MEMORIAL HEALTHCARE SYSTEM

EMPLOYEE HEALTHCARE PROGRAM

PLAN DOCUMENT

Effective as of January 1, 2024

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Part I. Purpose and Effective Date of Plan

This written plan document constitutes the Memorial Healthcare System Employee Healthcare Program (hereinafter referred to as the "Plan"), which is hereby restated in its entirety effective as of January 1, 2024. The Plan is intended to be maintained for the exclusive benefit of its Participants, and consists of the following component plans: the Memorial Managed Care Plan (hereinafter referred to as the "MMCP"), and the Memorial Consumer Health Plan (hereinafter referred to as the "MCHP").

This plan document will be made available to each Eligible Employee who has enrolled in the Plan. This document and any attachments such as the applicable Schedule of Benefits, Your enrollment form and identification card constitute the written summary of your benefits, rights and obligations under the Plan.

By enrolling in the Plan, the Member agrees to abide by the rules as described in this plan document. Members are eligible to receive Medically Necessary services and benefits described in the plan document in exchange for the Premium paid to Memorial Healthcare System.

If You have any questions about this document, please call Human Resources at your facility. Claims payment and other questions should be directed to customer services of the specific program in question (see your Benefits Guide for most current information).

Part II. Definitions

Adverse Benefit Determination means a coverage determination by Us that an admission, availability of care, continued stay, or other health care service has been reviewed and, based upon the information provided, does not meet our requirements for medical necessity, appropriateness, healthcare setting, or level of care or effectiveness. Coverage for the requested service is therefore denied, reduced or terminated.

Appeal means the process by which a Member may ask for review of a denied service or claim.

Appeals Coordinator means the person or entity authorized by the Plan to review appeals submitted by Members and confirm they are addressed in accordance with Plan policy.

Authorized Representative: A Claimant may authorize a representative to act on their behalf in pursuing a benefit claim or appeal of an Adverse Benefit Determination. The Claimant must authorize the representative in writing, and this written authorization must be provided to the Plan. The Plan will recognize this Authorized Representative when the Plan receives the written authorization. In the case of a claim involving urgent care, a Health Care Professional with knowledge of the Claimant's medical condition is also permitted to act as the Claimant's Authorized Representative.

Benefits: The Plan provides payment as shown under **Schedule of Benefits** for eligible expenses subject to the limitations, specifications, exclusions and provisions of the Plan.

Benefits Guide means the annual publication of plans available to Memorial Healthcare System Eligible Employees that details contact information and processes that can change over time.

Calendar Year means the twelve month period beginning January 1 and ending December 31.

Claimant means a person requesting benefits under the Plan. A Claimant may or may not be a Member under the Plan.

Claims Administrator means the third party administrator appointed by the Plan to administer claims and benefits under the Plan.

Complaint means any expression of dissatisfaction by a Member, including dissatisfaction with the administration, claims practices, or provision of services, which relates to the quality of care provided by a provider pursuant to our contract and which is submitted to us or the Agency for Health Care Administration or the Department of Insurance, a state agency. A complaint is a part of the informal steps of a grievance procedure.

Coinsurance means the percentage of eligible expenses a Member is required to pay as shown in the **Schedule of Benefits**.

Copayment means an amount paid or payable by you directly to the health care provider at the time services are received.

Deductible means the total amount of eligible expenses, as shown in the **Schedule of Benefits**, which must be incurred by a Member during any Calendar Year before covered expenses are payable under the Plan. The Family Deductible maximum, as shown in the **Schedule of Benefits**, is the maximum amount (number of Deductibles) which must be incurred by the covered family members during a Calendar Year. However, each

individual in a family is not required to contribute more than one individual Deductible amount to the family Deductible.

Dependent means any person in an Eligible Employee's family who meets the eligibility requirements for coverage as described in Part III of this Contract and has been enrolled by the Subscriber.

Durable Medical Equipment means equipment which can withstand repeated use, is primarily and usually used to serve a medical purpose, is generally not useful to a person in the absence of illness or injury and is appropriate for use in the home.

Eligible Employee means a person who meets all eligibility requirements described in Part III of this plan document; and has completed an enrollment form and has paid, or has had paid on his or her behalf, all applicable Premiums.

Employer means Memorial Healthcare System, and its subsidiaries, a hospital organization located in South Florida, that complies with the laws of the State of Florida.

Emergency Care Services means medical screening, examination and evaluation by a physician, or, to the extent permitted by applicable law, by other appropriate personnel under the supervision of a physician, to determine if any emergency medical condition exists and, if it does, the care, treatment or surgery for a covered service by a physician necessary to relieve or eliminate the emergency medical condition, within the service capability of a hospital.

Emergency Medical Condition means:

a. A medical condition manifesting itself by acute symptoms of sufficient severity, which may include severe pain or other acute symptoms, such that the absence of immediate medical attention could reasonably be expected to result in any of the following:

   1. Serious jeopardy to the health of a patient, including a pregnant woman or fetus.

   2. Serious impairment of bodily functions.

   3. Serious dysfunction of any bodily organ or part.

b. With respect to a pregnant woman:

   1. That there is inadequate time to affect safe transfer to another hospital prior to delivery;

   2. That a transfer may pose a threat to the health and safety of the patient or fetus; or

   3. That there is evidence of the onset and persistence of uterine contractions or rupture of the membranes.

Exclusion(s) mean(s) service(s) or item(s) which are not covered under the Plan.

Experimental/Investigational: A drug, device, treatment, or procedure is Experimental or Investigational: (1) 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; (2) if Reliable Evidence shows that the drug, device, treatment, or procedure is the subject of ongoing Phase I, II or III clinical trials, or is 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; except that the treatment and/or services related to side effects and or complications from participation in an ongoing Phase I, II, or III clinical trial shall not be considered Experimental/Investigational; or (3) if Reliable Evidence shows that the prevailing opinion among experts regarding the drug, device, 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 or scientific literature; the written protocol or protocols used by the treatment facility or another facility studying substantially the same drug, device, treatment, or procedures; or the written informed consent used by the treating facility or another facility studying substantially the same drug, device, treatment, or procedure.

Health Plan means the Memorial Healthcare System Employee Healthcare Program, which is a self-insurance program of Memorial Healthcare System, created pursuant to Ch.112, Florida Statute.

Health Professional means non-physician providers of care, which have contracted with the Plan to provide medical and health care services to Members of the Plan.

Home Health Care Agency means a public or private agency or organization that specializes in providing medical care and treatment in the home.

Home Health Services means the services provided by health professionals in your home when you are confined to your home, and when Medically Necessary and authorized by a Participating Provider and the Plan.

Hospice means a Medicare-certified organization or agency that primarily provides services for pain relief, symptom management and supportive services to terminally ill persons and their families.

Hospital means an acute care hospital licensed by the State of Florida and approved by the Joint Commission on Accreditation of Health Care Organizations (JCAHO), or the American Osteopathic Association and certified by the Medicare Program, which has an agreement with the Plan. Not included are Federal hospitals, a place for rest, and a place for the aged or a nursing home.

Independent Review Organization (IRO) means an organization independent of affected parties that conducts independent or external medical review. An IRO conducts a review of a case to determine if a conflict of interest exists, whether the case relates to a clinical or administrative issue, whether the case refers to medical necessity or experimental/investigational process and whether the case requires standard or expedited review.

Late Enrollee means an Eligible Employee or Dependent who does not elect coverage under the Plan within thirty (30) days of their Eligibility Date and who is not otherwise considered a Special Enrollee. An employee not enrolled for coverage under the Employer's previous Employer-sponsored plan will be considered a Late Enrollee.

Medical Director means a physician designated by the Plan to monitor the quality of health services rendered to Members and to make medical necessity determinations based on national evidence based utilization review criteria.

Medically Necessary means the use of services and/or supplies, as described under the Plan, which are required to identify or treat Your illness or injury and which, as determined by the Plan, are:

1. Consistent with the symptoms or diagnosis and treatment of Your condition, disease, ailment or injury;

2. Appropriate, safe and effective with regard to standards of good medical practice;

3. Not solely for Your or Your family members' convenience, Your physician, hospital or other health care provider; and

4. The most appropriate supply or level of service which can be safely provided to You. When applied to an inpatient, it further means that Your medical symptoms or condition require that the treatment cannot be safely provided to You as an outpatient.

5. The fact that a treating physician has prescribed, performed, or approved a particular service or supply does not in and of itself make it Medically Necessary. In making the determination of whether a service or supply was Medically Necessary, the Plan or its designee, may request and rely upon the opinion of Your Primary Care Physician, a Specialist or the Medical Director. The determination of the Plan, including a decision of an IRO retained by the Plan, shall be final and binding on all Members.

Member means any Eligible Employee or enrolled Eligible Dependents entitled to benefits under the Plan.

Mental Disorder means any disease or condition, regardless of whether the cause is organic, that is classified as a Mental Disorder in the current edition of the International Classification of Diseases, published by the World Health Organization.

Network – A group of doctors, hospitals and other health care providers contracted to provide services to an insurance company or employer for less than their usual fees.

Nonstandard/Unevaluated Procedures and Items means those items and procedures which (1) are not accepted by the relevant community of medical professionals as a reliable and effective technique for treating the illness or injury in question under the conditions and circumstances existing at the time the treatment, item or procedure is recommended; (2) have not been widely adopted in the organized medical community; (3) are undertaken principally for purposes of research; (4) are approved for a specific medical condition, but apply to another condition; or (5) have not been approved for general use by the relevant government agency if such approval is normally required, (e.g., FDA for medication, Medicare Program, National Institute of Health, etc.)

Facility and provider portions of clinical trials approved as a standard of care by Medicare shall be covered.

Open Enrollment Period means those periods of time established by the Plan during which Eligible Employees who have not previously enrolled with the Plan may do so. The Open Enrollment Period will be established from time to time, but at least once every twelve (12) months.

Out-of-Network Services means those services provided by health care providers who are not Participating Providers. The MCHP plan allows members to utilize non-contracted physicians and health professionals at a higher cost than in network providers for certain services.

Out-of-pocket limit means the maximum amount of Copayments, Co-insurance and Deductible an Eligible Employee and/or all family members will pay for eligible expenses during a Calendar Year before the covered percentage increases to 100%. NOTE: Expenses incurred for the following cannot be applied toward the Out-of-Pocket Limit: (1) any penalty amounts; and (2) any charges as defined in **Exclusions, Limitations and Non-Covered Services (**Part VI).

Participating Provider means a health professional, a supplier of health care items or a health care facility having an agreement with the Plan to provide medical services to Plan Members.

Plan means the Memorial Healthcare System Employee Healthcare Program as set forth in this document, the Schedules of Benefits, and any amendments that may be added in the future, which explain the services and benefits covered by the Plan and define the rights and responsibilities of Members and the Plan.

Plan Administrator means Memorial Healthcare System.

Premium means the periodic payment per pay period made to the Plan by You, or on Your behalf, that entitles You to the benefits outlined in this plan document.

Pre-Service Claim means requests for approval that the Plan requires You to obtain before You get medical care, such as preauthorization or a decision on whether a treatment or procedure is Medically Necessary.

Post-Service Claim means all other claims for Benefits under the Plan after medical services have been provided, such as requests for reimbursement or payment of the costs of the services provided.

Primary Care Physician means a physician who practices in the specialty of Family Practice, General Practice, Internal Medicine, Pediatrics or Osteopathy, who is selected by You from the Plan's physician list.

Prior or Pre-Authorization means that a Participating Provider, Primary Care Physician, or other provider must receive approval from the Plan's Medical Services Department, before You receive certain health care services.

Professional Services mean those services (except as excluded or limited under the Plan) performed by Participating Providers (or, in the case of Emergency Care Services, non-Participating Providers) which are Medically Necessary and generally recognized as appropriate care within the Service Area and in accordance with the Plan's policies and procedures.

Qualified Health Plan means any of the following: (1) a group health plan; (2) health insurance coverage; (3) Medicare; (4) Medicaid; (5) TRI-CARE; (6) an Indian Health Service plan or tribal organization plan; (7) a state risk pool coverage; (8) a federal employees health insurance coverage; (9) a public health plan (this includes plans established or maintained by a state, the U.S. government, a foreign country, a state or federal penitentiary, the U.S. Veterans Administration, or any political subdivision of a state, the U.S. government, or a foreign country that provides health coverage to individuals who are enrolled in the Plan); (10) a Peace Corps plan; or (11) the State Children's Health Insurance Program.

Qualifying Event means any of the events described in Internal Revenue Code §4980B(f)(3) with respect to continuation of Benefits under Part XIII of this plan document.

Rescission means a cancellation or discontinuation of coverage which has retroactive effect. Rescissions of coverage under the Plan are generally prohibited except in the case of fraud or an intentional misrepresentation of material fact. In general, the Plan is not allowed to rescind (i.e., retroactively cancel or terminate) Your (or Your Dependent's) medical plan coverage once You (or Your Dependents) become covered under the Plan. However, Your (and/or Your Dependent's) coverage under the Plan may be rescinded (i.e., cancelled or discontinued with a retroactive effective date) if You (and/or Your Dependent) performs an act, practice, or omission that constitutes fraud, or makes an intentional misrepresentation of material fact as prohibited under the terms of this Plan. For example, if the Employer determines You have enrolled an individual who does not meet the Plan's eligibility requirements as stated herein or as stated in the enrollment materials, Your enrollment of such Plan ineligible individual(s) will be treated as an intentional misrepresentation of a

material fact, or fraud, and the Plan reserves the right to rescind Your (and/or Your Dependent's) Plan coverage. If the Employer seeks to rescind medical coverage for fraud or an intentional misrepresentation of a material fact, the Employer will provide at least thirty (30) days advance written notice to each participant who would be affected before coverage is rescinded. Your (and/or Your Dependent's) coverage also may be terminated retroactively for failure to pay the required premiums or contributions on a timely basis, or in certain other limited circumstances without the Employer having to provide thirty (30) days advance written notice.

Skilled Nursing Facility means a facility which is licensed by the State in which it is located to provide inpatient medical and nursing care, is recognized as such by Medicare, and which has a contract with the Plan. Care in a Skilled Nursing Facility is provided only if skilled nursing care is required. The term "Skilled Nursing Facility" does not include a convalescent nursing home, rest facility or facility for the aged.

Specialist Physician means a physician who provides specialized services.

Substance Use Disorder means any disease or condition that is classified as a Substance Use Disorder in the current edition of the International Classification of Diseases, published by the World Health Organization.

Urgent Care Claim means any Pre-Service Claim for medical care or treatment with respect to which the application of the time periods for making non-urgent care determinations could seriously jeopardize the life or health of the Claimant or the ability of the Claimant to regain maximum function, or in the opinion of a Physician with knowledge of the Claimant's medical condition, would subject the Claimant to severe pain that cannot be adequately managed without the care or treatment that is the subject of the claim. A Post-Service Claim is never an Urgent Care Claim.

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

Urgent Care Services are Medically Necessary services provided in connection with a medical condition which could, without timely treatment (in or out of service area), be expected to result in deterioration to an emergency, or prolonged temporary impairment in bodily function, or development of a chronic illness, or need for a more complex or hazardous treatment. Examples include, but are not limited to: unremitting abdominal pain of unknown cause, new symptom of dizziness, cause unknown or suspected fracture.

Usual and Customary Charge means charges made for medical services or supplies essential to the care of the individual will be subject to a Usual and Customary determination. Usual and Customary allowances are based on what is usually and customarily accepted as payment for the same service within a geographical area. In determining whether charges are Usual and Customary, consideration will be given to the nature and severity of the condition and any medical complications or unusual circumstances which require additional time, skill or experience.

We or Us means the Memorial Healthcare System Employee Healthcare Program.

You or Your means the Eligible Employee/Member and/or his or her eligible enrolled Dependents (Members).

Part III. Eligibility, Enrollment and Effective Date of Coverage

A. Eligibility

1. Eligible Employee

Regularly scheduled employees of the Employer who work forty (40) or more hours per pay period will be eligible to enroll for coverage under this Plan. Other employees scheduled to work less than 40 hours per pay period, and temporary or seasonal employees, will not be eligible to enroll for coverage under this Plan.

Employees of the Memorial Federal Credit Union are also eligible to enroll in this Plan.

2. Eligible Dependent

Eligible Dependents will be an Eligible Employee's legally married spouse and each child until the end of the Calendar Year in which they attain age twenty-six (26).

A dependent child may be covered from the end of the Calendar Year they attain age twenty-six (26) through the end of the year attaining age thirty (30) provided such dependent meets all the following:

- Is unmarried and does not have dependents of their own;
- is a resident of the State of Florida or is a full-time or part-time student; and
- is not provided coverage as insured, enrollee, or eligible employee under any other group, blanket, or franchise health insurance policy or individual health benefits plan, or is not entitled to benefits under Title XVIII of the Social Security Act.

The term "child", as used herein, shall be defined as: (a) a natural born child; (b) a stepchild; (c) a foster child; (d) an adopted child (from the date of placement with the employee for the purpose of legal adoption); (e) a child for whom the employee is the legal guardian; (f) a child of a covered Dependent child for the first eighteen (18) months from birth; or (g) a child for whom the employee is required to provide health coverage due to a Qualified Medical Child Support Order ("QMCSO"). Procedures for determining a QMCSO may be obtained from the Claims Administrator at no cost.

No individual may be covered under this Plan as both an employee and a dependent. Also, no individual will be considered an eligible Dependent of more than one employee.

3. Eligibility Extension for Dependent Children

Mentally or Physically Handicapped Child: If an unmarried dependent child, upon reaching the dependent age limit, is incapacitated, unable to be self-supporting, and resides with the employee, then such child will continue to be an eligible Dependent.

The employee may be required to provide the Plan with written evidence of child's handicapped status.

4. Affordable Care Act benefit eligible

Employees are provided an opportunity to participate in the Memorial Healthcare System sponsored benefits program after satisfying the new hire waiting period and annually during Open Enrollment. You are eligible for benefits following a thirty (30) day waiting period if you meet the 30 hours per week requirement. Please refer to the following guidelines regarding eligibility and election changes.

Dependent Eligibility - *Medical*

A dependent is defined as a covered employee's legal spouse or a dependent child of the employee or employee's spouse. Dependent children will be covered through the end of the calendar year in which they turn age 26 and in some cases until age 30. A dependent child is defined as:

- A natural child
- A step-child
- A legally adopted child
- A child placed for adoption
- A child placed for foster care
- A child for whom legal guardianship has been awarded to the covered employee or the employee's spouse.
- Unmarried children of any age who become mentally or physically disabled before reaching the age limit

FL Statute 627.6562 Dependent Coverage: Health insurance coverage is available for dependents ages 26 to 30. Please contact your Human Resources Department for more information.

B. Plan Enrollment

An eligible Dependent is able to participate in the Plan when the Eligible Employee completes, signs, and returns an enrollment form indicating dependent coverage to the Employer. The employee must enroll the dependent(s) within thirty (30) days of whichever of the following occurs first:

1. The employee's Eligibility Date if the employee has any eligible Dependents at that time; or

2. The date the employee acquires an eligible Dependent.

Newborn children and adopted children will be covered on the date of birth or adoption (or placement for adoption) if enrolled within sixty (60) days of the birth, or within thirty (30) days of adoption or placement for adoption.

Failure to enroll for dependent coverage within this time limit will be deemed a waiver of participation and future coverage for dependents under the Plan will be subject to the Late Enrollee or Special Enrollee provisions.

Special Enrollee: If an employee is declining enrollment for family coverage because of other health coverage (see definition of Qualified Health Plan), the employee may, in the future, be able to enroll for family coverage, provided the request for enrollment is received within thirty (30) days after coverage under the Qualified Health Plan terminates due to loss of eligibility or termination of Employer contributions toward the cost of coverage.

If the employee has a new dependent as a result of marriage, birth, adoption, or placement for adoption, the employee may be able to enroll for dependent coverage provided the employee requests enrollment within thirty (30) days after the marriage, adoption or placement for adoption or sixty (60) days following birth.

Loss or Gain of Eligibility for a State Children's Health Insurance Plan (CHIP) or Medicaid: If You are eligible for, but not enrolled in, the Plan (or Your Dependent is eligible for, but not enrolled in, the Plan), You (and Your Dependent) may enroll in the Plan, if either of the following conditions is met:

- You (or Your Dependent) is covered under CHIP or Medicaid and such coverage is terminated as a result of loss of eligibility, and You request coverage under the Plan not later than sixty (60) days after the date of termination of such CHIP or Medicaid coverage; or

- You (or Your Dependent) becomes eligible for CHIP or Medicaid premium assistance subsidy with respect to coverage under the Plan, if you request coverage under the Plan not later than sixty (60) days after the date You or Your Dependent is determined to be eligible for such premium assistance subsidy.

If you enroll Yourself and/or Your eligible Dependents in this Plan due to a loss or gain of eligibility for coverage event described above, coverage under this Plan will begin the first day of the first calendar month after the completed special enrollment form is received.

Late Enrollee: A Late Enrollee (employee) may enroll for coverage under the Plan during the re-enrollment period.

Return to Work/Military Reservists

Military reservists who are called-up to active duty for a period of more than thirty (30) days will be eligible for coverage on the date they return to work, provided:

1. The employee is honorably discharged; and

2. The employee returns to work with the Employer within the specific time period in the Uniformed Services Employment and Reemployment Rights Act (USERRA).

Coverage for a reservist will be on the same basis it is for active employees and dependents.

Premium Assistance Under Medicaid and the Children's Health Insurance Program (CHIP)

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

If you or your dependents are already enrolled in Medicaid or CHIP and you live in a State listed below, contact your State Medicaid or CHIP office to find out if premium assistance is available.

If you or your dependents are NOT currently enrolled in Medicaid or CHIP, and you think you or any of your dependents might be eligible for either of these programs, contact your State Medicaid or CHIP office or dial **1-877-KIDS NOW** or **www.insurekidsnow.gov** to find out how to apply. If you qualify, ask your State if it has a program that might help you pay the premiums for an employer-sponsored plan.

If you or your dependents are eligible for premium assistance under Medicaid or CHIP, as well as eligible under your employer plan, your employer must allow you to enroll in your employer plan if you aren't already enrolled. This is called a "special enrollment" opportunity, and **you must request coverage within 60 days of being determined eligible for premium assistance**. If you have questions about enrolling in your employer plan, contact the Department of Labor at **www.askebsa.dol.gov** or call **1-866-444-EBSA (3272)**.

If you live in the State of Florida, you may be eligible for assistance paying your employer health plan premiums. You should contact the State of Florida for further information on eligibility:

FLORIDA – Medicaid
Website: https://www.flmedicaidtplrecovery.com/flmedicaidtplrecovery.com/hipp/index.html Phone: 1-877-357-3268

To see if any other states have added a premium assistance program since July 31, 2020, or for more information on special enrollment rights, contact either:

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

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

C. Waiting Period

All Employees: An employee's participation in the Plan is subject to a waiting period of thirty (30) days of continuous employment from the date such employment begins.

An employee's eligibility date is the next day following completion of the waiting period. Residents in the GME program are not subject to a waiting period and are eligible for participation on the date employment begins.

D. Effective Date of Coverage

Employees – Coverage for an Eligible Employee who enrolls in the Plan will be effective on whichever of the following occurs first:

- The employee's eligibility date if the employee enrolls within thirty (30) days thereafter;
- The day following the date the employee's coverage terminated due to loss of eligibility or termination of Employer contributions toward the cost of coverage through a Qualified Health Plan, provided enrollment is made within thirty (30) days in the case of a Special Enrollee, or sixty (60) days in the case of a CHIP or Medicare Special Enrollee;
- The date of marriage, provided the employee enrolls within thirty (30) days of the marriage;
- The date of birth or adoption (or placement for adoption) of a new Dependent, provided the employee enrolls within sixty (60) days of the birth, or thirty (30) days after the adoption or placement for adoption;

- The day following the date in which COBRA coverage is exhausted if the employee had elected COBRA coverage under a Qualified Health Plan in the case of a Special Enrollee; or

- Effective date of coverage is January 1st.

Dependents – When an Eligible Employee enrolls an Eligible Dependent in the Plan, the dependent's coverage will be effective on which of the following occurs later:

- The Eligible Employee's effective date;

- The day following the date the dependent's coverage through a Qualified Health Plan is terminated due to loss of eligibility or termination of Employer contributions toward the cost of coverage, provided enrollment is made within thirty (30) days in the case of a Special Enrollee;

- The date of marriage, provided the Dependent is enrolled within thirty (30) days following the marriage;

- The date of birth or adoption (or placement for adoption) if enrolled within sixty (60) days of the birth or thirty (30) days of the adoption or placement for adoption;

- The day following the date in which COBRA coverage is exhausted if the Dependent had elected COBRA coverage under a Qualified Health Plan in the case of a Special Enrollee; or

- January 1st following the date the Late Enrollee enrolls.

Part IV. Medical Services and Benefits

You are eligible to receive the following medical care and services of physicians and other providers, including medical, surgical, diagnostic, therapeutic and preventive services which are generally and customarily provided in the service area. Coverage is only applicable to the following services if they are determined by the Plan to be Medically Necessary. Members of the MMCP must go to an in-network provider; however, Members of the MCHP may go either in-network or out-of-network when selecting a provider as discussed in the attached Schedule of Benefits. References to a Primary Care Physician refer only to the MMCP, not the MCHP.

Except for Emergency Care Services as described below in Section H of this Part IV, ONLY services which are performed, prescribed, directed or authorized by Your Primary Care Physician or an authorized Specialist or approved in advance by the Plan are covered benefits. Specific services (a list of these services may be obtained through the Plan's member services department) which are received without authorization or services rendered by a non-Participating Provider (for MMCP enrollees) are not covered benefits and payment will be Your responsibility.

Some services require You to make a payment to the Participating Provider. Copayments must be made at the time the services are received. Copayment amounts are included in Your Schedule of Benefits which is attached. Coinsurance and deductible may apply.

A. Professional Services

For The MMCP only, You must select a Primary Care Physician. You have the right to designate any Primary Care Physician who participates in the MHS network and who is available to accept You or Your family members. For children, You may designate a pediatrician as the primary care provider. For information on how to select a primary care provider, and for a list of the participating primary care providers, contact the Plan's Member Services department.

1. **Physician Office Visits.** Services are provided for the prevention diagnosis and treatment of illness or injury when provided in the medical office of the Primary Care Physician or Specialist. A visit to a Specialist does not need a referral. Authorizations for services performed by the Specialist should be secured by the Specialist's office.

2. **Physician Hospital Visits.** Participating provider and authorized Specialist services for diagnosis, treatment and consultation are provided while You are hospitalized for authorized services and/or Emergency Care Services as described under the Plan.

3. **Other Home Visits.** Care in the home by health care professionals, including, but not limited to, nurses, physical therapists, respiratory therapists, speech therapists, occupational therapists and others, are a covered Benefit when prescribed and authorized.

4. **OB/GYN Services.** You do not need prior authorization from the Plan or from any other person (including a primary care provider) in order to obtain access to obstetrical or gynecological care from a health care professional in our network who specializes in obstetrics or gynecology. The Participating Provider, however, may be required to comply with certain procedures, including

obtaining prior authorization for certain services or following a pre-approved treatment plan. For a list of participating health care professionals who specialize in obstetrics or gynecology, contact the customer services department of the plan You are enrolled in.

B. Hospital Services

Hospital services are subject to Prior Authorization, except as otherwise described.

1. Inpatient Services. Coverage is provided for the following inpatient services:

a. Semi-private room and board, with no limit to number of days except as described elsewhere in this Part IV. Private rooms are covered only when Medically Necessary, and approved by the Plan.

b. Inpatient physician services.

c. Laboratory, x-ray and other diagnostic services.

d. Drugs, medications, biologics and their administration.

e. Use of operating and delivery rooms and related facilities.

f. Oxygen services and anesthesia services, whether provided by an anesthesiologist or certified registered nurse anesthetist.

g. Physical therapy and other rehabilitation services while confined as an inpatient, limited to services which are anticipated to result in significant clinical improvement within a reasonable period of time.

h. Radiation therapy, chemotherapy and dialysis.

i. Blood and blood plasma and their administration.

j. Short Term Rehabilitation inpatient care provided in a Rehabilitation Facility, provided such confinement: (a) is under the recommendation and general supervision of a Physician; (b) begins within fourteen (14) days after discharge from a required Hospital or Extended Care Facility confinement if at least three (3) days in length for which room and board benefits are paid; (c) is for the purpose of receiving medical care necessary for convalescence from the conditions causing or contributing to the precedent Hospital or Extended Care Facility confinement; and (d) is not for custodial care.

2. Outpatient Services. Coverage for services provided through a Participating outpatient facility is provided for the following services:

a. Radiation therapy, chemotherapy and dialysis.

b. Short-term rehabilitation services limited to services which result in significant clinical improvement within a reasonable period of time, or until maximum medical improvement is achieved, per episode, whichever is less.

c. Outpatient surgery which is Medically Necessary and authorized by a participating provider and covered by the Plan.

C. Laboratory and X-ray Services

Prescribed laboratory and radiological procedures, services and materials, including diagnostic x-rays, x-ray therapy, chemotherapy, fluoroscopy, mammography screening for occult breast disease, electrocardiograms, laboratory tests, endoscopic procedures, and therapeutic radiology services are provided. Certain laboratory and radiological procedures require Prior Authorization, which will be obtained by the ordering Primary Care Physician or Specialist. These services may be provided in an inpatient or outpatient setting. If they are provided in an inpatient setting in connection with an authorized Hospital stay, these services will be considered Prior Authorized when they are ordered by the Primary Care Physician or an authorized Specialist.

1. Mammography Screening

a. A mammogram at any age for Members having a prior history of breast cancer or whose mother or sister has a prior history of breast cancer upon the recommendation of a Participating Physician; and

b. A single baseline mammogram for persons aged thirty-five through thirty-nine, inclusive; and

c. Mammograms shall be covered every year for Members 40 years of age and above, or more frequently for all Members upon the recommendation of a Participating Physician.

2. Lung Cancer Screening

a. A preventive screening for members between ages 55 – 74 who have a written prescription from their provider;

b. Screening must be done at an MHS facility;

c. Patient must meet specific clinical criteria as determined by CCP including a history of smoking;

d. Patient must be free of co-morbidities that would preclude potentially curative treatment and/or limit life expectancy

D. Maternity and Family Planning Services

1. Maternity Care. Coverage is provided for maternity care including prenatal and postnatal care of the mother and child, postpartum assessment of the mother and the performance of any Medically Necessary clinical tests and immunizations in keeping with prevailing medical standards; circumcisions are covered for infants; use of Hospital delivery rooms; special procedures as may be Medically Necessary and authorized by a Primary Care Physician or an authorized Specialist.

2. Newborn Care. Coverage for Care of Your newborn child provided by a Primary Care Physician from the date of birth, provided the child is enrolled within sixty (60) days of the date of birth.

3. **Family Planning Services.** Testing and Diagnostic procedures, for problems of fertility and infertility are covered.

   a. Testing for problems of infertility, as determined by the Plan, will be provided.

      Diagnostic procedures include sperm count, endometrial biopsy, hysterosalpinography, diagnostic laparoscopy.

      Infertility testing is limited to one (1) sequence of the above-listed tests and diagnostic procedures per Member per lifetime.

   b. Fertility treatments are administered through Progyny. Progyny's program does not require a medical diagnosis of infertility in order to access fertility treatment services. Through Progyny's benefit, members have access to a full suite of fertility treatment options, which may include (but may not be limited to): Artificial Insemination (IUI), Cryopreservation of oocytes and sperm, FDA Bloodwork and Testing, Fresh IVF Cycle, Frozen Embryo Transfer (FET), Frozen Oocyte Transfer (includes fertilization of previously frozen oocytes and transfer), IVF Freeze-All, Patient Care Advocate (PCA) Concierge Support, pre-authorized fertility medications (via Progyny Rx), PGT-A (PGS, or Pre-implantation Genetic Screening) to assess embryo viability, PGT-M (PGD, or Pre-implantation Genetic Diagnosis), Pregnancy Gap Coverage (Pregnancy monitoring coverage until the in-network fertility clinic releases the member into the care of the member's OBGYN medical provider), Tissue Transportation (transportation of member's previously frozen reproductive tissue to in-network facilities), and the purchase of donor tissue (eggs and sperm). Coverage is limited to 1 SmartCycle of treatment.

   c. Complete pregnancy terminations (abortions) are covered when performed in accordance with the laws of the State of Florida.

   d. Voluntary sterilizations are a covered benefit; however, reversal of sterilization is not a covered benefit.

   e. Interinteruine devices and insertion and removal of intrauterine devices are a covered benefit.

   f. Birth control pills are covered under the Plan's pharmacy benefit plan.

4. **Genetic Amniocentesis.** Genetic amniocentesis and chorionic villus sampling are covered when determined to be Medically Necessary and are subject to prior authorization.

E. Rehabilitation Services

1. **Physical Therapy/Occupational Therapy/Speech Therapy (PT/OT/ST)** is subject to medical necessity. PT/OT/ST is not covered in physician's office or out of network. Therapies are limited to sixty (60) visits per calendar year.

2. **Speech Therapy** for developmental purposes is a covered benefit. Speech therapy for the identification and treatment of neurological deficiencies related to feeding problems, congenital or

trauma-related maxillofacial anomalies, autism, or neurological conditions which affect oral motor functions is also a covered benefit subject to medical necessity and the limitations in E. (1) above.

3. **Cardiac Rehabilitation** must be initiated within six (6) months of a designated cardiac event, and the patient must not have absolute contra-indications to cardiac rehabilitation. Cardiac rehabilitation must be prescribed by Your cardiologist.

F. Mental Health Services

1. **Inpatient Mental Health Services.** Coverage is provided for inpatient and day treatment mental health services, including Professional Services.

2. **Outpatient Mental Health Services.** Coverage is provided for outpatient mental health services for crisis intervention and short-term evaluative.

G. Alcohol and Substance Abuse Services

1. **Detoxification.** Coverage is provided under this benefit for medical services relating to short duration medical detoxification and alcohol or drug abuse treatment on an inpatient basis, by contracted mental health network and Emergency Care Services Participating Providers.

2. **Alcohol and Substance Abuse Rehabilitation Services.** Coverage is provided for rehabilitation of addiction to alcohol and/or substance abuse when the medical need for these services has been determined by the Plan or its contracted network.

   Inpatient days may be converted two-for-one for participation in a Plan approved day treatment program (i.e., 1 inpatient day = 2 day treatment program days).

3. **Outpatient Alcohol and Substance Abuse Services.** Coverage is provided for outpatient alcohol and substance abuse services when medical need for these services has been determined and approved by the Plan's contracted network.

4. **Other Services.** No coverage is provided under the Plan for non-Medically Necessary ancillary services resulting from abuse of or addiction to alcohol or drugs; however, determination of the need for those services will be provided.

H. Emergency Care Services

Emergency Care Services are a covered benefit. MCHP Plan and MMCP Participants should remember:

Emergency Care Services means medical screening, examination, and evaluation by a physician, or, to the extent permitted by applicable law, by other appropriate personnel under the supervision of a physician, to determine if any emergency medical condition exists and, if it does, the care, treatment, or surgery for a covered service by a physician necessary to relieve or eliminate the emergency medical condition, within the service capability of a hospital.

1. Coverage is provided for Emergency Care Services resulting from an Emergency Medical Condition, which if immediate care is not received (within 12 hours of illness and 72 hours from accidental injury), could be expected to result in long-term or permanent disability or loss of life.

2. If you are a MMCP Participant, You should contact Your Primary Care Physician within the next business day, or as soon as reasonably possible.

3. Emergency Care Services provided by non-contracted providers will be covered for services described in this Contract.

4. For the MMCP, out-of-network coverage is provided only for Emergency Care Services as described in this Contract. Elective, routine or specialized care received on a non-emergency basis is not covered.

5. If You are an MMCP member and hospitalized for Emergency Care Services in a non-contracted Hospital or out-of-area Hospital, the Plan may require that You be transferred to a contracted Hospital or other facility within the service area as soon as medically possible.

I. Ambulance Services

Ambulance Service. Commercial ground or air ambulance service is covered when used to transport the patient to the nearest hospital equipped to treat the specific illness or injury, in an emergency situation when Medically Necessary, or when required by Plan Administrator.

Non-Emergency Use of an Ambulance. Air or land transport is covered when authorized by the Plan Administrator.

J. Durable Medical Equipment

Durable Medical Equipment (DME) is medical equipment which can withstand repeated use, is primarily and usually used to serve a medical purpose and is generally not useful to You in the absence of illness or injury. It is subject to Medical Necessity review.

1. Coverage is provided for DME as prescribed by a Primary Care Physician or an authorized Specialist.

2. DME must meet the approved current Medicare Guidelines, and must be provided as a result of medical necessity, not for your convenience.

3. Repair, replacement and maintenance of DME will be covered. Coverage is limited to normal wear and use and body growth or change. There is no coverage for equipment which has been abused or improperly cared for.

4. There is no coverage for devices and equipment used for environmental control, convenience functions or physical fitness.

5. Equipment that is lost or damaged due to negligence will be the Member's responsibility to replace.

6. Purchase may be authorized if rental price is projected to exceed purchase price. Duplicate DME rentals are not covered by the Plan.

K. Prosthetic and Orthotic Devices

1. Prosthetic devices which aid body functioning or replace a limb or body part after accidental or surgical loss to correct a defect of body form or function are covered. Benefits are provided only for the basic prosthetic and any Medically Necessary special features prescribed by the Primary Care Physician or an authorized Specialist.

Prosthetic devices are limited to standard/evaluated internal and external devices such as artificial limbs, organic lenses, pacemakers, heart-valve replacements, artificial joints, external breast prostheses.

2. Orthotic devices such as braces and trusses are covered. Other supports for the feet are not covered ***unless*** they are an integral part of the leg brace or are physician prescribed therapeutic shoes for a Member diagnosed with one of the following: diabetes, rheumatoid arthritis, arterial insufficiencies, of the lower limb, peripheral vascular disease, or meets the requirements of medical necessity.

3. The appliance must be a prosthetic or orthotic device as defined by the Medicare DME Manual and approved by the Plan.

4. Benefits are provided for the initial prescription lenses (eye glasses or contact lenses) following an operation for cataract or other diseases of the eye in accordance with Medicare guidelines. This Benefit falls under the Memorial Healthcare System Employee Health Plan and not the contracted vision plan.

L. Skilled Nursing Facility Services

Coverage is provided for Skilled Nursing Facility Services subject to Prior Authorization.

Services should not be custodial in nature. Exceptions may be allowed when days are in lieu of inpatient days.

M. Home Health Services

Home Health Services, up to sixty (60) visits per year, are covered to include: nursing care; a home health aide or licensed practical nurse under the supervision of a registered nurse; physical, occupational or speech therapy, if provided by the home health care agency; and/or medical supplies, laboratory services and medications, if prescribed by a physician with a plan of care. Services provided by a relative, social worker, transportation, housekeeping services, meals, etc. are not covered under the Plan.

Note that the extension of Home Health benefits will be considered when Home Health services can be provided in lieu of an inpatient stay.

N. Oral Surgery Services

Benefits are provided for the following limited oral surgical procedures provided in an inpatient or outpatient setting when prescribed by a physician and the Plan.

General Dental services are not covered under the MMCP and MCHP Plans.

Oral Surgery is covered when expected to improve physical function impairment such as dysphasia, intra-oral trauma, mastication/malocclusion or speech abnormality in situations such as:

1. Treatment resulting directly from an accidental injury to sound natural teeth, the jaw bones or surrounding tissues and initiated within twelve (12) months of the accident.

2. Treatment or correction of a non-dental physiological condition, which has resulted in severe functional impairment.

3. Treatment for tumors and cysts requiring pathological examination of the jaws, cheeks, lips, tongue, roof and floor of the mouth.

4. Surgical and Hospital diagnostic and surgical treatment services relating to temporomandibular joint conditions (TMJ) are covered when Medically Necessary; however, related appliances are not covered.

O. Health Maintenance and Preventive Services

1. Periodic health assessments, based upon nationally recommended guidelines relative to age, sex and medical history (i.e., mammograms, annual gynecological examinations, annual physicals, etc.). The Plan will cover in-network preventive care at 100% with no Deductible or Coinsurance to pay as required under the Patient Protection and Affordable Care Act (PPACA).

2. Well child visits, which include hearing and vision screening and preventive care services when ordered and performed by a Provider for health maintenance and preventive care. Services include physician-delivered or physician-supervised visits from birth to 21 years which includes a history, a physical examination, developmental assessment and anticipatory guidance and appropriate immunizations and laboratory tests. Services and periodic visits are provided in accordance with prevailing medical standards consistent with the Recommendations for Preventive Pediatric Health Care of the American Academy of Pediatrics.

3. Immunizations and vaccinations for Members under the age of eighteen (18), and adult coverage according to generally accepted medical practice standards.

4. Influenza vaccinations for all members shall be considered preventive and covered at 100% when administered in a Memorial Healthcare System urgent care center.

P. Plastic and Reconstructive Surgery

Plastic and reconstructive surgery is covered, subject to Prior Authorization, when the reconstructive surgery is incidental to or follows surgery resulting from trauma, infection or other diseases of the involved part; and when there is a congenital disease or anomaly, which has caused a severe functional impairment, but only when the surgery is reasonably expected to correct the condition and is performed at the earliest medically appropriate time.

Q. Allergy Care

1. Coverage is provided for allergy testing and evaluation when provided by Your Primary Care Physician or an authorized Specialist.

2. Coverage is provided for the preparation of allergy serum when prepared by the Primary Care Physician or authorized Specialist.

3. Allergy injections are covered when provided by a Primary Care Physician or an authorized Specialist.

R. Hospice Care

A Member is entitled to receive Hospice care. All care must be provided by a certified Hospice organization and must be approved by a Participating Provider and the Plan.

1. Care may be provided on an inpatient basis (in either a Hospice or a Hospital), or on an outpatient basis as determined by Your Physician and approved by the Plan.

2. Coverage is provided for drugs and medical supplies provided by the Hospital or Hospice.

3. Coverage is provided for up to five (5) visits for bereavement counseling for Your covered family Members.

4. A Member is considered terminally ill if the Primary Care Physician has certified the Member as having a life expectancy of six (6) months or less. Coverage is limited to $10,000 maximum benefit.

S. Chiropractic Services

1. **Chiropractic Services**. The first visit does not require authorization, subsequent visits require authorization. Note: chiropractic services are authorized by a contracted network no out of network coverage is provided.

2. Benefits are provided for an initial (one-time) visit, per episode or condition, for evaluation of the need for Chiropractic Services when using a Participating Chiropractor.

3. Additional Chiropractic visits must be in accordance with the treatment plan developed by the Chiropractor and approved by the Plan's contracted network.

T. Dermatologic Services

Benefits are provided by a Participating Provider without authorization.

U. Podiatric Services

1. A Podiatrist can be utilized for Podiatric services only.

2. Benefits are provided for evaluation of the need for Podiatric Services when using a Podiatric Provider.

3. Additional Podiatric visits must be in accordance with the treatment plan developed by the Podiatrist.

4. The following services are covered when provided by a Podiatric Provider:

a. Surgical office procedures including debridement of ulcers, infected skin and mycotic toenails.

b. Surgical procedures including digital surgery, soft tissue surgery, metatarsophalangeal surgery, lesser metatarsal surgery, metatarsal with internal fixation and tarsal surgery.

5. Routine foot care, in the absence of localized illness, injury or symptoms involving the foot, is not covered.

V. Diabetes Treatment Services

Diabetes treatment services including all medically appropriate and necessary equipment, supplies and diabetes outpatient self-management training and educational services used to treat diabetes, when the Member's Primary Care Physician or a physician that specializes in the treatment of diabetes certifies that such services are necessary.

Diabetic education delivered through an American Diabetes Association-approved program is covered for one (1) visit after the initial diagnosis, one (1) visit after a significant change in condition; and one (1) visit for re-education/refresher per calendar year.

W. Osteoporosis Screening

Coverage for the Medically Necessary diagnosis and treatment of osteoporosis for high-risk Members, including, but not limited to, estrogen-deficient Members, who are at clinical risk for osteoporosis, Members who have vertebral abnormalities, Members who are receiving long-term glucocorticoid (steroid) therapy, Members who have primary hyperparathyroidism, and Members who have a family history of osteoporosis.

X. Organ Transplant Services

1. Coverage is provided when using the Transplant network for Medically Necessary human organ transplants and any non-experimental transplant approved by the FDA.

2. Coverage is provided for donor expenses as related to testing and typing when the Plan Member is the organ recipient.

3. There is no coverage for organ transplants which are determined by the Plan to be Nonstandard/Unevaluated Procedures and Items. There will be coverage for bone-marrow transplant procedures recommended by the referring physician and treating physician if the particular use of the bone marrow transplant procedure is determined to be accepted within the appropriate oncologic specialty and not experimental pursuant to federal guidelines and regulations.

4. There is no coverage for related travel, lodging, meals, organ transportation and the services or medical expenses incurred by the donor not listed in #2.

Y. Breast Cancer Treatment

Coverage for breast cancer treatment includes inpatient hospital care and outpatient post-surgical follow-up care for mastectomies when Medically Necessary, in accordance with prevailing medical standards. Coverage for outpatient post-surgical care is provided in the most medically appropriate setting, which may include the hospital, treating physician's office, outpatient center, or the Member's home. Inpatient hospital treatment for mastectomies will not be limited to any period that is less than that determined by the Participating physician.

Coverage for mastectomies includes coverage for prosthetic devices, mastectomy bras and breast reconstructive surgery incident to the mastectomy which reestablishes symmetry between the two breasts due to the removal of all or part of the breast for Medically Necessary reasons.

Genetic testing of breast cancer patients for the breast cancer gene (BRCA testing) shall be covered when prior authorization for such testing has been approved by the Plan.

Z. Second Opinion

A consultation by a second Physician, when a Member disputes the appropriateness or necessity of a procedure, or diagnosis, or is subject to a serious injury or sickness, including failure to respond to the current treatment plan. This consultation includes the physical examination, laboratory work and x-rays not previously performed by the original Physician. If the second opinion is provided, Deductible, Coinsurance, and Co-payments are applicable. For the MMCP, if the network cannot provide an alternate provider for a second opinion, the member may seek an out-of-network physician in the tri-county area, with an appropriate authorization and the standard Co-payments would apply. If the MMCP Member chooses an out-of-network provider, when an in-network alternative is available, the member will be responsible for 40% of the Physician's billed charges.

We will cover the second opinion services for a Member obtaining a second opinion, after he or she has received a recommendation to have elective surgery, which is covered under the Plan, if the following conditions are met:

1. The consulting Physician must personally examine the Member, and We must receive a copy of the written opinion; and

2. The consulting Physician must not perform the surgery to correct the condition for which the original recommendation was given.

AA. Hearing Services

Hearing testing is covered for one (1) exam per year. Hearing aids are covered with an annual maximum of $2,500, which includes fitting and servicing. Replacement of each hearing aid device is limited to once every thirty (36) months. Batteries are not covered by the Plan.

BB. Cleft Lip and Cleft Palate

Coverage is provided for the treatment of cleft lip and cleft palate for a dependent child under age eighteen (18). Coverage includes medical, dental, speech therapy, audiology, and nutrition services, if such services are prescribed by the Primary Care Physician or treating referral physician as Medically Necessary. Coverage is subject to applicable cost sharing provisions and any benefit limitations listed in the Covered Services and Exclusions and Limitations sections.

CC. Prescription Drug Benefit

Coverage is provided by the MMCP and MCHP Plan for Medically Necessary prescription drugs and refills. The Prescription Drug Benefit includes a formulary list of covered medications managed by the pharmacy benefits manager.

The pharmacy benefit manager or pharmacy benefits plan or program to, upon revising its formulary of covered prescription drugs during a plan year, provide a 60-day continuity-of-care period in which the covered prescription drug that is being revised from the formulary continues to be provided at the same cost for the patient for a period of 60 days. The 60-day continuity-of-care period commences upon notification to the patient. This requirement does not apply if the covered prescription drug:

1. Has been approved and made available over the counter by the United States Food and Drug Administration and has entered the commercial market as such;

2. Has been removed or withdrawn from the commercial market by the manufacturer; or

3. Is subject to an involuntary recall by state or federal authorities and is no longer available on the commercial market.

DD. Autism, Attention Deficit Disorder and Attention Deficit Hyperactivity Disorder

No coverage for benefits to address learning disabilities including ADHA and dyslexia. Services related to PT/OT/ST are considered Medically Necessary only when the criteria for standard PT/OT/ST are met (restoring or improving function related to an illness, injury or congenital anomaly) and are not duplicative of school-based programs. PT/OT/ST is not covered in physician's office.

Coverage is provided for well-baby and well-child screening for diagnosing the presence of autism spectrum disorder (which includes **Asperger's syndrome**), and to provide coverage for the treatment of autism spectrum disorder through speech therapy, occupational therapy, physical therapy, and applied behavior analysis.

EE. Bariatric Surgery

Bariatric Surgery procedures for obesity are covered if considered Medically Necessary, if in accordance with established Plan medical policy and guidelines.

FF. Cochlear Implants

Coverage of Cochlear Implants is subject to medical necessity review.

GG. Speech Processor

Upgrade to or replacement of an existing external speech processor, controller or speech processor and controller (integrated system) is considered Medically Necessary for an individual whose response to existing components is inadequate to the point of interfering with the activities of daily living or when components are no longer functional.

HH. Cognitive Rehabilitation Therapy

Cognitive Rehabilitation Therapy is considered as adjunctive treatment of cognitive deficits (e.g., attention, language, memory, reasoning, executive functions, problem solving, and visual processing) and covered as Medically Necessary when the cognitive deficits have been acquired as a result of neurologic impairment due to traumatic brain injury, brain surgery, stroke, or encephalopathy. Services are limited to services which result in significant clinical improvement within a reasonable period of time, or until maximum medical improvement is achieved, per episode, whichever is less.

Cognitive Rehabilitation Therapy that is considered Medically Necessary for the treatment of autism, Asperger's syndrome, Rett syndrome, childhood disintegrative disorder and pervasive developmental disorder is covered.

II. Developmental Therapy

Speech therapy for developmental purposes to treat developmental deformities are covered (see specific benefit). Developmental assessments are included in well child visits. Other treatment/therapy is not covered.

JJ. Human Growth Hormone

Human Growth Hormone is not covered. Exceptions can be made only if prescribed by a Memorial Health Network Pediatric Endocrinologist, subject to prior authorization, and in compliance with clinical guidelines.

KK. Nutritional Counseling

Nutritional Counseling for chronic disease states when prescribed by a physician is covered, subject to medical necessity review.

LL. Nutritional Supplements

Nutritional Supplements/formulas when prescribed by a Participating Provider are covered, subject to medical necessity review.

MM. Wigs and Compression Sleeves

Wigs for hair loss related to a medical condition are covered up to a lifetime maximum of $750.
Compression Sleeves deemed Medically Necessary will be covered.

NN. Sleep Study

Sleep studies are covered if performed at a specifically designated Memorial Healthcare System facility, subject to prior authorization, and in compliance with clinical guidelines.

Unattended (home) sleep studies medically necessary for members with symptoms suggestive of Obstructive Sleep Apnea (OSA) when submitted by participating provider and criteria met for facility-based study will be covered.

OO. Treatment of Varicose Veins

The treatment of Varicose Veins is covered only if medically necessary, the procedure is performed by a Memorial Healthcare System employed Vascular Surgeon, and subject to prior authorization.

Part V. Alternative Medical Benefits

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

The Plan shall provide such alternative benefits at its sole discretion and only when and for so long as it determines that alternative care services are Medically Necessary and cost effective.

If the Plan elects to provide alternative benefits for a Member in one instance, it shall not be obligated to provide the same or similar benefits for other Members under this Plan in any other instance, nor shall it be construed as a waiver of the Plan Administrator's rights to administer this Plan thereafter in strict accordance with its express terms.

Part VI. Exclusions, Limitations and Non-Covered Services

A. **Exclusions.** Except as described under Part IV, Medical Services and Benefits, the following services are excluded from coverage under the Plan:

1. Except for Emergency Care Services (as described in part IV), or services not available within the network, services of non-participating providers and services rendered out-of-service area are not covered under the MMCP Plan.

2. Outpatient Chemotherapy, OT/PT/ST, Chiropractic and Acupuncture are not covered Out of Network.

3. Any cosmetic surgery or procedure to include adult circumcision or any related Hospital services, except as described in Part IV, is not covered. Cosmetic surgery procedures or any related services which may be Medically Necessary, but which are a result of complications arising from a non-covered service, will not be covered, except as may be required by applicable state law.

4. Any procedures or treatments designed to alter physical characteristics of the Member to those of the opposite sex, and any other treatment or studies related to sex transformation are not covered.

5. Artificial insemination, sperm bank, in vitro fertilization (IVF), embryo implants, embryonic transfer (ZIFT), gamete transfer (GIFT), human chorionic gonadotropin (HCG) and related services or treatments are not covered. Tests primarily ordered to determine the sex of a fetus are not covered.

6. Dental Care services, dental examinations and any other dental product, appliance, device or service, except as may be described elsewhere in the Plan, are not covered.

7. Custodial Care, which is primarily for rest or custodial purposes, is not covered with the exception of Hospice.

8. Any services or supplies furnished by a non-contracted institution, which is defined as other than a Hospital or Skilled Nursing Facility, and which is primarily a place of rest, a place for the aged, nursing home or any similar institution, are not covered.

9. Personal comfort or convenience items are not covered.

10. Private duty nursing and private Hospital rooms, unless determined to be Medically Necessary by the Plan are not covered.

11. Physical examinations or immunizations are excluded when required for employment, insurance, licensing, or marriage, which are not otherwise Medically Necessary.

12. Long-term mental health and psychiatric treatment, services or treatment for mental retardation or chronic mental illness, the monitoring of medications prescribed for treatment of such conditions or enrollment in special schools, except as described in Part IV of this plan document, are not covered.

13. Services which would normally be provided without charge are not covered.

14. Nonstandard/Unevaluated Procedures and Items, as defined in Part II, are not covered.

15. Services for military service connected disabilities and conditions for which the Member is legally entitled to services from the military and for which facilities are reasonably accessible to the Member are not covered.

16. Services for conditions that Federal, State or local law require to be treated in a public facility are not covered.

17. Services which are not Medically Necessary are not covered.

18. Pretrial or court testimony and the preparation of court related reports are not covered. Court ordered treatment for substance abuse or mental conditions are not covered.

19. Treatment and health care services required as a result of committing a felony, are not covered.

20. Treatment and services, as a result of work related injuries or illnesses are not covered.

21. Nicotine patches and nicotine gum are not covered.

22. Drinking and driving programs mandated by State or local law; court ordered drug screening are not covered.

23. Hypnotherapy is excluded.

24. Weight loss programs are not covered.

25. Birth control, other than as described above in Section IV, D (Maternity and Family Planning Services), or as required under the PPACA, are not covered.

26. Surgery for the reduction or augmentation of the size of the breast, except when Medically Necessary or as a result of mastectomy or cancer surgery, are not covered.

27. Scar reduction except as related to authorized surgery and resulting in functional deficit, tattoo removal, ear lobe repair and other non-medically necessary cosmetic surgical procedures, are not covered.

28. Health care services while incarcerated are not covered.

29. Mechanical or animal organ transplants, autologous skin transplant, expenses as an organ donor and expenses of another donor are not covered except as related to testing and typing when plan member is organ recipient.

30. Pharmacogenomics Testing, the study or clinical testing of genetic variation that gives rise to differing responses to drugs is not covered.

31. Treatment or procedures to reverse sterilization are not covered.

32. Expenses which would be eligible for payment under any Plan or policy required by law, whether the Member chose to be covered under such plan or not, will not be considered eligible. Under required No-Fault auto coverage, the minimum required coverage or actual coverage elected, whichever is higher, will be treated as an additional Deductible.

33. Benefits and services not specified as covered in this Contract or in any Supplemental Benefit (Rider) attached hereto, unless such service is specifically required by applicable State or Federal law.

34. Marriage and family counseling, and sex therapy are not generally covered.

35. Biofeedback is not covered.

36. Genetic testing and counseling is not covered for screening or treatment that is not Medically Necessary.

37. Self-directed exercise programs are not covered.

38. Foot care that is not Medically Necessary is not covered. This includes: (1) Diagnosis and treatment for weak, strained, unstable or flat feet. (2) The trimming and care of corns and calluses is not covered except for individuals with diabetes or significant peripheral vascular disease. (3) The treatment of corns calluses, or toenails unless the charges are for the removal of nail roots or in conjunction with a metabolic or peripheral vascular disease.

    i. Foot orthotics are not covered unless they are part of a shoe integral to a brace, or for members with a diagnosis of diabetes, rheumatoid arthritis, arterial insufficiencies of the lower limbs, Peripheral Vascular Disease, or meets the requirements of medical necessity.

39. Magnetic Resonance Imaging (MRI) is not covered in physician's office.

40. There is no coverage for related travel, lodging, meals, organ transportation and the services or medical expenses incurred by the donor not specifically listed.

41. Health services provided in a foreign country, unless required as Emergency Health Services;

42. Home Ovulation Prediction Kits

43. Charges related to fertility coverage for dependent Children

44. Services and supplies, related to fertility coverage, furnished by an out-of-network provider or not listed as covered in the Progyny Member Guide

45. Charges associated with a gestational carrier program for the person acting as the carrier, including but not limited to laboratory tests

46. Treatments considered experimental by the American Society of Reproductive Medicine

47. If an item is not specifically included, it is considered excluded.

B. **Limitations.** For MMCP in the event that, due to circumstances not within the control of the Plan including, but not limited to, a major disaster, epidemic, the complete or partial destruction of facilities, riot, civil insurrection, disability of a significant part of the Plan's providers' personnel or similar causes, the rendering of Professional Services or Hospital Services provided under the Plan is delayed or rendered impractical, the Plan shall make a good faith effort to arrange for an alternative method of providing coverage. In such event, the Plan and Participating Providers shall render the Hospital and Professional Services provided under the Plan insofar as practical, and according to their best judgment; but the Plan and Participating Providers shall incur no liability or obligation for delay, or failure to provide or arrange for services if such failure or delay is caused by such an event.

Part VII. Plan Administration and Forms

A. **Relationship of Parties.** Certain Participating Providers are employees of Memorial Healthcare System. The relationship between the Plan and all other Participating Providers is that of independent contractors. Such independently contracted Participating Providers are neither agents nor employees of the Plan, nor is the Plan or any of its employees, an employee or agent of such Participating Providers.

The Plan shall not be liable for any claim or demand on account of damages arising out of, or in any manner connected with, any injuries suffered by You in connection with the furnishing of or failure to furnish services by any Participating Provider.

B. **Patient/Provider Relationship.** Participating Providers maintain a provider-patient relationship with You and are solely responsible to You for all health services. If You are unable to establish an acceptable patient-provider relationship You may request another Participating Provider, and likewise, Participating Providers may request that You be transferred to another Participating Provider.

C. **Refusal to Accept Treatment.** You may, for personal reasons, refuse to accept procedures or treatment from Your Primary Care Physician or an authorized Specialist. Primary Care Physicians or an authorized Specialist may regard such refusal to accept their recommendations as incompatible with continuance of the physician-patient relationship, and, if no acceptable alternative exists for what the physician believes to be proper medical care, You will be so advised.

D. **Changes in Benefits or Premiums.** Memorial Healthcare System reserves the right to revise the Plan's Schedule(s) of Benefits, to revise the Premium schedule, or to make other changes under the Plan, in accordance with the Plan's procedures and with the applicable laws of the State of Florida;

E. **Identification Cards.** Identification Cards are issued for the purpose of identification only. If You willfully or knowingly permit another person to use Your Identification Card, no benefits will be paid for those services, and Your coverage under the Plan may be rescinded.

F. **Plan Discretion.** The Plan Administrator has the discretionary authority to interpret the Plan, to make decisions concerning whether a service is Medically Necessary, to make decisions regarding Nonstandard/Unevaluated Procedures and Items, to prescribe procedures and forms and to determine coverage/non-coverage issues.

To the fullest extent permitted by law, the Plan Administrator will have the exclusive right and discretionary authority to interpret the Plan and decide any and all matters arising hereunder in the administration and operation of the Plan, and any interpretations or decisions so made will be conclusive and binding on all persons having an interest in the Plan. Any action or determination by the Plan Administrator shall be reviewable (by a court or otherwise) only for an abuse of discretion.

Part VIII. Coordination of Benefits

If a Member is covered under more than one group plan as defined below, including this Plan, Benefits will be coordinated. The Coordination of Benefits ("COB") rules under this Section VIII, will determine which group health plan is primary and which group health plan is secondary. The Benefits payable under this Plan for any Claim Determination Period, will be either this Plan's regular Benefits (if this Plan is the primary plan) or reduced Benefits (if this Plan is the secondary plan) which, when added to the benefits of the other plan, may not exceed the full amount (100%) of the Allowable Expenses defined below.

A. Definitions

Allowable Expenses: Any Medically Necessary, Usual and Customary item of expense incurred by a Member which is covered, at least in part, under this Plan.

Claim Determination Period: A Calendar or Plan Year or that portion of a Calendar or Plan Year during which the Member for whom claim is made has been covered under this Plan.

Plan: For the purposes of this Part VIII, any plan under which benefits or services are provided by:

1. Group, blanket or franchise insurance coverage;

2. Any group Hospital service prepayment, group medical service prepayment, group practice or other group prepayment coverage;

3. Group coverage under labor-management trustee plans, union welfare plans, Employer organization plans or employee benefit plans;

4. Coverage under Medicare and any other governmental program that the Member is liable for payment, except State-sponsored medical assistance programs and TRICARE, in which case the Plan pays primary;

5. Coverage provided through a school or other educational institution;

6. Coverage under any Health Maintenance Organization (HMO); or

7. Coverage provided by no-fault auto insurance, by whatever name it is called, when not prohibited by law.

B. Order of Benefit Administration

When a claim is made, and this Plan is primary plan, the Plan pays its benefit without regard to any other plans. When this Plan is the secondary plan, the Plan adjusts its benefits so that the total benefits paid by both plans will not exceed 100% of the Allowable Expenses.

A plan without a Coordination of Benefits provision is always the primary plan. If all plans have a Coordination of Benefits provision:

1. The Plan covering the person directly, rather than as an employee's dependent, is primary, and the other plans are secondary.

2. Dependent children of parents not separated or divorced, or unmarried parents living together: the plan covering the parent whose birthday falls earlier in the year (month and day) pays first. The plan covering the parent whose birthday falls later in the year pays second.

   However, if the other plan does not have this rule, but instead has a rule based upon the gender of the parent, and if, as a result, the plans do not agree on the order of benefits, the rule in the other plan will determine the order of benefits.

3. Dependent children of separated or divorced parents, or unmarried parents not living together: When parents are separated or divorced or unmarried and not living together, neither the male/female, nor the birthday rules apply. Instead:

   a. The plan of the parent with custody pays first;

   b. The plan of the spouse of the parent with custody (the step-parent) pays next;

   c. The plan of the parent without custody pays next; and

   d. The plan of the spouse of the non-custodial parent pays last.

   However, if specific terms of a court decree state that one of the parents is responsible for the child's health care expenses, and the insurer or other entity obliged to pay or provide the benefits of that parent's plan has actual knowledge of those terms, that plan pays first.

4. Active/Laid-Off Employees: The Plan, which covers that person as an active employee (or as that employee's dependent), determines its benefits before the plan, which covers that person as a laid-off employee (or as that employee's dependent). If the plan, which covers that person, has not adopted this rule, and if, as a result, the plans do not agree on the order of benefits, this rule (4) will not apply.

5. If a person whose coverage is provided under a right of continuation pursuant to State or Federal law (i.e., COBRA) is also covered under another plan, the plan covering the person as an Eligible Employee, Member, or retiree (or as that person's Eligible Dependent) is primary and the continuation coverage is secondary. If the other plan does not have this rule, and if, as a result, the plans do not agree on the order of benefits, this rule (5) is ignored.

6. If none of the above rules determines the order of benefits, the plan covering a person longer pays first. The plan covering that person for the shorter time pays second.

Coordination of Benefits may operate to reduce the total amount of benefits otherwise payable during any Claim Determination Period with respect to a Member under this Plan. When the benefits of this Plan are reduced, each benefit is reduced proportionately. The reduced amount is then charged against any applicable benefit limit of this Plan.

When a plan provides benefits in the form of services, rather than cash payments, the reasonable cash value of each service rendered will be considered to be both an Allowable Expense and a benefit paid.

C. Recovery

If the amount of the payment made by this Plan is more than it should have been, the Claims Administrator, on behalf of the Plan, has the right to recover the excess from one or more of the following:

1. The person this Plan has paid or for whom it has paid;

2. Providers of care;

3. Insurance companies; or

4. Other organizations.

D. Payment to Other Carriers

Whenever payments, which should have been made under this Plan in accordance with the above provisions, have been made, this Plan will have the right to pay any organization making those payments any amounts it determines to be warranted in order to satisfy the intent of the above provisions. Amounts paid in this manner will be considered to be benefits paid under this Plan, and, to the extent of these payments, this Plan will be fully discharged from liability.

Part IX. Effect of Medicare

In accordance with Federal Medicare regulations, the following is a brief explanation of the Medicare guidelines, not to be considered all inclusive.

1. **Working Aged Benefits**. The Plan will be primary when an active employee or spouse is age sixty-five (65) and over and elected coverage under the Plan. The employee must decline coverage under the Plan in order to have Medicare pay primary.

2. **Disabled Employees/Spouses**. The Plan will be primary when an active employee or dependent is disabled and covered by Medicare.

3. **Disability Due to End State Renal Disease (ESRD)**. When ESRD coverage begins, the Plan remains primary for the first thirty (30) months of ESRD coverage. Medicare is primary beginning on the thirty-first (31st) month of ESRD coverage.

Members should be certain to enroll in Medicare Parts A, B, and/or D in a timely manner to assure maximum coverage. Contact the Social Security Administration office to enroll in Medicare.

If the Plan is secondary, Benefits under the Plan will be coordinated with the dollar amount that Medicare will pay, subject to the rules and regulations specified in federal law. A Member who is eligible for Medicare will be considered to be covered for all Benefits available under Medicare (Parts A, B and/or D), regardless of whether or not the person has actually applied for Medicare coverage.

Part X. Termination of Benefits

An Eligible Employee or Dependent's coverage shall terminate at the earliest time indicated below:

A. In the event the Eligible Employee fails to make any required contributions when due, Benefits shall automatically terminate at the end of the period for which the contribution was made;

B. Upon termination of employment, Benefits will cease at the end of the month during which the Eligible Employee terminated. Cessation of active status by an employee shall be deemed termination of employment, except as follows:

1. In the event an Eligible Employee is absent on account of illness or injury, employment shall be deemed to continue for the purpose of Benefits hereunder until the earlier of: (i) the date contributions received from the Employer for such Eligible Employee's Benefits are discontinued; or (ii) twelve (12) months;

2. The Benefits of an Eligible Employee who is temporarily laid-off or granted leave of absence may be continued, but not beyond the end of the leave of absence or lay-off. The leave of absence or lay-off may not exceed twelve (12) months;

C. The date the Eligible Employee or Dependent ceases to be eligible for coverage or ceases to be in a class eligible for coverage;

D. The date the Dependent becomes an Eligible Employee;

E. When the Eligible Employee or Dependent enters the military service on a full-time active duty basis other than scheduled drills or other training not exceeding one month in any Calendar Year; or

F. The date the Plan is terminated.

Part XI. Family and Medical Leave Act (FMLA)

An Eligible Employee is entitled to a maximum of twelve (12) weeks of unpaid leave in any twelve (12) month period for reasons that qualify under FMLA.

An employee may choose not to retain health coverage during the FMLA leave. However, when an employee returns from leave, the employee is entitled to have coverage reinstated on the same basis as it would have been if the leave had not been taken. (Coverage will be reinstated without any additional qualification requirements imposed by the Plan. The Plan's provisions with respect to Pre-Existing Conditions, Deductibles and Co-insurance amounts will apply on the same basis as they did prior to the FMLA leave.)

Notwithstanding any Plan provision to the contrary, an employee who is on a FMLA leave and who does not elect to revoke his or her coverage shall continue to participate in the Plan for the duration of his FMLA leave. An employee who continues coverage while on FMLA leave will be responsible for paying his share of the cost of coverage based on the benefit election currently in effect under the Plan and in accordance with such payment options and procedures as may be prescribed by the Plan Administrator.

Notwithstanding the above provisions, if the employee is receiving compensation during all or a portion of his or her FMLA leave, and such employee has elected to continue coverage during the FMLA leave, the required contributions shall be made in the same manner as if the employee was on any other type of paid leave.

An employee who has elected to continue coverage while on unpaid FMLA leave and who elects not to return to work for at least thirty (30) days following the expiration of the FMLA leave will be required to reimburse the Plan for its share of the cost of the Premiums during the unpaid FMLA leave, unless such individual cannot return to work because of a serious health condition or such other circumstances approved by the Plan Administrator.

Part XII. Uniformed Services Employment and Reemployment Rights Act (USERRA)

If an individual was covered under the Plan immediately prior to being called to active duty by any of the armed forces of the United States of America, coverage may continue for up to twenty-four (24) months or the period of uniformed service leave, whichever is shortest, if the individual pays any required contributions toward the cost of coverage during the leave. If the leave is less than thirty (30) days, the contribution rate will be the same as for active employees. If the leave is longer than thirty (30) days, the required contribution will not exceed 102% of the cost of coverage.

Whether or not the individual elects continuation coverage under the USERRA, coverage will be reinstated on the first day the individual returns to active employment with the Employer, if released under honorable conditions and the individual returns to employment: (a) on the first full business day following completion of the military service for a leave of thirty (30) days or less; or (b) within fourteen (14) days of completing military service for a leave of thirty-one (31) to one hundred eighty (180) days; or (c) within ninety (90) days of completing military service for a leave of more than one hundred eighty (180) days. A reasonable amount of travel time or recovery time for an illness or injury determined by the Veteran's Administration will be allowed.

When coverage under this Plan is reinstated, all provisions and limitations in this Plan will apply to the extent that they would have applied if the military leave had not been taken and coverage had been continuous under this Plan. The eligibility waiting period will be waived and the pre-existing condition limitation will be credited as if the individual had been continuously covered under this Plan from the original effective date. This waiver of limitations does not provide coverage for any illness or injury caused or aggravated by the military service, as determined by the Veteran's Administration. For complete information regarding the rights under USERRA, contact the Plan Administrator.

Part XIII. Continuation of Benefits (COBRA)

A. A Member whose coverage has been terminated for any Qualifying Event enumerated below has the right to continue coverage for all benefits of this Plan if covered for such benefits on the day immediately preceding the termination date. A child born or placed for adoption with an Eligible Employee during the continuation period will also be eligible for continuation of benefits.

The time period for which the continuation is available is indicated below, in conjunction with the corresponding Qualifying Event.

If COBRA is elected, coverage will continue as though termination of employment or loss of eligible status had not occurred. Any accumulation of deductibles or benefits paid prior to termination or loss of eligibility, which had been credited toward any deductibles or maximum benefit of this Plan, will be retained.

COBRA may not be denied to an individual who had coverage under another group health plan or Medicare prior to a Qualifying Event.

Also, no new or additional waiting periods or pre-existing condition limitation requirements will apply. If any changes are made to the coverage for employees actively-at-work, the coverage provided to the individuals under this continuation provision will be similarly changed.

B. Qualifying Events

An **eighteen (18) month** continuation is available to employees and/or dependents in the event of any one or both of the following Qualifying Events:

1. An employee's termination of employment for any reason, except gross misconduct;

2. An employee's loss of eligibility to participate due to reduced work hours.

In the event an employee and/or dependent has both qualifying events happen, the total length of the continuation will not exceed eighteen (18) months.

A total of **twenty-nine (29) month** continuation shall be available to all covered family members in the event a Member is disabled on or before the date of the employee's Qualifying Event, or is disabled during the first sixty (60) days of the COBRA continuation. If a Member was disabled within sixty (60) days after a Qualifying Event that occurred prior to January 1, 2013, this individual would be eligible for the additional eleven (11) month extension.

The Member must provide the Plan Administrator with notice of the disability within sixty (60) days of the determination of the disability and before the end of the original eighteen (18) month COBRA coverage period. The Member must notify the Plan Administrator of a determination by Social Security that the individual is no longer disabled within thirty (30) days of such determination.

A Member will be determined disabled per Social Security guidelines.

A **thirty-six (36) month** continuation shall be available to a dependent spouse and/or child in the event of any one of the following Qualifying Events:

1. An employee's death;

2. Divorce or legal separation from the employee;

3. A dependent child's loss of eligibility to participate;

4. A dependent's loss of eligibility to participate in this Plan due to the employee becoming entitled to Medicare benefits as a result of a disability or choosing Medicare in place of this Plan at the age of sixty-five (65).

Individuals may be covered under multiple Qualifying Events, but in no case will coverage be continued for more than thirty-six (36) months.

C. Notice of Continuation

A Member has sixty (60) days from the date of loss of coverage as a result of a Qualifying Event or sixty (60) days from the date the Plan Administrator notifies the Member of their rights, whichever is longer, to elect coverage. The Plan Administrator will also notify the Member of the cost of the continuation. (Payment of premium for the period from the date of loss of coverage to election of continuation is not required until the forty-fifty (45th) day after the election.) All payments for coverage after the date of election are subject to a thirty (30) day grace period.

If a Member waives coverage under COBRA, and later re-elects coverage within the initial sixty (60) days, the Member will be eligible to continue coverage under COBRA. However, coverage will not begin until the date of the revocation of the waiver.

The Member is required to notify the Plan Administrator within sixty (60) days of any Qualifying Event, which affects the eligibility of a dependent.

D. Termination of Continuation of Coverage

Continuation of Coverage shall not be provided beyond whichever of the following dates is first to occur:

1. The date the maximum continuation period expires for the corresponding Qualifying Event;

2. The date this Plan is terminated;

3. The date the individual fails to make the required contribution to continue coverage;

4. The date the individual becomes covered under any other group health plan after the date of COBRA election which does not contain any exclusion or limitation with respect to any pre-existing condition;

5. The date the individual becomes entitled to Medicare benefits after the date of COBRA election; or

6. In the month that begins more than thirty (30) days after a final determination has been made that an individual is no longer disabled.

Part XIV. Member Rights and Responsibilities

A. **Confidentiality of Health Care Records.** Information from Your medical records and information received from physicians or hospitals incident to the physician-patient relationship or hospital-patient relationship shall be kept confidential; and, except for use incident to bona fide medical research and education, or reasonably necessary in connection with the administration of the Plan program, may not be disclosed without Your consent or when release is required by law.

B. **Primary Care Physician.** Every MMCP Member must have a Primary Care Physician. You have the right to select, or have selected on Your behalf, a Primary Care Physician from the Plan's physician panel. Your Primary Care Physician has agreed to act as the coordinator and manager of Your health care needs.

C. **Explanation of Treatment.** You have the right to have any treatment or diagnostic study explained to You by Your physician prior to receiving treatment or undergoing diagnostic studies.

D. **Notice of Claim.** You should not have to make payments to health care professionals or hospitals for covered services except for the required Copayments, Deductibles and Coinsurance. If, however, You have paid for covered services, You may be reimbursed when:

1. You provide the Plan with satisfactory evidence (proof of payment) that You have properly made such payment to a health care professional or hospital; and

2. You make the request for reimbursement within twelve (12) months of the date of service. The contact information for the request is listed in the Benefit Guide.

E. **Healthy Lifestyle.** As a Member in the Plan You have access to medical care and coverage of medical care as described in the plan document. Additionally, Plan Members are offered a variety of health education and prevention programs directly and through Participating Providers. You are encouraged to maintain a healthy lifestyle, seek medical care when appropriate, and follow the direction and instruction provided by the health care professionals.

F. **Maintain Appointments.** You have a responsibility to keep the appointments made by or for You with physicians and other providers of care.

G. **Authorization to Review Records.** By receiving benefits under the Plan, You and Your covered Dependents automatically agree that any health professional or hospital is authorized to furnish the Plan, upon request, all information and records, or copies of records relating to Your diagnosis or treatment.

H. **Insurance Coverage.** It is Your responsibility to provide accurate and current insurance documentation to any provider rendering services, or you may be subject to payment of the rendered services**.**

I. **Plan Coverage Requirements.** By receiving benefits under the Plan, You and Your covered Dependents agree to abide by the Plan's various utilization review, care and claims management, authorization, Medical Necessity, and other applicable requirements for coverage and Benefits under the Plan.

Part XV. Member Claims and Appeals

A. Claim Determinations

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

To receive Benefits under the Plan, the Claimant must follow the procedures established by the Claims Administrator, who has the responsibility for making the particular Benefit payments to the Claimant.

Initial claims for Plan Benefits are made to the Claims Administrator providing that Benefit. The Claims Administrator will review the claim itself or appoint an individual or an entity to review the claim, following these procedures:

1. **Urgent Care Claims**. If Your claim is considered an Urgent Care Claim, the Claims Administrator will notify you of the Plan's benefit determination (whether adverse or not) as soon as possible, taking into account the medical exigencies, but not later than 24 hours after receipt of the claim by the Plan, unless You fail to provide sufficient information to determine whether, or to what extent, Benefits are covered or payable under the Plan. In the case of such a failure, the Claims Administrator will notify you as soon as possible, but not later than 24 hours after receipt of the claim by the Plan, of the specific information necessary to complete the claim. The notification may be oral unless written notification is requested by You. You will be afforded a reasonable amount of time, taking into account the circumstances, but not less than 48 hours, to provide the specified information. The Claims Administrator will notify you of the Plan's determination as soon as possible, but in no case later than 48 hours after the earlier of (1) the Plan's receipt of the specified additional information or (2) the end of the period afforded the Claimant to provide the specified additional information.

A claim for Benefits is considered an Urgent Care Claim if the application of the time periods for making non-urgent care determinations could seriously jeopardize Your life or health or Your ability to regain maximum function or, in the opinion of a Physician with knowledge of Your medical condition, would subject You to severe pain that could not be adequately managed without the care or treatment which is the subject of the claim.

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

Any request by You to extend a previously approved course of urgent care treatment beyond the approved period of time or number of treatments shall be decided as soon as possible, taking into account the medical exigencies, and the Claims Administrator will notify you of the Benefit determination, whether adverse or not, within twenty-four (24) hours after receipt of the claim by

the Plan, provided that any such claim is made to the Plan at least twenty-four (24) hours prior to the expiration of the prescribed period of time or number of treatments.

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

   A claim for Benefits is considered a Pre-Service Claim if the claim requires approval, in part or in whole, in advance of obtaining the health care in question.

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

   A claim for Benefits is considered a Post-Service Claim if it is a request for payment of services for which you have already received.

B. Calculation of Time Periods

For purposes of the time periods relating to the Plan's initial Benefit determination, the period of time during which an initial Benefit determination is required to be made begins at the time a claim is filed in accordance with the Plan procedures without regard to whether all the information necessary to make a decision accompanies the request. If a period of time is extended due to a Claimant's failure to submit all information necessary, the period for making the determination is "frozen" from the date the notification is sent to You until the date you respond to the request for additional information.

C. Manner and Content of Notice of Initial Claim Denial

If the Claims Administrator denies a claim, it must provide to you in writing or by electronic communication:

1. The specific reasons for the denial;

2. A reference to the Plan provision upon which the denial is based;

3. A description of any additional information or material that You must provide in order to perfect the claim;

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

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

6. A statement describing Your right to request an external review;

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

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

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

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

2. Information sufficient to identify the claim involved, including the diagnosis code (and an explanation of its meaning) and the treatment code (and an explanation of its meaning);

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

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

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

The Plan will provide You, upon request, notice of available internal claims and appeals and external review procedures in a culturally and linguistically appropriate manner, if applicable. Any notice given subsequent to such a request will be made in the same manner.

For an Adverse Benefit Determination concerning an Urgent Care Claim, the information described in this Section may be provided to you orally within the permitted time frame, provided that a written or electronic notification in accordance with this Section is furnished to you no later than three (3) days after the oral notification.

D. Internal Review of Initially Denied Claims

If You submit a claim for Plan Benefits and it is initially denied under the procedures described above, You may request a review of that denial under the following procedures:

Health Benefit Claims. You have one hundred eighty (180) days following receipt of a notification of an adverse initial Benefit determination within which to request a review of the adverse initial Benefit determination. In such cases, the review will meet the following requirements:

1. The Plan will provide a review that does not afford deference to the adverse initial Benefit determination and that is conducted by an appropriate named fiduciary of the Plan who did not make the adverse initial Benefit determination that is the subject of the appeal, nor is a subordinate of the individual who made the adverse initial determination.

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

3. The Plan will identify the medical or vocational experts whose advice was obtained on behalf of the Plan in connection with the adverse initial Benefit determination, without regard to whether the advice was relied upon in making the adverse initial Benefit determination.

4. In the case of a requested review of a denied adverse initial Benefit determination involving an Urgent Care Claim, the review process shall meet the expedited deadlines described below. Your request for such an expedited review may be submitted orally or in writing and all necessary information, including the Plan's determination on review, shall be transmitted between the Plan and You by telephone, facsimile or other available similarly expeditious method.

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

6. You will be provided, free of charge, any new or additional evidence or rationale considered, relied upon, or generated by the Plan in connection with the claim. Such evidence or rationale will be provided as soon as possible and sufficiently in advance of the date in which the notice of final internal adverse Benefit determination to give You a reasonable opportunity to respond prior to such determination.

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

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

E. Deadline for Internal Review of Initially Denied Claims

1. Urgent Care Claims. For Urgent Care Claims, the reviewer will notify You of the Plan's determination on review as soon as possible, taking into account the medical exigencies, but not later than 72 hours after receipt of Your request for review of the adverse initial Benefit determination by the Plan.

2. Pre-Service Claims. For a Pre-Service Claim, the reviewer will notify You of the Plan's determination on review within a reasonable period of time appropriate to the medical circumstances, but in no event later than thirty (30) days after receipt by the Plan of Your request for review of the adverse initial Benefit determination.

3. Post-Service Claims. For a Post-Service Claim, the reviewer will notify You of the Plan's benefit determination on review within a reasonable period of time, but in no event later than sixty (60) days after receipt by the Plan of Your request for review of the adverse initial Benefit determination.

F. Calculation of Time Periods.

For purposes of the time periods specified in this Section, the period of time during which a Benefit determination on review is required to be made begins at the time relating to the Plan's review of adverse initial benefit determination is filed in accordance with the Plan procedures without regard to whether all the information necessary to make a Benefit determination or review accompanies the request for review.

G. Manner and Content of Notice of Decision on Internal Review of Initially Denied Claims

Upon completion of its review of an adverse initial benefit determination, the reviewer will give You, in writing or by electronic notification, a notice containing:

1. Its decision;

2. The specific reasons for the decision;

3. The relevant Plan provisions on which its decision is based;

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

5. A statement describing Your right to request an external review;

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

7. If the adverse determination on review is based on a Medical Necessity, experimental treatment or similar exclusion or limit, either: (a) an explanation of the scientific or clinical judgment on which the

determination was based, applying the terms of the Plan to the claimant's medical circumstances, or (b) a statement that such an explanation will be provided without charge upon request; and

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

Any notice of adverse determination will include the following information:

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

2. Information sufficient to identify the claim involved, including the diagnosis code (and an explanation of its meaning) and the treatment code (and an explanation of its meaning);

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

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

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

The Plan will provide you, upon request, notice of available internal claims and appeals and external review procedures in a culturally and linguistically appropriate manner, if applicable. Any notice given subsequent to such a request will be made in the same manner.

H. External Review of Denied Claims

If You have exhausted the Plan's internal appeal process, you may request an external review of the Plan's final Adverse Benefit Determination.

The Plan shall provide for an external review process in accordance with Federal law. As such, the following requirements shall apply:

1. With respect to health benefit claims (i.e. Urgent Care, Post-Service and Pre-Service claims), You have four (4) months following the date of receipt of a notification of a final internal Adverse Benefit Determination within which to request an external review.

2. Within five (5) business days following the date of receipt of the external review request the Plan will complete a preliminary review and notify You in writing within one (1) business day after completion of the preliminary review whether the claim is eligible for the external review process:

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

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

3. The only types of claims eligible for review under the federal external review process are those that involve medical judgment, as determined by the external reviewer, or a rescission of coverage (regardless of whether the rescission has any effect on any particular benefit at the time). Claims that involve medical judgement include determinations based on:
   a) Requirements for medical necessity, appropriateness, health care setting, level of care, or effectiveness of a covered benefit;
   b) Whether a treatment is experimental or investigational;
   c) Whether a participant or beneficiary is entitled to a reasonable alternative standard for a reward under a wellness program; or
   d) Whether a plan or issuer is complying with the nonquantitative treatment limitation provisions of the Mental Health Parity and Addiction Equity Act, which generally require, among other things, parity in the application of medical management techniques.
   e) In addition, effective for plan years beginning on or after Jan. 1, 2022, claims involving surprise medical bills or surprise air ambulance bills under the No Surprises Act are eligible for review under the federal external review process.

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

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

6. Within forty-five days after receipt of the external review request from the Plan, the IRO must provide written notice to You and the Plan. Such notice will contain the following:

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

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

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

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

e) A statement that the determination is binding except that other remedies may be available under State or Federal law to either the group health plan or to You;

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

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

I. Expedited External Review

If the request for an external review is for an Urgent Care Claim, you may request an expedited external review. The following requirements apply to an expedited external review:

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

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

   b) If the request is not complete, the notice will describe any information or materials needed to make the request complete. If the request is not complete and additional information or materials is needed to complete the preliminary review, You will have until the later of (i) 48 hours following the date of receipt of the notification or (ii) the end of the four-month deadline described in (1) above under the section entitled External Review of Denied Claims.

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

3. The IRO must provide notice to the Claimant and the Plan (either in writing or orally) as expeditiously as the Claimant's medical condition or circumstance require, and no later than seventy-two hours after receipt of the expedited external review request from the Plan. If notice is not provided in writing, the IRO must provide written notice to You and the Plan as confirmation of the decision within forty-eight hours after the date of the notice. The notice will contain the following information:

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

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

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

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

e) A statement that the determination is binding except that other remedies may be available under State or Federal law to either the group health plan or to You;

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

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

J. Plan's Failure to Follow Procedures

If the Plan fails to follow the claims procedures described above, You will be deemed to have exhausted the administrative remedies available under the Plan and will be entitled to pursue any available remedy under State or Federal law on the basis that the Plan has failed to provide a reasonable claims procedure that would yield a decision on the merits of the claim.

K. Statute of Limitations for Plan Claims

No legal action may be commenced or maintained to recover benefits under the Plan more than twelve (12) months after the final review/appeal decision by the Plan Administrator has been rendered (or deemed rendered).

Part XVI. Subrogation, Recovery and Right of Reimbursement

Benefits are payable only upon the Member's acceptance of the terms of the Plan. As a condition to receiving benefits under this Plan, a Member agrees:

1. To serve as a constructive trustee, and to hold in constructive trust such money or property resulting from any payments or settlement proceeds and agrees that they will not dissipate any such money or property without prior written consent of the Plan, regardless of how such money or property is classified or characterized, from any person, corporation, entity, no-fault carrier, uninsured motorist carrier, underinsured motorist carrier, other insurance policies for funds; and

2. To restore to the Plan any such benefits paid or payable to, or on behalf of, the Member when said benefits are paid or established by any person, corporation, entity, no-fault carrier, uninsured motorist carrier, underinsured motorist carrier, other insurance policies for funds; and

3. To refrain from releasing any party, person, corporation, entity, insurance company, insurance policies or funds that may be liable for or obligated to the Member for the injury or condition without obtaining the Plan's written approval; and

4. Without limiting the preceding, to subrogate the Plan to any and all claims, causes of action or rights that they have or that may arise against any person, corporation and/or other entity and to any coverage, no-fault coverage, uninsured motorist coverage, underinsured motorist coverage, other insurance policies or funds ("Coverage") for which the Member claims an entitlement to benefits under this Plan, regardless of how classified or characterized.

In the event a Member settles, recovers, receives, or is reimbursed by any third party or Coverage, the Member agrees that they are a constructive trustee, and shall hold any such funds received in constructive trust for the benefit of the Plan, and to transfer title to the Plan for all benefits paid or that will be paid as a result of said injury or condition. The Member acknowledges that the Plan has a property interest in the Member's settlement, recovery, or reimbursement, and that the Plan's subrogation rights shall be considered a first priority claim and shall be paid before any other claims for the Member as the result of the illness or injury, regardless of whether the Member is made whole. If the Member fails to reimburse the Plan for all benefits paid or to be paid, as a result of said injury or condition, out of any recovery or reimbursement received, the Member will be liable for any and all expenses (whether fees or costs) associated with the Plan's attempt to recover such money from the Member.

The Member shall execute and return a Subrogation Agreement to the Plan Administrator and shall supply other reasonable information and assistance as requested by the Plan Administrator regarding the claim or potential claim. If the Subrogation Agreement is not executed and returned or if information and assistance is not provided to the Plan Administrator upon request, no benefits will be payable under the Plan with respect to costs incurred in connection with such illness or injury.

If the Member (or guardian or estate) decides to pursue a third party or any coverage available to them as a result of the said injury or condition, the Member agrees to include the Plan's subrogation claim in that action and if there is failure to do so the Plan will be legally presumed to be included in such action or recovery. In the event the Member decides not to pursue any and all third parties or coverage, the Member authorizes the Plan to pursue, sue, compromise or settle any such claims in their name, to execute any and all documents necessary to pursue said claims in their name, and agrees to fully cooperate with the Plan in the prosecution of any such claims. The Member (or guardian or estate) agrees to take no prejudicial actions against the subrogation rights of the Plan or to in any

way impede the action taken by the Plan to recover its subrogation claim. Such cooperation shall include a duty to provide information, execute and deliver any acknowledgment and other legal instruments documenting the Plan's subrogation rights and take such action as requested by the Plan to secure the subrogation rights of the Plan.

The Plan will not pay or be responsible, without its written consent, for any fees or costs associated with a Member pursuing a claim against any coverage or third party. The Plan Administrator retains sole and final discretion for interpreting the terms and conditions of the Plan document. This right of subrogation shall bind the Member's guardian(s), estate, executor, personal representative, and heir(s).

Rights of Recovery

In the event of any overpayment of benefits by this Plan, the Plan will have the right to recover the overpayment. If a Member is paid a benefit greater than allowed in accordance with the provisions of this Plan, the Member will be requested to refund the overpayment. If payment is made on behalf of a Member to a Hospital, Physician or other provider of health care, and that payment is found to be an overpayment, the Plan will request a refund of the overpayment from the provider first. If the provider does not honor the Plan's request for a refund, the Plan will then request the overpayment from the Member. If the refund is not received from the provider or Member, the amount of the overpayment will be deducted from future benefits.

Right to Receive and Release Necessary Information

For the purposes of implementing the terms of this Plan, the Claims Administrator retains the right to request any medical information from any insurance company or provider of service it deems necessary to properly process a claim. The Claims Administrator may without consent of the Member, release or obtain any information it deems necessary. Any person claiming benefits under this Plan shall furnish to the Claims Administrator such information as may be necessary to implement this provision.

Reimbursement Rights

The Member, by accepting benefits under this Plan, agrees to hold in constructive trust any money or property resulting from any recovery, insurance payments or settlement proceeds, third party payments, settlement proceeds or judgment for the Plan's benefits under this provision. If a Member fails to reimburse the Plan for all benefits paid or to be paid, as a result of their illness or injury, out of any recovery or reimbursement received, the Member will be liable for any and all expenses (whether fees or costs) associated with the Plan's attempt to recover such money from the Member. This right of reimbursement shall bind the Member's guardian(s), estate, executor, personal representative, and heir(s).

Part XVII. General Provisions

A. **Entire Contract.** This plan document, the Schedule(s) of Benefits, any Supplemental Benefits (Riders), and the individual Eligible Employee's application constitute the entire contract of coverage between the Plan, the Employer, and Members, and as of the effective date of the plan document, supersede any and all other agreements between the Plan, Employer, and/or Members.

B. **Form or Content of Contract.** No agent or representative of the Plan, other than the President and CEO of the Employer, is authorized to change the terms of this plan document.

C. **Administration of Contract.** The Plan may adopt reasonable policies, procedures and rules and interpretations to promote the orderly and efficient administration of the Plan, and You agree to follow such policies.

D. **Assignment.** Your Benefits under the Plan are not assignable by the Employer or by You without the prior written consent of the Plan.

E. **Amendment.** The Employer may amend the Plan:

1. Upon at least thirty (30) days prior written notice to You and to the Plan Administrator,

2. If the amendment is accepted by You or the Plan Administrator, which acceptance shall be evidenced by continued payment of charges after the thirty (30) days' notice to the Plan Administrator.

F. **Notice.** When notice is required under the Plan, it may be mailed to:

Memorial Healthcare System
Employee Healthcare Program
3501 Johnson Street
Hollywood, FL 33021
ATTN: Human Resources

and to the Plan Administrator and/or to You at the most recent address on file with the Plan. You are required to inform the Plan of any change of address.

G. **Clerical Error.** Clerical error(s), whether of the Plan Administrator, Claims Administrator, or the Plan in keeping any record pertaining to the coverage under the Plan, will not invalidate the coverage otherwise validly enforce or continue coverage otherwise validly terminated.

H. **Information.** Information as to how services may be obtained will be furnished to You upon enrollment and may also be obtained upon request from the Plan's Customer Service Department.

I. **Plan Interpretation.** All decisions concerning the interpretation or the application of this Plan and its terms, shall be at the discretion of the Plan Administrator.

J. **Subtitles**. The subtitles included in this plan document are provided for the purpose of identification and convenience and are not part of the Plan.

Part XVIII. Use and Disclosure of Protected Health Information (PHI) under the Health Insurance Portability and Accountability Act (HIPAA)

Section 1 – Permitted Uses and Disclosures of Protected Health Information (PHI)

The Employer may only use and disclose protected health information it receives from the Plan as permitted and/or required by, and consistent with the HIPAA Privacy and Security regulations found at 45 CFR Part 164. This includes, but is not limited to, the right to use and disclose a Member's protected health information (including electronic protected health information) in connection with payment, treatment and health care operations.

The Plan will disclose protected health information to the Employer only upon receipt of a certification by the Employer that the Plan documents have been amended to incorporate all the required provisions as described below.

Memorial Healthcare System agrees to:

(1) Not use or further disclose the information other than as permitted or required by the Plan documents or as required by law;

(2) Ensure that any agents, including a subcontractor, to whom it gives protected health information received from the Plan, agrees to the same restrictions and conditions that apply to the Employer with respect to such information;

(3) Implement administrative, physical and technical safeguards that reasonably and appropriately protect the confidentiality, integrity and availability of the electronic protected health information that it creates, receives, maintains or transmits on behalf of the Plan;

(4) Ensure that any agent, including a subcontractor, to whom it gives electronic protected health information, agrees to implement reasonable and appropriate security measures to protect such information;

(5) Not use or disclose the information for employment-related actions and decisions or in connection with any other benefit or employee benefit plan of the Employer;

(6) Report to the Plan any use or disclosure of the information that is inconsistent with the uses or disclosures provided for of which the Employer becomes aware;

(7) Report to the Plan any security incident of which the Employer becomes aware;

(8) Make available protected health information in accordance with individuals' rights to review their protected health information;

(9) Make available protected health information for amendment and incorporate any amendments to protected health information consistent with the HIPAA rules;

(10) Make available the information required to provide an accounting of disclosures in accordance with the HIPAA rules;

(11) Make its internal practices, books and records relating to the use and disclosure of protected health information received from the Plan available to the Secretary of the Department of Health and Human Services for purposes of determining compliance by the Plan; and

(12) If feasible, return or destroy all protected health information received from the Plan that the Employer still maintains in any form. The Employer will retain no copies of protected health information when no longer needed for the purpose for which disclosure was made. An exception may apply if such return or destruction is not feasible, but the Plan must limit further uses and disclosures to those purposes that make the return or destruction of the information infeasible.

Section 2 – Separation of Employer and the Plan

The Employer shall restrict the access to and use of protected health information by such employees and other persons described in this section to the Plan administration functions that the Employer performs for the Plan, including payment and health care operations. No other persons shall have access to protected health information. The Employer shall ensure that the separation between the Plan and the Employer is supported by reasonable and appropriate security measures.

The following is the list of positions or classes of employees or other persons under the control of the Memorial Healthcare System who shall be granted access to protected health information as minimally necessary to perform proper Plan administrative functions:

- The Plan Administrator, and/or
- Staff designated by the Plan Administrator

Access to and use by such employees and other persons described in this section shall be restricted to the Plan administration functions that the Employer as Employer performs for the Plan. Any incidents of noncompliance by such individuals with the provisions of this section shall subject such individuals to disciplinary action and sanctions, including the possibility of termination of employment. The Employer will report such noncompliance to the Plan and will cooperate with the Plan to correct the noncompliance, impose an appropriate disciplinary action or sanction, and mitigate the effect of noncompliance.

Appendix A: MMCP Schedule of Benefits

Benefit/Service	Member Copayment	Limits/Maximums/Requirements
CALENDAR YEAR ANNUAL DEDUCTIBLE		
Individual Family	$100 $300	Copayments do not accumulate towards the deductible
Professional Services Primary Care Office Visit Specialty Physician Visit	 $20 copay per visit $30 copay per visit	 Each member must select a PCP
Hospital Services Inpatient/Observation Admission Outpatient Surgery @ Hospital or Ambulatory Surgery center	 $150 copay/day for up to 5 days $250 copay per visit	
Laboratory & X-Ray Services Radiologic Testing outpatient (X-ray) Diagnostic Lab Advanced Imaging (MRI, CT/PET/SPECT Scans)	 $50 copay Covered in full $100 copay per test type	 MRI, CT/PET scans require prior authorization
Maternity & Family Planning Pre-Natal/Post-Partum Care	 Covered in full after $150 global delivery fee	 No authorization required for initial visit
Hospital Delivery	$0 copay	
Newborn Nursery	Covered in full if stay with mother. If the baby stays, subject to inpatient copay	
Labor Checks	$50 copay at MHS (waived if admitted) $75 copay at non-MHS facility (waived if admitted)	
Infertility Testing	$50 copay per visit	Limited to 1 sequence per lifetime
Infertility Services	20% coinsurance	Limited to 1 Progyny Smart Cycle per lifetime
Voluntary Sterilization Inpatient Outpatient	 Inpatient copay applies Covered in full	
Elective Termination of Pregnancy	$100 copay	
Rehabilitation Services Inpatient Rehabilitation	 $150 copay/day for up to 5 days	
Outpatient Rehabilitation (includes PT/OT/ST)	$20 copay per day	Limited to 60 visits per calendar year (combined modalities)
Cardiac Rehabilitation	Covered in full	Limited to 36 visits per episode

Benefit/Service	Member Copayment	Limits/Maximums/Requirements
Wigs and Compression Sleeves	Medically necessary compression sleeves will be covered Wigs for hair loss related to a medical condition are covered up to a lifetime maximum of $750	
Mental Disorder Services Outpatient Inpatient	 $20 copay per visit Inpatient copay applies	
Substance Use Disorders Withdrawal Treatment (detox) Inpatient Treatment Program Outpatient Counseling	 Covered in full Inpatient copay applies $20 copay per visit	
Emergency Care Services ER visit • CVS Minute Clinic/ Walgreens • Memorial Primary Care • Holy Cross Urgent Care Centers • MHS Urgent Care Centers • Memorial Pembroke 24/7 Care Center (Douglas Rd) • MDNOW Urgent Care • Selected Broward Health locations	 $150 copay Copays waived if admitted $20 copay $20 copay $20 copay $20 copay $50 copay $75 copay $75 copay	 All
Ambulance Services	$50 copay	Emergent situations only air and ground
DME/Prosthetics and Orthotics	Covered in full	
Skilled Nursing Facility Services	Covered in full	45 days per calendar year
Dental Care Services	Copays apply in accordance with service rendered	Oral surgery covered in limited circumstances
Home Health Services	$15 copay per day	Maximum 60 visits per calendar year
Health Maintenance and Preventive Services Annual Routine Physical Annual Well Child Visit Annual Gynecological Well Woman Exam Baseline/Annual Mammography Immunizations and Vaccinations Only – no Office visit Health Education/Counseling	 Covered in full Covered in full Covered in full Covered in full Covered in full Covered in full Covered in full	 PCP or OB/GYN

Benefit/Service	Member Copayment		Limits/Maximums/Requirements
Allergy Care Services Testing Allergy injection Serum	 $50 copay per visit $20 copay Covered in full		
Hospice Care Services	Covered in full		Life expectancy of <6 months. Coverage is limited to $10,000 maximum benefit.
Transplant Services	Inpatient copay applies Copays apply in accordance with service rendered		
Chiropractic Services Acupuncture	$40 copay $40 copay		Initial visit without authorization, ongoing visits require authorization 60 visit maximum.
Hearing Aids	Member responsible for balance of charge		Each hearing aid device is limited to once every 36 months to a maximum benefit of $2,500
Pharmacy - Retail **Tier 1** **Tier 2** **Tier 3** **Pharmacy – Mail Order** **Tier 1** **Tier 2** **Tier 3**	30 day retail supply $10 copay $35 copay 40% ($50 minimum, $150 maximum) 90 day mail order supply $20 copay $70 copay 40% ($70 minimum, $210 maximum)	90 day retail supply $20 copay $70 copay 40% ($150 minimum, $210 maximum)	Important note: In the event a Tier 1 equivalent medication is available the member will be responsible for a co-pay of 40% (a minimum $50 and a maximum of $150) plus the cost difference between the Tier 1 equivalent and the Tier 3 medication. *****One copay per month (3 copays) will apply for 90 day retail prescriptions outside of the First Choice network
Pharmacy – MHS Pharmacies **Tier 1** **Tier 2** **Tier 3**	30 day supply $10 copay $20 copay 40% ($35 minimum, $135 maximum)	90 day supply $20 copay $55 copay 40% ($55 minimum, $195 maximum)	
Specialty Drugs (Only covered at MHS pharmacies and the CRx Specialty Pharmacy.)	40% ($150 minimum, $300 maximum)		
ANNUAL OUT-OF-POCKET MAXIMUM (includes deductible) Individual Family	 $4,000 $8,000		

PHYSICIANS MUST BE PARTICIPATING WITH MEMORIAL MANAGED CARE, UNLESS OTHERWISE AUTHORIZED

Appendix B: MCHP Schedule of Benefits

	MEMBER COST SHARE		
	MHS PROVIDERS		**NON-MHS PROVIDERS**
CALENDAR YEAR ANNUAL DEDUCTIBLE			
Individual Family	$1,000 $2,000		$4,000 $8,000
PREVENTIVE MEDICAL CARE			
Immunizations/Vaccinations	Covered in full		0%
Well Child Care	Covered in full		0% to $150 maximum then deductible and 40%
Routine OB/GYN Exam (including Routine pap smears) Maximum Benefits: One Exam Per 12-Month Period	Covered in full		
Routine Care Maximum Benefit: One Exam Per Calendar Year	Covered in full		
Routine Mammograms	Covered in full		
NON-PREVENTIVE MEDICAL CARE			
Includes physician, hospital, home health, mental health, outpatient surgery, hospice, durable medical equipment, skilled nursing facility, and hearing (except for services subject to copays noted below); see limits below.	Deductible and 20% coinsurance		Deductible and 40% coinsurance
Infertility Services	Deductible & 20% coinsurance Limited to 1 Progyny Smart Cycle		Not Covered
Emergency Room	Deductible & 20% coinsurance		Deductible & 20% coinsurance
Outpatient Therapies (PT/OT/ST) Chiropractic Acupuncture	Deductible and 20% coinsurance $40 copay $40 copay		**NOT COVERED**
Outpatient Mental Health	$20 copay		Deductible and 40% coinsurance
Anesthesia	Covered in full		Deductible and 40% coinsurance
PHARMACY			
Pharmacy - Retail **Tier 1** **Tier 2** **Tier 3** **Pharmacy – Mail Order** **Tier 1** **Tier 2** **Tier 3**	30 day retail supply $10 copay $35 copay 40% ($50 minimum, $150 maximum) 90 day mail order supply $20 copay $70 copay 40% ($70 minimum, $210 maximum)	90 day retail supply $20 copay $70 copay 40% ($150 minimum, $210 maximum)	Important note: In the event a Tier 1 equivalent medication is available the member will be responsible for a co-pay of 40% (a minimum $50 and a maximum of $150) plus the cost difference between the Tier 1 equivalent and the Tier 3 medication. *****One copay per month (3 copays) will apply for 90 day retail prescriptions outside of the First Choice network

Pharmacy – MHS Pharmacies **Tier 1** **Tier 2** **Tier 3**	30 day supply $10 copay $20 copay 40% ($35 minimum, $135 maximum)	90 day supply $20 copay $55 copay 40% ($55 minimum, $195 maximum)	
Specialty Drugs (Only covered at MHS pharmacies and the CRx Specialty Pharmacy.)	40% ($150 minimum $300 maximum)		**NOT COVERED**
ANNUAL OUT-OF-POCKET MAXIMUM (**includes deductible)** Individual Family Wigs and Compression Sleeves	 $4,000 $8,000 Medically necessary compression sleeves will be covered Wigs for hair loss related to a medical condition are covered up to a lifetime maximum of $750		 $10,000 $20,000

- Note: Inpatient visits at MHS facilities will be paid at the In-network level of benefits.
- After each family member meets his or her individual annual deductible, the plan will pay his or her claims, less any coinsurance amount. After the family annual deductible has been met, each individual's claims will be paid by the plan, less any coinsurance amount.
- Copayments to do not accumulate towards the annual deductible.
- Annual deductibles are included in the out of pocket maximum.

Appendix C: Diabetes Management Program

Employees ages 18 and over with a documented diabetic condition, participating in the Diabetes Management Program, will have certain cost share waived based on active participation.

Benefit changes will take place on the first of the month following enrollment. In order to complete enrollment, the employee must complete the following steps:

- voluntarily enroll in program via MyChart
- complete SDOH screening
- indicate whether a wearable is wanted
- select appointment date for program

Nutrition/Dietician Consultation	No copay, coinsurance or deductible
Pharmacy Consultation	No copay, coinsurance or deductible
Diabetic Medications • Generic only, if available • Home delivery services only	No copay, coinsurance or deductible
PCP Visits	No copay, coinsurance or deductible
Endocrinology Visits	No copay, coinsurance or deductible
HbA1c Testing	No copay, coinsurance or deductible
Remote Patient Monitoring	No copay, coinsurance or deductible