



**Collective
Health®**

2025 Plan Details

Energy Transfer LP PPO

Hello!

Welcome to your Energy Transfer LP PPO Plan, presented in partnership with Collective Health.

We always try to keep things simple at Collective Health. This booklet is not exactly short, but here's why it's important to share it with you: this is your benefit booklet. It describes the benefits of your health Plan and it's something that you can refer to when you have questions. If there are any material changes to this or future benefit booklet, you will receive a Summary of Material Modifications (SMM) to let you know what the changes are.

This benefit booklet is organized by topic so you can quickly find what you need. Here are some of the topics that you can read about inside:

- What's covered by the Plan, what's not covered, and how much you can expect to pay for your healthcare
- How to submit a claim, and what to do if your claim is denied
- Your rights and responsibilities as a member of this Plan

Collective Health wants to help you understand everything about your healthcare benefits and what's covered for you and your dependents. You can get 24/7 access to information about your plan and your healthcare claims by activating your account at my.collectivehealth.com. If you have any additional questions, get in touch with us by calling 855-399-5599 or chatting with one of our Member Advocates through the Collective Health website or mobile app from 4 am to 6 pm PT, Monday through Friday, and 7 am to 11 am PT on Saturdays. You can also sign into your Collective Health account and use Messages to communicate with a Member Advocate directly.

Here's to a happy and healthy year ahead!

Este folleto tiene un resumen en inglés de los derechos y beneficios de su PPO plan. Si tiene dificultades entendiendo la información que se encuentra aquí, por favor contacte 855-399-5599. También nos puede contactar directamente ingresando a su cuenta de Collective Health y usando la opción "Messages."

本手册含有您 PPO plan 保险计划提供的福利和权利的英文总结. 如果您对本手册的内容有任何疑问, 请拨打 855-399-5599. 你也可以登入你的 Collective Health 账号, 用 Messages 功能和我们一起交流.

Fast Facts About Your Health Plan	6
Section 1: Your Contributions & Costs.....	8
<i>How the Network Can Work for You.....</i>	<i>8</i>
<i>Allowed Amounts.....</i>	<i>11</i>
<i>Surprise Billing Protections</i>	<i>12</i>
<i>Continuity of Care Under the No Surprises Act</i>	<i>14</i>
<i>Paying for Treatment You Receive</i>	<i>14</i>
Section 2: Quality & Value Programs	18
<i>Maximum Medical Benefits</i>	<i>18</i>
<i>Prior Authorization for Certain Procedures</i>	<i>18</i>
<i>Case Management Services</i>	<i>19</i>
<i>Get a Second Opinion.....</i>	<i>19</i>
Section 3: What's Covered & How Much It Costs.....	21
<i>Preventive Care</i>	<i>21</i>
<i>Emergency Care</i>	<i>24</i>
<i>Treatment for Medical Conditions other than Preventive or Emergency Care</i>	<i>28</i>
<i>Pharmacy Benefits.....</i>	<i>63</i>
Your Pharmacy Network.....	63
Types of Prescriptions.....	63
What You Pay.....	64
Over-the-Counter Medications	67
Section 4: What's Not Covered (Exclusions)	67
Section 5: How to File a Claim.....	75
<i>Regular Post-Service Claims</i>	<i>76</i>
<i>Concurrent Care Claims</i>	<i>78</i>
<i>Pre-Service Claims</i>	<i>78</i>
Section 6: How to Appeal	80
<i>How to Appeal Prior Authorization and Medical Necessity Determinations.....</i>	<i>81</i>
<i>How to Appeal Non-Clinical Post-Service Adverse Benefit Determinations</i>	<i>82</i>
<i>Notice of Final Adverse Benefit Determination.....</i>	<i>84</i>
<i>External Review Program</i>	<i>85</i>

Standard External Review	86
Expedited External Review	88
Limitation on Your Right to Sue	89
Section 7: Coordination of Benefits	90
<i>Definitions</i>	90
<i>Order of Benefit Determinations</i>	92
<i>Determination of Benefits</i>	95
<i>Medicare Coordination of Benefits</i>	96
<i>Medicaid and Tricare Coordination of Benefits</i>	96
<i>No Fault Liability Insurance</i>	96
<i>Travel Insurance</i>	97
Section 8: The Plan's Right to Repayment	97
<i>Recovery from the Person Responsible for Your Injuries</i>	97
<i>Refund of Payments</i>	99
Section 9: Changes to This Plan's Terms.....	101
<i>Disclosure Authorization</i>	101
Section 10: Plan Administration	103
Plan Information Summary	103
Section 11: Legal Provisions and Your Legal Rights	105
<i>Your ERISA Rights</i>	105
<i>Mental Health Parity and Addiction Equity</i>	107
<i>Genetic Information Nondiscrimination Act</i>	107
<i>Affordable Care Act</i>	107
Appendix A: Information About the Extended Blues Network	109

Fast Facts About Your Health Plan

What kind of health Plan is this?

This is a "PPO" (preferred provider organization) plan. This includes a preferred network (Blue Cross and Blue Shield of Texas) that includes many, but not all, doctors and hospitals. You do not need to designate a primary care physician or get your primary care physician's referrals to see specialists; you can see the doctors you choose for your medical needs. If you see in-network doctors, you will generally pay less than if you see doctors out-of-network.

Who pays?

The Energy Transfer LP PPO is a self-insured healthcare plan. That means there is no health insurance company paying for your claims; Energy Transfer LP ("Energy Transfer LP") is the Plan sponsor, and they pay doctors and hospitals for the medical care you receive. Collective Health partners with Energy Transfer LP and takes on many administrative responsibilities for this Plan (such as processing your claims and answering your questions). Blue Cross and Blue Shield of Texas provides the medical network for the Plan, and gives you access to a nationwide network of healthcare providers through the BlueCard program. CVS Caremark provides pharmacy benefit management services for the Plan. You help pay for the cost of your healthcare under this Plan. More information about cost sharing is in Section 1.

Key Plan Information

- The Plan year begins on January 1 and ends on December 31.
- Depending on how many people you enroll, your in-network deductible will be:
 - \$1,250 for an individual
 - \$3,000 for your family
- Depending on how many people you enroll, your in-network out-of-pocket maximum will be:
 - \$4,000 for an individual
 - \$8,000 for your family
- Find information about what's covered in Section 3. Information about what's not covered is in Section 4.

Questions? We're here to help.

Register for 24/7 access to your healthcare information at my.collectivehealth.com. Collective Health Member Advocates are available at 855-399-5599. You can also sign into your Collective Health account and use Messages to communicate with a Member Advocate directly.

Section 1: Your Contributions & Costs

Your membership in this Plan includes a responsibility to contribute to the cost of your healthcare benefits. You may be required to pay an employee contribution to pay for your (and/or your dependents) coverage under the Plan. In most cases, when you actually receive healthcare services, you must also pay part of the cost of those services, as described further in Section 3. The Plan is designed so you generally pay less when you use providers and facilities in the Blue Cross and Blue Shield of Texas network.

How the Network Can Work for You

Your membership in this Plan includes access to a network of healthcare service providers (doctors, nurses, and other licensed professionals) and facilities (such as hospitals, urgent care centers, and pharmacies). The providers and facilities in this network have agreed to accept negotiated rates for the services they provide to you and your dependents. Because health services from in-network providers and facilities often cost less than the same services outside the network, this Plan is designed to encourage you to use in-network services whenever possible. Please note that if you have signed a waiver with an in-network provider, they may bill you for amounts in excess of the network's allowed amount. This amount will not be covered by the Plan (see Section 4 for other circumstances for which you may be responsible for the full cost of your care).

- Blue Cross and Blue Shield of Texas is this Plan's preferred medical network. Through Blue Cross and Blue Shield of Texas, you have access to providers outside of Texas in the BlueCard program. You can find additional important information about Blue Cross and Blue Shield of Texas and BlueCard in Appendix A. Blue Cross and Blue Shield of Texas, an independent member of the Blue Shield Association, provides administrative claims payment services only and does not assume any financial risk or obligation with respect to claims.
- This Plan's preferred pharmacy network is CVS Caremark, which includes all major retail pharmacies as well as a mail order pharmacy option.
- The Plan may also have preferential arrangements that provide enhanced benefits if you use specific healthcare facilities or services.

In most circumstances, this Plan provides richer benefits for services provided by in-network healthcare providers or facilities. If you receive services out-of-network, you will generally be responsible for a greater share of the cost. Note that out-of-network providers can balance bill you for any amounts not covered by the Plan, except in the case of certain emergency services covered by the No Surprises Act. These balance bills can sometimes be substantial, so you are encouraged to carefully evaluate whether you can afford to see such out-of-network provider in advance.

If your in-network doctor refers you to an out-of-network provider or facility for a covered service, or you choose to see an out-of-network provider because there is no in-network provider available, the Plan may authorize the in-network benefits to an out-of-network provider claim. If this applies to your situation, please contact Collective Health in advance of obtaining the covered service. If you receive authorization for in-network benefits to apply to a covered service received from an out-of-network provider, you may still be responsible for the difference between the allowed amount and the out-of-network provider's billed amount.

Ultimately, the choice of which provider or facility to use (whether in- or out-of-network) is yours. To find out whether a doctor is in your network, check my.collectivehealth.com, the mobile app, or contact a Collective Health Member Advocate. Because provider or facility network status may change throughout the year, it is best practice to always double check with the provider or facility on their current status with the Blue Cross and Blue Shield of Texas network.

This Plan requires your provider to have specific credentials in order to cover your treatment. This helps the Plan ensure that you receive medically necessary, quality care. In most cases, the required credentials are state medical licenses, which must be active and unrestricted in the state where you are receiving care.

If a provider's license is not active or current, your claim will not be covered. If a provider has an active professional certification to provide covered benefits in that state, the claim will be covered. If a mental or behavioral health provider, with the appropriate and relevant training, is practicing under the guidance of a licensed and active provider, the claim will be covered as long as the services rendered are covered benefits on your Plan.

The following table provides examples of specific provider credentials required for Plan coverage. If you choose to visit an out-of-network provider, make sure to confirm that the provider has the appropriate credentials to administer the care you need. You may be responsible for submitting validation of their credentials. Contact Collective Health if you have questions about your specific provider. Remember that services still need to be medically necessary to be covered by your Plan.

Provider Type	Sample Credentials by Provider Type
Audiologist	Doctor of Audiology (AuD) American Board of Audiology (ABA) Certified Audiologist
Chiropractor	Doctor of Chiropractic (DC)
Dentist	Doctor of Dental Surgery (DDS) Doctor of Medicine in Dentistry (DMD)
Lactation consultant	International Board Certified Lactation Consultant (IBCLC), Academy of Lactation Policy and Practice (ALPP)
Massage Therapist	Licensed Massage Therapist (LMT)
Midwife	Certified Nurse Midwife (CNM) (certified midwives are not covered)
Nurse	Nurse Practitioner (NP) Registered Nurse (RN) Licensed Vocational Nurse (LVN)
Nutritionist or Registered Dietician	Licensed Dietitian (LD) Licensed Nutritionist (LN) Licensed Dietician Nutritionist (LDN)
Occupational Therapist	Registered/Licensed Occupational Therapist (OTR)
Optometrist	Doctor of Optometry (OD)
Pharmacist	Doctor of Pharmacy (PharmD)
Physician	Doctor of Medicine (MD) Doctor of Osteopathic Medicine (DO)
Physical Therapist	Physical Therapist (PT) Master of Physical Therapy (MPT or MSPT) Doctor of Physical Therapy (DPT)

Physician Assistant	Physician Assistant (PA)
Podiatrist	Doctor of Podiatric Medicine (DPM)
Psychiatrist	Doctor of Medicine (MD) Doctor of Osteopathic Medicine (DO)
Psychologist	Clinical Psychologist (PhD) Doctor of Psychology (PsyD)
Respiratory Care Practitioner	Certified Respiratory Therapist (CRT) Registered Respiratory Therapist (RRT)
Speech Therapist/Pathologist	Licensed Speech Language Pathologist (SLP)
Therapist/Counselor/Social Worker	Licensed Clinical Social Worker (LCSW) Licensed Master Social Worker (LMSW) Marriage and Family Therapist (MFT/LMFT)

If you have questions about whether your provider may be covered by your Plan, contact Collective Health.

Allowed Amounts

One benefit of visiting an in-network doctor or hospital is that Blue Cross and Blue Shield of Texas has negotiated the rates for most healthcare services in advance. When you choose to visit an out-of-network provider or facility for medical treatment, it's much harder to know how much your treatment might cost. The providers may charge a reasonable rate for the services they provide you, or they may charge a lot more.

This Plan will not pay charges that are excessive. Instead, this Plan sets an allowed amount for each medical service, and this allowed amount is the most the Plan will pay for that service when you receive it from an out-of-network provider. Allowed amounts are determined by reference to industry benchmarks. The Plan will use Medicare reimbursement rates as a benchmark and will set the allowed amount to the lesser of the billed charges or 140% of the Medicare reimbursement rate. If Medicare pricing is not available, the Plan will set the allowed amount to the lesser of the billed charges or the Plan's maximum allowance for out-of-network providers. The out-of-network maximum allowance is developed from base Medicare reimbursements and represents approximately 100% of the base Medicare reimbursement rate or determined if the following apply: 1) if service is for Coordinated Home Care Program Covered Services, it will be 50% of the out-of-network provider's Claim for such Covered

Services; 2) if service is for Ambulance Transportation services provided by out-of-network providers and services are not covered under the No Surprises Act, it will be out-of-network provider's Claims for such Covered Service; 3) if services are provided by other unsolicited out-of-network providers the maximum allowance will be the amount which in-network providers have agreed to accept as payment in full for a particular Covered Service, or the reimbursement amount set by the Claim Administrator or the Host Blue Plan for providers designated as in-network providers for a particular Covered Service. If there is no rate according to the Schedule of maximum allowances, then the maximum allowance will be 25% of out-of-network provider's Claim charges. The Plan will utilize the same Claim processing rules, edits or methodologies that it utilizes in processing in-network provider Claims for processing Claims submitted by out-of-network providers which may also alter the non-contracting maximum allowance for a particular Covered Service. In the event the Claim Administrator does not have any Claim edits, rules or methodologies, the Plan may utilize the Medicare claim rules or edits that are used by Medicare in processing such Claims. The allowed amount for out-of-network emergency room and ambulance claims may be based on your medical network's in-network pricing. You may contact Collective Health for more information.

Because the Plan doesn't have contracts in place with out-of-network providers, those providers may charge more than the allowed amount for the treatment you receive. Your benefits under this Plan will be based on the allowed amount, and the provider may bill you for the excess. (This practice is called balance billing.) It is your responsibility to pay any amounts in excess of the allowed amount—in addition to any deductibles, copays, or coinsurance. Balance billed charges can be significant, and they also don't count toward your out-of-pocket maximum. If you choose to see an out-of-network provider, you may want to ask them about their billed charges before you receive care.

If you can gather some information from your out-of-network provider in advance, Collective Health can help you determine whether you're likely to be balance billed. Contact Collective Health for guidance or visit my.collectivehealth.com.

Surprise Billing Protections

The following out-of-network services will be covered with in-network cost-sharing (including in-network deductible and out-of-pocket maximum) and your cost-sharing will be calculated based on the lesser of the provider's billed charges or the median in-network rate in the geographic region (also referred to as the qualifying payment amount); the allowed amount will be based on

one of the following in the order listed as applicable: the initial payment made by the Plan (which is the median in-network rate in the geographic region), the amount subsequently agreed to by the out-of-network provider or out-of-network emergency facility and the Plan, or the amount determined by the Independent Dispute Resolution (IDR) process if the parties enter into the IDR process and do not agree on a payment amount before the date when the IDR entity makes a determination:

- **Emergency Services** including services you may get after you're in stable condition, as covered under the No Surprises Act.
- **Non-emergency services provided by out-of-network providers at an in-network hospital or ambulatory surgical center**, including emergency medicine, anesthesia, pathology, radiology, laboratory, neonatology, assistant surgeon, hospitalist, or intensivist services.
- **Air Ambulance Services**

Out-of-network providers cannot balance bill you for these services. However, the prohibition against balance billing does not apply if the provider has satisfied the notice and consent criteria under federal law to obtain your voluntary and informed written consent for the following services: (1) non-ancillary services received at in-network facilities on a non-emergency basis from out-of-network providers, and (2) post-stabilization services if you are able to travel using non-medical transportation or non-emergency medical transportation to an available in-network provider or in-network facility located within reasonable travel distance and the out-of-network provider or out-of-network emergency facility follows detailed notice and consent requirements.

With respect to non-emergency services provided by out-of-network providers at an in-network facility, for ancillary services, non-ancillary services provided without satisfying the notice and consent criteria under federal law, and non-ancillary services for unforeseen or urgent medical needs that arise at the time an item or service is furnished, you are not responsible, and an out-of-network provider may not bill you, for amounts in excess of your applicable copayment, coinsurance, or deductible.

You're never required to give up your protections from balance billing. You also aren't required to get care out-of-network. You can choose a provider or facility in your Plan's network. If you believe you've been wrongly billed, you may contact the U.S. Department of Labor Employee Benefits Security Administration at 1-866-487-2365.

Continuity of Care Under the No Surprises Act

When a provider goes out of network, plans must permit individuals who are undergoing treatment for a serious and complex condition, pregnant, receiving inpatient care, scheduled for non-elective surgery, or are terminally ill to elect up to 90 days of continued, in-network covered services. Please contact Collective Health for more information.

Paying for Treatment You Receive

For most healthcare services, the Plan pays for some, but not all, of the cost of treatment. Generally, you and the Plan share the cost of your care. This Plan shares the cost of healthcare with you in a couple of ways: annual medical and pharmacy deductibles, copays, coinsurance, and an out-of-pocket maximum (OOPM).

Until you hit your OOPM, you'll have to share the cost of your healthcare with the Plan. You'll have to meet your annual deductibles, and also pay a copay or coinsurance for most services you receive.

Coverage Tier	In-Network Deductible	Out-of-Network Deductible
Individual	\$1,250	\$2,500
Family	\$3,000	\$6,000

What is a deductible?

- A deductible is the amount you'll pay up-front for care until your benefits kick in. This applies only to some benefits.
- Remember that in-network preventive care is fully covered, even if you haven't met your deductible yet.

What is the difference between copays (\$) and coinsurance (%)?

- Copays are fixed dollar amounts. You typically pay the copay at the time you receive a medical service or fill a prescription.
- Coinsurance is a percentage of the cost of care. Your provider will typically bill you later.
- The cost sharing for each medical service, and whether or not the deductible applies to the benefit, is listed in the benefits table in section 3.

What spending counts toward your deductible?

- The amount you pay for covered prescriptions does not accumulate toward your medical deductible. Additionally, you do not need to meet your medical deductible before your pharmacy benefits kick in; however, you have to meet your pharmacy deductible as described further below.
- Benefits can interact differently with your deductible:
 - Some benefits are entirely separate from your deductible. For these benefits, if a service requires a copay or coinsurance, you only pay that amount, even if you haven't met your deductible. However, when you pay these copay or coinsurance benefits, that amount doesn't accumulate toward your deductible.
 - For other benefits, you must pay the full cost of care for services until you meet your medical or pharmacy deductibles for the year. After you've met your medical deductible, the medical benefits will kick in, and you'll be responsible only for your copay or coinsurance amount. The same is true for your pharmacy deductible and benefits.
- The amounts you pay for covered medical care in-network only count toward your in-network deductible. Likewise, the amounts you pay for covered medical care out-of-network only count toward your out-of-network deductible.
- Your employee contributions don't count toward your deductible, and neither do the amounts you pay for non-covered services or amounts in excess of the allowed amount.

How do deductibles work if you have a family plan?

- Each person on the plan has an individual deductible. Some of your copay and coinsurance benefits kick in before you meet your individual deductible, and some will kick in after. Even on a family plan, no one member will ever have to satisfy more than their individual deductible.
- If you have dependents, then your family has a family deductible. Once your whole family combined has paid enough to meet the family deductible, benefits will kick in for the entire family. This is true even for members who haven't yet hit their individual deductible.

The OOPM is the most you'll be required to pay for covered services in a Plan year.

Coverage Tier	In-Network Out-of-Pocket Max	Out-of-Network Out-of-Pocket Max
Individual	\$4,000	\$8,000
Family	\$8,000	\$16,000

What spending counts toward your OOPM?

- All money you pay for covered medical and pharmacy services counts toward your OOPM (including your deductible, copays, and coinsurance).
- The amounts you pay for covered medical services in-network only count toward your in-network OOPM. Likewise, the amounts you pay for covered medical services out-of-network only count toward your out-of-network OOPM.
- Your employee contributions don't count toward your OOPM, and neither do the amounts you pay for non-covered services or balance-billed amounts.

What happens after you hit your OOPM?

- Once you meet your OOPM for in-network care, the plan will pay for all of your covered in-network healthcare costs for the rest of the plan year. Your out-of-network OOPM works the same way.
- Remember that the OOPM only applies to covered services; even after you hit your OOPM, the Plan won't pay for non-covered services or amounts in excess of the allowed amount.

How do OOPMs work if you have a family plan?

- Each person on the plan has an individual OOPM. After an individual reaches their individual OOPM, their healthcare will be fully covered by the plan, and they won't have to share the cost of medical and pharmacy services.
 - Your whole family's costs are also capped at the family OOPM amount. Once your family's covered medical and pharmacy costs hit the OOPM, all enrolled members will have full coverage for the rest of the plan year. This is true even if some individuals haven't yet hit their individual OOPM.

Assignment of Benefits

You (or your dependents) may not assign or transfer in any manner your benefits or other rights that you have under this Plan, to any other person, including a healthcare provider. Any attempt to assign or transfer your rights under this Plan will not be recognized and is void. For convenience, the Plan may pay any undisputed benefit directly to a healthcare provider. The Plan Administrator reserves the discretionary authority to determine the validity of any arrangement to direct the payment of benefits to a third party and does not guarantee that any arrangement will be valid under the Plan. Any payment to a third party is not a waiver of the Plan's anti-assignment provision and does not make the provider an assignee or confer any rights on the provider, including any right to receive future payments or ERISA rights. Nothing contained in the written description of the Plan shall be construed to make the Plan or Energy Transfer LP liable to any third-party to whom a participant may be liable for medical care, treatment, or services.

Section 2: Quality & Value Programs

Maximum Medical Benefits

This Plan does not cap the total aggregate value of medical benefits you can receive, either in a given year or over your lifetime as a Plan member. So long as you remain eligible, and your treatment falls within the scope of the Plan and the allowed amount, your healthcare costs will continue to be covered by the Plan.

If specific services have maximum visits or benefit caps, that information will be clearly stated alongside the service costs in the benefit table in Section 3.

Prior Authorization for Certain Procedures

This Plan requires your provider to receive prior authorization for certain services. This means the provider must get clearance from the Plan in advance, before providing treatment to you. If the provider does not get prior authorization for a service that requires it, the Plan may not pay for the treatment. You may be responsible for the full cost of your care in the following cases:

- Your provider does not apply for prior authorization or a post-service review (also called a “post authorization”) with the medical network.
- The prior authorization or post-service review is denied.
- You sign a waiver promising to pay for charges not allowed by your Plan.

Prior authorization is typically required anytime you will be admitted to the hospital on an elective (non-emergency) basis—for example, if you need to be admitted for a scheduled surgery. Prior authorization may also be required for services such as non-emergency imaging (CT, MRI, MRA, and PET scans), rental or purchase of certain durable medical equipment, and intensive spinal procedures (surgery, injections, and implants). Routine preventive care services never require prior authorization. When a delay in treatment could seriously jeopardize your life or health or the ability to regain maximum function or, in the opinion of a physician with knowledge of your medical condition, could cause severe pain, your provider should request expedited processing.

The prior authorization requirements change from time to time. The current list of services requiring prior authorization will always be available from Blue Cross and Blue Shield of Texas. Please contact Collective Health for help accessing this list.

If prior authorization is denied, your physician can appeal that denial. You can also file your own appeal with Blue Cross and Blue Shield of Texas to contest a prior authorization denial (see Section 6).

If you have questions about prior authorization in general, or about whether a specific treatment needs prior authorization, contact Collective Health. If you would like to request a prior authorization, contact Blue Cross and Blue Shield of Texas.

Case Management Services

You have access to a program called Care Navigation, an interdisciplinary care management program offered by Collective Health. The Care Navigation team will identify and engage members with more complex care needs.

If you are identified or you call the program yourself and express interest, a member of the Care Navigation team will reach out to you. With your permission, the Care Navigation team can also reach out to and work with your supports, family, and/or healthcare providers. The Care Navigation team is composed of social workers, pharmacists, dieticians, registered nurses, and care coordinators who can help with, among other things, coordination among providers, resolution of complex claims issues, providing emotional and psychosocial support, referrals to relevant clinical point solutions (e.g., second opinion services), and local community resources.

Participation in the Care Navigation program is completely voluntary. You do not have to speak to a Care Navigation team member if you prefer not to. Your participation (or not) in the Care Navigation program will not affect your benefits.

If you feel you could benefit from the Care Navigation program but no one has reached out to you, you can contact Collective Health for a referral.

Get a Second Opinion

A second opinion is a process where you consult with an expert in the field of your diagnosis to make sure that your diagnosis is correct and that you are set on the right treatment path. We encourage you to get a second opinion under the following circumstances:

- You have, or are diagnosed with, a rare or complex condition that requires the navigation and understanding of treatment options.
- Whenever your doctor recommends that you have surgery—that is, any surgery that can be scheduled in advance (not an emergency). Even if your doctor recommends surgery, there may be other, less invasive treatment options that could give you as good (or better) results. In some cases, having surgery could actually make your overall health worse.

In these situations, not only can you get a second opinion—you can even get a third opinion if you wish. A second or third opinion is 100% voluntary, and you are not required to get one if you prefer not to. You can choose to get a second or third opinion anytime your doctor recommends elective surgery, for any reason.

The doctor who gives you a second (or third) opinion about your complex condition or elective surgery would be independent from the doctor who either diagnosed you or recommended the surgery in the first place.

How much will this cost? The Plan will cover second and third opinions like other covered services described in Section 3. So, if you visit a specialist's office to get a second opinion, you will pay your regular copay or coinsurance for a specialist doctor visit. When you choose to visit an out-of-network provider or facility for medical treatment, the Plan will cover the allowed amount, and the provider may balance bill you for any excess. It is your responsibility to pay any amounts in excess of the allowed amount—in addition to any deductibles, copays, or coinsurance.

Section 3: What's Covered & How Much It Costs

This section describes your Plan's benefits in detail. Benefits are split into three categories: preventive care, emergency care, and everything else.

This Plan covers most medically necessary healthcare services, except those that are specifically excluded. All services may be subject to a medical necessity review by the medical network or an independent review organization (IRO). The Plan administrator and/or claims administrator has full discretionary authority to adjudicate benefit claims, including taking a holistic view of the member's healthcare needs and condition, and current and future financial implications. Section 4 of this document includes a definition of medical necessity as well as a list of services that are excluded from your Plan.

Preventive Care

Preventive care is generally provided when you are well and is intended to keep you healthy. The federal government—specifically, the U.S. Preventive Services Task Force, the Health Resources and Services Administration, and the Centers for Disease Control and Prevention—has recommended certain healthcare services as preventive care.

This plan must cover the full cost of in-network preventive care services, even if you haven't met your deductible. You can get preventive care services from out-of-network providers if you choose, but this plan will pay for only part of the cost of out-of-network preventive care, and may require you to meet your deductible before benefits kick in. When you choose to visit an out-of-network provider or facility for preventive care services, the plan will cover the allowed amount, and the provider may balance bill you for any excess. If no in-network provider of a specific preventive care service is available in your geographic area, the plan will provide in-network benefits for that out-of-network care.

Certain medical services qualify as “preventive care” depending on your age, biological sex, medical conditions, or timing. The following services are examples of preventive care:

- Breastfeeding supplies and support (including breast pumps) if you become pregnant, both during pregnancy and while nursing.
- Colorectal cancer screening (including colonoscopy) for adults aged 45 to 75.
- Immunizations against whooping cough, measles, chickenpox, and other diseases for children from birth to age 18, at recommended doses and cadence.

Preventive and diagnostic care may occur during the same visit. For more information about which preventive services are recommended for you, visit www.healthcare.gov/coverage/preventive-care-benefits. Services you receive as part of your annual wellness exam may not always be considered preventive and be subject to your plan’s regular cost share. Please contact Collective Health for more information on the specific procedure and diagnosis codes that comprise your preventive benefits.

Your plan provides the following preventive care coverage:

- Evidence-based items or services that have in effect a rating of “A” or “B” in the current recommendations of the United States Preventive Services Task Force (“USPSTF”);
- Immunizations recommended by the Advisory Committee on Immunization Practices of the Centers for Disease Control and Prevention (“CDC”) with respect to the individual involved;
- Evidence-informed preventive care and screenings provided for in the comprehensive guidelines supported by the Health Resources and Services Administration (“HRSA”) for infants, children, and adolescents; and
- With respect to women, such additional preventive care and screenings, not described in item a. above, as provided for in comprehensive guidelines supported by the HRSA.

This section includes information about your plan’s medical & prescription coverage. When seeking care, you may require services which affect both your medical and your pharmacy benefits. Please be sure to refer to the Pharmacy Benefits shown later on in this section for questions related to prescription drugs.

Service	Description	What You Pay
Preventive care for adults	Routine annual physical exam and associated counseling and screening, including immunizations and some lab services. The list of recommended services is available at: www.healthcare.gov/preventive-care-adults	In-network: Fully covered (the plan pays 100%). You do not have to meet your deductible first. Out-of-network: You'll owe the full cost of this service until you've met your deductible. After that, you pay 45% of the allowed amount; the plan pays the remainder of the allowed amount.
Preventive care for women	Annual well-woman exam and associated counseling and screening, including contraception, routine recommended mammograms, and lab services. Includes preventive care during pregnancy and breastfeeding support and supplies. The list of covered services is available at: www.healthcare.gov/preventive-care-women	<i>Mammogram Screenings are limited to 1 exams per year per member.</i> In-network: Fully covered (the plan pays 100%). You do not have to meet your deductible first. Out-of-network: You'll owe the full cost of this service until you've met your deductible. After that, you pay 45% of the allowed amount; the plan pays the remainder of the allowed amount.
Preventive care for babies and children	Periodic exams and associated counseling and screening, including immunizations, behavioral assessments and autism screening, and lab services. Also includes routine care for your healthy newborn child while they are in the hospital immediately after birth. The list of covered services is available at: www.healthcare.gov/preventive-care-children	In-network: Fully covered (the plan pays 100%). You do not have to meet your deductible first. Out-of-network: You'll owe the full cost of this service until you've met your deductible. After that, you pay 45% of the allowed amount; the plan pays the remainder of the allowed amount.

Emergency Care

Emergency care is designed to diagnose and treat an illness, injury, symptom or condition so serious that a reasonable person would seek care right away to avoid severe harm. You should seek emergency care in an urgent care center or in a hospital's emergency room.

Urgent care centers are generally cheaper than emergency rooms, especially if you use an urgent care center in your network. If you are in a position to choose—and if you know your condition is not too serious—you should consider going to a local urgent care center instead of a hospital emergency room. If your condition is life-threatening (or you're not sure), you can and should go to the emergency room.

This Plan provides the same level of cost-sharing for in-network and out-of-network emergency care in an emergency room. The same level of cost-sharing is provided if you need emergency care when you are traveling outside the United States. Out-of-network emergency services, as defined by the No Surprises Act, will be covered at the median in-network rate in the geographic region or as otherwise required by applicable law (see Section 1 for more on surprise billing and balance billing protections). See Appendix A for additional information about access to Blue Cross and Blue Shield of Texas' network services outside the U.S. These providers will be out-of-network but may assist with coordinating your coverage.

This Plan covers medically necessary emergency air and ground ambulance services.

Ground emergency ambulance services are considered medically necessary when all of the following criteria are met:

- The ambulance is equipped with appropriate emergency and medical supplies and equipment;
- The patient's condition is such that any other form of transportation would not be advisable by a physician or other licensed medical provider; and
- The member is transported to the nearest hospital with the appropriate facilities and requisite level of care for the treatment of the member's illness or injury.

Air ambulance services are considered medically necessary when all of the criteria pertaining to ground transportation (listed above) are met and at least one of the following criteria are met:

- The member's medical condition requires immediate and rapid ambulance transport to the nearest appropriate medical facility that could not be reached by land ambulance;
- The point of pick-up is inaccessible by a ground ambulance;
- Great distances, limited time frames, or other obstacles limit the member's access to the nearest hospital with appropriate facilities for treatment; or
- The member's condition is such that the time needed to transport the member by land to the nearest appropriate medical facility poses a threat to the member's health.

Service	Description	What You Pay
Emergency ambulance	Medically necessary emergency transport by an air or ground ambulance to the nearest hospital with the appropriate facilities and requisite level of care for the treatment of the member's illness or injury. An ambulance is a specially designed vehicle that is staffed with qualified medical personnel and appropriately equipped to provide life-saving and supportive treatments or interventions during the transportation of ill or injured members. See "Emergency Care" above for more details on ambulance service requirements.	In-network: You'll owe the full cost of this service until you've met your deductible. After that, you pay 20% of the cost; the plan pays the rest. Out-of-network: You'll owe the full cost of this service until you've met your deductible. After that, you pay 20% of the allowed amount; the plan pays the remainder of the allowed amount. Regardless of whether you receive services in-network or out-of-network, this benefit is subject to your in-network deductible and out-of-pocket maximum.
Emergency room expenses	Services and supplies in a hospital emergency room (including doctor fees), which are required to stabilize you or initiate treatment in an emergency. Follow-up treatment after you leave the emergency room is covered separately. If you go to an emergency room and you are admitted to the hospital, your emergency room copay is waived.	In-network: You pay a \$200 copay per visit. After that, you pay the remaining cost of this service until you've met your deductible. Then, you pay 20% of the cost; the plan pays the rest. Out-of-network: You pay a \$200 copay per visit. After that, you pay the remaining cost of this service until you've met your deductible. Then, you pay 20% of the allowed amount; the plan pays the remainder of the allowed amount. Regardless of whether you receive services in-network or out-of-network, this benefit is subject to your in-network deductible and out-of-pocket

		maximum (and your copay doesn't apply to your deductible).
Urgent care center expenses	Services and supplies in a licensed urgent care center, for conditions reasonably requiring immediate treatment. An urgent care center is a clinic or acute-care facility that provides outpatient treatment for illnesses or injuries that require immediate treatment but are not necessarily life-threatening.	In-network: You pay a \$50 copay per visit; the plan pays the rest. You do not have to meet your deductible first (and your copay doesn't apply to your deductible). In addition, you'll be responsible for the applicable cost sharing for any other treatments or services billed as part of an urgent care visit. Out-of-network: You'll owe the full cost of this service until you've met your deductible. After that, you pay 45% of the allowed amount; the plan pays the remainder of the allowed amount.

Treatment for Medical Conditions other than Preventive or Emergency Care

The benefits table on the following pages describes what the Plan will pay for medical treatment other than preventive or emergency care. Different medical services may require you to pay different copays or coinsurance, and some services are subject to limits and annual benefit maximums. When you choose to visit an out-of-network provider or facility for medical treatment, the Plan will cover the allowed amount, and the provider may balance bill you for any excess. It is your responsibility to pay any amounts in excess of the allowed amount—in addition to any deductibles, copays, or coinsurance.

The table below may not fully address every possible medical situation. If you have questions about how your unique medical needs may be covered by the Plan, contact Collective Health.

Service	Description	What You Pay
Acupuncture	Acupuncture and associated treatment by a licensed provider.	In-network: Not covered. Out-of-network: Not covered.
Allergy care	Testing and appropriate treatment (including allergy serum and injections) by a healthcare provider.	<u>Allergy testing</u> In-network: Services and supplies are covered based on who provides your care and where you receive your treatment. Out-of-network: Not covered. <u>Allergy serum/Allergy therapy</u> In-network: You'll owe the full cost of this service until you've met your deductible. After that, you pay 20% of the cost; the plan pays the rest. Out-of-network: You'll owe the full cost of this service until you've met your deductible. After that, you pay 45% of the allowed amount; the plan pays the remainder of the allowed amount.
Ambulance (non-emergency)	Medically necessary, non-emergency transport by an air or ground ambulance to the nearest medical facility where you can receive the treatment you need. An ambulance is a specially designed vehicle that is staffed with qualified medical personnel and equipped to transport an ill or injured person.	<i>May require a prior authorization.</i> In-network: You'll owe the full cost of this service until you've met your deductible. After that, you pay 20% of the cost; the plan pays the rest. Out-of-network: You'll owe the full cost of this service until you've met your deductible. After that, you pay 20% of the

		allowed amount; the plan pays the remainder of the allowed amount.
Anesthesia	Medication, supplies, and administration of anesthetics when administered by a healthcare provider.	Anesthesia services and supplies are covered based on where you receive your treatment (for example, in a doctor's office or in a hospital).
Autism	Diagnosis, care and treatment for adults and children with autism spectrum disorders, including applied behavioral analysis and, physical, occupational, and speech therapies.	<u>Applied behavioral analysis/Applied behavioral therapy</u> <i>May require a prior authorization.</i> In-network: You pay 20% of the cost; the plan pays the rest. You do not have to meet your deductible first (and your coinsurance doesn't apply to your deductible). Out-of-network: You'll owe the full cost of this service until you've met your deductible. After that, you pay 45% of the allowed amount; the plan pays the remainder of the allowed amount. <u>Other rehabilitation services for mental health treatment</u> <i>May require a prior authorization.</i> In-network: You pay 20% of the cost; the plan pays the rest. You do not have to meet your deductible first (and your coinsurance doesn't apply to your deductible). Out-of-network: You'll owe the full cost of this service until you've met your deductible. After that, you pay 45% of the allowed amount; the plan pays the remainder of the allowed amount. <u>Telemedicine applied behavioral analysis/Telemedicine applied behavioral therapy</u>

		<i>May require a prior authorization.</i> In-network: Not covered. Out-of-network: Not covered.
Auditory rehabilitation	Auditory rehabilitation, by a licensed therapist, as part of a short-term rehabilitative program following illness or injury.	In-network: You'll owe the full cost of this service until you've met your deductible. After that, you pay 20% of the cost; the plan pays the rest. Out-of-network: You'll owe the full cost of this service until you've met your deductible. After that, you pay 45% of the allowed amount; the plan pays the remainder of the allowed amount.
Bariatric surgery	<i>Coverage for bariatric surgery recipients only.</i> Surgical procedures performed to induce weight loss in people for whom it is medically necessary. Certain tests, treatments, or other medical services may be required prior to or following a planned medical procedure with a Lantern provider. Any medical services performed by anyone other than a Lantern doctor, including pre- and post-care, shall be subject to the applicable benefit. Bariatric surgery will only be covered through Lantern. <i>Pre-certification may be required.</i>	In-network: Not covered. Out-of-network: Not covered.
Cancer treatment	Diagnosis and treatment for cancer, including doctor visits, labs and scans, radiation and chemotherapy treatment, and	<u>Specialist visit</u> In-network: You pay a \$40 copay per visit; the plan pays the rest. You do not have

	routine patient care costs for clinical trials (please see "Clinical trials," below). <i>Wigs are subject to the durable medical equipment cost share and associated limitations described below.</i>	to meet your deductible first (and your copay doesn't apply to your deductible). In addition, you'll be responsible for the applicable cost sharing for any other treatments or services billed by your provider. Out-of-network: You'll owe the full cost of this service until you've met your deductible. After that, you pay 45% of the allowed amount; the plan pays the remainder of the allowed amount. <u>Labs</u> <i>May require a prior authorization.</i> In-network: You'll owe the full cost of this service until you've met your deductible. After that, you pay 20% of the cost; the plan pays the rest. Out-of-network: You'll owe the full cost of this service until you've met your deductible. After that, you pay 45% of the allowed amount; the plan pays the remainder of the allowed amount. <u>X-rays</u> <i>May require a prior authorization.</i> In-network: You'll owe the full cost of this service until you've met your deductible. After that, you pay 20% of the cost; the plan pays the rest. Out-of-network: You'll owe the full cost of this service until you've met your deductible. After that, you pay 45% of the allowed amount; the plan pays the remainder of the allowed amount. <u>Scans</u>
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		<i>This benefit may require a prior authorization. When you go out-of-network, if you receive a service before getting a prior authorization, you will owe a \$250 penalty. The amount you pay toward the penalty is considered to be "not covered" and is excluded by the plan.</i> In-network: You'll owe the full cost of this service until you've met your deductible. After that, you pay 20% of the cost; the plan pays the rest. Out-of-network: You'll owe the full cost of this service until you've met your deductible. After that, you pay 45% of the allowed amount; the plan pays the remainder of the allowed amount. <u>Chemotherapy & radiation</u> <i>This benefit may require a prior authorization. When you go out-of-network, if you receive a service before getting a prior authorization, you will owe a \$250 penalty. The amount you pay toward the penalty is considered to be "not covered" and is excluded by the plan.</i> In-network: You'll owe the full cost of this service until you've met your deductible. After that, you pay 20% of the cost; the plan pays the rest. Out-of-network: You'll owe the full cost of this service until you've met your deductible. After that, you pay 45% of the allowed amount; the plan pays the remainder of the allowed amount.
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Cardiac rehabilitation	Cardiac rehabilitation to treat or prevent heart attack, heart failure, or coronary artery disease, or to recover after heart surgery.	In-network: You'll owe the full cost of this service until you've met your deductible. After that, you pay 20% of the cost; the plan pays the rest. Out-of-network: You'll owe the full cost of this service until you've met your deductible. After that, you pay 45% of the allowed amount; the plan pays the remainder of the allowed amount.
Chiropractic care	Chiropractic treatment and spinal manipulation by a licensed provider.	<i>Limited to 26 sessions per year per member.</i> In-network: You pay a \$40 copay per session; the plan pays the rest. You do not have to meet your deductible first (and your copay doesn't apply to your deductible). Out-of-network: You'll owe the full cost of this service until you've met your deductible. After that, you pay 45% of the allowed amount; the plan pays the remainder of the allowed amount.
Clinical trials	Routine patient care (as defined by the ACA) costs provided as part of a clinical trial that is recommended by your physician and covered by the Plan as determined upon medical necessity review. Routine patient care includes the non-experimental health services you receive during the clinical trial (doctor's visits, medical equipment, treatment of complications), but does not include the cost of unapproved drugs (including the subject of	<i>May require a prior authorization.</i> Services and supplies are covered based on who provides your care and where you receive your treatment (for example, an oncologist visit, medical equipment, or labs/scans).

	the trial) or research administration costs.	
Diabetes	Diagnosis, care, and treatment for adults and children with diabetes (type I and II), including diagnostic testing, doctor visits, foot care, medical equipment, and education and training for diabetes patients in disease management (when recommended by your physician). Certain services related to your diabetes may be considered preventive. Contact Collective Health for more information. Insulin and other prescription medications are covered by your pharmacy benefits.	<u>Specialist visit</u> In-network: You pay a \$40 copay per visit; the plan pays the rest. You do not have to meet your deductible first (and your copay doesn't apply to your deductible). In addition, you'll be responsible for the applicable cost sharing for any other treatments or services billed by your provider. Out-of-network: You'll owe the full cost of this service until you've met your deductible. After that, you pay 45% of the allowed amount; the plan pays the remainder of the allowed amount. <u>Diabetes self-management training</u> In-network: You pay a \$25 copay per visit; the plan pays the rest. You do not have to meet your deductible first (and your copay doesn't apply to your deductible). Out-of-network: You'll owe the full cost of this service until you've met your deductible. After that, you pay 45% of the allowed amount; the plan pays the remainder of the allowed amount. <u>Labs</u> <i>May require a prior authorization.</i> In-network: You'll owe the full cost of this service until you've met your deductible. After that, you pay 20% of the cost; the plan pays the rest.

		Out-of-network: You'll owe the full cost of this service until you've met your deductible. After that, you pay 45% of the allowed amount; the plan pays the remainder of the allowed amount. <u>Medical equipment</u> <i>This benefit may require a prior authorization. When you go out-of-network, if you receive a service before getting a prior authorization, you will owe a \$250 penalty. The amount you pay toward the penalty is considered to be "not covered" and is excluded by the plan.</i> In-network: You'll owe the full cost of this service until you've met your deductible. After that, you pay 20% of the cost; the plan pays the rest. Out-of-network: You'll owe the full cost of this service until you've met your deductible. After that, you pay 45% of the allowed amount; the plan pays the remainder of the allowed amount.
Dialysis	Kidney dialysis services for hemodialysis, peritoneal dialysis, and home dialysis. If you are diagnosed with a condition requiring dialysis, you may be able to enroll in Medicare. Upon beginning dialysis treatments, Medicare, if applicable, will coordinate benefits with the Plan as the secondary payer for months four (4) through thirty-three (33) of the coordination period while	<u>Dialysis (Inpatient/Home)</u> <i>May require a prior authorization</i> In-network: After deductible is met, 20% coinsurance. Out-of-network: After deductible is met, 45% coinsurance. Out-of-network services will be paid at the Allowed Amount, which is generally 140% of Medicare. <u>Dialysis (Outpatient)</u>

	you are receiving dialysis treatments. All outpatient dialysis medical claims will be considered at the Allowed Amount, which is generally 140% of Medicare's reimbursement level, regardless of Medicare enrollment/eligibility status or diagnosis. The Plan will not enroll you in Medicare. It is your decision and your responsibility to enroll in Medicare, if applicable. Refer to Section 11: Coordination of Benefits of the SPD for more information.	Please call Collective Health at (855) 399-5599 to obtain your outpatient dialysis ID card prior to initiating care. The Plan does not access any network for outpatient Dialysis claims. After in-network deductible is met, 20% coinsurance. Services will be paid at the Allowed Amount, which is generally 140% of Medicare.
Doctor's office visits	Visits and services from your primary care provider or specialist healthcare provider when you need treatment for a medical condition. In-network preventive care visits are free for you. Please contact Collective Health for more information on the specific procedure and diagnosis codes that comprise your preventive benefits.	<u>Primary care provider</u> <i>Certain services or items provided during your visit may require prior authorization. Please see Section 2 for how to check for prior authorization requirements.</i> In-network: You pay a \$25 copay per visit; the plan pays the rest. You do not have to meet your deductible first (and your copay doesn't apply to your deductible). In addition, you'll be responsible for the applicable cost sharing for any other treatments or services billed by your provider. Out-of-network: You'll owe the full cost of this service until you've met your deductible. After that, you pay 45% of the allowed amount; the plan pays the remainder of the allowed amount. <u>Specialist provider</u>

		<i>Certain services or items provided during your visit may require prior authorization. Please see Section 2 for how to check for prior authorization requirements.</i> In-network: You pay a \$40 copay per visit; the plan pays the rest. You do not have to meet your deductible first (and your copay doesn't apply to your deductible). In addition, you'll be responsible for the applicable cost sharing for any other treatments or services billed by your provider. Out-of-network: You'll owe the full cost of this service until you've met your deductible. After that, you pay 45% of the allowed amount; the plan pays the remainder of the allowed amount.
Emergency room expenses (non-emergency)	Services and supplies in a hospital emergency room (including doctor fees), which are provided in a non-emergent capacity. Follow-up treatment after you leave the emergency room is covered separately.	<i>May require a prior authorization.</i> <u>Emergency room expenses (non-emergency)</u> In-network: You pay a \$200 copay per visit. After that, you pay the remaining cost of this service until you've met your deductible. Then, you pay 20% of the cost; the plan pays the rest. Out-of-network: You pay a \$200 copay per visit. After that, you pay the remaining cost of this service until you've met your deductible. Then, you pay 45% of the allowed amount; the plan pays the remainder of the allowed amount. Regardless of whether you receive services in-network or out-of-network, this benefit is subject to

		your in-network deductible and out-of-pocket maximum (and your copay doesn't apply to your deductible).
Eye care	Medically necessary eye care related to specific medical conditions, including but not limited to diabetic retinopathy, glaucoma, cataracts, and other diseases and infections of the eye. Routine eye care, such as vision screenings (including refraction), is not covered by this Plan. Some routine eye care may be considered preventive for individuals under the age of 18. Please contact Collective Health for more information on the specific procedure and diagnosis codes that comprise your preventive benefits.	Services and supplies are covered based on what care you receive and who provides it (for example, medical equipment or outpatient surgery).
Family planning	Coverage for preventive contraceptives includes prescription barrier methods, prescription female condoms, generic hormonal methods, implanted devices, and emergency contraception. Coverage for non-preventive contraceptives includes male sterilization. Termination of pregnancy (only if the mother is endangered or the pregnancy is a result of rape or incest) is covered.	<u>Preventive contraceptive services (generic)</u> In-network: Fully covered (the plan pays 100%). You do not have to meet your deductible first. Out-of-network: You'll owe the full cost of this service until you've met your deductible. After that, you pay 45% of the allowed amount; the plan pays the remainder of the allowed amount. <u>Non-preventive covered birth control services</u> Covered based on what care you receive and where (for example, a brand-name prescription, OB/GYN appointment, or outpatient surgery).

Fertility	Coverage for fertility is provided through Progyny. Progyny has a separate deductible & out-of-pocket maximum. Progyny’s SMART Cycles allow individuals a full suite of fertility treatment options, which include: Consultation at a credentialed Progyny network provider. Diagnostic tests, ultrasounds, IUI, IVF cycle management, retrieval, ICSI, embryo assessment and transfer. PGS (pre-implantation genetic screening) to ensure embryo viability. Access to telephonic advice. Egg, embryos, and semen freezing. Surrogacy and Adoption consultation. In addition to fertility-specific benefits, this Plan provides coverage for the diagnosis and treatment of underlying medical conditions (such as endometriosis) that also cause infertility; these treatments are covered outside of your Progyny fertility benefits and do not count against your fertility benefits allowance. The plan has a lifetime maximum of 3 Progyny SMART Cycles per participant for fertility benefits, subject to all applicable plan copay, coinsurance, and deductible requirements. Costs associated with gestational surrogacy are	<u>Progyny Deductible & Out-of-Pocket Maximum:</u> Deductible: \$4,000 Coinsurance: 20% Out-of-Pocket Maximum: \$8,000 <u>Medical treatment</u> In-network: You'll owe the full cost of this service until you've met your Progyny deductible. After that, you pay 20% of the cost until you’ve met your OOP Max; the plan pays the rest. Out-of-network: Not covered. <u>Pharmaceutical therapy</u> In-network: Not covered. Out-of-network: Not covered. Fertility Rx is <i>only</i> available through Progyny
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	subject to a \$40,000 benefit maximum per child. Costs associated with adoption are subject to a \$10,000 per child reimbursement maximum through Progyny. You must contact Progyny to confirm eligibility and authorize your services prior to treatment. You may contact Progyny for questions in relation to cryopreservation services and storage. You must utilize a Progyny Network Provider to access your benefit. To begin your fertility treatment plan, please contact Progyny at (888) 203-4825.	
Foot care	Exams by podiatrists, foot care associated with metabolic or peripheral-vascular disease (including related to diabetes), and custom-made foot orthotics, when prescribed by a physician. Pedicures, spa treatments, and cosmetic treatment of corns, calluses, or toenails are not covered.	<u>Podiatrist visit</u> In-network: You pay a \$40 copay per visit; the plan pays the rest. You do not have to meet your deductible first (and your copay doesn't apply to your deductible). In addition, you'll be responsible for the applicable cost sharing for any other treatments or services billed by your provider. Out-of-network: You'll owe the full cost of this service until you've met your deductible. After that, you pay 45% of the allowed amount; the plan pays the remainder of the allowed amount. <u>Orthotics</u> In-network: You'll owe the full cost of this service until you've met your deductible. After that, you pay 20% of the cost; the plan pays the rest.

		Out-of-network: You'll owe the full cost of this service until you've met your deductible. After that, you pay 45% of the allowed amount; the plan pays the remainder of the allowed amount.
Gender affirming services	Diagnosis and treatment for services related to gender affirming services. Gender care services, or treatment for transsexualism, gender dysphoria, or sexual reassignment or change, including drugs, medication, implants, hormone therapy, other surgical treatment, or psychiatric care or treatment are not covered on this plan.	<u>Gender affirming surgery and related services</u> In-network: Not covered. Out-of-network: Not covered.
Habilitation	Habilitative services that help you keep, learn, or improve skills and functional abilities for daily living that may not be developing normally, including physical, occupational, and speech therapies.	In-network: You pay 20% of the cost; the plan pays the rest. You do not have to meet your deductible first (and your coinsurance doesn't apply to your deductible). Out-of-network: You'll owe the full cost of this service until you've met your deductible. After that, you pay 45% of the allowed amount; the plan pays the remainder of the allowed amount.
Hearing screening & aids	Hearing exams for newborns and children as part of preventive care, or for adults when recommended by a medical provider. Additional services and supplies associated with hearing aids are excluded.	<u>Preventive hearing screenings for newborns and children (office visit)</u> In-network: Fully covered (the plan pays 100%). You do not have to meet your deductible first. Out-of-network: You'll owe the full cost of this service until you've met your deductible.

		After that, you pay 45% of the allowed amount; the plan pays the remainder of the allowed amount. <u>Non-preventive hearing screenings</u> <i>Limited to 1 exam per year per member.</i> In-network: Fully covered (the plan pays 100%). You do not have to meet your deductible first. Out-of-network: You'll owe the full cost of this service until you've met your deductible. After that, you pay 45% of the allowed amount; the plan pays the remainder of the allowed amount. <u>Hearing aids</u> In-network: Not covered. Out-of-network: Not covered.
Home-based care	At-home care and treatment of an illness or injury, with a prescription from your doctor that specifies how long you'll need home care. Includes visits by trained medical personnel (including nurses) and supplies.	<i>Limited to 100 days per year per member.</i> <i>This benefit may require a prior authorization. When you go out-of-network, if you receive a service before getting a prior authorization, you will owe a \$250 penalty. The amount you pay toward the penalty is considered to be "not covered" and is excluded by the plan.</i> In-network: You'll owe the full cost of this service until you've met your deductible. After that, you pay 20% of the cost; the plan pays the rest. Out-of-network: You'll owe the full cost of this service until you've met your deductible.

		After that, you pay 45% of the allowed amount; the plan pays the remainder of the allowed amount.
Hospice care	Hospice care is an integrated program that provides comfort and support services for people who are terminally ill (usually meaning they are not expected to live more than six months). Hospice care often includes emotional support services for the immediate family. Respite care provides caregivers a temporary rest from caregiving. Respite care as part of hospice care is covered under this benefit. Bereavement counseling is limited to Hospice Care.	<i>May require a prior authorization.</i> In-network: You'll owe the full cost of this service until you've met your deductible. After that, you pay 20% of the cost; the plan pays the rest. Out-of-network: You'll owe the full cost of this service until you've met your deductible. After that, you pay 45% of the allowed amount; the plan pays the remainder of the allowed amount.
Hospital stays	Inpatient hospital stays (admission for a scheduled procedure, or admission after an emergency). Includes room & board, doctor visits, supplies (like dressings, splints, or other materials), and medications or other substances (like blood, oxygen, fluids) during your stay. See "Surgery" below for more details on costs for surgical procedures.	<i>This benefit may require a prior authorization. When you go out-of-network, if you receive a service before getting a prior authorization, you will owe a \$250 penalty. The amount you pay toward the penalty is considered to be "not covered" and is excluded by the plan.</i> In-network: You'll owe the full cost of this service until you've met your deductible. After that, you pay 20% of the cost; the plan pays the rest. Out-of-network: You'll owe the full cost of this service until you've met your deductible. After that, you pay 45% of the allowed amount; the plan pays the remainder of the allowed amount.

Infusion therapy	Intravenous or other infusion-based administration of medication in a medical facility (hospital or outpatient center) or as part of an office or home healthcare visit, under the care of a physician.	<i>May require a prior authorization.</i> In-network: You'll owe the full cost of this service until you've met your deductible. After that, you pay 20% of the cost; the plan pays the rest. Out-of-network: You'll owe the full cost of this service until you've met your deductible. After that, you pay 45% of the allowed amount; the plan pays the remainder of the allowed amount.
Injectable medications	Injections (other than allergy injections or other benefits separately listed in this chart) administered by a medical provider. Includes, for example, steroid or pain medication injections when medically necessary. Drugs you take yourself (not administered by a healthcare provider) are covered separately, under your pharmacy benefits.	<i>This benefit may require a prior authorization. When you go out-of-network, if you receive a service before getting a prior authorization, you will owe a \$250 penalty. The amount you pay toward the penalty is considered to be "not covered" and is excluded by the plan.</i> In-network: You'll owe the full cost of this service until you've met your deductible. After that, you pay 20% of the cost; the plan pays the rest. Out-of-network: You'll owe the full cost of this service until you've met your deductible. After that, you pay 45% of the allowed amount; the plan pays the remainder of the allowed amount.
Medical equipment and supplies	Rental or purchase of durable medical equipment, which is medical equipment that is not disposable and is customarily used for a medical purpose, and associated supplies. A prescription from your physician is required.	<i>Compression stockings are limited to 2 items per year per member.</i> <i>Mastectomy Bras and Camisoles are limited to 4 items per year per member.</i> <i>This benefit may require a prior authorization. When you go out-of-network, if you receive a service before getting a prior authorization,</i>

	You may repair or replace equipment that is outgrown or after reasonable wear and tear. <i>Wigs are subject to 1 wig up to a \$500 benefit maximum per year per member.</i>	<i>you will owe a \$250 penalty. The amount you pay toward the penalty is considered to be "not covered" and is excluded by the plan.</i> In-network: You'll owe the full cost of this service until you've met your deductible. After that, you pay 20% of the cost; the plan pays the rest. Out-of-network: You'll owe the full cost of this service until you've met your deductible. After that, you pay 45% of the allowed amount; the plan pays the remainder of the allowed amount.
Medical tests	Medically necessary diagnostic tests, including laboratory tests, radiology (such as X-rays or ultrasounds), and advanced imaging (such as MRI, PET, or CT scans), when recommended by a healthcare provider. Preventive care medical tests (for example, routine recommended mammograms) are covered at 100% in-network.	<i>Mammogram Screenings are limited to 1 exams per year per member.</i> <u>Preventive care tests</u> In-network: Fully covered (the plan pays 100%). You do not have to meet your deductible first. Out-of-network: You'll owe the full cost of this service until you've met your deductible. After that, you pay 45% of the allowed amount; the plan pays the remainder of the allowed amount. <u>Diagnostic labs</u> <i>May require a prior authorization.</i> In-network: You'll owe the full cost of this service until you've met your deductible. After that, you pay 20% of the cost; the plan pays the rest. Out-of-network: You'll owe the full cost of this service until you've met your deductible. After that, you pay 45% of the

		allowed amount; the plan pays the remainder of the allowed amount. <u>Radiology</u> <i>May require a prior authorization.</i> In-network: You'll owe the full cost of this service until you've met your deductible. After that, you pay 20% of the cost; the plan pays the rest. Out-of-network: You'll owe the full cost of this service until you've met your deductible. After that, you pay 45% of the allowed amount; the plan pays the remainder of the allowed amount. <u>Advanced imaging</u> <i>This benefit may require a prior authorization. When you go out-of-network, if you receive a service before getting a prior authorization, you will owe a \$250 penalty. The amount you pay toward the penalty is considered to be "not covered" and is excluded by the plan.</i> In-network: You'll owe the full cost of this service until you've met your deductible. After that, you pay 20% of the cost; the plan pays the rest. Out-of-network: You'll owe the full cost of this service until you've met your deductible. After that, you pay 45% of the allowed amount; the plan pays the remainder of the allowed amount.
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Mental health	Care and treatment by (or directed by) psychiatrists, psychologists, counselors, social workers, or other qualified medical professionals to address conditions impairing behavior, emotion reaction, or thought process.	<u>Office visits</u> <i>Certain services or items provided during your visit may require prior authorization. Please see Section 2 for how to check for prior authorization requirements.</i> In-network: You pay a \$25 copay per visit; the plan pays the rest. You do not have to meet your deductible first (and your copay doesn't apply to your deductible). In addition, you'll be responsible for the applicable cost sharing for any other treatments or services billed by your provider. Out-of-network: You'll owe the full cost of this service until you've met your deductible. After that, you pay 45% of the allowed amount; the plan pays the remainder of the allowed amount. <u>Rehabilitative services (physical, occupational, and speech therapy) for mental health treatment</u> <i>This benefit may require a prior authorization. When you go out-of-network, if you receive a service before getting a prior authorization, you will owe a \$250 penalty. The amount you pay toward the penalty is considered to be "not covered" and is excluded by the plan.</i> In-network: You pay 20% of the cost; the plan pays the rest. You do not have to meet your deductible first (and your coinsurance doesn't apply to your deductible). Out-of-network:
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		You'll owe the full cost of this service until you've met your deductible. After that, you pay 45% of the allowed amount; the plan pays the remainder of the allowed amount. <u>Intensive Outpatient Treatment</u> <i>This benefit may require a prior authorization. When you go out-of-network, if you receive a service before getting a prior authorization, you will owe a \$250 penalty. The amount you pay toward the penalty is considered to be "not covered" and is excluded by the plan.</i> In-network: You pay a \$25 copay per visit; the plan pays the rest. You do not have to meet your deductible first (and your copay doesn't apply to your deductible). Out-of-network: You'll owe the full cost of this service until you've met your deductible. After that, you pay 45% of the allowed amount; the plan pays the remainder of the allowed amount. <u>Inpatient/residential stays</u> <i>This benefit may require a prior authorization. When you go out-of-network, if you receive a service before getting a prior authorization, you will owe a \$250 penalty. The amount you pay toward the penalty is considered to be "not covered" and is excluded by the plan.</i> In-network: You'll owe the full cost of this service until you've met your deductible. After that, you pay 20% of the cost; the plan pays the rest. Out-of-network:
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		You'll owe the full cost of this service until you've met your deductible. After that, you pay 45% of the allowed amount; the plan pays the remainder of the allowed amount.
Mouth, tooth & jaw injury	Dental care (such as cleanings or fillings) is not covered by this Plan. Coverage is limited to: • Excision of tumors and benign bony growths in the jaw or mouth • Emergency repair of natural teeth after injury • Surgical repair of jaws, cheeks, lips, tongue, and floor/roof of mouth after injury • External incision and drainage of cellulitis • Incision of sensory sinuses, salivary glands or ducts • Professional anesthesia fees associated with routine dental care rendered at a medical facility, if moderate or deep anesthesia is medically necessary, and if the dental plan cannot be billed. May require a prior authorization.	Services and supplies are covered based on who provides your care and where you receive your treatment (for example, in a doctor's office or in a hospital).
Nutritional counseling	Nutritional evaluation and counseling by a registered dietitian or licensed nutritionist.	In-network: Not covered, unless considered a preventive service or a medically necessary condition. Out-of-network: Not covered, unless considered a preventive service or a medically necessary condition.

Occupational therapy	Occupational therapy, by a licensed therapist and under the direction of a physician, as part of a short-term rehabilitative program following illness or injury. Recreational or exercise programs are not covered.	<i>Limited to 18 sessions per year per member. You may qualify for additional sessions if your provider provides documentation of the rationale and the number of sessions requested. Mental health, substance use disorder, and preventive care claims are not subject to this limit.</i> In-network: You'll owe the full cost of this service until you've met your deductible. After that, you pay 20% of the cost; the plan pays the rest. Out-of-network: You'll owe the full cost of this service until you've met your deductible. After that, you pay 45% of the allowed amount; the plan pays the remainder of the allowed amount.
Orthotics	Initial purchase, fitting, and repair of orthotic appliances (like back braces or leg splints) required to support a body part that is disabled after injury or because of a congenital condition. Also includes custom-made foot orthotics, when prescribed by a physician, to treat weak, unstable, unbalanced, or flat feet.	In-network: You'll owe the full cost of this service until you've met your deductible. After that, you pay 20% of the cost; the plan pays the rest. Out-of-network: You'll owe the full cost of this service until you've met your deductible. After that, you pay 45% of the allowed amount; the plan pays the remainder of the allowed amount.
Physical therapy	Physical therapy, by a licensed therapist and under the direction of a physician when required, as part of a short-term rehabilitative program following illness or injury. Recreational or exercise programs are not covered.	<i>Limited to 18 sessions per year per member. You may qualify for additional sessions if your provider provides documentation of the rationale and the number of sessions requested. Mental health, substance use disorder, and preventive care claims are not subject to this limit.</i> <i>May require a prior authorization.</i>

		In-network: You'll owe the full cost of this service until you've met your deductible. After that, you pay 20% of the cost; the plan pays the rest. Out-of-network: You'll owe the full cost of this service until you've met your deductible. After that, you pay 45% of the allowed amount; the plan pays the remainder of the allowed amount.
Pregnancy & childbirth	Care and treatment during pregnancy and childbirth, including required prenatal care, hospital stays, physician services, surgery, breastfeeding support and supplies, and hospital nursery care for your newborn child. Please keep in mind that some services related to your pregnancy may be considered preventive and will be covered under the Plan's preventive care benefit. The Plan covers inpatient care for at least 48 hours after delivery (96 hours after cesarean section), though your physician may discharge you earlier. If you are pregnant or you have just given birth, rental or purchase of a hospital-grade or commercial breast pump (manual or electric) is covered during and after the pregnancy.	<u>Prenatal care (primary care visits)</u> In-network: You pay a \$25 copay per visit; the plan pays the rest. You do not have to meet your deductible first (and your copay doesn't apply to your deductible). In addition, you'll be responsible for the applicable cost sharing for any other treatments or services billed by your provider. Out-of-network: You'll owe the full cost of this service until you've met your deductible. After that, you pay 45% of the allowed amount; the plan pays the remainder of the allowed amount. <u>Prenatal care (specialist visits)</u> In-network: You pay a \$40 copay per visit; the plan pays the rest. You do not have to meet your deductible first (and your copay doesn't apply to your deductible). In addition, you'll be responsible for the applicable cost sharing for any other treatments or services billed by your provider. Out-of-network:

		You'll owe the full cost of this service until you've met your deductible. After that, you pay 45% of the allowed amount; the plan pays the remainder of the allowed amount. <u>Genetic testing</u> <i>May require a prior authorization.</i> In-network: You'll owe the full cost of this service until you've met your deductible. After that, you pay 20% of the cost; the plan pays the rest. Out-of-network: You'll owe the full cost of this service until you've met your deductible. After that, you pay 45% of the allowed amount; the plan pays the remainder of the allowed amount. <u>Ultrasounds</u> <i>May require a prior authorization.</i> In-network: You'll owe the full cost of this service until you've met your deductible. After that, you pay 20% of the cost; the plan pays the rest. Out-of-network: You'll owe the full cost of this service until you've met your deductible. After that, you pay 45% of the allowed amount; the plan pays the remainder of the allowed amount. <u>Hospital admission for delivery</u> <i>This benefit may require a prior authorization. When you go out-of-network, if you receive a service before getting a prior authorization, you will owe a \$250 penalty. The amount you pay toward the penalty is considered to be "not covered" and is excluded by the plan.</i>
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		In-network: You'll owe the full cost of this service until you've met your deductible. After that, you pay 20% of the cost; the plan pays the rest. Out-of-network: You'll owe the full cost of this service until you've met your deductible. After that, you pay 45% of the allowed amount; the plan pays the remainder of the allowed amount. <u>Newborn nursery</u> <i>This benefit may require a prior authorization. When you go out-of-network, if you receive a service before getting a prior authorization, you will owe a \$250 penalty. The amount you pay toward the penalty is considered to be "not covered" and is excluded by the plan.</i> In-network: You'll owe the full cost of this service until you've met your deductible. After that, you pay 20% of the cost; the plan pays the rest. Out-of-network: You'll owe the full cost of this service until you've met your deductible. After that, you pay 45% of the allowed amount; the plan pays the remainder of the allowed amount. <u>Breastfeeding support and counseling (excluding breast pumps and accessories)</u> In-network: Fully covered (the plan pays 100%). You do not have to meet your deductible first. Out-of-network: You'll owe the full cost of this service until you've met your deductible.
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		After that, you pay 45% of the allowed amount; the plan pays the remainder of the allowed amount. <u>Breast pumps and accessories</u> Over-the-counter pumps are limited to 1 device up to \$500 per member per year. In-network: Fully covered (the plan pays 100%). You do not have to meet your deductible first. Out-of-network: You'll owe the full cost of this service until you've met your deductible. After that, you pay 45% of the allowed amount; the plan pays the remainder of the allowed amount.
Prosthetics	Initial purchase, fitting, and repair of artificial limbs and other prosthetic devices to replace body parts that are missing after amputation or because of a congenital condition. Includes replacement for prosthetic devices that have been outgrown or that require replacement due to reasonable wear and tear.	<i>This benefit may require a prior authorization. When you go out-of-network, if you receive a service before getting a prior authorization, you will owe a \$250 penalty. The amount you pay toward the penalty is considered to be "not covered" and is excluded by the plan.</i> In-network: You'll owe the full cost of this service until you've met your deductible. After that, you pay 20% of the cost; the plan pays the rest. Out-of-network: You'll owe the full cost of this service until you've met your deductible. After that, you pay 45% of the allowed amount; the plan pays the remainder of the allowed amount.
Pulmonary rehabilitation	Pulmonary rehabilitation, by a licensed therapist, to improve lung function, reduce symptom severity, and improve quality of	In-network: You pay 20% of the cost; the plan pays the rest. You do not have to

	life as part of a treatment plan for chronic illness.	meet your deductible first (and your coinsurance doesn't apply to your deductible). Out-of-network: You'll owe the full cost of this service until you've met your deductible. After that, you pay 45% of the allowed amount; the plan pays the remainder of the allowed amount.
Respiratory rehabilitation	Respiratory rehabilitation, by a licensed therapist, as part of a short-term rehabilitative program following illness or injury.	In-network: You'll owe the full cost of this service until you've met your deductible. After that, you pay 20% of the cost; the plan pays the rest. Out-of-network: You'll owe the full cost of this service until you've met your deductible. After that, you pay 45% of the allowed amount; the plan pays the remainder of the allowed amount.
Skilled nursing facilities	Inpatient care at a skilled nursing facility, after or in place of hospitalization or home healthcare, with a doctor's prescription (which specifies how long you should stay at the facility). A skilled nursing facility is licensed by Medicare to provide 24-hour inpatient care by registered nurses, directed by a physician, for patients convalescing from physical illness or injury (also known as a rehab hospital, nursing home, or extended care facility). Coverage includes care by doctors and nurses, supplies (like dressings, splints, or other materials), and medications or	<i>Limited to 90 days per year per member.</i> <i>Acquired brain injuries are limited to 180 days per year per member.</i> <i>This benefit may require a prior authorization. When you go out-of-network, if you receive a service before getting a prior authorization, you will owe a \$250 penalty. The amount you pay toward the penalty is considered to be "not covered" and is excluded by the plan.</i> In-network: You'll owe the full cost of this service until you've met your deductible. After that, you pay 20% of the cost; the plan pays the rest. Out-of-network:

	other substances (like blood, oxygen, fluids) during your stay.	You'll owe the full cost of this service until you've met your deductible. After that, you pay 45% of the allowed amount; the plan pays the remainder of the allowed amount.
Speech therapy	Speech therapy by a licensed therapist as part of a short-term rehabilitative program.	<i>Limited to 18 sessions per year per member. You may qualify for additional sessions if your provider provides documentation of the rationale and the number of sessions requested. Mental health, substance use disorder, and preventive care claims are not subject to this limit. May require prior authorization.</i> In-network: You'll owe the full cost of this service until you've met your deductible. After that, you pay 20% of the cost; the plan pays the rest. Out-of-network: You'll owe the full cost of this service until you've met your deductible. After that, you pay 45% of the allowed amount; the plan pays the remainder of the allowed amount.
Substance Use Disorder	Care by (or directed by) psychiatrists, psychologists, counselors, social workers, or other appropriate licensed healthcare providers to treat the dependency on, and excessive use of, chemical substances. Plan coverage for substance use disorder services depends on the setting of your treatment: in an office visit, in an outpatient facility, or in an inpatient or residential facility.	<u>Office visits</u> <i>Certain services or items provided during your visit may require prior authorization. Please see Section 2 for how to check for prior authorization requirements.</i> In-network: You pay a \$25 copay per visit; the plan pays the rest. You do not have to meet your deductible first (and your copay doesn't apply to your deductible). In addition, you'll be responsible for the applicable cost sharing for any

	Tobacco: Prescription therapies to quit smoking are covered by your pharmacy benefits.	other treatments or services billed by your provider. Out-of-network: You'll owe the full cost of this service until you've met your deductible. After that, you pay 45% of the allowed amount; the plan pays the remainder of the allowed amount. <u>Intensive Outpatient Treatment</u> <i>This benefit may require a prior authorization. When you go out-of-network, if you receive a service before getting a prior authorization, you will owe a \$250 penalty. The amount you pay toward the penalty is considered to be "not covered" and is excluded by the plan.</i> In-network: You pay a \$25 copay per visit; the plan pays the rest. You do not have to meet your deductible first (and your copay doesn't apply to your deductible). Out-of-network: You'll owe the full cost of this service until you've met your deductible. After that, you pay 45% of the allowed amount; the plan pays the remainder of the allowed amount. <u>Inpatient/Residential stay</u> <i>This benefit may require a prior authorization. When you go out-of-network, if you receive a service before getting a prior authorization, you will owe a \$250 penalty. The amount you pay toward the penalty is considered to be "not covered" and is excluded by the plan.</i> In-network: You'll owe the full cost of this service until you've met your deductible.
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		After that, you pay 20% of the cost; the plan pays the rest. Out-of-network: You'll owe the full cost of this service until you've met your deductible. After that, you pay 45% of the allowed amount; the plan pays the remainder of the allowed amount.
Surgery	Professional services, supplies, medications, and other services provided with or during surgery. "Surgery" includes open or minimally-invasive surgical operations, sutures and skin grafts, and manipulation of broken bones and dislocations. Surgery performed to improve your appearance is considered cosmetic and is not covered, but reconstructive surgery of abnormal congenital conditions and reconstructive surgery after a mastectomy are covered. Certain tests, treatments, or other medical services may be required prior to or following a planned medical procedure. Non-emergent spine and bariatric surgery will only be covered through Lantern. <i>Pre-certification may be required.</i>	<u>Ambulatory surgery center</u> In-network: You'll owe the full cost of this service until you've met your deductible. After that, you pay 20% of the cost; the plan pays the rest. Out-of-network: You'll owe the full cost of this service until you've met your deductible. After that, you pay 45% of the allowed amount; the plan pays the remainder of the allowed amount. <u>Hospital outpatient</u> <i>This benefit may require a prior authorization. When you go out-of-network, if you receive a service before getting a prior authorization, you will owe a \$250 penalty. The amount you pay toward the penalty is considered to be "not covered" and is excluded by the plan.</i> In-network: You'll owe the full cost of this service until you've met your deductible. After that, you pay 20% of the cost; the plan pays the rest. Out-of-network: You'll owe the full cost of this service until you've met your deductible. After that, you pay 45% of the allowed amount; the plan pays the remainder of the allowed amount.

		<u>Hospital inpatient</u> <i>This benefit may require a prior authorization. When you go out-of-network, if you receive a service before getting a prior authorization, you will owe a \$250 penalty. The amount you pay toward the penalty is considered to be "not covered" and is excluded by the plan.</i> In-network: You'll owe the full cost of this service until you've met your deductible. After that, you pay 20% of the cost; the plan pays the rest. Out-of-network: You'll owe the full cost of this service until you've met your deductible. After that, you pay 45% of the allowed amount; the plan pays the remainder of the allowed amount.
Telemedicine	Your employer has partnered with Doctor on Demand to provide access to telemedicine services.	<u>Doctor on Demand medical visits</u> In-network: You pay a \$25 copay per visit; the plan pays the rest. You do not have to meet your deductible first (and your copay doesn't apply to your deductible). Out-of-network: Not covered. <u>Doctor on Demand mental health visits</u> In-network: You pay a \$25 copay per visit; the plan pays the rest. You do not have to meet your deductible first (and your copay doesn't apply to your deductible). Out-of-network: Not covered.

		<u>Medical visits (through Blue Cross and Blue Shield of Texas)</u> In-network: You pay a \$25 copay per visit; the plan pays the rest. You do not have to meet your deductible first (and your copay doesn't apply to your deductible). Out-of-network: Not covered. <u>Mental health visits (through Blue Cross and Blue Shield of Texas)</u> In-network: You pay a \$25 copay per visit; the plan pays the rest. You do not have to meet your deductible first (and your copay doesn't apply to your deductible). Out-of-network: Not covered.
Transplants	Transplants are defined as the transplant of organs or tissues from human to human or the transplantation of bone marrow, stem cell or cord blood. Travel expenses for transplant services are reimbursed to a maximum of \$10,000 per transplant per member for reasonable expenses when travel exceeds 100 miles from your home or outside of your home state. You'll owe the full cost of these expenses until you've met your in-network deductible. Reasonable expenses include initial consultations and necessary follow-up services. For more	<i>This benefit may require a prior authorization. When you go out-of-network, if you receive a service before getting a prior authorization, you will owe a \$250 penalty. The amount you pay toward the penalty is considered to be "not covered" and is excluded by the plan.</i> In-network: You'll owe the full cost of this service until you've met your deductible. After that, you pay 20% of the cost; the plan pays the rest. Out-of-network: You'll owe the full cost of this service until you've met your deductible. After that, you pay 45% of the allowed amount; the plan pays the remainder of the allowed amount.

	information on eligible expenses, contact Collective Health. Search expenses to find an organ donor are not covered.	
Travel Expenses	This plan provides reimbursement for eligible travel expenses related to services outlined in Section 5 of this benefit booklet, or those covered by the plan. For more information on how to file a travel expense claim, see Section 5 of this benefit booklet or contact Collective Health.	Travel expenses for services covered by the plan are reimbursed to a maximum of \$10,000 per year per member for reasonable expenses when travel exceeds 100 miles from your home or outside of your home state. You do not have to meet your deductible first. Reasonable expenses include initial consultations and necessary follow-up services. For more information on eligible expenses, contact Collective Health.
Vaccines	Immunizations for children and adults at recommended ages and doses, along with additional elective vaccines (for example, if recommended for foreign travel) recommended and administered by a physician. The recommended vaccine schedule is available at www.vaccines.gov.	<u>Preventive vaccines</u> In-network: Fully covered (the plan pays 100%). You do not have to meet your deductible first. Out-of-network: You'll owe the full cost of this service until you've met your deductible. After that, you pay 45% of the allowed amount; the plan pays the remainder of the allowed amount. <u>Travel vaccines</u> In-network: Not covered. Out-of-network: Not covered.

Pharmacy Benefits

The pharmacy benefits in this Plan help you pay for the medications you need. In general, this Plan covers all medically necessary medications prescribed to you by your doctor, except those that are specifically excluded (see Section 4 for more on exclusions).

The benefits described below cover the medications you get from a pharmacy. The drugs administered to you by a healthcare provider during an office visit, outpatient procedure, or hospital stay are covered separately by your medical benefits. In addition, certain infusions or implantable products (such as plasma, blood products, or implantable androgen products) are covered by your medical benefits and not your pharmacy benefits.

Your Pharmacy Network

CVS Caremark is the pharmacy benefits manager for this Plan, and most retail pharmacies are in-network. To find out whether a pharmacy is in your network, you can contact Collective Health; you can check the CVS Caremark website by logging in via my.collectivehealth.com, then navigating to Get Care and clicking on “Pharmacy”; or you can ask the pharmacist whether the pharmacy is in the CVS Caremark network.

You can get your medications from an in-network retail pharmacy or CVS Caremark's mail order pharmacy. If your drugs are available through mail order, they may cost less overall, for you and for the Plan, so these benefits are designed to encourage you to use mail order whenever possible.

Types of Prescriptions

Certain medications are classified as “preventive care.” (These include medications like hormonal birth control, aspirin for heart attack prevention, and tobacco cessation products.) For preventive care prescriptions, if you use in-network pharmacies and select generic alternatives, your Plan will cover 100% of the cost. If you'd like to know if your medication is considered preventive, you can contact Collective Health for help.

On this Plan, some medications will cost you more than others. Generic prescriptions are less expensive versions of brand name drugs. Generic drugs are considered identical to their brand name equivalents (in terms of efficacy and safety) by the FDA.

If you take a brand name drug, it's important to know that some brands are treated differently under this Plan. Brand name drugs are more expensive than generics, but your Plan has negotiated discounts on some—these are called preferred brand drugs. Non-preferred brands aren't discounted, so you'll pay more for these. Often, there will be generic options for medications prescribed by your doctor. When you fill your prescription, you can ask the pharmacist whether a generic or preferred brand name version of your medication is available.

You must fill a prescription within the time specified by the doctor. Only the number of refills specified by the doctor will be covered.

What You Pay

	In-Network Pharmacy Deductible
Individual	\$150
Family	\$300

- This plan only covers medications that are obtained from in-network pharmacies.
- This plan has a deductible that is specific to brand-name medications (both preferred and non-preferred). For those medications, you will have to pay full price until you meet your deductible. For generic drugs, you will not need to meet your deductible in order to receive your pharmacy benefits. Your medical out-of-pocket maximum applies to these pharmacy benefits as well. Each person on the plan has an individual pharmacy-specific deductible. Even on a family plan, no one member will ever have to satisfy more than their individual deductible. If you have dependents, then your family has a family pharmacy-specific deductible. Once your whole family combined has paid enough to meet the family deductible, benefits will kick in for the entire family. This is true even for some members who haven't yet hit their individual deductible.
- Money you spend on covered prescriptions will accumulate toward your out-of-pocket maximum just like money you spend on covered medical care.
- You can get preventive care medications fully covered from in-network pharmacies from day one on this Plan. But to learn how much you will owe for any other medications, see

the table below. Please note this does not apply to any expenses incurred out-of-network.

- Once you hit the deductible, if the total cost for a medication is less than your copay, you'll only have to pay the lesser amount.
- Maintenance medications are typically prescribed for chronic, long-term conditions and are taken on a regular, recurring basis. Maintenance medications include those used to treat high blood pressure, heart disease, asthma, or diabetes.
- If you or your provider choose a brand-name medication when a generic version is available, you'll pay what you usually do for generic drug cost sharing, plus the difference in cost between the generic and brand-name drug. The difference you pay does not accumulate towards your deductible or your out-of-pocket maximum. Though you will not be responsible for the drug cost sharing, you will continue to be responsible for the difference in cost after you have met your out-of-pocket maximum.

Some medications are excluded from coverage. Contact your Pharmacy Benefits Manager for more information.

Drug Type	In-Network Retail Pharmacy (30-day supply)	In-Network Mail Order Pharmacy (90-day supply)	Out-of-Network Retail Pharmacy
Preventive drugs	Fully covered (the plan pays 100%). You do not have to meet your pharmacy deductible first.	Fully covered (the plan pays 100%). You do not have to meet your pharmacy deductible first.	Not covered.
Generic drugs	You pay a \$7 copay; the plan pays the rest. You do not have to meet your pharmacy deductible first (and your copay doesn't apply to your pharmacy deductible).	You pay a \$14 copay; the plan pays the rest. You do not have to meet your pharmacy deductible first (and your copay doesn't apply to your pharmacy deductible).	Not covered.
Preferred brand drugs	You'll owe the full cost of this medication until	You'll owe the full cost of this medication until	Not covered.

	you've met your pharmacy deductible. After that, you pay a \$40 copay; the plan pays the rest.	you've met your pharmacy deductible. After that, you pay a \$80 copay; the plan pays the rest.	
Non-preferred brand drugs	You'll owe the full cost of this medication until you've met your pharmacy deductible. After that, you pay a \$70 copay; the plan pays the rest.	You'll owe the full cost of this medication until you've met your pharmacy deductible. After that, you pay a \$140 copay; the plan pays the rest.	Not covered.
Specialty generic, Preferred specialty, and Non-preferred specialty drugs	You pay a \$100 copay; the plan pays the rest. You do not have to meet your pharmacy deductible first (and your copay doesn't apply to your pharmacy deductible).	Not covered	Not covered
Fertility medication	Covered through Progyny.		

When you go to an in-network retail pharmacy, you can pick up your medication up to the numbered day supply in the table above. You have the option to enroll in mail order medications through your pharmacy network. See the table above to check if any limits apply to mail order medications.

You will not be able to collect more than the numbered day supply indicated in the above table in one order whether you purchase at an in-network retail pharmacy or mail order pharmacy. You will have to wait until your supply is low before you can refill your prescription.

Please note certain prescriptions may require prior authorization in order to be covered under your pharmacy benefits. For more information about which medications require a prior authorization, see Section 2 or contact Collective Health.

Over-the-Counter Medications

Over-the-counter medications (ibuprofen, vitamins, etc.) are not covered by this Plan. In accordance with Affordable Care Act guidelines, there are four exceptions to this exclusion:

- When a drug is prescribed by your doctor and you purchase it behind the counter, from the pharmacist (for example, aspirin or folic acid), then you may be able to use your pharmacy benefits even if the drug is also available over-the-counter.
- Over-the-counter supplies for treating diabetes (such as insulin and blood sugar detection equipment) are not excluded from coverage.
- If covered contraceptives are available over-the-counter in your area, those will be covered by this Plan if prescribed by a doctor.
- Over-the-counter smoking cessation treatments are covered by this Plan if prescribed by a doctor.

If you have questions about your pharmacy benefits, including whether certain medications are preferred, non-preferred, or excluded, you can always contact Collective Health for help.

Section 4: What's Not Covered (Exclusions)

Some treatments and services are not covered by this Plan. Items that are not covered are called exclusions and are listed below. Certain exclusions may also be described in the benefits table in Section 3.

Any service, item, or treatment that is not medically necessary is excluded. Services are medically necessary if all the following criteria are met:

1. Recommended and provided by a licensed physician, dentist or other medical practitioner who is covered by the Plan and practicing within the scope of their license;
2. Generally accepted as the standard of medical practice and care for the diagnosis and treatment of your condition, or for preventive care;

3. Clinically appropriate (in terms of type, frequency, duration, and other factors) for your condition;
4. Not performed mainly for your convenience or the convenience of your doctor;
5. Approved by the FDA, if applicable.

The Plan administrator and/or claims administrator has full discretionary authority to adjudicate benefit claims, including taking a holistic view of the member's healthcare needs and condition, and current and future financial implications. When you choose to visit an out-of-network provider or facility for medical treatment, the Plan will cover the allowed amount, and the provider may balance bill you for any excess. It is your responsibility to pay any amounts in excess of the allowed amount—in addition to any deductibles, copays, or coinsurance. This Plan may not cover all possible medically necessary treatments; in other words, some services are excluded from coverage even if they would be medically necessary for you.

Non-medical services are excluded:

- **Custodial care**, which can be provided by individuals without medical training, and is given principally for personal hygiene or for assistance in daily activities (however, treatment typically considered custodial care is covered if the treatment is considered medically necessary as part of the individual's Adaptive Behavioral Therapy)
- **Dietary or nutrition supplements**, except when prescribed to treat specific medical conditions (such as PKU)
- Any type of **education or training**, except as expressly stated in Section 3 as covered or services that are medically necessary and performed by licensed medical professionals
- **Exercise programs** (except for physician-supervised cardiac rehabilitation, physical therapy, or occupational therapy expressly stated in Section 3 as covered)
- **Hypnotherapy**
- **Personal comfort items**, including:
 - Air conditioners
 - Air purification units
 - Humidifiers
 - Electric heating units
 - First aid supplies
 - Elastic bandages or stockings
 - Non-hospital adjustable beds
 - Orthopedic mattresses

- Non-prescription drugs and medicines, except as expressly stated in Section 3 as covered
- Scales
- **Rest cures**
- Charges for **travel or non-medical accommodations**, except as expressly stated in Section 3 as covered

This Plan excludes any care you receive when you are not a member. Healthcare services you receive before your coverage effective date are excluded—even if you are charged for the services after your coverage begins. Services you receive after your coverage ends are excluded—even if you got sick while you were still covered.

This Plan also excludes the following services, supplies, or treatments:

- Any of the following **applied behavior analysis (ABA)** services, as defined by the HCSC Medical Policies,
<http://www.medicalpolicy.hcsc.net/medicalpolicy/index?corpEntCd=IL1>:
 - Services with a primary diagnosis that is not Autism Spectrum Disorder;
 - Services that are facilitated by a Provider that is not properly credentialed. Please see the definition of Qualified ABA Provider in the Medical Policies;
 - Activities primarily of an educational nature;
 - **Compound medication** ingredients that have not shown clinical benefit over lower-cost alternatives, or bulk ingredients used in compound medications where a standard equivalent exists.
 - **Concierge membership fees**, retainers, or premiums paid to a concierge medical practice in order to access the medical services provided by that practice.
 - Charges for **cosmetic procedures** or pharmaceuticals, which are procedures performed or medications taken for plastic, reconstructive, or cosmetic purposes, or which are intended primarily to improve, alter, or enhance appearance.

- Wigs are excluded, except for wigs provided for the loss of hair resulting from alopecia areata, endocrine diseases, chemotherapy or radiation to treat cancer, or permanent loss of hair from an accidental injury.
- Hair transplants are excluded, except for medically necessary transplants provided for the loss of hair resulting from chemotherapy or radiation to treat cancer.
- Drugs for cosmetic effect, such as Retin-A or hair removal substances, are excluded unless they are medically necessary to treat a medical condition.
- Growth hormones, anabolic steroids, and appetite suppressants are excluded unless they are prescribed by a physician to treat a covered medical condition (such as HGH deficiency).
- Reconstructive surgery to correct congenital abnormality or deformity caused by accident, injury, or illness (including after mastectomy) is not excluded.
- **Dental care**, except specific treatments for mouth, tooth, or gum injury expressly stated in Section 3 as covered.
- Charges for services provided by a **doula**.
- **Donor expenses** for a Participant in connection with an organ and tissue transplant if the recipient is not covered under this Plan.
- **Excess charges** for services, items, or treatment—in other words, charges by out-of-network providers that exceed the allowed amount for the services provided.
- Care or treatment provided or prescribed by **excluded providers**, including:
 Yourself;
 A member of your immediate family by birth, adoption, or marriage;
 A person residing in your household;
 A provider operating without a license or operating outside the scope of his or her license.
 If you are treated by a hospital or other healthcare facility, additional payments to an employee or contractor of that facility are excluded, when the facility is itself obligated to pay that individual for their services.
- Charges associated with **experimental treatments**, which are treatments that are not accepted as good medical practice by most practitioners or that lack credible evidence to support positive short- or long-term outcomes for patients.
- Treatments include any treatment, procedure, service, device, supply or drug provided to a covered person.

- Drugs that are not approved by the FDA for any use are considered unproven and experimental and are excluded. Off-Label Drug Use is defined as the use of a drug for a purpose other than that for which it was approved by the FDA. Off-Label Drug Use may be covered on the Plan if:
 1. The drug is not excluded under your Plan; and
 2. The drug has been approved by the FDA; and
 3. It can be demonstrated that the Off-Label Drug Use is appropriate for the condition being treated.
- Clinical trials are not covered by this Plan, unless determined to be eligible for coverage upon medical necessity review and not deemed to be experimental or investigational. Routine patient care costs for approved clinical trials may be covered by this Plan, as described in Section 3.
- Experimental/Investigational treatment is not covered by this Plan.
- Routine **eye care** and vision-correction surgery, except:
 - Care and treatment of aphakia and aniridia.
 - Lenses or shells for use as corneal bandages.
 - As otherwise covered by the Preventive Care provisions of this Plan.
 - As expressly stated in Section 3 as covered.
- Charges beyond the Plan's **financial obligations**, including:
 - Amounts in excess of the "allowed amount."
 - Medical treatments outside the Plan's scope (i.e., services that are not listed as covered benefits).
 - Services, items, medications, or treatment for which there would not have been a charge, if no coverage were available.
 - Expenses actually incurred by other persons (not you or your covered dependents).
 - Charges that should be repaid to the Plan under the subrogation, reimbursement, or third-party responsibility provisions (Section 8).
 - Expenses for services that are also covered under any government-sponsored Plan or program (e.g., Tricare, CHAMPUS, VA), unless the government program expressly provides otherwise.
 - For services you obtain before you were covered under this Plan.
 - For services you obtain after your coverage under this Plan ends.
- **Non-medical foot treatments**, such as pedicure or spa treatments or non-medical treatment of corns, calluses, or toenails.

- **Gender affirming services**, treatment for transsexualism, gender dysphoria, or sexual reassignment or change, including drugs, medication, implants, hormone therapy, other surgical treatment, or psychiatric care or treatment.
- **Hearing aids** and any associated charges for accessories or services related to their implantation and maintenance.
- Any services or supplies provided for the following, as defined by the **HCSC Medical Policies**, <http://www.medicalpolicy.hcsc.net/medicalpolicy/index?corpEntCd=IL1>:
 - Cognitive rehabilitation therapy - Services designed to address therapeutic cognitive activities, based on an assessment and understanding of the individual's brain- behavioral deficits;
 - Cognitive communication therapy - Services designed to address modalities of comprehension and expression, including understanding, reading, writing, and verbal expression of information;
 - Neurocognitive rehabilitation - Services designed to assist cognitively impaired individuals to compensate for deficits in cognitive functioning by rebuilding cognitive skills and/or developing compensatory strategies and techniques;
 - Neurocognitive therapy - Services designed to address neurological deficits in informational processing and to facilitate the development of higher level cognitive abilities;
 - Neurofeedback therapy - Services that utilize operant conditioning learning procedure based on
 - Electroencephalography (EEG) parameters, and which are designed to result in improved mental performance and behavior, and stabilized mood;
 - Post- acute transition services - Services that facilitate the continuum of care beyond the initial neurological insult through rehabilitation and community reintegration; and
 - Community reintegration services - Services that facilitate the continuum of care as an affected individual transitions into the community.
 - Biofeedback (except for an Acquired Brain Injury diagnosis) or other behavior modification services.
- **Illegal drugs**, including otherwise legal medications (such as oxycodone) procured through illegal means.
- Care, supplies, medications, and services for the treatment of **infertility**, except as expressly stated in Section 3 as covered, including:
 - Egg and sperm freezing are not covered.

- Fertility services are not covered if your infertility is the result of a prior voluntary sterilization procedure.
- The purchase of donor sperm and purchase of donor oocytes or embryos and any charges associated with care of the donor required for donor oocytes retrievals or transfers or gestational carriers, in excess of the benefit expressly stated in Section 3 as covered; all charges associated with a gestational carrier program for the person acting as the carrier (if that person is not a member of this plan), including but not limited to fees for laboratory tests.
- Home ovulations prediction kits.
- Services and supplies furnished by an out-of-network provider.
- **Marijuana** or marijuana-derived substances (like THC oil), even if you have a prescription and marijuana is legal in the state where you live.
- Non-emergency medical care outside the United States, including all **medical tourism**.
 - Emergency care outside the United States is covered. This includes services or treatment that you must receive in order to safely travel back to the United States. See Appendix A for more information.
- Charges for **naturopathic** or **homeopathic** services or supplies that are not covered under the medical plan.
- Any related services to a **non-covered service**. Related services are:
 - Services in preparation for the non-covered service;
 - Services in connection with providing the non-covered service; and
 - Hospitalization required to perform the non-covered service.
- **Non-prescription contraceptive** medications or devices for male use.
- **Over-the-counter drugs**, except as expressly stated in Section 3 as covered.
- **Pharmaceutical medications** that are obtained from an out-of-network pharmacy.
- **Pharmaceutical medications** that are specifically excluded by CVS Caremark from coverage. Contact your Pharmacy Benefits Manager for more information.
- **Private duty nursing** provided in a setting outside the home.
- **Respite care**, unless received as part of hospice care.
- Treatments for intentionally **self-inflicted injuries** or injuries that you sustain while incarcerated are excluded. However, if the injury is due to a medical or mental health condition, or is the result of domestic violence, this exclusion does not apply.
- Charges for **sterilization reversal** procedures, except as expressly stated in Section 3 as covered.
- Charges for **telemedicine**.
- Charges resulting from the failure to keep a **scheduled visit** with a physician.

- **Vitamins** or other dietary supplements, except as expressly stated in Section 3 as covered.
- Charges for health services received as a result of an act of **war** or foreign terrorism.
- Services, items, or treatment for **work-related illness or injury**—that is, an illness or injury that arises from work for wage or profit (including self-employment).

Section 5: How to File a Claim

When you use in-network services, the provider will generally send a claim to the Plan for payment of your treatment. Sometimes out-of-network providers will do the same. Other times, out-of-network providers may bill you for the total cost of your treatment, and you will need to submit the claim to the Plan to be paid. Whether you pay out-of-pocket or your provider bills the Plan directly, you are still entitled to the same benefits.

Claims are considered filed and received by the Plan when they are received by Collective Health. If you have an HSA, distributions and all other matters relating to your HSA are outside of the Plan and are governed by the agreement between you and the HSA custodian.

There are different kinds of Claims and each one has a specific timetable for each step in the review process. Upon receipt of the Claim, it will be processed and either approved or denied. You will be notified of the decision as soon as practical and not later than the time specified below for the type of claim. However, if the Claim has not been filed properly, or if it is incomplete, or if there are other matters beyond the control of Collective Health, you may be notified that the period for providing the notification will need to be extended. If the period is extended because more information is needed, you must provide the requested information within the time shown below. Once the claim is complete, a decision will be made. If your claim is denied, in whole or in part, you will receive a written notification setting forth the reasons for the denial and describing your rights, including your right to appeal the decision. The time period shown below begins at the time the claim or appeal is filed in accordance with the Plan's procedures. Decisions will be made within a reasonable period of time appropriate to the circumstances, but within the maximum time periods listed below. Unless otherwise noted, "days" means calendar days.

In the event a check for reimbursement or payment is not cashed within 12 months from the date of issue, the Plan administrator, as applicable, will deem the right to such benefit waived and the check will be voided. Upon such waiver, the Plan shall have no liability for payment of the benefit otherwise payable, and the amount of such benefit shall be deemed a forfeiture. These funds may be applied only to the payment of benefits (including administrative fees) under the Plan pursuant to ERISA. No funds shall escheat to any state.

If you would like more details about claims procedures and your rights and responsibilities, contact Collective Health.

Regular Post-Service Claims

Post-service claims are non-urgent claims after you have received treatment. (Other types of claims have different timelines and requirements; see below.) Generally, you do not need to file a claim when you receive services from in-network providers—the provider, Blue Cross and Blue Shield of Texas, and Collective Health will handle the processing of the claim. For bills from out-of-network providers or emergency care providers outside of the United States that will not submit claims to Blue Cross and Blue Shield of Texas, you may receive reimbursement from the Plan by following this procedure.

You can submit a post-service claim by mail or through my.collectivehealth.com. You will need to provide several pieces of information for Collective Health to be able to process your claim and determine the appropriate Plan benefits:

- The name and birthdate of the patient who received the care
- The member ID listed on the patient ID card
- An itemized bill from the patient's provider, which must include:
 - The facility name, provider's name, address, and license number (if available)
 - The date(s) the patient received care
 - The medical diagnosis and procedure codes for each service provided
 - The place of service (POS) code indicating where the service was provided
 - The charges for each service provided
 - Information about any other health coverage the patient has
 - Proof of payment as needed to substantiate your claim (but is not required upon initial submission to Collective Health)

For travel expenses and breast pumps, a medical bill is not required. Instead, please submit a detailed receipt.

Claims must be submitted within one year from the date you received the healthcare services. If your claim relates to an inpatient stay, the date you were admitted counts as the date you received the healthcare service for claims purposes. Contact Collective Health if you have any questions on the items above.

Within 30 days of Collective Health receiving the claim, Collective Health will review the claim and a decision is made to either approve or deny the claim in whole or in part. You'll receive a written notice of the claim decision. Claims will be processed when administratively feasible, typically in the order they are received.

If we need more time or information due to matters beyond our control to process a claim, the 30-day period to provide you with a decision may be extended for up to 15 days. We will notify you of the extension, the reason for the delay, request any additional information needed, and the date by which we expect to render a decision. If an extension is necessary because you have not submitted the information necessary to decide the claim, you will have at least 45 days from receipt of the extension notice to submit the required information.

Claims for pharmacy benefits will be reviewed by CVS Caremark. Claims for medical (non-pharmacy) benefits will be reviewed by Collective Health and/or Blue Cross and Blue Shield of Texas depending on the type of claim. If more time is needed to decide your claim due to matters beyond the control of Collective Health and/or Blue Cross and Blue Shield of Texas, the Plan may make a one-time extension of not more than 15 days. If this additional time is needed, you will be notified before the end of the initial 30-day period.

Urgent Care Claims

An urgent care claim is a claim for services when a delay in treatment could seriously jeopardize your life or health or the ability to regain maximum function or, in the opinion of a physician with knowledge of your medical condition, could cause severe pain that could not be adequately managed without the care or treatment that is the subject of the claim. An urgent care prior authorization is considered an urgent care claim. Because your provider is the one who initiates prior authorization with Blue Cross and Blue Shield of Texas, it will usually be your provider who will request expedited processing. If a physician with knowledge of your medical condition determines that the claim is an urgent care claim as described above, then the Plan will treat the claim as an urgent care claim. Urgent care claims will be decided within 72 hours after submission. Urgent care claims filed improperly or missing information may be denied.

If your urgent care claim is denied, you'll receive an explanation of why it was denied and how you can appeal (including how to request expedited review) within the following time frames:

Notification, orally or in writing that there is insufficient information	24 hours
Your response to the notification	48 hours
Notification of the Benefit Determination	48 hours

Concurrent Care Claims

In some cases, you may have an ongoing course of treatment approved for a specific period of time or a specific number of treatments. Before your ongoing course of treatment is reduced or terminated, you will be notified sufficiently in advance to allow you to give you an opportunity to appeal an obtain a decision before the treatment is reduced or terminated. This is called a concurrent care claim or a concurrent care review. Similar to urgent care claims, your provider is typically the one who initiates a concurrent care claim with Blue Cross and Blue Shield of Texas.

If your extension request is not “urgent” (as defined in the previous section), your request will be considered a new request and will be decided according to the applicable procedures and timeframes. If your request for an extension is urgent and you submit the claim at least 24 hours before the end of the course of treatment, you (or your provider) will be notified of the determination within 24 hours. If you did not submit the request within 24 hours before the end of the course of treatment, but it is still urgent, you will be notified as soon as possible, taking into account the medical exigencies, but not later than 72 hours after receipt of the request.

Pre-Service Claims

Pre-Service Claims are claims for a benefit under this Plan where the Plan conditions receipt of the benefit, in whole or in part, on approval in advance of obtaining medical care. This can be in the form of a pre-authorization or a decision on medical necessity. Please see Section 2 of this booklet for more information on Prior Authorization.

Pre-Service claims must be decided no later than 15 days after Blue Cross and Blue Shield of Texas receives the claim. This time period may be extended for up to an additional 15 days if, for reasons beyond the Plan’s control, the decision cannot be made within the first 15 days. You will be informed of the reason for the delay and when a final decision is expected before the end of the first 15-day period. If more information is requested from you to make the decision, you have a minimum of 45 days to provide it. A decision will be made upon the date which is earlier

of: 15 days after the additional information is supplied or the expiration of the 45 days you have to submit the additional information, whichever comes first.

If you did not follow the proper filing procedures, you will be notified of the failure and the proper procedures to be followed within 5 days (within 24 hours in the case of an Urgent Care Claim).

The notice may be oral, but you may request a written notification.

Notice of an Adverse Benefit Determination

If your claim is denied in whole or in part (“adverse benefit determination”), you’ll receive a written explanation of why it was denied and how you can appeal. For Urgent Care Claims, this notification may be oral followed by written or electronic notification within three days of the oral notification. This notice will include:

- Information sufficient to allow you to identify the claim involved (including the date of services, the healthcare provider, and the claim amount, if applicable), and a statement that the diagnosis code and treatment code and their corresponding meanings will be provided to you as soon as feasible upon request.
- The specific reason(s) for the denial, including the denial code and its corresponding meaning, and a description of the Plan standard, if any, that was used in denying the Claim;
- Reference to the specific Plan provision(s) on which the denial is based;
- A description of additional material or information necessary to perfect the claim and an explanation of why such material or information is necessary;
- A description of the Plan’s internal and external appeal procedures and applicable time limits including your right to sue the Plan under ERISA section 502;
- For urgent care claims, a description of the Plan’s expedited review process for such claims;
- If the Adverse Benefit Determination is based on the Medical Necessity or Experimental or Investigational treatment or similar exclusion or limit, an explanation of the scientific or clinical judgment for the determination, applying the terms of the Plan to the claimant’s medical circumstances, will be provided. If this is not practical, a statement will be included that such explanation will be provided free of charge, upon request;
- Information about the availability of, and contact information for, any applicable office of health insurance consumer assistance or ombudsman established under applicable federal law to assist individuals with the internal claims and appeals and external review process; and

- A statement that a copy of any rule, guideline, protocol, or other similar standard relied on in the denial will be provided free of charge upon request.

If the denial is based on medical necessity or experimental treatment, an explanation of the determination will be provided free of charge upon request. Payment for claims that are fully or partially approved for benefits may be sent to you by check through U.S. mail. If a payment issued for your claim is more than 12 months outstanding, your right to the benefit may be waived. You are responsible for informing the Plan Administrator of any change of address.

Section 6: How to Appeal

When you receive a notification of an adverse benefit determination, you have the right to appeal. Appeals of an adverse benefit determination must be specific to you and/or your dependents. You cannot appeal changes to the Plan's terms, termination of the Plan, or other decisions that affect plan members beyond you and your dependents. You generally have 180 days following receipt of the notification in which to file a written request for an appeal of the decision.

Blue Cross and Blue Shield of Texas and Collective Health share the responsibility of rendering appeal determinations. This section describes your appeal rights and the steps you must take to exercise those rights with each party.

If you are confused or dissatisfied about a determination of your benefits (for example, if a particular claim has been paid at a lower rate or denied), we encourage you to contact Collective Health before filing an appeal. You are not required to call Collective Health first, but reaching out to the Member Advocate team may help clear up any preliminary questions you have about why a particular decision was made. The Member Advocate team can also help guide you as you compile the information you need to submit an appeal.

If you request, you will be provided, free of charge, reasonable access to, and copies of, all documents, records and other information relevant to the Claim. This will be provided, as soon as possible and sufficiently in advance of the time within which a final determination on Appeal is required to allow you time to respond with any new or additional evidence that is relied upon, considered or generated by or at the direction of the Plan. This evidence shall be provided free of charge.

A document, record, or other information shall be considered relevant to a Claim if it:

- Was relied upon in making the benefit determination.
- Was submitted, considered, or generated in the course of making the benefit determination, without regard to whether it was relied upon in making the benefit determination.
- Demonstrated compliance with the administrative processes and safeguards designed to ensure and to verify that benefit determinations are made in accordance with Plan documents and Plan provisions have been applied consistently with respect to all members; or
- Constituted a statement of policy or guidance with respect to the Plan concerning the denied treatment option or benefit.

You may have someone else help you to file an appeal. If someone submits an appeal for you, it must include documentation that they are your authorized representative. The documentation must be signed by both you and the authorized representative. Contact Collective Health if you would like to request an authorized representative appointment form.

The section below explains where to submit different types of appeals. If you are still unsure of where to submit your appeal, please reach out to Collective Health for assistance. If your appeal is submitted to the incorrect party, we will coordinate to get it to the right place. Please note the appeal determination timeline begins when the appropriate party receives the appeal.

How to Appeal Prior Authorization and Medical Necessity Determinations

Because your provider is the one who initiates prior authorizations (including urgent claims) with Blue Cross and Blue Shield of Texas, it will usually be your provider who appeals if prior authorization is denied. Your provider will also usually appeal if a claim is denied based on a medical necessity determination. You can choose to appeal the denial if you wish—for example, if your provider doesn't want to pursue an appeal. If you need or want help navigating this process, you can contact Collective Health for assistance.

You must appeal a denial of prior authorization, urgent care, concurrent care, or medical necessity to Blue Cross and Blue Shield of Texas, not Collective Health, but if you need or want help navigating this process, you can contact Collective Health at 855-399-5599 and they can transfer you to Blue Cross and Blue Shield of Texas. You must begin your appeal process within 180 days of receiving the denial. Blue Cross and Blue Shield of Texas will consider your appeal and make a decision within the applicable legal timeframes.

How do I submit an Expedited Appeal? You have the right to an expedited decision if a delay could seriously jeopardize your life or health or cause you severe pain. To request an expedited appeal, submit your appeal either orally or in writing directly to Blue Cross and Blue Shield of Texas. You will be notified of the decision within 72 hours from the date Blue Cross and Blue Shield of Texas receives the appeal. You may also request an expedited review under the External Review Process below.

How to Appeal Non-Clinical Post-Service Adverse Benefit Determinations

This section describes Collective Health's appeals process for any adverse benefit determination other than a prior authorization or medical necessity denial by your network (for example, if coverage for a particular treatment has been denied because it is outside the scope of this Plan).

Use this procedure for medical benefit appeals. For pharmacy appeals, reach out to Collective Health with the information below so we can help route your appeal to the right place. You must submit your appeal within 180 days of receiving the adverse benefit determination.

To appeal, you must submit the following information to Collective Health in writing:

- Enough information to identify the adverse benefit determination that is the subject of your appeal—either attach a copy of the relevant Medical Benefit Statement, or provide:
 - Member ID
 - Patient name
 - Claim number
 - Provider name
 - Date of the medical service
- Your explanation of what happened and why you believe the original decision was incorrect

- Any documents or other information that support your appeal—for example:
 - A letter or prescription from your doctor
 - A receipt for money you paid
 - Relevant excerpts of your medical records

You can send the appeal submission and attachments by mail or through Messages in your Collective Health account.

Attn: Appeals Team
 Collective Health
 1557 W Innovation Way, Suite 300
 Lehi, UT 84043
 855-399-5599

Collective Health or the medical network will review your appeal and issue a decision within 30 days of receiving your appeal if your appeal is pre-service, and within 60 days if your appeal is post-service. The period of time within which a benefit determination on Appeal is required to be made shall begin at the time an Appeal is filed in writing in accordance with the procedures of the Plan. This timing is without regard to whether all the necessary information accompanies the filing. The Plan must obtain your consent if it needs more time to review your appeal. Your appeal will be reviewed by someone other than, and not a subordinate of, the person who made the original claim denial. The appeal review will look at all of the information submitted, including any new information, and give no consideration to the original claim decision.

Before a Final Adverse Benefit Determination is issued based on new or additional rationale, you must be provided, free of charge, with a copy of the rationale. The rationale must be provided as soon as possible and sufficiently in advance of the within which a final determination on Appeal is required to allow you time to respond. If it is impossible under the circumstances to give you reasonable time to respond, the period for issuing the Final Adverse Benefit Determination will be delayed until you have a reasonable opportunity to respond. After you respond, or if you fail to do so, the Final Adverse Benefit Determination will be issued as soon as reasonably possible, taking into account the medical exigencies.

If the adverse benefit determination was based on a medical judgment, including whether a particular treatment, drug, or other item is not Medically Necessary or appropriate, a health care professional who was not involved in the original benefit determination will be consulted. This health care professional will have appropriate training and experience in the field of medicine

involved in the medical judgment. You can request copies of the information relating to your appeal, including billing and diagnosis codes, and the name and title of any experts who assisted with the determination. If Collective Health upholds the original adverse benefit determination, you will receive a notice of final adverse benefit determination that explains the reason for that decision and describes your rights.

Notice of Final Adverse Benefit Determination

If the Appeal of a Claim is denied, in whole or in part, you will receive written notification of the Adverse Benefit Determination on Appeal, or Notice of Final Benefit Determination. This notice will state, in a culturally and linguistically appropriate manner and in a manner calculated to be understood by the claimant:

- Information sufficient to allow you to identify the Claim involved (including date of service, the healthcare provider, and the claim amount, if applicable), and a statement that the diagnosis code and treatment code and their corresponding meanings will be provided to you as soon as feasible upon request.
- The specific reason or reasons for the adverse determination, including the denial code and its corresponding meaning, and a description of the Plan's standard, if any, that was used in denying the Claim.
- A reference to the specific Plan provisions on which the determination was based.
- A description of any additional material or information necessary for you to perfect the Claim and explanation of why such material or information is necessary.
- A description of the Plan's internal and external review procedures and the time limits applicable to such procedures. This will include a statement of your right to bring a civil action under Section 502 of ERISA following an Adverse Benefit Determination on review.
- A statement that you are entitled to receive, upon request and free of charge, reasonable access to, and copies of, all documents, records and other information relevant to the claim.
- If the Adverse Benefit Determination was based on an internal rule, guideline, protocol or other similar criterion, the specific rule, guideline, protocol, or criterion will be provided free of charge. If this is not practical, a statement will be included that such rule, guideline, protocol, or criterion was relied upon in making the Adverse Benefit Determination and a copy will be provided free of charge to you upon request.

- If the Adverse Benefit Determination is based on the Medical Necessity or Experimental or Investigational treatment or similar exclusion or limit, an explanation of the scientific or clinical judgment for the determination, applying the terms of the Plan to the claimant's medical circumstances, will be provided. If this is not practical, a statement will be included that such explanation will be provided free of charge, upon request.
- Information about the availability of, and contact information for, any applicable office of health insurance consumer assistance or ombudsman established under applicable federal law to assist individuals with the internal claims and appeals and external review process.

Because of this exhaustive review, Collective Health only does one level of appeal. If your internal appeal is denied, you may have the right to an external review as described below. You have four months from the date of the most recent adverse determination to send in additional relevant information or request an external review.

External Review Program

If you are not satisfied with the determination of your internal appeal, you may have the right to request an external review by an independent review organization (IRO). All external reviews are facilitated by Blue Cross and Blue Shield of Texas, regardless of which party rendered the internal appeal determination. The Plan has entered into agreements with three or more IROs that have agreed to perform external reviews. The external review process is available at no charge to you.

External review is available only when the Plan's adverse benefit determination is based on one of the following:

- Medical necessity or clinical reasons (which includes but is not limited to, Plan requirements for medical necessity, appropriateness, health care setting, level of care, or effectiveness of a covered benefit);
- The claim was denied due to the Plan exclusions for experimental, investigational, or unproven services;
- Rescission of coverage (coverage that was canceled retroactively);
- Whether the Plan is complying with the non-quantitative treatment limitation provisions under certain federal laws;

- An adverse benefit determination that involves consideration of whether the Plan is complying with the surprise billing and cost-sharing protections set forth in the No Surprises Act; or
- As otherwise required by applicable law.

Every external review request should include all of the following information:

- A specific request for an external review
- The subscriber's name, patient's name, and member ID and group number
- The service that was denied
- Any new, relevant information that was not provided during the internal appeal

The notification of the Final Adverse Benefit Determinations provides information about the external review program including where review requests may be submitted. A request for external review must be made within four months after you receive the internal appeal determination. An external review is the final level of appeal available under the Plan.

Standard External Review

When you submit a request for standard external review, here's what will happen:

First, Blue Cross and Blue Shield of Texas will do a preliminary review of your request within five business days. This preliminary review will confirm that:

- The patient was covered by the Plan at the time they received the healthcare service(s)
- The patient has finished the internal appeal process (this is called "exhaustion")
- The claim or appeal decision is eligible for external review
- All of the required information has been provided

After that, within one business day after completion of the preliminary review, Blue Cross and Blue Shield of Texas will provide a notification to you in writing about its preliminary review. If the request is completed but not eligible for external review, the notification will include the reasons for its ineligibility and current contact information, including the phone number for the Department of Labor, Employee Benefits Security Administration. If the request is not complete, the notification will describe the information or materials needed to complete it. You will have 48 hours or until the last day of the 4-month filing period, whichever is later, to submit the additional information.

If all four criteria above are met and your request is eligible for the External Review process, your case will be assigned to an IRO for review. Blue Cross and Blue Shield of Texas will randomly select from one of the contracted IROs so your review is not biased. The IRO will then confirm with you that your request has been accepted for external review. The notice will include a statement that you may submit in writing, within 10 business days, additional information the IRO must consider when conducting the review. The IRO will share this information with the Plan. The Plan may consider this information and decide to review its denial. If the denial is reversed, the External Review process will end.

If you submit additional information later than 10 business days, the IRO may (but is not required to) consider that additional information. Either way, Blue Cross and Blue Shield of Texas will, within 5 business days after the assignment of the IRO, give the IRO all of the documents and information that were used in making the internal appeal determination (the adverse benefit determination), such as:

- Internal appeal determination letter(s)
- Any other documents relied upon by the Plan
- All other information or evidence that you or your physician submitted for consideration as part of the internal appeal

The IRO will make a decision on the basis of its review. The IRO will provide an unbiased assessment that will not be bound by any decisions or conclusions reached in the initial appeal determination. The decision of the IRO will be based on all of the information in the record as well as additional information where appropriate and available, such as:

- The medical records;
- The medical provider's recommendation;
- Reports from appropriate health care professionals and other documents submitted by the Plan or issuer, claimant, or the claimant's treating provider;
- The terms of the Plan;
- Appropriate practice guidelines;
- Any applicable clinical review criteria developed and used by the Plan; and
- The opinion of the IRO's clinical reviewer.

The IRO will provide its final external review decision to you in writing within 45 days after receipt of the request for the external review—unless the IRO requests additional time, and you agree. The notice, including the clinical basis for the determination, will be provided to you and Blue Cross and Blue Shield of Texas. The IRO's decision notice must include the following:

- A general description of the reason for the External Review, including information sufficient to identify the claim;
- The date the IRO received the assignment to conduct the review and the date of the IRO's decision;
- References to the evidence or documentation the IRO considered in reaching its decision;
- A discussion of the principal reason(s) for the IRO's decision;
- A statement that the determination is binding and that judicial review may be available to you; and
- Contact information for any applicable office of health insurance consumer assistance or ombudsman established under the PPACA.

If the IRO reverses the internal appeal determination, the Plan will provide coverage or payment for your claim, in accordance with the terms of the Plan.

Expedited External Review

An expedited external review is just like a standard external review, except shorter. If your case qualifies for expedited external review, you can submit your request before you've completed the internal appeals process.

A case qualifies for expedited external review if:

1. You receive an Adverse Benefit Determination that involves a medical condition for which the time to complete the internal Claims and Appeals procedures would seriously jeopardize the claimant's life or health or the ability to regain maximum function and you have submitted an expedited internal appeal; or
2. You receive a Final Adverse Benefit Determination that involves a medical condition where the time for completion of a standard External Review process would seriously jeopardize the claimant's life or health other ability to regain maximum function, or if the Final Adverse Benefit Determination concerns an admission, availability of care,

continued stay, or health care item or service for which the claimant received emergency services, but has not been discharged from a facility.

Requests for expedited external review do not need to be submitted in writing; you may request review by phone, by calling Collective Health.

Immediately upon receipt of the request for expedited external review, Blue Cross and Blue Shield of Texas will determine whether the request meets the requirements for expedited external review. Blue Cross and Blue Shield of Texas will immediately send a notice that includes specific information to you regarding the Plan's preliminary review determination. Upon determining that a request is eligible for expedited external review Blue Cross and Blue Shield of Texas will assign an IRO. Blue Cross and Blue Shield of Texas will use the quickest means to submit your case to the IRO, such as by phone or digital transmission. The IRO, to the extent the information or documents are available and the IRO considers them appropriate, must consider the information or documents described above under the procedures for standard external review. In reaching a decision, the IRO must review the claim de novo and is not bound by any decisions or conclusions reached during the internal claims and appeals process. The IRO must make its determination and provide a notice of the decision as expeditiously as the claimant's medical condition or circumstances require, but in no event more than 72 hours of receiving your request. The IRO may notify you of its decision by phone; if so, you'll also receive written confirmation within 48 hours after that.

Limitation on Your Right to Sue

You generally cannot bring any legal action against the Plan, the Plan administrator, or Collective Health unless you first complete all the steps in the appeal process and exhaust your appeal rights. The appeal process is complete only when you have received a final determination from the Plan or claims administrator.

After completing the appeal process, if you want to bring a legal action, you must do so within two years. If you do not sue within two years, you lose any rights to bring such an action against the Plan, the Plan administrator, or Collective Health.

Section 7: Coordination of Benefits

This section describes how benefits under this Plan will be coordinated with any other healthcare Plan that provides benefits to you or your dependents. For example, if you are a member of this Plan and also enrolled as a dependent on your spouse's employer-sponsored health plan, this Plan will coordinate its benefits with your other plan's benefits. One plan will pay out full benefits first (called primary), and then the other plan will begin paying benefits (called secondary), until all of the benefits are exhausted or until the allowed amount for your care is paid. Your total benefits from all of your healthcare Plans will never exceed the actual cost of your care.

The rules governing who pays primary and who pays secondary are different depending on the other healthcare benefits plan you have. This section lays out those rules. If you are confused or have any questions, you can contact Collective Health for guidance.

Definitions

Allowable expense means any health care expense that is covered in full or in part by any of the Plans covering the person. This includes any coinsurance, copayments, or deductible the Plans may apply.

- An expense or a portion of an expense that is not covered by any of the Plans is not an allowable expense.
- Any expense that a provider by law or in accordance with a contractual agreement is prohibited from charging a covered person is not an allowable expense.
- When a Plan provides benefits in the form of services, the reasonable cash value of each service will be considered an allowable expense and a benefit paid.
- The amount of the reduction may be excluded from allowable expense when a covered person's benefits are reduced under a primary Plan because the covered person:
 - Does not comply with the Plan provisions concerning second surgical opinions or precertification of admissions for services; or
 - Has a lower benefit for services rendered by out-of-network providers.

Birthday means the month and day in a calendar year and does not include the year in which an individual is born.

Claim means a request that Plan benefits be provided or paid.

COBRA means Consolidated Omnibus Budget Reconciliation Act of 1985. COBRA coverage is provided under a right of continuation pursuant to this federal law.

Coordination of benefits or *COB* means a procedure establishing the order in which Plans will pay their claims, and permitting secondary Plans to reduce their benefits so that the combined benefits of all Plans do not exceed total allowable expenses.

Custodial parent means:

- a. The parent awarded custody of a child by a court decree; or
- b. In the absence of a court decree, the parent with whom the child resides more than one half of the calendar year without regard to any temporary visitation.

Plan means a form of coverage with which coordination is allowed. Separate parts of a Plan for members of a group that are provided through alternative contracts that are intended to be part of a coordinated package of benefits are considered one Plan and there is no "COB" among the separate parts of the Plan.

The term *Plan* does not include:

- Hospital indemnity benefits or other fixed indemnity coverage;
- Accident only coverage or specified accident coverage;
- A supplemental sickness and accident policy excluded from coordination of benefits;
- School accident-type coverage;
- Benefits provided in long term care insurance policies for non-medical services, for example, personal care, adult day care, homemaker services, assistance with activities of daily living, respite care and custodial care or for contracts that pay a fixed daily benefit without regard to expenses incurred or the receipt of services;
- Medicare supplement policies; or
- A state Plan under Medicaid, or other governmental Plan when, by law, its benefits are in excess of those of any private insurance Plan or other non-governmental plan.

Primary Plan means a Plan whose benefits for a person's health care coverage will be determined without taking the existence of any other Plan into consideration. A Plan is a primary Plan if either of the following conditions is true:

- a. A Plan either does not contain order of benefit rules, or has rules which differ from those permitted by this rule; or
- b. All Plans which cover the person use the order of benefits determination required by this rule, and under this rule that Plan determines its benefits first.

Secondary Plan means any Plan which is not a primary plan. If a person is covered by more than one secondary plan, the order of benefit determination rules in this section will determine the order in which their benefits are determined in relation to each other.

Order of Benefit Determinations

Order of benefits will be determined by the first applicable provision set forth in this paragraph:

Non-dependent or dependent. The benefits of a Plan covering the person as an employee, member, insured, subscriber or retiree, other than as a dependent, will be determined before those of a Plan which covers the person as a dependent. However, the benefits of a Plan covering the person as a dependent will be determined before the benefits of a Plan covering the person as other than a dependent if the person is a Medicare beneficiary. Please see the rules regarding Medicare coordination of benefits in this Plan.

Dependent child covered under more than one plan. Unless there is a court decree stating otherwise, plans covering a dependent child will determine the order of benefits as follows:

- a. For a dependent child whose parents are married (not separated or divorced) or are living together, whether or not they have ever been married:
 - I. The plan of the parent whose birthday falls earlier in the calendar year is the primary plan;
 - II. If both parents have the same birthday, the plan which has covered the parent for a longer period of time is the primary plan;
- b. For a dependent child whose parents are divorced or separated or are not living together, whether or not they have ever been married:

- I. If the specific terms of the court decree state that one of the parents is responsible for the health care expenses or health care coverage of the child, and the Plan of that parent has actual knowledge of those terms, that Plan is primary. If the parent with responsibility has no health care coverage for the dependent child's health care expenses, but that parent's spouse does, that parent's spouse's Plan is the primary plan. This item will not apply with respect to any plan year during which benefits are paid or provided before the entity has actual knowledge of the court decree provision.
- II. If a court decree states that both parents are responsible for the dependent child's health care expenses or health care coverage, the birthday rule applies.
- III. If the specific terms of the court decree state that the parents will share joint custody, without stating that one of the parents is responsible for the health care expenses or health care coverage of the child, the Plans covering the child will be subject to the birthday rule.
- IV. If there is no court decree allocating responsibility for the child's health care expenses or health care coverage, the order of benefits for the child are as follows:
 - a. The Plan covering the custodial parent;
 - b. The Plan covering the custodial parent's spouse;
 - c. The Plan covering the non-custodial parent; and then
 - d. The Plan covering the non-custodial parent's spouse.
- c. For a dependent child covered under more than one Plan of individuals who are not the parents of the child, the order of benefits will be determined, as applicable, as if those individuals were the parents of the child.

Active employee or retired or laid-off employee. The benefits of a Plan which covers a person as an active employee who is neither laid off nor retired, or as that active employee's dependent, is the primary plan. If the other Plan does not have this provision, and if, as a result, the Plans do not agree on the order of benefits, this provision will be ignored.

Coverage provided an individual as a retired worker and as a dependent of that individual's spouse as an active worker will be determined under the non-dependent/dependent rules above.

COBRA or state continuation coverage. If a person whose coverage is provided under a right of continuation pursuant to federal or state law also is covered under another plan, the following will be the order of benefit determination:

- The Plan covering the person as an employee, member, subscriber or retiree (or as that person's dependent) is the primary plan;
- The continuation coverage provided pursuant to federal or state law is the secondary plan.

Longer or shorter length of coverage. If none of the preceding provisions determines the order of benefits, the Plan which has covered the person for the longer period of time is the primary Plan and the Plan which covered that person for the shorter period of time is the secondary plan. For the purposes of this provision:

- a. The time covered under a Plan is measured from the claimant's first date of coverage under that plan, or, if that date is not readily available for a group plan, the date the claimant first became a member of the group covered by that Plan will be used as the date from which to determine the length of time the person's coverage under the present Plan has been in force;
- b. Two successive Plans will be treated as one if the covered person was eligible under the second Plan within twenty-four hours after coverage under the first Plan ended;
- c. The start of a new Plan does not include:
 - I. A change in the amount or scope of a plan's benefits;
 - II. A change in the entity that pays, provides or administers the Plan's benefits; or
 - III. A change from one type of Plan to another, such as, from a single Plan to a multiple employer plan.

If none of the preceding rules determines the order of benefits, the allowable expenses will be shared equally between the Plans.

Determination of Benefits

If this plan is the primary payer for your claim, it will pay or provide its benefits as if the secondary plan does not exist.

If this plan is the secondary payer for your claim, these steps are followed to calculate the secondary payment:

1. When plans have differing allowable expenses, the lower allowable expense will be used. When this plan is secondary to Medicare, Medicare allowable expense will be used.
2. The secondary plan will calculate its benefits, including any deductible, copay, and coinsurance, in absence of the primary plan, using the allowable expense determined in step 3. This benefit amount is the secondary plan's standard benefit amount.
4. The secondary plan will calculate the member liability by subtracting the primary plan paid amount from the allowable expense determined in step 1.
5. The secondary plan will pay the member liability calculated in step 3, but no more than the standard benefit amount calculated in step 2.

The secondary plan will not pay any amount over its standard benefit amount calculated using the lower or Medicare allowable expenses. In no event, when combined with the amount paid by the primary plan, will payments by the secondary plan exceed one hundred per cent of the lower or Medicare expenses allowable under the provisions of the applicable policies and contracts. A secondary plan will not be required to pay for services unless such services are received in accordance with the rules and provisions outlined in its policy, contract or certificate. Any deductible calculated in the secondary plan's standard benefit amount will contribute to your secondary plan's accumulators.

If the primary plan does not cover a service that is covered by the secondary plan. The secondary plan will pay or provide benefits as if it were the primary plan when a covered person for that service.

Nothing in these rules will be construed to prevent a third party payer and a provider from entering into an agreement under which the provider agrees to accept, as payment in full from any or all plans providing benefits to a beneficiary, an amount which is less than the provider's regular charges.

Medicare Coordination of Benefits

If this plan covers you as a retiree, Medicare pays first.

If you are 65 or older and have group health plan coverage as an active employee under you or your spouse's current employment and the employer has 20 or more employees, this plan pays first.

If you are 65 or older, have group health plan coverage based on your or your spouse's current employment, and the employer has fewer than 20 employees, Medicare pays first.

If you are under 65 and have a disability, have group health plan coverage based on your or a family member's current employment, and the employer has 100 or more employees, this plan pays first.

If you are under 65 and have a disability, have group health plan coverage based on your or a family member's current employment, and the employer has fewer than 100 employees, Medicare pays first.

If you are under 65 and have group health plan coverage based on your or a family member's current employment, and you are eligible for Medicare because of End-Stage Renal Disease (ESRD) (permanent kidney failure requiring dialysis or a kidney transplant), this plan pays first for the first 30-months after you become eligible to join Medicare.

If you are under 65 and you are eligible for Medicare because of ESRD and are on COBRA, COBRA pays primary for the first 30-months after you become eligible to join Medicare.

If you are 65 or older and covered by Medicare and COBRA, Medicare pays primary.

If you are disabled and covered by Medicare and COBRA, Medicare pays primary.

Medicaid and Tricare Coordination of Benefits

This Plan pays first. Medicaid and Tricare are secondary payers.

No Fault Liability Insurance

No-fault or liability insurance pays primary for accident or other situation-related health care services claimed or released. This Plan pays secondary.

Travel Insurance

If you have travel insurance with medical coverage, the order of payment will be determined by the applicable state regulations and the coordination of benefits rules of your travel insurance.

Section 8: The Plan's Right to Repayment

In some circumstances, this Plan will be entitled to a refund for some or all of the benefits it pays for your medical care—for example, because a third party is responsible for your injuries, your provider over-billed the Plan, the Plan made a payment in error, or you engaged in fraudulent or similar activity. This section describes the Plan's rights to seek recovery from the person responsible for your injuries and refunds of overpayments.

Read this section carefully, because it describes your obligations to the Plan and the potential consequences of not meeting those obligations.

Recovery from the Person Responsible for Your Injuries

Your illness or injury may be someone else's fault. For example, if you are in a car accident and you dislocate your shoulder, the other driver may be held responsible for the accident and for your resulting injuries. The Plan may pay for the treatment of your dislocated shoulder in the first instance after your accident. But if you receive money from the person responsible for your injuries, the Plan is entitled to be paid back from those proceeds. Even if you choose not to pursue your claim, the Plan is entitled to seek recovery from the person who is financially responsible for your injuries (in the car accident example, this could be the other driver or his insurance company or even your own insurance company).

This section describes the rules that apply when another person or entity (a "third party") may be responsible for your injury or illness. Third party includes, but is not limited to, no-fault auto coverage, personal injury protection coverage, medical payment coverage, uninsured and underinsured motorist coverage, and third-party assets and insurance coverage. The rights and obligations described in this section apply to you and also independently to your dependents.

By accepting healthcare benefits under this Plan, you agree to automatically assign to the Plan any rights you may have to recover from third parties for your injuries.

- The Plan has the right to repayment for the full cost of your care (both medical and pharmacy), from the first dollar you recover, up to 100% of what the third party pays you. But the Plan will not seek recovery for amounts over what the Plan paid for your care.
- The Plan is entitled to any funds you recover from the third party, even if they are labeled as something other than medical costs, such as “non-economic damages” or “punitive damages.”
- The Plan has the right to recover funds even if you are not made whole. The “make whole” doctrine does not apply.
- The Plan is not required to reimburse you for any attorneys’ fees or costs that you incur during the process of seeking damages from a third party. The “common fund,” “fund,” or “attorneys’ fund” doctrines do not apply.
- Whether or not you decide to pursue a claim against the third party responsible for your illness or injury, the Plan can make its own claim against the third party.
- You must cooperate with the Plan’s efforts to seek recovery from a responsible third party. Such cooperation includes, but is not limited to, the following, and you must:
 - Respond to any requests for information about any accidents or injuries. These requests may come from someone other than Collective Health.
 - Provide any relevant information requested.
 - Sign, and deliver, any required documents.
 - Notify the Plan of any legal claims you may have against third parties for your injuries or illness.
 - Participate as needed in the Plan’s efforts to recover funds, including participating in medical examinations and appearing at legal proceedings (such as depositions or court hearings).
 - If requested, assign to the Plan all rights of recovery you have against third parties, to the extent the Plan paid benefits to you.
- You may not settle or release your claims against the third party without first obtaining the consent of the Plan Administrator.
- If you receive any payment from a third party, and the Plan claims that those funds are owed to the Plan, you must hold those funds in trust—either in a separate bank account in your name, or in your attorney’s trust account. You must serve as trustee over those funds, to the extent the Plan paid benefits to you.
- You must promptly reimburse the Plan if you receive any recovery related to your injuries or illness.
- The Plan’s rights under this section apply even if you die as a result of your injuries, if a third party is responsible to your survivors.

If a child receives benefits from the Plan for an illness or injury caused by a third party, then these rules apply to the parents, guardians, or other representatives of that child.

If you fail to meet your obligations under this section, the Plan may refuse to pay benefits for your injuries, may reduce your future benefits until the Plan has been fully repaid, or otherwise seek payment or reimbursement from you as otherwise permitted by applicable law.

Refund of Payments

Occasionally, benefits are paid more than once; are paid based upon improper billing or misstatement in a proof of loss or enrollment information; are not paid according to the *Plan's* terms, conditions, limitations, or exclusions; or should otherwise not have been paid by the *Plan*. As such this *Plan* may pay benefits that are later found to be greater than the *benefits payable*. In this case, this *Plan* may recover the amount of the overpayment from the source to which it was paid, primary payers, or from the party on whose behalf the charges(s) were paid. As such, whenever the *Plan* pays benefits exceeding the amount of benefits payable under the terms of the *Plan*, the *Plan Administrator* has the right to recover any such erroneous payment directly from the person or entity who received such payment and/or from other payers and/or the *plan participant or dependent* on whose behalf such payment was made.

A *plan participant, dependent, provider, another benefit plan, insurer, or any other person or entity* who receives a payment exceeding the amount of benefits payable under the terms of the *Plan* or on whose behalf such payment was made, shall return or refund the amount of such erroneous payment to the *Plan* within thirty (30) days of discovery or demand. The *Plan Administrator* shall have no obligation to secure payment for the expense for which the erroneous payment was made or to which it was applied.

The person or entity receiving an erroneous payment may not apply such payment to another expense. The *Plan Administrator* shall have the sole discretion to choose who will repay the *Plan* for an erroneous payment and whether such payment shall be reimbursed in a lump sum. When a *plan participant* or other entity does not comply with the provisions of this section, the *Plan Administrator* shall have the authority, in its sole discretion, to deny payment of any *claims* for benefits by the *plan participant* and to deny or reduce future benefits payable (including payment of future benefits for other *injuries or illnesses*) under the *Plan* by the amount due as reimbursement to the *Plan*. The *Plan Administrator* may also, in its sole discretion, deny or reduce future benefits (including future benefits for other *injuries or illnesses*) under any other

group benefits plan maintained by the *Plan Sponsor*. The reductions will equal the amount of the required reimbursement.

Providers and any other person or entity accepting payment from the *Plan* or whom a right to benefits has been assigned, in consideration of services rendered, payments, and/or rights, agrees to be bound by the terms of this *Plan* and agree to submit *claims* for reimbursement in strict accordance with their state's health care practice acts, ICD-10 or CPT standards, *Medicare* guidelines, HCPCS standards, or other standards approved by the *Plan Administrator*. Any payments made on *claims* for reimbursement not in accordance with the above provisions shall be repaid to the *Plan* within thirty (30) days of discovery or demand. If the *Plan* must bring an action against a *plan participant*, provider, or other person or entity to enforce the provisions of this section, then the *plan participant*, provider, or other person or entity agrees to pay the *Plan's* attorneys' fees and costs, regardless of the action's outcome.

Further, *plan participants* and/or their *dependents*, beneficiaries, estate, heirs, guardian, personal representative, or assigns (*plan participant*) shall assign or be deemed to have assigned to the *Plan* their right to recover said payments made by the *Plan*, from any other party and/or recovery for which the *plan participant(s)* are entitled, for or in relation to facility-acquired condition(s), provider error(s), or damages arising from another party's act or omission for which the *Plan* has not already been refunded.

The *Plan* reserves the right to deduct from any benefits properly payable under this *Plan* the amount of any payment which has been made:

1. In error
2. Pursuant to a misstatement contained in a proof of loss or a fraudulent act
3. Pursuant to a misstatement made to obtain coverage under this *Plan* within (2) years after the date such coverage commences
4. With respect to an ineligible person
5. In anticipation of obtaining a recovery if a *plan participant* fails to comply with the *Plan's* **Reimbursement, Subrogation, and Recovery Provisions**
6. Pursuant to a *claim* for which benefits are recoverable under any policy or act of law providing for coverage for occupational *injury* or *disease* to the extent that such benefits are recovered

This provision (6) shall not be deemed to require the *Plan* to pay benefits under this *Plan* in any such instance.

The *deduction* may be made against any *claim* for benefits under this *Plan* by a *plan participant* or by any of his/her covered *dependents* if such payment is made with respect to the *plan participant* or any person covered or asserting coverage as a *dependent of the plan participant*.

If the *Plan* seeks to recoup funds from a provider due to a *claim* being made in error, a *claim* being fraudulent on the part of the provider, and/or a *claim* that is the result of the provider's misstatement, said provider shall, as part of its *assignments of benefits* from the *Plan*, abstain from billing the *plan participant* for any outstanding amount.

Section 9: Changes to This Plan's Terms

Energy Transfer LP (as the Plan's sponsor) reserves the right to change, interpret, modify, withdraw or add benefits to, or terminate this Plan—at any time, in its sole discretion, and without your approval. Any amendments, changes, or termination are effective on the date specified by Energy Transfer LP. If the terms of this Plan or its costs change substantially, you may be given a right to change your enrollment selection mid-year.

If this Plan is terminated, your rights and benefits are limited to the healthcare services you incurred before termination. Energy Transfer LP may set a deadline for submission of claims after termination of the Plan.

Any amendment to or termination of the Plan will be made in writing, and you will receive notice of termination or any material modification to the Plan. No one has the authority to make any oral modification to this Plan's terms.

Disclosure Authorization

If you file a claim for benefits, it will be necessary that you authorize any health care Provider, insurance carrier, or other entity to furnish the Claim Administrator all information and records or copies of records relating to the diagnosis, treatment, or care of any individual included under your coverage. If you file claims for benefits, you and your Dependents will be considered to have waived all requirements forbidding the disclosure of this information and records.

Participant/Provider Relationship

The choice of a Participating Pharmacy health care Provider should be made solely by you or your Dependents. The Claim Administrator does not furnish prescription drugs services or supplies but only makes payment for Covered Drugs Eligible Expenses incurred by Participants. The Claim Administrator is not liable for any act or omission by any Participating Pharmacy. The Claim Administrator does not have any responsibility for a Participating Pharmacy's failure or refusal to provide prescription drugs or supplies to you or your Dependents. The Claim Administrator is not liable for any act or omission by any Participating Pharmacy health care Provider. The Claim Administrator does not have any responsibility for a health care Provider's failure or refusal to provide services or supplies to you or your Dependents. Care and treatment received are subject to the rules and regulations of the health care Provider selected and are available only for sickness or injury treatment acceptable to the health care Provider.

The Claim Administrator and Participating Pharmacies are independent contractors with respect to each other. The Claim Administrator in no way controls, influences, or participates in the drug dispensing decisions entered into by said Participating Pharmacies. The Claim Administrator does not furnish medical, surgical, hospitalization, or similar services or supplies, or practice medicine, dispense drugs, or treat patients. The Participating Pharmacies, their employees, their agents, their ostensible agents, and/or their representatives do not act on behalf of BCBSTX nor are they employees of BCBSTX.

Section 10: Plan Administration

Plan Information Summary

Plan name	Energy Transfer LP PPO plan, a component program under the Energy Transfer LP Health and Welfare Program for Active Employees
Plan sponsor's Employer Identification Number (EIN)	30-0108820
Plan number	506
Plan year	January 1 through December 31
Type of plan	Group health plan
Type of administration	Self-insured, with Collective Health serving as the third-party administrator
Plan administrator	Energy Transfer LP 1300 Main St, 15th Floor Houston, TX 77002 (713) 989-2161
Plan sponsor	Energy Transfer LP 1300 Main St, 15th Floor Houston, TX 77002
Agent for legal service	Energy Transfer LP 1300 Main St, 15th Floor Houston, TX 77002 Service of legal process may be made to the head of the legal department or to the Plan administrator.
Named fiduciary	Energy Transfer LP 1300 Main St, 15th Floor Houston, TX 77002

Medical claims administrator	Attn: Collective Health Claims Administrators Collective Health Administrators, LLC 1557 W Innovation Way, Suite 300 Lehi, UT 84043 855-399-5599 Not an insurer; does not guarantee benefits
Funding medium and contributions	This Plan is self-insured: benefits are paid from the general assets of the Plan sponsor (Energy Transfer LP) and not guaranteed under an insurance policy or contract. The operating expenses for this Plan are paid with contributions by the Plan sponsor (Energy Transfer LP) and contributions by participating employees. Employee contributions will be used first to cover benefits under the Plan.

Section 11: Legal Provisions and Your Legal Rights

Your ERISA Rights

As a participant in this plan, you are entitled to certain rights and protections under the Employee Retirement Income Security Act of 1974 (ERISA). ERISA provides that all Plan participants shall be entitled to:

- Receive information about your Plan and benefits

You may examine, without charge, at the Plan administrator's office and at other specified locations, all documents governing the Plan.

You may obtain, upon written request to the Plan administrator, copies of documents governing the operation of the Plan and updated benefit booklet. The Plan administrator may make a reasonable charge for the copies.

- Continue group health plan coverage

You may continue healthcare coverage for yourself, your spouse, or your dependents if there is a loss of coverage under the Plan as a result of a qualifying life event. You or your dependents may have to pay for such coverage. Review this benefit booklet and the documents governing the Plan on the rules governing your COBRA continuation coverage rights.

- Prudent actions by Plan fiduciaries

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

- Enforce your rights

If your claim for a welfare benefit is denied or ignored, in whole or in part, you have a right to know why this was done, to obtain copies of documents relating to the decision without charge, and to appeal any denial, all within certain time schedules.

Under ERISA, there are steps you can take to enforce the above rights. For instance, if you request a copy of Plan documents from the Plan and do not receive them within 30 days, you may file suit in a Federal court. In such a case, the court may require the Plan administrator to provide the materials and pay you up to \$110 a day until you receive the materials, unless the materials were not sent because of reasons beyond the control of the Administrator. If you have a claim for benefits which is denied or ignored, in whole or in part, you may file suit in a state or Federal court. In addition, if you disagree with the Plan's decision or lack thereof concerning the qualified status of a domestic relations order or a medical child support order, you may file suit in Federal court. If it should happen that Plan fiduciaries misuse the Plan's money, or if you are discriminated against for asserting your rights, you may seek assistance from the U.S. Department of Labor, or you may file suit in a Federal court. The court will decide who should pay court costs and legal fees. If you are successful, the court may order the person you have sued to pay these costs and fees. If you lose, the court may order you to pay these costs and fees, for example, if it finds your claim is frivolous.

- Assistance with your questions

If you have any questions about this Plan, you should contact the Plan administrator. If you have any questions about this statement or about your rights under ERISA, or if you need assistance in obtaining documents from the Plan administrator, you should contact the nearest office of the Employee Benefits Security Administration, U.S. Department of Labor, listed in your telephone directory or the Division of Technical Assistance and Inquiries, Employee Benefits Security Administration, U.S. Department of Labor, 200 Constitution Avenue N.W., Washington, D.C. 20210. You may also obtain certain publications about your rights and responsibilities under ERISA by calling the publications hotline of the Employee Benefits Security Administration.

Mental Health Parity and Addiction Equity

Pursuant to the Mental Health Parity and Addiction Equity Act of 2008, as amended, this Plan applies its terms uniformly and enforces parity between covered medical/surgical and covered mental health or substance use disorder benefits. Claims that are billed with a primary or principal diagnosis code categorized by the International Statistical Classification of Diseases and Related Health Problems (ICD-10) as a mental health condition, behavioral health condition, or substance use disorder are adjudicated as mental health claims. For further details, please contact Collective Health.

Genetic Information Nondiscrimination Act

This Plan will be operated and maintained in a manner consistent with the Genetic Information Nondiscrimination Act, which provides federal protection from genetic discrimination in health insurance and employment.

Affordable Care Act

This section describes some of the applicable provisions of the federal healthcare reform laws (known as the Affordable Care Act). These provisions have been incorporated into the Plan.

- You can cover your adult children to age 26.
- You do not need prior authorization to see an in-network OB/GYN provider.
- If your medical coverage requires you to designate a primary care physician, you have the right to designate any in-network primary care physician accepting new patients and may designate an in-network pediatrician for your children.
- You may seek emergency medical services at an in-network or out-of-network provider without having to obtain prior authorization and with the same cost sharing.
- Your medical coverage cannot be retroactively canceled, unless you fail to timely pay premiums or commit intentional misrepresentation or fraud or as otherwise permitted by applicable law. In other circumstances, you will generally be provided advance notice of cancellation.
- There are no pre-existing condition exclusions and no aggregate annual or lifetime limits on essential health benefits.

- You are not required to pay a co-payment or other cost sharing for in-network preventive and wellness services, such as routine exams, immunizations, mammograms, and routine baby care (see www.healthcare.gov for more information).
- The plan provides minimum value and is affordable as required under the Affordable Care Act.
- You may be entitled to external review of certain healthcare claims. More detailed information may be found in Section 5.

Appendix A: Information About the Extended Blues Network

This information is provided by Blue Cross and Blue Shield of Texas and describes benefits you may receive through the BlueCard Program.

Out-of-Area Services

Overview

The Administrator has a variety of relationships with other Blue Cross and/or Blue Shield Plans Licensees. Generally, these relationships are called Inter-Plan Arrangements and they work based on rules and procedures issued by the Blue Cross Blue Shield Association. Whenever you receive Services outside of Texas, the claims for these services may be processed through one of these Inter-Plan Arrangements described below.

When you access Covered Services outside of Texas, but within the United States, the Commonwealth of Puerto Rico, or the U. S. Virgin Islands (BlueCard® Service Area), you will receive the care from one of two kinds of providers. Participating providers contract with the local Blue Cross and/or Blue Shield Licensee in that other geographic area (Host Blue). Non-participating providers don't contract with the Host Blue. The Administrator's payment practices for both kinds of providers are described below.

Inter-Plan Arrangements

Emergency Services

Members who experience an Emergency Medical Condition while traveling outside of Texas should seek immediate care from the nearest Hospital. The Benefits of this Plan will be provided anywhere in the world for treatment of an Emergency Medical Condition.

BlueCard Program

Under the BlueCard® Program, benefits will be provided for Covered Services received outside of Texas, but within the BlueCard Service Area (the United States, Puerto Rico, and U.S. Virgin Islands). When you receive Covered Services within the geographic area served by a Host Blue, the Plan will remain responsible for providing the benefits described in this benefit booklet. However, the Host Blue is responsible for contracting with and generally handling all interactions with its participating healthcare providers, including direct payment to the provider.

The BlueCard Program enables you to obtain Covered Services outside of Texas, as defined, from a healthcare provider participating with a Host Blue, where available. The participating healthcare provider will automatically file a claim for the Covered Services provided to you, so there are no claim forms for you to fill out. You will be responsible for the member Copayment, Coinsurance and Deductible amounts, if any, as stated in this benefit booklet.

The Plan calculates the Member's share of cost either as a percentage of the Allowable Amount or a dollar Copayment, as defined in this booklet. Whenever you receive Covered Services outside of Texas, within the BlueCard Service Area, and the claim is processed through the BlueCard Program, the amount you pay for Covered Services, if not a flat dollar copayment, is calculated based on the lower of:

1. The billed charges for Covered Services; or
2. The negotiated price that the Host Blue makes available to the Plan.

Often, this "negotiated price" will be a simple discount that reflects an actual price that the Host Blue pays to your healthcare provider. Sometimes, it is an estimated price that takes into account special arrangements with your healthcare provider or provider group that may include types of settlements, incentive payments, and/or other credits or charges.

Occasionally, it may be an average price, based on a discount that results in expected average savings for similar types of healthcare providers after taking into account the same types of transactions as with an estimated price.

Estimated pricing and average pricing, going forward, also take into account adjustments to correct for over- or underestimation of modifications of past pricing of claims as noted above.

However, such adjustments will not affect the price the Plan used for your claim because these adjustments will not be applied retroactively to claims already paid.

Laws in a small number of states may require the Host Blue to add a surcharge to your calculation. If any state laws mandate other liability calculation methods, including a surcharge, we would then calculate your liability for any Covered Services according to applicable law.

To find participating BlueCard providers you can call BlueCard Access® at 1-800-810-BLUE (2583) or go online at www.bcbs.com and select “Find a Doctor”.

Prior authorization may be required for non-emergency services. To receive prior authorization, the out-of-area provider should call the provider customer service number noted on the back of your identification card.

Non-participating Providers Outside of Texas

When Covered Services are provided outside of Texas and within the BlueCard Service Area by non-participating providers, the amount you pay for such services will normally be based on either the Host Blue’s non-participating provider local payment, the Allowable Amount the Plan pays a Non-Participating Provider in Texas if the Host Blue has no non-participating provider allowance, or the pricing arrangements required by applicable state law. In these situations, you will be responsible for any difference between the amount that the non-participating provider bills and the payment the Plan will make for Covered Services as set forth in this paragraph.

If you do not see a participating provider through the BlueCard Program, you will have to pay the entire bill for your medical care and submit a claim to the local Blue Cross and/or Blue Shield plan, or to Collective Health directly for reimbursement. Collective Health will review your claim and notify you of the Plan’s coverage determination within 30 days after receipt of the claim; you will be reimbursed as described in the preceding paragraph. Remember, your share of cost is higher when you see a non-participating provider.

Federal or state law, as applicable, will govern payments for out-of-network Emergency Services. The Plan pays claims for covered Emergency Services based on the Allowable Amount as defined in this benefit booklet.

Prior authorization is not required for Emergency Services. In an emergency, go directly to the nearest hospital. Please notify the Administrator of your emergency admission within 24 hours or as soon as it is reasonably possible following medical stabilization.

Blue Shield Global® Core

Care for Covered Urgent and Emergency Services Outside the BlueCard Service Area

If you are outside of the BlueCard® Service Area, you may be able to take advantage of Blue Shield Global Core when accessing Out-of-Area Covered Health Care Services. Blue Shield Global Core is unlike the BlueCard Program available within the BlueCard Service Area in certain ways. For instance, although Blue Shield Global Core assists you with accessing a network of inpatient, outpatient, and professional providers, the network is not served by a Host Blue. As such, when you receive care from providers outside the BlueCard Service Area, you will typically have to pay the provider and submit the claim yourself to obtain reimbursement for these services.

If you need assistance locating a doctor or hospital outside the BlueCard Service Area you should call the service center at 1-800-810-BLUE (2583) or call collect at 1-804-673-1177, 24 hours a day, seven days a week. Provider information is also available online at www.bcbs.com: select “Find a Doctor” and then “Blue Shield Global Core”.

Submitting a Blue Shield Global Core Claim

When you pay directly for services outside the BlueCard Service Area, you must submit a claim to obtain reimbursement. You should complete a Blue Shield Global Core claim form and send the claim form along with the provider’s itemized bill to the service center at the address provided on the form to initiate claims processing. Following the instructions on the claim form will help ensure timely processing of your claim. The claim form is available from Collective Health, the service center or online at www.bcbsglobalcore.com. If you need assistance with your claim submission, you should call the service center at 1-800-810-BLUE (2583) or call collect at 1-804-673-1177, 24 hours a day, seven days a week.

Special Cases: Value-Based Programs

Claims Administrator Value-Based Programs

You may have access to Covered Services from providers that participate in a Value-Based Program. Claims Administrator Value-Based Programs include, but are not limited to, Accountable Care Organizations, Episode Based Payments, Patient Centered Medical Homes and Shared Savings arrangements.

BlueCard® Program

If you receive covered services under a Value-Based Program inside a Host Blue's service area, you will not be responsible for paying any of the Provider Incentives, risk-sharing, and/or Care Coordinator Fees that are a part of such an arrangement, except when a Host Blue passes these fees to Blue Shield through average pricing or fee schedule adjustments.