excessively weakened by multiple dental procedures.

Diabetic Education and Diabetic Nutrition Education

Diabetic education regarding nutrition and insulin management of diabetes is covered. The education may take place in classes through approved diabetic courses or as individual instruction.

Diagnostic Testing

The plan covers testing such as lab and radiology for diagnostic purposes when medically necessary and ordered by a qualified health care provider.

Durable Medical Equipment (DME) and Supplies

DME is medical equipment that can withstand repeated use, is not disposable, is used for a medically therapeutic purpose, is generally not useful in the absence of sickness or injury and is appropriate for use in the home. DME may be rented or purchased (at FCH’s discretion) and total cost for rental must not exceed the purchase price. Repair or replacement is only covered when needed due to normal use, a change in the patient’s physical condition or the growth of a child. Duplicate items are not covered. When more than one option exists, benefits will be limited to the least expensive model or item appropriate to treat the patient’s covered condition.

Examples of DME include, but are not limited to:

- Crutches
- Oxygen and equipment for administering oxygen
- Walkers
- Wheelchairs

This benefit also covers:

- **Breast Pumps:** Benefits include electric, hospital grade, or manual breast pumps, as well as replacements of tubing, power adapters, breast shields, caps for breast pump bottles, polycarbonate bottles, and locking ring. Breast milk storage/freezer bags, breastfeeding supplies, including nursing pads, nipple shields, nipple cream, and nursing bras are not covered.
- **Diabetic monitoring equipment,** such as the initial cost of an insulin pump and blood glucose monitor (including supplies related to such equipment). Diabetic supplies such as insulin, syringes, needles, lancets, etc., are covered under the pharmacy benefit.
- **Medical supplies** needed for the treatment or care of an appropriate covered condition, including but not limited to compression garments, mastectomy supplies and ostomy supplies. Supplies available over-the-counter are excluded.
- **Oral appliances** when related to the treatment of Sleep Apnea or TMJ
- **Orthopedic appliances/braces:** These include appliances used to support abnormal joints, limit pressure on a joint after injury to allow it to heal or correct abnormal curves in the spine.

- **Prosthetic devices:** Benefits include external prosthetic appliances that are used to replace all or part of a missing body part and are necessary for the alleviation or correction of illness, injury, or congenital defect.

Surgically implanted devices may be covered under the appropriate surgical benefit and are not considered DME. Benefits for durable medical equipment are determined by the type of device and its intended use, and not by the entity that provides or bills for the device.

Emergency Services and Urgent Care

The Plan covers emergency department visits (including pre-stabilization, post-stabilization, certain ancillary services) at in network & non-network facilities and in-network urgent care visits to evaluate an Emergency Medical Condition at in-network facilities. Non-Network Urgent Care visits are not covered.

Emergency (or emergent) means the sudden and acute onset of a symptom(s), including severe pain, that would lead a person, acting reasonably, to believe a health condition exists that requires immediate medical attention and that failure to provide medical attention would result in serious impairment to bodily functions or serious dysfunction of a bodily organ or part, or would place the person's health in serious jeopardy.

Examples of **emergent** conditions include severe pain, difficulty breathing, deep cuts or severe bleeding, poisoning, drug overdose, broken bones, unconsciousness, stab or gunshot wounds, automobile accidents, and pain or bleeding during pregnancy. Examples of **urgent** conditions include cuts and lacerations, diarrhea, allergic reactions, sprains, urinary tract infections and vomiting.

In the case of an emergency, home or away, seek the most immediate care available. To receive the network level of benefits, you must obtain all follow-up care from network providers.

Family Planning

Voluntary sterilization procedures and FDA-approved birth control methods are covered. Over-the-counter products are not covered, except medications required under the Affordable Care Act. Oral, patch and ring contraceptives are covered under the prescription drug benefit.

Termination of Pregnancy

Medically necessary termination of pregnancy is covered when allowed for all female plan participants when due to rape, incest or when the mother's life is endangered if carried to term.

Foot Orthotics

Custom-designed foot orthotics, when prescribed by a physician and required for all normal, daily activities are covered by the Plan.

Gender Affirming Services

FCH pre-authorization required for inpatient admissions and gender affirming surgery. These services are intended to provide treatment for patients with gender dysphoria. This coverage may include primary care, gynecologic and urologic care, sterilization options, mental health services (e.g., assessment, counseling, psychotherapy, psychotropic medication management),

hormonal therapy, and limited gender affirming surgical treatments. Gender affirming surgical treatments are limited to members age 18 and older. Transportation and lodging are not covered. FDA-approved medications for support and treatment of transgender related services are covered through the Pharmacy Benefit.

Genetic Services

Genetic testing, counseling, are covered when determined to be an essential component of medically necessary care or treatment of a covered condition, or a medically necessary precursor to obtaining prompt treatment of a covered condition.

Habilitative Services

Benefits are provided for habilitative services when medically necessary and related to a Developmental Disability. These services must be recognized by the medical community as efficacious:

- For partial or full development;
- For keeping and learning age appropriate skills and functioning within the individual's environment; and
- To compensate for a progressive physical, cognitive, and emotional Illness.

Covered services include speech, occupational, physical and aural therapy services.

Day habilitation services designed to provide training, structured activities and specialized assistance to adults, chore services to assist with basic needs, vocational and custodial services are not covered.

Home Health Care

FCH pre-authorization is required for wound therapy, enteral formula, medical food and associated services and home hospice. Home health care is covered when prescribed by your physician. The patient must be homebound (except for lactation and perinatal services) and require skilled care services (as defined by the Plan). Benefits are limited to intermittent visits by a licensed home health care.

For this benefit, a visit is a time-limited session or encounter with any of the following home health agency providers:

- Nursing services (RN, LPN)
- Licensed or registered physical, occupational or speech therapist (or an assistant working under the supervision of one of these providers)
- Home health aide working directly under the supervision of one of the above providers
- Licensed as a social worker - masters prepared
- Registered dietician

Private duty nursing, shift or hourly care services, custodial care, maintenance care, housekeeping services, respite care and meal services are not covered.

This benefit is not intended to cover care in the home when FCH determines care in a skilled nursing facility or a hospital is more cost-effective. Any charges for home health care that qualify

under this benefit and under any other benefit of this plan will be covered under the most appropriate benefit, as determined by FCH.

Hospice Care

FCH pre-authorization is required for inpatient hospice, home hospice and all respite care. Hospice care is covered when prescribed by your physician and s/he has determined that life expectancy is 12 months or less and a palliative, supportive care treatment approach has been chosen. *Note: patients are not required to discontinue treatment or "curative care" in order to access the hospice benefit.* This benefit includes acute, respite, and home care to meet the physical, psychosocial, and special needs of a patient-family unit during the final stages of illness and dying. Hospice care is provided at a variety of levels to meet the individual needs of the patient-family unit. Levels offered are:

- **Intermittent in-home visits** are provided on an as needed basis by the hospice team, which includes health care professionals, support staff, and a twenty-four (24) hour a day "on-call" registered nurse. This level of care does not cover room and board while a member resides in a skilled nursing facility, adult family home, or assisted living facility.
- **Inpatient Hospice** care is needed when care cannot be managed where the patient resides. The care will be provided at an inpatient facility until the patient's condition stabilizes.
- **Respite Care**
  - **Continuous home care** is provided when a medical crisis occurs where the patient resides and care can be provided at the residence. During such periods, the hospice team can provide around-the-clock care.
  - **Inpatient respite care** is available to provide the patient's caregiver a rest. This acknowledges that caring for a dying person can be difficult. Care for the patient is provided at an inpatient facility and includes room and board costs.

When provided within the above-defined levels of care, additional covered expenses include:

- Approved medications and infusion therapies furnished and billed by an approved hospice agency
- Durable Medical Equipment
- Supplies required for palliative care

If the patient exhausts the hospice benefit maximum, limited extensions may be granted if it is determined that the treatment is medically necessary. Any charges for hospice care that qualify under this benefit, and under any other benefit of this plan, will be covered under the most appropriate benefit as determined by FCH.

Hospital Inpatient Medical and Surgical Care

Hospital inpatient and facility charges for medically necessary care are covered. **FCH pre-authorization is required** for all non-emergency inpatient admissions to a hospital or facility. Covered inpatient care includes room and board, operating room and anesthesia, radiology, lab and pharmacy services furnished by and used while in the hospital.

Hospital Outpatient Surgery and Services

Certain outpatient surgery/procedures **require FCH pre-authorization**; please see *Pre-authorization Requirements* for details. Covered outpatient care includes outpatient surgery, procedures and services, operating room and anesthesia, radiology, lab, and pharmacy services furnished by and used while at a hospital or ambulatory surgical center.

Infertility Diagnostic Services

Coverage is provided for the initial evaluation and diagnosis of infertility only. Examples of covered services for the initial diagnosis of infertility include endometrial biopsy, hysterosalpingography, reproductive screening services, or sperm count. A pre-authorization must be obtained from FCH if care is provided inpatient. Treatments and procedures for the purposes of producing a pregnancy are not covered.

Infusion Therapy

FCH pre-authorization required for certain infusion therapy drugs; please see *Pre-authorization Requirements* for details. This benefit covers the administration of medications using intravenous, subcutaneous, and epidural routes (into the bloodstream, under the skin, and into the membranes surrounding the spinal cord). Drug therapies commonly administered via infusion include, but are not limited to, antibiotics, chemotherapy, pain management, parenteral nutrition, and immune globulin. Diagnoses commonly requiring infusion therapy include infections that are unresponsive to oral antibiotics; cancer and cancer-related pain; gastrointestinal diseases or disorders which prevent normal functioning of the GI system; congestive heart failure; immune disorders; and more. Nursing visits (related to home health only) associated with infusion therapy are covered under the Home Health Care benefit, regardless of whether the patient is home bound.

Maternity and Newborn Care

Coverage for pregnancy and childbirth, for an employee, his/her spouse, or female dependent children, in a hospital or birthing center, is provided on the same basis as any other medical condition, as are complications of pregnancy. Medically necessary screening(s) and diagnostic procedures during pregnancy for prenatal diagnosis of congenital disorders of the fetus are covered. The services of a licensed physician, an advanced registered nurse practitioner (ARNP), a licensed midwife, or a certified nurse midwife (CNM) are covered under this benefit.

Coverage for newborns is provided when s/he is enrolled as a dependent under this Plan (see Eligibility and Enrollment for details). Benefits are subject to the newborn child's own coinsurance and deductible requirements.

Newborn care includes inpatient hospital services and professional care (including circumcision) performed during the initial period of hospitalization immediately following birth. Any services performed after the baby is discharged from this level of care are covered under the benefit applicable to the services billed, and are not considered newborn care. Circumcisions are covered up to 28 days following birth. Circumcisions performed after 28 days must be medically necessary as determined by FCH.

Newborns' and Mothers' Health Protection Act of 1996 This Act states that group health plans may not restrict benefits for any hospital length of stay in connection with childbirth for the

mother or newborn child to less than 48 hours following a normal vaginal delivery or less than 96 hours following a cesarean section. However, federal law generally does not prohibit the mother's or newborn's attending provider, after consulting with the mother, from discharging the mother or newborn earlier than these periods. In any case, the Plan may not, under federal law, require that a provider obtain authorization from the Plan or the insurance issuer or TPA for prescribing a length of stay not in excess of these periods.

Mayo Clinic Complex Care Program

Mayo Clinic Complex Care coverage is by approved referral only, and referrals are only approved if the member has received a letter from Monument Health stating approval and additional benefits associated with an approved referral. Those members with approved referrals will have Monument Health Providers benefits applied. There are no Mayo Clinic Complex Care benefits for those who self-refer.

Monument Health contributes toward the cost of your coverage when participating in the Mayo Clinic Complex Care Program as part of the Monument Health Plan. In some cases, Monument Health pays a portion of the cost of eligible covered services under the Monument Health Plan as allowed by applicable law. In other cases, you share the cost of your coverage when participating in the Mayo Clinic Complex Care program available under the Monument Health Plan, or pay the full cost.

Such costs include:

- EPO Plan – may receive a credit up to a $1,000 maximum for deductible, copay and coinsurance per plan year. Without an approved referral, benefits will be denied.

Travel expenses:

- EPO Plan – are eligible for up to $1,000 of travel expenses per plan year. Costs include one (1) travel companion for an adult patient or up to two (2) travel companions for a pediatric patient, unless prohibited by law.
- Precertification and/or pre-authorization requirements are waived for Mayo Clinic when receiving care through the Mayo Clinic Complex Care Program. A review of medical documentation will occur post-care to determine coverage amounts and medical necessity. A service or supply that is not deemed a medical necessity may be denied in whole or in part. *Experimental and investigational services are not covered.*

Services that are not approved as part of the Mayo Clinic Complex Care Program are not covered at the Mayo Clinic.

Travel Expenses related to Mayo Clinic Complex Care Program

This benefit is for travel expenses related to the medical services pursued at Mayo Clinic. Cash advances will not be provided, and any qualifying costs will be reimbursed upon submission of receipts.

Travel allowance is paid for travel between the patient's home and the provider/facility for round trip air (coach class only), train, shuttle and bus transportation costs.

Personal auto travel will be reimbursed mileage based upon the published IRS standard rate for mileage from the patient's home address to the Mayo clinic in addition to parking, tolls. Payment rate information is available at www.irs.gov. Gasoline will not be reimbursed separately as that is included in the IRS mileage rate.

Lodging will be reimbursed for the cost of hotel/motel accommodations up to the IRS "lodging" (excluding taxes) per diem rate. Meals will be reimbursed up to the IRS "meal" per diem rate. The IRS per diem rate is a flat rate of reimbursement to cover lodging/meals and is updated annually on the General Services Administration web site (www.gsa.gov/perdiem). Payment will be based on the submitted receipts provided or IRS per diem rate whichever is less. Itemized receipts must be provided; a credit card statement or credit card receipt is not sufficient.

Expenses that are not appropriately documented will not be reimbursed. Additional expenses that are not reimbursable include, but are not limited to:

- Roaming cell phone charges or calls
- Alcoholic beverages
- Car maintenance
- Cards, stationery, stamps
- Clothing
- Dry cleaning/laundry services
- Entertainment (cable televisions, books, magazines, movie rentals, etc.)
- Flowers

Mental Health Care

All inpatient admissions and partial hospital programs **require FCH pre-authorization** by calling (800) 640-7682. The plan covers treatment of mental health or psychiatric conditions.

Care must be medically necessary and provided at the least restrictive level of care. Facilities offering inpatient level of care must have a medical model with physician and/or nursing staffing on site 24 hours each day.

Care may be received at a hospital or treatment facility, and/or received through residential treatment programs, partial hospital programs, and intensive outpatient programs or through group or individual outpatient services.

Family counseling and psychotherapeutic programs are covered only if related to the treatment of an approved clinical mental health diagnosis, specifically, those noted in the most current version of the Diagnostic and Statistical Manual of Mental Disorders (DSM).

Pursuant to the Mental Health Parity Act of 1996 (MHPA) and the Mental Health Parity and Addiction Equity Act of 2008 (MHPAEA), collectively, the mental health parity provisions in Part 7 of ERISA, this Plan applies its terms uniformly and enforces parity between covered health care benefits and covered mental health and substance disorder benefits relating to financial cost sharing restrictions and treatment duration limitations. For further details, please contact the Plan Administrator.

Nutritional Counseling

Coverage provided for health services rendered by a registered dietician or other licensed professional for individuals with medical conditions that require a special diet. Some examples of such medical conditions include coronary heart disease, congestive heart failure, severe obstructive airway disease, gout, renal failure, phenylketonuria and hyperlipidemias. Nutritional counseling for diabetes is covered under the *Diabetic Education & Diabetic Nutrition Education* benefit.

Nutritional and Dietary Formulas

Coverage for nutritional and dietary formulas is provided when medically necessary. The following conditions must be met:

- The formula is a specialized formula for treatment of a recognized life-threatening metabolic deficiency such as phenylketonuria **or**
- The formula is the significant source of a patient's primary nutrition or is administered in conjunction with intravenous nutrition **and**
- The formula is administered through a feeding tube (nasal, oral or gastrostomy).

Oral Surgery

Coverage for oral surgery is offered when a medical diagnosis is present. Oral Surgery required for a dental diagnosis such as periodontal disease is not covered. Examples of covered services include:

- The reduction or manipulation of fractures of facial bones
- Excision of lesions, cysts, and tumors of the mandible, mouth, lip or tongue
- Incision of accessory sinuses, mouth salivary glands or ducts
- Extraction of teeth damaged due to radiation therapy that occurred while under this Plan

Pharmacy

Prescription drug benefits for Plan participants are administered by ClearScript, a separate provider not affiliated with FCH. Monument Health may require certain products to be dispensed by Monument Health pharmacies only. Covered medications must meet these requirements:

- Prescribed by a licensed physician,
- Approved by the Food and Drug Administration (FDA), and
- Must be warranted to treat a covered condition, and
- Must be listed on the formulary.

You may obtain up to a 90-day refill directly through Monument Health Preferred Network Pharmacy. You may also obtain up to a 30-day supply from the ClearScript retail network pharmacy. See *Filling a Prescription* below for more detailed information on how and where you can obtain your prescription drugs.

The Summary of Pharmacy Benefits section notes the amounts for which you are responsible. To assist in keeping your out-of-pocket costs down when purchasing a prescription, it may be helpful to know that six tiers exist within the pharmacy formulary tiers:

- **Generics** – Generic drugs have the same active ingredients as their equivalent brand name drugs.
- **Formulary Brand Name –** Brand drugs are typically the original ingredients that do not have a generic equivalent.
- **Non-Formulary Brand Name** – Brand drugs that often include ingredients that are higher cost or have a generic equivalent.

- **Diabetic Supplies** – Including but not limited to, insulin, blood monitors and kits, blood test strips, insulin syringes and needles, devices and insulin pump supplies and lancets.
- **Specialty Formulary** – Specialty drugs are high cost drugs that often require special handling or monitoring. Preferred brands are typically the original ingredients that do not have a generic or biosimilar equivalent.
- **Specialty Non-Formulary** – Specialty drugs are high cost drugs that often require special handling or monitoring. Non-preferred brands drugs include ingredients that are higher cost or have a generic equivalent.
- **Specialty Limited Distribution and Orphan Drugs** – The Plan excludes certain specialty drugs that cannot be obtained and dispensed by Monument Health Specialty Pharmacy. This includes, but is not limited to, some Orphan Drugs and many Limited Distribution Drugs. If you are not sure about the coverage status of your medication, please contact ClearScript at 855-816-6389 for assistance or questions.

If a brand name drug is prescribed by your physician because s/he feels it is medically necessary, or selected by you, when a generic equivalent drug is available, you will be responsible for paying the difference in price between the brand name drug and the generic, plus the applicable co-pay/coinsurance. This difference in price does not apply toward your annual out-of-pocket maximum. This provision does not apply to drugs that are considered preventive under PPACA.

In addition to a copay/coinsurance, you are responsible for the cost of any prescription not covered under your pharmacy benefit and for any prescription purchased without presenting your medical benefit ID card.

Filling a Prescription

Following are details for filling a prescription through the retail network, mail order, and specialty pharmacies. Contact ClearScript for any questions on filling a prescription.

Monument Health Preferred Pharmacy Network

A Monument Health Preferred Network Pharmacy includes Monument Health retail and specialty pharmacies.

ClearScript Participating Retail Pharmacy Network

With the ClearScript retail pharmacy network program, you may receive up to a 30-day supply of medication. Additionally, a 90-day supply of medication may be received through Monument Health Network Pharmacy.

If you need assistance in determining if your local, independent pharmacy is part of the ClearScript network of retail pharmacies, you may call ClearScript directly at (855) 816-6389. They are available 24 hours a day, 7 days a week. You can also visit them on the web at www.clearscript.org.

Maintenance medications (taken on a regular basis for ongoing conditions, such as high blood pressure or asthma) should be filled through the Monument Health Preferred Pharmacy Network or Fairview mail-order Pharmacy. You may only fill maintenance medications **one time** outside of the Monument Health Preferred Pharmacy Network. If you decide to fill the same medication again outside of the Monument Health Preferred Pharmacy Network, you will be

responsible for paying 100% of the cost. This excludes urgent medication, such as antibiotics and acute pain medication, which will continue to be fillable at all ClearScript participating pharmacies.

Non-network Pharmacy

There is no non-network pharmacy coverage under this plan. If a covered individual chooses to fill medication outside of a Monument Health Preferred Network Pharmacy or ClearScript Network, the covered individual will be 100% responsible for the charge.

Quantity Limit

For some medications, there is a limit on the quantity of a drug that can be dispensed for a particular period of time. Quantity limits are based on U.S. Food and Drug Administration (FDA) guidelines, manufacturer recommendations and accepted industry practices.

That means, if you refill a prescription too soon or if you submit a prescription for an amount greater than the recommended guidelines, the pharmacy can fill the prescription only up to the quantity limit. If you or your physician request an amount greater than the quantity limit of medication, a pre-authorization may be required.

The goal of the ClearScript Quantity Limit Program is to promote the effective use of drugs based on nationally accepted treatment protocols or well-documented clinical drug studies. These limits are reviewed and revised on an ongoing basis as clinical information changes and new guidelines and standards of care are updated.

Shingles Vaccine

Shingles vaccine can also be covered under the pharmacy benefit when using a participating ClearScript pharmacy. For all other vaccinations or if not using a participating pharmacy, please refer to the medical benefit.

Plastic and Reconstructive Services

Reconstructive/plastic procedures **require FCH pre-authorization** and are covered when performed to correct or repair abnormal structures of the body caused by congenital defects, trauma, infection, tumors, disease, accidental injury or prior surgery (if the prior surgery would be covered under this Plan). Reconstructive surgeries to improve the function of a body part in limited situations such as when the malfunction is due to an accidental injury, birth defect, sickness, or following a mastectomy. Specific criteria follow:

- Services performed to correct congenital defects of a child must be completed before the child’s 18th birthday
- In the case of accidental injury, services must be completed within 12 months of the initial injury

Women’s Health and Cancer Rights Act of 1998 The federal law titled “Women’s Health and Cancer Rights Act of 1998” states group health plans that are providing medical and surgical benefits for mastectomy resulting from disease, illness or injury must also cover, for those affected participants:

- Reconstruction of the breast on which the mastectomy was performed

- Reconstruction of the other breast to produce a symmetrical appearance
- Internal or external prosthesis
- Treatment of physical complications in all stages of post-mastectomy reconstruction, including lymphedema

FCH pre-authorization is not required for breast reconstruction and nipple/areola reconstruction following mastectomy.

Podiatric Care

Coverage is provided for certain surgical podiatric services, including incision and drainage of infected tissue of the foot, removal of lesions of the foot, removal or debridement of infected toenails, and treatment of fractures and dislocations of bones of the foot. Routine foot care, such as the non-surgical treatment of corns, calluses, non-surgical care of toenails, fallen arches and other symptomatic complaints of the feet are not covered, except for members with peripheral vascular disease and diabetes.

Preventive Care

The Plan covers certain preventive services such as well woman, well man and well child exams that are submitted and billed by your provider as preventive care. How often and what kind of preventive care services you need depends upon your age, gender, health, and family history. The list of services is normally updated annually, so you should contact the Plan to determine if a service is considered preventive or to request a current list of covered preventive care services. This list may not represent all possible tests or benefits, and inclusion of a service or item on this list does not guarantee coverage.

Preventive care does not include diagnostic treatment, lab, x-ray, follow-up care, or maintenance care of existing conditions or chronic disease.

For information on the recommendations of the CDC, US Preventive Services Task Force, and the Health Resources and Services Administration, visit the following website: www.healthcare.gov

Professional/Physician Services

This benefit applies to in-person, face-to-face office visits, and Telemedicine. Telemedicine includes videoconferences, scheduled telephone visits and electronic visits (e-Visits).

Telemedicine visits must be initiated by the patient. Scheduling and medical record documentation of these visits, as well as creation of a claim, follows the same standard as in-person office visits. Please review this with your provider before receiving services to ensure your telephonic or e-visit meets the requirements above.

Rehabilitation Therapy

Coverage for disabling conditions is provided through inpatient and outpatient rehabilitation therapy. Examples of such therapies include, but are not limited to, physical therapy, speech therapy, aural therapy, cardiac rehabilitation therapy, and occupational therapy. The following conditions must be met:

- Services are to restore and significantly improve function that was previously present but lost due to acute injury or illness,
- Services are not for palliative, recreational, relaxation or maintenance therapy, and
- Loss of function was not the result of a work-related injury.

Coverage for cardiac rehabilitation requires that participants have experienced a cardiac event in the preceding twelve (12) month period, such as myocardial infarction, chronic stable angina, heart transplants or heart and lung transplants.

Inpatient Rehabilitation

Inpatient rehabilitation **requires FCH pre-authorization** and must be furnished and billed by a rehabilitative unit of a hospital or by another approved rehabilitation facility. When rehabilitation follows acute care in a continuous inpatient stay, this benefit starts on the day the care becomes primarily rehabilitative. Inpatient care includes all room and board, services provided and billed by the inpatient facility and therapies performed during the rehabilitative stay.

Outpatient Rehabilitation

Outpatient rehabilitation benefits are subject to the following provisions:

- You must not be confined in a hospital or other medical facility.
- Services must be billed by a hospital, physician, physical, occupational or speech therapist.

Speech therapy is covered only when required as a result of brain or nerve damage secondary to an accident, disease or stroke.

Once the benefits under this provision are exhausted, coverage may not be extended by using the benefits under any other provision.

Skilled Nursing Facility

Inpatient skilled nursing facility care **requires FCH pre-authorization.** Benefits include room and board and ancillary services. The care must be therapeutic or restorative and require in-facility delivery by licensed professional medical personnel, under the direction of a physician, to obtain the desired medical outcome. (Neither maintenance care nor custodial care are covered.)

Temporomandibular Joint Syndrome (TMJ)

FCH pre-authorization is required for inpatient admissions related to TMJ. Medical, dental, surgical and related hospital services are covered for the treatment of TMJ including the correction of malocclusion of the jaw or any dental treatment for dental conditions involved in temporomandibular joint pain dysfunction, syndrome or disease collectively referred to as Temporomandibular Joint Dysfunction (TMJ). Orthodontia for TMJ is not a covered benefit.

Tobacco Cessation

Coverage is provided for tobacco cessation counseling/interventions, office visits, testing, X-rays and hypnotherapy.

Transplants, Organ and Bone Marrow

FCH pre-authorization is required for transplant service. Services directly related to organ transplants must be coordinated by your participating provider. **Proposed transplants will not be covered if considered experimental or investigational for the participant's condition.** FCH pre-authorization approval for transplants is based on these criteria:

- A written recommendation with supporting documentation received from your provider
- The request for the transplant is based on medical necessity
- The requested procedure and associated protocol is not considered experimental or investigational treatment for your condition
- The procedure is performed at a facility, and by a provider, approved by FCH
- Upon evaluation you are accepted into the approved facility's transplant program and comply with all program requirements

The Plan Sponsor has contracted with OptumHealth and other networks. Any one of these networks may be used as a transplant network option. These networks are independent contractors and provide centers of excellence for specific types of transplant procedures. Coverage for transplants and transplant-related services are based on the plan's terms, exclusions, limitations and conditions, and include the plan's eligibility requirements and coverage guidelines. For more information, please contact First Choice Health.

Please Note: Corneal transplants are not considered an organ transplant and are covered under the medical-surgical benefit, and not under the transplant benefit.

Have your provider send a request, prior to evaluation, to:

Email:
preauthorization@fchn.com

Written:
FCH Medical Management
600 University St., Suite 1400
Seattle, WA 98101

Fax:
(833) 227-4256 or (833) 227-4259

Recipient Services

Covered transplant recipient services include:

- Medical and surgical services directly related to the transplant procedure and follow-up care
- Diagnostic tests and exams directly related to the transplant procedure and follow-up care
- Inpatient facility fees and pharmaceutical fees incurred while an inpatient
- Pharmaceuticals administered in an outpatient setting
- Anti-rejection drugs
- Storage of the patient's own blood in advance of an approved transplant surgical procedure

Donor Services

Donor expenses are covered if all criteria are met below:

- FCH approves the transplant procedure
- The recipient is enrolled in this plan
- Expenses are for services directly related to the transplant procedure
- Donor services are not covered under any other health plan or government program

Covered donor expenses include:

- Donor typing, testing and counseling
- When you or your covered family member is the recipient of a donated organ, this plan will also cover the donor's medical expenses incurred as the result of the transplant, provided that the expense is charged to the covered individual and no other source is available to pay the actual donor's medical expenses
- Donor organ selection, removal, storage and transportation of the surgical/harvesting team and/or the donor organ or bone marrow
- $20,000 per organ transplant procedure for harvesting, storage and transportation of the organ

When both the recipient and the donor are participants under this Plan, covered charges for all covered services and supplies received by both the donor and the recipient will be payable.

Please Note: If you, as a participant, choose to donate an organ or bone marrow, donor expenses are not covered under this Plan unless the recipient is also enrolled in this Plan. However, complications arising from the donation would be covered to the extent that they are not covered under the recipient's health plan.

Travel expenses for Organ and Bone Marrow Transplants

Travel and lodging expenses for approved transplants and associated pre-transplant evaluation are available for the recipient and his/her guardian/caregiver and the donor. **Travel and lodging expenses require FCH preauthorization**; and if authorized are paid, up to a maximum of $150 per day for lodging, $10,000 per transplant for all transportation and lodging combined at the site of the transplant procedure when the transplant network is utilized. Travel allowance is paid for the eligible patient and costs of one (1) travel companion for an adult patient or up to two (2) travel companions for a pediatric patient (age 18 and younger). The maximum applies to all associated transportation, lodging and meal expenses incurred by the transplant recipient, travel companion(s) and donor(s).

Travel allowance is paid for travel between the patient's home and the provider/facility for round trip air (coach class only), train, shuttle and bus transportation costs.

Personal auto travel will be reimbursed mileage based upon the published IRS standard rate for mileage from the patient's home address to the Mayo clinic in addition to parking, tolls. Payment rate information is available at www.irs.gov. Gasoline will not be reimbursed separately as that is included in the IRS mileage rate.

Lodging will be reimbursed for the cost of hotel/motel accommodations up to the IRS "lodging" (excluding taxes) per diem rate. Meals will be reimbursed up to the IRS "meal" per diem rate. The IRS per diem rate is a flat rate of reimbursement to cover lodging/meals and is updated annually on the General Services Administration web site (www.gsa.gov/perdiem). Payment will

be based on the submitted receipts provided or IRS per diem rate, whichever is less. Itemized receipts must be provided; a credit card statement or credit card receipt is not sufficient.

Expenses that are not appropriately documented will not be reimbursed. Additional expenses that are not reimbursable include, but are not limited to:

- Roaming cell phone charges or calls
- Alcoholic beverages
- Car maintenance
- Cards, stationery, stamps
- Clothing
- Dry cleaning/laundry services
- Entertainment (cable televisions, books, magazines, movie rentals, etc.)
- Flowers

Vision Care

Vision is covered through VSP.

Frames, lenses, and contact lenses needed to treat a medical condition, or needed as a result of a medical condition are covered under the Durable Medical Equipment benefit.

Weight Management

Any expenses, whether surgical, non-surgical, or therapeutic (including prescription drugs) that are related to weight management or the treatment of obesity will not be covered under the plan regardless of the existence of any co-morbid conditions or psychological condition, unless the participant is enrolled in, participates in and follows the defined clinical pathway of the Monument Health Care Management Program; the drug is included on the preferred list; and is prescribed by a Monument Health Primary Care provider. Surgical procedures associated with this program do require pre-authorization, see *Bariatric Surgery* benefit noted above.

Benefits for surgical obesity treatment are provided only for eligible participants who meet specific criteria; see *Bariatric Surgery.*

Plan Exclusions and Limitations

Covered services are limited to the diagnosis, therapeutic care or treatment, and prevention of disease, sickness or injury as described in this document. This plan does not cover non-emergency services from out-of-network providers. In addition to limits and exclusions stated elsewhere in this document, coverage is specifically excluded for each of the following items and any related services and charges:

- Adoption expenses
- Aduhelm
- Alternative care (includes acupuncture and massage therapy)
- Amounts over and above UCR, as defined by the Plan
- Amounts for which the covered person has no obligation to pay
- Any charges by a facility owned or operated by the United States or any state or local government unless the participant is legally obligated to pay (excluding: (i) covered expenses rendered by a medical facility owned or operated by the United States Veteran's Administration when the services are provided to a participant for a non-service related illness or injury, and (ii) covered expenses rendered by a United States military medical facility to participants who are not on active military duty)
- Any condition resulting from participation in declared or undeclared acts of terrorism, war, military service, participation in a riot or civil disobedience
- Any service not medically necessary for the diagnosis, treatment or prevention of injury or illness, even if it is not specifically listed as an exclusion (except for specific services offered through the Preventive Care benefit)
- Any service received before the participant's effective date of coverage or after the coverage termination date
- Applied Behavior Analysis - the following are not covered:
  - Providers accompanying children or family members to health care appointments that are not part of the direct provision of ABA services
  - Services by more than one program manager for each child/family (program development, treatment planning, supervision)
  - Training of therapy assistants and family members (as distinct from supervision)
  - Parent training or classes, except for one-on-one or one-on-two direct training of the parents of one identified patient
  - Services provided in a home school, or public/private school environment that are part of a child's schooling as distinct from specific ABA treatment services (e.g. acting as the "Teacher's Aide," or helping a child with homework)
- Aromatherapy
- Athletic training, body-building, fitness training or related expenses
- Autopsies
- Bariatric Surgery when services received from a non-Monument Health facility or provider, prescription drugs for weight loss (outside of Monument Health Care Management Program), gym membership (might be available outside of medical benefits), prescription or non-prescription nutritional and/or food supplements including weight loss shakes, exercise programs and equipment, other surgical procedures

primarily for reduction of adipose tissue, and other cosmetic surgery/liposuction. *Note: If a covered surgical procedure is being performed in the same operative session as a non-covered procedure, then the entire surgical session would not be covered.

- Benefits relating to any condition, illness, or injury for which the participant receives compensation or reimbursement through another contractual arrangement or benefit (other than employer-based disability payments), such as surrogate pregnancy.
- Biofeedback
- Botanical or herbal medicines, as well as other over-the-counter medications
- Charges for failure to keep a scheduled visit, for the copying of medical records or for the completion of a claim or administrative forms
- Chemical Dependency treatments listed below:
  - Alcoholics Anonymous or other similar chemical dependency programs or support groups
  - Biofeedback, pain management and/or stress reduction classes
  - Care necessary to obtain shelter, to deter antisocial behavior, to deter runaway or truant behavior
  - Court-ordered or other assessments to determine the medical necessity of court-ordered treatments
  - Court-ordered treatments or treatments related to deferral of prosecution, deferral of sentencing or suspended sentencing or treatments ordered as a condition of retaining driving rights, when no medical necessity exists
  - Custodial care, including housing that is not integral to a medically necessary level of care, such as care necessary to obtain shelter, to deter antisocial behavior, to deter runaway or truant behavior or to achieve family respite
  - Emergency patrol services
  - Housing for individuals in a Partial Hospital Program or Intensive Outpatient Program
  - Information or referral services
  - Information schools
  - Long-term or custodial care
  - Non substance related disorders
  - Therapeutic group homes, residential community homes, therapeutic schools, adventure-based and/or wilderness programs or other similar programs
  - Treatment without ongoing concurrent review to ensure that treatment is being provided in the least restrictive setting required
- Claims for services that are the result of any injury or illness incurred by a participant while that participant is participating in the commission of a felony, unless the injury or illness is the result of domestic violence or a physical or mental health condition.
- Court ordered examinations or treatment of any kind, except when medically necessary
- Day habilitation services designed to provide training, structured activities and specialized assistance to adults, chore services to assist with basic needs, vocational and custodial services are not covered.
- Dental, oral surgery or orthodontic related services, such as (but not limited to) those listed below (unless accident related or otherwise specifically covered by the Plan):
  - Care of the teeth or dental structures
  - Tooth damage due to biting or chewing
  - Dental X-rays
  - Extractions of teeth, impacted or otherwise (except as covered under the Plan)

- Orthodontia
- Procedures in preparation for dental implants, except as covered under the Dental Trauma benefits
- Services to correct malposition of teeth

- DME and medical supply charges listed below:
  - Biofeedback equipment
  - Breast milk storage/freezer bags, breastfeeding supplies, including nursing pads, nipple shields, nipple cream, and nursing bras are not covered.
  - Equipment or supplies whose primary purpose is preventing illness or injury
  - Exercise equipment
  - Items not manufactured exclusively for the direct therapeutic treatment of an illness or injured patient
  - Items used outside the home primarily for sports/recreational activities Over-the-counter items (except medically necessary crutches, walkers, standard wheelchairs, diabetic supplies and ostomy supplies are covered)
  - Personal comfort items including but not limited to air conditioners, lumbar rolls, heating pads, diapers or personal hygiene items
  - Phototherapy devices related to seasonal affective disorder
  - Supportive equipment/environmental adaptive items including, but not limited to, hand rails, chair lifts, ramps, shower chairs, commodes, car lifts, elevators, and modifications made to the patient's home, place of work, or vehicle.
  - The following medical equipment/supplies: standard car seats or strollers, push chairs, air filtration/purifier systems or supplies, water purifiers, allergenic mattresses, orthopedic or other special chairs, pillows, bed-wetting training equipment, corrective shoes, whirlpool baths, vaporizers, room humidifiers, hot tubs or other types of tubs, home UV or other light units (light boxes or specialized lamps or bulbs), home blood testing equipment and supplies (except diabetic equipment and supplies, and home anticoagulation meters)
- Experimental, investigational, or unproven services
- FDA-approved drugs, medications or other items for non- approved indications, except when an FDA-approved drug has been proven clinically effective to treat such indication and is supported in peer-reviewed scientific medical literature
- Gender Affirming Services
  - The following procedures are considered cosmetic when used to improve the gender specific appearance of an individual who has undergone or is planning to undergo a sex reassignment surgery, including, but not limited to, the following:
    - Abdominoplasty
    - Blepharoplasty
    - Body contouring (liposuction of waist)
    - Brow lift
    - Calf Implants
    - Cheek/malar implants
    - Chin augmentation (reshaping or enhancing the size of the chin)
    - Collagen injections
    - Construction of a clitoral hood
    - Drugs for hair loss or growth
    - Face-lift
    - Facial bone reconstruction
    - Facial bone reduction

    - Facial feminization/masculinization surgery
    - Feminization/masculinization of torso
    - Forehead lift
    - Jaw reduction (jaw contouring)
    - Hair removal (e.g., electrolysis, laser hair removal)
    - Hair transplantation
    - Lip reductions/enhancement (decreasing/increase lip size)
    - Liposuction
    - Mastopexy (breast lift)
    - Neck tightening
    - Nipple reconstruction
    - Nose implants
    - Pectoral implants
    - Pitch-raising surgery
    - Reduction thyroid chondroplasty (trachea shave)
    - Removal of redundant skin
    - Rhinoplasty
    - Skin resurfacing (dermabrasion/chemical peel)
    - Tracheal shave (reduction thyroid chondroplasty)
    - Voice modification surgery (laryngoplasty, cricothyroid approximation or shortening of the vocal chords)
    - Voice therapy/voice lessons
  - Reversal of gender affirming surgery
  - Travel and lodging
- Gene therapy services, treatments, or therapies (including, but not limited to):
  - Certain gene therapy products
  - Any associated services, such as:
    - Medical, surgical, professional, and facility service(s) directly related to the administration of the gene therapy product or service
- Hearing
  - Earwax removal (unless medically necessary)
  - Hearing aids, devices, (unless loss of hearing was due to an accidental injury or illness or congenital permanent childhood hearing impairment).
  - Routine hearing testing (unless required under the Affordable Care Act)
  - Treatment for presbycusis
- Home births
- Home health care listed below:
  - Custodial care
  - Housekeeping or meal services
  - Maintenance care
  - Shift or hourly care services
- Hospice care listed below:
  - Custodial care or maintenance care, except palliative care to the terminally ill patient subject to the stated limits
  - Financial or legal counseling services
  - Housekeeping or meal services

- Services by a participant or the patient's family or volunteers
  - Services not specifically listed as covered hospice services under the Plan
  - Supportive equipment such as handrails or ramps
  - Transportation
- Immunizations for travel
- Infertility treatments to achieve pregnancy (regardless of the cause) including but not limited to:
  - Artificial insemination
  - In vitro fertilization (IVF)
  - Gamete intra-fallopian transplant (GIFT)
  - Ultrasound or diagnostics to determine the success of IVF or GIFT procedures
- Injuries while illegally under the influence of a controlled substance and/or alcohol
- Lab and/or radiology services not ordered by a qualified health care provider
- Labiaplasty or clitoroplasty
- Learning disabilities and related services, educational testing or associated training
- LINX Implantation (if being performed in the same operative session as a covered procedure, the entire surgical session would NOT be covered)
- Medication therapy management
- Mental health care listed below:
  - Adventure-based and/or wilderness programs that focus primarily on education, socialization or delinquency
  - Biofeedback, pain management, and stress reduction classes
  - Court-ordered assessments
  - Custodial care, including housing that is not integral to a medically necessary level of care, such as care necessary to obtain shelter, to deter antisocial behavior, to deter runaway or truant behavior or to achieve family respite
  - Marriage and couples counseling
  - Family therapy, in the absence of an approved mental health diagnosis
  - Housing for individuals in a Partial Hospital Program or Intensive Outpatient Program
  - Nontraditional, alternative therapies that are not based on American Psychiatric and American Psychological Association acceptable techniques and theories
  - Sensitivity training
  - Sexual dysfunctions, and paraphilic disorders
  - Therapeutic group homes, residential community homes, therapeutic schools, adventure-based and/or wilderness programs or other similar programs
- Non-covered services or complications arising from non-covered services. Non-covered services include those services that would not have been covered by this Plan at the time the complication arose
- Non-duplication of payment/coordination of benefits to prevent double coverage, benefits under this Plan will not be paid for expenses that are reimbursed by other insurance companies, medical plan, or subscriber contracts
- Orthodontia for Temporomandibular Joint Dysfunction (TMJ)
- Orthodontic treatment, appliances or services; dentures or related services
- Over-the-counter products, except as covered by the Plan
- Penile prosthesis implantation

- Personal, convenience or comfort services, supplies, house cleaning, house call home visits from a doctor, or items including but not limited to phones, TVs, guest services, deluxe or suite hospital room, air conditioners, diapers or hygiene items
- Pharmacy services listed below:
  - Anorectics (any drug used for the purpose of weight loss), unless enrolled in the Monument Health Care management program and on the approved list
  - Any prescription refilled in excess of the number specified by the physician, or any refill dispensed after one year from the physician's original order
  - Charges for the administration or injection of any drug
  - Diagnostic tests
  - Drugs labeled "Caution: Limited by federal law to investigational use" or experimental drugs, even though a charge is made to the individual
  - Drugs used for cosmetic purposes, including but not limited to drugs such as Botox, Minoxidil (Rogaine), Tretinoin (Retin A, covered through age 24, pre-authorization is required for age 25 and above)
  - Fluoride (through age 6 only)
  - Immunological agents, biological sera, blood or blood plasma
  - Impotency drugs
  - Infertility medications
  - Medication which is to be taken by or administered to an individual, in whole or in part, while he or she is a patient in a licensed medical facility, rest home, sanitarium, extended care facility, convalescent medical facility, nursing home, or similar institution which operates on its premises, or allows to be operated on its premises, a facility for dispensing pharmaceuticals
  - Non-legend drugs other than insulin and certain over-the-counter medications required under the Affordable Care Act.
  - Non-systemic contraceptives and implants, such as diaphragms, IUDs, cervical caps which would be covered through the medical benefits; or condoms which are over-the-counter
  - Nutritional supplements
  - Prescriptions which an eligible individual is entitled to receive without charge from any Workers' Compensation laws
  - Replacement of lost or stolen medications/items, some medications (excluding C2 through C5 drugs) may receive an override for a one-time replacement up to a 90-day supply)
  - Specialty Limited Distribution and Orphan Drugs: The Plan excludes certain specialty drugs that cannot be obtained and dispensed by Monument Health Specialty Pharmacy. This includes, but is not limited to, some Orphan Drugs and many Limited Distribution Drugs. If you are not sure about the coverage status of your medication, please contact Clear Scripts at (855) 816-6389 for assistance or questions.
  - Therapeutic devices or appliances, including support garments and other non-medical substances, regardless of intended use, except those listed above
  - Vitamins, singly or in combination, except prenatal and federal legend vitamins to treat covered medical conditions
- Physical examinations, reports or related services for the purpose of obtaining or maintaining employment, insurance, or licenses or permits of any kind, school admission, school sports clearances, immigration, foreign travel, medical research, camps, or government licensure, or other reasons not related to medical needs.
- Plastic and reconstructive services such as those listed below:
  - Complications resulting from non-covered services

- Cosmetic services, supplies or surgery primarily for the purpose of changing the appearance or to repair, modify or reshape a functioning body structure for improvement of the patient's appearance or self-esteem;
  - Dermabrasion, chemical peels or skin procedures to improve appearance or to remove scars or tattoos
  - Medically unnecessary surgical procedures, usually, but not limited to, plastic surgery directed toward preserving beauty or correcting scars, burns, or disfigurements
- Procedures, regardless of medical necessity, outside the scope of the provider's license, registration or certification
- Repair or replacement of items not used in accordance with manufacturer's instructions or recommendations
- Replacement of lost or stolen items, such as but not limited to prescription drugs, prostheses or DME
- Respite care, except as covered by the Plan
- Reversal of any surgical procedure for transgender/gender affirming surgeries
- Reversal of sterilization
- Routine foot care, except as covered by the Plan for diabetes and peripheral vascular disease
- Services beyond the specified Plan Benefit Maximums
- Services for any condition, illness or injury that arises from or during the course of work for wages or profit that is covered by state insurance workers' compensation and federal act or similar law
- Services or supplies for the treatment of male or female sexual dysfunction such as, but not limited to, treatment of erectile dysfunction (including penile implants), anorgasmy, and premature ejaculation
- Services or supplies payable under a contract or insurance for uninsured or underinsured (UIM) coverage, motor vehicle, motor vehicle no-fault, or personal injury protection (PIP) coverage, commercial premises or homeowner's medical premise coverage or other similar type of contract or insurance
- Services or supplies received without charge from a medical department maintained by an employer, a mutual benefit association, labor union, trustee or similar group
- Services or supplies required by an employer as a condition of employment
- Services provided at the Mayo Clinic without participation in the Mayo Clinic Complex Care Program
- Services provided by a family member (spouse, parent or child)
- Services provided by a spa, health club or fitness center, except covered medically necessary services provided within the scope of the provider's license
- Services provided by clergy
- Services provided in a school setting (such as early learning and K-12)
- Snoring treatment (surgical or other)
- Special diets, nutritional supplements, vitamins and minerals or other dietary formulas or supplements except as covered by the Plan
- Special education for the developmentally disabled
- Specialized intraocular lenses associated with cataract surgery that correct vision disorders, such as Multifocal and Toric intraocular lenses

- Specialty Limited Distribution and Orphan Drugs
  - The Plan excludes certain specialty drugs that cannot be obtained and dispensed by Monument Health Specialty Pharmacy. This includes, but is not limited to, some Orphan Drugs and many Limited Distribution Drugs.
  - If you are not sure about the coverage status of your medication, please contact First Choice Health at (800) 305-0849 for assistance or questions.
- Surrogate mother charges. The Plan will not prevent medically necessary care for the surrogate mother; however, once the child is delivered and is identified as a surrogate child, the Plan will recover all medical care expenses through subrogation. The surrogate agreement should include coverage of all medical care expenses.
- Tooth damage due to biting or chewing
- Transplant services listed below (Organ and Bone Marrow):
  - Animal-to-human transplants
  - Artificial or mechanical devices designed to permanently replace human organs
  - Complications arising from the donation procedure if the donor is not a Plan participant
  - A donor's medical expenses incurred because of the transplant when the recipient is a covered individual but does not incur a charge for the expense
  - Transplants considered experimental and investigational, as defined by the Plan
- Transportation, except as covered by the Plan
- Treatment furnished without charge or paid directly or indirectly by any government or for which a government prohibits payment of benefits
- Vision Care, the following vision benefits are not covered:
  - Vision exams
  - Vision hardware (except covered by the Plan)
  - Non-prescription sunglasses or safety glasses
  - Radial keratotomy, Lasik or any other refractive surgery, orthoptics, pleoptics, vision therapy, visual analysis therapy or training related to muscular imbalance of the eye; optometric therapy
  - Services or supplies received principally for cosmetic purposes other than contact lenses selected in place of eyeglasses
- Vitamin B-12 injections except to treat Vitamin B-12 deficiency
- Vocational rehabilitation, work hardening or training programs regardless of diagnosis or symptoms that may be present, or for non-medically necessary education
- Weight management programs (except as covered by the Plan)

Eligibility and Enrollment

Eligible Classes of Employees

All active, full-time Monument Health, Inc. (and eligible affiliates) employees are eligible to enroll in the Plan. Full-time employees are scheduled to work a minimum, on average, 30 hours per week.

Active, part-time employees are also eligible to enroll in the Plan, provided they are scheduled to work a minimum of 20 hours per week.

In order to be considered eligible, you must satisfy the waiting period described below.

Examples of employees who are considered non-eligible are those classified on Monument Health, Inc.'s books or records as:

- Independent contractors, whether or not misclassified,
- Leased or temporary employees, whether or not misidentified,
- One who is enrolled as a dependent on another Monument Health, Inc. employee's plan, or;
- One who has not completed the applicable waiting period.

Waiting Period

As an eligible **employee**, you may participate in the plan described in this booklet on the first day of the month following 30 consecutive days of employment. If you are a variable hour employee, you will be eligible to enroll on the 1st day of the month following a determination of your status as full-time or eligible part-time at the close of the applicable standard measurement period.

Coverage will take effect on the date you are rehired and the waiting period will be waived if:

- you were previously covered by this Plan at the time of termination, AND
- you are rehired within 13 weeks of termination of employment, AND
- your application for coverage is received by the Plan before you become eligible again or within 30 consecutive days from your date of re-hire.

Enrollment Periods

Enrollment periods for eligible employees and dependents are:

- Within thirty (30) days of initial eligibility, or
- During any open enrollment.

If a completed enrollment application is not received by the Plan Administrator within the 30 days of the employee's initial eligibility period, the employee and their dependents cannot enroll until the next group open enrollment period.

How to Enroll

To enroll, complete the online enrollment form through our enrollment portal. It is very important that the online enrollment form is complete and accurate and submitted within the 30 days of the employee's initial eligibility period. Incomplete information will result in delayed eligibility, delayed access and denial of coverage to benefits and non-payment of claims.

Discovery of false or misrepresented information will result in the complete nullification of coverage and you will be held financially responsible for any benefits paid. Examples of false or misrepresented information are failing to provide requested information, providing incorrect or incomplete information, enrolling an ineligible dependent, and failing to comply with the Plan's requirements for eligibility. It is your responsibility to notify the enrollment vendor of all dependent eligibility changes.

Open Enrollment

Open enrollment is a defined period when you, if an eligible employee, are allowed to enroll or make changes to your Plan coverage. Open enrollment occurs once each Plan year. Under no circumstances will you be able to change Plan enrollment outside of open enrollment unless you experience a special or qualified event as permitted by the Plan.

Special Enrollment Periods

The Health Insurance Portability and Accountability Act of 1996 (HIPAA) gives you special enrollment rights as described within this section.

Change in Status

If you decline Plan coverage and later acquire a new dependent by marriage, birth, adoption or placement for adoption, you may be eligible to enroll yourself and your dependents into the Plan (or terminate coverage) if you request a change within 30 days after the marriage or 60 days after the birth, adoption or placement (see also *Dependents*). If you decline Plan coverage and later experience a change in status (as described below) and become eligible to participate in a premium assistance program under Medicaid or the Children's Health Insurance Program (CHIP) Reauthorization Act of 2009 you have 60 days to enroll in the Plan.

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

In addition, a special enrollment period is available if a change of status occurs.

A change in status includes:

- Marriage, divorce or legal separation
- Death of your spouse or dependent
- Birth, adoption, or placement for adoption of child

- A change in employment status, such as a switch between part-time and full-time
- Changes in your dependent's age status or other factor affecting his or her eligibility
- Change in your eligibility to participate in a premium assistance program under Medicaid or CHIP
- Change in you or your dependents participation of another health plan (including but not limited to a non-renewal of spouse's health plan during the open enrollment period)
- Mid-year eligibility for Medicare coverage

Any changes made in elections must be consistent with the change in status.

Involuntary Loss of Other Coverage

You may enroll for coverage under this Plan outside of open enrollment when one of the following requirements are met:

- You waived coverage under this Plan at the time this coverage was previously offered because you were already covered under another plan
- Your coverage under the other health care plan was terminated as a result of:
  - Loss of eligibility for the coverage (including as a result of legal separation, divorce, death, termination of employment or the reduction in the number of hours of employment)
  - Termination of employer contributions toward such coverage
- You were covered under COBRA at the time coverage under this Plan was previously offered and your COBRA coverage has been exhausted
- You, or your dependent(s), were covered under Medicaid or CHIP but have since lost eligibility for either program

The enrollment vendor must receive a completed enrollment form within 30 days of the date your prior coverage ended and dependent verification documents within the deadline provided. Coverage under this Plan will become effective on the first of the month following loss of coverage.

Late Enrollment

Late enrollments are not accepted. An enrollment is late if it is not submitted within the timeframe set forth in the sections *Enrollment Period, Open Enrollment* and *Special Enrollment Periods*.

Effective Date

Effective Date of Coverage for You

The employee's coverage will become effective on the first day of the calendar month following the date that the employee has satisfied: 1) the eligibility requirements noted under *Eligible Classes of Employees* 2) the waiting period and, 3) the Plan is in receipt of the completed online enrollment form.

Effective Date of Coverage for Your Dependents

If you have one or more eligible dependents on the date that you become covered under this Plan and you elect to insure them, they will be covered on the date your coverage becomes effective. Only dependents for which you have submitted an online enrollment form and paid any required premiums will be covered. Your dependent will be considered a late enrollee if we do not receive the online enrollment form and premium payment within 30 days of the date he or she is eligible for coverage. **Late enrollments are not accepted.**

Effective Date for Adding Dependents (Other than Newborn and Adopted Children)

Any dependents added after your effective date of coverage will be covered on the date they become eligible. You must submit an online enrollment form to us for any such dependent and pay any required premiums. The Plan Administrator must receive the online form within 30 days of the date the dependent becomes eligible for coverage. If you do not notify us within 30 days, the dependent will be considered a late enrollee. **Late enrollments are not accepted.**

Special Rule

If an employee and spouse are each employees of Monument Health, Inc. and are eligible for benefits, employees may not double cover each other as dependents.

If Monument Health, Inc. employees are married, one may enroll as the dependent on their spouse's employee coverage. In such a case, the spouse enrolled as a dependent would not be eligible for employee only coverage in addition to their dependent coverage.

Children whose parents are both Monument Health, Inc. employees may enroll under only one parent.

If you are covered under a family member employed by Monument Health, Inc. and become eligible for benefits due to your own employment status, your family member must contact the Plan Administrator to cancel your coverage within 30 days.

Waiver of Plan Benefits

As an eligible employee, you may elect to waive participation in the Plan by completing the online enrollment form, stating you choose to waive coverage and providing proof of coverage if applicable. If you waive coverage, you may not enroll your dependents – a dependent is not eligible for coverage without the eligible employee also enrolled.

Dependents

Dependent Eligibility

Dependents become eligible for Plan benefits on either the day you become eligible or the day you acquire your first dependent, whichever is later. Dependents can be enrolled in the Plan only if you also are enrolled. Dependents include:

- Legally married opposite-sex or same-sex spouse as defined by federal law.
- Natural child, adopted child, child placed with you for legal adoption or foster care, stepchild, or other legally designated ward up to age 26, or,
- Natural child, adopted child, child placed with you for legal adoption or foster care, stepchild, or other legally designated ward that a health care professional determines is not capable of self-sustaining employment due to a physical or developmental disability. Proof of such incapacity must be furnished to the enrollment vendor within 30 days prior to the date the child reaches age 26.

A child who loses dependent status for coverage eligibility under this provision may be eligible for continuation of coverage under COBRA (see *COBRA* section). You are responsible for paying the contribution for your dependent's Plan benefits.

Eligible dependents do not include any other individuals such as:

- A spouse who is divorced.
- *A spouse who is legally separated. Unless coverage is required by a court order or decree*;
- A spouse or child living outside the United States or Canada;
- A spouse or child enrolled in employee coverage under the Plan;
- Any person who is on active duty in any armed forces of any country;
- You or your spouse's natural child for whom you have given up rights through legal adoption.
- A parent of an employee or spouse; or
- The newborn child or spouse of an enrolled dependent child.

Documentation of Dependent Eligibility

Employees must provide dependent eligibility verification documents within communicated deadlines. Failure to follow the plan administrator's (or its delegated vendors) rules, communicated deadlines or processes regarding this documentation will result in the termination of applicable dependent coverage.

Dependents Acquired Through Marriage

If you acquire a new dependent through marriage, the Plan Administrator must receive the completed online enrollment application within 30 days of the marriage for coverage to be effective, or your new dependent will not be able to enroll until the next open enrollment.

Coverage for your new dependent will become effective on the first of the month following the date of lawful marriage.

Dependent Children

An online enrollment form is required to enroll any dependent child. Your dependent will not be denied based on health status. The enrollment vendor will ask for added information to establish a dependent child's eligibility.

Children whose parents are both Monument Health, Inc. employees may enroll under only one (1) parent (see *Special Rule*).

Natural Newborn Children

If you acquire a new dependent through birth, the Plan Administrator must receive the enrollment form within 60 days from the date of birth. In order for coverage to exist for a newborn, the child must be enrolled within this timeframe. Coverage for the facility nursery charges will be in effect until discharge from this level of care under the enrolled mother's coverage. There is no coverage for physician services or other facility levels of care other than nursery until the newborn is enrolled. If enrolled, coverage becomes effective on the date of birth.

Adopted Children Acquired

Any child under age 18 you legally adopt or who is placed with you for adoption is eligible on the date of placement. A child is considered placed for adoption when you become legally obligated to support that child totally or partially before the legal adoption. If the child is placed but not adopted, all Plan benefits stop when the placement ends and will not be continued.

If the enrollment form is received within 30 days of placement, coverage becomes effective on the date of placement. The Plan Administrator may request additional information.

Children Acquired Through Legal Guardianship

If the enrollment form is received within 30 days of obtaining legal guardianship, dependent coverage becomes effective on the date of the order. The Plan Administrator may request added information.

Children Covered Under Qualified Medical Child Support Orders

If the enrollment form, with notification of the medical child support order (from you, the custodial parent or a state agency administering Medicaid) is received within 60 days of the order, coverage becomes effective on the date of the order. If received after 60 days, coverage becomes effective on the first of the month after the Plan Administrator has the enrollment information. (See *Qualified Medical Child Support Orders* for more information).

Dependent Children Out of Area

To receive the network level of coverage, non-emergent medically necessary care for covered services must be provided by Monument Health Providers or certain Monument Health

Independent Providers & Facilities within the Western Providers Network. There is no non-network coverage for this Plan, with the exception of emergent care.

A full description of the provider networks is in Section I - Medical, and Pharmacy Benefits, under *How to Obtain Health Services*.

Continued Eligibility for a Child who is Disabled

Coverage may be extended beyond age 26 if the child is:

- Incapable of self-sustaining employment due to mental or physical disability, and
- Depends primarily on you for support.

Contact the Plan Administrator for details and enrollment forms. For continued eligibility of a child who is disabled, the enrollment form must be received within 30 days of the date the child reaches age 26. Thereafter, employees are required to resubmit proof of continued disability once per year.

Proof may be defined as a copy of the State Disability check for the current month. If a copy of the State Disability check for the current month is not available, the provider of care must complete a physician statement to confirm the following:

- Name of dependent child;
- Dependent child's date of birth;
- Dependent child's Plan ID number;
- Date of onset of disabling condition;
- Description of disabling condition and functional limitations
- Expected duration of disabling condition and prognosis; and
- Signature of provider.

The participant must also submit the following:

- Signed statement that the participant provides total support for this child;
- Participant social security number; and,
- Date information provided.

A child who is disabled will continue to be eligible for coverage until the employee participant fails to submit proof of dependence due to disability, or if coverage terminates for the employee or the dependent due to any of the reasons noted under *Termination of Coverage*.

Qualified Medical Child Support Orders

Monument Health, Inc. will provide medical coverage to certain children (called alternate recipients) if directed by a Qualified Medical Child Support Order (QMCSO) (defined in ERISA §609(a)), including benefits for adopted children in accordance with ERISA §609(c). The participant, the child's custodial parent, or a state agency administering Medicaid may submit notification.

A medical child support order:

- Is any decree, judgment, order (including approval of settlement agreement) or administrative notice from a state court or state agency with jurisdiction over the child's support

- Recognizes the child as an alternate recipient for plan benefits
- Provides for, based on a state domestic relations law (including a community property law), the child's support or health plan coverage.

A QMCSO is a medical child support order qualified under the Omnibus Budget Reconciliation Act of 1993. A medical child support order is qualified if it creates or recognizes the existence of an alternate recipient's right to receive plan benefits and specifies this information:

- Employee's name and last known address
- Each alternate recipient's name and address (or state official/agency name and address if the order provides)
- Reasonable description of coverage the alternate recipient is entitled to receive
- Coverage effective date
- How long the child is entitled to coverage
- That the plan is subject to the order.

If the medical child support order is a QMCSO:

- The Plan Administrator notifies you and the alternate recipient of the Plan's procedures and allows the alternate recipient to name a representative to receive copies of any QMCSO notices
- Alternate recipient coverage begins on the first of the month after the QMCSO is received
- If a dependent contribution is required, your specific authorization isn't needed to establish the payroll deduction, which would be retroactive to the alternate recipient's coverage effective date
- The Plan pays network providers directly for covered services; when an alternate recipient, custodial parent, legal guardian or employee pays a covered expense, the Plan reimburses the person who paid the expense.

If the medical child support order is not a QMCSO, the Plan Administrator notifies you and each alternate recipient of the specific reason it does not qualify, along with procedures for submitting a corrected medical child support order.

The enrollment form with the notification of the medical child support order needs to be received within 60 days of the order in order for coverage to become effective on the date of the order. If the enrollment information is received after 60 days of the order, coverage will become effective on the first of the month following the date we receive the enrollment information for coverage.

Termination of Coverage

For participating employees, coverage ends at these events:

- Non-payment of a contribution that is your responsibility
- You no longer meet eligibility requirements for coverage (see *Eligibility and Enrollment*); coverage ends the last day of employment or last day of the month after moving to an ineligible benefit class.
- The employee or any participant performs an act or practice that constitutes fraud or made an intentional misrepresentation of material fact under the terms of this plan
- The Plan Sponsor ceases to offer coverage in the group market under which this coverage is issued

For participating dependents, coverage ends at these events:

- The date the participant's coverage ends for any reason
- The last day for which any required Plan contributions are paid
- The last day of the month in which the participant dies
- The participating employee and spouse legally divorce (the Plan Administrator must receive a copy of the decree);
- The last day of the month a dependent child reaches age 26 or disabled (see *Continued Eligibility for a Child who is Disabled*)

Related Details

A terminated employee who is rehired will be treated as a new hire for benefit purposes and be required to satisfy all eligibility and enrollment requirements unless re-hired within 13 weeks as otherwise described in the Plan.

If you or your dependents lose coverage under this Plan, you may be eligible to continue coverage. For more information, read the COBRA section or ask your COBRA Administrator.

Amendment and Termination

Amendment

The Plan Sponsor reserves the right to amend any part or all of the Plan at any time or from time to time by written instrument with respect to any Employee, Dependent, former Participant, and/or disabled individual, as may be applicable, in its sole discretion.

Termination

The Plan Sponsor reserves the right to terminate the Plan at any time by written instrument with respect to any Employee, Dependent, former Participant, and/or disabled individual, as may be applicable, in its sole discretion. If the Plan is terminated, only the claims you have incurred before the date of termination will be paid.

Consolidated Omnibus Budget Reconciliation Act of 1985 (COBRA)

If your coverage terminates under this group health plan, you may be eligible under COBRA to continue the same coverage you had when coverage ended, on a temporary self-pay basis. COBRA requires this continuation of coverage be made available to covered persons – called qualified beneficiaries under COBRA – on the occurrence of a qualifying event, described below.

Continuation of coverage under COBRA is not automatic; you must elect COBRA by completing and properly providing an enrollment form to your Plan Administrator. You must contact your Plan Administrator and apply for continuation of your group health plan coverage within 60 days of the termination of coverage. You will also be required to pay applicable contributions for you and/or your dependent(s) directly to the Plan.

This Plan provides no greater COBRA rights than what COBRA requires. Nothing in this Summary Plan Description is intended to expand your rights beyond COBRA's requirements.

This section describes your COBRA coverage rights; contact the Plan Administrator for more information.

Who Is a COBRA Qualified Beneficiary?

Employees and covered dependents who participate in the Plan may be eligible for COBRA in the case of a qualifying event if they are also a qualified beneficiary. Qualified beneficiaries include:

- Employees enrolled in the Plan on or before the date of the event that causes them to lose that coverage (called the qualifying event)
- An employee's spouse enrolled in this Plan on the day before the qualifying event
- The employee's dependent children enrolled in this Plan on the day before the qualifying event
- Dependent children born to, or placed for adoption with, the employee while the employee has COBRA coverage
- Dependent children acquired through legal guardianship while the employee has COBRA coverage
- Dependent children covered under medical child support orders while the employee has COBRA coverage

A qualified beneficiary may choose to continue any one benefit, or all of the benefits that s/he was enrolled in prior to the qualifying event.

Certain qualified beneficiaries may have additional COBRA rights and possible tax credits if they are certified by the Department of Labor or state labor agencies as eligible under the Trade Adjustment Assistance Reform Act of 2002. (Contact the Plan Administrator for more details.)

Qualifying Events and Continuation Periods

Qualifying events and continuation periods are explained below:

- If employment terminates (voluntary or involuntary), you and your covered dependents may continue coverage under this Plan for up to 18 months unless the cause is gross misconduct
- If your work hours are reduced, resulting in loss of eligibility for group coverage under the terms of this Plan, you and your covered dependents may continue coverage under this Plan for up to 18 months
- If you and your spouse legally divorce or are legally separated, your spouse and covered dependent children may continue coverage under this Plan for up to 36 months
- When your covered dependent child no longer meets the Plan's definition of dependent child, the child may continue coverage under this Plan for up to 36 months
- When you become Medicare eligible, your Medicare-ineligible covered dependents may continue coverage under this Plan for up to 36 months
- If you die your spouse or covered dependents may continue coverage under this Plan for up to 36 months
- If you enter into uniformed service, you may elect to continue Plan coverage for up to 24 months (See also Military Leave under Other Continuation of Coverage section)
- If while covered under COBRA you (or a COBRA-eligible dependent) become disabled, you may be eligible for a coverage extension. The 18-month COBRA coverage period may be extended another 11 months for a total of 29 months COBRA coverage. To qualify for this disability extension, you must:
  - Meet the definition of disability under Title II or XVI of the Social Security Act at the time of the qualifying event or within the first 60 days of COBRA coverage
  - Provide the Plan Administrator with the notice of the disability determination (from Social Security) within 60 days after the determination date if such determination is made while enrolled in COBRA, or within the first 60 days COBRA enrollment if such determination was made prior to initial COBRA enrollment. If the beneficiary who is disabled is later determined by Social Security to no longer be disabled, the Plan Administrator must receive notice within 31 days of that determination date.

When COBRA Coverage Ends

COBRA coverage ends before the 18-, 29-, or 36-month period expires for any of these reasons:

- The Plan no longer provides group health coverage to any employees
- The COBRA coverage premium is not paid within 31 days of the due date (the initial grace period is 45 days after the first COBRA election)
- The qualified beneficiary becomes covered under another group health plan with no applicable pre-existing condition exclusion or limit
- The qualified beneficiary enrolls in Medicare
- If an extension from 18 to 29 months was granted due to a disability and the individual receives a final determination from the Social Security Administration stating the individual is no longer disabled the individual must notify the plan administrator within

31 days after the date of that determination. Coverage ends on the last day of the month through which contribution payments have been received, so long as that date is within the first month that begins within 31 days after the final determination date, and after the initial 18-month COBRA coverage period

Please note: Once COBRA coverage ends, it cannot be reinstated.

Contribution Payment Requirements

You are required to pay any and all applicable contributions for you and your covered dependents. You must pay the first contribution for continuation of coverage within 45 days of the date you elect COBRA coverage. Contributions consist of the full cost of coverage, plus 2% (a total of 102%).

If you are eligible and receive a disability extension under Title II or XVI of the Social Security Act, your contribution will also be 150% of the full cost of coverage.

If the cost for similarly situated active employees or dependents changes, the COBRA coverage premium also changes (only once a year before the Plan year begins).

Failure to make payments within the designated time frame will result in automatic termination of coverage to the last day of the month for which a complete payment was made. Payments need to be sent directly to bSwift COBRA PO Box 860475 Minneapolis, MN 55486-0475. If you have COBRA related questions, you may call (866) 365-2413 Option 1, to speak with a COBRA representative.

Election Requirements

At the time of a qualifying event, such as termination of employment or reduction in hours, the qualified beneficiary must be notified of the right to continue coverage within 14 days of FCH receiving notice of the qualifying event from the Plan Administrator.

In the case of divorce, legal separation or the ineligibility of a dependent, the employee or qualified beneficiary is responsible for notifying the Plan Administrator within 60 days of the divorce, legal separation or ineligibility of a dependent. The Plan is not obligated to offer COBRA benefits to beneficiaries if this notification is not received within the 60 days.

What Coverage Must Be Offered When Electing COBRA?

The Plan is required to continue the following coverage for COBRA participants:

- **Identical coverage** – the qualified beneficiary must be offered the opportunity to continue the coverage received immediately before the qualifying event
- **Independent rights** – once a qualifying event occurs each qualified beneficiary has an independent right to elect continuation coverage. For example, if an employee and family are offered COBRA coverage, each individual can make an election. Although an active employee must be covered to cover a dependent, it is possible to have COBRA coverage for a dependent when the former employee does not elect to continue coverage
- **Open enrollment** – Qualified beneficiaries must be notified of any benefit or carrier changes at open enrollment and be given the opportunity to change coverage just like

active employees. Qualified beneficiaries have the same rights as active employees during open enrollment to add or drop family members, change coverages and change carriers, if available. However, if a qualified beneficiary adds a family member during open enrollment who was not previously covered, that added family member does not become a qualified beneficiary

- **Modification of coverage** – if an employer modifies coverage for similarly situated active employees; the coverage for qualified beneficiaries must be modified similarly. Some examples of modifications include benefit enhancements, elimination of coverage and changes in carriers

Other Continuation of Coverage

Leaves of Absence

Family Medical Leave Act of 1993 (FMLA) Leaves

The FMLA gives employees on FMLA leave the same rights and privileges as active employees. The FMLA allows an eligible employee to take 12 weeks of leave each year (during a rolling backward calendar year) for the following reasons:

- The birth or adoption of the employee's child
- Placement of a foster child in the employee's care
- To care for the employee's spouse, parent or child if suffering from a serious health condition
- An employee's own disabling serious health condition
- For qualifying exigencies arising out of the fact that the employee's spouse, parent or child is on active duty with the Armed Forces, including the National Guard or Reserves (Examples of "qualifying exigencies" include, but may not be limited to, short-notice deployment, military events and related activities, certain childcare and related activities, financial and legal arrangements, counseling, rest and recuperation, post-deployment activities and/or any other event that the employer and employee agree constitute a qualifying exigency)

The FMLA also allows an eligible employee to take 26 weeks of leave each year (during a rolling backward calendar year) for the following reasons:

- For military caregiver leave, an employee may be allowed for up to 26 weeks of leave, per service member, per injury, to care for a family member who (1) is an current member of the Armed Forces, Guard or Reserves; (2) who suffered a serious illness or injury or whose pre-existing illness or injury was aggravated in the line of duty while on active duty; and (3) is undergoing medical treatment, recuperation, therapy, outpatient care, or has been placed on the temporary disability retirement list by the military (Please note the Department of Labor (DOL) has established an order of familial priority for family members seeking this leave; your employer is within its rights to request information seeking proof and/or clarification of your relationship to the service member)

If you are granted an authorized leave of absence from work, you continue coverage under this Plan during the approved leave time as long as you pay your required contribution. Continuation of coverage under this provision is extended automatically. Any and all applicable monthly contributions must be paid directly to the Plan. Failure to make the established monthly contribution may result in the termination of Plan benefits.

If your leave is a paid leave, the contribution costs will continue to come out of your paycheck as a deduction. If your leave is unpaid, you are responsible for paying your share of contribution directly.

If you lose coverage during your leave because you did not make the required contributions, you may enroll again within 30 days of returning to work. Your coverage will start on the first day of the month after you return to work and make any required contributions.

Military Leave

If you take a military leave, for active duty or training, you will be covered under the Plan's health benefits as if you were an active employee, as long as you are in an active paid status.

If your uniformed service lasts beyond your paid time or 30 days, whichever is longer, you may continue coverage under the self-pay option for approved leaves (as described in the COBRA section) according to your rights under the Uniformed Services Employment and Reemployment Rights Act (USERRA). While continued, coverage will be what was in force on the last day you worked as an active employee. However, if benefits decrease for others in the class, yours will also decrease.

If you return to active employment promptly after your military leave, in accordance with federal law, your medical and pharmacy coverage will be reinstated on the date you return to the active payroll. You must submit a written request for reinstatement within 90 days of your discharge from active military service, or one year following a hospitalization that continues after you are discharged from active military service.

Medical Leave

Coverage for you and your covered **dependents** will continue up to the end of the month following 12 weeks from the date your leave began, plus a possible additional 12 weeks under certain circumstances. You must continue to make your regular contributions for coverage. You and your **dependents** may then be eligible for continuation of coverage as explained in the section titled "Qualifying Events and Continuation Periods." The time between the **COBRA** event date and the date coverage ends is considered part of the time of coverage allowed under **COBRA**.

You and your dependents may then be eligible for continuation of coverage as explained in the section titled "Qualifying Events and Continuation Periods."

Personal Leave of Absence

Coverage for you and your covered **dependents** will continue up to 12 weeks from the date in which your leave began. You must continue to make your regular contribution for coverage. Please see company Leave of Absence Policy for additional information.

You and your **dependents** may then be eligible for continuation of coverage as explained in the section titled "Qualifying Events and Continuation Periods."

Furlough

Furlough is defined as mandatory suspension from work where an employee is prohibited from working at the direction of the employer, but is considered actively employed.

During a furlough, the employer may contribute some or all of a premium payment for you and your covered dependents for a designated period of time. If the employer does not contribute towards your premium or ceases to contribute towards your premium and you remain on

furlough, you and your dependents may be eligible for continuation of coverage as explained in the section titled "*Qualifying Events and Continuation Periods*."

All Leaves of Absence

If your coverage has been terminated, you must re-enroll within 30 days of returning to work in a benefit-eligible status. There is no automatic re-enrollment process. Contact the Plan Administrator if you have further questions.

Please note: In addition to FMLA, this plan will allow continuation coverage in accordance with applicable state law.

Claim and Appeal Procedures

Claim

A claim means any request for a Plan benefit made by you (Claimant) or your authorized representative (an individual acting on behalf of the Claimant in obtaining or appealing a benefit claim). The authorized representative must be designated as such in writing with an approved form signed by the claimant (except for urgent care benefits or urgent care appeals). Once an authorized representative is selected, all information and notifications should be directed to that representative until the claimant states otherwise.

Note: This Plan does not consider an assignment of benefits to confer standing or assign any other rights afforded to a participant or beneficiary under ERISA, other than the payment of benefits. A Plan participant or beneficiary may not assign or transfer rights to a provider of services, other than assignment of benefit payment. A provider cannot be a designated authorized representative, but can submit additional information to support the member's appeal.

How to File a Claim for Plan Benefits

In most cases network providers, hospitals and licensed vision providers submit claims for you, and there are no claim forms for you to complete. If you do receive a bill for services from a provider, write your name, participant ID number and group number on the bill and send a copy to the claim address on your ID card. (Your group number can also be found on your ID card.) Any bill you submit must contain:

- Provider name
- Provider tax ID information
- Specific date(s) of service
- Diagnosis codes (ICD-10 codes) or description of the symptoms or a diagnosis
- Specific medical procedure codes (CPT codes) or description of the medical service or procedure.
- Specific dental procedure codes (CDT codes) or description of the dental service or procedure.

It is best to submit charges as soon as possible. However, charges for covered services submitted to Monument Health Employee Benefit Plan must be received within 12 months of the date the service or supply was rendered or received, or sixty (60) calendar days after provider first receives notice that this Plan is secondary, whichever is later. Claims will not be considered for benefits if received after this timeframe. (See your ID card for the Monument Health/FCH claim address.) Claim forms are available from your Plan Administrator (Monument Health, Inc.)

Claim Types

- **Pre-service claim** means any claim for a Plan benefit for which the Plan requires approval before medical care is obtained.
- **Concurrent claim** means any claim reconsidered after initial approval for an ongoing course of treatment which results in a reduced or terminated benefit.

- **Post-service claim** means any claim for a Plan benefit that is not a pre-service claim and is a request for payment or reimbursement for covered services already received.
- **Urgent care claim** means a claim for medical care or treatment that, if normal pre-service standards are applied, would in the opinion of a physician with knowledge of the claimant's medical condition:
  - Seriously jeopardize the claimant's life, health or ability to regain maximum function
  - Subject the claimant to severe pain that cannot be adequately managed without the care or treatment requested.

Claim Procedure

First Choice Health (FCH) has final authority over appeals as the appropriate named fiduciary, and the Plan delegates to FCH, as it relates to benefits issues, the authority, responsibility and discretion to:

- Interpret and construe Plan provisions, as necessary
- Reach factually supported conclusions
- Make a full and fair review of each denied claim under ERISA requirements, as amended.

Benefit issues include questions regarding medical necessity, health care setting, level of care, experimental or investigational treatment, cost-sharing requirements or imposition of preexisting condition exclusions or other limits on otherwise covered benefits.

All claims for benefits are subject to a full and fair review within a reasonable time appropriate to the medical circumstances. Payment of any benefits will be subject to the applicable deductibles, coinsurance, copays and benefit maximums. FCH will notify the claimant in writing of the decision of claim review.

It is important to note the Plan Administrator itself holds the authority, responsibility and discretion to deny claims based on administrative issues such as questions of eligibility status for you, your spouse and your dependents; change in status; special enrollment; termination and continuation of coverage; and qualified medical child support orders. The same appeal process (an ERISA mandated process) described below applies to administrative issues, however, such appeals are handled by the Plan Administrator, not FCH.

Adverse Benefit Determination

An adverse benefit determination means a denial, decrease or termination of a benefit. This includes a failure to provide or make payment (in whole or in part) for a benefit based on:

- A determination that a benefit is not covered by the Plan;
- A determination based on an individual's eligibility to participate in the Plan, or to receive plan benefits at time of service (these appeals are considered administrative and handled by the Plan Administrator, see *Claim Procedure* above);
- A determination that a service is experimental, investigational or not medically necessary; and/or
- A rescission of coverage (If applicable these appeals are considered administrative and handled by the Plan Administrator, see *Claim Procedure* above).

The different claim types have specific times for approval, payment, and request for information or denial, as shown below:

Time Table for Adverse Benefit Determinations for Claim Procedures			
Type of Review	**FCH Notice of Incorrectly Filed Claim – Notice to Claimant**	**FCH Notice of Incomplete Claim – Notice to Claimant**	**Initial Benefit Determination by FCH**
Pre-Service Claim	5 days	Not required (may be part of extension notice)	Reasonable period = 15 days 15-day extension with notice to claimant Reasonable period suspended up to 45 days on incomplete claim
Concurrent Claim	n/a	n/a	In time to permit appeal and determination before treatment ends or is reduced
Post-Service Claim	n/a	Not required (may be part of extension notice)	Reasonable period = 30 days 15-day extension with notice to claimant Reasonable period suspended up to 45 days on incomplete claim
Urgent Care Claim	24 hours	24 hours	72 hours No extensions from claimant

If your claim is denied wholly or in part, you will receive a written notice of adverse benefit determination. For a denial of a pre-service claim, such notice will be in the form of a letter from FCH explaining the denial. For a post-service claim, your Explanation of Benefits (EOB) will serve as your notice of adverse benefit determination. Both will include information necessary to identify the claim, such as the date of service, provider name, amount billed, as well as the reason for the denial(s), which will include:

- Reference to the specific Plan provisions on which the determination is based;
- Reference to any internal Plan rule, guideline, protocol or similar criterion relied upon in making the decision.
- For pre-service claims, the standards for medical necessity relied upon in making the adverse benefit determination (for example, an explanation of the scientific or clinical judgment used in making the decision) if applicable;

In addition to the above information, the notice of adverse benefit determination will also include:

- A description of any additional material or information needed to support your claim and an explanation of why it is needed; and,
- A description of the available appeal process (including both internal and external review processes, as also outlined below), as well as information about how to initiate the appeal process.

Appeal Procedure

FCH performs functions associated with the internal review of medical and pharmacy appeals for this Plan. Pharmacy Appeals are handled by an independent third party utilization management company, ClearScript. First Choice Health (FCH) has final authority over appeals as the appropriate named fiduciary.

If your claim is denied wholly or in part, you have the right to request an internal review of an adverse benefit determination (commonly referred to as an appeal). Upon request, you may obtain free of charge reasonable access to, and copies of, all documents, records and information relevant to your claim for benefits, and relied upon in making the adverse benefit determination. You may also request the name of the health care expert who reviewed your claim for medical necessity or experimental or investigational care or treatment.

If your situation is urgent, you may call the FCH Appeals Coordinator at (877) 749-2031. An urgent care situation is one in which, in the opinion of a physician with knowledge of the claimant's medical condition, the application of the time periods for making non-urgent care determinations could seriously jeopardize the claimant's life, health, or ability to regain maximum function; or would subject the claimant to severe pain that cannot be adequately managed without the care or treatment that is the subject of the claim.

For all other appeals, you may submit them in writing to the following address:

Medical Appeals:

First Choice Health
Attn: Appeals Coordinator
600 University Street, #1400
Seattle, WA 98101
Fax: (206) 268-2920

Pharmacy Appeals:

ClearScript Prior Authorization
Appeals
2550 University Avenue West
Suit 320N
St. Paul, MN 55114
Fax: (855) 875-7443

Internal Appeal Process

You, or your authorized representative, must file your appeal within 180 days of the date you receive the adverse benefit determination or you lose your right of appeal. The appeal must be in writing and sent to the address noted above.

The appeal should include comments, documents, records and/or other information noting the reason you feel your claim should have been approved. FCH will send a letter acknowledging receipt of your appeal within 5 calendar days.

FCH's designated Appeals Coordinator will prepare your documents and any applicable documentation from the Summary Plan Description for review and discussion by the FCH Appeals Committee or Medical Director (the individual who made the original adverse benefit determination will not be involved in the internal appeal process). The committee or Medical Director will review the information and make a recommendation to the Plan Fiduciary to either uphold or overturn the original adverse benefit determination. FCH will notify you in writing of the decision to either uphold the original denial or overturn it within 30 calendar days of pre-service claims or 60 calendar days if your appeal involves a post-service claim. If the determination is to uphold the original denial, the letter will also include information on how to initiate the next level of appeal (External Review) if the determination is based on medical

judgment. If the determination is not based on medical judgment, the letter will advise you of your right to file a civil action for benefits under ERISA §502(a)(1)(b). **Note: A decision regarding an urgent care claim will be made as soon as possible, but not later than 72 hours after receipt of a request for internal review if a delay would jeopardize the member's or their dependent's health.**

External Review

If the decision upon internal appeal review is to uphold the original denial, and such denial is based on medical judgment or rescission, this Plan offers an external review. Denials that do not involve rescission or medical judgment (i.e., denials that involve only contractual or legal interpretation without any use of medical judgment) are not eligible for external review. You must first submit an internal appeal and receive a final internal adverse benefit determination before you may request external review. Your request for external review must be received within 125 calendar days of receipt of the final internal adverse benefit determination.

You are entitled to external review described in this section only if you receive a final internal adverse benefit determination for a claim covered by the protections of the No Surprises Act, including claims relating to (i) out-of-network emergency services; (ii) non-emergency services performed by out-of-network providers at in-network facilities; or (iii) air ambulance services furnished by out-of-network providers of air ambulance services.

Within 5 calendar days of the receipt of a request for external review, FCH will conduct a preliminary review to determine whether the claim is eligible for external review, and will send you notification if its decision within one business day thereafter. This notice will include the following:

- If your request is found ineligible for external review, the reason for its ineligibility;
- If your request is eligible for external review but not complete, a description of any additional information or materials required to complete your request;
- If your request is complete and eligible for external review, contact information for the Independent Review Organization (IRO) assigned by FCH, and details about your right to provide additional information.

If eligible for external review, FCH will forward your appeal (including all information and documentation considered in both the original denial and the internal review, as well as any additional documentation you submit) to an Independent Review Organization (IRO) within 6 business days of the receipt of a request for external review. The IRO consists of independent physicians or other specialists that are not associated with FCH or Monument Health, Inc. If applicable, they will also possess medical training specific to the appeal.

The IRO will notify you that your appeal has been received, and will allow you at least 10 business days to submit any additional information to the IRO that you wish to be considered in reviewing your appeal. The IRO will review all information submitted, make a determination, and notify both you and FCH of the results within 45 calendar days. **Note: A decision regarding an urgent care claim will be made as soon as possible, but not later than 72 hours after receipt of a request for external review if a delay would jeopardize the member or their dependent's health.**

The decision made by the IRO is the final decision of the Plan. If the IRO overturns the original adverse benefit determination, the Appeals Coordinator will forward that decision to the appropriate party for claim payment or, if a pre-service claim, approval of the request for authorization.

You have a right to file a civil action for benefits under ERISA §502(a)(1)(b) after you exhaust these claim procedures; the civil action must be filed within 180 days from your receipt of the Plan's final determination regarding your claim.

Independent Dispute Resolution

If your Plan and an out-of-network provider or facility that provided an item or service to you cannot agree on how much the provider or facility will be paid by the Plan for the item or service, then the dispute may be submitted by either the Plan or the provider to Independent Dispute Resolution (IDR). As a Plan participant, you are not involved in the IDR process (though your medical information will be shared with the certified IDR entity). Regardless of what the certified IDR entity decides, you will not have any additional cost-sharing for the affected item or service under the Plan, as your cost-sharing is limited to the in-network costs for that item or service. To the extent that you have a dispute about any adverse benefit determination you received relating to the item or service, you can appeal that decision under the Plan's Claim and Appeal Procedures.

Coordination of Benefits

This section describes how benefits are paid when you are covered by more than one plan. Coordination of Benefits (COB) means that, when you are covered by two or more plans, one plan pays its benefits first (the Primary Plan), and the other plan pays second (the Secondary Plan). If a third plan is involved (a Tertiary Plan), that plan would pay after both the primary and secondary plans have paid.

Coordination of Benefits ensures that you do not receive more in benefits than what you would otherwise be responsible to pay for the care or treatment you receive.

This Plan coordinates pharmacy benefits if you have other pharmacy coverage. Please call ClearScript at (855) 816-6389 for details about pharmacy coordination of benefits.

Calculation of Benefit Payments

The Primary Plan always pays its benefits as if you were not covered under any other plan.

The Secondary Plan pays its benefits taking into account what the Primary Plan has already paid. Similarly, a Tertiary Plan pays benefits after taking into account what the primary and secondary plans have paid. This Plan coordinates benefits using the "traditional method" of coordination of benefits. When this Plan is secondary to another plan, benefits will be calculated according to the following steps:

1. This Plan will credit any amounts to this Plan's deductible that would have been credited if this Plan were primary.
2. This Plan will pay 100% of the remaining patient liability, not to exceed the lesser of: 1) the amount this Plan would have paid as primary, or 2) the amount that, when added to the Primary Plan payment, totals 100% of the Primary Plan's Allowed Amount.

Example

Primary Plan Allowed Amount	**$75**
Primary Plan Paid	$60
= (equals)	$15 (this Plan's secondary payment)

There are different ways in which a plan may calculate its benefit payment when it is the Secondary Plan. If this Plan is your Primary Plan (as determined by the rules in the following paragraphs), refer to your Secondary Plan's Coordination of Benefits rules to find out how its benefits are calculated when secondary.

How Do I Know Which Plan is my Primary Plan?

The rules in this section determine the order in which your plans pay benefits (i.e. which plan is your Primary Plan, and which is your Secondary Plan, also known as the order of benefits). **If you have Medicare coverage in addition to coverage under this Plan, refer to *What if I'm Covered by Medicare?* for more information.** These rules are intended to be applied in the order in which they are listed (i.e., if the order of benefits can be determined by Rule 1, but Rule

3 also speaks to your situation, Rule 1 will determine the order of benefits). If you are covered by more than one secondary plan, these rules also determine the order in which the secondary plans' benefits are determined in relation to each other.

1. **Dependent or non-dependent**: A plan covering a person as other than a dependent (i.e., as an active employee, retiree, member or subscriber) pays before a plan covering a person as a dependent.

   If you are a Medicare beneficiary, and Medicare is secondary to the plan covering the person as a dependent and primary to the plan covering the person as other than a dependent (according the rules under *What if I'm Covered by Medicare?)* then the order of benefits is reversed so that the plan covering the person as an employee, member, subscriber, policyholder or retiree is secondary to the plan covering the person as a dependent.

2. Child covered under more than one plan:

   A. For a dependent child whose parents are married or are living together, whether or not they have ever been married:

      1) The plan of the parent whose birthday falls earlier in the calendar year is the Primary Plan; or
      2) If both parent have the same birthday, the plan that has covered the parent longest is the Primary Plan.

   B. For a dependent child whose parents are divorced or separated or are not living together, whether or not they have ever been married:

      1) If a court decree states that one of the parents is responsible for the dependent child's health care expenses or health care coverage, the plan is primary. If the parent with responsibility has no health care coverage for the dependent child's health care expenses, but the parent's spouse does, the parent's spouse's plan is the primary plan. This does not apply to any plan year during which benefits are paid or provided before the plan has actual knowledge of the court decree provision.
      2) If a court decree states one parent is to assume primary financial responsibility for the dependent child but does not mention responsibility for health care expenses, the plan of the parent assuming financial responsibility is primary
      3) If a court decree states that both parents are responsible for the child's health care expenses or health care coverage, or that the parents have joint custody without mentioning financial responsibility or responsibility for health care expenses, the birthday rule of the policyholders determines the order of benefits.
      4) If there is no court decree allocating responsibility for the child's health care expenses or health care coverage, the plans covering the child pay in the following order:
         a. The plan covering the custodial parent
         b. The plan covering custodial parent's spouse
         c. The plan covering the non-custodial parent
         d. The plan covering the non-custodial spouse

         For a dependent child covered under more than one plan of individuals who are not the parents of the child, the order of benefits is determined as if those individuals were parents of the child.

      5) If there is no court decree that allocates responsibility for the child's health care expenses or that specifies a custody arrangement (for example, if the child is over 18), the birthday rule of the policyholders will determine the order of benefits.

3. **Active or inactive:** A plan covering a person as an active employee or dependent of an active employee pays before a plan covering a person as a retiree, laid-off or inactive employee or dependent of a retiree, laid-off or inactive employee.

   This rule does not apply if Rule 1 can determine the order of benefits.

4. **COBRA or State Continuation Coverage:** If a person whose coverage is provided pursuant to COBRA or under a right of continuation pursuant to state or other federal law is covered under another plan, the plan covering the person as an employee, member, subscriber or retiree or covering the person as a dependent of an employee, member, subscriber or retiree is the primary plan and the plan covering that same person pursuant to COBRA or under a right of continuation pursuant to state or other federal law is the secondary plan.

   If the other plan does not have this rule, and if, as a result, the plans do not agree on the order of benefits, this rule is ignored.

   This rule does not apply if Rule 1 can determine the order of benefits.

5. **Length of coverage**: If none of the preceding rules establish which plan pays first, the plan that has covered the person the longest is primary. To determine the length of time a person has been covered under a plan, two successive plans are treated as one if the covered person was eligible under the second plan within twenty-four hours after coverage under the first plan ended. The start of a new plan does not include:
   a. A change in the amount or scope of a plan's benefits;
   b. A change in the entity that pays, provides or administers the plan's benefits; or
   c. A change from one type of plan to another, such as, from a single employer plan to a multiple employer plan.

   A person's length of time covered under a plan is measured from the person's first date of coverage under that plan. If that date is not readily available, the date the person first became a member of the group must be used as the date to determine the length of time the person's coverage under the present plan has been in force.

Note: This Plan is always primary to TRICARE, CHAMPVA, state Medicaid programs and the Indian Health Service (IHS).

What if I'm Covered by Medicare?

Federal rules govern coordination of benefits with Medicare. In most cases, Medicare is secondary to a plan that covers a person as an active employee or dependent of an active employee. Medicare is primary in most other circumstances.

If your Medicare entitlement is due to:

- **Age:** If you are covered under this Plan as an active employee or a dependent of an active employee and you become entitled to Medicare because of reaching age 65, this Plan will be primary. If you are covered under this Plan as a COBRA qualified beneficiary and are also entitled to Medicare based on age, Medicare is primary.
- **Disability:** If you are covered under this Plan as an active employee or dependent of an active employee and become entitled to Medicare due to disability, this Plan will be primary. Once you or your dependent is declared disabled by Social Security, the individual who is disabled should apply for coverage under Medicare Parts A and B.

If you are covered under this Plan as COBRA qualified beneficiary and are also entitled to Medicare based on disability, Medicare is primary.

- **End Stage Renal Disease (ESRD)**: If you become entitled to Medicare on the basis of ESRD, this Plan will pay primary during the initial coordination period (refer to the Medicare Secondary Payer Manual at www.cms.gov/manuals/downloads/msp105c02.pdf for more information regarding the initial coordination period). After this initial coordination period, this Plan will pay secondary to Medicare. This is true even if you are covered under this Plan as a COBRA qualified beneficiary.

In all cases, this Plan will act in accordance with federal law when determining its status as either primary or secondary when Medicare is the other plan. Please visit the website of the Centers for Medicare and Medicaid Services at www.cms.gov for more information.

Pre-authorization when this Plan is Secondary

With the exception of transplant services (which always require pre-authorization), pre-authorization is not required if this Plan is your secondary plan. First Choice Health will honor a determination of medical necessity made by your primary plan. This means that if your primary plan determines a service to be medically necessary, this Plan will apply its normal benefit, subject to all other Plan provisions and exclusions. If your primary plan determines a service to be not medically necessary, coverage under this Plan will be denied. Benefits that are excluded by your primary plan but payable under this Plan are subject to medical review by First Choice Health.

Meaning of Plan for COB

For COB purposes, the term “plan” means any agreement for benefits or services from any of the following sources for medical or other covered health care services:

- This Plan
- Group and non-group insurance contracts and subscriber contracts
- Uninsured arrangements of group or group-type coverage
- Group and non-group coverage through closed panel plans
- Group-type contracts (“group-type contract” means a contract that is not available to the general public and is obtained and maintained only because of membership in or a connection with a particular organization or group, including blanket coverage.) It does not include an individually underwritten and issued guaranteed renewable policy even if the policy is purchased through payroll deduction at a premium savings to the insured since the insured would have the right to maintain or renew the policy independently of continued employment with the employer.
- The medical care components of long-term care contracts, such as skilled nursing care
- The medical benefits coverage in automobile “no fault” and traditional automobile “fault” type contracts
- Medicare or other governmental benefits, as permitted by law

“Plan” does not include:

- Hospital indemnity coverage benefits or other fixed indemnity coverage

- Accident only coverage
- Specified disease or specified accident coverage
- School accident type coverages that cover students for accidents only, including athletic injuries, either on a twenty-four-hour basis or on a “to and from school” basis
- Benefits provided in long-term care insurance policies for non-medical service, for example, personal care, adult day care, homemaker services, assistance with activities of daily living, respite care and custodial care or for contracts that pay a fixed daily benefit without regard to expenses incurred or the receipt of services
- Medicare supplemental policies
- A state plan under Medicaid
- A governmental plan, which, by law, provides benefits that are in excess of those of any private insurance plan or other non-governmental plan.

If in any situation the rules contained in this section cannot determine the order of benefits, this Plan will follow the NAIC Model COB Regulation as its basis for determining the order of benefits in these extenuating circumstances.

Claim Determination Period

The claim determination period used when applying this COB provision is the Plan year, July 1 through June 30.

Right of Recovery

This provision does not reduce the benefits allowed under this agreement when this Plan is the primary plan. However, if the Plan pays in excess of the maximum necessary at the time to satisfy the intent of this COB provision, the Plan will exercise the right to recover the excess payments from any person(s), insurer(s) or other organizations, as the Plan deems appropriate.

This Plan will not seek to recover funds on any claim with a date of service that is more than 365 days prior to the date on which the Plan receives (receipt date) information regarding a participant’s other coverage.

Facility of Payment

When another plan makes payments that should have been made under this Plan and in accordance with this provision, the Plan may, at its sole discretion, elect to reimburse to the other plan the amount necessary to satisfy the intent of this COB provision. Any amount paid under this subsection will be considered benefits paid under this agreement, and the Plan will be fully discharged from liability under this agreement to the extent of those payments.

This Plan will not make any additional payment on any claim with a date of service that is more than 365 days prior to the date on which the Plan receives (receipt date) information regarding a participant’s other coverage.

Right to Receive and Release Information

The Plan Administrator and FCH may, with consent as required by law, receive or release to another insurer or organization any information concerning the participant and covered benefits deemed necessary to implement and determine the applicability of this COB provision.

The Plan Administrator and FCH have the right to require the participant to complete and return a Multiple Coverage Inquiry when primary liability is not clearly established or to verify that multiple coverage information on hand is accurate. Claim payment will be withheld until the Multiple Coverage Inquiry is complete and received by FCH.

Subrogation, Reimbursement and Right of Recovery

By enrolling in the Plan and applying for benefits from the Plan, you and your covered dependents (including minor dependents), agree and acknowledge that benefits are not payable to or on behalf of a covered person or dependent when the injury or illness occurs through an act or omission of another person, party, or entity, and any such payments made or advanced by the Plan are subject to the following terms and conditions.

No application of “make whole,” “double recovery,” and “common fund” rules

The Plan’s provisions concerning subrogation/right of recovery, equitable liens, and other equitable remedies (outlined above and more fully below) supersede the applicability of the federal common law and equitable doctrines commonly referred to as the “make whole” rule, the “double-recovery” rule and the “common fund” rule. These doctrines have no applicability to the Plan’s right of recovery hereunder.

Assignment of Rights (Subrogation)

By accepting benefits from this Plan, you and your covered dependents automatically assign to the Plan any rights you or they may have to recover all or part of the same covered expenses of the benefits paid on behalf of you and/or your covered dependents from another source, including another group health plan, insurer or individual, limited, however, to the amount of covered expenses the Plan has paid on behalf of you and/or your covered dependents. This assignment also grants the Plan a right to recover from your no-fault auto insurance carrier in a situation where no third party may be liable, and from any uninsured or underinsured motorist coverage.

By virtue of this assignment, the Plan is entitled to recover 100% of the amounts paid, or to be paid, by the Plan on behalf of you or your covered dependents (including minor dependents) from all recoveries by you or your covered dependents from any other party (whether by lawsuit, mediation, arbitration, settlement, award, judgment, order, insurance or otherwise) (“Recovered Funds”). This assignment includes, without limitation, the assignment to the Plan of a right to any Recovered Funds paid by any other party to you or your covered dependents (including minor dependents and wrongful death beneficiaries) or paid on behalf of you or your covered dependents (including minor dependents and wrongful death beneficiaries), or on behalf of the estate of any covered person.

You and your covered dependents are required to reimburse the Plan on a first-dollar basis (which means that the Plan will have a first priority claim to any Recovered Funds), regardless of whether the Recovered Funds amount to a full or partial recovery. Further, the Plan is entitled to recovery regardless of how the Recovered Funds are characterized (*e.g.*, pain and suffering, punitive damages, benefits, lost wages, loss of future earnings, medical expenses, costs and/or expenses, attorneys’ fees) and regardless of whether the recovery is designated as payment for medical services or expenses. The Plan’s share of the recovery will not be reduced because

you or your covered dependent (including your minor dependent) has not received the full damages claimed, unless the Plan agrees in writing to a reduction.

Any reduction is subject to prior written approval by the Plan, or agent of the Plan who administers the Plan's subrogation, reimbursement recoveries.

This assignment also allows the Plan to pursue any claim that you or your covered dependent (including your minor dependent) may have against any third party, or its insurer, whether or not you or your covered dependent choose to pursue that claim. In the event you or your covered dependent elects not to pursue your claim(s) against a third party, the Plan shall be equitably subrogated to your (or your covered dependent's) right of recovery.

When you, or your covered dependent – and not the Plan – pursue and obtain any Recovered Funds, you or your covered dependent shall be responsible for all expenses involved in obtaining that recovery (whether obtained by lawsuit, mediation, arbitration, settlement or, award, judgment, order, insurance or otherwise), including but not limited to, all attorneys' fees, costs, and expenses; which fees, costs, and expenses shall not reduce the amount that you or your covered dependents (including minor dependents) are required to reimburse the Plan, and the Plan's rights shall not be reduced due to covered person's own negligence. For purposes of clarity, the Plan is not subject to any state laws or equitable doctrine, and the Plan's first claim on the recovery operates on every dollar received from a third party, even those covering your or your covered dependent's litigation costs and attorneys' fees.

Equitable Lien and Other Equitable Remedies

By accepting benefits from this Plan, you agree that the Plan has established an equitable lien against any money or property you or your covered dependents (or any individual or entity acting on your or their behalf such as a legal representative or agent) recover from any other party, including but not limited to, an insurer (including but not limited to third-party, no-fault, med-pay, uninsured, or underinsured motorist), another group health plan or another individual, sufficient to reimburse the Plan in full for benefits advanced. For purposes of clarity, this equitable lien also attaches to any payment received from workers' compensation, whether by judgment, award, settlement or otherwise, where the Plan has paid benefits prior to a determination that the covered expenses arose out of and in the course of employment. Payment by workers' compensation insurers will be deemed to mean that such a determination has been made.

The Plan's lien exists at the time the Plan pays benefits, and if you or your covered dependents file a petition for bankruptcy, you and your covered dependents agree that the Plan's lien existed prior to the creation of the bankruptcy estate.

You further agree to hold any reimbursement or recovery received by you or your covered dependents (or any legal representative or agent) in trust on behalf of the Plan to cover all benefits paid by the Plan.

The Plan reserves all rights to seek enforcement of its rights hereunder, including but not limited to, the right to file a lawsuit against you or your covered dependent or any other party possessing or controlling any Recovered Funds, and the right to recoup amounts owed in any other manner prescribed by law.

Obligation to Assist in the Plan's Reimbursement Activities

As a participant in this plan, the covered person is required to cooperate with efforts to recover benefits paid under the Plan. The covered person must also notify the Plan Administrator within 45 days of the notice which is given to a third party of the intention to recover damages due to the covered person's illness or injury.

This cooperation includes providing the Plan with relevant information (including information concerning any other applicable insurance coverage that may be available such as automobile, home and other liability insurance coverage and coverage under another group health plan), providing the identity of any other person or entity and their insurers, if applicable) that may be obligated to provide payments or benefits on account of the same illness or injury for which the Plan made payments, signing and delivering documents the Plan reasonably requests, and obtaining the Plan's consent before releasing any party from liability. If you enter into litigation or settlement negotiations regarding the obligations of other parties, you must not prejudice, in any way, the Plan's subrogation and reimbursement rights.

Failure by you or your covered dependents to cooperate with the Plan in the exercise of these rights may result, at the discretion of the Plan or the Plan Administrator, in a denial or reduction of future benefit payments available to you or your covered dependents under the Plan by an amount, up to the aggregate amount paid by the Plan that was subject to the Plan's equitable lien, but for which the Plan was not reimbursed.

Health Insurance Portability and Accountability Act of 1996

Privacy Rights

The Health Insurance Portability and Accountability Act of 1996 (HIPAA) provides you certain rights with respect to the use and disclosure of your protected health information. For details on HIPAA privacy standards, contact the Plan Administrator for a copy of the Monument Health, Inc. HIPAA Privacy Notice.

Disclosures to the Plan Sponsor

The Plan may disclose your health information to Monument Health, Inc., the Plan Sponsor of the Plan, to carry out plan administration functions performed by the Plan Sponsor on behalf of the Plan. The plan documents have been amended in accordance with federal law to permit this use and disclosure.

The Plan may also disclose "summary health information", if requested by the Plan Sponsor for the purpose of

1. Obtaining premium bids from health plans for providing health insurance coverage under the Plan; or
2. Modifying, amending or terminating the Plan. Summary health information is information (which may be personal information) from which personal identifiers (except zip code) have been removed, and which summarizes claims history, claims expense or types of claims experienced by individuals for whom the Plan sponsor has provided health benefits under the Plan.

The Plan may also disclose to the Plan Sponsor whether an individual is participating in the Plan. The Plan **will not** disclose your personal information to the Plan Sponsor for purposes of employment-related decisions or actions, or in connection with any other benefit plan of the Plan Sponsor.

Plan Benefit Information

Benefits, Contributions and Funding

This Plan provides eligible employees and dependents with medical and pharmacy benefits.

This Plan is an employer-sponsored self-funded group health plan with administration provided through the third party administrator (TPA), FCH. The benefits will be funded in part by the Plan Sponsor's general assets and contributions made by Plan participants. The Plan will determine, and periodically communicate, your share of the cost for benefits under each component benefit plan, and may change that determination at any time.

The Plan will make employer contributions in an amount that, at the Plan's sole discretion, is at least sufficient to fund the benefits or a portion of the benefits not otherwise funded by employee contributions, then use these contributions to pay benefits directly to or for participants from the Plan's general assets. Employee contributions will be used in their entirety before using the Plan's contributions to pay for the cost of such benefit.

The Plan will provide benefits in accordance with the requirements of all applicable laws, including but not limited to, the Employee Retirement Income Security Act of 1974 (ERISA), the Consolidated Omnibus Budget Reconciliation Act of 1985 (COBRA), the Health Insurance Portability and Accountability Act of 1996 (HIPAA), the Newborns' and Mothers' Health Protection Act of 1996 , the Women's Health and Cancer Rights Act of 1998, the Mental Health Parity and Addiction Equity Act of 2008, and the Affordable Care Act (ACA).

Plan Administrator's Power of Authority

The Plan Administrator role for this Plan rests with Monument Health, Inc.'s Human Resources Department. The Plan Administrator is responsible for:

- Determining eligibility for and the amount of any benefits payable under the Plan, and
- Prescribing procedures to be followed and forms to be used by participants in this Plan

The Plan Administrator may delegate any of these administrative duties among one or more entities, in writing. The written delegation must describe the nature and scope of the delegated relationship.

The Plan Administrator has the authority to amend or eliminate benefits under the Plan. The Plan Administrator also has the authority to require employees to furnish it with such information as it determines is necessary for proper administration of the Plan.

The Plan Administrator will administer this Plan in accordance with its terms and establish its policies, interpretations, practices and procedures.

An individual, or individuals, may be appointed by the Plan Sponsor to serve as Plan Administrator at the convenience of the Plan Sponsor. If a Plan Administrator resigns, dies or is otherwise removed from the position, the Plan Sponsor will appoint a new Plan Administrator as soon as reasonably possible.

Discretionary Authority

The Plan Administrator has the discretionary authority to interpret the Plan and to resolve any ambiguities under the Plan. The Plan Administrator also has the discretionary authority to make factual determinations as to whether any individual is entitled to receive benefits under this Plan and to decide questions of Plan interpretation and of fact relating to the Plan. Plan Administrator decisions will be final and binding on all interested parties.

Clerical Error

If, due to a clerical error, an overpayment occurs in a Plan reimbursement amount, the Plan retains the contractual right to the overpayment. The person or institution receiving the overpayment will be required to return the incorrect amount to the Plan through FCH. In the case of a Plan participant, if it is requested, the amount of overpayment will be deducted from future benefits payable.

Statement of ERISA Rights

As a participant in the Plan, you are entitled to certain rights and protection under the Employee Retirement Income Security Act of 1974. ERISA provides that all Plan participants will be entitled to:

- Examine, without charge, at the Plan Administrator's office and at other specified locations, such as work sites, all documents governing the Plan, including insurance contracts, and a copy of the latest annual report (Form 5500 Series), if any, filed by the Plan with the US Department of Labor and available at the Public Disclosure Room of the Employee Benefits Security Administration (formerly Pension and Welfare Benefits Administration).
- Obtain, on written request to the Plan Administrator, copies of documents governing the operation of the Plan, including insurance contracts, copies of the latest annual report (Form 5500 Series) and an updated plan description. The Plan Administrator may make a reasonable charge for the copies.
- Receive a summary of the Plan's annual financial report, if any is required by ERISA to be prepared. The Plan Administrator is required by law to furnish each participant with a copy of this summary annual report.

Prudent Actions by Plan Fiduciaries

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

Enforce Your Rights

If your claim for a benefit is denied or ignored, in whole or in part, you have a right to know why this was done, to obtain copies of documents relating to the decision without charge, and to obtain 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 materials from the Plan and do not receive them within 30 days, you may file suit in a federal court. In such a case, the court may require the Plan Administrator to provide the materials and pay you up to $110 a day until you receive the materials, unless the materials were not sent because of reasons beyond the Plan Administrator's control. If you have a claim for benefits that is denied or ignored, in whole or in part, you may file suit in a state or federal court.

If it should happen that Plan fiduciaries misuse the Plan's money, or if you are discriminated against for asserting your rights, you may seek assistance from the US Department of Labor, or you may file suit in a federal court. The court will decide who should pay court costs and fees. If you are successful, the court may order the person you have sued to pay these costs and fees. If you lose, the court may order you to pay these costs and fees, for example, if it finds your claim frivolous.

Continue Plan Coverage

You may 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 Summary Plan Document and the documents governing your COBRA continuation coverage rights.

Assistance with Your Questions

If you have questions about your Plan, contact the Plan Administrator. If you have any questions about your rights under ERISA or HIPAA, or if you need assistance in obtaining documents from the Plan Administrator, contact the nearest office of the Employee Benefits Security Administration, US Department of Labor, listed in your phone directory or:

The Division of Technical Assistance and Inquiries
Employee Benefits Security Administration, US Department of Labor
200 Constitution Avenue NW
Washington DC 20210

You may also obtain certain publications about your rights and responsibilities under ERISA by calling the publication hotline of the Employee Benefits Security Administration.

Your Rights and Protections Against Surprise Medical Bills

What is Balance Billing (sometimes called Surprise Billing)?

When you see a doctor or other health care provider, you may owe certain out-of-pocket costs, such as a copayment, coinsurance, and/or a deductible. You may have other costs or have to pay the entire bill if you see a provider or visit a health care facility that is not in your health plan's network.

Out-of-network describes providers and facilities that have not signed a contract with your health plan. Out-of-network providers may be permitted to bill you for the difference between what your plan agreed to pay and the full amount charged for a service. This is called balance billing. This amount is likely more than in-network costs for the same service and might not count toward your annual out-of-pocket limit.

Surprise billing is an unexpected balance bill. This can happen when you cannot control who is involved in your care, like when you have an emergency or when you schedule a visit at an in-network facility, but are unexpectedly treated by an out-of-network provider.

You Are Protected from Balance Billing for Emergency Services

If you have an emergency medical condition and get emergency services from an out-of-network provider or facility, the most the provider or facility may bill you is your plan's in-network cost-sharing amount (such as copayments and coinsurance). You **cannot** be balance billed for these emergency services. This includes services you may get after you are in stable condition, unless you give written consent and give up your protections not to be balanced billed for these post-stabilization services.

Your plan is subject to ERISA, so in general, state balance billing laws are inapplicable to your plan, unless your plan has voluntarily opted into compliance with state balance billing laws or unless the state has an All-Payer Model Agreement with Centers for Medicare & Medicaid Services (CMS) that applies to the plan with respect to certain services at issue (e.g., in Maryland, Vermont and Pennsylvania).

You Are Protected from Balance Billing for Out-of-Network Providers

When you get services from an in-network hospital or ambulatory surgical center, certain providers there may be out-of-network. In these cases, the most those providers may bill you is your plan's in-network cost-sharing amount. This applies to emergency medicine, anesthesia, pathology, radiology, laboratory, neonatology, assistant surgeon, hospitalist, or intensivist services. These providers **cannot** balance bill you and may **not** ask you to give up your protections not to be balance billed.

If you get other services at these in-network facilities, out-of-network providers **cannot** balance bill you, unless you give written consent and give up your protections.

You are never required to give up your protections from balance billing. You also are not required to get care out-of-network. You can choose a provider or facility in your plan's network.

When balance billing is not allowed, you also have the following protections:

- You are only responsible for paying your share of the cost (like the copayments, coinsurance, and deductibles that you would pay if the provider or facility was in-network). Your health plan will pay out-of-network providers and facilities directly.
- Your health plan generally must:
  - Cover emergency services without requiring you to get approval for services in advance (prior authorization).
  - Cover emergency services by out-of-network providers.
  - Base what you owe the provider or facility (cost-sharing) on what it would pay an in-network provider or facility and show that amount on your explanation of benefits.
  - Count any amount you pay for emergency services or out-of-network services toward your deductible and out-of-pocket limit.

If you believe you have been wrongly billed under your ERISA plan, you may contact the Employee Benefits Security Administration at 1-866-444-3272 or you may call 1-800-985-3059. Visit www.dol.gov/ebsa or www.cms.gov/nosurprises for more information about your rights under federal law. If the medical service at issue was performed in a state with an All-Payer Model Agreement with Centers for Medicare & Medicaid Services (CMS), such as Maryland, Vermont and Pennsylvania, you may call that applicable state Department of Insurance for more information about your rights under applicable state law.

Maryland:

Maryland Insurance Administration
200 Saint Paul Place, Suite 2700
Baltimore, Maryland 21202-2272

Phone: (410) 468-2000

Pennsylvania:

Pennsylvania Insurance Department
1326 Strawberry Square
Harrisburg, Pennsylvania 17120

Phone: (717) 787-7000

Vermont:

Vermont Department of Financial Regulation
89 Main Street
Montpelier, Vermont 05620-3101

Phone: (802) 828-3301

Summary Plan Description and General Information

Plan Name:	Monument Health Medical Plan – under the Monument Health, Inc. Employee Benefit Plan
Plan Year:	July 1st through June 30th
Type of Plan:	Group health plan (a type of welfare benefit plan subject to ERISA provisions)
Plan Coverage Status:	This is a "non-grandfathered health plan" under the Patient Protection and Affordable Care Act.
Plan Number:	503
Funding Medium:	Claims are paid directly out of the general assets of the Company. Employee contributions are placed in the general assets of the company and accounted for separately in the accounting records of the Company. Employee contributions shall only be used to pay medical or dental claims.
Source of Contributions:	The company bears the entire cost of this benefit Plan, minus the participants' contribution.
Name, address and telephone number of Plan Sponsor, Administrator and Agent for Service of Legal Process:	Monument Health, Inc. 353 Fairmont Blvd. Rapid City, SD 57701 (605) 755-5510
Named Fiduciary for claims and appeals:	First Choice Health Network, Inc. 600 University Street Ste. 1400 Seattle, WA 98101 / (206) 292-8255
Named Fiduciary for all other matters:	Monument Health, Inc. 353 Fairmont Blvd. Rapid City, SD 57701 (605) 755-5510
Plan Sponsor's Employer Identification Number:	46-0319070
Third Party Administrator:	First Choice Health Network, Inc. d/b/a First Choice Health 600 University Street, Suite 1400 Seattle, WA 98101 (800) 430-3818/Local (206) 268-2360 www.fchn.com
Plan Description:	The written Plan Description required by ERISA §402 consists of this entire document.

Plan Definitions

Adverse benefit determination means a denial, decrease or ending of a benefit. This includes a failure to provide or make payment (in whole or in part) for a benefit including claims based on medical necessity or experimental and investigational exclusions.

Allowed amount means the maximum amount considered for payment by the Plan for a medically necessary covered service. This amount is equal to the following:

- The contracted amount agreed to by Monument Health providers and certain Monument Health Independent Providers & Facilities within the Western Providers Network in South Dakota.
- The Usual, Customary and Reasonable (UCR) amount for services received from non-network providers (see related definition).
- For non-network emergency services, the Allowed Amount is determined annually by FCH based on federal guidelines stating the Allowed Amount must be equal to the greatest of the following amounts: 1) the median of the contracted amounts described above; 2) the Usual, Customary and Reasonable (UCR) amount (see related definition); or 3) the Medicare amount.

For Emergency Services provided by out-of-network emergency facilities and out-of-network providers, certain non-emergency services furnished by out-of-network providers at certain in-network facilities, and out-of-network air ambulances, the cost-sharing amount is determined by the Qualifying Payment Amount (see related definition).

For services received from out-of-network providers (who are not covered under Recognized No Surprises Provider), you are responsible to pay the provider's actual charges.

Ancillary Services means services related to Emergency Services, such as radiology, anesthesiology, pathology, neonatology, laboratory, and specialty services needed to respond to unexpected complications (such as those delivered by a neonatologist or cardiologist) and also in situations where an in-network provider is not available at the in-network facility to provide the services.

Applied Behavior Analysis (ABA) is a term describing principles, techniques and interventions used in assessment and treatment to increase behaviors that are helpful, reduce behaviors that are harmful and demonstrate that the interventions employed are responsible for the improvement of behavior in individuals with autism. ABA incorporates many techniques for understanding and changing behavior and may involve a multi-disciplinary approach to increase language and communication skills, improve attention, focus, social skills and memory. ABA is flexible in that it can be adapted to meet the needs of each individual.

Aural therapy is a service provided to both children and adults who have been diagnosed with hearing loss. Typically, aural therapy is an intervention that takes place following hearing aid fitting or cochlear implant hook-up. It involves working with the hearing-impaired individual providing the patient with strategies to better utilize his or her listening skills. Aural therapy involves training the brain to process and understand auditory information, teaching how to monitor speech through listening, and learning to develop listening skills in each ear separately and integrated. Usually provided by a speech therapist.

Authorized representative means an individual acting on behalf of the participant or beneficiary claimant in obtaining or appealing a benefit claim. The authorized representative

must have a signed form (specified by the Plan) by the claimant except for urgent care benefits or appeals. Once an authorized representative is selected, all information and notifications should be directed to that representative until the claimant states otherwise.

Birthing center means any freestanding licensed health facility, place, professional office or institution, that is not a hospital or in a hospital, where births occur in a home-like atmosphere. This facility must be licensed and operated in accordance with the laws pertaining to birthing centers in the jurisdiction where the facility is located. It must:

- Have facilities for obstetrical delivery and short-term recovery after delivery
- Provide care under the full-time supervision of a physician and either a registered nurse or a licensed nurse-midwife
- Have a written agreement with a hospital in the same locality for immediate acceptance of patients who develop complications or require pre- or post-delivery confinement.

Calendar year means the 12-month period beginning January 1 and ending December 31 of the same year.

Chemical dependency condition means a condition characterized by a physiological or psychological abuse/dependency of a controlled substance and/or alcohol that impairs or endangers the participant's or beneficiary's health. It must be listed in the most current version of the Diagnostic and Statistical Manual of Mental Disorders (DSM), published by the American Psychiatric Association. The following conditions are either not considered Chemical Dependency Conditions or are covered under other benefits offered by this Plan (subject to all terms, limitations and exclusions):

- Conditions related to Mental Health (see Mental Health Condition definition)
- Nicotine Related Disorders (see Tobacco Cessation, if applicable to this Plan)
- Non-substance related disorders.

Claim means any request for a Plan benefit made by you or your authorized representative. A participant making a claim for benefits is a claimant.

Concurrent claim means any claim that is reconsidered after an initial approval for ongoing treatment and results in a reduced or terminated benefit.

COVID-19 is an infectious respiratory illness caused by the virus SARS-CoV-2.

Developmental Disabilities is an umbrella term that can include physical, cognitive and intellectual disability that are apparent during childhood.

Some developmental disabilities are largely physical issues, such as cerebral palsy or epilepsy. Some individuals may have a condition that includes a physical and intellectual disability, for example Down syndrome or fetal alcohol syndrome.

Intellectual disability encompasses the "cognitive" part of this definition, that is, a disability that is broadly related to thought processes. Because intellectual and other developmental disabilities often co-occur, intellectual disability professionals often work with people who have both types of disabilities.

Emergency Department (ED) is an emergency department of a hospital, or an Independent, Freestanding Emergency Department (or a hospital, with respect to services that are included in Emergency Services).

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

1. Jeopardy to the health of the individual (or with respect to a pregnant woman, the health of the woman or her unborn child);
2. Serious impairment to bodily functions; or
3. Serious dysfunction of any bodily organ or part.

Emergency Services means, with respect to an Emergency Medical Condition, a medical screening examination (as required under section 1867 of the Social Security Act) that is within the capability of the Emergency Department of a hospital or an Independent, Freestanding Emergency Department, including pre-stabilization services, post-stabilization services, and Ancillary Services to evaluate such an Emergency Medical Condition, and within the capabilities of the staff and facilities available at the hospital, to treat such an Emergency Medical Condition.

Pre-stabilization services provided after the patient is moved out of the Emergency Department (ED) and admitted to a hospital, post-stabilization services and Emergency Services provided at an Independent, Freestanding Emergency Department. Emergency Service are subject to the protections of the No Surprises Act.

Post-Stabilization services are also subject to the protections of the No Surprises Act, unless the patient is able to travel to an in-network facility using non-medical transportation, but elects to stay at the out-of-network facility.

Employee contribution is the employee portion of the costs for a benefit plan.

ERISA is the federal Employee Retirement Income Security Act of 1974, as amended, which governs plan administration, supervision and management.

Essential Health Benefits shall mean, under section 1302(b) of the Affordable Care Act, those health benefits to include at least the following general categories and the items and services covered within the categories: ambulatory patient services; emergency services; hospitalization; maternity and newborn care; mental health and substance abuse disorder services, including behavioral health treatment; prescription drugs; rehabilitative and habilitative services and devices; laboratory services; preventive and wellness services and chronic disease management; and pediatric services, including oral and vision care.

The determination of which benefits provided under the plan are Essential Health Benefits shall be made in accordance with the benchmark plan of the State of South Dakota as permitted by the Departments of Labor, Treasury, and Health and Human Services.

Experimental, investigational and unproven procedures mean services determined to be either:

- Not in general use in the medical community,
- Not proven safe and effective or to show a demonstrable benefit for a particular illness or disease,
- Under continued scientific testing and research
- A significant risk to the health or safety of the patient, or,

- Not proven to result in greater benefits for a particular illness or disease than other generally available services.

Family Member means a person who is a spouse, former spouse, child, stepchild, grandchild, parent, stepparent, grandparent, niece, nephew, mother-in-law, father-in-law, son-in-law, daughter-in-law, brother, sister, brother-in-law, or sister-in-law, including adoptive relationships.

Fiduciary means, under ERISA, a person who exercises discretionary authority or control over the management of an ERISA plan or its assets or has discretionary authority or responsibility in Plan administration.

First Choice Health (FCH) is the Third Party Administrator for this Plan.

First Responder User Fee is a charge to patients who were treated or evaluated by a First Responder Unit of a municipality or other government agency that responded to a 9-1-1 call for medical services.

Formulary (The ClearScript Formulary) is a list of generic and brand name medications that can be used to guide you and your physician in selecting medications that offer the best clinical and cost value. This formulary and clinical review criteria are developed based on the recommendations of an independent Pharmacy and Therapeutics Committee, which includes practicing physicians and pharmacists. The drugs on this formulary have been evaluated for their safety, effectiveness, uniqueness, and cost.

The formulary search tool and the printable files are posted at www.clearscript.org and includes all drugs on the Clearscript Formulary. This formulary is not a complete list of medications and is subject to change throughout the year.

You may call ClearScript directly at (855) 816-6389 or visit them on the web at www.clearscript.org.

Gene Therapy typically involves replacing a gene that causes a medical problem with one that does not; adding genes to help the body fight or treat disease; or, inactivating genes that cause medical problems. Gene Therapy includes a wide range of products, treatments and services designed to replicate natural substances in the body. These therapies introduce, remove, or change the content of a person's genetic code with the goal of treating or curing a disease.

Independent, Freestanding Emergency Department is any health care facility that is geographically separate and distinct from a hospital, and that is licensed by a state to provide Emergency Services, even if the facility is not licensed under the term, "Independent, Freestanding Emergency Department."

Legal Separation and/or Legally Separated shall mean an arrangement under the applicable state laws to remain married but maintain separate lives, pursuant to a valid court order.

Levels of Care related to Mental Health and Chemical Dependency Conditions:

- **Intensive Outpatient Programs** provide services for Mental Health or Chemical Dependency Conditions on an outpatient basis through planned, structured services available at least two hours per day and three days per week. Services include group, individual and when indicated family or multi-family group treatment. Medical monitoring, evaluation and adjunctive services are available. Treatment must follow a written plan of care.
- **Inpatient Psychiatric Hospitalization Programs** provide around-the-clock psychiatric and nursing interventions in secure, State-licensed psychiatric facilities for individuals diagnosed with a mental health disorder. These facilities operate under the supervision of a licensed and Board eligible/certified psychiatrist who evaluates the patient within

24 hours of admission. Subsequent face-to-face visits with a psychiatrist or psychiatric ARNP occur at least once every 24 hours along with daily medication management. Treatment must follow a written plan of care and include psychosocial and substance abuse evaluations. Individual, group, and/or family therapy occurs daily. The focus of the program is stabilization of client's psychiatric symptoms through the use of assessment, medication management, evidenced-based treatment strategies, group and individual therapy, behavior management, and active family engagement/therapy.

- **Partial Hospitalization Programs** provide multi-disciplinary care for Mental Health or Chemical Dependency Condition at least 6 hours a day, 5 days a week, and schedule at least three distinct services per day. Services include individual and group therapy, medication evaluation and management, family therapy, activity therapy, occupational therapy, and education training directed at treating the Condition. Services for Mental Health Conditions must include evaluation by a psychiatrist within 48 hours and weekly thereafter. All programs must include a substance abuse evaluation. Treatment must follow a written plan of care.
- **Mental Health Residential Treatment Program** provides around- the- clock behavioral health services that do not need the high level of physical security and psychiatric and nursing interventions that are available in an acute inpatient program. Care is medically monitored with on-site nursing and medical services. The focus of the program is an improvement of client's psychiatric symptoms through the use of assessment, evidenced-based treatment strategies, group and individual therapy, behavior management, medication management and active family engagement/therapy. Treatment must follow a written plan of care. The facility must be state licensed for residential treatment. Residential settings not meeting these criteria, such as group homes, halfway houses or adult/child foster homes, are not considered to be Mental Health Residential Treatment Programs.
- **Chemical Dependency Rehabilitation/Residential Programs** provide 24-hour rehabilitation treatment 7 days a week for Substance Related Conditions. Care is medically monitored, with 24-hour medical and/or nursing availability. Services include group, individual and when indicated family or multi-family group. The facility must offer sufficient availability of medical and nursing services to manage ancillary detoxification needs. Treatment must follow a written plan of care.

Lifetime is a reference to benefit maximums and limitations, understood to mean while covered under this Plan. Under no circumstances does lifetime mean during the lifetime of the participant.

Limited Distribution Drug status is generally assigned to specialty medications with complex regimens to manage. These drugs require special handling, administration, or monitoring.

Medical group means a group or association of providers, including hospital(s), listed in the provider directory.

Medically necessary is a medical service or supply that meets all the following criteria:

- It is required for the treatment or diagnosis of a covered medical condition
- It is the most appropriate supply or level of care that is essential for the diagnosis or treatment of the patient's covered medical condition
- It is known to be effective in improving health outcomes for the patient's medical condition in accordance with sufficient scientific evidence and professionally recognized standards
- It is not furnished primarily for the convenience of the patient or provider of services

- It represents the most economically efficient use of medical services and supplies that may be provided safely and effectively to the patient.

The fact that a service or supply is furnished, prescribed or recommended by a physician or other provider does not, of itself, make it medically necessary. A service or supply may be medically necessary in part only.

Mental Health Condition means a mental disorder listed in the most current version of the Diagnostic and Statistical Manual of Mental Disorders (DSM), published by the American Psychiatric Association. The following conditions, although considered mental health conditions under the DSM, are not included in the Mental Health Care benefit under this Plan, and are either excluded altogether or are covered under other benefits offered by this Plan (subject to all terms, limitations and exclusions):

- Conditions related to Substance Related and Addictive Disorders (see Chemical Dependency definition).
- Relational, family, and lifestyle stressors absent of an approved mental health diagnosis.
- Sexual dysfunctions, personality disorders, paraphilic disorders.

Network provider means Monument Health Providers and certain Monument Health Independent Providers & Facilities within the Western Providers Network.

No Surprises Act holds patients harmless from surprise medical bills and pre-authorization requirements. See *Your Rights and Protections Against Surprise Medical Bills.* This act:

- Bans balance billing for Emergency Services.
- Requires that patient cost-sharing, such as copayments, co-insurance, or a deductible, for Emergency Services and certain non-emergency services provided by an out-of-network provider at an in-network facility cannot be higher than if such services were provided by an in-network provider, and any cost-sharing obligation must be based on in-network provider rates.
- Prohibits out-of-network charges for items or services provided by an out-of-network provider at an in-network facility, unless certain notice and consent is given. Providers and facilities must provide patients with a plain-language consumer notice explaining that patient consent is required to receive care on an out-of-network basis before that provider can bill the patient more than in-network cost-sharing rates.

Non-network provider means a provider who delivers or furnishes health care services but is not a contracted Monument Health Provider or a certain Monument Health Independent Providers & Facilities within the Western Providers Network provider.

Open enrollment period is a defined time when you are allowed to enroll yourself and/or your dependents for benefit coverage.

Orphan Drugs are pharmaceutical agents that have been developed specifically to treat a medical condition itself being referred to as an Orphan Disease. Orphan Disease is a condition that affects fewer than 200,000 people nationwide.

Out of area/out of the service area means outside the Monument Health service area.

Plan Administrator means the department designated by an employer group to administer a plan on behalf of participants. Usually, the Plan Administrator is your Benefits Department. The principal duty of the Plan Administrator is to see that the Plan is carried out, in accordance with its terms, for the exclusive benefit of eligible participants and beneficiaries, without

discrimination. The Plan Administrator has the power and exclusive authority necessary, at its discretion, to:

- Construe and interpret the Plan document and to decide all questions of eligibility and participation,
- Make all findings of fact for Plan administration, including payment of reimbursements,
- Prescribe procedures to be followed and forms to be used by participants and beneficiaries,
- Request and receive from all employees the information necessary for proper Plan administration, and,
- Appoint and employ the individuals or entities to assist in Plan administration as necessary or advisable, including benefit consultants and legal counsel.

Plan Document means the document that describes requirements for eligibility and enrollment, covered services, limitations and exclusions, and other terms and conditions that apply to participation in this Plan.

Plan Year means the twelve (12) month period beginning July 1 and ending June 30.

Post-service claim means any claim for a Plan benefit that is not a pre-service claim and is a request for payment or reimbursement for covered services already received.

Pre-authorization is the process of obtaining coverage determination from FCH before receiving inpatient and certain outpatient services, as specified in the component plans' benefit description booklets.

Pre-service claim means any claim for a Plan benefit for which the Plan requires approval before medical care is obtained.

Primary Care Provider (PCP) includes the following provider types:

- Family Practice
- Family Practice with OB
- Internal Medicine
- General practice
- Pediatrics
- Nurse Practitioners listed below - working in a primary care setting
  - Family Practice
  - Pediatrics
  - Adult
  - Women's Health
  - Geriatric Medicine
- Geriatric Medicine
- Obstetrics & Gynecology
- Gynecology
- Physician Assistants - working in primary care setting

Provider means any person, organization, health facility or institution licensed to deliver or furnish health care services.

Qualifying event means, under COBRA, the triggering event that causes a loss of coverage under a group health plan, including termination of employment, reduction in hours, death or divorce. (See the COBRA section for more details.)

Qualifying Payment Amount (QPA) means consumer cost-sharing amounts for Emergency Services provided by out-of-network emergency facilities and out-of-network providers, certain non-emergency services furnished by out-of-network providers at certain in-network facilities, and out-of-network air ambulances that must be calculated based on one of the following amounts:

- An amount determined by an applicable All-Payer Model Agreement under section 1115A of the Social Security Act;
- If there is no such applicable All-Payer Model Agreement, an amount determined under a specified state law; or
- If neither of the above apply, the lesser amount of either the billed charge or the QPA, which is generally the plan's or issuer's median contracted rate.

Recognized No Surprises Provider is a provider acting within the scope of his/her license that the No Surprises Act applies to and whom: 1) FCH does not offer agreements to his/her category of providers, or 2) agreements are offered but do not cover the particular provider at issue or no written notice and consent was provided. This includes:

- Ambulance services
- Anesthesiologists services
- Assistant surgeon services
- Emergency services
- Hospital services
- Intensivist services
- Laboratory services
- Neonatology services
- Pathology services
- Radiology services
- Services of non-contracted providers when rendering care within an in-network facility, except a primary surgeon for a non-emergent admission

If you receive any of the services listed above, then those out-of-network providers cannot balance bill you, unless you are provided with written notice and give written consent to waive your protections against balance billing.

Recognized Providers are providers acting within the scope of his/her license but for whom: 1) FCH does not offer agreements to his/her category of providers, or 2) agreements are offered but covered participant choice is not provided. Examples of both types are outlined below:

- Ambulance services
- Anesthesiologists
- Assistant surgeon
- Blood banks
- Dental services covered by the Plan; provider types may include:
  - Dentist

- Oral and Maxillofacial Surgeon
- Otolaryngologist (Ear, Nose & Throat specialist, or ENT)

- Non-contracted laboratories used by FCHN referring provider
- Ocular prosthetics (if covered by the Plan)
- PKU formula
- Services of non-contracted providers when rendering care within a network facility, except a primary surgeon for a non-emergent admission
- Suppliers of oral appliances (if covered by the Plan)
- Suppliers of wigs (if covered by the Plan)
- TMJ providers (if covered by the Plan)

For services received from out-of-network providers (not covered under *Recognized No Surprises Providers*), you are responsible to pay the provider's actual charges.

Special enrollment means, under HIPAA, special mid-year enrollment rights that group health plans must offer to certain unenrolled employees and dependents who experience a mid-year loss of other coverage or when there is a mid-year birth, adoption or marriage.

Surrogacy means a participant who bears a child for another person, often for pay, either through artificial insemination or by carrying until birth another participant's surgically implanted fertilized egg.

Telemedicine means the use of medical information exchanged from one site to another via both synchronous and asynchronous electronic communications.

- **Synchronous** communication includes the use of audio and video equipment permitting two-way, real time interactive communication between the patient and provider at a distant site (example: videoconference).
- **Asynchronous** (or "store and forward") communication includes the use of audio and video equipment that records and stores information to be sent to a provider at a distant site to be interpreted at a later time.

Temporomandibular Joint (TMJ) Disorders mean disorders that have one or more of the following characteristics:

- Pain in the musculature associated with the temporomandibular joint
- Internal derangement of the temporomandibular joint
- Arthritic problems with the temporomandibular joint
- An abnormal range of motion or limited motion of the temporomandibular joint.

Third Party Administrator (TPA) is the organization providing services to this Plan's Administrator and Sponsor, including processing and payment of claims. FCH is the Third Party Administrator for this Plan.

Urgent care means services that are medically necessary and immediately required as a result of an unforeseen illness, injury or condition that is not an emergency, but it was not reasonable given the circumstances to wait for a routine appointment.

Urgent care claim means a claim for medical care or treatment that, if normal pre-service standards are applied:

- Would seriously jeopardize the claimant's life, health or ability to regain maximum function

- In the opinion of a physician with knowledge of the claimant's medical condition, would subject the claimant to severe pain that cannot be adequately managed without the care or treatment requested.

Usual, Customary and Reasonable (UCR) is the maximum amount that the Plan will consider for a covered health care service received from a non-network provider (outside of the Recognized No Surprises Providers) that is consistent with and based upon what providers in a given particular geographic area charge for a same or similar medical procedure.

The Plan's UCR calculation is based upon the 90th percentile of the market rate for identical and similar services within a particular geographic area that has been obtained from a commercially-reasonable, independent, third-party source, which is updated semi-annually. If the third party source does not have enough data to establish a UCR amount for a given medical procedure, the UCR will be calculated as a multiple of Medicare, specifically the lesser of billed or 400% of Medicare. If there is no value from the third-party source, and there is no Medicare allowed amount, and the service is deemed payable, the Plan will allow 50% of billed charges. Coinsurance, copayments, deductible, or non-covered services are applied against UCR amount as patient responsibility. The provider can balance bill the member the difference between the Plan payment and the provider's actual charges.