2024 Plan Document and Summary Plan Description
for
The FMOLHS Health Plan

covering employees of:

- **Franciscan Missionaries of Our Lady, North American Province, Inc.**
- **Franciscan Missionaries of Our Lady Health System, Inc.**
- **Franciscan Missionaries of Our Lady University**

TABLE OF CONTENTS

Important Contacts			
Contact	**Purpose**	**Phone Number**	**Email Address**
askHR	General Plan Information	(833) 482-7547	askhr@fmolhs.org
BCBS	Medical TPA Member Services	(833) 468-3594	www.MyHealthToolkitLA.com/links/FMOLHS
BCBS	Medical Precertification	(888) 376-6544	
BCBS	Mental Health/Substance Abuse Precertification	(800) 868-1032	
Express Scripts (ESI)	Pharmacy Benefit Manager	(877) 816-8717	www.express-scripts.com
Voya Financial	COBRA Administrator	(833) 232-4673	HASInfo@voya.com

SCHEDULE OF BENEFITS

Verification of Eligibility: Contact Blue Cross at (833) 468-3594

Call this number to verify eligibility and Plan benefits **before** the charge is incurred.

MEDICAL BENEFITS

All benefits described in this Schedule are subject to the exclusions and limitations described more fully herein including, but not limited to, the Plan Administrator's determination that: care and treatment is Medically Necessary; that charges are Usual and Reasonable; that services, supplies and care are not Experimental and/or Investigational. The meanings of these capitalized terms are in the Defined Terms section of this document.

Please note: There are different deductibles and out-of-pocket maximums for in-Network and out-of-Network services and the same charges cannot be applied to satisfy both the in-Network amounts and the out-of-Network amount.

SPECIAL EXCEPTIONS WHEN CERTAIN BILLS FOR NON-NETWORK PROVIDERS WILL BE PAID AS IF THE SERVICES ARE RENDERED BY IN-NETWORK PROVIDERS:

Exception #1: Out-of-Network Service with a Network Exception Authorization. This exception arises if a Covered Person is unable to find an EPO Network Provider, FMOLHS Provider (Tier I) Level or Preferred Provider (Tier II) to perform a specific medical service. Although this is not common, there may be times when an in-network specialist is not available within the statewide FMOLHS customized Network of Providers that can provide the specialty care that you need. In such a situation, if you follow the procedures required by the Plan and obtain prior authorization before the services are performed, you can receive care from out-of-network providers and arrange for your claim to be paid at the in-network level of coverage. This arrangement is called a Network Exception Authorization. A Network Exception Authorization identifies the services from the out-of-network provider as in-network services and will ensure your claim is processed at the in-network level. This means your co-payment, deductible and out-of-pocket maximum will be the same as if you received services from an in-network provider according to your plan election. Although your pre-authorized services will be covered at the in-network level of coverage, you will be responsible for any provider charges which are above customary and reasonable.

The authorization for these Out-of-Network services must take place prior to the delivery of the service. You must submit a Network exception Request Form signed by your PCP or referring physician to Blue Cross Blue Shield in writing via fax to 803-870-9528, or email to FMOLHSEXCEPTION@BCBSSC.com. You may also mail the forms to Blue Cross Blue Shield of South Carolina, Attn: Network Waiver, FMOLHS Exception, AX-820, PO Box 100300, Columbia, SC, 29202.

Although a Network Exception authorization may be in place, there may be associated services that do not automatically process at the in-network level of coverage. Examples may include the radiologist who reads your X-Rays, the pathologist who completes your lab work. When you have a Network Exception authorization, some of the claims may require manual intervention. If you have claims questions regarding your tier exception, please contact Blue Cross Customer Service at 833-468-3594.

If you receive treatment from an in-network hospital and one or more of the providers assigned to provide you care is out-of-network, such as an anesthesiologist or radiologist, your claim for that provider could be paid at the out-of-network benefit level. If this occurs, call Blue Cross Customer Service at 833-468-3594 to have your claim investigated and, if appropriate, adjusted to the in-network benefit level.

If you have additional questions about your referral or claims, please contact askHR@fmolhs.org; 1-833-482-7547.

If there is a Network Provider who can provide the specialty service and you choose to go to a Non-Network Provider without obtaining the pre-authorization from the Plan, the Plan will do one of the following depending on the plan you are enrolled in: (a) under the EPO Plan the bill will be processed as out of network resulting in no coverage or (b) under the PPO or HDHSA plan the bill will be processed as a payment to a non-Network

Provider if coverage is available. This means that the Plan will pay eligible charges at 110% of the Medicare reimbursement cost and you will be responsible to pay the unreimbursed amount.

Exception #2: Out-of-Network Service Rendered During a Medical Emergency. If a Covered Person has a Medical Emergency requiring immediate care and is treated by a Non-Network Provider, the medical bills will automatically be processed and paid based on the In-Network rates.

Exception #3: No Surprises Act Requirement. The No Surprises Act requires that Emergency Services performed by a Non-Network Provider or ancillary services provided at an in-network facility be processed so that the deductible, coinsurance and co-payments are determined at in-network levels, apply to out of pocket maximums and that the Covered Person not be subject to balance billing. See the attached Appendix for more information.

RULES FOR TRAVEL If you travel outside the United States to obtain medical services, such services will not be covered by the Plan. If you travel outside the United States for pleasure and you have a medical emergency, you will be responsible to pay your medical bills, seek an itemized bill for your services and then seek reimbursement from the Plan.

PREAUTHORIZATION REQUIREMENT LIST

Note: Except to the extent required otherwise by the No Surprises Act, the following services, supplies and care listed on the Preauthorization Requirement List below must be preauthorized or reimbursement from the Plan may be reduced. Medical Services Requiring Preauthorization and Mental Health and Substance Abuse services requiring Preauthorization, Call Blue Cross 833-468-3594.The number can also be found on the back of your ID card.

If preauthorization requirements are not met, covered expenses will be paid at 50% if the services are Medically Necessary and 0% if the services are not Medically Necessary. If you have any questions regarding preauthorization, call Blue Cross Customer Service 833-468-3594.

- All Inpatient Admissions (Includes acute, Skilled, Rehabilitation, LTAC, Residential, and Treatment Room Services)
- All Clinical Trials, Experimental & Investigational Procedures/Treatment
- All Transplant Services Including Pre-Transplant Evaluations
- All Out-of-Network and Out-of-Area Services, Procedures, Surgeries
- All Plastic & Reconstructive Surgeries & Procedures (Cosmetic procedures are excluded from coverage)
- All CT Scans. MRIs, and PET scans including CTAs and MRAs

17 Alpha-Hydroxyprogesterone Caproate (17P)
Alcohol/Substance Abuse
Bariatric Surgery, including revisional surgery
Durable Medical Equipment (purchases over $500 and all rentals)
Enteral Feedings
Genetic Studies/Testing/Therapy
Home Health
Hyperbaric Oxygen Therapy
Specialty Medications including Injectables and IV Infusions
Insulin Pump
Mental Health Services (Inpatient, Outpatient, and Residential Services only)
Orthotics and Prosthetics over $500
Pain Management procedures including Epidural Steroid Injections
Podiatry treatment/Foot Care
Diagnostic studies and/or treatment of Sleep Disorders
Surgery (hysterectomy, varicose vein, nasal/septal surgery, breast reduction, surgical intervention to correct sleep apnea, oral surgery)
Therapies – Physical, Speech, Occupational and ABA
Non-Emergent Air Ambulance and Non-Emergent Ambulance Transportation
Weight Loss Medications (Authorized by Healthy Lives)

This list is not inclusive of all codes requiring prior authorizations; please contact Member Services for benefits, eligibility, and code specific requirements. **Blue Cross number: 833-468-3594.**

SCHEDULE OF BENEFITS CHART FOR EPO PLAN		
EPO PLAN Available to Class A and Class B Participant		
	FMOLHS EPO Network	**Out-of-Network**
Annual Deductible		
Employee Only	$300	No Coverage
Employee with Dependents*	$600	No Coverage
Maximum Out-of-Pocket (includes deductible)		
Employee Only	$2,500	No Coverage
Employee with Dependents	$5,000	No Coverage
Coinsurance		
Employee Cost Share	10%	No Coverage
Once you reach your Maximum Out-of-Pocket, the Plan will pay 100% of the remainder of Covered Charges for the rest of the Calendar Year unless stated otherwise. Covered Charges are generally limited to FMOLHS EPO Network Charges and do not generally include Out-of-Network coverage charges or Out-of-Area coverage. * Spouse coverage is not available to a Class B Participant **The $3,000 Bariatric Surgery copay does not apply to the deductible or the out-of-pocket maximum amount.** You will be required to pay the $3,000 Bariatric Surgery copay even if you have reached your Deductible and Maximum Out-of-Pocket amount.		
The following charges do not apply toward the Out-of-Pocket Maximum and are never paid at 100%: Cost containment penalties and Above Usual & Customary charges fees		
COVERED CHARGES		
	FMOLHS EPO Network	**Out-of-Network**
Preventive Care & Condition Management		
Routine Well Adult Care *Generally limited to approved preventive or wellness services, which could include the following annual screenings depending on your age, gender, and health status: Lipid (Cholesterol), HGB A1C (Diabetes), Bone Marrow Density Test, Mammogram, Pap Test, Fecal Occult Blood Test, Colonoscopy, Depression Screening, Obesity Screening and Counseling* **Please call the Claims Administrator to confirm coverage***	100% coverage Limited to one routine physical examination annually and approved wellness screenings annually	No Coverage
Adult Immunizations *Immunizations are subject to current CDC Recommendations which include age limitations*	100% coverage	No Coverage
Routine Well Child Care *Unlimited routine office visits through age two (2); annually ages three (3) and up. Includes: office visits, routine physical examinations and immunizations in accordance with CDC Guidelines and preventive care in accordance with federal guidelines.*	100% coverage	No Coverage
Smoking Cessation Aids *Smoking cessation is available through the prescription benefit program.*	100% coverage of screening for tobacco use and two tobacco cessation attempts per year which includes four tobacco cessation counseling sessions of at least 10	No Coverage

	minutes each without prior authorization and 90 day supply of Smoking Cessation Aids when prescribed by a health care provider without prior authorization	
* FMOLHS follows federal guidelines for coverage of preventive/wellness screenings.		
Office Visit		
Primary Care Physician (PCP)	$0 copay	No Coverage
Specialist	$35 copay	No Coverage
Emergent/Urgent Care		
Urgent Care	$60 copay	No Coverage
Emergent Care	$250 copay	$250 copay*
Ambulance Service	90% coverage after deductible	90% coverage after deductible*
* Out of Network coverage and benefits will be modified to the extent required by and in accordance with the No Surprises Act. See Exhibit D.		
Facility Services		
Outpatient Surgery	$250 copay	No Coverage
Inpatient Care (Includes ICU and SNF)	$200 copay per day (4 day/$800 max)	No Coverage
Bariatric Surgery *Plan Coverage for Bariatric surgery is available only to a Full-Time or Part-Time Active employee who is a Class A Participant who remains in that status on the date of service and satisfies the requirements in Exhibit C and employee's covered spouse and dependent who satisfies the requirements in Exhibit C.*	$3,000 copay; Surgery must be performed at a MBSAQIP Accredited FMOLHS facility	No Coverage
Organ Transplant *Blue Distinction Centers coverage only*	90% coverage after deductible when performed at Blue Distinction Center facility	No Coverage
Maternity Care		
Prenatal Care	One-time $50 copay applies for coverage of routine OB visits, initial routine labs and one ultrasound per term pregnancy.	No Coverage
Labor & Delivery and Associated Charges	$200 copay per day (4 day/$800 max)	No Coverage
Maternal/Fetal Ultrasound	90% coverage after deductible or included in office visit copay, depending on place of service and other than one ultrasound included in prenatal care)	No Coverage
In Network breast pump and lactation counseling through Healthy Lives	100% coverage	No Coverage
Mental Health and Substance Abuse		
Office Visit	$0 Copay	No Coverage
Outpatient Services	90% coverage after deductible or included in office visit copay, depending on place of service	No Coverage
Inpatient including Partial Hospitalization (PHP), Intensive Outpatient Program (IOP), and	$200 copay per day (4 day/$800 max)	No Coverage

Residential		
Other Services		
Allergy Testing/Serums and Injections	90% coverage after deductible or included in office visit copay, depending on place of service	No Coverage
Laboratory & Diagnostics Services	90% coverage after deductible or included in office visit copay, depending on place of service	No Coverage
Chemotherapy	90% coverage after deductible or included in office visit copay, depending on place of service	No Coverage
Home Health Care	90% coverage after deductible; limited to 50 visits per calendar year	No Coverage
Hospice Care	90% coverage after deductible	No Coverage
Occupational Therapy Physical Therapy Speech Therapy	90% coverage after deductible; maximum of 120 visits per year (and maximum of 20 visits per week) combined Occupational, Physical, and Speech Therapy	No Coverage
Applied Behavior Analysis (ABA)	90% coverage after deductible; maximum of 20 hours per week annually	No Coverage
Specific Genetic Testing *(MUST SATISFY MEDICALLY NECESSARY CRITERIA)*	90% coverage after deductible drawn/ordered by FMOLHS Geneticist	No Coverage
Durable Medical Equipment (DME)	90% coverage after deductible	No Coverage
Insulin Pump	90% coverage after deductible; limited to 1 per 5 years	No Coverage
Orthotics and Prosthetics	90% coverage after deductible	No Coverage

EPO PRESCRIPTION PLAN		
	In-House	**Network (In-Network)**
RETAIL PHARMACY (30-DAY SUPPLY)		
GENERIC DRUG	$10 copay	$15 copay
GENERIC DIABETIC PRESCRIPTION MEDICATIONS AND SUPPLIES	$0 copay	$0 copay
PREFERRED DRUG	$35 copay	$70 copay
NON-PREFERRED DRUG	$70 copay	$110 copay
SPECIALTY DRUG	Filled by RxOne - $100 copay	Filled by Express Scripts – $150 copay
MAIL ORDER PHARMACY (90-DAY SUPPLY – RXONE OR EXPRESS SCRIPTS)		
GENERIC DRUG PREFERRED DRUG NON-PREFERRED DRUG	2x in-house copay*	3x network copay*
BRAND-NAME DRUGS WHEN GENERIC IS AVAILABLE		
The brand copay, plus the difference between the retail cost of the brand-name drug and of the generic drug. Note: the difference will not be applied to the out-of-pocket maximum.		
IMMUNIZATIONS		
According to the CDC Immunization Schedules; Subject to age limitations		

*Mail order copays do not apply to mail order Specialty Prescriptions

SCHEDULE OF BENEFITS CHART FOR PPO PLAN				
PPO MEDICAL PLAN Available to Class A Participant				
	FMOLHS Network (TIER 1)	**Preferred Provider Network (TIER 2)**	**Non-Preferred Provider Network (TIER 3)**	**Out-of-Network**
Annual Deductible				
Employee Only	$800	$1,200	$3,000	$5,000
Employee with Dependents*	$1,600	$2,400	$6,000	$10,000
Maximum Out-of-Pocket (includes deductible)				
Employee Only	$3,000	$4,500	$6,000	$10,000
Employee with Dependents	$6,000	$9,000	$12,000	$20,000
Coinsurance				
Employee Cost Share	20%	30%	40%	60%
Once you reach your Maximum Out-of-Pocket, the Plan will pay 100% of the remainder of Covered Charges for the rest of the Calendar Year unless stated otherwise. *Spouse coverage is not available to a Class B Participant. **The $3,000 Bariatric Surgery copay does not apply to the deductible or the out-of-pocket maximum amount.** You will be required to pay the $3,000 Bariatric Surgery copay even if you have reached your Deductible and Maximum Out-of-Pocket amount.				
The following charges do not apply toward the Out-of-Pocket Maximum and are never paid at 100%: Cost containment penalties and Above Usual & Customary charges fees				
Out-of-Area Coverage. A subscriber (team member) who is enrolled in the PPO Plan and whose home address is in a state other than Louisiana or Mississippi may (i) access care at Tier 2 network coverage with a BCBS PPO network provider in their home state for themselves and their enrolled dependents or (ii) access providers in the FMOLHS Louisiana and Mississippi networks at Tier 1 or Tier 2 coverage. Any other network access would follow the Tier 3 or Out-of-Network coverage. The Out of Area Coverage is based solely on the subscriber's (team member's) home address. A dependent's address does not entitle the dependent to Out of Area Coverage.				
COVERED CHARGES				
	FMOLHS Network (TIER 1)	**Preferred Provider Network (TIER 2)**	**Non-Preferred Provider Network (TIER 3)**	**Out-of-Network**
Preventive Care & Condition Management				
Routine Well Adult Care *Generally limited to approved preventive or wellness services, which could include the following annual screenings depending on your age, gender, and health status:* *Lipid (Cholesterol), HGB A1C (Diabetes), Bone Marrow Density Test, Mammogram, Pap Test, Fecal Occult Blood Test, Colonoscopy, Depression Screening, Obesity Screening and Counseling* **Please call the Claims Administrator to confirm coverage***	100% coverage Limited to one routine physical examination annually and approved wellness screenings annually.	100% coverage Limited to one routine physical examination annually and approved wellness screenings annually.	100% coverage Limited to one routine physical examination annually and approved wellness screenings annually.	40% coverage after deductible; Limited to one routine physical examination annually and approved wellness screenings annually.
Adult Immunizations *Immunizations are subject to current CDC Recommendations*	100% coverage	100% coverage	100% coverage	40% coverage after deductible

which include age limitations				
Routine Well Child Care *Unlimited routine office visits through age two (2); annually ages three (3) and up. Includes: office visits, routine physical examinations and immunizations in accordance with CDC Guidelines and preventive care in accordance with federal guidelines.*	100% coverage	100% coverage	100% coverage	40% coverage after deductible
Smoking Cessation Aids *Smoking cessation is available through the prescription benefit program.*	100% coverage of screening for tobacco use and two tobacco cessation attempts per year which includes four tobacco cessation counseling sessions of at least 10 minutes each without prior authorization and 90 day supply of Smoking Cessation Aids when prescribed by a health care provider without prior authorization	100% coverage of screening for tobacco use and two tobacco cessation attempts per year which includes four tobacco cessation counseling sessions of at least 10 minutes each without prior authorization and 90 day supply of Smoking Cessation Aids when prescribed by a health care provider without prior authorization	100% coverage of screening for tobacco use and two tobacco cessation attempts per year which includes four tobacco cessation counseling sessions of at least 10 minutes each without prior authorization and 90 day supply of Smoking Cessation Aids when prescribed by a health care provider without prior authorization	No Coverage
* FMOLHS follows federal guidelines for coverage of preventive/wellness screenings.				
Office Visit				
Primary Care Physician (PCP)	$5 copay office visit only, all other services subject to deductible and coinsurance	$30 copay office visit only, all other services subject to deductible and coinsurance	60% coverage after deductible	40% coverage after deductible
Specialist	$45 copay office visit only, all other services subject to deductible and coinsurance	$70 copay office visit only, all other services subject to deductible and coinsurance		
Emergent/Urgent Care				
Urgent Care	$75 copay	$75 copay	60% coverage after deductible	40% coverage after deductible
Emergency Room	80% coverage after deductible	80% coverage after deductible *	80% coverage after deductible *	80% coverage after deductible *
Ambulance Service	80% coverage after deductible	80% coverage after deductible*	80% coverage after deductible*	80% coverage after deductible*
*Out of Network coverage and benefits will be modified to the extent required by and in accordance with the No Surprises Act. See Exhibit D.				

Facility Services				
Outpatient Surgery	80% coverage after deductible	70% coverage after deductible	60% coverage after deductible	40% coverage after deductible
Inpatient Care (Including ICU and SNF)	80% coverage after deductible	70% coverage after deductible	60% coverage after deductible	40% coverage after deductible
Bariatric Surgery *Plan Coverage for Bariatric surgery is available only to a Full-Time or Part-Time Active employee who is a Class A Participant who remains in that status on the date of service and satisfies the requirements in Exhibit C and employee's covered spouse and dependent who satisfies the requirements in Exhibit C*	$3,000 copay; Surgery must be performed at a MBSAQIP Accredited FMOLHS facility	No coverage	No coverage	No coverage
Organ Transplant *Blue Distinction Centers coverage only*	80% coverage after deductible when performed at Blue Distinction Center facility	80% coverage after deductible when performed at Blue Distinction Center facility	80% coverage after deductible when performed at Blue Distinction Center facility	No coverage
Maternity Care				
Prenatal Care	One time $50 copay applies to routine OB visits, initial routine labs and one ultrasound per term pregnancy.	One time $50 copay applies to routine OB visits, initial routine labs and one ultrasound per term pregnancy.	One time $50 copay applies to routine OB visits, initial routine labs and one ultrasound per term pregnancy.	40% coverage after deductible
Labor & Delivery and Associated Charges	80% coverage after deductible	70% coverage after deductible	60% coverage after deductible	40% coverage after deductible
Maternal/Fetal Ultrasound	80% coverage after deductible – other than included in pre-natal care	70% coverage after deductible- other than included in pre-natal care	60% coverage after deductible- other than included in pre-natal care	40% coverage after deductible
In Network breast pump and lactation counseling through Healthy Lives	100% coverage	100% coverage	100% coverage	No Coverage
Mental Health and Substance Abuse				
Office Visit	$5 copay	$30 copay	60% coverage after deductible	40% coverage after deductible
Outpatient Services	80% coverage after deductible	70% coverage after deductible	60% coverage after deductible	40% coverage after deductible
Inpatient including Partial Hospitalization (PHP), Intensive Outpatient Program (IOP), and Residential	80% coverage after deductible	70% coverage after deductible	60% coverage after deductible	40% coverage after deductible
Other Services				
Allergy Testing/Serums and Injections	80% coverage after deductible	70% coverage after deductible	60% coverage after deductible	40% coverage after deductible

Laboratory & Diagnostics Services	80% coverage after deductible	70% coverage after deductible	60% coverage after deductible	40% coverage after deductible
Chemotherapy	80% coverage after deductible	70% coverage after deductible	60% coverage after deductible	40% coverage after deductible
Home Health Care	80% coverage after deductible; maximum of 50 visits per calendar year	70% coverage after deductible; maximum of 50 visits per calendar year	60% coverage after deductible; maximum of 50 visits per calendar year	No Coverage
Hospice Care	80% coverage after deductible	70% coverage after deductible	60% coverage after deductible	40% coverage after deductible
Occupational Therapy Physical Therapy Speech Therapy	80% coverage after deductible; maximum of 120 visits per year (and maximum of 20 visits per week) combined with Occupational, Physical, and Speech Therapy	70% coverage after deductible; maximum of 120 visits per year (and maximum of 20 visits per week) combined with Occupational, Physical, and Speech Therapy	60% coverage after deductible; maximum of 120 visits per year (and maximum of 20 visits per week) combined with Occupational, Physical, and Speech Therapy	No Coverage
Applied Behavior Analysis (ABA)	80% coverage after deductible; maximum of 20 hours per week annually	70% coverage after deductible; maximum of 20 hours per week annually	60% coverage after deductible; maximum of 20 hours per week annually	No Coverage
Specific Genetic Testing *(MUST SATISFY MEDICALLY NECESSARY CRITERIA)*	80%; drawn/ordered by FMOLHS Geneticist	No coverage	No coverage	No coverage
Durable Medical Equipment (DME)	80% coverage after deductible	70% coverage after deductible	60% coverage after deductible	No Coverage
Insulin Pump	80% coverage after deductible; limited to 1 per 5 years	70% coverage after deductible; limited to 1 per 5 years	60% coverage after deductible; limited to 1 per 5 years	No Coverage
Orthotics and Prosthetics	80% coverage after deductible	70% coverage after deductible	60% coverage after deductible	40% coverage after deductible

PPO PRESCRIPTION PLAN		
	In-House	**Network**
RETAIL PHARMACY (30-DAY SUPPLY)		
GENERIC DRUG	$10 copay	$15 copay
GENERIC DIABETIC PRESCRIPTION MEDICATIONS AND SUPPLIES	$0 copay	$0 copay
PREFERRED DRUG	$45 copay	$70 copay
NON-PREFERRED DRUG	$70 copay	$110 copay
SPECIALTY DRUG	Filled by RxOne - $100 copay	Filled by Express Scripts – $150 copay
MAIL ORDER PHARMACY (90-DAY SUPPLY – RXONE OR EXPRESS SCRIPTS)		
GENERIC DRUG PREFERRED DRUG NON-PREFERRED DRUG	2x in-house copay*	3x network copay*
BRAND-NAME DRUGS WHEN GENERIC IS AVAILABLE		
The brand copay, plus the difference between the retail cost of the brand-name drug and of the generic drug. Note: the difference will not be applied to the out-of-pocket maximum.		
IMMUNIZATIONS		
According to the CDC Immunization Schedules; Subject to age limitations		

*Mail order copays do not apply to mail order Specialty Prescriptions

SCHEDULE OF BENEFITS CHART FOR HIGH DEDUCTIBLE HSA PLAN				
High Deductible HSA Plan Available to Class A Participant				
	FMOLHS Network TIER 1	**Preferred Provider Network TIER 2**	**Non-Preferred Provider Network TIER 3**	**Out-of-Network**
HSA Annual Employer Contributions*				
Employee Only	$750			
Employee with Dependent	$1,500			
*Team Member must enroll in the HSA and HDHSA Plan to be eligible to receive the HSA Employer Contribution				
Annual Deductible (Aggregated)				
Employee Only	$1,750	$2,500	$3,500	$5,000
Employee with Dependents	$3,500	$5,000	$7,000	$10,000
Maximum Out-of-Pocket (includes deductible) (Embedded OOP)				
Employee Only	$3,500	$5,000	$7,000	$10,000
Employee with Dependents	$7,000	$10,000	$14,000	$20,000
Coinsurance				
Employee Cost Share	20%	30%	40%	60%
Once you reach your Maximum Out-of-Pocket, the Plan will pay 100% of the remainder of Covered Charges for the rest of the Calendar Year unless stated otherwise. **The $3,000 Bariatric Surgery copay does not apply to the deductible or the out-of-pocket maximum amount.** You will be required to pay the $3,000 Bariatric Surgery copay even if you have reached your Deductible and Maximum Out-of-Pocket amount.				
The following charges do not apply toward the Out-of-Pocket Maximum and are never paid at 100%: Cost containment penalties and Above Usual & Customary charges fees				
The Out-of-Area coverage is not available under the High Deductible HSA Plan.				
COVERED CHARGES				
	FMOLHS Network (TIER 1)	**Preferred Provider Network (TIER 2)**	**Non-Preferred Provider Network (TIER 3)**	**Out-of-Network**
Preventive Care & Condition Management				
Routine Well Adult Care *Generally limited to approved preventive or wellness services, which could include the following annual screenings depending on your age, gender, and health status: Lipid (Cholesterol), HGB A1C (Diabetes), Bone Marrow Density Test, Mammogram, Pap Test, Fecal Occult Blood Test, Colonoscopy, Depression Screening, Obesity Screening and Counseling* **Please call the Claims Administrator to confirm coverage***	100% coverage Limited to one routine physical examination annually and approved wellness screenings annually.	100% coverage Limited to one routine physical examination annually and approved wellness screenings annually.	100% coverage Limited to one routine physical examination annually and approved wellness screenings annually.	40% coverage after deductible; Limited to one routine physical examination annually and approved wellness screenings annually.
Adult Immunizations *Immunizations are subject to current CDC Recommendations which include age limitations*	100% coverage	100% coverage	100% coverage	40% coverage after deductible
Routine Well Child Care	100% coverage	100% coverage	100% coverage	40% coverage

Unlimited routine office visits through age two (2); annually ages three (3) and up. Includes: office visits, routine physical examinations and immunizations in accordance with CDC Guidelines and preventive care in accordance with federal guidelines.				after deductible
Smoking Cessation Aids *Smoking cessation is available through the prescription benefit program.*	100% coverage of screening for tobacco use and two tobacco cessation attempts per year which includes four tobacco cessation counseling sessions of at least 10 minutes each without prior authorization and 90 day supply of Smoking Cessation Aids when prescribed by a health care provider without prior authorization	100% coverage of screening for tobacco use and two tobacco cessation attempts per year which includes four tobacco cessation counseling sessions of at least 10 minutes each without prior authorization and 90 day supply of Smoking Cessation Aids when prescribed by a health care provider without prior authorization	100% coverage of screening for tobacco use and two tobacco cessation attempts per year which includes four tobacco cessation counseling sessions of at least 10 minutes each without prior authorization and 90 day supply of Smoking Cessation Aids when prescribed by a health care provider without prior authorization	No Coverage
* FMOLHS follows federal guidelines for coverage of preventive/wellness screenings.				
Office Visit				
Primary Care Physician (PCP)	80% coverage after deductible	70% coverage after deductible	60% coverage after deductible	40% coverage after deductible
Specialist	80% coverage after deductible	70% coverage after deductible	60% coverage after deductible	40% coverage after deductible
Emergent/Urgent Care				
Urgent Care	80% coverage after deductible	70% coverage after deductible	60% coverage after deductible	40% coverage after deductible
Emergency Room	80% coverage after deductible	80% coverage after deductible *	80% coverage after deductible *	80% coverage after deductible *
Ambulance Service	80% coverage after deductible	80% coverage after deductible*	80% coverage after deductible*	80% coverage after deductible*
*Out of Network coverage and benefits will be modified to the extent required by and in accordance with the No Surprises Act. See Exhibit D.				
Facility Services				
Outpatient Surgery	80% coverage after deductible	70% coverage after deductible	60% coverage after deductible	40% coverage after deductible
Inpatient Care (Including ICU and SNF)	80% coverage after deductible	70% coverage after deductible	60% coverage after deductible	40% coverage after deductible
Bariatric Surgery *Plan Coverage for Bariatric*	$3,000 copay; Surgery must be	No coverage	No coverage	No coverage

surgery is available only to a Full-Time or Part-Time Active employee who is a Class A Participant who remains in that status on the date of service and satisfies the requirements in Exhibit C and employee 's covered spouse and dependent who satisfies the requirements in Exhibit C	performed at a MBSAQIP Accredited FMOLHS facility			
Organ Transplant *Blue Distinction Centers coverage only*	80% coverage after deductible when performed at Blue Distinction Center facility	80% coverage after deductible when performed at Blue Distinction Center facility	80% coverage after deductible when performed at Blue Distinction Center facility	No coverage
Maternity Care				
Prenatal Care	80% coverage after deductible	70% coverage after deductible	60% coverage after deductible	40% coverage after deductible
Labor & Delivery and Associated Charges	80% coverage after deductible	70% coverage after deductible	60% coverage after deductible	40% coverage after deductible
Maternal/Fetal Ultrasound	80% coverage after deductible	70% coverage after deductible	60% coverage after deductible	40% coverage after deductible
In Network breast pump and lactation counseling through Healthy Lives	100% coverage	100% coverage	100% coverage	No Coverage
Mental Health and Substance Abuse				
Office Visit	80% coverage after deductible	70% coverage after deductible	60% coverage after deductible	40% coverage after deductible
Outpatient Services	80% coverage after deductible	70% coverage after deductible	60% coverage after deductible	40% coverage after deductible
Inpatient including Partial Hospitalization (PHP), Intensive Outpatient Program (IOP), and Residential	80% coverage after deductible	70% coverage after deductible	60% coverage after deductible	40% coverage after deductible
Other Services				
Allergy Testing/Serums and Injections	80% coverage after deductible	70% coverage after deductible	60% coverage after deductible	40% coverage after deductible
Laboratory & Diagnostics Services	80% coverage after deductible	70% coverage after deductible	60% coverage after deductible	40% coverage after deductible
Chemotherapy	80% coverage after deductible	70% coverage after deductible	60% coverage after deductible	40% coverage after deductible
Home Health Care	80% coverage after deductible; maximum of 50 visits per calendar year	70% coverage after deductible; maximum of 50 visits per calendar year	60% coverage after deductible; maximum of 50 visits per calendar year	No Coverage
Hospice Care	80% coverage after deductible	70% coverage after deductible	60% coverage after deductible	40% coverage after deductible
Occupational Therapy Physical Therapy Speech Therapy	80% coverage after deductible; maximum of 120	70% coverage after deductible; maximum of 120	60% coverage after deductible; maximum of 120	No Coverage

	visits per year (and maximum of 20 visits per week) combined with Occupational, Physical, and Speech Therapy	visits per year (and maximum of 20 visits per week) combined with Occupational, Physical, and Speech Therapy	visits per year (and maximum of 20 visits per week) combined with Occupational, Physical, and Speech Therapy	
Applied Behavior Analysis (ABA)	80% coverage after deductible; maximum of 20 hours per week annually	70% coverage after deductible; maximum of 20 hours per week annually	60% coverage after deductible; maximum of 20 hours per week annually	No Coverage
Specific Genetic Testing *(MUST SATISFY MEDICALLY NECESSARY CRITERIA)*	80%; drawn/ordered by FMOLHS Geneticist	No coverage	No coverage	No coverage
Durable Medical Equipment (DME)	80% coverage after deductible	70% coverage after deductible	60% coverage after deductible	No Coverage
Insulin Pump	80% coverage after deductible; limited to 1 per 5 years	70% coverage after deductible; limited to 1 per 5 years	60% coverage after deductible; limited to 1 per 5 years	No Coverage
Orthotics and Prosthetics	80% coverage after deductible	70% coverage after deductible	60% coverage after deductible	40% coverage after deductible

HDHSA PRESCRIPTION PLAN

	In-House	Network
RETAIL PHARMACY (30-DAY SUPPLY)		
GENERIC DRUG	20% after deductible	20% after deductible
GENERIC DIABETIC PRESCRIPTION MEDICATIONS AND SUPPLIES	20% after deductible	20% after deductible
PREFERRED DRUG	20% after deductible	20% after deductible
NON-PREFERRED DRUG	20% after deductible	20% after deductible
SPECIALTY DRUG	20% after deductible	20% after deductible
MAIL ORDER PHARMACY (90-DAY SUPPLY – RXONE OR EXPRESS SCRIPTS)		
GENERIC DRUG PREFERRED DRUG NON-PREFERRED DRUG	20% after deductible	
BRAND-NAME DRUGS WHEN GENERIC IS AVAILABLE		
The brand copay, plus the difference between the retail cost of the brand-name drug and of the generic drug. Note: the difference will not be applied to the out-of-pocket maximum.		
IMMUNIZATIONS		
According to the CDC Immunization Schedules; Subject to age limitations		

*Mail order copays do not apply to mail order Specialty Prescriptions

Prescription Discount Available under All Plans: Generic, Preferred, and Non-Preferred Brand prescriptions written by the Franciscan Clinic are eligible for a $5.00 reduction in member cost when filled at an in-house pharmacy.

INTRODUCTION

This document is a description of the Franciscan Missionaries of Our Lady Health System Health Plan (the "Plan" or the "FMOLHS Health Plan"). No oral interpretations can change this Plan. The Plan described is designed to protect Plan Participants against certain catastrophic health expenses.

Coverage under the Plan will take effect for an eligible Employee and designated Dependents when the Employee and such Dependents satisfy all the eligibility requirements of the Plan.

The Employer intends to maintain this Plan indefinitely; however, it reserves the right to terminate, suspend, discontinue or amend the Plan at any time and for any reason.

Changes in the Plan may occur in any or all parts of the Plan including benefit coverage, deductibles, maximums, exclusions, limitations, definitions, eligibility and the like.

Failure to follow the eligibility or enrollment requirements of this Plan may result in delay of coverage or no coverage at all. Reimbursement from the Plan can be reduced or denied because of certain provisions in the Plan, such as coordination of benefits, subrogation, exclusions, timeliness of Continuation Coverage elections, utilization review or other Utilization Management requirements, lack of Medical Necessity, lack of timely filing of claims or lack of coverage.

The Plan will pay benefits only for the expenses incurred while this coverage is in force. No benefits are payable for expenses incurred before coverage began or after coverage terminated. An expense for a service or supply is incurred on the date the service or supply is furnished.

No action at law or in equity shall be brought to recover under any section of this Plan until the appeal rights provided have been exercised and the Plan benefits requested in such appeals have been denied in whole or in part.

If the Plan is terminated, amended, or benefits are eliminated, the rights of Covered Persons are limited to Covered Charges incurred before termination, amendment or elimination.

This Plan is intended to be operated in compliance with the terms of the Patient Protection and Affordable Care Act requirements, to the extent applicable and any provision not in compliance is deemed modified as necessary to be compliant. This Plan is also intended to be operated in compliance with the terms of the No Surprises Act requirements, to the extent applicable and any provision not in compliance is deemed modified as necessary to be compliant.

The Plan is and has been a church plan as described in Code Section 414(e) and ERISA Section 3(33) since inception and no election has been made under Code Section 410(d) to be subject to ERISA and therefore, the Plan is exempt from Title I and Title IV of ERISA and certain provisions of the Code. The Plan Sponsor, the Employers and the Administrator are controlled by and associated with the Roman Catholic Church and take direction from the Roman Catholic Church.

This document summarizes the Plan rights and benefits for covered Employees and their Dependents and is divided into the following parts:

Eligibility, Funding, Effective Date and Termination. Explains eligibility for coverage under the Plan, funding of the Plan and when the coverage takes effect and terminates.

Open Enrollment. Explains the process to enroll in the Plan.

Exclusive Provider Organization and Preferred Provider Organization. Details two of the three benefit options under the Plan.

Schedule of Benefits and Chart. Provides an outline of the Plan reimbursement formulas as well as payment limits on certain services.

Benefit Descriptions. Explains when the benefit applies and the types of charges covered.

Utilization Management Services. Explains the methods used to curb unnecessary and excessive charges.

> **This part should be read carefully since each Participant is required to take action to assure that the maximum payment levels under the Plan are paid.**

Defined Terms. Defines those Plan terms that have a specific meaning.

Plan Exclusions. Shows what charges are **not** covered.

Prescription Drug Benefits. Details the covered benefits.

Claim Filing Provisions. Explains the rules for filing claims and the claim appeal process.

Affordable Care Act Grievance Procedures with respect to Illegal Discrimination.

Coordination of Benefits. Shows the Plan payment order when a person is covered under more than one plan.

Third Party Recovery Provision. Explains the Plan's rights to recover payment of charges when a Covered Person has a claim against another person because of injuries sustained.

Continuation Coverage Rights. Explains when a person's coverage under the Plan ceases and the continuation options which are available.

General Plan Information. Provides general information about the Plan.

Please Note: This Plan covers employees of the different Facilities listed below:

- **Franciscan Missionaries of Our Lady, North American Province, Inc.**
- **Franciscan Missionaries of Our Lady Health System, Inc.**
- **Franciscan Missionaries of Our Lady University**

For additional information about the Plan, please contact askHR@fmolhs.org or call 1-833-482-7547

ELIGIBILITY, FUNDING, EFFECTIVE DATE AND TERMINATION PROVISIONS

A Plan Participant should contact askHR@fmolhs.org or call 1-833-482-7547 to obtain additional information, free of charge, about Plan coverage of a specific benefit, particular drug, treatment, test or any other aspect of Plan benefits or requirements.

ELIGIBILITY

Eligible Classes of Employees. All Active and Retired Employees of the Employer that meet eligibility requirements as indicated below:

Eligibility Requirements for Active Employee Coverage.
General Rules. A person is eligible for Employee coverage as a Class A Participant on the first day of the month following 30 days of employment in either category below.

(1) is a Full-Time, Active Employee of the Employer who has not elected FPTNB/FTNB Employee status. An Employee is considered to be Full-Time if he or she is a .8 to 1.0 FTE and is normally scheduled to work at least thirty-two (32) hours per week and is on the regular payroll of the Employer for that work at an applicable Facility; or

(2) is a Part-Time, Active Employee of the Employer who has not elected FPTNB Employee status. An Employee is considered to be Part-Time if he or she is a .5 to .799 FTE and is normally scheduled to work at least twenty (20) hours per week and is on the regular payroll of the Employer for that work at an applicable Facility.

Special Rule #1: If the Employer acquires the stock or assets of an unrelated company which results in employees of the acquired entity being employed by the Employer in Benefit Eligible Positions, the Benefit Eligible Position employees will be eligible to enroll in the Plan during the month in which the acquisition occurs and coverage will be effective as of the first day of the month following the month containing the acquisition date. The Employer reserves the right to determine the enrollment period in the acquisition month and the enrollment requirements (which include providing dependent verification documentation to askHR via Oracle Employee Self Service).

Special Rule #2: If the Employer acquires the stock or assets of an unrelated company which results in employees of the acquired entity being employed by the Employer in Benefit Eligible Positions, the Benefit Eligible Position employees will be eligible to enroll in the Plan on day one of the acquisition date if continuation coverage or COBRA is not available with the prior health plan. The Employer reserves the right to determine the enrollment period prior to the acquisition month and the enrollment requirements (which include providing dependent verification documentation to askHR via Oracle Employee Self Service).

Special Rules #1 and #2 are available only if such action does not cause the Plan to discriminate in favor of highly compensated individuals as to eligibility to participate or benefits provided under the Plan, in accordance with the requirements of Code Section 105(h).

Special Rules for Variable Hour Employees: A Variable Hour Employee (PRN) who (i) is an Active Employee, (ii) is not classified as a Full-Time or Part-Time Employee and (iii) satisfies the requirements under the Patient Protection and Affordable Care Act (PPACA) to be treated as a full-time employee under the PPACA (by regularly working 30 or more hours per week during the relevant measurement period), will be eligible for Employee coverage as of the first day of the stability period following the completion of the initial or standard measurement period, as applicable. Such Employee will be referred to as a "PPACA FTE" under this Plan. If a PPACA FTE elects coverage under the Plan, the PPACA FTE will be a Class B Plan Participant.

Special Rules for FTPNB/FTNB Employees: A FPTNB/FTNB Employee is (i) a Full-Time Active Employee (ii) working in a clinical position which is classified as a FPTNB/FTNB category for the Plan Year and who has made

an election to receive an Hourly Pay Differential in lieu of participating in the Plan. Unless a FPTNB/FTNB Employee incurs a Special Enrollment Period under Code Section 9801(f), such FPTNB/FTNB Employee will be ineligible to participate in the Plan for the Plan Year Such FPTNB/FTNB Employee shall not be treated as a Class A Participant. If a FPTNB/FTNB Employee incurs a Special Enrollment Period under the Plan and elects coverage under the Plan mid-year, such FPTNB/FTNB Employee will cease to be a FPTNB/FTNB Employee and will be treated as a Class A Participant on the date such coverage is effective. Note that a FPTNB Employee can include a Part-Time Active Employee.

Effective as of January 1, 2024, there are two categories of FPTNB/FTNB positions:
(a)"Grandfathered". FPTNB positions are "grandfathered" meaning that no additional positions will be designated as FPTNB positions and each existing FPTNB position will remain a "FPTNB" only if the current Employee elects to continue in the position as a FPTNB employee for the 2024 Plan year. This "grandfathered" class contain both full-time and part-time positions. If a current Employee does not elect to be a FPTNB employee while working the grandfathered FPTNB position for 2024, the position shall cease to be a FPTNB position for 2024 and future years

(b) "Open". FTNB positions are "open" meaning that each position designated as FTNB position will remain a FTNB during each benefit year regardless of whether the employee in the position elects FTNB status.

A FPTNB/FTNB Employee may be employed in a second position with the Employer and the second position does not have to be a FPTNB/FTNB position because only the first position is reviewed for benefit purposes.

The Plan will have two categories of Plan Participants: A Class A Plan Participant is a Full-Time or Part-Time Active Employee who has not elected FPTNB/FTNB Employee status, or a Retired Employee of the Employer who satisfies the eligibility requirements detailed below and elected coverage under the Plan. A Class B Plan Participant will be limited to a Variable Hour Employee who satisfies the requirements detailed above and elected coverage under the Plan. A reference to a Plan Participant shall include a Class A Plan Participant and a Class B Plan Participant except where specifically noted otherwise.

Eligible Classes of Dependents.

Dependent may include the following individuals, depending upon the coverage elected by the Participant and the Plan requirement that a Class B Plan Participant may not elect coverage for a Spouse:

(1) For a Class A Plan Participant, a Spouse (see "Defined Terms").

(2) An Employee's "Child" will be an eligible Dependent through the last day of the month in which the Dependent reaches the limiting age of twenty-six (26). For this purpose, the term "Child" includes a natural child, stepchild, adopted child, a child placed with the Employee for adoption, foster children and a child for whom the Participant is required to provide coverage due to a medical child support order that the Plan Administrator determines is a "qualified medical child support order." An Employee's Child will be an eligible Dependent until reaching the limiting age of twenty-six (26), without regard to student status, marital status, financial dependency or residency status with the Employee or any other person or the death of the biological parent (in the case of an Employee's stepchild who qualifies as a Child) . When the child reaches the applicable limiting age, coverage will end on the last day of the month in which the dependent reaches the limiting age of twenty-six (26).

(3) Any unmarried child who is incapable of self-support because of a Handicap (as defined in paragraph (5) below) is entitled to continue coverage under the Plan beyond the month in which the child turn age 26 provided (i) the child is dependent upon the Participant for principal support and maintenance, (ii) the Participant is entitled to an exemption for federal income tax purposes for the child and (iii) the child was covered under the Plan before the end of the month in which he reached age 26. Proof of the continued existence of such incapacity may be requested by the Plan Administrator from time to time.

(4) A Participant's grandchild who does not qualify for coverage under paragraph (2) above will be considered a "child" and will be able to have coverage until the last day of the month in which the grandchild reaches the limiting age of twenty-six (26) if the Participant (i) has court appointed legal custody or joint legal

custody of the grandchild as evidenced by a court order by a court of competent jurisdiction and (ii) has court appointed responsibilities for medical expenses (as evidenced by a court order by a court of competent jurisdiction), and is entitled to an exemption on the Participant's federal income tax return.

(5) For purposes of this definition, "Handicap" means Mental Retardation or any congenital or acquired physical or mental defect or characteristic preventing or restricting an unmarried child of a covered Employee or Retiree from participating in normal life or limiting and/or preventing the individual's capacity to work. Such child's Handicap must be certified by a Physician and approved by the Plan Administrator within 30 calendar days after the date the child would otherwise lose Dependent status.

Eligibility Requirements for Active Employee Dependent Coverage. A family member of an Employee will become eligible for Dependent coverage on the first day that the Employee is eligible for Employee coverage and the family member satisfies the requirements for Dependent coverage. Such Dependent coverage will be effective as of the later of the date the family member satisfies the requirements for Dependent coverage, and the date the Employee's coverage is effective. The Spouse of a Class B Plan Participant is not eligible for Dependent Coverage.

At any time, the Plan may require proof that a Spouse or a child qualifies or continues to qualify as a Dependent as defined by this Plan.

If both parents are Employees, their Children will be covered as Dependents of one parent, but not of both.

An Employee cannot have simultaneous coverage as an Active Employee and Dependent.

Eligibility Requirements for Retired Employee Coverage.
General Rules. A person is eligible for Retired Employee coverage as a Class A Participant if he satisfies either category below:

(1) is a Retired Employee of Our Lady of Lourdes, a Retired Employee of St. Francis Medical Center, Inc. or a Retired Employee of Our Lady of Lake who participated in the LakeVet55 program who satisfies the special rules for retiree coverage detailed below.

(2) is a Retired Employee of St. Dominic Health Services who satisfies the requirements below.

Special Rules for Retiree Coverage. In order to qualify for retiree health coverage, an Employee must have health coverage on the day before he retired. In the limited situations outlined below, the Plan will provide Retiree coverage which could extend beyond the normal period of Continuation Coverage:

If you worked for Our Lady of Lourdes and:

- you retired prior to February 1, 2006, you can maintain your health Plan coverage until you die as long as you enroll in Medicare Parts A and B once you become eligible for Medicare. If you do not enroll in Medicare Parts A and B, the Plan's benefit payments will be reduced by an estimate of the amount Medicare would have paid had you enrolled in Medicare.

- you retired on and after February 1, 2006 and before February 1, 2007, you can maintain your health Plan coverage until the last day of the month prior to the date you become eligible for Medicare. You are not required to file for Medicare Parts A and B because retiree coverage terminates upon Medicare eligibility.

- you retired on and after February 1, 2007, are not eligible for coverage as a Retiree (only Continuation Coverage applies).

If you worked for St. Francis and you retired prior to July 1, 2006, you can maintain your health Plan coverage until the last day of the month prior to the date you become eligible for Medicare (age 65).

If you worked for Our Lady of the Lake and retired under the LakeVet55 Program, you can maintain your health Plan coverage (without any cost to you) until the earlier of the date of your death or the last day of the month prior to the date you become eligible for Medicare.

If you worked for St. Dominic Health Services and are either an Early Retiree or Disabled Retiree (as defined by the Retirement Plan for Employees of St. Dominic Health Services, Inc.) as of 12.31.2019, you can maintain your health Plan coverage until you reach age 65. An Early Retiree's Spouse is also allowed to remain on the Plan until age 65, but not longer than 10 years, whichever comes first. The Early Retiree's Spouse can only retain coverage if the Early Retiree personally selects and maintains such coverage. If the coverage is not selected by the Early Retiree upon retirement or upon termination of full time employment (which, prior to 1.1.2020, required working at least 30 hours per week) or if early retirement coverage is canceled by the Early Retiree or terminated for any reason after early retirement has been selected, coverage will not be reinstated.

Eligibility Requirements for Dependent Coverage for Retired Employees other than St. Dominic Retirees. A family member of a Retiree will become eligible for Dependent coverage if two requirements are satisfied:

- The family member qualifies as an Eligible Dependent under the rules listed above; and
- The family member was covered under the Plan on the Retiree's date of retirement.

Unless otherwise required by the Patient Protection and Affordable Care Act, Dependents cannot be added to the Plan after the date of retirement. Dependent coverage for a retiree who is in the LakeVet55 Program may be continued until the earlier of (i) the date the LakeVet55 Early Retiree dies, (ii) the date the LakeVet55 Early Retiree reaches age 66½ or (iii) when the spouse of the LakeVet55 turns age 65.

FUNDING

Cost of the Plan. FMOLHS determines how the cost of Employee and Dependent coverage will be shared between the Employee and the Facility and can make different determinations for a Class A Plan Participant and a Class B Plan Participant. You may be able to reduce your portion of the premiums if you take certain steps and submit a complete premium reduction application that meets the premium reduction criteria.

The level of any Employee contributions (for a Class A Plan Participant and a Class B Plan Participant) or Retiree contributions is set by FMOLHS.

Notwithstanding the foregoing, the Plan is intended to offer Employee only coverage at a rate which is deemed to be affordable under the PPACA.

ENROLLMENT

Enrollment Requirements for Class A Plan Participants.

Once you are hired as a Full-Time Active Employee or a Part-Time Active Employee, you will be provided with information about the Plan. Note: Certain Full-Time or Part-Time Employees working in a clinical position which is classified as a FPTNB/FTNB category for the Plan Year will be given the option under the FMOLHS Cafeteria Plan to elect to receive an Hourly Pay Differential in lieu of participating in the Plan. If you choose to work as a FPTNB/FTNB Employee for the Plan Year you are ineligible to participate in the Plan.

You should study the information carefully then complete the online enrollment including submission of required dependent verification documents. Paper enrollment will be provided if online enrollment is not available. The enrollment and required documents must be completed and received by askHR within 30 calendar days of your date of hire or newly eligible date. The enrollment completed online will be stamped electronically with a date and time. If you submit your enrollment online, you will receive a confirmation message on the online Oracle screen after submitting your enrollment. If your online enrollment is incorrect, you will receive an error message after submitting your enrollment and will need to contact askHR. Once you receive a confirmation message on the Oracle online enrollment screen, you need to review pending documents required to complete your enrollment. It is recommended that you print

out a copy of your online elections as this date and time stamp will serve as your electronic signature as well as proof of enrollment in the health plan.

If the enrollment is completed, received and accepted along with required dependent verification documents during your first 30 calendar days of employment, you and each of your eligible dependents who you request to be enrolled in the Plan will become a Covered Member on the first day of the month following 30 days of eligibility if on such date the Covered Member is a Full-time or Part-Time Employee of the Employer and has not elected FPTNB/FTNB status. Proof of your relationship with the dependents you enroll will be required. An incomplete online or paper enrollment, or insufficient dependent verification documents may delay your enrollment or the enrollment of your eligible dependents in the Plan.

If your enrollment and all required dependent verification documents are not completed, received by the Plan and accepted within 30 calendar days of your date of hire or newly eligible date, you must wait until the next open enrollment period to join the Plan.

Enrollment Requirements for Class B Plan Participants.

If you are hired as a Variable Hour Employee, you will be provided information about the Plan and your ability to enroll in the Plan once you satisfy the requirements to be considered a PPACA FTE.

Enrollment Requirements for Newborn Children.

A newborn child of a covered Employee with Dependent coverage is not automatically enrolled in this Plan. You must complete the online enrollment and return required dependent verification document(s) for your newly adopted or birth child within the 30 day period following the birth. If you complete the online enrollment and return the required dependent verification documents within 30 calendar days of the child's birth, coverage will be retroactive to the date of birth. A child who is not enrolled within the 30-day enrollment period will generally be ineligible for coverage under the plan until the next open enrollment period.

TIMELY ENROLLMENT

Timely Enrollment - The enrollment will be "timely" if the online enrollment is completed and the required dependent verification documents are received by askHR within 30 calendar days of the date the person becomes eligible for the coverage, either initially or under a Special Enrollment Period. The Employer may allow a 30 day extension in the limited situation where an Employee is mentally incapacitated and lacks an immediate adult family member who can make a timely election on his behalf.

If two Employees (the mother and father of the child(ren)) are covered under the Plan and the Employee who is covering the Dependent children terminates coverage, the Dependent coverage may be continued by the other covered Employee as long as the Dependent's coverage has been continuous. If the Employee is terminated, a "Change in Family Status" has occurred and the remaining employee may elect to continue the Dependent health coverage within 30 calendar days.

Grace Period for Deficient Documentation that was Timely Submitted - If the online enrollment and the required dependent verification documents are received by askHR within 30 calendar days of your date of hire, your newly eligible date (because of Special Enrollment or otherwise), or your status change date, as applicable, they are "timely" submitted. If the documentation is provided within the 30 day period, but it is deficient, an Employee will have a seven (7) calendar day grace period from the notification date by askHR to cure insufficient documentation. If the Employee does not return required documentation within the 7-calendar day grace period, the requested enrollment will be denied. If no documentation was not submitted within the initial 30 calendar day period, the 7 calendar day grace period will not apply.

SPECIAL ENROLLMENT RIGHTS

Federal law provides Special Enrollment provisions under some circumstances. If an Employee is declining enrollment for himself or his dependents (including his spouse, if a Class A Participant) because of other health insurance or group health plan coverage, there may be a right to enroll in this Plan if there is a loss of eligibility for that other coverage (or if the employer stops contributing towards the other coverage). However, unless a special time period is detailed below a request for enrollment must be made within 30 calendar days after the coverage ends (or after the employer stops contributing towards the other coverage).

In addition, in the case of a birth, marriage, adoption or placement for adoption, there may be a right to enroll in this Plan. However, a request for enrollment must be made within 30 calendar days of the birth, marriage, adoption or placement for adoption. For example: a newborn who is born on November 1 must be enrolled by November 30.

Special Enrollment Rights are available to a FPTNB/FTNB Employee who elects to receive an Hourly Pay Differential in lieu of participating in the Plan. In such a situation, a mid-year election change is permitted if a timely election is made.

The Special Enrollment rules are described in more detail below. To request Special Enrollment or obtain more detailed information of these portability provisions, contact askHR@fmolhs.org or call 1-833-482-7547.

SPECIAL ENROLLMENT PERIODS

The Enrollment Date for anyone who enrolls under a Special Enrollment Period is the first date of coverage. Thus, the time between the date a special enrollee first becomes eligible for enrollment under the Plan and the first day of coverage is not treated as a Waiting Period. A Special Enrollment Period is also provided to the extent required by IRC Section 9801 and the underlying regulations. To the extent required by law, the 30 day deadline period (or 60 day deadline period, if applicable) to request special enrollment under the tax law is determined by disregarding certain periods. The deadlines have a "tolling period" that ends on the earlier of one year from the date the original deadline for such Participant would have begun running or until 60 days after the end of the National Emergency declared by the Federal government due to the COVID 19 pandemic.

Individuals losing other coverage creating a Special Enrollment right. An Employee or Dependent who is eligible, but not enrolled in this Plan, may enroll if loss of eligibility for coverage is due to each of the following conditions listed below. Such coverage will be effective as of the later of the following dates: (i) first day of the month after a completed request for enrollment is received or (ii) the date immediately following the loss of the other coverage, if a completed enrollment form is received prior to the loss of the other coverage.

(a) The Employee or Dependent was covered under a group health plan or had health insurance coverage at the time coverage under this Plan was previously offered to the individual.

(b) If required by the Plan Administrator, the Employee stated in writing at the time that coverage was offered that the other health coverage was the reason for declining enrollment.

(c) The coverage of the Employee or Dependent who had lost the coverage was under COBRA and the COBRA coverage was exhausted, or was not under COBRA and either the coverage was terminated as a result of loss of eligibility for the coverage or because employer contributions towards the coverage were terminated.

(d) The Employee or Dependent requests enrollment in this Plan not later than 30 calendar days after the date of exhaustion of COBRA coverage or the termination of non-COBRA coverage due to loss of eligibility or termination of employer contributions, described above. Coverage will begin no later than the first day of the first calendar month following the date the completed enrollment form is received.

(e) For purposes of these rules, a loss of eligibility for purposes of these rules include, but is not limited to, the following:

(i) The Employee or Dependent has a loss of eligibility due to the plan no longer offering any benefits to a class of similarly situated individuals (i.e., part-time employees).

(ii) The Employee or Dependent has a loss of eligibility as a result of divorce, cessation of dependent status (such as attaining the maximum age to be eligible as a dependent child under the plan), death, termination of employment, or reduction in the number of hours of employment or contributions towards the coverage were terminated.

(iii) The Employee or Dependent has a loss of eligibility when coverage is offered through an HMO, or other arrangement, in the individual market that does not provide benefits to individuals who no longer reside, live or work in a service area, (whether or not within the choice of the individual).

(iv) The Employee or Dependent has a loss of eligibility when coverage is offered through an HMO, or other arrangement, in the group market that does not provide benefits to individuals who no longer reside, live or work in a service area, (whether or not within the choice of the individual), and no other benefit package is available to the individual.

If the Employee or Dependent lost the other coverage as a result of the individual's failure to pay premiums or required contributions, for cause (such as making a fraudulent claim or an intentional misrepresentation of a material fact in connection with the plan), or for failure to provide required documentation or information, that individual does not have a Special Enrollment right except to the extent permitted by Medicaid.

(2) **Dependent beneficiaries.** If:

(a) The Employee is a participant under this Plan (or is eligible to be enrolled under this Plan but for a failure to enroll during a previous enrollment period), and

(b) A person becomes a Dependent of the Employee through marriage, birth, adoption or placement for adoption,

then the Dependent (and if not otherwise enrolled, the Employee) may be enrolled under this Plan. In the case of the birth or adoption of a child, the Spouse of the covered Employee may be enrolled as a Dependent of the covered Employee if the Spouse is otherwise eligible for coverage. If the Employee is not enrolled at the time of the event, the Employee must enroll under this Special Enrollment Period in order for his eligible Dependents to enroll.

The Dependent Special Enrollment Period is a period of 30 calendar days and begins on the date of the marriage, birth, adoption or placement for adoption. To be eligible for this Special Enrollment, the Dependent and/or Employee must request enrollment during this 30-day period.

The coverage of the Dependent and/or Employee enrolled in the Special Enrollment Period will be effective:

(a) in the case of marriage, the first day of the month after a completed request for enrollment is received; or

(b) in the case of a Dependent's birth, as of the date of birth; or

(c) in the case of a Dependent's adoption or placement for adoption, the date of the adoption or placement for adoption.

Special Rules Effective April 1, 2009. A federal law provides an Employee and his Dependents with a special enrollment period if either of the following situations occurs and the Employee requests enrollment in the Plan within the time period specified below:

(a) the Employee or his Dependents loses coverage under a Medicaid plan or a State child health plan and the Employee requests coverage under this Plan within 60 days after the termination of the other coverage; or

(b) the Employee or his Dependents becomes eligible for assistance under this Plan under the Medicaid plan or a State child health plan and the Employee requests coverage under this Plan within 60 days after the Employee is determined to be eligible for assistance, in which case the enrollment will be effective as of the day following the loss of the Medicaid coverage.

EFFECTIVE DATE

Effective Date of Employee Coverage. An Employee will be covered under this Plan as of the first day that the Employee satisfies all of the following:

(1) The Eligibility Requirement.

(2) The Active Employee Requirement.

(3) The Enrollment Requirements of the Plan.

Active Employee Requirement. An Employee must be an Active Employee (as defined by this Plan) and not elect FPTNB/FTNB Employee status for this coverage to take effect.

Effective Date of Dependent Coverage. A Dependent's coverage will take effect on the day that the Eligibility Requirements are met; the Employee is covered under the Plan; and all Enrollment Requirements are met.

TERMINATION OF COVERAGE

The Employer or Plan has the right to rescind any coverage of the Employee and/or Retiree and/or Dependents for cause, making a fraudulent claim or an intentional material misrepresentation in applying for or obtaining coverage, or obtaining benefits under the Plan. The Employer or Plan may either void coverage for the Employee and/or covered Retirees and/or covered Dependents for the period of time coverage was in effect, may terminate coverage as of a date to be determined at the Plan's discretion, or may immediately terminate coverage. If coverage is to be terminated or voided retroactively for fraud or misrepresentation, the Plan will provide at least 30 calendar days' advance written notice of such action. The Employer will refund all contributions paid for any coverage rescinded if required by law; however, claims paid will be offset from this amount. The Employer reserves the right to collect additional monies if claims are paid in excess of the Employee's and/or Retiree's and/or Dependent's paid contributions.

When Employee Coverage Terminates. Employee coverage will terminate on the earliest of these dates (except in certain circumstances, a covered Employee may be eligible for Continuation Coverage. For a complete explanation of when Continuation Coverage is available, what conditions apply and how to select it, see the section entitled Continuation Coverage Rights):

(1) The date the Plan is terminated.

(2) The end of the pay period for which the employee is an eligible participant. This includes termination of Active Employment of the covered Employee.

(3) The end of the period for which the required contribution has been paid if the charge for the next period is not paid when due, in accordance with the ACA Employer Mandate Policy and/ or the Employer FMLA Policy, as applicable.

(4) To the extent permitted by the Patient Protection and Affordable Care Act, the date the Employee does not timely provide a complete and accurate response to an information request and/or audit inquiry of the Facility H.R. Department.

(5) With regard to a Class B Participant, the end of the pay period which includes the date that FMOLHS ceases to have a legal requirement to offer health insurance to certain variable hour employees in order to comply with the Affordable Care Act.

(6) With regard to a Class A Participant who experiences a gain of other coverage, FMOLHS coverage will terminate on the last day before the new coverage begins or the end of the pay period, whichever is later, based upon the Event being reported online and all required documents being received within 30 days of the event

Continuation During Periods of Employer-Certified Disability, Leave of Absence or Layoff. Subject to the requirements of the Patient Protection and Affordable Care Act, a person may remain eligible for a limited time if Active, eligible work ceases due to disability, leave of absence or layoff. This continuance will end as follows:

For disability leave only: the date the Employer ends the continuance.

For leave of absence (including FMLA, Non FMLA Medical Leave, Personal Leave, or any approved administrative leave) or layoff only: the date the Employer ends the continuance.

While continued, coverage will be that which was in force on the last day worked as an Active Employee. However, if benefits reduce for others in the class, they will also reduce for the continued person.

Special Rule for Continuation During Periods of Layoff As a Result of Participating in the System-wide Severance Policy: Notwithstanding the foregoing, a person may remain eligible for a limited time if Active, eligible work ceases and the person is laid off under the System-wide Severance Policy. Such laid off employee is entitled to continuation in accordance with the terms of the System-wide Severance policy. While continued, coverage will be that which was in force on the last day worked as an Active Employee. However, if benefits reduce for others in the class, they will also reduce for the Severed Participant. When the continuation period for the Severed Participant ends, the Severed Participant shall be entitled to receive continuation coverage rights to the extent there is any remaining period of continuation coverage. Coverage under System-wide Severance Policy and Continuation of Coverage run simultaneously, so that the post termination coverage provided by the Severance Policy shall not extend the continuation period.

Continuation During Family and Medical Leave. Regardless of the established leave policies mentioned above, this Plan shall at all times comply with the Family and Medical Leave Act of 1993 as promulgated in regulations issued by the Department of Labor.

During any leave taken under the Family and Medical Leave Act, the Employer will maintain coverage under this Plan on the same conditions as coverage would have been provided if the covered Employee had been continuously employed during the entire leave period.

If Plan coverage terminates during the FMLA leave, coverage will be reinstated for the Employee and his or her covered Dependents if the Employee returns to work in accordance with the terms of the FMLA leave. Coverage will be reinstated only if the person(s) had coverage under this Plan when the FMLA leave started, and will be reinstated when the employee returns to work to the same extent that it was in force when that coverage terminated. The continuation and reinstatement rules will be applied in accordance with the Employer FMLA Policy which is incorporated by reference.

Rehiring a Terminated Employee. If an individual is rehired within 30 calendar days, the Plan Administrator reserves the right to continue the prior benefit elections. If an individual who elected FPTNB/FTNB status for the Plan Year is rehired within 30 calendar days, his FPTNB/FTNB election will continue and he will not be permitted to make new benefit elections. See the Plan Administrator for application of these rules to your situation.

For purposes of the ACA, a terminated Employee who is rehired will be treated as a new hire and be required to satisfy all Eligibility and Enrollment requirements if the period of non-employment is at least 13 consecutive weeks, or is less than 13 consecutive weeks, but is longer than the period of employment immediately preceding the period of non-employment.

For rehired employees that are treated as continuing employees, the measurement and stability period that would have applied to the employee had the employee not experienced the period of non-employment would continue to apply upon the employee's resumption of service.

Employees on Military Leave. Employees going into or returning from military service may elect to continue Plan coverage as mandated by the Uniformed Services Employment and Reemployment Rights Act ("USERRA") under the following circumstances. These rights apply only to Employees and their Dependents covered under the Plan immediately before leaving for military service.

(1) The maximum period of coverage of a person under such an election shall be the lesser of:

(a) The 24 month period beginning on the date on which the person's absence begins; or

(b) The day after the date on which the person was required to apply for or return to a position of employment and fails to do so.

(2) A person who elects to continue health plan coverage is required to pay 102% of the full contribution under the Plan, except a person on active duty for 30 calendar days or less is required to pay 100% of the Employee's share, if any, for the coverage.

(3) An exclusion or Waiting Period may not be imposed in connection with the reinstatement of coverage upon reemployment if one would not have been imposed had coverage not been terminated because of service. However, an exclusion or Waiting Period may be imposed for coverage of any Illness or Injury determined by the Secretary of Veterans Affairs to have been incurred in, or aggravated during, the performance of uniformed service.

If the Employee wishes to elect this USERRA coverage or obtain more detailed information, contact the Plan's Continuation Coverage Administrator, Voya Financial at (833) 232-4673. The Employee may also have continuation rights under COBRA. In general, the Employee must meet the same requirements for electing USERRA coverage as are required under COBRA continuation coverage requirements. Coverage elected under these circumstances is concurrent not cumulative. The Employee may elect USERRA continuation coverage for the Employee and their Dependents. Only the Employee has election rights. Dependents do not have any independent right to elect USERRA health plan continuation.

When Dependent Coverage Terminates. A Dependent's coverage will terminate on the earliest of these dates (except in certain circumstances, a covered Dependent may be eligible for Continuation Coverage. For a complete explanation of when Continuation Coverage is available, what conditions apply and how to select it, see the section entitled Continuation Coverage Rights):

(1) The date the Plan or Dependent coverage under the Plan is terminated.

(2) The date that the Employee's coverage under the Plan terminates for any reason including death. (See the section entitled Continuation Coverage.)

(3) In the case of a Class A Plan Participant, the date a covered Spouse loses coverage due to loss of dependency status. (See the section entitled Continuation Coverage Rights.)

(4) On the first date that a Dependent child ceases to be a Dependent as defined by the Plan. (See the section entitled Continuation Coverage Rights.)

(5) The end of the period for which the required contribution has been paid if the charge for the next period is not paid when due, in accordance with the ACA Employer Mandate Policy and/ or the Employer FMLA Policy, as applicable.

(6) To the extent permitted by the Patient Protection and Affordable Care Act, the date the Employee does not timely provide a complete and accurate response to an information request and/or audit inquiry of the Facility H.R. Department.

(7) If a spouse or dependent have access to new coverage, the FMOLHS Health Plan will terminate on the date before new coverage begins or the end of the pay period, whichever is later based upon the event being reported online and all required documents being received within 30 days of the event.

When Retiree Coverage Terminates. A Retiree Participant's participation (and the participation of the Retiree Participant's covered Dependents) under the Plan shall end on the earliest of the following dates:

(1) With regard to an Our Lady of the Lake employee who retired under the LakeVet55 Plan:

(a) the last day of the month prior to the month in which the Retiree attains age 65;

(b) the date the Retiree dies;

(c) the January 1 next following the annual enrollment period during which the Retiree Participant elects to terminate his participation (and/or the participation of any covered Dependents) in the Plan;

(d) the date FMOLHS no longer offers coverage under the Plan to Retirees;

(e) the date the Plan terminates;

(f) the date the Retiree does not timely provide a complete and accurate response to an information request and/or audit inquiry by the Facility H.R. Department.

With regard to the Dependents of the LakeVet55 Retired participant:

(a) if the Retiree fails to pay any required contributions the date through which such required contributions are paid, as determined by the Plan Administrator;

(b) the last day of the month in which the Retiree attains age 66.5;

(c) the date the Retiree dies;

(d) the last day of the month during which the Retiree Participant's Spouse who is covered under the Plan attains age 65;

(e) the date the Plan terminates;

(f) the date the Retiree does not timely provide a complete and accurate response to an information request and/or audit inquiry by the Facility H.R. Department, or.

(g) the date the covered Dependent loses his status as a Dependent.

Once a Retiree Participant's participation in the Plan (and the participation of his covered Dependents) terminates under this Section, the Retiree (and his covered Dependents) shall not be permitted to become a Participant again.

(2) With regard to a retired participant from Our Lady of Lourdes and St. Francis Medical Center:

(a) the last day of the month in which the Retiree dies;

(b) the last day of the month in which the Retiree fails to pay any required contribution;

(c) the date the Plan or retiree coverage under the Plan terminates;

(d) the last day of the month before the Retiree becomes eligible for Medicare. (This applies to all retirees of St. Francis Medical Center and individuals who retire from Our Lady of Lourdes on and after February 1, 2006 and before February 1, 2007); and

(e) the date the Retiree does not timely provide a complete and accurate response to an information request and/or audit inquiry by the Facility H.R. Department.

(3) The rules for the St. Dominic retirees are detailed on page 7.

Rules with Transferring Employees. This Plan generally covers FMOLHS employees who work for various facilities within the FMOLHS controlled group. If you transfer to a different facility during the Plan Year, your health plan coverage will generally remain the same. You will not be permitted to select a different level of coverage.

Rules with Employees Who Change Their Status During The Plan Year. If you are a Class A Participant (who is not a FPTNB/FTNB Employee) and you change your employment status during the Plan Year, so that you switch from Full-Time to Part-Time or from Part-Time to Full-Time, the change is a qualifying event and would permit you to make a mid-yearchange in your Elections consistent with the status change. If you are a Class B Participant and you change your employment status to Full-Time or Part-Time, the change would also be a qualifying event which would permit you to make a mid-year change in your Elections (consistent with the status change). For a Participant who requests a change in coverage, the prior coverage will terminate on the last day of the pay period prior to the change in status if the online enrollment is completed within 30 calendar days of the change in status. FMOLHS will monitor job status changes and modify the rules in this policy as necessary to insure compliance with the PPACA based on current or subsequent guidance. If you have multiple status changes during the Plan Year (i.e., FT to PRN and back to FT), the Plan Administrator reserves the right to disregard status changes and continue the prior benefit elections. See the Plan Administrator for application of these rules to your situation.

Special Rules for FPTNB/FTNB Employees. If you elect to be a FPTNB/FTNB Employee for the Plan Year you can make a mid-year change if you experience a Special Enrollment Period under Code Section 9801(f). You cannot make a mid-year change if you experience a qualifying event that does not entitle you to Special Enrollment Rights.

OPEN ENROLLMENT

OPEN ENROLLMENT

Every year there is an open enrollment period (determined by the Employer), and Eligible Employees and their Eligible Dependents will be able to change some of their benefit decisions based on which benefits and coverage level are right for them. Benefit choices made during the open enrollment period will become effective and remain in effect until the next Plan Year unless there is a Special Enrollment event. In addition, a non-FPTNB/FTNB Employee can make a mid-year change if he incurs a change in family status during the year (birth, death, marriage, divorce, adoption, or certain job status changes or loss of coverage due to loss of a Spouse's employment). If a Covered Member is mentally incapacitated during the Open Enrollment period and lacks an immediate adult family who can make a timely election, the Employer may re-enroll the Covered Member in his existing coverage or similar coverage should there be plan changes.

The following categories of Covered Persons have a limited ability to participate in the Open Enrollment:

(1) Retirees of Our Lady of Lourdes, St. Francis Medical Center, Our Lady of the Lake and St Dominic; or

(2) Covered Persons on Continuation Coverage. If you are covered under the Plan as a result of electing Continuation Coverage, you do not participate in Open Enrollment. You cannot change your Plan and you cannot add additional family members to the Plan during Open Enrollment.

(3) Variable Hour Employees who qualify as PPACA FTE. If you are being offered coverage under the Plan because you qualify as a PPACA FTE, you can elect coverage for yourself and your non-spouse Dependents under the EPO Plan. You cannot elect coverage under the PPO Plan or HDHSA Plan and you cannot elect coverage for your Spouse under the EPO Plan, PPO Plan or HDHSA Plan.

Please contact askHR@fmolhs.org or call 1-833-482-7547 with open enrollment questions.

EXCLUSIVE PROVIDER ORGANIZATION (EPO)

The FMOLHS Customized Exclusive Provider Organization ("EPO") is a network of local Physicians, Hospitals and other health care providers established specifically to provide comprehensive medical services to Plan Participants at reduced rates. As a Participant in the Plan, you will have access to a list of providers that belong to the FMOLHS Customized EPO Network as stated in the Schedule of Benefits. It is the Participant's choice as to which provider to use.

If you choose the EPO network option, please follow the procedures for its use carefully. Except to the extent required by the No Surprises Act, there is no out of network coverage under the EPO network. When medical care is needed, be sure the provider is still under contract with the FMOLHS Customized EPO network shown on your ID card. When your doctor refers you to another provider, make sure that provider is also under contract with the FMOLHS Customized EPO network before services are rendered.

A current list of FMOLHS Customized EPO network providers is available free of charge for all locations for review through the website www.MyHealthToolkitLA.com/links/FMOLHS and by calling Member Services at (833) 468-3594. You may access these websites from home. If you have any questions about how to do this, please contact askHR@fmolhs.org or call 1-833-482-7547.

Each Participant has a free choice of any provider, and the Participant, together with his provider, is ultimately responsible for determining the appropriate course of medical treatment, regardless of whether the Plan will pay for all or a portion of the cost of such care. The FMOLHS Customized EPO network providers are independent contractors; neither the Plan nor the Plan Administrator makes any warranty as to the quality of care that may be rendered by any FMOLHS Customized EPO network provider.

PREFERRED PROVIDER ORGANIZATION (PPO)

The FMOLHS Customized Preferred Provider Organization ("PPO") is a network of local Physicians, Hospitals and other health care providers established specifically to provide comprehensive medical services to Plan Participants at reduced rates. As a Participant in the Plan, you will have access to a list of providers that belong to the FMOLHS Customized PPO network (called the "FMOLHS Providers (Tier 1)" and the "PPO Preferred Provider (Tier 2)" in the Schedule of Benefits). It is the Participant's choice as to which provider to use.

If you choose the in-network option, please follow the procedures for its use carefully. When medical care is needed, be sure the provider is still under contract with the FMOLHS Customized PPO network shown on your ID card. When your doctor refers you to another provider, make sure that provider is also under contract with the FMOLHS Customized PPO network before services are rendered.

A current list of FMOLHS Customized PPO network providers is available free of charge for all locations for review through the website www.MyHealthToolkitLA.com/links/FMOLHS and by calling Member Services at (833) 468-3594. You may access these websites from home. If you have any questions about how to do this, please contact askHR@fmolhs.org or call 1-833-482-7547.

Each Participant has a free choice of any provider, and the Participant, together with his provider, is ultimately responsible for determining the appropriate course of medical treatment, regardless of whether the Plan will pay for all or a portion of the cost of such care. The FMOLHS Customized PPO network providers are independent contractors; neither the Plan nor the Plan Administrator makes any warranty as to the quality of care that may be rendered by any FMOLHS Customized PPO network provider.

HIGH DEDUCTIBLE HSA PLAN

A High Deductible HSA Plan is a high deductible health plan combined with an employer/employee-funded account that reimburses employees for qualified medical expenses. The High Deductible Health Plan/HSA Option is only available to Class A Participants.

Aggregated Deductible - With an aggregate family deductible, the health plan doesn't begin paying for the health care expenses of anyone in the family until the entire family deductible has been met. Once the aggregate family deductible has been met, health insurance coverage kicks in for the entire family.
There are two ways the aggregate deductible can be met:

1. As each member of the family uses and pays for health care services, the amount they pay out-of-pocket for those services is credited toward the family's aggregate deductible. After several family members have paid deductible expenses, the combined total of those expenses reaches the aggregate deductible. The health plan then begins to pay the health care expenses of the entire family (either in full or with the coinsurance split that applies to the plan after the deductible is met).
2. One member of the family has high health care expenses. The amount he pays out-of-pocket for those expenses is large enough to meet the family's aggregate deductible. The health plan then begins to pay the health care expenses of the entire family.

Note: The only expenses your HDHP will count toward your aggregate deductible are expenses for covered health plan benefits.

Annual Employer Contributions - $750 individual; $1,500 family (any coverage level but employee) – Contributions are available January 1 of each plan year for members who enroll in the plan for an effective date of January 1. HSA contributions will be pro-rated on a monthly basis for new entrants (new hires; qualifying events) to the plan during any plan year.

Contribution Limits – The IRS places an annual limit on the maximum amount that can be contributed to HSA accounts. For 2024, employer and employee contributions cannot exceed the following amounts: $4,150 individual and $8,300 family. An additional catch-up contribution of $1,000 may be made by Participants who are age 55 or older. HSA contributions which exceed the annual limit are not tax deductible and are generally subject to a 6% excise tax.

Covered Expenses - The HSA can be used to pay "qualified medical expenses," which are amounts paid by a Covered Member for medical care as defined in IRC Section 213(d).

Order of Payment – A Covered Member may participate in the HSA as well as a limited use flexible spending account. Distributions are handled by Voya Financial in accordance with the rules established by Voya Financial.

Account Balances – The HSA is not an Employer-sponsored employee benefit plan. It is an individual account separately established and maintained outside the Plan. The Employer will forward HSA contributions to HSAs established with the Employer-approved HSA vendor but will not forward such contributions to HSAs established with any other trustees/custodians. The Plan Administrator will maintain records to track contributions to a Participant's HSA, but it will not create a separate fund or otherwise segregate assets for this purpose. The Employer has no authority or control over the funds deposited in an HSA.

Account Rollover – Unused HSA dollars at year-end automatically roll over to the next plan year.

Termination of Employment –HSA account balances are portable, meaning it will be available to you after you terminate employment, in accordance with the rules established by the federal tax laws and Voya Financial.

MEDICAL BENEFITS

Medical Benefits apply when Covered Charges are incurred by a Covered Person for care of an Injury or Sickness and while the person is covered for these benefits under the Plan.

DEDUCTIBLE

Deductible Amount. This is an amount of Covered Charges for which no benefits will be paid. Before benefits can be paid in a Calendar Year a Covered Person must meet the deductible shown in the Schedule of Benefits. If: (i) both parties in a marriage are Active Employees of the Employer and have coverage as Active Employees (and not as a Dependent) and (ii) one of the Active Employees terminates employment with the Employer, then the Active Employee who is continuing in employment with the Employer can add the terminated Active Employee to his coverage as a Dependent and if both the current and terminated Active Employee elected the same option under the Plan (EPO, PPO or HDHSA), amounts paid by the terminated Active Employee toward the Deductible and Out-Of-Pocket maximums in the Plan Year of the termination will be aggregated with the amounts paid by Active Employee who is continuing employment with the Employer.

BENEFIT PAYMENT

Each Calendar Year, benefits will be paid for the Covered Charges of a Covered Person that are in excess of the deductible. Payment will be made at the rate shown under reimbursement rate in the Schedule of Benefits.

ANNUAL MAXIMUM BENEFIT AMOUNT

The Annual Maximum Benefit Amount is unlimited for FMOLHS Health Plan.

COVERED CHARGES

Covered charges are the Usual and Reasonable Charges that are incurred for the following items of service and supply. These charges are subject to the benefit limits, exclusions and other provisions of this Plan. A charge is incurred on the date that the service or supply is performed or furnished.

(1) **Hospital Care.** The medical services and supplies furnished by a Hospital or Ambulatory Surgical Center. Covered charges for room and board will be payable as shown in the Schedule of Benefits. After 23 observation hours, a confinement will be considered an inpatient confinement.

Charges for an Intensive Care Unit stay are payable as described in the Schedule of Benefits.

(2) **Clinical Trials.** The Plan will pay for certain routine patient costs for items and services furnished in connection with participation in certain approved clinical trials that are offered by In-Network Providers or an Out of network Provider if the approved clinical trial is only offered outside the Covered Person's state of residence to the extent required by the Affordable Care Act. For this purpose an approved clinical trial is generally a Phase I, Phase II, Phase III or Phase IV clinical trial that is conducted in relation to the prevention, detection, or treatment of cancer or another life-threatening disease and which satisfies certain funding requirements. Please contact the Plan Administrator for more information.

(2) **Coverage of Pregnancy.** The Usual and Reasonable Charges for the care and treatment of Pregnancy are covered the same as any other Sickness for a covered Employee, covered Spouse or dependent.

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

may not, under Federal law, require that a provider obtain authorization from the plan or the issuer for prescribing a length of stay not in excess of 48 hours (or 96 hours.)

(3) **Skilled Nursing Facility Care.** The room and board and nursing care furnished by a Skilled Nursing Facility will be payable if and when:

(a) the patient is confined as a bed patient in the facility; and

(b) the attending Physician certifies that the confinement is needed for further care of the condition that caused the Hospital confinement; and

(c) the attending Physician completes a treatment plan which includes a diagnosis, the proposed course of treatment and the projected date of discharge from the Skilled Nursing Facility.

(4) **Physician Care.** The professional services of a Physician for surgical or medical services.

Charges for **multiple surgical procedures** will be a Covered Charge subject to the following provisions:

(a) If bilateral or multiple surgical procedures are performed by one (1) surgeon, benefits will be determined based on the Usual and Reasonable Charge that is allowed for the primary procedures; 50% of the Usual and Reasonable Charge will be allowed for each additional procedure performed through the same incision. Any procedure that would not be an integral part of the primary procedure or is unrelated to the diagnosis will be considered "incidental" and no benefits will be provided for such procedures;

(b) If multiple unrelated surgical procedures are performed by two (2) or more surgeons on separate operative fields, benefits will be based on the Usual and Reasonable Charge for each surgeon's primary procedure. If two (2) or more surgeons perform a procedure that is normally performed by one (1) surgeon, benefits for all surgeons will not exceed the Usual and Reasonable percentage allowed for that procedure; and

(c) If an assistant surgeon is required, the assistant surgeon's covered charge will not exceed 20% of the surgeon's Usual and Reasonable allowance. If a nurse practitioner performs as an assistant surgeon, the nurse practitioner's covered charge will not exceed 10% of the surgeon's Usual and Reasonable allowance.

(5) **Private Duty Nursing Care.** The private duty nursing care by a licensed nurse (R.N., L.P.N. or L.V.N.). Covered charges for this service will be included to this extent:

(a) **Inpatient Nursing Care.** Charges are covered only when care is Medically Necessary or not Custodial in nature and the Hospital's Intensive Care Unit is filled or the Hospital has no Intensive Care Unit.

(b) **Outpatient Nursing Care.** Charges are covered only when care is Medically Necessary and not Custodial in nature. The only charges covered for Outpatient nursing care are those shown below, under Home Health Care Services and Supplies. Outpatient private duty nursing care on a 24-hour-shift basis is not covered.

(6) **Home Health Care Services and Supplies.** Charges for home health care services and supplies are covered only for care and treatment of an Injury or Sickness when Hospital or Skilled Nursing Facility confinement would otherwise be required. The diagnosis, care and treatment must be certified by the attending Physician and be contained in a Home Health Care Plan.

(7) **Hospice Care Services and Supplies.** Charges for hospice care services and supplies, including Palliative and Supportive Care are covered only when the attending Physician has diagnosed the Covered Person's condition as being terminal, determined that the person is not expected to live more than six months and

placed the person under a Hospice Care Plan. Covered charges for Hospice Care Services/Supplies are payable as described in the Schedule of Benefits.

Hospice care must be furnished according to a written "hospice care program." A "hospice care program" is a coordinated program for meeting the special needs of the terminally ill Covered Person. It must be set up and reviewed periodically by the Covered Person's doctor.

Under a hospice care program, subject to all terms of this Plan, the Plan covers any services and supplies including prescription drugs, to the extent they are otherwise covered by this Plan. Services and supplies may be furnished on an inpatient and outpatient basis. If services and supplies are rendered in a home setting, such services and supplies will apply toward the Hospice benefit to the extent that they are included in the Hospice care program.

The services and supplies must be: (1) needed for palliative and supportive care; (2) ordered by the Covered Person's doctor; (3) included in the hospice care program; and (4) furnished by, or coordinated by a hospice. "Palliative and Supportive Care" means care and support aimed mainly at lessening or controlling pain or symptoms; it makes no attempt to cure the Covered Person's terminal illness.

The Plan does not pay for: (a) services and supplies provided by volunteers or others who do not regularly charge for their services; (b) funeral services and arrangements; (c) legal or financial counseling or services; (d) treatment not included in the hospice care plan; (e) services supplied to family members, other than the terminally ill Covered Person; or (f) counseling of any type which is for the sole purpose of adjusting to the terminally ill Covered Person's death.

(8) **Other Medical Services and Supplies.** Those services and supplies not otherwise included in the items above are covered as follows:

(a) Local Medically Necessary professional land or air **ambulance** service. A charge for this item will be a Covered Charge only if the service is to the nearest Hospital or Skilled Nursing Facility where necessary treatment can be provided unless the Plan Administrator finds a longer trip was Medically Necessary. The Plan does not pay for chartered air flights or travel or communication expenses of patient, doctors, nurses or family members.

(b) **Anesthetic**; oxygen; blood and blood derivatives that are not donated or replaced; intravenous injections and solutions. Administration of these items is included.

(c) **Applied Behavior Analysis (ABA) Therapy** - ABA Therapy will be covered for the diagnosis of Autism Spectrum Disorder if ordered by a physician/psychologist following prior authorization. Preapproval and coverage limits must be tied to the treatment plan. The treatment plan is designed and supervised by licensed BCBA practitioners; treatment is provided by a certified, licensed and qualified Registered Behavior Technician. Structured program with specific metrics and goals by which to track progress. Demonstrated effectiveness and significant progress required at 6-month intervals for continued coverage. Coverage limitations: Maximum 20 hours per week annually.

(d) **Bariatric surgery,** limited to Roux-en-Y Gastric Bypass (RYGB), Sleeve Gastrectomy, and Duodenal Switch (a) rendered by a FMOLHS Customized Tier 1 PPO Network Provider (Tier 1 providers are also in the EPO Network) b) at an FMOLHS MBSAQIP accredited Tier 1 network or owned facility (c) for an employee or spouse or dependent of an employee who satisfies the requirements detailed on Exhibit C attached to the end of this document and (d) in accordance with the requirements of Exhibit C. Bariatric Surgery coverage is limited to actively employed Full Time and Part Time (0.5 to 1.0 FTE) employees who are Class A Participants who have been employed and enrolled in the FMOLHS Health Plan for a minimum of one year, measured from the date of the pre-authorization of the surgery or the spouse or dependent of an employee who is a Class A Participant if such spouse or dependent has been enrolled in the FMOLHS Health Plan for a minimum of one year measured from the date of pre-authorization of the surgery and if such Class A Participant employee or their spouse or dependent continue to satisfy all requirements detailed in Exhibit C between the date of the pre-authorization and the date of the actual surgery and (e) the

surgery is not a complication of or a revision to a surgery performed prior to January 1, 2021 with exception of Medically Necessary revisions as covered under this Plan and in accordance with the requirements in Exhibit C.

(e) **Breast Pump** purchase is a Covered Charge for female health plan members up to 2 months prior to their own scheduled delivery date and up to 6 months (or later if breastfeeding and plan coverage has been continuous) following their own delivery.

(f) **Cardiac rehabilitation** as deemed Medically Necessary provided services are rendered (a) under the supervision of a Physician; (b) in connection with a myocardial infarction, coronary occlusion or coronary bypass surgery; (c) initiated within 12 weeks after other treatment for the medical condition ends; and (d) in a Medical Care Facility as defined by this Plan.

(g) Radiation or **chemotherapy** and treatment with radioactive substances. The materials and services of technicians are included.

(h) Effective March 18, 2020 through the end of the public health emergency, Charges incurred by a Participant or Retiree or their Dependents for the following items and services will be covered by the Plan without being subject to any cost-sharing requirements (including any deductible, copayments or coinsurance), prior authorization requirements or other medical management requirements: An in vitro diagnosis test (including serological tests to detect antibodies) as defined in section 809.3 of title 21, Code of Federal Regulations, (or its successor regulations) for the detection of SARS-CoV-2 or the diagnosis of COVID-19, and the administration of such a test, that:

- Is approved, cleared, or authorized under section 510(k), 513, 515 or 564 of the Federal Food, Drug, and Cosmetic Act (21 U.S.C. §§ 360(k), 360c, 360e, 360bbb-3);
- The developer has requested, or intends to request, emergency use authorization under section 564 of the Federal Food, Drug, and Cosmetic Act (21 U.S.C. 360bbb-3), unless and until the emergency use authorization request under such section 564 has been denied or the developer of such test does not submit a request under such section within a reasonable timeframe;
- Is developed in and authorized by a State that has notified the Secretary of HHS of its intention to review tests intended to diagnose COVID-19; or
- Other tests that the Secretary of HHS determines appropriate in formal written guidance.

Beginning January 15, 2022 through the end of the public health emergency, most FDA-authorized or approved at-home over-the-counter (OTC) COVID-19 tests will be covered under the FMOLHS Health Plan if purchased on or after January 15, 2022. A prescription or physician evaluation is not needed to obtain these at-home (OTC) tests. When you use your pharmacy benefit at a network pharmacy, each Covered Person can receive up to 8 at-home tests per calendar month at $0 member copay. (If kits contain 2 tests, then no more than 4 kits per calendar month.) If a Covered Person purchases a test through an online retailer that does not accept insurance (such as Amazon), you can submit a receipt for reimbursement to Express Scripts (ESI), our pharmacy benefit manager, for up to $12 per test.

(i) Rental of **durable medical or surgical equipment** if deemed Medically Necessary. These items may be bought rather than rented (purchase price limited to six-month rental fee), with the cost not to exceed the fair market value of the equipment at the time of purchase, but only if agreed to in advance by the Plan Administrator. Repair and replacement of Durable Medical Equipment is covered when the repairs, including the replacement of essential accessories are necessary to make the item/device serviceable; the physician provides documentation that the condition of the enrollee

changes; routine wear on the equipment renders it non-functional and the enrollee still requires the equipment

(j) **Enteral Feedings** – enteral nutrients, supplies and equipment if the patient is unable to digest or carry food to the small bowel to maintain weight and strength. Enteral nutrition may be given by a syringe, gravity, or a pump. An order (prescription) must be on file with the supplier, signed and dated by the treating physician.

(k) **Genetic Testing** – The following Genetic Testing will be covered based upon established medical necessity guidelines following prior authorization through BlueCross. Such genetic testing includes, but is not limited to BRCA1/BRCA2 (for Breast and/ovarian cancer) and counselling to prescribe risk-reducing medications, such as tamoxifen or raloxifene.

The following criteria must be met for the test to be considered **Medically Necessary**:

Test result must impact medical management of a current disease state OR;
The member displays clinical features of (the specific mutation in question) or is presymptomatic, but has a clear risk of inheritance (e.g., belongs to a high-risk group based on personal and/or family history of a genetic mutation.): AND
Definitive diagnosis is not established despite comprehensive workup.

Hereditary Cancer Next generation sequencing panels

- The Covered Member must have consultation with Genetic Services for risk assessment prior to insurance authorization.
- Testing will be ordered based on established medical necessity guidelines.
- Must be ordered by Genetic Services only.

Clinical Genetic Testing

- **'First tier' genetic testing- may be ordered by Genetic Services, Pediatric Neurology, or Pediatric Developmental specialist:**
  - Routine chromosome study (karyotype)
  - Chromosomal microarray
  - Fragile X molecular analysis
- **'Second tier' genetic testing- must be ordered by Genetic Services only**
  - Next generation sequencing panels other than oncology.
  - Exome/mitome sequencing tests.
  - Specific molecular analyses for disorders not identified by next generation sequencing or Exome testing disorders of methylation, etc.).

The following genomic testing may be ordered based upon established medical necessity guidelines following prior authorization:

Somatic Tumor Tissue Genomic Testing
Cytogenetics and Flow Cytometry in conjunction with bone marrow procedures/transplants.
Oncotype DX

(l) **Laboratory studies** deemed Medically Necessary and not otherwise excluded.

(m) Treatment of **Mental Nervous Disorders and Substance Abuse**. Covered charges for care, supplies and treatment of Mental Disorders and Substance Abuse will be limited as follows:

All treatment is subject to the benefit payment maximums shown in the Schedule of Benefits.

Psychiatrists (M.D.), Psychologists (Ph.D.), Licensed Professional Counselors (LPC) or Licensed Clinical Social Worker (LCSW) may bill the Plan directly. Unless otherwise prohibited by law, other licensed mental health practitioners must be under the direction of and must bill the Plan through these professionals.

(n) Injury to or care of **mouth, teeth and gums.** Charges for Injury to or care of the mouth, teeth, gums and alveolar processes will be Covered Charges under Medical Benefits only if that care is for the following oral surgical procedures:

Conditions arising from congenital anomaly.

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

Emergency surgical repair due to Injury to sound natural teeth.

Surgery needed to correct accidental injuries to the jaws, cheeks, lips, tongue, floor and roof of the mouth.

Excision of benign bony growths of the jaw and hard palate.

External incision and drainage of cellulitis.

Incision of sensory sinuses, salivary glands or ducts.

No charge will be covered under Medical Benefits for dental and oral surgical procedures involving removal of boney or non-boney impacted teeth, orthodontic care of the teeth, periodontal disease and preparing the mouth for the fitting of or continued use of dentures.

(o) **Occupational therapy** rendered by a licensed occupational therapist under the supervision of a physician as a result of Injury or Illness to improve a Functional Skill. Covered Charges do not include recreational programs, maintenance therapy or supplies used in occupational therapy. Functional improvement and measurable progress must be made toward achieving functional goals within a predictable period of time toward a Covered Member's maximum potential. Measurable progress emphasizes accomplishment of Functional Skills and independence in the context of the Covered Member's potential ability as specified within a care plan or treatment goals.

(p) **Organ transplant** limits. Charges otherwise covered under the Plan that are incurred for the care and treatment at a Blue Distinction Center due to a kidney, kidney/pancreas, pancreas, liver, heart, lung, heart/lung, small bowel and/or bone marrow or stem cell transplants for certain conditions are subject to these limits:

The transplant must be performed to replace a kidney, kidney/pancreas, pancreas, liver, heart, lung, heart/lung, small bowel and/or bone marrow or stem cell transplants
If the organ or tissue donor is a Covered Person and the recipient is not, then the Plan will cover donor organ or tissue charges for:
evaluating the organ or tissue;
removing the organ or tissue from the donor.

No transportation charges will be considered. The Plan will always pay secondary to any other coverage.

(q) The initial purchase, fitting and repair of **orthotic appliances** such as braces, splints or other appliances which are required for support for an injured or deformed part of the body as a result of a disabling congenital condition or an Injury or Sickness.

(r) **Physical therapy** rendered by a licensed physical therapist under the supervision of a physician as a result of Injury or Illness to improve a Functional Skill. Covered Charges do not include recreational programs, maintenance therapy or supplies used in physical therapy. Functional improvement and measurable progress must be made toward achieving functional goals within a predictable period of time toward a Member's maximum potential. Measurable progress emphasizes

accomplishment of Functional Skills and independence in the context of the Member's potential ability as specified within a care plan or treatment goals.

(s) **Plantar Fasciitis.** Physical therapy; steroid injections; purchase of initial night splint if prescribed by a physician and determined to be medically appropriate. Surgery will be considered after 12 month trial of conservative therapy.

(t) **Prescription** Drugs (as defined).

(u) Routine **Preventive Care.** Covered charges under Medical Benefits are payable for routine Preventive Care as described in the Schedule of Benefits.

(v) **Charges for Routine Well Adult Care.** Routine well adult care is care by a Physician that is not for an Injury or Sickness.

(w) **Charges for Routine Well Child Care.** Routine well child care is routine care by a Physician that is not for an Injury or Sickness.

(x) The initial purchase, fitting and repair of fitted **prosthetic devices** which replace body parts.

(y) **Reconstructive Surgery.** Breast reductions deemed Medically Necessary by the Plan, correction of abnormal congenital conditions and reconstructive mammoplasties will be considered Covered Charges.

This mammoplasty coverage will include reimbursement for:

(i) reconstruction of the breast on which a mastectomy has been performed,

(ii) surgery and reconstruction of the other breast to produce a symmetrical appearance, and

(iii) coverage of prostheses and physical complications during all stages of mastectomy, including lymphedemas,

in a manner determined in consultation with the attending Physician and the patient.

(z) Treatment and services for **Smoking Cessation aids** up to the maximum listed in the Schedule of Benefits for covered employee and/or spouse. Smoking Cessation aids are covered under the prescription drug benefits.

(aa) **Speech therapy** rendered by a licensed speech therapist under the supervision of a physician as a result of: (i) surgery for correction of a congenital condition of the oral cavity, throat or nasal complex of a person; (ii) an Injury; or (iii) an Illness that is other than a learning Disorder. Covered Charges do not include recreational programs, maintenance therapy or supplies used in speech therapy. Functional improvement and measurable progress must be made toward achieving functional goals within a predictable period of time toward a Covered Member's maximum potential. Measurable progress emphasizes accomplishment of Functional Skills and independence in the context of the Covered Member's potential ability as specified within a care plan or treatment goals.

(bb) **Surgical dressings**, splints, casts and other devices used in the reduction of fractures and dislocations.

(cc) **Telemedicine** involving the delivery of health care to a Participant when a Participant is not in the same physical location as his Provider. With telemedicine, health care is delivered through the use

of real time videos or by sending clinical information and/or picture images to the Participant's Provider for consultation, evaluation and/or treatment.

(dd) **Weight Loss Medication Benefit** provides coverage of generic weight loss medications through the FMOLHS Health Plan for employee members One weight loss medication will be authorized for a total of 12 weeks in a calendar year.

(ee) Coverage of **Well Newborn Nursery/Physician Care**.

(ff) **Charges for Routine Nursery Care.** Routine well newborn nursery care is care while the newborn is Hospital-confined after birth and includes room, board and other normal care for which a Hospital makes a charge. Routine nursery care is covered for the dependent of the Employee or Spouse.

(gg) Diagnostic **x-rays** as Medically Necessary.

UTILIZATION MANAGEMENT PROGRAM

PREAUTHORIZATION

Please refer to the Employee ID card for the Preauthorization and Member Service phone numbers.

When a Covered Person receives care from a Preferred or Non-Preferred Provider, the Provider is responsible for following the utilization management policies and procedures. If a Covered Person receives care from a Non-Network Provider, the Covered Person must comply with all of the policies and procedures of the utilization management program.

When a Covered Person receives care or intends to receive care from a Non-Network Provider, the Covered Person or family member or facility provider must call the number on the Plan ID card to notify Blue Cross of the services and receive certification of certain services in order for those services to be Covered under this Plan. This call must be made at least three (3) days in advance of services being rendered. If there is an Emergency admission to a Medical Care Facility, the Covered Person or someone on the Covered Person's behalf such as a family member, the Medical Care Facility or attending Physician, must contact the Claims Administrator within forty eight (48) hours after the admission. Notification must occur within 48 hours of admission to an acute inpatient facility or higher level of care. Failure to notify will result in a medical necessity review.

General Policies

Under all circumstances, the attending Physician bears the ultimate responsibility for the medical decisions regarding treatment of Covered Persons.

Benefits may be denied when using a Non-Network Provider if the Covered Person fails to call the Blue Cross Claims Administrator within the time deadlines set forth below:

- For a medical claim: at least three (3) days prior to an elective admission or outpatient surgery or procedure or, in the event of a Medical Emergency, within forty-eight (48) hours after the date of the Medical Emergency or as soon as reasonably possible. If the notification is provided after the 48 hour period expires, the Claims Administrator has the complete discretion to determine whether the delayed notice was provide as soon as "reasonably possible".

- For a Mental Health/Substance Abuse claim: within 48 hours after the date of the Medical Emergency or as soon as reasonably possible. If the notification is provided after the 48 hour period expires, the Claims Administrator has the complete discretion to determine whether the delayed notice was provide as soon as "reasonably possible".

If the Covered Person does not receive Preauthorization for Out-of-Network admissions, or acute inpatient or higher level of care, the benefit payment may be reduced by 50% if the services are deemed Medically Necessary by the Plan Administrator or by 100% if the services are not deemed Medically Necessary by the Plan Administrator. Note if the services are determined not to be Medically Necessary or otherwise not a Covered Charge, there will be no benefit payment under the Plan. Any reduced reimbursement due to failure to follow utilization management procedures will not accrue toward the Out-of-Pocket Maximum.

All Admissions and some Benefits require Preauthorization to determine the Medical Necessity. The Plan reserves the right to add or remove Benefits that are subject to Preauthorization. If Preauthorization is not obtained, Benefits may be reduced. Specific penalties are listed on the Schedule of Benefits. Preauthorization is obtained through the following procedures:

1. For all Admissions that are not the result of an Emergency Medical Condition, Preauthorization is granted or denied in the course of the Preadmission Review;

2. For all Admissions that result from an Emergency Medical Condition, Preauthorization is granted or denied in the course of the Emergency Admission Review;

3. For Admissions that are anticipated to require more days than approved through the initial review process, Preauthorization for additional days is granted or denied in the course of the Continued Stay Review;

4. For specific Benefits that require Preauthorization, Preauthorization is granted or denied in the course of the Preauthorization process; and,

5. For items requiring Preauthorization, the Claims Administrator must be called at the numbers given on the Identification Card which are listed below:

Medical Precertification: 888-376-6544;
Mental Health/Substance Abuse Precertification: 800-868-1032

Preauthorization means only that the Claims Administrator has determined that the Benefit is Medically Necessary. Preauthorization is not a guarantee of payment or a verification that Benefits will be paid or are available to the Covered Member. Notwithstanding Preauthorization, payment for Benefits is subject to a Covered Member's eligibility and all other limitations and exclusions contained in this Plan of Benefits. A Covered Member's entitlement to Benefits is not determined until the Member's claim is processed.

The Claims Administrator reserves the right to require documentation of Medical Necessity and/or Second Opinions prior to its Preauthorization of Covered Charges. Notwithstanding any review conducted by the Claims Administrator before the provision of a health care service, all benefits are subject to the terms and conditions of this Summary Plan Description/Plan Document.

OBTAINING PREAUTHORIZATION FOR VISITS TO OUT-OF-NETWORK PROVIDERS AT THE IN-NETWORK BENEFIT LEVEL

If a Physician feels that there is a need for a Covered Person to be seen by Physician or other medical Provider who does not participate in the network and that the services may be eligible for In-Network benefits, then the Physician must submit medical information to the Claims Administrator prior to the Covered Person receiving services. **Retroactive requests for consideration at the In-Network benefit level will not be considered.** Covered Charges from an Out-of-Network Provider are Preauthorized by the Claims Administrator for In-Network benefits only when the Claims Administrator does not have an In-Network Provider who can provide the service. The Physician must submit evidence that participating Plan Providers are unable to perform the requested services. The Claims Administrator has the right to determine where the services can be provided for Coverage when an In-Network Provider cannot render the service.

A Covered Person has the right to Appeal any utilization management program payment decision according to the Complaint and Appeal Procedures.

UTILIZATION REVIEW

Utilization review is a program designed to help insure that all Covered Persons receive necessary and appropriate health care while avoiding unnecessary expenses.

The program consists of:

(a) Preauthorization of Medically Necessary non-Emergency services before Mental Health/Substance Abuse, Medical and/or Surgical services are provided:

Refer to the Preauthorization Requirement List in the Schedule of Benefits. The attending Physician does not have to obtain Preauthorization from the Plan for prescribing a maternity length of stay that is forty-eight (48) hours or less for a vaginal delivery or ninety-six (96) hours or less for a cesarean delivery.

Note: The services above must be Preauthorized or reimbursement from the Plan may be reduced.

TO PREAUTHORIZE MEDICAL SERVICES CALL 888-376-6544.

TO PREAUTHORIZE MENTAL HEALTH/SUBSTANCE ABUSE SERVICES CALL 800-868-1032

(b) Retrospective review of whether the listed services provided on an Emergency basis were Medically Necessary;

(c) A review of the services that a member receives while admitted as inpatient for receipt of Covered Charges in order to certify that they continue to be Medically Necessary for the admission;

(d) Certification of services and planning for discharge from a Medical Care Facility or cessation of medical treatment; and

(e) Second Opinions, a medical opinion provided by a physician, with prior authorization, to assure that an elective surgical procedure is Medically Necessary.

The purpose of the program is to determine what charges may be eligible for payment by the Plan. This program is not designed to be the practice of medicine or to be a substitute for the medical judgment of the attending Physician or other health care Provider.

If a particular course of treatment or medical service is not certified/approved, it means that either the Plan will not pay for the charges or the Plan will not consider that course of treatment as appropriate for the maximum reimbursement under the Plan. The Covered Member is urged to find out why there is a discrepancy between what was requested and what was certified before incurring charges.

In order to maximize Plan reimbursements, please read the following provisions carefully.

Here's how the program works.

Pre-Service Requests for benefits (requests for benefits that require Preauthorization and are for services that have not yet been provided).

To make a pre-service request for benefits that will be provided by a Non-Network Provider or an In-Network Provider, the Covered Person should contact askHR@fmolhs.org and provide the following information:

- Patient: Name, birth date, address
- Supporting clinical documentation
- Employee or Retiree: Name, address, social security number
- Employer: Name, address
- Coverage type and group number
- Admitting diagnosis
- Proposed treatment/procedure
- Date and time of admission
- Estimated length of stay
- Admitting physician's name, specialty and office telephone number
- Hospital name, address and telephone number
- Supporting clinical information regarding the case requested

After the required information is received, the member will be notified of any additional information needed by the Plan to make its determination. The Plan will request additional information or will make its decision and notify the Provider within fifteen (15) days after it receives the request for benefits.

Urgent Care requests for benefits (requests for benefits related to services that the Covered Person or health care provider believes that the Covered Person's life, health or ability to regain maximum function is in immediate jeopardy, or for care that the treating Physician determines is urgent, or determines that a delay would subject the Covered Person to severe pain that could not be adequately managed without the treatment requested).

A Covered Person or provider may make an Urgent Care request for benefits by contacting the Claims Administrator. The Claims Administrator will make its decision and notify the Provider of that decision as quickly as possible, taking

into account medical exigencies, but in no event later than seventy-two (72) hours after it receives the request. In some cases, the Covered Person or the provider may not have provided the Claims Administrator with sufficient information to make a decision. If this is the case, the Claims Administrator will notify the provider of the additional information that it needs to make a determination. The Claims Administrator will give the provider a reasonable amount of time, to provide the information. As of the date required by law, the reference to "72 hours" shall be replaced with a reference to "24 hours."

Concurrent Stay Benefit Determinations

If a Covered Person is undergoing an approved course of treatment, and the Claims Administrator determines that the number or course of the treatment should be reduced or terminated and the Covered Person will be held financially responsible, the Claims Administrator will inform the Covered Person of its decision before the end of the approved course of treatment, so that the Covered Person has sufficient time to Appeal the decision to reduce or limit the treatment.

Notifications of Benefit Determinations

If the Claims Administrator denies a request for services in whole or in part, it will provide the Covered Person with a written explanation of the decision, including the specific reason that the request was denied, the Plan provision on which the denial was based, a description of any additional information that may be submitted and why the information is necessary, and a description of the Appeal procedures.

Admission/Continued Stay Review

In the event of an Emergency hospitalization or outpatient surgery or procedure, the Claims Administrator must be contacted within forty-eight (48) hours after the Medical Emergency or as soon as reasonably possible following the receipt of the services. If the notification is provided after the 48 hour period expires, the Claims Administrator has the complete discretion to determine whether the delayed notice was provide as soon as "reasonably possible".

If the Covered Person is being treated by a Network Provider, it is the responsibility of the attending Network Provider to contact the Claims Administrator.

If the Covered Person is being treated by a Non-Network Provider, it is the Covered Person's responsibility to contact the Claims Administrator. A friend or relative, the attending Physician, the Hospital, or anyone a Covered Person designates may contact the Claims Administrator.

If the Claims Administrator was contacted by the Covered Person or the Network Provider and the Emergency admission was not Medically Necessary, the Plan will not pay for the services.

In the event that a Covered Person wants to stay in the Hospital longer than authorized by the Claims Administrator, no further benefits will be treated as Covered Charges by the Plan.

If Medically Necessary, an extension of the number of days certified for Covered Charges will be approved. The provider is responsible for notifying the Claims Administrator prior to the last day of the Covered Member's certified stay, if an extension is recommended by the Covered Member's treating Physician. Based on information provided by the Covered Member's Physician, the Claims Administrator will certify or deny coverage for additional services. The Claims Administrator will inform the treating Provider(s), in writing, as to the number of additional days certified for coverage.

Second Opinions

The Claims Administrator may require a Second Opinion from a Physician of its choice, prior to authorizing coverage for an elective surgical procedure. There is no cost to the Covered Member for a Second Opinion. If the Second Opinion does not confirm the need for the proposed surgery, the Claims Administrator may require a third surgical opinion prior to authorization for coverage of the proposed surgery. The requirements for a Second Opinion do not apply to surgery involving Emergency medical conditions.

CASE MANAGEMENT

This additional health plan benefit consists of a comprehensive evaluation and assessment by a provider. In a collaborative role with the Physician and the Covered Member, the case manager will develop a mutually agreeable plan of care and advocate on behalf of the Covered Member

Complex/Intensive Case Management. The Claims Administrator strives for the early identification and effective management of selected Covered Members for whom intensive management can be expected to improve the quality of care and reduce overall medical expenses. The Complex Case Management Program offers special assistance to Covered Members with serious and complex, long-term medical needs and promotes quality of care to reduce the likelihood of extended, more costly health care. With regard to Medical Claims, the Claims Administrator identifies serious and complex medical conditions as ones that are persistent and substantially disabling or life-threatening and that require treatments and services across a variety of domains of care to ensure the best possible outcome for each unique Covered Member. Long-term medical needs are those that are more chronic than acute and can be expected to require extended use of health care resources.

Complex Case Management is a collaborative process which assesses, plans, implements, coordinates, monitors, and evaluates options and services to meet an individual Covered Member's health care needs through communication and available resources to promote quality, cost-effective outcomes.

Note: Case Management is a voluntary service. There are no reductions of benefits or penalties if the Covered Member and family choose not to participate.

Each treatment plan 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.

DEFINED TERMS

The following terms have special meanings and when used in this Plan will be capitalized.

Active Employee is an Employee who is on the regular payroll of the Employer and who has begun to perform the duties of his or her job with the Employer on a full-time or part-time basis or an as needed basis.

Administrative Appeal is an Appeal of a decision that has not been issued regarding Medical Necessity or medical appropriateness and is administrative in nature.

Adverse Benefit Determination is a denial of a request for service or a failure to provide or make payment in whole or in part for a benefit. An Adverse Benefit Determination based in whole or in part on a medical judgment also includes:

Any reduction or termination of a benefit;

The failure to cover services because they are determined to be Experimental or Investigational;

The failure to cover services because they are determined to be not Medically Necessary or inappropriate;

The failure to cover services because they are Cosmetic;

The failure to cover services because they involve out of area referrals;

The failure, reduction, or termination regarding the availability, delivery or quality of health care services;

The failure, reduction, or termination regarding claims payment, handling or reimbursement for health care services; and

The failure, reduction, or termination regarding terms of the contractual relationship between a Covered Member and the Plan.

Ambulatory Surgical Center is a licensed facility that is used mainly for performing outpatient surgery, has a staff of Physicians, has continuous Physician and nursing care by registered nurses (R.N.s) and does not provide for overnight stays.

Applied Behavior Analysis (ABA Therapy) is a systematic and structured behavioral health strategy for addressing challenging behavior problems often found in individuals with Autism Spectrum Disorders (ASD). Such challenging behavioral problems are culturally abnormal behaviors of such an intensity, frequency or duration that the physical safety of the individual or others is likely threatened, or, behavior which is likely to seriously limit the ability to participate in common social activities such as the educational system and in addition the individual may be denied access to, ordinary community facilities. The ABA approach relies on applying experimentally derived principles of behaviorism to modify behavior

Appeal is a request by a Covered Member or Covered Member's Authorized Representative for consideration of an Adverse Benefit Determination that a Covered Member believes he is entitled to receive.

Authorization/Prior Authorization/Preauthorization/Precertification refers to certain services that the Plan has given approval for payment or to be performed. Authorization does not guarantee payment if the Covered Person is not eligible for Covered Charges at the time the service is provided. Please refer to the Schedule of Benefits.

Authorized Representative is an individual authorized by a Covered Person or state law to act on behalf of the Covered Person in obtaining claim payment or during the Appeal process. A Provider may act on behalf of the Covered Person with the expressed consent of the Covered Person, or without the expressed consent of the Covered Person in emergent situations.

Bariatric Surgery is a Surgery on the stomach and/or intestines to help a person with extreme obesity lose weight. The covered benefit is limited to the following three covered procedures: (i) roux-en-gastric bypass, sleeve gastrectomy and duodenal switch performed in accordance with the requirements of Exhibit C.

Behavioral Disorder means any disease or condition, regardless of whether the cause is organic, that is classified as a Behavioral Disorder in the current edition of International Classification of Diseases, published by the U.S. Department of Health and Human Services or is listed in the current edition of Diagnostic and Statistical Manual of Behavioral Disorders, published by the American Psychiatric Association.

Blue Distinction Center means specifically identified providers who are contracted with the FMOLHS Health Plan's network for transplant services.

Brand Name means a trade name medication.

Breast Pump means an approved device used to extract milk from the breast of a lactating mother for purposes of feeding an infant.

Calendar Year means January 1st through December 31st of the same year.

Case Management means a systematic process performed by the Claims Administrator to do the following:

(i) identify high cost cases;

(ii) assess potential opportunities to coordinate care;

(iii) implement treatment plans that improve quality and control cost; and

(iv) manage total health care to promote optimum outcome.

Claims Administrator means the entity hired by the Plan Administrator to adjudicate claims under the Plan. The Medical Claims Administrator and the Mental Health/Substance Abuse Claims Administrator is Blue Cross 833-468-3594.

Class A Plan Participant is a Full-Time Active Employee, a Part-Time Active Employee or Retiree of the Employer who has elected coverage under the Plan.

Class B Plan Participant is a Variable Hour Employee (PRN) who (i) is an Active Employee, (ii) is not classified as a Full-Time or Part-Time Employee and (iii) satisfies the requirements under the Patient Protection and Affordable Care Act (PPACA) to be treated as a full-time employee under the PPACA (by regularly working 30 or more hours per week during the relevant measurement period) who is eligible for Employee coverage as of the first day of the stability period following the completion of the initial or standard measurement period, as applicable and has elected coverage under the Plan.

COBRA means the Consolidated Omnibus Budget Reconciliation Act of 1985, as amended.

Complaint is any expression of dissatisfaction expressed by a Covered Person or the Authorized Representative of a Covered Person regarding a health plan issue. A verbal Complaint is informational in nature and cannot be Appealed (e.g., a Complaint concerning long wait times at a Physician's office). A written Complaint is considered to be a Grievance.

Conservative Therapy for Plantar Fasciitis consists of physical therapy, rest/ice, nsaids prescribed by a physician, home exercise stretching, proper footwear, OTC shoe inserts (arch supports, heel lifts) or other foot orthotics.

Continuation Coverage Administrator means the entity hired by the Plan Administrator to assist with Continuation Coverage Administration. Voya Financial is the Continuation Coverage Administrator.

Continued Stay Review/Concurrent Review means a review of the services that a Covered Member received while admitted as inpatient for receipt of Covered Charges in order to certify the continued Medical Necessity of the admission.

Corporation is the Claims Administrator, Blue Cross.

Covered Charge(s) means those Medically Necessary services or supplies that

(i) are covered under this Plan,

(ii) are provided by or under the direction of a Physician or Other Professional Provider, acting within the scope of his license,

(iii) do not exceed

- **(a)** the usual, customary and reasonable fee in a locality within the geographical area in which the service or supply is rendered;
- **(b)** the specified fee schedule for Exclusive Provider Network services; or
- **(c)** the contracted rates (e.g., per diems, discounts, fee schedule costs), and

(iv) complies with the Ethical and Religious Directives for Catholic Health Care Services. The guidelines adopted by the Claims Administrator shall be used to determine whether the cost requirements of (iii) are satisfied.

Covered Member and or Person is an Employee, Retiree or Dependent that meets the eligibility criteria and that is covered under this Plan.

Custodial Care is care (including Room and Board needed to provide that care) that is given principally for personal hygiene or for assistance in daily activities and can, according to generally accepted medical standards, be performed by persons who have no medical training. Examples of Custodial Care are help in walking and getting out of bed; assistance in bathing, dressing, feeding; or supervision over medication which could normally be self-administered.

Dependent is defined in the Eligibility Section of the Plan.

Generic Diabetes Prescription Medication and Supplies include generic prescription medications, needles, syringes, lancets, testing strips and blood glucose testing monitors, which are Medically Necessary for the treatment of Type I, Type II, and gestational diabetes when purchase is made through an in-house pharmacy, network retail pharmacy or mail order program.

Durable Medical Equipment means equipment which (a) can withstand repeated use, (b) is primarily and customarily used to serve a medical purpose, (c) generally is not useful to a person in the absence of an Illness or Injury and (d) is appropriate for use in the home.

Emergency means the sudden onset of a medical condition manifesting itself by acute symptoms severe enough that the lack of immediate medical attention could reasonably be expected to result in any of the following:

(i) The patient's health would be placed in serious jeopardy;

(ii) Bodily function would be seriously impaired;

(iii) There would be serious dysfunction of a bodily organ or part.

Employee means any individual who is employed by an Employer and who is treated as a "common law" employee of the Employer, pursuant to the Employer's records, provided however that the term "Employee" shall not include any individual who is employed by Pinnacle Care Holdings, LLC regardless of whether such individual is later found to be a common law employee or a leased employee of an Employer. The term "Employee" shall also not include any individual who is considered a leased employee under Code § 414(n) or an independent contractor or who is subject to collective bargaining unless an agreement between the Employer and the collective bargained group specifies coverage of such individual.

Employer is the Franciscan Missionaries of Our Lady Health System, Inc. and its affiliated hospitals and subsidiaries who are listed as "**Facilities**" under the terms of the Plan.

Enrollment Date is the first day of coverage under the Plan.

Ethical and Religious Directives for Catholic Health Care Services shall mean the most recent standards and guidance developed by the Committee on Doctrine of the National Conference of Catholic Bishops and approved by the full body of bishops that reaffirms the ethical standards of behavior in health care that flow from the Catholic Church's teaching about the dignity of the human person and provides guidance and direction on moral issues that Catholic health care providers face today.

Experimental and/or Investigational means services, supplies, care and treatment for procedures or operations or complications thereto which do not constitute accepted medical practice properly within the range of appropriate medical practice under the standards of the case and by the standards of a reasonably substantial, qualified, responsible, relevant segment of the medical community or government oversight agencies at the time services were rendered.

The Plan Administrator must make an independent evaluation of the experimental/nonexperimental standings of specific technologies. The Plan Administrator shall be guided by a reasonable interpretation of Plan provisions. The decisions shall be made in good faith and rendered following a detailed factual background investigation of the claim and the proposed treatment. The decision of the Plan Administrator will be final and binding on the Plan. The Plan Administrator will be guided by the following principles:

(i) if the drug or device cannot be lawfully marketed without approval of the U.S. Food and Drug Administration and approval for marketing has not been given at the time the drug or device is furnished; or

(ii) if the drug, device, medical treatment or procedure, or the patient informed consent document utilized with the drug, device, treatment or procedure, was reviewed and approved by the treating facility's Institutional Review Board or other body serving a similar function, or if federal law requires such review or approval; or

(iii) if Reliable Evidence shows that the drug, device, medical treatment or procedure is the subject of on-going phase I or phase II clinical trials, is the research, experimental, study or Investigational arm of on-going phase III clinical trials, or is otherwise under study to determine its maximum tolerated dose, its toxicity, its safety, its efficacy or its efficacy as compared with a standard means of treatment or diagnosis; or

(iv) if Reliable Evidence shows that the prevailing opinion among experts regarding the drug, device, medical treatment or procedure is that further studies or clinical trials are necessary to determine its maximum tolerated dose, its toxicity, its safety, its efficacy or its efficacy as compared with a standard means of treatment or diagnosis.

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

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

Facilities means the entities listed below who are participating in the Plan:

- Franciscan Missionaries of Our Lady, North American Province, Inc.
- Franciscan Missionaries of Our Lady Health System, Inc.
- Franciscan Missionaries of Our Lady University

Family Unit is the covered Employee or Retiree and the family members who are covered as Dependents under the Plan and under the terms of the Retiree coverage (i.e., the only Dependent able to use St. Dominic retiree coverage is a Spouse).

Formulary means a list of prescription medications compiled by the third party payor of safe, effective therapeutic drugs specifically covered by this Plan.

Full/Part Time No Benefits Employee or **FPTNB/FPTNB Employee** means a Full-Time Active Employee working in a clinical position which is classified as a FPTNB/FTNB category for the Plan Year and who has made an election to receive an Hourly Pay Differential in lieu of participating in the Plan. Note: A FPTNB Employee can include a Part-Tiem Active Employee. Unless a FPTNB/FTNB Employee incurs a Special Enrollment Period under Code Section 9801(f), such FPTNB/FTNB Employee will be ineligible to participate in the Plan for the Plan Year Such FPTNB/FTNB Employee shall not be treated as a Class A Participant. The FPTNB Employee is a closed employee type as of 12/31/21 resulting in no new entry.

Functional skills are defined as essential activities of daily life common to all Covered Members such as dressing, feeding, swallowing, mobility, transfers, final motor skills, and communication.

Generic drug means a Prescription Drug which has the equivalency of the brand name drug with the same use and metabolic disintegration. This Plan will consider as a Generic drug any Food and Drug Administration approved generic pharmaceutical dispensed according to the professional standards of a licensed pharmacist and clearly designated by the pharmacist as being generic.

Genetic Information means information about genes, gene products and inherited characteristics that may derive from an individual or a family member. This includes information regarding carrier status and information derived from laboratory tests that identify mutations in specific genes or chromosomes, physical medical examinations, family histories and direct analysis of genes or chromosomes.

Genetic Testing is a type of medical test that identifies changes in chromosomes or genes (deleted 'proteins'). The results of a genetic test can confirm or rule out a suspected genetic condition, help determine a person's chance of developing or passing on a genetic disorder, inform treatment decisions, or provide molecular profiling to guide cancer treatment.

Genetic Services includes Geneticists and/or Certified Genetic Counselors.

Grievance is a written Complaint submitted by or on behalf of a Covered Member regarding any of the following items concerning a Mental Health/Substance Abuse Claim:

Availability, delivery or quality of Covered Charges, including a Complaint regarding an adverse determination made pursuant to utilization review; or

Claims payment, handling or reimbursement for Covered Charges; or

Matters pertaining to the relationship between a Covered Member and the Plan.

Depending on the nature of the Grievance, the Plan will handle the Grievance as a Complaint, Pre-Service Appeal, Post-Service Appeal, or Urgent Care Appeal. See the "**Claims Review Procedure**" section for additional information regarding the resolution of Complaints and Grievances.

Health Savings Account (HSA Account) means a separate account established and maintained outside the Plan. The HSA Account is funded by Employer and employee contributions.

Healthy Lives are free services offered to Covered Employees and their Covered Spouse that includes personalized health assessment, special programs to help manage a chronic illness, access to personalized health coaching services, and the opportunity to earn incentives for achieving health goals. Covered Dependents may access personalized health coaching services.

High Deductible Health Plan means a health plan with higher deductible and out of pocket limits that satisfies certain requirements of the federal tax law.

Home Health Care Agency is an organization that meets all of these tests: its main function is to provide Home Health Care Services and Supplies; it is federally certified as a Home Health Care Agency; and it is licensed by the state in which it is located, if licensing is required.

Home Health Care Plan must meet these tests: it must be a formal written plan made by the patient's attending Physician which is reviewed at least every thirty (30) days; it must state the diagnosis; it must certify that the Home Health Care is in place of Hospital confinement; and it must specify the type and extent of Home Health Care required for the treatment of the patient.

Home Health Care Services and Supplies include: part-time or intermittent nursing care by or under the supervision of a registered nurse (R.N.); part-time or intermittent home health aide services provided through a Home Health Care Agency (this does not include general housekeeping services); physical, occupational and speech therapy; medical supplies; and laboratory services.

Hospice Agency is an organization where its main function is to provide Hospice Care Services and Supplies and it is licensed by the state in which it is located, if licensing is required.

Hospice Care Plan is a plan of terminal patient care that is established and conducted by a Hospice Agency and supervised by a Physician.

Hospice Care Services and Supplies are those provided through a Hospice Agency and under a Hospice Care Plan and include inpatient care in a Hospice Unit or other licensed facility, home care, and family counseling during the bereavement period.

Hospice Unit is a facility or separate Hospital Unit that provides treatment under a Hospice Care Plan and admits at least two unrelated persons who are expected to die within six (6) months.

Hospital is an institution which is engaged primarily in providing medical care and treatment of sick and injured persons on an inpatient basis at the patient's expense and which fully meets these tests: it is accredited as a Hospital by the Joint Commission on Accreditation of Healthcare Organizations or the American Osteopathic Association Healthcare Facilities Accreditation Program; it is approved by Medicare as a Hospital; it maintains diagnostic and therapeutic facilities on the premises for surgical and medical diagnosis and treatment of sick and injured persons by or under the supervision of a staff of Physicians; it continuously provides on the premises 24-hour-a-day nursing services by or under the supervision of registered nurses (R.N.s); and it is operated continuously with organized facilities for operative surgery on the premises.

The definition of "Hospital" shall be expanded to include the following:

(i) A facility operating legally as a psychiatric Hospital or residential treatment facility for mental health and licensed as such by the state in which the facility operates.

(ii) A facility operating primarily for the treatment of Substance Abuse if it meets these tests: maintains permanent and full-time facilities for bed care and full-time confinement of at least 15 resident patients; has a Physician in regular attendance; continuously provides 24-hour a day nursing service by a registered nurse (R.N.); has a full-time psychiatrist or psychologist on the staff; and is primarily engaged in providing diagnostic and therapeutic services and facilities for treatment of Substance Abuse.

Illness means a bodily disorder, disease, physical sickness or Mental Disorder. Illness includes Pregnancy, childbirth, miscarriage or complications of Pregnancy.

Infertility means the inability of a woman to conceive or carry to term a Pregnancy.

Injectables are prescription medications injected by or under the direct supervision of a Physician. Self-Injectables are medications that are injected by the patient.

Injury means an accidental physical Injury to the body caused by unexpected external means.

Inquiry refers to any question from a Covered member or the Covered Member's Authorized Representative that is not a Pre-Service Appeal, a Post-Service Appeal or an Urgent Care Appeal, or Complaint.

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

Maintenance Therapy refers to rehabilitative services and associated expenses designed primarily to be long-term, with no significant medical improvement to the patient being reasonably expected as determined by the Primary Care Physician or Medical Director.

Medical Care Facility means a Hospital, a facility that treats one or more specific ailments or any type of Skilled Nursing Facility.

Medical Emergency means a medical condition manifesting itself by a sudden and unexpected onset of acute symptoms of sufficient severity that in the absence of immediate medical attention could reasonably be expected to result in death or serious harm to bodily functions.

Medically Necessary/Medical Necessity means care and treatment that is recommended or approved by a Physician; is consistent with the patient's condition or accepted standards of good medical practice; is medically proven to be effective treatment of the condition; is not performed mainly for the convenience of the patient or provider of medical services; is not conducted for research purposes; and is the most appropriate level of services which can be safely provided to the patient.

All of these criteria must be met; merely because a Physician recommends or approves certain care does not mean that it is Medically Necessary.

The Plan Administrator has the discretionary authority to decide whether care or treatment is Medically Necessary.

Medical Necessity Appeal is an Appeal of a determination by the Plan or its designed utilization review organization that is based in whole or in part on a medical judgment that includes an admission, availability of care, continued stay or other service which has been reviewed and, based on the information provided, does not meet the Plan's requirements for Medical Necessity, appropriateness, health care setting, level of care or effectiveness and payment for the service is denied, reduced or terminated.

Medicare is the Health Insurance For The Aged and Disabled program under Title XVIII of the Social Security Act, as amended.

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

Mental Retardation means the onset in a Plan Participant before age 18 of significant sub-average intelligence (i.e., an I.Q. below 70) associated with deficits in the function of others of like age and/or appropriate behavior.

Morbid Obesity is a diagnosed condition in which the body weight exceeds the medically recommended weight by either 100 pounds or is twice the medically recommended weight for a person of the same height, age and mobility as the Covered Person.

Nanometrics refers to Nanometric-based therapeutics that are products that use ultra-small (Nanometric/molecular-sized) electronic or mechanical devices.

Network Provider/In-Network Provider means any health care Provider that has entered into an agreement with the Claims Administrator to furnish Covered Charges to Covered Persons.

No-Fault Auto Insurance is the basic reparations provision of a law providing for payments without determining fault in connection with automobile accidents.

Non-Participating Pharmacy is a Pharmacy who has no direct or indirect written agreement with the Plan to provide Covered Charges to Covered Members.

Orthotic Appliances and Prosthetic Devices refer to Orthotic Appliances that correct a defect of a body form or function and to Prosthetic Devices that aid body functioning or replace a limb or body part.

Out of Area Coverage. A subscriber (team member) who is enrolled in the PPO Plan and whose home address is in a state other than Louisiana or Mississippi may (i) access care at Tier 2 network coverage with a BCBS PPO network provider in their home state for themselves and their enrolled dependents and (ii) access providers in the FMOLHS Louisiana and Mississippi networks at Tier 1 or Tier 2 coverage. Any other network access would follow the Tier 3 or Tier 4 coverage. The Out of Area Coverage is based solely on the subscriber's (team member's) home address. A

dependent's home address is not relevant to determine whether the Out of Area Coverage option is available to the dependent. Out of Area Coverage is not available under the High deductible HSA Plan or the EPO.

Out-of-Pocket Maximum means the limit on the amount a Covered Member and Covered Dependents must pay out of their pocket for specified Covered Charges in a Plan Year. It does not include the $3,000 Bariatric Surgery copay, cost containment penalties and Above Usual & Customary charges fees.

Outpatient Care and/or Services is treatment including services, supplies and medicines provided and used at a Hospital under the direction of a Physician to a person not admitted as a registered bed patient; or services rendered in a Physician's office, laboratory or X-ray facility, an Ambulatory Surgical Center, or the patient's home.

Partial Hospitalization is an outpatient program specifically designed for the diagnosis or active treatment of a Behavioral Disorder or Substance Abuse when there is reasonable expectation for improvement or when it is necessary to maintain a Covered Member's functional level and prevent relapse; this program shall be administered in a psychiatric facility which is accredited by the Joint Commission on Accreditation of Health Care Organizations and shall be licensed to provide partial hospitalization services, if required, by the state in which the facility is providing these services. Treatment lasts less than twenty-four (24) hours, but more than four (4) hours, a day and no charge is made for room and board.

Patient Protection and Affordable Care Act (PPACA) means the federal law, P.L. 111-148.

Pharmacy means a licensed establishment where covered Prescription Drugs are filled and dispensed by a pharmacist licensed under the laws of the state where he or she practices.

Physician means a Doctor of Medicine (M.D.), Doctor of Osteopathy (D.O.), Doctor of Podiatry (D.P.M.), Psychiatrist, Psychologist (Ph.D.), acting within the scope of his or her license and professional training.

Plan means the FMOLHS Health Plan, which is a health benefit plan for certain Employees of Franciscan Missionaries of Our Lady Health System, Inc. and its affiliated and subsidiary hospitals as described in this document. The Plan is and has been a church plan as described in Code Section 414(e) and ERISA Section 3(33) since inception and no election has been made under Code Section 410(d) to be subject to ERISA and therefore, the Plan is exempt from Title I and Title IV of ERISA and certain provisions of the Code. The Plan Sponsor, the Employers and the Administrator are controlled by and associated with the Roman Catholic Church and take direction from the Roman Catholic Church.

Plan Administrator means the Committee appointed by the FMOLHS Board, the principal purpose of which is to maintain and administer the Plan according to its terms, consistent with the teachings and tenets of the Roman Catholic Church.

Plan Participant any Employee, Retiree or Dependent that meets eligibility criteria and who is covered under this Plan. The Plan has two categories of Plan Participants: A Class A Plan Participant is a Full-Time Active Employee who is not working in a FPTNB/FTNB status, a Part-Time Active Employee who is not working in a FPTNB status or a Retired Employee of the Employer who satisfies the eligibility requirements detailed in the Plan's Eligibility Section and elected coverage under the Plan. A Class B Plan Participant is limited to a Variable Hour Employee who satisfies the requirements in the Plan's Eligibility Section and elected coverage under the Plan. A reference to a Plan Participant shall include a Class A Plan Participant and a Class B Plan Participant except where specifically noted otherwise.

Plan Year is the 12-month period beginning on January 1 and ending December 31.

Post-Service Appeal is an Appeal for which an Adverse Benefit Determination has been rendered for a service that has already been provided.

PPACA FTE is a Variable Hour Employee who routinely works 30 or more hours per week during the initial or standard measurement period, as applicable.

A **Pre-Existing Condition** is a condition for which medical advice, diagnosis, care or treatment was recommended or received within three months prior to the person's Enrollment Date under this Plan (e.g. the three month look back

period for an Enrollment Date of August 15 is May 15 through August 14). Genetic Information is not a condition. Treatment includes receiving services and supplies, consultations, diagnostic tests or prescribed medicines. In order to be taken into account, the medical advice, diagnosis, care or treatment must have been recommended by, or received from, a Physician. The Pre-Existing Condition does not apply to any Covered Person after December 31, 2013.

Pregnancy is childbirth and conditions associated with Pregnancy, including complications.

Premium is the monthly fee required from each Coverer Person in accordance with the terms of the Plan.

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

Pre-Service Appeal is an Appeal for which an Adverse Benefit Determination has been rendered for a service that has not yet been provided and requires Prior Authorization.

Preventive/Wellness Screenings are preventive screenings as identified by United States Preventive Services Task Force and may be subject to age and other limitations.

Provider/Provider Network refers to a Physician, Hospital, SNF, Home Health Care Agency, hospice, pharmacy, podiatrist, or other health care institution or practitioner, licensed, certified or otherwise authorized pursuant to the law of the jurisdiction in which care or treatment is received. Optometrists are not participating providers in the medical plan

Reconstructive Surgery is any surgery which is incidental to an Injury, Illness, or congenital anomaly when the primary purpose is to restore normal physiological functioning of the involved part of the body. (A congenital anomaly is a defective development or formation of a part of the body, when such defect is determined by the treating Physician to have been present at the time of birth.) For the purpose of Coverage under the Plan, Reconstructive Surgery on the opposite breast to restore symmetry, including Prosthetic Devices/implants or reduction mammoplasty, is included in this definition.

Revisional Bariatric Surgery is a surgery that is performed after a prior bariatric surgery for severe obesity and involves one of the following: (a) Conversion: a change from one type of procedure to a different type; (b) Corrective: a procedure that attempts to remedy complications or incomplete treatment effects of a previous bariatric surgery; or (c) Reversal: a procedure that restores the original anatomy. The covered benefit for a revisional bariatric surgery is in accordance with the requirements of Exhibit C.

Retired Employee is (a) a former Active Employee of Our Lady of Lourdes who retired prior to February 1, 2007 who elected to continue the health Plan coverage and to pay the required contributions (b) a retired employee of Our Lady of the Lake who elected to participate in the LakeVet55 Plan by April 16, 2001, or (c) a Employee who retired from St. Francis Medical Center prior to July 1, 2006 and elected to continue the health Plan coverage and to pay the required contributions or (d) an Employee of St. Dominic who qualified as an Early Retiree or Disabled Retiree (as defined by the Retirement Plan for Employees of St. Dominic Health Services Inc.) as of 12.31.2019 and elected to continue the health Plan coverage and pay the required contributions.

Schedule of Benefits is the chart of Covered Charges set forth in the Plan.

Second Opinion means a medical opinion provided by a physician, with prior authorization, to assure the medical necessity of an elective surgical procedure.

Self-Administered Injectable Drugs means Injectable Prescription Drugs that are commonly and customarily administered by the Covered Person. Examples of Self-Administered Injectable Drugs include but are not limited to the following: multiple sclerosis agents, growth hormones, colony stimulating factors given more than once monthly, chronic medications for hepatitis C, certain rheumatoid arthritis medications, certain Injectable HIV drugs, certain osteoporosis agents, and heparin products. Self-Administered Injectable Drugs are obtained from a Specialty

Pharmacy. The following are not considered Self-Administered Injectable Drugs because they are not obtained from a Specialty Pharmacy: insulin, glucagon, bee sting kits, and Imitrex.

Serious Illegal Act means any act or series of acts that, if prosecuted as a criminal offense, a sentence to a term of imprisonment in excess of one year could be imposed. It is not necessary that criminal charges be filed, or, if filed, that a conviction result, or that a sentence of imprisonment for a term in excess of one year be imposed for an act to be categorized as an illegal act. Proof beyond a reasonable doubt is not required.

Sickness is a person's Illness, disease or Pregnancy (including complications).

Skilled Nursing Facility is a facility that fully meets all of these tests:

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

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

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

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

(v) It has an effective utilization review plan.

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

(vii) It is approved and licensed by Medicare.

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

Smoking Cessation Aids include nicotine patch, gum, inhaler, lozenges, nasal spray, and prescription medications approved by the FDA. The program does not cover hypnosis, acupuncture, laser therapy, filters, herbs, and supplements.

Special Enrollment Period is the period set forth in the "Eligibility, Funding, Effective Date and Termination Provisions" section of this SPD.

Specialist is a Physician who provides Covered Charges to Covered Members within the range of a medical specialty.

Specialty Pharmacy means a pharmacy that has a contract with the Claims Administrator, and is designated as a Specialty Pharmacy by the Claims Administrator for Covered Persons to obtain Self-Administered Injectable Drugs.

Spinal Manipulation/Chiropractic Care means skeletal adjustments, manipulation or other treatment in connection with the detection and correction by manual or mechanical means of structural imbalance or subluxation in the human body. Such treatment is done by a Physician to remove nerve interference resulting from, or related to, distortion, misalignment or subluxation of, or in, the vertebral column.

Spouse means a person who is married to a Participant as a result of a legal ceremony which is recognized by the State of Louisiana. For purposes of this Plan, a "Spouse" will not result from a common law marriage. A Class B Plan Participant cannot elect coverage for a Spouse.

Substance Abuse is regular excessive compulsive drinking of alcohol and/or physical habitual dependence on drugs. This does not include dependence on tobacco and ordinary caffeine-containing drinks.

Telemedicine, frequently referred to as Telehealth, is the use of electronic technologies to provide and support health care services when distance separates the physician and patient. Telemedicine services are medical services provided via telephone, the Internet or other communications networks or devices that do not involve direct in-person patient contact. There are applicable federal and state regulations governing the practice of telemedicine.

The FDA has defined the term 'telemedicine' as the delivery and provision of healthcare and consultative services to individual patients, and the transmission of information related to care, over distance, using telecommunications technologies, and incorporating:

- Direct clinical, preventive, diagnostic, and therapeutic services and treatment;
- Consultative and follow-up services;
- Remote monitoring;
- Rehabilitative services; and
- Patient education.

"Telehealth" services are live, interactive audio and visual transmissions of a physician-patient encounter from one site to another using telecommunications technologies. These services may include transmissions of real-time telecommunications or those transmitted by store-and-forward technology.

Temporomandibular Joint (TMJ) syndrome is the treatment of jaw joint disorders including conditions of structures linking the jaw bone and skull and the complex of muscles, nerves and other tissues related to the Temporomandibular Joint.

Total Disability (Totally Disabled) means: In the case of a Dependent child, the complete inability as a result of Injury or Sickness to perform the normal activities of a person of like age and gender in good health.

Urgent Care Appeal is an Appeal that must be reviewed under an expedited Appeal process because the application of non-Urgent Care Appeal time frames could seriously jeopardize:

- The life or health of the Covered Member; or
- The Covered Member's ability to regain maximum function.

In determining whether an Appeal involves Urgent Care, the Plan must apply the judgment of a prudent layperson who possesses an average knowledge of health and medicine.

- An Urgent Care Appeal also is an Appeal involving;
- Care that the treating Physician deems urgent in nature; or
- The treating Physician determines that a delay in the care would subject the Covered Member to severe pain that could not be adequately managed without the care or treatment that is being requested.

Urgent Care Services refers to when a condition that requires care is an unexpected Illness or Injury that requires prompt medical attention. Examples of Urgent Care conditions include fractures, lacerations, or severe abdominal pain. These conditions may also constitute an Emergency in those situations that would lead a prudent layperson, possessing an average knowledge of health and medicine, to believe immediate medical care is required.

Urgent Care Services received while a Covered Member is outside of the service area are Covered Charges when the Urgent Care Services are provided for an Emergency.

If a condition requiring Urgent Care develops, a Covered Member may go to the nearest network Urgent Care center or Physician's office. The Plan will provide Covered Charges for a condition requiring Urgent Care that occurs when the Covered Member is out of the state under the following conditions:

The Covered Member's medical condition does not permit the Covered Member's return to the service area for treatment; and
The reason for being outside the service area is for some purpose other than the receipt of treatment for a medically related condition.

Usual and Customary Charge is a charge which is not higher than the usual charge made by the provider of the care or supply and does not exceed the usual charge made by most providers of like service in the same area. This test will consider the nature and severity of the condition being treated. It will also consider medical complications or unusual circumstances that require more time, skill or experience. The Plan will reimburse the actual charge billed if it is less than the Usual and Customary Charge. The Plan Administrator has the discretionary authority to decide whether a charge is Usual and Customary.

Variable Hour Employee is a PRN employee who works on an as needed basis.

Weight Management Medications are medications provided through a structured Weight Management program that can reduce comorbidities such as diabetes and heart disease caused by obesity. The medication coverage is limited to the generics Phentermine and Benzphetamin.

PLAN EXCLUSIONS

Note: All exclusions related to Prescription Drugs are shown in the Prescription Drug Plan.

For all Medical Benefits shown in the Schedule of Benefits, a charge for the following is not covered:

(1) Any medical services that conflict with the Ethical and Religious Directives for Catholic Health Services or the teaching of the Catholic Church.

(2) ADD/HD Testing.

(3) Alcohol or Drug Impairment Services, supplies, care or treatment to a Covered Person in connection with any injury resulting from or for which a contributing cause was the impairment or intoxication of such person from drugs or alcohol or resulting from the individual's being influenced by drugs, alcohol or any controlled substance, drug, hallucinogen, or narcotic that was not taken or administered on the advice of a Physician, including driving while under the influence of such drug(s). A police officer's or treating Provider's determination that the Covered Member was functioning under the influence of such drug(s) when the Injury was sustained will be sufficient evidence for this Exclusion to apply. The impairment, intoxication, or influence shall be determined by the attending medical personnel, or in accordance with the applicable laws of the state in which the Covered Person resides, and shall include all impairment, influence or intoxication caused by ingestion or administration of drugs or alcohol other than according to a Covered person's prescription. To the extent the evidence indicates that the Covered Person was under the influence of drugs or alcohol, the Plan Administrator shall have the discretion to pay or deny the requested benefits. This exclusion does not apply if the Injury resulted from an act of domestic violence or a medical (including both physical and mental health) condition.

(4) Allergy services - Those non-Physician allergy services or associated expenses relating to an allergic condition including, but not limited to, installation of air filters, air purifiers, or air ventilation system cleaning.

(5) Alternative therapies - Alternative therapies, including, but not limited to, recreational, educational, music or sleep therapies and any related diagnostic testing.

(6) Ambulance service - Ambulance transportation due to the absence of other transportation on the part of the Member is excluded. Non-Medical Emergency ambulance services are excluded regardless of who requested the services.

(7) Anorexiants.

(8) Autism Spectrum Disorders therapy coverage other than ABA Therapy (e.g., Music Therapy; Relationship Development Intervention (RDI);Gluten- and Casein-Free Diet; Facilitated Communication, etc.)

(9) Autopsy - Those services and associated expenses related to the performance of autopsies to the extent that payment for such services is, by law, paid by any governmental agency as a primary plan.

(10) Bariatric surgery procedures other than Roux-en-Y gastric bypass, Sleeve gastrectomy and Duodenal switch procedures performed after December 31, 2020 in accordance with the requirements in Exhibit C. Complications of and/or revisions to any bariatric surgeries procedures performed prior to January 1, 2021 are not covered under the Plan with exception of Medically Necessary revisions as covered under this Plan and in accordance with the requirements in Exhibit C.

(11) Biofeedback, hypnosis, acupuncture and massage therapy.

(12) Blood storage - Those services and associated expenses related to personal blood storage, unless associated with a scheduled surgery.

(13) Braces and supports needed for athletic participation or employment.

(14) Chelation therapy.

(15) Complications of non-covered treatments. Care, services or treatment required as a result of complications from a treatment not covered under the Plan are not covered.

(16) Contraceptive measures (oral or other).

(17) Cosmetic procedures (unless accident related or required by the Women's Health and Cancer Rights Act of 1998) including but not limited to; breast reduction (except as deemed medically necessary by the plan), breast augmentation and radial keratotomy (unless due to corneal lesions). For this purpose, the term "Cosmetic" means both (a) the surgical correction of a disqualifying defect; and (b) procedures, products or services that affect appearance only, or which are performed for a purely superficial benefit.

(18) Counseling - Services and treatment related to religious counseling, marital/relationship counseling, vocational or employment counseling, and sex therapy are not Covered Charges. Notwithstanding the foregoing, the Plan will process claims for sex-specific services by applying the same terms and conditions, regardless of an individual's sex assigned at birth, gender identity or recorded gender to the extent such provision does not substantially burden the exercise of the Catholic religion by FMOLHS, or otherwise violate federal statutory protections for religious freedom and conscience, and to the extent that ACA 1557 is in effect and applicable to the Plan.

(19) Custodial care. Services or supplies provided mainly as a rest cure, maintenance or Custodial Care.

(20) Dental service & supplies unless explicitly covered under the plan.

(21) Educational or vocational testing. Services for educational or vocational testing or training.

(22) Educational Services - Those educational services for remedial education including, but not limited to, evaluation or treatment of learning disabilities, minimal brain dysfunction, cerebral palsy, mental retardation, developmental and learning disorders and behavioral training.

(23) Equipment or services for use in altering air quality or temperature.

(24) Elective or voluntary enhancement - Elective or voluntary enhancement procedures, services, and medications (growth hormone and testosterone), including, but not limited to: weight loss, hair growth, sexual performance, athletic performance, Cosmetic purposes, anti-aging, mental performance, salabrasion, chemosurgery, laser surgery or other skin abrasion procedures associated with the removal of scars, tattoos, or actinic changes. In addition, service performed for the treatment of acne, even when the medical or surgical treatment has been provided by the Plan for the condition resulting in the scar, are not Covered.

(25) Excess charges. The part of an expense for care and treatment of an Injury or Sickness that is in excess of the Usual and Reasonable Charge.

(26) Services or complications resulting from specifically excluded charges.

(27) Exercise equipment.

(28) Experimental or not Medically Necessary. Care and treatment and any complications thereof that is either Experimental/Investigational or not Medically Necessary.

(29) Eye care. Radial keratotomy or other eye surgery to correct refractive disorders, including but not limited to blepharoplasty, laser eye surgery, and Ptosis. Also, routine eye examinations, including refractions, lenses for the eyes and exams for their fitting (including any sitting fees). This exclusion does not apply to aphakic patients and soft lenses or sclera shells intended for use as corneal bandages.

(30) Food or food supplements.

(31) Foot care.

(A) Routine foot care (unless needed in treatment of an infection, a metabolic or peripheral-vascular disease), including: weak, strained, flat, unstable or unbalanced feet and metatarsalgia; supportive devices for the foot; fallen arches; care of corns, calluses and toe nails; bunions (except capsular or bone surgery).

(B) Extracorporeal shock wave therapy, radiotherapy, cryosurgery, radiofrequency lesioning, and marrow stimulation techniques, for plantar fasciitis treatment.

(32) Foreign travel. Care, treatment or supplies out of the U.S. if travel is for the sole purpose of obtaining medical services.

(33) Gene therapy.

(34) Genetic Testing whether or not prescribed by a Physician, unless specifically listed as covered in the schedule of Covered Benefits and authorized through Blue Cross. Exclusions include but are not limited to genome sequencing; home testing (e.g. direct-to-consumer; aka home-testing kits) or self-referral testing (e.g., genetic tests ordered by members via telephone or internet); population screening; testing considered experimental or investigational; genetic testing not specifically listed as a covered benefit.

(35) Government coverage. Care, treatment or supplies furnished by a program or agency funded by any government. This does not apply to Medicaid or when otherwise prohibited by law.

(36) Growth hormone. Growth hormone therapy for any condition, except in children less than eighteen (18) years of age which have been appropriately diagnosed to have an actual growth hormone deficiency. However, this exclusion does not apply to growth hormone therapy for the treatment of Turner's Syndrome or to HIV wasting syndrome.

(37) Hair loss. Care and treatment for hair loss including wigs, hair transplants or any drug that promises hair growth, whether or not prescribed by a Physician.

(38) Hearing aids and exams. Charges for services or supplies in connection with hearing aids or exams or for their fitting.

(39) Home services to help meet personal, family, or domestic needs.

(40) Hypnotherapy is not Covered.

(41) Illegal acts. Charges for services received as a result of an Illness or Injury occurring directly, or indirectly as a result of a serious criminal act, or a riot or public disturbance, or regardless of causation, if such Illness or Injury occurs in connection with, or while engaged in, or attempting to engage in, a serious criminal act, or a riot or public disturbance. For the purposes of this exclusion, the term "serious criminal act" shall mean any act or series of acts by the Plan Participant, or by the Plan Participant in concert with another or others, for which, if prosecuted as a criminal offense, a sentence to a term of imprisonment in excess of one year could be imposed. For this exclusion to apply, it is not necessary that criminal charges be filed, or if filed, that a conviction result, or that a sentence of imprisonment for a term in excess of one year be imposed. This exclusion does not apply if the Injury resulted from an act of domestic violence or a medical (including physical and mental health) condition.

(42) Immunizations for international travel not work related.

(43) Implants. Health Services and associated expenses for implants are excluded, except as specifically stated in the "Schedule of Benefits" section of this SPD. The repair or replacement for an implant is not a Covered Charge except when Medically Necessary due to a change in Covered Member's medical condition.

(44) Infertility. Care, supplies, services and treatment for infertility, artificial insemination, or in vitro fertilization.

(45) Maintenance Therapy. There is no Coverage for Maintenance Therapy.

(46) Medical complications. Complications arising directly or indirectly from a non-Covered Charge.

(47) Military Health Services. Those charges for treatment of military service-related disabilities when the Covered Member is legally entitled to other coverage and for which facilities are reasonably available to the Covered Member; or those services for any otherwise Covered Member who is on active military duty except as required by the Uniformed Services Employment and Reemployment Rights Act; or Health Services received as a result of war or any act of war, whether declared or undeclared or caused during service in the armed forces of any country.

(48) Miscellaneous service charges. Telephone consultations, charges for failure to keep a scheduled appointment, or any late payment charge.

(49) Nanometrics. There is no Coverage for Nanometrics.

(50) Newborn home delivery.

(51) No charge Care and treatment for which there would not have been a charge if no coverage had been in force.

(52) Non-compliance. All charges in connection with treatments or medications where the patient either is in non-compliance with or is discharged from a Hospital or Skilled Nursing Facility against medical advice.

(53) Non-durable medical equipment.

(54) Non-emergency Hospital admissions. Care and treatment billed by a Hospital for non-Medical Emergency admissions on a Friday or a Saturday. This does not apply if surgery is performed within 24 hours of admission.

(55) Non-medically necessary. Services, treatments, procedures, equipment, drugs, devices, items or supplies that are not Medically Necessary. The fact that a Physician or other providers prescribes, orders, recommends, or approves a service or supply, or that a court orders a service or supply to be rendered, does not make it Medically Necessary.

(56) Non-Prescription Drugs. Over-the-counter drugs (except as listed in the drug Formulary) and medications incidental to Outpatient Care and Urgent Care Services are excluded. Take home drugs and medications resulting from an Emergency visit or Hospital stay are Covered.

(57) No obligation to pay. Charges incurred for which the Plan has no legal obligation to pay.

(58) No Physician recommendation. Care, treatment, services or supplies not recommended and approved by a Physician; or treatment, services or supplies when the Covered Person is not under the regular care of a Physician. Regular care means ongoing medical supervision or treatment which is appropriate care for the Injury or Sickness.

(59) Not specified as covered. Non-traditional medical services, treatments and supplies which are not specified as covered under this Plan.

(60) Obesity/Morbid Obesity. Care and treatment of obesity or morbid obesity and weight reduction unless specifically outlined in the plan document or under the Bariatric Surgery benefit as Covered under this Plan.

(61) Occupational. Care and treatment that is occupational in nature -- that is, arises from work for wage or profit including self-employment or maintenance of insurance or licensure.

(62) Oral surgery. No charge will be covered under Medical Benefits for dental and oral surgical procedures involving removal of boney or non-boney impacted teeth, orthodontic care of the teeth, periodontal disease and preparing the mouth for the fitting of or continued use of dentures.

(63) Orthotic Appliances and Prosthetic Devices. No Coverage is provided for duplicates. Over-the-counter braces, splints and Orthotics are not Covered Charges. Advanced versions of devices are not Covered Charges. Cranial helmets are not Covered Charges to affect a cosmetically pleasing round cranium. Orthopedic Shoes and shoe inserts are not Covered Charges unless the Covered Member has a metabolic disorder or peripheral vascular disease or the insert is needed for a shoe that is part of a brace.

(64) Other Coverage Services. Those charges for which other coverage is required by federal, state or local law to be purchased or provided through other arrangements, including but not limited to coverage required by workers' compensation, No-Fault Automobile Insurance or other similar legislation.

(65) Over-the-counter supplies such as ACE wraps, elastic supports after the initial placement, finger splints, Orthotics, and braces.

(66) Personal comfort items. Personal comfort items or other equipment, such as, but not limited to, air conditioners, air-purification units, humidifiers, electric heating units, orthopedic mattresses, blood pressure instruments, scales, elastic bandages or stockings, nonprescription drugs and medicines, and first-aid supplies and nonhospital adjustable beds

(67) Physical, psychiatric, or psychological examinations or testing, etc. Those physical, psychiatric, neuropsychological, or psychological examinations or testing, or vaccinations, immunizations (except as approved by the plan administrator), or treatments and associated expenses, when such services are for purposes of obtaining, maintaining or otherwise related to education, employment, insurance, travel, marriage or adoption, or relating to judicial or administrative proceeds or orders, or which are conducted for purposes of medical research, or to obtain or maintain a license or official document of any type.

(68) Plan design exclusions. Charges excluded by the Plan design as mentioned in this document.

(69) Pregnancy termination services or abortion.

(70) Private duty nursing. Private duty nursing services, nursing care on a full-time basis in the home of a Covered Member, or home health aides, unless specified as Covered under this Plan.

(71) Private inpatient room, unless Medically Necessary.

(72) Reduction or augmentation mammoplasty. Reduction or augmentation mammoplasty is excluded unless associated with Reconstructive Surgery following a Medically Necessary mastectomy or as otherwise deemed by the Plan as Medically Necessary. Breast reduction for male gynecomastia is also excluded unless Medically Necessary.

(73) Relative giving services. Professional services performed by a person who ordinarily resides in the Covered Person's home or is related to the Covered Person as a Spouse, parent, child, brother or sister, whether the relationship is by blood or exists in law.

(74) Replacement braces. Replacement of braces of the leg, arm, back, neck, or artificial arms or legs, unless there is sufficient change in the Covered Person's physical condition to make the original device no longer functional.

(75) Services before or after coverage. Care, treatment or supplies for which a charge was incurred before a person was covered under this Plan or after coverage ceased under this Plan.

(76) Sex changes. Care, services or treatment for non-congenital transsexualism, gender dysphoria or sexual reassignment or change. This exclusion includes medications, implants, hormone therapy, surgery, medical or psychiatric treatment. Notwithstanding the foregoing, the Plan will process claims for sex-specific services by applying the same terms and conditions, regardless of an individual's sex assigned at birth, gender identity or recorded gender to the extent such provision does not substantially burden the exercise of the Catholic religion by FMOLHS, or otherwise violate federal statutory protections for religious freedom and conscience, and to the extent that ACA 1557 is in effect and applicable to the Plan.

(77) Sexual dysfunction. Charges incurred or services rendered to diagnose and treat sexual dysfunction, including impotence regardless if caused by a medical reason.

(78) Charges for shipping and handling.

(79) Sleep disorders. Care and treatment for sleep disorders unless deemed Medically Necessary.

(80) Skin abrasion, etc. Salabrasion, chemosurgery, laser surgery or other such skin abrasion procedures associated with the removal of scars, tattoos, actinic changes and/or which are performed as a treatment for acne even when the medical or surgical treatment has been provided by the Plan for the condition resulting in the scar.

(81) Speech therapy, Physical Therapy, Occupational Therapy. Covered Charges do not include recreational programs, maintenance therapy or supplies used in therapy;

(82) Spinal Manipulation/Chiropractic Care. Any spinal manipulation care, services or treatment.

(83) Sports related services. Those services or devices used specifically as safety items or to affect performance primarily in sports-related activities, and all expenses related to physical conditioning programs such as athletic training, body-building, exercise, fitness, flexibility, and diversion or general motivation including braces and Orthotics.

(84) Surgery performed solely to address psychological or emotional factors.

(85) Surgical sterilization. Care and treatment for surgical sterilizations or their reversal.

(86) Surrogate motherhood services and supplies, including, but not limited to, all services and supplies relating to the conception and Pregnancy of a Covered Member acting as a surrogate mother.

(87) Syringes. Disposable syringes (except for insulin syringes).

(88) Charges for federal, state or local taxes for services or supplies rendered.

(89) Temporomandibular Joint Syndrome. All diagnostic and treatment services related to the treatment of jaw joint problems including temporomandibular joint (TMJ) syndrome.

(90) Timely filing requirements for an in-network provider will comply with the limitations in the provider's current network contract with a maximum of 365 days if the contract has no limit. Timely filing requirements for an out of network provider will be a maximum of 365 days.

(91) Transplant organ removal - Those health services and associated expenses for removal of an organ for the purposes of transplantation from a donor who is not a Covered Member. Also excluded are health services and associated expenses for transplants involving mechanical or animal organs. Services relating to an excluded transplant, that would not be performed except in association with the transplant, are excluded for

coverage under this Plan. Any medical and surgical complications resulting from non-covered transplants are excluded from coverage under this Plan. No coverage is provided under this Plan, for a transplant procedure that is not approved for coverage by the claims administrator, based on their established criteria. Double listing at a second transplant facility for the same transplant procedure that has been approved at a designated transplant facility is not covered. Transplant services, screening tests, and any related conditions or complications related to organ donation when a member is donating organ or tissue to a non-covered individual.

(92) Travel or accommodations. Charges for travel or accommodations, whether or not recommended by a Physician, except for ambulance charges as defined as a Covered Charge

(93) Treatment for disorders relating to learning, motor skills, communication, and certain non-pervasive developmental conditions unless specified as Covered under this Plan.

(94) Vocational therapy.

(95) Any loss that is due to a declared or undeclared act of war.

(96) Weight Management Programs unless specified as Covered under this Plan.

(97) Wilderness therapy.

(98) Work hardening programs.

(99) Workers' Compensation or Occupational Injury. Care and treatment of an Injury or Sickness that is occupational – that is, arises from work for wage or profit including self-employment. This exclusion applied even though the Plan Participant: (i) has waived his/her rights to Workers' Compensation benefit; (ii) was eligible for Workers' Compensation benefits and failed to properly file a claim for such benefits; or (iii) the Plan Participant is permitted to elect not to be covered under Workers' Compensation and has affirmatively made that election.

PRESCRIPTION DRUG BENEFITS

Pharmacy Drug Charge

Participating pharmacies have contracted with the Plan to charge Covered Persons reduced fees for covered Prescription Drugs. Express Scripts (ESI) is the administrator of the pharmacy drug plan.

Member Cost Share

The member cost share is applied to each covered pharmacy drug charge and is shown in the Schedule of Benefits. The member cost share amount is not a covered charge under the medical Plan.

If a drug is purchased from a Non-Participating Pharmacy, or a Participating Pharmacy when the Covered Person's ID card is not used, the amount payable in excess of the amounts shown in the Schedule of Benefits will be the ingredient cost and dispensing fee.

If a doctor or Covered Member requests a brand name drug when a generic equivalent exists, the Covered Member will pay the difference between the brand and generic in addition to the applicable brand co-pay/coinsurance. The differential amount will not apply to deductibles or out of pocket maximums.

Covered Prescription Drugs

(1) Drugs prescribed by a Physician that require a prescription either by federal or state law except those specifically excluded.

(2) Certain Compounded prescriptions may be covered under the Plan.

(3) CDC recommended immunizations subject to age limitations.

(4) Pharmacy clinical programs such as prior authorization, step therapy, drug class exclusions and quantity limits may apply to your prescription drug coverage.

Limits To This Benefit

This benefit applies only when a Covered Person incurs a covered Prescription Drug charge. The covered drug charge for any one prescription will be limited to:

(1) Refills only up to the number of times specified by a Physician.

(2) Refills up to one year from the date of order by a Physician.

Expenses Not Covered

This benefit will not cover a charge for any of the following:

(1) **Administration.** Any charge for the administration of a covered Prescription Drug.

(2) **Appetite suppressants.** A charge for appetite suppressants unless specifically listed as covered under the Weight Loss Medication Benefit, dietary supplements or vitamin supplements.

(3) **Consumed on premises.** Any drug or medicine that is consumed or administered at the place where it is dispensed.

(4) **Devices.** Devices of any type, even though such devices may require a prescription. These include (but are not limited to) therapeutic devices, artificial appliances, braces, support garments, or any similar device.

(5) **Experimental.** Experimental drugs and medicines, even though a charge is made to the Covered Person.

(6) **FDA.** Any drug not approved by the Food and Drug Administration.

(7) **Gene Therapy and Cell Therapy**.

(8) **Immunization.** Immunization agents or biological sera.

(9) **Inpatient medication.** A drug or medicine that is to be taken by the Covered Person, in whole or in part, while Hospital confined. This includes being confined in any institution that has a facility for the dispensing of drugs and medicines on its premises.

(10) **Investigational.** A drug or medicine labeled: "Caution - limited by federal law to investigational use".

(11) **Medical exclusions.** A charge excluded under Medical Plan Exclusions.

(12) **No charge.** A charge for Prescription Drugs which may be properly received without charge under local, state or federal programs.

(13) **No prescription.** A drug or medicine that can legally be bought without a written prescription. This does not apply to injectable insulin or certain other covered diabetic supplies.

(14) **Refills.** Any refill that is requested more than one year after the prescription was written or any refill that is more than the number of refills ordered by the Physician.

(15) **Contraceptives, fertility agents, or sexual performance medications; all dosage forms and indications** are specifically excluded.

(16) Drugs used for **cosmetic purposes**. Charges for drugs used for cosmetic purposes such as steroids, Retin A, depigmenting agents, or medications for hair growth or removal. For this purpose, the term "Cosmetic" means both (a) the surgical correction of a disqualifying defect; and (b) procedures, products or services that affect appearance only, or which are performed for a purely superficial benefit.

(17) **Growth hormones**. Charges for drugs to enhance physical growth or athletic performance or appearance, unless deemed Medically Necessary.

(18) **Vitamins,** vitamin prescriptions, cosmetics, minerals, health or beauty aids except for prenatal vitamins requiring a prescription or prescription vitamin supplements containing fluoride.

(19) Proton Pump Inhibitors (all) with the exception of children under age 12.

(20) Alcohol Swabs.

(21) Syringes, other than insulin type.

(22) Dental Products (i.e. chlorhexidene, fluoride rinses and gels, etc.).

(23) Drugs with an identical formulation and stated indications as previously FDA-approved agents, ("Me-Too Drugs").

(24) Blood and blood plasma.

WHEN PRESCRIPTION DRUG CLAIMS SHOULD BE FILED

Claims should be filed with the Administrator of the pharmacy drug plan within 365 days of the date charges for the service were incurred. Benefits are based on the Plan's provisions at the time the charges were incurred. Claims filed later than that date may be declined or reduced unless:

(a) it is not reasonably possible to submit the claim in that time; and

(b) the claim is submitted within one year from the date incurred. This one year period will not apply when the person is not legally capable of submitting the claim.

The pharmacy drug plan Administrator will determine if enough information has been submitted to enable proper consideration of the claim. If not, more information may be requested from the claimant.

All pharmacy drug plan claims should be filed to the Administrator at this address:

Express Scripts (ESI)
ATTN: Commercial Claims
P.O. Box 14711
Lexington, KY 40512-4711

CLAIM FILING PROCEDURES

A. GENERAL RULES

1. Where a Participating Provider renders services, generally the Participating Provider should either file the claim on a Covered Member's behalf or provide an electronic means for the Covered Member to file a claim while the Covered Member is in the Participating Provider's office. However, the Covered Member is responsible for ensuring that the claim is filed.

2. For Benefits not provided by a Participating Provider, the Covered Member is responsible for filing claims with the Corporation. For purposes of this Section the term "Corporation" means "BlueCrossBlueShield". When filing the claims, the Covered Member will need the following:

   a. A claim form for each Covered Member. Covered Members can get claim forms from a Covered Member services representative at the telephone number indicated on the Identification Card, via the Corporation's website, www.MyHealthToolkitLA.com.

   b. Itemized bills from the Provider (s). These bills should contain all the following:

      i. Provider's name and address;
      ii. Covered Member's name and date of birth;
      iii. Covered Member's Identification Card number;
      iv. Description and cost of each service;
      v. Date that each service took place; and,
      vi. Description of the illness or injury and diagnosis.

   c. Covered Members must complete each claim form and attach the itemized bill(s) to it. If a Covered Member has other insurance that already paid on the claim(s), the Covered Member should also attach a copy of the other Plan's EOB notice.

   d. Covered Members should make copies of all claim forms and itemized bills for the Covered Member's records since they will not be returned. Claims should be mailed to the Corporation's address listed on the claim form.

3. Except in the absence of legal capacity, claims must be filed no later than twelve (12) months following the date services were received.

4. Receipt of a claim by the Corporation will be deemed written proof of loss and will serve as written authorization from the Covered Member to the Corporation to obtain any medical or financial records and documents useful to the Corporation. The Corporation, however, is not required to obtain any additional records or documents to support payment of a claim and is responsible to pay claims only on the basis of the information supplied at the time the claim was processed. Any party who submits medical or financial reports and documents to the Corporation in support of a Covered Member's claim will be deemed to be acting as the agent of the Covered Member. If the Covered Member desires to appoint an authorized representative in connection with such Covered Member's claims, the Covered Member should contact the Corporation for an authorized representative form.

5. Appointing an Authorized Representative for Claims and Appeals. Claims and Appeals can be filed by a Covered Member or the Authorized Representative of a Covered Member. An Authorized Representative is an individual authorized by the Covered Member to act on his behalf in obtaining claim payment. In order to ensure compliance with federal and state privacy laws, a Covered Member must complete and return an Authorized Representative form before the Plan will discuss any of a Covered Member's confidential health or financial information with the Authorized Representative. An Authorized Representative form can be obtained by calling: 833-468-3594.

The treating Provider may act as an Authorized Representative in the Appeals if the Covered Member appoints the Provider as an Authorized Representative on an Authorized Representative form. The treating Provider may act on behalf of the Covered Member in Appeals without the express consent of the Covered Member in an Emergency.

6. Notice of Determination

   a. If the Covered Member's claim is filed properly and the claim is in part or wholly denied, the Covered Member will receive notice of an Adverse Benefit Determination that will include:

      i. The title and qualifying credentials of the Provider affirming the Adverse Benefit Determination;
      ii. A statement of the Covered Member's right to appeal;
      iii. An explanation of the reviewer's decision in clear terms and medical rationale in sufficient detail;
      iv. A description of the process to obtain a second level of a decision; and,
      v. The written procedures governing a second level review, including any required timeframes.

   b. The Covered Member will also receive a notice if the claim is approved.

B. PROVIDER INFORMAL RECONSIDERATION

A peer-to-peer communication between an appropriately qualified and licensed practitioner with the same licensure status as the ordering practitioner may occur within a ten (10) day period following the date of the Adverse Benefit Determination. Once requested, the peer to peer shall occur within twenty-four (24) hours of the receipt of the request and shall be conducted between the Provider rendering the service and the Plan's Provider authorized to make the Adverse Benefit Determination or a clinical peer designated by the medical director if the Provider who made the Adverse Benefit Determination cannot be available within one (1) day. If the informal reconsideration process does not resolve the differences of opinion, the Adverse Benefit Determination may be appealed by the Covered Member or the Provider on behalf of the Covered Member, if the Provider is an Authorized Representative. Informal reconsideration shall not be a prerequisite to a standard or expedited appeal of an Adverse Benefit Determination.

C. EXPEDITED APPEALS PROCEDURES

1. Internal Urgent Care Claim

   a. The Covered Member may request an expedited internal appeal of an Urgent Care Claim. This expedited appeal request may be made verbally, and the Employer will communicate with the Covered Member by telephone or facsimile. The Employer will decide the appeal within a reasonable period of time, taking into account the medical circumstances, but no later than seventy-two (72) hours after receipt of the request for an expedited internal appeal. The Covered Member cannot request an expedited external appeal for a Post-Service Claim. Refer to your ID card for contact information.

2. External Urgent Care Claim

   a. The Provider may request an expedited external appeal of an Urgent Care Claim. This expedited appeal request may be made verbally, and the Employer will communicate with the Provider (on behalf of the Covered Member) by telephone or facsimile within seventy-two (72) hours of the Adverse Benefit Determination. The external review organization ("ERO") will decide the appeal within a reasonable period of time, taking into account the medical circumstances, but no later than seventy-two (72) hours after receiving the appropriate medical information. The Covered Member cannot request an expedited external appeal for a Post-Service Claim. Refer to your ID card for contact information. **This process shall be the Covered Member's sole recourse in disputes concerning Adverse Benefit Determinations of whether a health service or item is or was Medically Necessary.**

   b. An expedited appeal of an adverse decision is available if the Covered Member's life, health or ability to regain maximum function is in serious jeopardy; or when in the opinion of the treating Provider, the

Covered Member may experience pain that cannot be adequately controlled while waiting for a decision on a second level external appeal.

D. STANDARD APPEALS PROCEDURES

1. First Level. This is a mandatory appeal level. The Covered Member must exhaust the following internal procedures before taking any outside legal action:

   a. A Covered Member or the Provider (on behalf of the Covered Member) has one hundred eighty (180) days from receipt of an Adverse Benefit Determination to file an appeal. An appeal must meet the following requirements:

      i. An appeal must be in writing;

      ii. An appeal must be sent (via U.S. mail) to the address on the Covered Member's Identification Card;

      iii. The appeal request must state that a formal appeal is being requested and include all pertinent information regarding the claim in question; and,

      iv. An appeal must include the Covered Member's name, address, identification number and any other information, documentation or materials that support the Covered Member's appeal.

   b. The Covered Member may submit written comments, documents or other information in support of the appeal and will (upon request) have access to all documents relevant to the claim. Appeals for Adverse Benefit Determinations for Medical Necessity are evaluated by an appropriate clinical peer or peers in the same or similar specialty as would typically manage the case being reviewed. The clinical peer shall not have been involved in the initial Adverse Benefit Determination. No deference will be afforded to the initial determination.

   c. If the benefit denial was based in whole or in part on a medical judgment, the Plan will consult with a health care professional with training and experience in the relevant medical field. This healthcare professional may not have been involved in the original denial decision and may not be supervised by the health care professional who was involved. If the Plan has consulted with medical or vocational experts in connection with the claim, these experts will be identified upon the Covered Member's request, regardless of whether or not the Plan relies on their advice in making any benefit determinations.

   d. For Pre-Service, Post-Service and Concurrent Care Claims, the Corporation (on behalf of the Group Health Plan) will decide the appeal within a reasonable period of time, taking into account the medical circumstances, but no later than thirty (30) working days after receipt of the appeal and supporting documentation.

   The notification will also inform the Covered Member of their right to a second level appeal.

2. Second Level. This is a mandatory appeal level. The Covered Member must exhaust the following internal procedures before taking any outside legal action:

   a. A Covered Member or his Authorized Representative has thirty (30) days from receipt of the Adverse Benefit Determination to file a second level appeal. An appeal request must meet the following requirements:

      i. An appeal must be in writing;

      ii. An appeal must be sent (via U.S. mail) to the address on the Covered Member's Identification Card;

      iii. The appeal request must state that a formal appeal is being requested and include all pertinent

information regarding the claim in question; and,

iv. In appeal must include the Covered Member's name, address, identification number and any other information, documentation or materials that support the Covered Member's appeal.

b. Appeals for Adverse Benefit Determinations for Medical Necessity are evaluated by an appropriate clinical peer or peers in the same or similar specialty as would typically manage the case being reviewed. The clinical peer shall not have been involved in the initial Adverse Benefit Determination. A majority of any review panel used shall be comprised of persons who were not previously involved in the appeal; however a person who was previously involved with the appeal may be a Covered Member of the panel or appear before the panel to present information or answer questions. The panel shall have the legal authority to bind the Plan Administrator to the panel's decision. If the Plan has consulted with medical or vocational experts in connection with the claim, the experts will be identified upon the Covered Member's request, regardless of whether or not the Plan relied on their advice in making the benefit determination.

c. The Corporation (on behalf of the Group Health Plan) will hold a review panel meeting within forty-five (45) working days of receiving the request from a Covered Member .

d. The Covered Member shall be notified of the time and place of the review meeting in writing at least fifteen (15) working days in advance of the review date; such notice shall also advise the Covered Member of their rights, and the Corporation will not unreasonably deny a request for postponement of the review meeting made by a Covered Member.

e. The meeting shall be held during regular business hours at a location reasonably accessible to the Covered Member.

f. Where face to face meetings are not practical, the Covered Member or Authorized Representative shall be offered, at no cost to the Covered Member, the opportunity to participate by conference call, video conferencing, or other appropriate technology.

g. The Corporation will not unreasonably deny a request for postponement of the review meeting made by a Covered Member .

h. The Covered Member shall have the right to the following:

i. Attend the second level review;
ii. Present their case to the review panel;
iii. Submit supporting material and provide testimony in person or in writing or affidavit both before and at the review meeting; and,
iv. Ask questions of any representative of Medical Necessity review organization.

i. The written notification of appeal decisions will be provided to the Covered Member and Provider of record within five (5) working days following the completion of the review meeting. The decision shall include the following:

i. The title and qualifying credentials of the appropriate clinical peer affirming an Adverse Benefit Determination;
ii. A statement of the nature of the appeal and all pertinent facts;
iii. The rationale for the decision;
iv. Reference to evidence or documentation used in making that decision, and in the event of new or additional evidence or any new rationale relied upon during the appeals process in connection with a claim that is being appealed, the Plan will automatically provide the relevant information to the Covered Member;
v. The instructions for requesting a written statement of the clinical rationale, including the clinical review criteria used to make the determination; and,
vi. Notice of the Covered Member's right to an external review, including the following;

aa. A description of the process to obtain an external review of a decision; and,
bb. The written procedures governing an external review, including any required time frame for review.
cc. It will also notify the Covered Member of his right to file suit under state law after he has completed all mandatory appeals levels described in this SPD.

Regarding the above appeal level, the Plan agrees that any statutory limitations that are applicable to pursuing the claim in court will be put on hold during the period of this appeal process. The appeal process is available only after the Covered Member has followed the mandatory first level appeal level as required above. A Covered Member's decision about whether to submit a benefit dispute through this appeal level will have no effect on his or her rights to any other benefits under the Plan. If a Covered Member has any questions regarding the level of appeal including applicable rules, a Covered Member's right to representation (i.e. to appoint an Authorized Representative) or other details, please contact the Plan.

j. The Employer may retain the Corporation to assist the Employer in making the determination on appeal. Regardless of its assistance, the Corporation is only acting in an advisory capacity and is not acting in a fiduciary capacity. The Employer at all times retains the right to make the final determination.

3. External Review Procedures

a. Opportunity for a Covered Member or a Provider (if an Authorized Representative) to request review of a Medical Necessity Adverse Benefit Determination by an independent ERO pursuant to Louisiana Department of Insurance guidelines on external review. Upon the completion of the second level appeal, the Corporation provides the Covered Member and Authorized Representative the option for external review. The Covered Member or Authorized Representative has up to four (4) months from the date of the denial of the second level appeal to request an external appeal review.

i. After a Covered Member has completed the second level appeal process, a Covered Member may be entitled to an additional, external review of the Covered Member's claim at no cost to the Covered Member. A Covered Member or an Authorized Representative may request review of a Medical Necessity Adverse Benefit Determination by an independent ERO pursuant to Louisiana Department of Insurance guidelines on external review. The Covered Member or Authorized Representative has up to four (4) months from the date of the denial of the second level appeal to request an external appeal review. In order to qualify for external review, the claim must have been denied, reduced, or terminated. The Covered Member will be required to authorize the release of such Covered Member's medical records (if needed in the review for the purpose of reaching a decision on Covered Member's claim).

ii. The Covered Member or Authorized Representative may include the following with the appeal:

aa. The treating healthcare professional's recommendation;
bb. The reason and basis for appeal;
cc. A listing of any documents previously submitted to support the appeal;
dd. The dates of service and procedure(s) or service(s) which have been denied and for which you are requesting an appeal; and,
ee. The Covered Member or Authorized Representative may include additional medical records or documentation to support the appeal.

iii. The Corporation will forward the Covered Member's request along with the previous reviews, available medical records and the review criteria used to make the Adverse Benefit Determination to the ERO.

iv. Within six (6) business days of the date of receipt of a Covered Member's request for an external review, the Corporation will respond by either:

aa. Assigning the Covered Member's request for an external review to an independent review organization and forwarding the Covered Member's records to such organization; or,
bb. Notifying the Covered Member in writing that the Covered Member's request does not meet the requirements for an external review and the reasons for the Corporation's decision.

v. The ERO will take action on the Covered Member's request for an external review within forty-five (45) days after it receives the request for external review from the Corporation.

vi. The ERO's decision will be in writing and will include the clinical basis for the determination. The ERO will provide the Covered Member and the Corporation and/or the Covered Member's employer with the reviewer's decision, a description of the qualifications of the reviewer and any other information deemed appropriate by the organization and/or required by applicable law. If the final independent decision is to approve payment or referral, the Plan will accept the decision and provide benefits for such service or procedure in accordance with the terms and conditions of the Plan. If the final independent review decision is that payment or referral will not be made, the Plan will not be obligated to provide benefits for the service or procedure.

vii. As of the date required by law, the Plan shall provide notices of available internal claims and Appeals, and external review processes, in a culturally and linguistically appropriate manner, by providing such notices in a non-English language to the extent required by law.

Note: The period of time to submit and appeal claims and to request or perfect an external review of a denied claim is being extended in accordance with the federal government guidance so that the period from March 1, 2020 until sixty days after the announced end of the National Emergency or such other date announced by the Agencies in a future notification is disregarded in determining the required deadlines.

Legal Actions Following Appeals. After completing all mandatory appeal levels through this Plan, a Covered Member has the right to further appeal an Adverse Benefit Determinations by bringing a civil action under state law. Any lawsuit for benefits under the Plan must be filed within three years from the date services were rendered, or if shorter, twelve months after the final review/appeal decision by the Plan has been rendered.

Administrative Denials

An Administrative Denial is a determination that a health care treatment, service, or supply is not a Covered Charge under the terms of the Plan. Administrative Denials are not based on a medical determination. For example, the Plan will issue an Administrative Denial if a Covered Member requests a service that is listed under the Exclusions and Limitations section of the Plan/SPD because these services are not covered under the terms of the Plan/SPD. Appeals challenging the Out-of-Network status of a provider/service will also be handled as Administrative Denials.

Administrative Denials are subject to only one level of review (an "Administrative Appeal").

An Administrative Appeal request must include the following information:

i. An appeal must be in writing;
ii. An appeal must be sent to askHRDocuments@fmolhs.org or 225-765-9905;
iii. The appeal request must state that a formal appeal is being requested and include all pertinent information regarding the claim in question; and,
iv. An appeal must include the Covered Member's name, address, identification number and any other information, documentation or materials that support the Covered Member's appeal.

A Covered Member may also request- free of charge- copies of the documents, records, and other information relevant to the Administrative Denial.

Administrative Appeal requests must be filed within one hundred eighty (180) calendar days after the initial notice of denial has been sent to the Covered Member. Administrative Appeal requests that are submitted after one hundred

eighty (180) calendar days will not be processed. Administrative Appeals will be handled as follows: By a subcommittee of the FMOLHS Benefits Committee which will consist of one (1) to three (3) members of the FMOLHS Benefits Committee who were not involved in the original denial.

Administrative Appeals do not involve an in-person or telephonic hearing.

The Plan will notify the Covered Member in writing of an Administrative Appeal decision within sixty (60) calendar days of receipt of the Appeal and supporting information.

If a Covered Member is not satisfied with the Administrative Appeal decision, the Covered Member may pursue any remedies available under law. If the Plan fails to adhere strictly to the requirements of its internal claims and Appeals process, the Covered Member will be considered to have exhausted the internal claims and Appeals process and will have the right to pursue an External Review and other rights available under law, if applicable. Notwithstanding the foregoing, any lawsuit for benefits under the Plan must be filed within three years from the date services were rendered, or if shorter, twelve months after the final review/appeal decision by the Plan has been rendered.

Administrative Denials Involving a Law Enforcement Investigation

In the event that a Covered Member obtains an Injury or Illness as a result of his involvement in an incident or accident that is under investigation by the police or other law enforcement officials, the Plan will request a copy of the incident or accident report from the applicable law enforcement office, as well as copies of all of the medical records related to the Injury or Illness. If all or a portion of the accident or incident report has not been released at the time of the Administrative Appeal (including alcohol and toxicology reports as applicable), the Plan will make the decision to approve or deny payment of the Covered Member's claims based on the information that is accessible to it at that time. However, please be advised that the Plan may reopen their decision at a later date if new material information becomes available to it, such as an official investigation report, alcohol or toxicology test results, or medical records that were not accessible to the Plan on the date of the Administrative Appeal. In the event that the Plan makes a different benefit determination based on this new material information, the Covered Member will be given the right to another Administrative Appeal. Please be advised that the Plan reserves the right to rely on the content of an official accident or incident report in making the benefit determination (including alcohol and toxicology test results as applicable), regardless of whether criminal charges are ultimately pursued by the government or a conviction actually occurs.

If the Plans discovers that a Covered Member or the Authorized Representative of a Covered Member intentionally withheld material information and/or materially misrepresented information related to an Injury or Illness during the Administrative Appeal, the Plan may initiate a fraud investigation, which could result in the termination of the Covered Member's health coverage.

COORDINATION OF BENEFITS

Coordination of the benefit plans. Coordination of benefits sets out rules for the order of payment of Covered Charges when two or more plans -- including Medicare -- are paying. When a Covered Person is covered by this Plan and another plan, or the Covered Person's Spouse is covered by this Plan and by another plan or the couple's Covered children are covered under two or more plans, the plans will coordinate benefits when a claim is received.

The plan that pays first according to the rules will pay as if there were no other plan involved. The secondary and subsequent plans will pay the balance due up to 100% of the total Allowable Charges.

Benefit plan. This provision will coordinate the medical benefits of a benefit plan. The term benefit plan means this Plan or any one of the following plans:

(1) Group or group-type plans, including franchise or blanket benefit plans.

(2) Blue Cross and Blue Shield group plans.

(2) Group practice and other group prepayment plans.

(3) Federal government plans or programs. This includes Medicare.

(4) Other plans required or provided by law. This does not include Medicaid or any benefit plan like it that, by its terms, does not allow coordination.

(5) No Fault Auto Insurance, by whatever name it is called, when not prohibited by law.

Allowable Charge. For a charge to be allowable it must be a Usual and Customary Charge and at least part of it must be covered under this Plan.

In the case of HMO (Health Maintenance Organization) or other in-network only plans: This Plan will not consider any charges in excess of what an HMO or network provider has agreed to accept as payment in full. Also, when an HMO or network plan is primary and the Covered Person does not use an HMO or network provider, this Plan will not consider as an Allowable Charge any charge that would have been covered by the HMO or network plan had the Covered Person used the services of an HMO or network provider.

In the case of service type plans where services are provided as benefits, the reasonable cash value of each service will be the Allowable Charge.

Automobile limitations. When any payments are available under vehicle insurance, the Plan shall pay excess benefits only, without reimbursement for vehicle plan deductibles. This Plan shall always be considered the secondary carrier regardless of the individual's election under PIP (personal injury protection) coverage with the auto carrier.

Benefit plan payment order. When two or more plans provide benefits for the same Allowable Charge, benefit payment will follow these rules:

(1) Plans that do not have a coordination provision, or one like it, will pay first. Plans with such a provision will be considered after those without one.

(2) Plans with a coordination provision will pay their benefits up to the Allowable Charge:

(a) The benefits of the plan which covers the person directly (that is, as an employee, member or subscriber) ("Plan A") are determined before those of the plan which covers the person as a dependent ("Plan B").

(b) The benefits of a benefit plan which covers a person as an Employee who is neither laid off nor retired are determined before those of a benefit plan which covers that person as a laid-off or Retired Employee. The benefits of a benefit plan which covers a person as a Dependent of an Employee who is neither laid off nor retired are determined before those of a benefit plan which covers a person as a Dependent of a laid off or Retired Employee. If the other benefit plan does not have this rule, and if, as a result, the plans do not agree on the order of benefits, this rule does not apply.

(c) The benefits of a benefit plan which covers a person as an Employee who is neither laid off nor retired or a Dependent of an Employee who is neither laid off nor retired are determined before those of a plan which covers the person as a Continuation Coverage beneficiary.

(d) When a child is covered as a Dependent and the parents are not divorced or separated, or for a person whose divorced or separated parents have joint custody of a child, these rules will apply:

(i) The benefits of the benefit plan of the parent whose birthday falls earlier in a year are determined before those of the benefit plan of the parent whose birthday falls later in that year;

(ii) If both parents have the same birthday, the benefits of the benefit plan which has covered the parent for the longer time are determined before those of the benefit plan which covers the other parent.

(e) When a child's parents are divorced or separated, these rules will apply:

(i) The benefit plan of the parent who is responsible for the child's health care under the terms of a court decree will be considered primary.

(ii) The benefit plan of the parent with custody will be considered primary, then the plan of the step-parent with custody will be considered primary, and finally, the plan of the parent without custody will be considered primary.

(iii) If the specific terms of the court decree state that the parents shall share joint custody, without stating that one of the parents is responsible for the health care expenses of the child, the plans covering the child shall follow the order of benefit determination rules outlined above when a child is covered as a Dependent and the parents are not separated or divorced.

(iv) For parents who were never married to each other, the rules apply as set out above as long as paternity has been established.

(f) The benefits of a benefit plan which covers a person as a Dependent spouse are determined before those of a plan which covers the person as a Dependent child.

(g) If there is still a conflict after these rules have been applied, the benefit plan which has covered the patient for the longer time will be considered first. When there is a conflict in coordination of benefit rules, the Plan will never pay more than 50% of Allowable Charges when paying secondary.

(3) Medicare will pay primary, secondary or last to the extent stated in federal law. When Medicare is to be the primary payer, this Plan will base its payment upon benefits that would have been paid by Medicare under Parts A and B, regardless of whether or not the person was enrolled under both of these parts.

Please note the following special rules for Retirees:

The Plan will be the primary payor of expenses of an Active Employee who retired and qualified for Retiree coverage from the LakeVet55 program or Our Lady of Lourdes or St. Francis until the individual reaches age 65. If you retired from Our Lady of Lourdes prior to February 1, 2006 or participate in the LakeVet55 Program, the Retiree coverage can continue past age 65 in which case, Medicare will become the primary payor and the Plan will base its payments upon benefits that would have been paid under Medicare Parts A and B, regardless of whether or not the Retiree was enrolled under both of those parts.

(4) If a Plan Participant is under a disability extension from a previous benefit plan, that benefit plan will pay first and this Plan will pay second.

Claims determination period. Benefits will be coordinated on a Calendar Year basis. This is called the claims determination period.

Right to receive or release necessary information. To make this provision work, this Plan may give or obtain needed information from another insurer or any other organization or person. This information may be given or obtained without the consent of or notice to any other person. A Covered Person will give this Plan the information it asks for about other plans and their payment of Allowable Charges.

Facility of payment. This Plan may repay other plans for benefits paid that the Plan Administrator determines it should have paid. That repayment will count as a valid payment under this Plan.

Right of recovery. This Plan may pay benefits that should be paid by another benefit plan. In this case this Plan may recover the amount paid from the other benefit plan or the Covered Person. That repayment will count as a valid payment under the other benefit plan.

Further, this Plan may pay benefits that are later found to be greater than the Allowable Charge. In this case, this Plan may recover the amount of the overpayment from the source to which it was paid.

THIRD PARTY RECOVERY PROVISION

Benefits Subject to Subrogation and Reimbursement Rules
This provision shall apply to all Benefits provided under any section of the Plan of Benefits. All Benefits under this Plan of Benefits are being provided by a self-funded church plan.

Statement of Purpose
Subrogation and Reimbursement represent significant Plan assets and are vital to the financial stability of the Plan. Subrogation and Reimbursement recoveries are used to pay future claims by other Plan members. Anyone in possession of these assets holds them as a fiduciary and constructive trustee for the benefit of the Plan. The Plan has a fiduciary obligation under state law to pursue and recover these Plan assets to the fullest extent possible.

Definitions for this Section
(1) Another Party: Another Party shall mean any individual or entity, other than this Plan, who is liable or legally responsible to pay expenses, compensation or damages in connection with a Covered Member's injuries or illness. Another Party shall include the party or parties who caused the injuries or illness; the liability insurer, guarantor or other indemnifier of the party or parties who caused the injuries or illness; a Covered Member's own insurance coverage, such as uninsured, underinsured, medical payments, no-fault, homeowner's, renter's or any other insurer; a workers' compensation insurer or governmental entity; or, any other individual, corporation, association or entity that is liable or legally responsible for payment in connection with the injuries or illness.

(2) Corporation: BlueCross

(3) Covered Member: As it relates to the Subrogation and Reimbursement Provision, a Covered Member shall mean any person, dependent or representatives, other than the Plan, who is bound by the terms of the Subrogation and

Reimbursement Provision herein. A Covered Member shall include but is not limited to any beneficiary, dependent, spouse or person who has or will receive Benefits under the Plan, and any legal or personal representatives of that person, including parents, guardians, attorneys, trustees, administrators or executors of an estate of a Covered Member, and heirs of the estate.

(4) Recovery: Recovery shall mean any and all monies identified, paid or payable to the Covered Member through or from Another Party by way of judgment, award, settlement, covenant, release or otherwise (no matter how those monies may be characterized, designated or allocated) to compensate for any losses caused by, or in connection with, the injuries or illness. A Recovery exists as soon as any fund is identified as compensation for a Covered Member from Another Party. Any recovery shall be deemed to apply, first, for Reimbursement of the Plan's lien. The amount owed from the Recovery as Reimbursement of the Plan's lien is an asset of the Plan.

(5) Reimbursement: Reimbursement shall mean repayment to the Plan of recovered medical or other Benefits that it has paid toward care and treatment of the injuries or illness for which there has been a Recovery.

(6) Subrogation: Subrogation shall mean the Plan's right to pursue the Covered Member's claims for medical or other charges paid by the Plan against Another Party.

When this Provision Applies
This provision applies when a Covered Member incurs medical or other charges related to injuries or illness caused in part or in whole by the act or omission of the Covered Member or another person; or Another Party may be liable or legally responsible for payment of charges incurred in connection with the injuries or illness; or Another Party may otherwise make a payment without an admission of liability. If so, the Covered Member may have a claim against that other person or Another Party for payment of the medical or other charges. In that event, the Covered Member agrees, as a condition of receiving Benefits from the Plan, to transfer to the Plan all rights to recover damages in full for such Benefits.

Duties of The Covered Member
The Covered Member will execute and deliver all required instruments and papers provided by the Plan or Corporation, including an accident questionnaire, as well as doing and providing whatever else is needed, to secure the Plan's rights of Subrogation and Reimbursement, before any medical or other Benefits will be paid by the Plan for the injuries or illness. The Plan or Corporation may determine, in its sole discretion, that it is in the Plan's best interests to pay medical or other Benefits for the injuries or illness before these papers are signed (for example, to obtain a prompt payment discount); however, in that event, the Plan will remain entitled to Subrogation and Reimbursement. In addition, the Covered Member will do nothing to prejudice the Plan's right to Subrogation and Reimbursement and acknowledges that the Plan precludes operation of the made-whole and common-fund doctrines. A Covered Member who receives any Recovery (whether by judgment, settlement, compromise, or otherwise) has an absolute obligation to immediately tender the portion of the Recovery subject to the Plan's lien to the Plan under the terms of this provision. A Covered Member who receives any such Recovery and does not immediately tender the Plan's portion of the Recovery to the Plan will be deemed to hold the Plan's portion of the Recovery in constructive trust for the Plan, because the Covered Member is not the rightful owner of the Plan's portion of the Recovery and should not be in possession of the Recovery until the Plan has been fully reimbursed. The portion of the Recovery owed by the Covered Member for the Plan's lien is an asset of the Plan.

As a condition of receiving Benefits, the Covered Member must:

1. Immediately notify the Plan or Corporation of an injury or illness for which Another Party may be liable, legally responsible or otherwise makes a payment in connection with the injuries or illness;

2. Execute and deliver to the Corporation an accident questionnaire within one hundred eighty (180) days of the accident questionnaire being mailed to the Covered Member;

3. Deliver to the Plan or Corporation a copy of the Personal Injury Protection Log, Medical Payments log and/or Medical Authorization within ninety (90) days of being requested to do so;

4. Deliver to the Plan or Corporation a copy of the police report, incident or accident report, or any other reports issued as a result of the injuries or illness within ninety (90) days of being requested to do so;

5. Authorize the Plan or Corporation to sue, compromise and settle in the Covered Member's name to the extent of the amount of medical or other Benefits paid for the injuries or illness under the Plan and the expenses incurred by the Plan or Corporation in collecting this amount, and assign to the Plan the Covered Member's rights to Recovery when this provision applies;

6. Include the amount paid for Benefits as a part of the damages sought against Another Party. Immediately reimburse the Plan or Corporation, out of any Recovery made from Another Party, the amount of medical or other Benefits paid for the injuries or illness by the Plan up to the amount of the Recovery and without reduction for attorneys' fees, costs, comparative negligence, limits of collectability or responsibility, or otherwise;

7. Immediately notify the Plan or Corporation in writing of any proposed settlement and obtain the Plan or Corporation's written consent before signing any release or agreeing to any settlement; and,

8. Cooperate fully with the Plan or Corporation in its exercise of its rights under this provision, do nothing that would interfere with or diminish those rights and furnish any information required by the Plan or Corporation.

First Priority Right of Subrogation and/or Reimbursement

Any amounts recovered will be subject to Subrogation or Reimbursement. The Covered Member's submission of claims for illnesses or injury caused by Another Party constitutes the Covered Member's agreement to the terms of this provision and the Covered Member's grant to the Plan of a first priority equitable lien by agreement. The Plan's right to recover exists regardless of whether it is based on Subrogation or Reimbursement.

The Plan will be subrogated to all rights the Covered Member may have against that other person or Another Party and will be entitled to first priority Reimbursement out of any Recovery to the extent of the Group Health Plan's payments. In addition, the Plan shall have a first priority equitable lien against any Recovery to the extent of Benefits paid and to be payable in the future. The Group Health Plan's first priority equitable lien supersedes any right that the Covered Member may have to be "made whole." In other words, the Plan is entitled to the right of first Reimbursement out of any Recovery the Covered Member procures or may be entitled to procure regardless of whether the Covered Member has received full compensation for any of his or her damages or expenses, including attorneys' fees or costs and regardless of whether the Recovery is designated as payment for medical expenses or otherwise. Additionally, the Group Health Plan's right of first Reimbursement will not be reduced for any reason, including attorneys' fees, costs, comparative or contributory negligence, limits of collectability or responsibility, characterization of Recovery as pain and suffering or otherwise. As a condition to receiving Benefits under the Plan and Plan of Benefits, the Covered Member agrees that acceptance of Benefits is constructive notice of this provision.

When a Covered Member Retains an Attorney

An attorney who receives any Recovery (whether by judgment, settlement, compromise, or otherwise) for an injury or illness in which the Plan has paid or will pay Benefits, has an absolute obligation to immediately tender the portion of the Recovery subject to the Plan's equitable lien to the Plan under the terms of this provision. As a possessor of a portion of the Recovery, the Covered Member's attorney holds the Recovery as a constructive trustee and fiduciary and is obligated to tender the Plan's portion of the Recovery immediately over to the Plan. A Covered Member's attorney who receives any such Recovery and does not immediately tender the Plan's portion of the Recovery to the Plan will be deemed to hold the Recovery in constructive trust for the Plan, because neither the Covered Member nor the attorney is the rightful owner of the portion of the Recovery subject to the Plan's lien. The portion of the Recovery owed for the Plan's lien is an asset of the Plan.

If the Covered Member retains an attorney, the Covered Member's attorney must recognize and consent to the fact that this provision precludes the operation of the "made-whole" and "common fund" doctrines, and the attorney must agree not to assert either doctrine against the Plan in his or her pursuit of Recovery. The Plan will not pay the Covered Member's attorneys' fees and costs associated with the recovery of funds, nor will it reduce its Reimbursement pro rata for the payment of the Covered Member's attorneys' fees and costs, without the expressed written consent of the Corporation.

When the Covered Member is a Minor or is Deceased or Incapacitated
This Subrogation and Reimbursement Provision will apply with equal force to the parents, trustees, guardians, administrators, or other representatives of a minor, incapacitated, or deceased Covered Member and to the heirs or personal and legal representatives, regardless of applicable law. No representative of a Covered Member listed herein may allow proceeds from a Recovery to be allocated in a way that reduces or minimizes the Plan's claim by arranging for others to receive proceeds of any judgment, award, settlement, covenant, release or other payment or releasing any claim in whole or in part without full compensation therefore or without the prior written consent from the Plan or Corporation.

When a Covered Member Does not Comply
When a Covered Member does not comply with the provisions of this section, the Plan or Corporation shall have the authority, in its sole discretion, to deny payment of any claims for Benefits by the Covered Member and to deny or reduce future Benefits payable (including payment of future Benefits for other injuries or illnesses) under the Plan of Benefits by the amount due as satisfaction for the Reimbursement to the Group Health Plan. The Plan or Corporation may also, in its sole discretion, deny or reduce future Benefits (including future Benefits for other injuries or illnesses) for the Covered Member under any other group benefits plan maintained by the Employer. The reductions will equal the amount of the required Reimbursement; however, under no circumstances shall the Reimbursement, denial or reduction of Benefits exceed the amount of the Recovery. If the Plan must bring an action against a Covered Member to enforce the provisions of this section, then the Covered Member agrees to pay the Plan's attorneys' fees and costs, regardless of the action's outcome.

Prior Recoveries
In certain circumstances, a Covered Member may receive a Recovery that exceeds the amount of the Plan's payments for past and/or present expenses for treatment of the injuries or illness that is the subject of the Recovery. In other situations, based on the extent of the Covered Member's injuries or illness, the Covered Member may have received a prior Recovery for treatment of the injuries or illness that is the subject of a claim for Benefits under the Group Health Plan. In these situations, the Plan will not provide Benefits for any expenses related to the injuries or illness for which compensation was provided through a current or previous Recovery. The Covered Member is required to submit full and complete documentation of any such Recovery in order for the Plan to consider eligible expenses. To the extent a Covered Member's Recovery exceeds the amount of the Plan's lien, the Plan is entitled to deny that amount as an offset against any claims for future Benefits relating to the injuries or illness. In those situations, the Covered Member will be solely responsible for payment of medical bills related to the injuries or illness. The Plan also precludes operation of the made-whole and common-fund doctrines in applying this provision. No "collateral source rule" or "make whole" doctrine or claims of unjust enrichment nor any other equitable limitation will limit our subrogation and recovery rights.

The Plan (and Administrator) or Corporation has sole discretion and maximum discretionary authority to construe the terms of the Plan and determine whether expenses are related to the injuries or illness to the extent this provision applies. Acceptance of Benefits under this Plan of Benefits for injuries or illness which the Covered Member has already received a Recovery may be considered fraud, and the Covered Member will be subject to any sanctions determined by the Plan (and Administrator) or Corporation, in their sole discretion, to be appropriate, including denial of present or future Benefits under this Plan of Benefits.

CONTINUATION COVERAGE

Continuation of Coverage

Certain Employees and their families covered under the FMOLHS Health Plan will be entitled to the opportunity to elect a temporary extension of health coverage (called "Continuation Coverage") where coverage under the Plan would otherwise end. This notice is intended to inform Plan Participants and beneficiaries, in summary fashion, of their rights and obligations under the Continuation Coverage. **Note: Because this Plan is a church Plan, it is not subject to the Continuation Coverage requirements under federal law.**

Continuation Coverage for the Plan is administered by Voya Financial. Complete instructions on Continuation Coverage as well as election forms and other information will be provided by the Plan Administrator or its designee to Plan Participants who become Qualified Beneficiaries under Continuation Coverage.

What is Continuation Coverage?

"Continuation Coverage" is a continuation of Plan coverage when coverage otherwise would end because of a life event known as a "Qualifying Event." Life insurance, accidental death and dismemberment benefits and weekly income or long-term disability benefits (if a part of your employer's plan) are not considered for continuation under this provision. The federal tax law includes stringent rules for continuation coverage that apply to non-church plans. Because the FMOLHS is a church entity, it is exempt from the federal tax rules. It operates to provide continuation coverage in a manner which is very similar to the requirements of the federal tax law.

You cannot add family members during the term of your Continuation Coverage. In addition, if you are covered under the Plan as a result of electing Continuation Coverage, during Open Enrollment you can elect coverage under any active Plan for the next plan year but you cannot add additional family members to the Plan during Open Enrollment.

What is a Qualifying Event?

Specific Qualifying Events are listed below. After a Qualifying Event, Continuation Coverage must be offered to each person who is a "Qualified Beneficiary." You, your Spouse, and your dependent children could become Qualified Beneficiaries if coverage under the Plan is lost because of the Qualifying Event.

If you are a Covered Employee (meaning that you are an employee and are covered under the Plan), you will become a Qualified Beneficiary if you lose your coverage under the Plan because either one of the following Qualifying Events happens:

(1) Your hours of employment are reduced; or

(2) Your employment ends for any reason other than your gross misconduct.

Notwithstanding the foregoing, an Employee who loses his job and is provided with severance benefits in accordance with the System-wide Severance Policy shall have the Continuation period measured from the date his employment ends. The continuation coverage provided by the System-wide Severance policy shall run concurrently with COBRA and shall not extend the period of the COBRA continuation coverage.

If you are the Spouse of a Covered Employee, you will become a Qualified Beneficiary if you lose your coverage under the Plan because any of the following Qualifying Events happens:

(1) Your Spouse dies;

(2) Your Spouse's hours of employment are reduced;

(3) Your Spouse's employment ends for any reason other than his or her gross misconduct;

(4) Your Spouse becomes entitled to Medicare benefits (under Part A, Part B, or both); or

(5) You become divorced from your Spouse.

Your dependent children will become Qualified Beneficiaries if they lose coverage under the Plan because any of the following Qualifying Events happens:

(1) The parent-Covered Employee dies;

(2) The parent-Covered Employee's hours of employment are reduced;

(3) The parent-Covered Employee's employment ends for any reason other than his or her gross misconduct;

(4) The parent-Covered Employee becomes entitled to Medicare benefits (Part A, Part B, or both);

(5) The parents become divorced; or

(6) The child is no longer eligible for coverage under the plan as a "dependent child."

The Employer must give notice of some Qualifying Events

When the Qualifying Event is the end of employment, reduction of hours of employment, death of the Covered Employee, or the Covered Employee's becoming entitled to Medicare benefits (under Part A, Part B, or both), the Employer must notify the Plan Administrator of the Qualifying Event.

You must give notice of some Qualifying Events

Each Covered Employee or Qualified Beneficiary is responsible for providing the Plan Administrator or the Continuation Coverage Administrator outlined in the "GENERAL PLAN INFORMATION" with the following notices, in writing, either by U.S. First Class Mail, hand delivery, or by facsimile:

(1) Notice of the occurrence of a Qualifying Event that is a divorce of a Covered Employee (or former employee) from his or her Spouse;

(2) Notice of the occurrence of a Qualifying Event that is an individual's ceasing to be eligible as a dependent under the terms of the Plan;

(3) Notice of the occurrence of a second Qualifying Event after a Qualified Beneficiary has become entitled to Continuation Coverage with a maximum duration of 18 (or 29) months;

(4) Notice that a Qualified Beneficiary entitled to receive Continuation Coverage with a maximum duration of 18 months has been determined by the Social Security Administration ("SSA") to be disabled at some time before the 60th day of Continuation Coverage; and

(5) Notice that a Qualified Beneficiary, with respect to whom a notice described in paragraph (4) above has been provided has subsequently been determined by the SSA to no longer be disabled.

The Plan Administrator is:

The FMOLHS Benefits Committee.
Plan Administrator
4200 Essen Lane
Baton Rouge, Louisiana 70809
225-923-2701

IMPORTANT:

For the other Qualifying Events (divorce of the employee and spouse or a dependent child's losing eligibility for coverage as a dependent child), you or someone on your behalf must notify the Plan Administrator or the Continuation Coverage Administrator (see GENERAL PLAN INFORMATION) in writing within 60 days after the Qualifying Event occurs, using the procedures specified below. If these procedures are not followed or if the notice is not provided in writing to the Plan Administrator or the Continuation Coverage Administrator (see GENERAL PLAN INFORMATION) during the 60-day notice period, any spouse or dependent child who loses coverage will not be offered the option to elect Continuation Coverage. You must send this notice to the Plan Administrator or the Continuation Coverage Administrator (see GENERAL PLAN INFORMATION) at the address at the end of this document.

NOTICE PROCEDURES:

Any notice that you provide must be ***in writing***. Oral notice, including notice by telephone, is not acceptable. You must mail, fax or hand-deliver your notice to the Continuation Coverage Administrator listed on a page near the end of this document.

If mailed, your notice must be postmarked no later than the last day of the required notice period. Any notice you provide must state:

- the **name of the plan or plans** under which you lost or are losing coverage,
- the **name and address of the employee** covered under the plan,
- the **name(s) and address(es) of the Qualified Beneficiary(ies)**, and
- the **Qualifying Event** and the **date** it happened.

If the Qualifying Event is a **divorce**, your notice must include **a copy of the divorce decree**.

Be aware that there are other notice requirements in other contexts, for example, in order to qualify for a disability extension.

Once the Plan Administrator or the Continuation Coverage Administrator receives *timely notice* that a Qualifying Event has occurred, Continuation Coverage will be offered to each of the qualified beneficiaries. Each Qualified Beneficiary will have an independent right to elect Continuation Coverage. Covered employees may elect Continuation Coverage for their spouses, and parents may elect Continuation Coverage on behalf of their children. For each Qualified Beneficiary who elects Continuation Coverage, Continuation Coverage will begin on the date that plan coverage would otherwise have been lost. If you or your spouse or dependent children do not elect Continuation Coverage within the 60-day election period described above, the right to elect Continuation Coverage will be lost.

Deadline for providing the notice

For Qualifying Events described in (1), (2) or (3) above, the notice must be furnished by the date that is 60 days after the latest of:

(1) The date on which the relevant Qualifying Event occurs;

(2) The date on which the Qualified Beneficiary loses (or would lose) coverage under the Plan as a result of the Qualifying Event; or

(3) The date on which the Qualified Beneficiary is informed, through the furnishing of the Plan's SPD or the general notice, of both the responsibility to provide the notice and the Plan's procedures for providing such notice to the Plan Administrator.

For the disability determination described in (4) above, the notice must be furnished by the date that is 60 days after the

latest of:

(1) The date of the disability determination by the SSA;

(2) The date on which a Qualifying Event occurs;

(3) The date on which the Qualified Beneficiary loses (or would lose) coverage under the Plan as a result of the Qualifying Event; or

(4) The date on which the Qualified Beneficiary is informed, through the furnishing of the Plan's SPD or the general notice, of both the responsibility to provide the notice and the Plan's procedures for providing such notice to the Plan Administrator.

In any event, this notice must be furnished before the end of the first 18 months of Continuation Coverage.

For a change in disability status described in (5) above, the notice must be furnished by the date that is 30 calendar days after the later of:

(1) The date of the final determination by the SSA that the Qualified Beneficiary is no longer disabled; or

(2) The date on which the Qualified Beneficiary is informed, through the furnishing of the Plan's SPD or the general notice, of both the responsibility to provide the notice and the Plan's procedures for providing such notice to the Plan Administrator.

The notice must be postmarked (if mailed), or received by the Plan Administrator (if hand delivered), by the deadline set forth above. If the notice is late, the opportunity to elect or extend Continuation Coverage is lost, and if you are electing Continuation Coverage, your coverage under the Plan will terminate on the last date for which you are eligible under the terms of the Plan, or if you are extending Continuation Coverage, such Coverage will end on the last day of the initial 18-month coverage period.

Who can provide the notice

Any individual who is the Covered Employee (or former employee), a Qualified Beneficiary with respect to the Qualifying Event, or any representative acting on behalf of the Covered Employee (or former employee) or Qualified Beneficiary, may provide the notice, and the provision of notice by one individual shall satisfy any responsibility to provide notice on behalf of all related Qualified Beneficiaries with respect to the Qualifying Event.

Required contents of the notice

The notice must contain the following information:

(1) Name and address of the Covered Employee or former employee;

(2) If you already are receiving Continuation Coverage and wish to extend the maximum coverage period, identification of the initial Qualifying Event and its date of occurrence;

(3) A description of the Qualifying Event (for example, divorce, cessation of dependent status, entitlement to Medicare by the Covered Employee or former employee, death of the Covered Employee or former employee, disability of a Qualified Beneficiary or loss of disability status);

(4) In the case of a Qualifying Event that is divorce, name(s) and address(es) of Spouse and dependent child(ren) covered under the Plan, date of divorce, and a copy of the decree of divorce;

(5) In the case of a Qualifying Event that is Medicare entitlement of the Covered Employee or former employee, date of entitlement, and name(s) and address(es) of Spouse and dependent child(ren) covered under the Plan;

(6) In the case of a Qualifying Event that is a dependent child's cessation of dependent status under the Plan, name and address of the child, reason the child ceased to be an eligible dependent (for example, attained limiting age, lost student status, married or other);

(7) In the case of a Qualifying Event that is the death of the Covered Employee or former employee, the date of death, and name(s) and address(es) of Spouse and dependent child(ren) covered under the Plan;

(8) In the case of a Qualifying Event that is disability of a Qualified Beneficiary, name and address of the disabled Qualified Beneficiary, name(s) and address(es) of other family members covered under the Plan, the date the disability began, the date of the SSA's determination, and a copy of the SSA's determination;

(9) In the case of a Qualifying Event that is loss of disability status, name and address of the Qualified Beneficiary who is no longer disabled, name(s) and address(es) of other family members covered under the Plan, the date the disability ended and the date of the SSA's determination; and

(10) A certification that the information is true and correct, a signature and date.

If you cannot provide a copy of the decree of divorce or the SSA's determination by the deadline for providing the notice, complete and provide the notice, as instructed, by the deadline; however, you must submit a copy of the decree of divorce or the SSA's determination within 30 calendar days after the date you have provided the notice. The notice will be timely if you do so. However, no Continuation Coverage, or extension of such Coverage, will be available until you have provided a copy of the decree of divorce or the SSA's determination.

Please note, if the notice does not contain all of the required information, the Plan Administrator may request additional information. If the individual fails to provide such information within the time period specified by the Plan Administrator in the request, the Plan Administrator may reject the notice if it does not contain enough information for the Plan Administrator to identify the plan, the Covered Employee (or former employee), the Qualified Beneficiaries, the Qualifying Event or disability, and the date on which the Qualifying Event, if any, occurred.

Electing Continuation Coverage

Complete instructions on how to elect Continuation Coverage will be provided by the Plan Administrator within 14 days of receiving the notice of your Qualifying Event. You then have 60 days in which to elect Continuation Coverage. The 60-day period is measured from the later of the date coverage terminates or the date of the notice containing the instructions. If Continuation Coverage is not elected in that 60-day period, then the right to elect it ceases.

Each Qualified Beneficiary will have an independent right to elect Continuation Coverage. Covered Employees may elect Continuation Coverage on behalf of their Spouses, and parents may elect Continuation Coverage on behalf of their children.

In the event that the Plan Administrator determines that the Participant is not entitled to Continuation Coverage, the Plan Administrator will provide to the Participant an explanation as to why he or she is not entitled to Continuation Coverage.

How long does Continuation Coverage last?

Continuation Coverage will be available up to the maximum time period shown below. Multiple Qualifying Events which may be combined under this provision will not continue coverage for more than 36 months beyond the date of the original Qualifying Event. When the Qualifying Event is "entitlement to Medicare," the 36-month continuation period is measured from the date of the original Qualifying Event. For all other Qualifying Events, the continuation period is measured from the date of the Qualifying Event, not the date of loss of coverage.

When the Qualifying Event is the death of the Covered Employee (or former employee), the Covered Employee's (or former employee's) becoming entitled to Medicare benefits (under Part A, Part B, or both), your divorce or legal

separation, or a dependent child's losing eligibility as a dependent child, Continuation Coverage lasts for up to a total of 36 months.

When the Qualifying Event is the end of employment or reduction of the Covered Employee's hours of employment, and the Covered Employee became entitled to Medicare benefits less than 18 months before the Qualifying Event, Continuation Coverage for Qualified Beneficiaries other than the Covered Employee lasts until 36 months after the date of Medicare entitlement. For example, if a Covered Employee becomes entitled to Medicare 8 months before the date on which his employment terminates, Continuation Coverage for his Spouse and children can last up to 36 months after the date of Medicare entitlement, which is equal to 28 months after the date of the Qualifying Event (36 months minus 8 months).

Otherwise, when the Qualifying Event is the end of employment (for reasons other than gross misconduct) or reduction of the Covered Employee's hours of employment, Continuation Coverage generally lasts for only up to a total of 18 months. There are two ways in which this 18-month period of Continuation Coverage can be extended.

Remember: If you lose your job and are provided with severance benefits in accordance with the System-wide Severance Policy, the continuation period shall be measured from the date your employment ends. The continuation coverage provided by the System-wide Severance policy shall run concurrently with and shall not extend the period of the continuation coverage.

Disability extension of 18-month period of Continuation Coverage

If you or anyone in your family covered under the Plan is determined by the SSA to be disabled and you notify the Plan Administrator as set forth above, you and your entire family may be entitled to receive up to an additional 11 months of Continuation Coverage, for a total maximum of 29 months. The disability would have to have started at some time before the 60th day of Continuation Coverage and must last at least until the end of the 18-month period of Continuation Coverage. An extra fee may be charged for this extended Continuation Coverage.

Second Qualifying Event extension of 18-month period of Continuation Coverage

If your family experiences another Qualifying Event while receiving 18 months of Continuation Coverage, the Spouse and dependent children in your family can get up to 18 additional months of Continuation Coverage, for a maximum of 36 months, if notice of the second Qualifying Event properly is given to the Plan as set forth above. This extension may be available to the Spouse and any dependent children receiving Continuation Coverage if the Covered Employee or former employee dies, becomes entitled to Medicare benefits (under Part A, Part B, or both), or gets divorced or legally separated, or if the dependent child stops being eligible under the Plan as a dependent child, but only if the event would have caused the Spouse or dependent child to lose coverage under the Plan had the first Qualifying Event not occurred. An extra fee may be charged for this extended Continuation Coverage.

Does Continuation Coverage ever end earlier than the maximum periods above?

Continuation Coverage also may end before the end of the maximum period on the earliest of the following dates:

(1) The date your employer ceases to provide a group health plan to any employee;

(2) The date on which coverage ceases by reason of the Qualified Beneficiary's failure to make payment of any required premium within the payment guidelines outlined below;

(3) The date that the Qualified Beneficiary first becomes, after the date of election, covered under any other group health plan (as an employee or otherwise), or entitled to either Medicare Part A or Part B (whichever comes first). However, a Qualified Beneficiary who becomes covered under a group health plan which has a Pre-existing condition limit must be allowed to continue Continuation Coverage for the length of a Pre-existing condition or to the maximum time period, if less; or

(4) The first day of the month that begins more than 30 calendar days after the date of the SSA's determination that the Qualified Beneficiary is no longer disabled, but in no event before the end of the maximum coverage period that applied without taking into consideration the disability extension.

Payment for Continuation Coverage

Once Continuation Coverage is elected, you must pay for the cost of the initial period of coverage within 45 days. Payments then are due on the first day of each month to continue coverage for that month. If a payment is not postmarked (if mailed) or received by the Plan Administrator (if hand delivered) within 30 calendar days of the due date, Continuation Coverage will be canceled and will not be reinstated.

Additional Information

Additional information about the Plan and Continuation Coverage is available from:

Voya Financial
P.O. BOX 929
Manchester, NH 03105
(833) 232-4673
HASInfo@voya.com

Current Addresses

In order to protect your family's rights, you should keep the Plan Administrator (who is identified above) informed of any changes in the addresses of family members.

RESPONSIBILITIES FOR PLAN ADMINISTRATION

PLAN ADMINISTRATOR. The Plan Administrator of the FMOLHS Health Plan is the FMOLHS Benefits Committee appointed by the Board, the principal purpose of which is to maintain and administer the Plan according to its terms, consistent with the teachings and tenets of the Roman Catholic Church. If a Committee member resigns, dies or is otherwise removed from the position, Franciscan Missionaries of Our Lady Health System, Inc. shall appoint a replacement as soon as reasonably possible.

The Plan Administrator shall administer this Plan in accordance with its terms and establish its policies, interpretations, practices, and procedures. It is the express intent of this Plan that the Plan Administrator shall have maximum legal discretionary authority to construe and interpret the terms and provisions of the Plan, to make determinations regarding issues which relate to eligibility for benefits, to decide disputes which may arise relative to a Plan Participant's rights, and to decide questions of Plan interpretation and those of fact relating to the Plan. The decisions of the Plan Administrator will be final and binding on all interested parties.

Service of legal process may be made upon the Plan Administrator.

DUTIES OF THE PLAN ADMINISTRATOR.

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

(2) To interpret the Plan, including the right to remedy possible ambiguities, inconsistencies or omissions.

(3) To decide disputes which may arise relative to a Plan Participant's rights.

(4) To prescribe procedures for filing a claim for benefits and to review claim denials.

(5) To keep and maintain the Plan documents and all other records pertaining to the Plan.

(6) To appoint a Claims Administrator to pay claims.

(7) To establish and communicate procedures to determine whether a medical child support order is qualified.

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

PLAN ADMINISTRATOR COMPENSATION. The Plan Administrator serves **without** compensation; however, all expenses for plan administration, including compensation for hired services, will be paid by the Plan.

FIDUCIARY. A fiduciary exercises discretionary authority or control over management of the Plan or the disposition of its assets, renders investment advice to the Plan or has discretionary authority or responsibility in the administration of the Plan.

FIDUCIARY DUTIES. A fiduciary must carry out his or her duties and responsibilities for the purpose of providing benefits to the Employees, Retirees and their Dependent(s), and defraying reasonable expenses of administering the Plan. These are duties which must be carried out:

(1) with care, skill, prudence and diligence under the given circumstances that a prudent person, acting in a like capacity and familiar with such matters, would use in a similar situation;

(2) by diversifying the investments of the Plan so as to minimize the risk of large losses, unless under the circumstances it is clearly prudent not to do so; and

(3) in accordance with the Plan documents.

CLAIMS ADMINISTRATOR IS NOT A FIDUCIARY. A Claims Administrator is **not** a fiduciary under the Plan by virtue of paying claims in accordance with the Plan's rules as established by the Plan Administrator.

COMPLIANCE WITH HIPAA PRIVACY STANDARDS. Certain members of the Employer's workforce perform services in connection with administration of the Plan. In order to perform these services, it is necessary for these employees from time to time to have access to Protected Health Information (as defined below).

Under the Standards for Privacy of Individually Identifiable Health Information (45 CFR Part 164, the "Privacy Standards"), these employees are permitted to have such access subject to the following:

(1) **General.** The Plan shall not disclose Protected Health Information to any member of the Employer's workforce unless each of the conditions set out in this HIPAA Privacy section is met. "Protected Health Information" shall have the same definition as set out in the Privacy Standards but generally shall mean individually identifiable health information about the past, present or future physical or mental health or condition of an individual, including information about treatment or payment for treatment.

(2) **Permitted Uses and Disclosures.** Protected Health Information disclosed to members of the Employer's workforce shall be used or disclosed by them only for purposes of Plan administrative functions. The Plan's administrative functions shall include all Plan payment and health care operations. The terms "payment" and "health care operations" shall have the same definitions as set out in the Privacy Standards, but the term "payment" generally shall mean activities taken with respect to payment of premiums or contributions, or to determine or fulfill Plan responsibilities with respect to coverage, provision of benefits, or reimbursement for health care. "Health care operations" generally shall mean activities on behalf of the Plan that are related to quality assessment; evaluation, training or accreditation of health care providers; underwriting, premium rating and other functions related to obtaining or renewing an insurance contract, including stop-loss insurance; medical review; legal services or auditing functions; or business planning, management and general administrative activities.

(3) **Authorized Employees.** The Plan shall disclose Protected Health Information only to members of the Employer's workforce who are designated and are authorized to receive such Protected Health Information, and only to the extent and in the minimum amount necessary for these persons to perform

duties with respect to the Plan. For purposes of this HIPAA Privacy section, "members of the Employer's workforce" shall refer to all employees and other persons under the control of the Employer.

(a) **Updates Required.** The Employer shall amend the Plan promptly with respect to any changes in the members of its workforce who are authorized to receive Protected Health Information.

(b) **Use and Disclosure Restricted.** An authorized member of the Employer's workforce who receives Protected Health Information shall use or disclose the Protected Health Information only to the extent necessary to perform his or her duties with respect to the Plan.

(c) **Resolution of Issues of Noncompliance.** In the event that any member of the Employer's workforce uses or discloses Protected Health Information other than as permitted by the Privacy Standards, the incident shall be reported to the privacy official. The privacy official shall take appropriate action, including:

(i) Investigation of the incident to determine whether the breach occurred inadvertently, through negligence, or deliberately; whether there is a pattern of breaches; and the degree of harm caused by the breach;

(ii) Applying appropriate sanctions against the persons causing the breach, which, depending upon the nature of the breach, may include, oral or written reprimand, additional training, or termination of employment;

(iii) Mitigating any harm caused by the breach, to the extent practicable;

(iv) Notifying the affected parties; and

(iv) Documentation of the incident and all actions taken to resolve the issue and mitigate any damages.

(4) **Certification of Employer.** The Employer must provide certification to the Plan that it agrees to:

(a) Not use or further disclose the Protected Health Information other than as permitted or required by the Plan documents or as required by law;

(b) Ensure that any agent or subcontractor, to whom it provides Protected Health Information received from the Plan, agrees to the same restrictions and conditions that apply to the Employer with respect to such information;

(c) Not use or disclose Protected Health Information for employment-related actions and decisions or in connection with any other benefit or employee benefit plan of the Employer;

(d) Report to the Plan any use or disclosure of the Protected Health Information of which it becomes aware that is inconsistent with the uses or disclosures hereunder or required by law;

(e) Make available Protected Health Information to individual Plan members in accordance with Section 164.524 of the Privacy Standards;

(f) Make available Protected Health Information for amendment by individual Plan members and incorporate any amendments to Protected Health Information in accordance with Section 164.526 of the Privacy Standards;

(g) Make available the Protected Health Information required to provide any accounting of disclosures to individual Plan members in accordance with Section 164.528 of the Privacy Standards;

(h) Make its internal practices, books and records relating to the use and disclosure of Protected Health Information received from the Plan available to the Department of Health and Human Services for purposes of determining compliance by the Plan with the Privacy Standards;

(i) If feasible, return or destroy all Protected Health Information received from the Plan that the Employer still maintains in any form, and retain no copies of such information when no longer needed for the purpose of which disclosure was made, except that, if such return or destruction is not feasible, limit further uses and disclosures to those purposes that make the return or destruction of the information unfeasible; and

(j) Ensure the adequate separation between the Plan and member of the Employer's workforce, as required by Section 164.504(f)(2)(iii) of the Privacy Standards.

COMPLIANCE WITH HIPAA ELECTRONIC SECURITY STANDARDS. Under the Security Standards for the Protection of Electronic Protected Health Information (45 CFR Part 164.300 et. seq., the "Security Standards"), the Employer agrees to the following:

(1) The Employer agrees to implement reasonable and appropriate administrative, physical and technical safeguards to protect the confidentiality, integrity and availability of Electronic Protected Health Information that the Employer creates, maintains or transmits on behalf of the Plan. "Electronic Protected Health Information" shall have the same definition as set out in the Security Standards, but generally shall mean Protected Health Information that is transmitted by or maintained in electronic media.

(2) The Employer shall ensure that any agent or subcontractor to whom it provides Electronic Protected Health Information shall agree, in writing, to implement reasonable and appropriate security measures to protect the Electronic Protected Health Information.

(3) The Employer shall ensure that reasonable and appropriate security measures are implemented to comply with the conditions and requirements set forth in Compliance With HIPAA Privacy Standards provisions (3) Authorized Employees and (4) Certification of Employers described above.

Complaints, questions, or requests for more information should be directed to the Facility H.R. Department.

FUNDING THE PLAN AND PAYMENT OF BENEFITS

The cost of the Plan is derived from the funds of the Employer and contributions made by the covered Employees and Retirees. The level of any Employee or Retiree contributions will be set by the Plan Administrator. Please contact askHR for more information.

Benefits are paid directly from the Plan through the Claims Administrator.

PLAN IS NOT AN EMPLOYMENT CONTRACT

The Plan is not to be construed as a contract for or of employment.

CLERICAL ERROR

Any clerical error by the Plan Administrator or an agent of the Plan Administrator in keeping pertinent records or a delay in making any changes will not invalidate coverage otherwise validly in force or continue coverage validly terminated. An equitable adjustment of contributions will be made when the error or delay is discovered.

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

AMENDING AND TERMINATING THE PLAN

If the Plan is terminated, the rights of the Plan Participants are limited to expenses incurred before termination.

The Franciscan Missionaries of Our Lady Health System, Inc. (FMOLHS) intends to maintain this Plan indefinitely; however, it reserves the right, at any time, to amend, suspend or terminate the Plan in whole or in part. This includes amending the benefits under the Plan. FMOLHS or designee has the authority to amend/terminate the plan. FMOLHS can periodically update the Exhibit A and Exhibit B, from time to time, without the necessity of a formal Plan amendment. FMOLHS can also update the contact information for Claim Procedures without the necessity of a Plan Amendment.

ANTI-ASSIGNMENT CLAUSE

No monies, property or equity of any nature whatsoever in the FMOLHS Health Plan shall be subject in any manner by any Participant, Dependent or Retiree, or person claiming through such Participant, Dependent or Retiree, to anticipation, alienation, sale, transfer, assignment, pledge, encumbrance, garnishment, mortgage, lien or charge and any attempt to cause the same to be subject thereto shall be null and void.

PHYSICAL EXAMINATION AND AUTOPSY

The Plan may require that a Covered Member have a physical examination, at the Plan's expense, as often as is necessary to settle a claim. In the case of death, the Plan may require an autopsy unless forbidden by law.

RIGHT TO REQUEST OVERPAYMENTS

The Plan reserves the right to recover any payments made by the Plan that were:

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

The Plan has the right to recover against Covered Members if the Plan has paid them or any other party on their behalf.

GENERAL PLAN INFORMATION

TYPE OF ADMINISTRATION

The Plan is a self-funded group health Plan and the administration is provided through a Third Party Claims Administrator. The funding for the benefits is derived from the funds of the Employer and contributions made by covered Employees and Retirees. The Plan is not insured.

PLAN NAME: FMOLHS Health Plan

TAX ID NUMBER: 72-1028323

PLAN EFFECTIVE DATE: January 1, 2024

PLAN YEAR ENDS: December 31

EMPLOYER INFORMATION

Franciscan Missionaries of Our Lady Health System, Inc.
4200 Essen Lane
Baton Rouge, Louisiana 70809
(225) 923-2701

PLAN ADMINISTRATOR/NAMED FIDUCIARY

FMOLHS Benefits Committee

4200 Essen Lane
Baton Rouge, Louisiana 70809
(225) 923-2701

PARTICIPATING FACILITIES

- Franciscan Missionaries of Our Lady, North American Province, Inc.
- Franciscan Missionaries of Our Lady Health System, Inc.
- Franciscan Missionaries of Our Lady University.

AGENT FOR SERVICE OF LEGAL PROCESS

The Plan Administrator which is the
FMOLHS Benefits Committee.
4200 Essen Lane
Baton Rouge, Louisiana 70809

MEDICAL, MENTAL HEALTH/SUBSTANCE ABUSE CLAIMS ADMINISTRATOR

BlueCross BlueShield
P.O. Box 10012
Columbia, South Carolina 29202

CONTINUATION COVERAGE ADMINISTRATOR

Voya Financial
Voya Benefits Company, LLC
P.O. BOX 929
Manchester, NH 03105
(833) 232-4673
HASInfo@voya.com

PARTICIPATION IN FMOLHS CONSOLIDATED WELFARE BENEFIT PLAN. The FMOLHS Health Plan is a Benefit Program included in the FMOLHS Consolidated Welfare Benefit Plan. The terms of the FMOLHS Health Plan are incorporated into the FMOLHS Consolidated Welfare Benefit Plan and to the extent there is any conflict between the two documents, the terms of the FMOLHS Health Plan will govern the benefits provided by the FMOLHS Health Plan.

BY THIS AGREEMENT, this FMOLHS Health Plan is hereby adopted as shown.

IN WITNESS WHEREOF, this instrument is executed for the Franciscan Missionaries of Our Lady Health System, Inc. on or as of the day and year first below written.

FRANCISCAN MISSIONARIES OF OUR LADY HEALTH SYSTEM, INC.

By: _____.
Michael E. Gleason Chief Financial Officer

Date: 12.20.2023

Witness: Debra Terrell Debra Terrell 12.20.2023
9755F

EXHIBIT A: FMOLHS CONTACT INFORMATION

All questions should be directed to:

FMOLHS Benefits Department
P.O. Box 83780
Baton Rouge, LA 70884-3780
askHR@fmolhs.org
1-833-482-7547 phone
1-225-765-9905 fax

EXHIBIT B: PATIENT PROTECTION AND AFFORDABLE CARE ACT DISCLOSURES

Patient Protection and Affordable Care Act Disclosures

The Health Plan complies with applicable federal civil rights laws and does not discriminate on the basis of race, color, national origin, age, disability, or sex. The Health Plan does not exclude people or treat them differently because of race, color, national origin, age, disability, or sex.

The Health Plan:

Provides free aids and services to people with disabilities to communicate effectively with us, such as:

- Qualified sign language interpreters;
- Written information in other formats (large print, audio, accessible electronic formats, other formats);

Provides free language services to people whose primary language is not English, such as:

- Qualified interpreters; and
- Information written in other languages.

If you need these services, contact the FMOLHS Benefits Committee, c/o askHR@fmolhs.org.

If you believe that the FMOLHS Health Plan has failed to provide these services or discriminated in another way on the basis of race, color, national origin, age, disability, or sex, you can file a grievance with the FMOLHS Benefits Committee c/o askHR@fmolhs.org, 4200 Essen Lane, Baton Rouge, Louisiana 70809; telephone number (833) 482-7547; FAX number (225) 765-9905; e-mail:askHR@fmolhs.org. You can file a grievance in person or by mail, fax or e-mail. If you need help filing a grievance, the FMOLHS Benefits Committee is available to help you. You can also file a civil rights complaint with the U.S. Department of Health and Human Services, Office for Civil Rights, electronically through the Office for Civil Rights Complaint Portal, available at https://ocrportal.hhs.gov/ocr/portal/lobby.jsf, or by mail or by phone at: U.S. Department of Health and Human Services, 200 Independence Avenue, S.W., Room 509F, HHH Building, Washington, D.C. 20211, 1-800-868-1019; 1-800-537-7697.

Complaint forms are available at: http://www.hhs.gov/ocr/office/file/index.html.

9755F

EXHIBIT C: BARIATRIC SURGERY REQUIREMENTS

Bariatric Surgery

To be eligible for the Bariatric Surgery Benefit (as defined below), you must obtain written Pre-authorization and you must satisfy the requirements detailed below between the date of the pre-authorization and the date of the surgery.

- Prior authorization is required through Blue Cross Blue Shield (BCBS). The provider must call BCBS when the workup begins to initiate the prior authorization process. The following pre-authorization requirements must be satisfied to be obtain pre-authorization for the Bariatric Surgery Benefit:

  (1) Member must be an actively employed as a Full-time or Part time employee (.5 to 1.0 FTE) for FMOLHS. The coverage is limited to actively employed Full-time or Part-time employees who qualify as Class A Plan Participants. It is not available to team members who are employed as a variable-hour-employees, or team members who are retired or on COBRA. Coverage under the Plan is available to an eligible spouse or dependent of an employee who is a Class A Participant if such spouse or dependent has been enrolled in the FMOLHS Health Plan for a minimum of one year measured from the date of pre-authorization of the surgery and if all requirements are satisfied and services are pre-authorized by BCBS.

  (2) Member or member's covered spouse or dependent must be a Participant in the FMOLHS Health Plan for a minimum period of 12 months, as measured from the date of the pre-authorization.

  (3) Member or member's covered spouse or dependent must have one of the following:(This is not required for revisional bariatric surgery except when due to (7)d listed below)
  (a) a BMI greater than 40 for at least the preceding full 12-month period measured from the date of the authorization; or
  (b) a BMI of 35 to 40 and significant co-morbidity(ies) such as hypertension, diabetes, hyperlipidemia, or sleep apnea which are not amenable to maximum conservative treatment, as determined by BCBS. If BCBS determines that a member or member's covered spouse or dependent with a BMI of 35 to 40 does not have sufficient co-morbidities which are not amenable to maximum conservative treatment, and gains weight to reach a BMI of 40, he or she will not satisfy the preauthorization requirements for one year.
  (c) a BMI of 30-35 with uncontrolled Diabetes Mellitus as evidence by A1C of >7.0 on optimal medical therapy of at least two (2) glucose lowering medications for a period greater than six (6) months.

  (4) Members or member's covered spouse or dependent must provide documentation of a complete a psychiatric/psychological assessment within 6 months prior to the surgery date. (This is not required for revisional bariatric surgery except when due to (7)d listed below)

  (5) Member or member's covered spouse or dependent must meet the FMOLHS Health Plan's established clinical criteria. A member may qualify for surgery through a bariatric center, ***BUT NOT*** meet FMOLHS Health Plan clinical criteria. In this instance the surgery will not be authorized.

  (6) Members or member's covered spouse or dependent must be enrolled in appropriate Weight Management Programs for six months prior to surgery. The FMOLHS Healthy Lives wellness program offers weight management programs free of charge to FMOLHS team members. (This is not required for revisional bariatric surgery except when due to (7)d listed below)

  (7) Members or member's covered spouse or dependents must satisfy one of the following additional requirements for a revisional bariatric surgery:
  (a) Replacement of an adjustable silicone gastric band or separate or concurrent band removal and conversion to a second bariatric surgical procedure is considered Medically Necessary if there is evidence of band slippage, erosion, obstruction, or band component malfunction and the faulty component cannot be repaired.
  (b) Gastric band removal is considered Medically Necessary for gastrointestinal symptomology (e.g.,

persistent nausea and/or vomiting, gastroesophageal reflux) with or without imaging evidence of obstruction.

(c) The following procedures are considered Medically Necessary when the individual develops a major complication from a primary bariatric surgery procedure (e.g., stricture, obstruction, erosion, gastric prolapse, ulceration, fistula formation, esophageal dilatation, gastroesophageal reflux disease refractory to medical therapy):
- surgical repair or reversal (i.e., takedown)
- conversion to a Medically Necessary bariatric surgery procedure

(d) Revision of a previous bariatric surgical procedure or conversion to another Medically Necessary procedure for an adult due to inadequate weight loss is considered Medically Necessary when one of the following is met:
- In the absence of a technical failure or major complication, individuals with weight loss failure ≥ two years following a primary bariatric surgery procedure must meet the initial Medical Necessity criteria for surgery and subject to the $3000 facility co-payment prior to the surgical procedure.
- Patients who require a staged approach (sleeve gastrectomy followed by gastric bypass or duodenal switch) because of excessive operative risk do not need to wait 2 years to undergo the second procedure and are not subject to the $3000 facility copayment prior to the second surgical procedure

NOTE: Inadequate weight loss due to individual noncompliance with postoperative nutrition and exercise recommendations is not a Medically Necessary indication for revision or conversion surgery.

(e) Surgical reversal (i.e., takedown), revision of a previous bariatric surgical procedure or conversion to another bariatric surgical procedure for ANY other indication is considered not Medically Necessary.

- A member or member's covered spouse or dependent must also satisfy the following additional requirements between the date of the pre-authorization and the date of the Bariatric Surgery:

(1) The Member must remain continuously employed by FMOLHS in a Full-time or Part-time position and a Participant in the FMOLHS Health Plan. The member's covered spouse/dependent must also remain a continuous participant in the FMOLHS Health Plan.

(2) The surgery is covered only when performed at an approved FMOLHS MBSAQIP Accredited facility. Additional requirements for the facility must be satisfied for a revisional bariatric surgery.

(3) The surgeon performing the bariatric surgery must be a Tier 1 FMOLHS Customized PPO Network Provider. The FMOLHS Customized EPO Network includes Tier 1 PPO Network Providers. Additional requirements for the surgeon must be satisfied for a revisional bariatric surgery.

(4) The member or member's covered spouse or dependent must timely complete pre-workup physician visits. Workup visits may include diagnostic and laboratory tests, assessments by endocrinology, psychiatry/psychology, nutrition, general surgery, and possibly other specialists such as cardiology. All testing is subject to the Plan's standard deductible and coinsurance and will process according to the standard coverage under the Plan.

(5) Payment of an upfront separate $3,000 facility co-payment prior to the surgical procedure. The $3,000 copay applies even if the member or member's covered spouse or dependent has met their deductible or out of pocket maximum, and it does not apply to an approved revisional surgery except as otherwise indicated in this Plan and Exhibit C. Applicable copayment, deductible, and/or coinsurance would apply to an approved revisional bariatric surgery where the $3000 facility copayment does not apply. The team member could participate in the FMOLHS My Health and Well-being Program. Engaging in approved health and well-being activities could earn the Team Member rewards to redeem including a cash option.

The following services are not covered:

(1) Complications of or Revisions to surgeries unless otherwise covered in accordance with the requirements in this Plan, Exhibit C.

(2) Laparoscopic band placement (lap band surgery)
(3) Any procedure outside the three covered procedures.

The Bariatric Surgery Benefit is limited to the following Covered Procedures:
Roux-en-Y gastric bypass (RYGB)
Sleeve gastrectomy (SG)
Duodenal switch (DS).

Exceptions to the additional requirements for the surgeon and facility for a revisional bariatric surgery include the following:
(1) Gastric band removal (this exception does not apply to a conversion of gastric band to another operation such as gastric bypass) and
(2) Staged procedures for inadequate weight loss.

EXHIBIT D: YOUR RIGHTS AND PROTECTIONS AGAINST SURPRISE MEDICAL BILLS

When you get emergency care or get treated by an out-of-network provider at an in-network hospital or ambulatory surgical center, you are protected from surprise billing or balance billing. In those cases, you shouldn't be charged more than your plan's copayment , coinsurance and/or deductible.

1. 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, like a copayment, coinsurance, or deductible. You may have additional costs or have to pay the entire bill if you see a provider or visit a health care facility that isn't in your health plan's network.

"Out-of-network" describes providers and facilities that haven't signed a contract with your health plan to provide services. Out-of-network providers may be allowed to bill you for the difference between what your plan pays 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 plan's deductible or annual out-of-pocket limit.

"Surprise billing" is an unexpected balance bill. This can happen when you can't 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. Surprise medical bills could cost thousands of dollars depending on the procedure or service.

2. 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 they can bill you is your plan's in-network cost-sharing amount (such as copayments, coinsurance and deductibles). You **can't** be balance billed for these emergency services. This includes services you may get after you're in stable condition, unless you give written consent and give up your protections not to be balanced billed for these post-stabilization services.

Health care services may be provided to you at a network health care facility by facility-based physicians who are not in your health plan. You may be responsible for payment of all or part of the fees for those Out-of-Network Services, in addition to applicable amounts due for co-payments, coinsurance, deductibles and non-Covered Services.

Specific information about In-Network and Out-of-Network facility-based physicians can be found at www.MyHealthToolkitLA.com/links/FMOLHS and by calling Member Services at (833) 468-3594. You may access these websites from home. If you have any questions about how to do this, please contact askHR@fmolhs.org or call 1-833-482-7547.

Certain services at an in-network hospital or ambulatory surgical center

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 can 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 **can't** 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 **can't** balance bill you, unless you give written consent and give up your protections.

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

Professional services rendered by independent healthcare professionals are not part of the hospital bill. These services will be billed to the patient separately. Please understand that physicians or other healthcare professionals may be called upon to provide care or services to you or on your behalf, but you may not actually see, or be examined by, all physicians or healthcare professionals participating in your care; for example, you may not see physicians providing radiology, pathology, and EKG interpretation. In many instances, there will be a separate charge for professional services rendered by physicians to you or on your behalf, and you will receive a bill for these professional services that is separate from the bill for hospital services. These independent healthcare professionals may not participate in your health plan and you may be responsible for payment of all or part of the fees for the services provided by these physicians who have provided out-of-network services, in addition to applicable amounts due for copayments, coinsurance, deductibles, and non-covered services.

We encourage you to determine if independent healthcare professionals are participating in the Plan by checking the Plan's website at www.MyHealthToolkitLA.com/links/FMOLHS and/or calling Member Services at (833) 468-3594. You may access these websites from home. If you have any questions about how to do this, please contact askHR@fmolhs.org or call 1-833-482-7547.

When balance billing isn't 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 any additional costs to out-of-network providers and facilities directly.
- Generally, your health plan must:
    - Cover emergency services without requiring you to get approval for services in advance (also known as "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 in 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've been wrongly billed, you may contact the Department of Health and Human Services (HHS) at 1-800-985-3059.

Visit: https://www.cms.gov/nosurprises/consumers for more information about your rights under federal law.

EXHIBIT E: NO SURPRISES ACT REQUIREMENTS

Requirements of the No Surprises Act. Claims for covered Charges rendered by a Non-PPO/Out-of-Network Providers to a Participant or Dependent as detailed in this Section may be submitted directly to the Plan by the Non-PPO/Out-of-Network Provider, or the Participant may need to submit the claim. In either case, it is the responsibility of the Participant to make sure that all claims are filed on time.

(1) Charges for Emergency Services covered under the Plan provided by a Non-PPO/Out-of-Network Provider that is an emergency department of a hospital or an Independent Freestanding Emergency Department will be covered as follows:

(a) Without the need for any prior authorization;

(b) Whether or not the health care provider furnishing such services is a participating provider or participating emergency facility;

(c) Without imposing any cost sharing requirement that is greater than the requirement that would apply if such services were provided by a participating provider or a participating emergency facility;

(d) Such cost-sharing shall be calculated as if the total amount that would have been charged for such services by the participating provider or participating emergency facility were equal to the Recognized Amount for such services, plan and year; and

(e) The Plan, not later than 30 calendar days after the bill for such service is transmitted by such provider or facility, sends an initial payment or notice of denial of payment; and pays a total Plan payment directly to such provider or facility that generally is equal to the Out-of-Network Rate reduced by the cost sharing for such services; and

(f) Any cost sharing payments made by the Participant will be subject to the requirements in Section (3).

(2) Charges for Non-Emergency Services (including Ancillary Services and services for unforeseen urgent medical needs) covered under the Plan which are furnished to a Participant or Dependent by a nonparticipating provider in a PPO/In-Network Health Care Facility, and who has not satisfied the notice and consent requirements of 45 CFR 149.420(c) through (i) detailed below will be covered in accordance with the requirements in Section (1)(c)-(f) above.

(a) Notice and Consent Requirements

(i) There are no Notice and Consent Requirement for Ancillary Services and unforeseen urgent medical needs.

(ii) The Notice and Consent Requirements under 45 C.F.R. §149.420 for non-Emergency Services which are not Ancillary Services or services for unforeseen urgent medical needs require the Non-PPO/Out of Network provider to:

(I) Provide to the Participant or Dependent a written notice in paper or, as practicable, electronic form, as selected by the individual that states that the health care provider is a Non-PPO/Out-of-Network Provider, includes a good faith estimate of the charges for the services, provides a statement that prior authorization or other care management limitations may be required in advance

of receiving such items or services and clearly states that consent to receive such items and services is optional and that the Participant or Dependent may instead seek care from an available participating provider (PPO) and that in such case, the cost-sharing would not exceed the responsibility that would apply for a participating provider; and

(i) Provide such notice in accordance with the guidance issued by HHS and in the form and manner specified in such guidance,

(ii) Provide the written notice with the consent document physically separate from other documents and provide such documents not attached to or incorporated into any other document; and

(iii) Provide the written notice in a timely manner which is not later than 72 hours prior to the date on which the individual is furnished such items or services if such items or services are scheduled at least 72 hours in advance and on the date of the appointment in the case where the appointment is not scheduled at least 72 hours in advance, subject to the requirement that the notice be provided at least three hours prior to furnishing the items or services.

(II) Obtain consent from the Participant or Dependent (or the Participant or Dependent's Authorized Representative) to be treated and balance billed by the Non-PPO/Out-of-Network Provider. The consent must:

(i) Be provided voluntarily, meaning the individual is able to consent freely, without undue influence, fraud or duress;

(ii) Be obtained in accordance with, and in the form and manner specified by HHS; and

(iii) Not be revoked in writing by the Participant prior to the receipt of the items and services to which the consent applies;

(iv) Acknowledge in clear and understandable language that the Participant has been provided the written notice under 4b(i), which informed the Participant that the payment of such charge by the Participant might not accrue toward meeting any limitation that the Plan or coverage places on cost sharing, including an in-network deductible or out-of-pocket maximum;

(v) State that by signing the consent the individual agreed to be treated and balanced billed and subject to cost-sharing requirements that apply to Non-PPO/Out of Network providers; and

(vi) Document the time and date of receipt of the Participant's written notice and the Participant's execution of the consent.

(III) Provide a copy of the signed written notice and consent to the Participant through mail or email as selected by the Participant.

(3) Any copayment, coinsurance, and/or other cost-sharing requirement for covered services provided by Non-PPO/Out-of-Network Providers **will be the same** as the copayment, coinsurance, and/or other cost-sharing requirement stated in the Plan for services provided by PPO/In-Network Providers, for the

following services and all cost-sharing payments made by the Participant for the following services, will contribute towards the Plan in-network deductible and out-of-pocket maximum:

(a) Emergency Services provided by Non-PPO/Out-of-Network Providers.

(b) Air Ambulance Services provided by Out-of-Network Providers.

(c) Non-Emergency Services provided by a Non-PPO/Out-of-Network Providers at PPO/in-network facilities (including Ancillary Services and services for unforeseen urgent medical needs), unless the Out-of-Network Provider has satisfied the Notice and Consent Requirements of 45 C.F.R. §149.420 (c) through (i), as applicable, with respect to such items and services.

(d) To the extent required by law, services provided by an Out-of-Network Provider, when the Participant relied on a database, provider directory, or information provided by the Plan regarding the health care provider's status (through a telephone call or electronic means) which incorrectly indicated that the health care provider was an In-Network Provider for the services received.

(4) In the event a Participant is a continuing care patient receiving a course of treatment from a provider which is a PPO/in-network provider and that provider is terminated, not renewed, or otherwise ends for any reason other than the provider's failure to meet applicable quality standards or for fraud, the Participant shall have the following rights to continuation of care, subject to any good faith requirements in the law:

(a) The Participant shall be notified in a timely manner that the Participant has rights to elect continued transitional care from the provider. If the Participant elects in writing to receive continued transitional care, Plan benefits will apply under the same terms and conditions as would be applicable had the termination not occurred, beginning on the date the Participant was notified of the provider's termination and ending 90 days later or when the Participant ceases to be a continuing care patient, whichever is sooner.

(b) For purposes of this provision, "continuing care patient" means an individual who:

(i) is undergoing a course of treatment for a serious and complex condition from a specific provider or facility,
(ii) is undergoing a course of institutional or Inpatient care from a specific provider or facility,
(iii) is scheduled to undergo non-elective surgery from a specific provider or facility, including receipt of postoperative care from such provider or facility with respect to such a surgery,
(iv) is pregnant and undergoing a course of treatment for the pregnancy from a specific provider or facility, or
(v) is or was determined to be terminally ill and is receiving treatment for such illness from a specific provider or facility.

Note that during continuation, Plan benefits will be processed as if the termination had not occurred, however, the provider may be free to pursue the Participant for any amounts above the Plan's benefit amount.

(5) Defined terms for purposes of this Section:

(a) Air Ambulance Service "Air Ambulance Service" means medical transport of a Participant or Dependent by a rotary wing air ambulance, as defined in 42 C.F.R. 414.605, or fixed wing air ambulance, as defined in 42 C.F.R. 414.605.

(b) Ancillary Services. "Ancillary Services" mean:

(i) Items and services related to emergency medicine, anesthesiology, pathology, radiology, and neonatology, whether provided by a physician or non-physician practitioner;
(ii) Items and services provided by assistant surgeons, hospitalists and intensivists;
(iii) Diagnostic services, including radiology and laboratory services; and
(iv) Items and services provided by a nonparticipating provider if there is no participating provider who can furnish such item or service at such facility.

(c) Authorized Representative. An "Authorized Representative" is an individual authorized under State law to provide consent on behalf of the Participant or Dependent, provided that the individual is not a provider affiliated with the facility or an employee of the facility unless such provider or employee is a family member of the Participant.

(d) Emergency Medical Condition. An "Emergency Medical Condition" is a medical condition, including a mental health condition or substance use disorder, manifesting itself by acute symptoms of sufficient severity (including severe pain) 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:

(i) Placing the health of the individual (or, with respect to a pregnant woman, the health of the woman or her unborn child) in serious jeopardy;
(ii) Serious impairment to bodily functions; or
(iii) Serious dysfunction of any bodily organ or part.

(e) Emergency Services. "Emergency Services" with respect to an Emergency Medical Condition means:

(i) A medical screening examination (as required under section 1867 of the Social Security Act, 42 U.S.C. 1395dd, or as would be required under such section if such section applied to an Independent Freestanding Emergency Department) that is within the capability of the emergency department of a hospital or Independent Freestanding Emergency Department, as applicable, including Ancillary Services routinely available to the emergency department to evaluate such Emergency Medical Condition; and

(ii) Any such further medical examination and treatment, to the extent they are within the capabilities of the staff and facilities available at the hospital or the Independent Freestanding Emergency Department, as are required under section 1867 of the Social Security Act (42 U.S.C. 1395dd) or as would be required under such section if such section applied to an Independent Freestanding Emergency Department, to stabilize the Participant, regardless of the department of the hospital in which such further examination or treatment is furnished to the Participant. The term "to stabilize" with respect to an Emergency Medical Condition, means to provide such medical treatment of the Emergency Medical Condition as may be necessary to assure, within reasonable medical probability, that no material deterioration of the condition is likely to result from or occur during the transfer of the Participant from a facility; and

(iii) Post-stabilization services (i.e., services provided after the Participant has been stabilized, as part of outpatient observation, or an inpatient or outpatient stay related to the Emergency Services provided, as described above) unless all the requirements detailed below are satisfied:

(I) Such provider or facility determines the Participant is able to travel using nonmedical transportation or nonemergency medical transportation to an

available participating provider or facility located within a reasonable travel distance, taking into account the individual's medical condition.

(II) The provider or facility furnishing such additional items and services satisfies the notice and consent criteria of 45 C.F.R § 149.420(c) through (g) with respect to such items and services,

(III) The individual (or an Authorized Representative of such individual) is in a condition to receive the information described in item b. above, as determined by the attending emergency physician or treating provider using appropriate medical judgment, and to provide informed consent in accordance with applicable State law.

(IV) The provider or facility satisfies any additional state law requirements.

(f) Health Care Facility. "Health Care Facility" means a hospital, hospital outpatient department, a critical access hospital and ambulatory surgical center and any other facility required by the federal government.

(g) Independent Freestanding Emergency Department. An "Independent Freestanding Emergency Department" means a health care facility that is geographically separate and distinct and licensed separately from a hospital under applicable State law; and provides any Emergency Services.

(h) Out-of-Network Rate. The "Out-of-Network Rate" means, with respect to an item or service furnished by a non-contracting provider, non-contracting emergency facility, or non-contracting provider of air ambulance services:

(i) In a State that has an All-Payer Model Agreement under section 1115A of the Social Security Act that applies to the plan/carrier, non-contracting provider/non-contracting emergency facility, and item/service, the amount that the State approves under the All-Payer Model Agreement for the item or service.

(ii) If there is no such All-Payer Model Agreement applicable to the item or service, but a specified State law is in effect and applicable, the amount for the item or service determined in accordance with such specified State law.

(iii) If there is no such All Payor Model Agreement or specified State law applicable to the item or service, an amount agreed upon by the Plan and the non-contracting provider or non-contracting emergency facility.

(iv) If none of the three conditions above apply, an amount determined by a certified independent dispute resolution (IDR) entity under the IDR Process described in section 2799A-l(c) or 2799A-2(b) of the federal Public Health Service Act, as applicable.

(i) Qualifying Payment Amount. The "Qualifying Payment Amount" means, subject to Code Section 9816(a)(3)(E), an amount calculated based on the median contracted rate for the Plan for the same or similar item or service that is:

(i) Provided by a health care provider in the same or similar specialty or facility of the same or similar facility type; and
(ii) Provided in the geographic region in which the item or service is furnished.

(j) Recognized Amount. The "Recognized Amount" is determined as follows:

(i) In a state or jurisdiction that has an applicable All-Payer Model Agreement, the amount that the state or jurisdiction approves under the All-Payer Model Agreement for the particular covered service.

(ii) If there is no applicable All-Payer Model Agreement, in a state or jurisdiction that has in effect an applicable law, the amount for the covered service determined in accordance with the law.

(iii) If neither an applicable All-Payer Model Agreement nor law apply to the specific covered service, the lesser of:

(I) The Out-of-Network Provider's actual charge; or

(II) The Qualifying Payment Amount.