INDEPENDENT COLLEGES AND UNIVERSITIES BENEFITS ASSOCIATION, INC.

MEDICAL, BEHAVIORAL HEALTH, AND PRESCRIPTION DRUG PLAN DOCUMENT

April 1, 2024

THIS DOCUMENT IS FOR ALL EMPLOYEES AND OTHER BENEFICIARIES ELIGIBLE FOR BENEFITS UNDER THE INDEPENDENT COLLEGES AND UNIVERSITIES BENEFITS ASSOCIATION MEDICAL, BEHAVIORAL HEALTH, AND PRESCRIPTION DRUG PLAN

INDEPENDENT COLLEGES AND UNIVERSITIES BENEFITS ASSOCIATION, INC.

ORLANDO, FLORIDA

benefitsadministration@icuba.org

866-377-5102

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ARTICLE ONE: INTRODUCTION

The Independent Colleges and Universities Benefits Association, Inc. Medical, Behavioral Health, and Prescription Drug Plan (the "Plan") was adopted on April 1, 2003, by the seven founding Member Institutions of the Independent Colleges and Universities Benefits Association, Inc. ("ICUBA"). Currently, there are twenty-six participating Member Institutions. A complete list of the participating Member Institutions is provided in Article Eighteen.

The Plan document reflects the terms as of April 1, 2024. A current version of the Plan will always be available on ICUBA's website at http://ICUBAbenefits.org.

This document (referred to as the Plan Document) is intended to meet the requirements of the Employee Retirement Income Security Act of 1974 ("ERISA") and is designed to serve as both the official plan document and the Summary Plan Description required by Section 102 of ERISA. In addition, the Plan is a Voluntary Employees' Beneficiary Association and is intended to meet the requirements of Section 501(c)(9) of the Internal Revenue Code of 1986 (the "Code") and the Treasury Regulations promulgated thereunder, as amended from time to time.

The Plan is designed and administered exclusively for the benefit of eligible Participants and beneficiaries.

Oral statements or representations by anyone, which are contrary to this Plan Document are not authoritative sources of information and may not be relied upon.

Advice on Reading this Document

Some of the terms used in this Plan Document begin with a capital letter. These terms have special meaning under the Plan and are defined in the Glossary, which is located at the end of this Plan Document. Other capitalized terms used within this Plan Document may be defined within their relevant Article. When reading the provisions of the Plan, You can refer to the Glossary at the end of this Plan Document. Becoming familiar with the terms defined therein will give You a better understanding of the procedures and Benefits described herein.

Attached to the back of this Plan Document are riders reflecting additional benefit provisions. Depending upon Your Employer, these riders may or may not apply to You. It is important that You read the attached riders and determine whether they apply to You.

IMPORTANT INFORMATION ABOUT YOUR HEALTH COVERAGE

Under the Plan, the Benefits You receive will generally depend upon whether the Provider of the services is a Participating or Non-Participating Provider (i.e., in-Network versus out of network).

You will receive the maximum Benefits that can be paid if You use Participating Providers and You get Preauthorization, when required before receiving care.

With some exceptions, such as emergencies, the amount You must pay will increase when You do not use Participating Providers and if You do not get Preauthorization. **It is Your responsibility to verify that services have been authorized before services are received.**

Unless an exception protected by the No Surprises Act applies (which are described in more detail in the Plan), You will have no protection from balance billing from the Provider if You use a Non-Participating Provider.

Blue Cross Blue Shield of Florida (BCBSF) is the medical and pharmacy Claims Administrator for the Plan. BCBSF has retained BlueCross Blue Shield of South Carolina as a primary Provider of claims processing, customer service, medical management, wellbeing, as well as other services. Aetna is the behavioral health Claims Administrator for the Plan.

ARTICLE TWO: ADMINISTRATIVE SERVICE PROVIDERS, NETWORK DESCRIPTIONS, NO SURPRISES ACT, AND WELLNESS PROGRAM

The Plan has contracted with the following third-party administrative services providers to assist with the delivery of Benefits to Participants and Beneficiaries:

- BlueCross BlueShield of Florida (BCBSF) – Medical Benefits
- BlueCross BlueShield of Florida (BCBSF) – Prescription Drug Benefits (see Article Four)
- Aetna – Behavioral Health Benefits and Employee Assistance Plan (EAP)
- Teladoc – Telemedicine
- SurgeryPlus – supplemental expert surgeon benefit for Medically Necessary non-emergent surgical procedures
- Hinge Health – virtual exercise therapy program designed to address back, knee, hip, neck, shoulder, and other musculoskeletal pain.
- Virta – type 2 diabetes reversal program.

YOUR IDENTIFICATION CARDS

The Blue Cross and Blue Shield suitcase on Your BCBSF PPO Identification (ID) Card is recognized throughout the country. You are encouraged to carry Your ID Card with You at all times, destroy any previously issued cards, and show this card to the Hospital or other Professional Provider whenever You need Medical Care. This card covers RxBin, RxGroup, ICUBAcares, pharmacy help desk, and buy and bill services.

The Aetna ID card is recognized throughout the country. You are encouraged to carry Your ID Card with You at all times, destroy any previously issued cards, and show this card to the Hospital or other Professional Provider whenever You need Behavioral Health Care, Substance Use Disorder, and Autism treatment or care.

The SurgeryPlus ID card should be presented when using the supplemental expert surgeon benefit.

Non-English-speaking members have access to a translator by calling BCBSF Customer Service at 1-855-258-9029. Non-English-speaking members can access Behavioral Health and EAP care by utilizing the same phone numbers dedicated to the ICUBA programs 877-398-5816. This line allows members to speak with a team member speaking the primary language of the member.

When You or one of Your Dependents receives Professional health care services:

- Show Your BCBSF ID card to the Hospital or other Professional Provider and to the Pharmacy, show Your Aetna Behavioral Health ID card for Behavioral Health, Substance Use Disorder, and Autism services, and show Your SurgeryPlus ID card for surgical procedures if applicable.
- Ask the Provider to file a Claim for You.

The following information will be displayed on Your BCBSF ID Card:

- Your name;
- Your identification number;
- Customer Service toll-free number at 1-855-258-9029 or online at www.MyHealthToolkitFL.com;
- Precertification toll-free number at 1-888-376-6544;
- Aetna Behavioral Health, Mental Health, Substance Use Disorder, and Resources for Living Employee Assistance Program number at 1-877-398-5816 (Behavioral Health and Substance Use Disorder phone number is listed on the on back of BCBSF card and You will also receive a separate Aetna ID card); and
- PPO in “suitcase” symbol.

There is a logo of a suitcase with “PPO” inside it on Your BCBSF ID Card. This PPO suitcase logo lets Hospitals and Providers know that You are a member of a Blue Cross and Blue Shield PPO, and that You have access to PPO Providers nationwide and worldwide. For worldwide coverage when services are needed outside the United States, call BCBSF Global Core at 1-800-810-2583 or visit www.bcbsglobalcore.com.

The Aetna card includes:

- Verbiage at top of card that states "BEHAVIORALHEALTH & SUBSTANCE ABUSE COVERAGE ONLY"
- the Aetna website address www.aetna.com on the front of the card
- On the back of the card it states the following: "See your plan documents for all plan requirements, including precertification. In an emergency, seek care immediately or call 911. This card does not guarantee coverage."

ICUBA members have access to any provider within the ABH (Aetna Behavioral Health) PPO Network. The Aetna Behavioral Health offering is provided Nationwide. Behavioral Health service needs outside of the U.S. are available in emergency situations only, but are not available for standard, everyday service needs. Members would utilize the same phone numbers (877-398-5816) in these rare instances.

Protect Your Cards (BCBSF ID card and Aetna Behavioral Health ID card)

- If Your BCBSF ID card is lost or stolen, please contact BCBSF Member Services immediately at 1-855-258-9029.
- To request additional BCBSF ID cards, contact Member Customer Service at 1-855-258-9029 or request cards online by going to the BCBSF website at www.MyHealthToolkitFL.com.
- To request additional Aetna Behavioral Health ID cards, contact Aetna Member Services at 1-877- 398-5816.
- Only You or Your covered Dependents are permitted to use Your cards. It is illegal to loan Your cards to persons who are not eligible to use Your BCBSF Benefits and/or Aetna Behavioral Health Benefits, as applicable.

YOUR MEDICAL, BEHAVIORAL HEALTH AND PRESCRIPTION DRUG NETWORK

ICUBA offers a Medical Network, a Behavioral Health Network, and a Prescription Drug Network. All plans also have Non-Network Benefits as they are all PPO programs that allow You to get the care You want from the Provider You select. **It is important to utilize Network Benefits whenever possible to receive the maximum Benefit available to You.**

Medical Network Care (BCBSF): Network care is care You receive from Providers in the program's Network. This Network includes Primary Care Physicians and a range of Specialists, as well as Hospitals and a variety of treatment facilities in the communities where You live and across the country. To locate the Provider nearest You or to check that Your current Provider is in the Network, call Blue Card Access at 1-800-810-BLUE (1-800-810-2583) or go to www.MyHealthToolkitFL.com.

Behavioral Health and Substance Use Disorder Network (Aetna): Network care is care You receive from Providers in the program's Network. In order to determine if a Behavioral Health or Substance Use Disorder Provider is a Network Provider, You must logon to www.aetna.com then select Provider Search. **You may also contact Aetna Behavioral Health directly by calling 1-877-398-5816 for assistance.**

Prescription Drug Network: In order to determine if a Prescription Drug Provider is a Network Provider, logon to myhealthtoolkitfl.com and select Pharmacy Locater. **You may also call BCBSF at 1-855-258-9029.**

BCBSF and Aetna are required to confirm the list of Network Providers in their Provider directories every 90 days. If You can show that You received inaccurate information from BCBSF and/or Aetna that a Provider was listed as in-Network on a particular claim, then You will only be liable for Network cost-shares (i.e., Copayments, Deductibles, and/or Coinsurance) for that claim. Your Network cost-shares will be calculated based upon the Maximum Allowed Amount.

When You receive health care and behavioral health care through Network Providers, You enjoy maximum coverage and maximum convenience. You present Your ID Card to the Provider who submits Your Claim to BCBSF and/or Aetna, as applicable.

Non-Network Care

- Non-Network care is care You receive from Providers who are not in the Network.
- Even when You go outside of the Network, You will still be covered for eligible services. However, Your Benefits will be paid at lower, Non-Network levels.
- If You go to a BCBSF Traditional Indemnity Provider that is not in the PPO Network, You may have less of a financial obligation than going to a Non-Network Provider that does not participate in any BCBSF Network.

- You may be responsible for paying the difference, if any, between the Provider's actual charge and the BCBSF payment and/or Aetna payment, as applicable.
- You may be responsible for filing Your Claim.

NetworkBlue (BlueCard PPO)

- This Network is available only in the State of Florida.
- If You go outside the State of Florida for benefits, You may use the BCBSF Traditional Indemnity Provider as in-Network. Such claims submitted for services received from these Providers will be treated as in-Network under the NetworkBlue (BlueCard PPO) medical plan.

For help with a Claim or a question about Your Medical benefits, You can call 1-855-258-9029 or log onto BCBSF's website www.MyHealthToolkitFL.com. A BCBSF customer service representative can also help You with any coverage inquiry. Representatives are trained to answer Your questions quickly, politely, and accurately.

Aetna Behavioral Health and Resources for Living (EAP)

- The Aetna Behavioral Health Network and EAP Network are available Nationwide.
- ICUBA members have access to any provider within the ABH (Aetna Behavioral Health) PPO Network or EAP Network

For access or claims questions about your Behavioral Health, Substance Use Disorder benefits, ICUBA members can contact Aetna 24-hours a day on ICUBA's dedicated phone number 877-398-5816. Representatives are trained to answer Your questions quickly, politely, and accurately.

NO SURPRISES ACT

Consolidated Appropriations Act of 2021 (CAA)

The Consolidated Appropriations Act of 2021 (CAA) is a Federal law that includes the No Surprises Act as well as the Provider transparency requirements that are described below.

Surprise Billing Claims

Surprise Billing Claims are claims that are subject to the No Surprises Act requirements:

- Emergency Services provided by Non-Network Providers;
- Covered Services provided by a Non-Network Provider at a Network Facility; and
- Non-Network Air Ambulance Services.

Emergency Services

As required by the CAA, Emergency Services are covered under the Plan:

- Without the need for Precertification;
- Whether the Provider is Network or Non-Network;

If the Emergency Services You receive are provided by a Non-Network Provider, Covered Services will be processed at the Network benefit level.

Note that if You receive Emergency Services from a Non-Network Provider, Your Out-of-Pocket costs will be limited to amounts that would apply if the Covered Services had been furnished by a Network Provider. However, Non-Network cost-shares (i.e., Copayments, Deductibles and/or Coinsurance) will apply to Your claim if the treating Non-Network Provider determines You are stable, meaning You have been provided necessary Emergency Care such that Your condition will not materially worsen and the Non-Network Provider determines:

(i) that You are able to travel to a Network Facility by non- emergency transport;

(ii) (ii) the Non-Network Provider complies with the notice and consent requirement; and

(iii) (iii) You are in condition to receive the information and provide informed consent.

If You continue to receive services from the Non-Network Provider after You are stabilized, You will be responsible for the Non-Network cost-shares, and the Non-Network Provider will also be able to charge You any difference between the Maximum Allowed Amount and the Non-Network Provider's billed charges. This notice and consent exception does not apply if the Covered Services furnished by a Non-Network Provider result from unforeseen and urgent medical needs arising at the time of service.

Non-Network Services Provided at a Network Facility

When You receive Covered Services from a Non-Network Provider at a Network Facility, Your claims will be paid at the Non-Network benefit level if the Non-Network Provider gives You proper written notice of its charges, and You give written consent to such charges. This means You will be responsible for Non-Network cost-shares for those services and the Non-Network Provider can also charge You any difference between the Maximum Allowed Amount and the Non-Network Provider's billed charges. This requirement does not apply to Ancillary Services.

Ancillary Services are one of the following services:

(A) Emergency Services; (B) anesthesiology; (C) laboratory and pathology services; (D) radiology; (E) neonatology; (F) diagnostic services; (G) assistant surgeons; (H) hospitalists; (I) intensivists; and (J) any services set out by the U.S. Department of Health & Human Services. In addition, we will not apply this notice and consent process to You if BCBSF does not have a Network Provider in Your area who can perform the services You require.

Post-stabilization

Post-stabilization consists of a four-part test:

1. The attending Physician determines that the Covered Person is able to travel using nonmedical transportation to a Network Provider or Facility within a reasonable distance, taking into consideration the Covered Person's medical condition;
2. The Network Provider/Facility satisfies notice and consent criteria;
3. The Covered Person or his or her authorized representative must be in the condition to provide informed and voluntary consent; and
4. The Network Provider/Facility must satisfy any additional state law requirements.

Non-Network Providers satisfy the notice and consent requirement as follows:

- By obtaining Your written consent not later than 72 hours prior to the delivery of services; or
- If the notice and consent is given on the date of the service, if You make an appointment within 72 hours of the services being delivered.

How Cost-Shares Are Calculated

The Maximum Allowed Amount will be used to determine payment for Emergency Care from a Non-Network Provider. However, Your cost-share will be based on the median Plan Network contract rate paid to Network Providers for the geographic area where the service is provided.

Appeals

If You receive Emergency Services from a Non-Network Provider or Covered Services from a Non-Network Provider at a Network Facility and believe those services are covered by the No Surprises Act, You have the right to appeal that claim. If Your appeal of a Surprise Billing Claim is denied, then You have a right to appeal the adverse decision to an Independent Review Organization as set out in the Claims and Appeals Procedures section of this document.

Continuity of Care

In the event a Covered Person is a continuing care patient receiving a course of treatment from a Provider which is In-Network or otherwise has a contractual relationship with the Plan governing such care and that contractual relationship is terminated, not renewed, or otherwise ends for any reason other than the Provider's failure to meet applicable quality standards or for fraud, the Covered Person shall have the following rights to continuation of care.

The Plan shall notify the Covered Person in a timely manner, and that the Covered Person has rights to elect continued transitional care from the Provider. If the Covered Person elects in writing to receive continued transitional care, Plan benefits will apply under the

same terms and conditions as would be applicable had the termination not occurred, beginning on the date the Plan's notice of termination is provided and ending 90 days later or when the Covered Person ceases to be a continuing care patient, whichever is sooner.

For purposes of this provision, "continuing care patient" means an individual who:

1. is undergoing a course of treatment for a serious and complex condition from a specific Provider,
2. is undergoing a course of institutional or Inpatient care from a specific Provider,
3. is scheduled to undergo non-elective surgery from a specific Provider, including receipt of postoperative care with respect to the surgery,
4. is pregnant and undergoing a course of treatment for the Pregnancy from a specific Provider, or
5. is or was determined to be terminally ill and is receiving treatment for such illness from a specific Provider.

Note that during continuation, although Plan benefits will be processed as if the termination had not occurred and the law requires the Provider to continue to accept the previously-contracted amount, the contract itself will have terminated, and thus the Plan may be unable to protect the Covered Person if the Provider pursues a balance bill.

If a Covered Person is under the care of a Non-Network Provider at the time of joining the Plan, there are a limited number of medical conditions that may qualify for transition of care. If transitional care is appropriate, specific treatment by a Non-Network Provider may be covered at the Network level of benefits for a limited period of time. The Third Party Administrator will review and approve or deny such requests.

Transparency Requirements

BCBSF and Aetna provide at their websites, www.MyHealthToolkitFL.com and www.aetna.com protections with respect to Surprise Billing Claims by Providers, including information on how to contact state and federal agencies if You believe a Provider has violated the No Surprises Act. You can find this information directly at www.MyHealthToolkitFL.com and www.aetna.com.

You may also obtain the following information on BCBSF's and Aetna's websites or by calling the phone number on the back of Your BCBSF Identification Card, **1-855-258-9029**, for BCBSF, and by calling the phone number on the back of Your Aetna Identification Card, **1-877-398-5816**, for Aetna:

- Cost sharing information for 500 defined services, as required by the Centers for Medicare & Medicaid Services (CMS); and
- A listing / directory of all Network Providers.

In addition, BCBSF and Aetna will provide access through their websites to the following information:

- Network negotiated rates; and
- Historical Non-Network rates

OTHER PROVIDERS AND SERVICES

To find Embold Preferred Providers for Medical Services:

- Log in to **My Health Toolkit** and select the **Resources** tab
- Choose **Find a Doctor or Hospital**
- Enter Your location and the specialty type and then select **Search**
- Select **Embold Preferred Provider**

You may also call the number on the back of Your BCBSF identification card, **1-855-258-9029,** to talk to a customer service advocate for assistance in locating an Embold Preferred Provider.

Hinge Health: To access Hinge Health for musculoskeletal concerns call **1-855-902-2777** or send an email to: **hello@hingehealth.com.**

SurgeryPlus: To access the supplemental network of expert surgeons for non-emergent surgical procedures, contact SurgeryPlus at 1-855-200-2119 or logon to http://ICUBAbenefits.org and click the link for SurgeryPlus.

Virta: To check eligibility and book a consultation, visit virtahealth.com/join.icuba.

Care Connected: BCBSF provides You and Your Eligible Dependents with access to Care Connected, a program that provides health advocacy tailored to bridge the gap between care and Benefits, Provider, and patient, Hospital, and home. Covered Persons will receive support and individualized assistance provided by experienced health care and Benefit experts. Services include but are not limited to:

Assistance in locating Providers through the BlueCross Doctor and Hospital Finder

Guidance on accessing online tools for treatment options and cost estimates

Education about Health Plan Benefits and how they work

Research of current treatments

Resolution of health care claim disputes

Preparing for medical appointments (including help scheduling)

Arranging medical transportation

Navigating the BCBSF website

You can reach Care Connected 8:30am to 8:00pm, Monday-Thursday and 8:30am to 5:00pm on Fridays at 1-855-258-9029.

Aetna Resources for Living (EAP) and Behavioral Health and Substance Use Disorder: Aetna provides Concierge Services to all ICUBA members 24 hours a day through the dedicated phone number of 877-398-5816 helping members navigate through available Behavioral Health and Substance Use Disorder care options, as well as EAP needs.

Health Coach: Ready to get on track with Your health but not sure where to start? You don't have to figure it out on Your own. BCBSF's health coaches are here to help! It can feel overwhelming to live with a chronic condition. Health coaches can help You determine if You are seeing the right doctors and taking the right medications to keep Your symptoms in check. Your personal health coach can help You better understand Your condition and the steps You can take to achieve Your best health. BCBSF offers programs for chronic conditions such as:

Asthma

Coronary artery disease (CAD)

Congestive heart failure (CHF)

Chronic obstructive pulmonary disease (COPD)

- Diabetes
- Hypertension (high blood pressure)
- Hyperlipidemia (high cholesterol)
- Migraines

You can reach a Health Coach by calling 1-855-838-5897 (Coaches are available Monday through Thursday 8:30 AM-8:00 PM and on Friday, 8:30 AM-5:00 PM.) You may also log onto BCBSF's website directly at www.MyHealthToolkitFL.com, click the Wellness tab and then select Health Coaching. You may also log on through Your secure ICUBA portal at http://ICUBAbenefits.org. If You have questions about logging on to the http://ICUBAbenefits.org website, email benefitsadministration@icuba.org for assistance.

CancerCare: Finding out you have cancer can cause a flood of emotions. CancerCare offers a program, at no cost to you, that will provide support and coordination for your care throughout your cancer treatment. This program will link you with a personal case manager, a registered nurse with extensive experience in cancer care management. Coping with cancer can be complicated. You may need intensive treatments and changes to your lifestyle, medications, diet, and coping with symptoms during your treatment. Your case manager can:

- Coordinate care among all your providers. This can include your primary care physician, oncologists, second opinion, and others.
- Provide support, education, and how best to manage your needs during treatment, including diet education, symptom management, answering your questions, and advocating for you.
- Help arrange counseling to support your desired quality of life.

- Addressing complex social barriers that may impact your ability to get the best care.
- Help you manage the costs associated with your condition by making the most of your health insurance benefits.
- Your case manager will be your support and guide through your cancer journey.
- Your case manager will have that extra time you need to discuss your questions and coordinate your care you need.

You can reach an Oncology case manager by calling 1-800-790-5770 (case managers are available Monday through Friday 8:00 AM – 5:00 PM).

RenalCare: Coping with kidney failure can be complicated. You will need to make changes in your lifestyle, medications, and diet. RenalCare offers a program, at no cost to you, that will help coordinate your care, assist you in best managing your chronic condition while maintaining your best quality of life. This program will link you with your own personal case manager, a registered nurse with extensive hands-on experience with kidney disease. This program is available if you have been diagnosed with chronic kidney disease stage 4, stage 5, or end stage renal disease. Your case manager will assist you with:

- Securing and maintaining placement on the kidney transplant list.
- Education with maintaining a healthy lifestyle.
- Assistance with maintaining your diet and fluid intake.
- Collaborating with the dialysis clinic.
- Provide support, education, and how best to manage your needs during treatment, including diet education, symptom management, answering your questions, and advocating for you.
- Addressing complex social barriers that may impact your ability to get the best care.
- Help you manage the costs associated with your condition by making the most of your health insurance benefits.
- Your case manager will be your support and guide through this complex condition.
- Your case manager will have that extra time you need to discuss your questions and coordinate your care you need.

You can reach a Renal case manager by calling 1-800-790-5770 (case managers are available Monday through Friday 8:00 AM – 5:00 PM).

Maternity Care: Maternity Care is a confidential program that provides individualized support to expectant mothers based on answers to a maternity assessment survey. A maternity nurse will work with You and Your doctor to coordinate Your care and provide You with information to help You make the best decisions for You and Your baby. Covered Persons eighteen years of age and older who enroll in this program will receive a program kit. **For more information and to enroll call 1-855-838-5897.**

Telemedicine: Teladoc® provides access 24 hours a day, 7 days a week to a U.S. board-certified doctor through the convenience of phone, video, or Your mobile phone application.

You may call 1-800-Teladoc (855-2362) or login at www.Teladoc.com to request a consultation. Follow these easy steps to register for Teladoc®:

1. Visit: www.Teladoc.com
2. Register as a Member
3. Enter Your general information
4. Select "I do not have a username"
5. Enter Company Name: ICUBA

Once You have registered with Teladoc® You can access the website through BCBSF's website (as described below), and You can download the Teladoc® application on Your mobile device.

Telemedicine for Mental Health and Substance Use Disorder. Aetna Behavioral Health / Resources for Living provides a virtual care through a service called Meru which combines digital content and human support to offer coaching that focuses on stress,

resilience, and mental health prevention. There are face to face interactions through telephonic and texting capabilities and a coach is assigned to work with the member to complete the eight week program.

Talkspace is an online therapy platform that makes it easy and convenient for You to connect with a network of 2,500+ licensed therapists from anywhere, anytime. With Talkspace, You can send unlimited text, video, and audio messages to Your dedicated therapist, via web browser or talk through the Talkspace mobile app.

Aetna also provides access to virtual care through Resources for Living, Talkspace and AbleTo all of which can be accessed by calling 877-398-5816.

BCBSF'S Website: Visit www.MyHealthToolkitFL.com for a wide range of health-related information, interactive tools, and services. As a Covered Person, You have access to health and wellness information, user-friendly services related to Your health care coverage, and valuable tools for managing Your own health and well-being. Simply log onto www.MyHealthToolkitFL.com where You can:

- Utilize online self-service capabilities.
- Access a variety of services related to Your BCBSF coverage (e.g., find a Physician, review Claim Status, or order an ID card or Claim form).
- Ask questions by sending a secure message by logging in at www.MyHealthToolkitFL.com and then clicking "Contact Us" at the top of the screen to send the message and check for a response from Member Service.
- Access Health and Wellness Content and Tools, including a treatment cost estimator and Personal Health Record (PHR) – more than just a place to store Your health information. As Your Medical or Laboratory claims are processed, the information is automatically updated on Your PHR. You can print medication lists, add doctor appointments, and read up-to-date health and wellness articles.
- Access valuable online health resources: You can contact a Health Coach or read the "Healthier You" newsletter, review recent claims, link directly to Teladoc®, and access the Strive Wellbeing portal.

Aetna Websites:

- www.Aetna.com: provides members with details on all Behavioral Health Service Offerings available to ICUBA members.
- www.resourcesforliving.com: Provides access to Employee Assistance Program offering covering mental wellbeing needs, work- life services, legal and financial needs and more.
- Username: ICUBA Password: 8773985816

WELLBEING PROGRAM

The Strive platform Powered by Virgin Pulse is a digital health experience that gives You the tools and information to help make simple changes to Your daily routine, set smart goals, and stay on target. Covered Employees and spouses are eligible to earn up to $350 each, during the April 1 through March 31 Plan Year. Participants can earn electronic gift card credits through participation in wellbeing activities within the online portal, at campus events, at Your doctor's office or clinic, and by phone. Please see the chart outlining activities and incentives on the next page.

Activity to Complete	Incentives
Personal Health Assessment	Required to earn incentives
Biometric Screening	$100 Strive Cash
Health Check-Up	$50 Strive Cash
Strive Points	Up to $100 Strive Cash (based on points achievement)
Onsite	
Onsite Campus Event - up to ten events	$100 Strive Cash ($10 each)

How do I get credit for completing my biometrics in Strive?

It's easy to complete Your biometric screenings with Your regular blood work through Your annual wellness exam with a PCP. The Physician Results Form allows ICUBA Medical Plan members and covered spouses to earn credit for biometrics in Strive by completing

it as a part of Your annual wellness visit. Screenings will include total cholesterol, HDL/LDL, triglycerides, blood sugar, blood pressure, and A1c.

Employees and spouses enrolled in the ICUBA Medical Plan can visit Your individual portal at My.QuestForHealth.com and download the Physician Results Form.

If You have never registered before, please use:

- Registration Key: **ICUBA**
- Unique ID: **Your BCBSF ICI#**

The Physician Results Form contains a bar code specific to the employee or spouse and cannot be shared – it is unique to You!

Pro Tip: If You have an established relationship with Your physician, request Your blood work ahead of Your annual wellness exam to save time and check this off Your list with one visit.

When You visit Your PCP, remember to take the form with You to Your annual physical. It is important both You and Your doctor sign the Quest Physician Results Form; then Your doctor's office can fax it to the number found on the form.

You are encouraged to request a copy for Your records, and if necessary, upload/fax the form to Your Quest portal.

Members should allow at least 30 days after the form is uploaded/faxed to see credit in Strive.

Remember, the final deadline for submission to Quest is no later than March 31, 2024.

Need help registering, downloading/uploading forms, etc.? Please contact Quest Customer Service at 855-623-9355.

THESE REWARDS MAY BE SUBJECT TO TAXES

As such, it is Your responsibility to determine the tax obligations, if any, related to Your receipt of any rewards, and You are responsible for all applicable taxes. You should consult with an appropriate tax professional to determine if You have any tax obligations from receiving rewards under ICUBA's Wellbeing Program.

The Program is administered according to federal rules permitting employer-sponsored wellness programs that seek to improve employee health or prevent disease, including the Americans with Disabilities Act of 1990, the Genetic Information Nondiscrimination Act of 2008, and the Health Insurance Portability and Accountability Act, as applicable, among others. If You choose to participate in the Program, You will be asked to complete a Personal Health Assessment (PHA) that asks a series of questions about Your health-related activities and behaviors and whether You have or had certain medical conditions (e.g., cancer, diabetes, or heart disease, etc.). You will also be asked to complete a biometric screening, which will include a blood test for current blood sugar (glucose), total cholesterol, HDL cholesterol and total/HDL ratio.

VOLUNTARY WELLBEING PROGRAM

The wellness program is completely voluntary. You are not required to participate in the Program or to complete the Personal Health Assessment (PHA) Survey or the biometric screening. However, Employees and covered spouses who choose to participate in the Program will receive an incentive of up to $350 for completing identified objectives outlined in the Program. Although You are not required to participate in the Program or to complete the PHA or the biometric screening, only Employees who do so will receive the incentive identified in the Program.

The Plan will not discriminate against Participants or Beneficiaries who are eligible to participate in the Program and does not require individuals to meet any standards related to a health factor to obtain a reward, as specified in 29 CFR 2590.702(f)(2)(iii). Rewards for completion of a PHA are available regardless of whether the individual answers the questions regarding genetic information (e.g., family history, etc.).

Incentives of up to $350 Strive Cash may be available for Employees and covered spouses who participate in certain health-related activities or achieve certain health outcomes identified in the Program. If You are unable to participate in any of the health-related activities or achieve any of the health outcomes required to earn an incentive, You may be entitled to a reasonable accommodation or an alternative standard. The reasonable alternatives for the outcome-based incentives are outlined in the Program (e.g., on site campus events, missions, and challenges). You may request additional reasonable accommodation or alternative standard information by contacting ICUBA Benefits Administration at benefitsadministraton@icuba.org.

The information from Your PHA and the results from Your biometric screening will be used to provide You with information to help You understand Your current health and potential risks and may also be used to offer You services through the Well-being program, such as health coaching, lifestyle challenges and missions and community forums. You also are encouraged to share Your results or concerns with Your own doctor.

PROTECTIONS FROM DISCLOSURE OF MEDICAL INFORMATION RELATED TO THE WELLBEING PROGRAM

- We are required by law to maintain the privacy and security of Your personally identifiable health information. Although the Program, ICUBA and its Member Institutions may use aggregate information that is collected to design a program based on identified health risks in the workplace, the Program will never disclose any of Your personal information either publicly or to Your employer, except to the extent as permitted by law. Medical information that is provided in connection with the Program that personally identifies You will not be provided to Your employer, supervisors, or managers; and may never be used to make decisions regarding Your employment.
- Your health information will not be sold, exchanged, transferred, or otherwise disclosed except to the extent permitted by law to carry out specific activities related to the Program, and You will not be asked or required to waive the confidentiality of Your health information as a condition of participating in the Program or receiving an incentive. Anyone who receives Your information for purposes of providing You services as part of the program will abide by the same confidentiality requirements only after Your permission is granted, the only individual(s) who will receive Your personally identifiable health information are health coaches or case managers in order to provide You with services under the Program.
- In addition, all medical information obtained through the Program will be maintained separately from Your personnel records, and if stored electronically it will be encrypted. Appropriate precautions will be taken to avoid any data breach, and in the event a data breach occurs that involved information provided in connection with the Program, we will notify You immediately.
- You may not be discriminated against in employment because of the medical information You provide as part of participating in the Program, nor may You be subjected to retaliation if You choose not to participate. In addition, no information that You provide as part of the Program will be used in making any employment decision.
- If You have questions or concerns regarding this notice, or about protections against discrimination and retaliation, please contact ICUBA Benefits Administration at 1-866-377-5102.

My Health Novel

BCBSF continues to support My Health Novel, designed to match You with helpful resources and tools based on Your specific health needs. These services are available to all members who are enrolled in the BCBSF Medical Plan following completion of the My Health Novel assessment to determine the appropriate matching to the program. Some available programs include healthy weight management, diabetes prevention, and intensive behavioral counseling.

Log into My Health Toolkit to take the assessment and access the resources and tools.

ARTICLE THREE: SCHEDULE OF MEDICAL AND BEHAVIORAL HEALTH BENEFITS, INCLUDING EMPLOYEE ASSISTANCE PROGRAM, TELADOC, SURGERYPLUS, HINGE HEALTH, AND UTILIZATION REVIEW

All Benefits below are subject to the Plan's terms and conditions, including Deductibles, Coinsurance, Network discounts and Reasonable and Customary charges. Benefit percentages payable by the Plan may change depending upon whether Covered Services are obtained from a Network Provider. The list of Network Providers may change from time to time.

It is Your responsibility to verify that the Provider who is treating You is currently a Network Provider. If You receive services from a Provider outside the Network, You may be billed by the Provider for any charges not covered by the Plan. This is commonly referred to as balanced billing. Please see Article Two for information regarding the No Surprises Act and its application to Non-Network Providers and balanced billing in certain situations.

A list of Network Physicians, Hospitals and other health care Professionals may be found on the BCBSF website, by logging onto www.MyHealthToolkitFL.com or calling 1-855-258-9029. Remember to always confirm with the Provider or facility that they are in the BCBSF BlueCard PPO Network.

A list of Network Behavioral Health and Substance Use Disorder and other mental health care Professionals may be found on the Aetna website, www.aetna.com for outpatient Behavioral Health Services.

BCBSF and Aetna are required to confirm the list of Network Providers in their Provider directories every 90 days. If You can show that You received inaccurate information from BCBSF and/or Aetna that a Provider was listed as in-Network on a particular claim, then You will only be liable for Network cost-shares (i.e., Copayments, Deductibles, and/or Coinsurance) for that claim. Your Network cost-shares will be calculated based upon the Maximum Allowed Amount.

Locate EAP providers and access online services at www.resourcesforliving.com:

- Username: ICUBA
- Password: 8773985816

You may also call 1-877-398-5816 for assistance.

If You are unable to locate a Participating Provider in Your area who can provide You with a service or supply that is covered under this Plan, You must call the number on the back of Your ID Card for medical: (1-855-258-9029); or for Behavioral Health and Substance Use Disorder: (1-877-398-5816) to obtain authorization for non-Participating Provider coverage. If You obtain authorization for these services, the Benefits will be covered at the Network Participating Provider or Reasonable and Customary amount. In such cases, Your out-of-pocket charges will be the same as the Network out-of-pocket changes.

Aetna Behavioral Health is the provider of ICUBA's Mental Health, Substance Use Disorder, and Employee Assistance Program (EAP) Plan benefits. You do not access Mental Health or Substance Use Disorder services through BCBSF. You are automatically enrolled in the Mental Health and Substance Use Disorder benefits when You enroll in an ICUBA Health Plan. **Except in the case of an Emergency, all inpatient Mental Health and Substance Use Disorder treatments must be pre-certified by calling the toll free 24-hour number 1-877-398-5816 and speaking with a licensed counselor**. Claims and appeals can be filed to Aetna, P.O. Box 14079, Lexington, KY 40512-4079.

The Plan will provide Mental Health and Substance Use Disorder Benefits in accordance with the provisions of the Paul Wellstone and Pete Domenici Mental Health Parity and Addiction Equity Act of 2008 (MHPAEA) and generally will not impose less favorable benefit limitations on those Benefits than on the medical/surgical Benefits provided by the Plan.

PPO PLAN GUIDELINES

1. Deductible applies to all services except:

Network primary physician office, Specialist office, Outpatient Substance Use Disorder, Teladoc, Convenient Care Clinic, Urgent Care visits, outpatient diagnostic imaging, short-term rehabilitative therapy, and spinal manipulation services (refer to the Schedule of Benefits for applicable Copayment or Coinsurance).

Emergency room services and Urgent Care visits, where only the Copayment applies.

Medically Necessary emergency transportation, where only the Copayment applies.

Network independent clinical lab services performed at a Network physician's office located within a participating Network hospital or outpatient facility, where only the Coinsurance applies.

2. If there is a Copayment with a Deductible and Coinsurance Percentage, the Copayment applies first, then the Deductible and Coinsurance.

3. Deductibles, Medical Copayments and Coinsurance apply toward the Out-of-Pocket Maximum.

4. Out-of-Pocket Maximums and Deductibles are **not** combined for Network and Non-Network services and Out-of-Pocket Maximums are not available for use in another Plan should a Plan change occur during the Plan Year (April 1 to March 31) (e.g., because You experience a Change in Status that allows for a Plan change between Open Enrollment periods). In addition, treatment or dollar maximums do not carry over to another Plan during the same Plan Year (April 1 to March 31). Out-of-Pocket Maximums and Deductibles renew each Plan Year (April 1 to March 31), effective April 1.

5. Beneficiaries are financially responsible for all Non-Network bills more than Reasonable and Customary charges.

6. Covered Services obtained from a Non-Network Provider will be covered at Network percentages and rates if the Covered Person was referred to a Non-Network Provider by the treating Network Provider and only if there are no viable Network Providers available within a 50-mile radius. In such a case, the Covered Services are subject to receipt of a letter of Medical Necessity by the referring Network Provider. This may require advance approval from BCBSF or Aetna. All services billed by an in-Network facility will be paid at the in-Network benefit level.

7. Covered Services will also be considered at Network levels if an Accident, Injury, or Illness occurs, and immediate services are required inside or outside the Network service area.

8. Non-Network Providers of Ancillary Services such as assistant surgeons (paid at the assistant surgeon rate), lab, radiology, anesthesia, Durable Medical Equipment, and emergency room Physicians will be paid at the Network level when rendered at a Network facility, or if the services were performed outside the patient's control or election.

9. Network and Non-Network services apply to the same treatment maximum, wherever such a limitation occurs. Treatment maximums do not carry over to another Plan during the Plan Year (April 1 to March 31).

10. Transplant Benefit: There is a $10,000 per transplant Benefit for travel, meals, and lodging for the transplant recipient and travel companion. All expenses must be pre-approved by BCBSF Care Management Services.

GUIDE TO BENEFITS CHART

When reading the Benefit Plan designs offered by ICUBA, it will be important to understand the following terms (especially in reference to the following pages).

Deductible - There is an annual (April 1 to March 31) Plan Year Deductible per person enrolled in the Plan. Each Plan Year there is a new Deductible. The Family Deductible can be satisfied by combining Covered Expenses from each covered Family member. However, each Covered Person cannot contribute more than one Individual Deductible amount to the Family Deductible.

Coinsurance - Coinsurance is the percentage of the covered charges paid by You for services rendered. For example, the Plan may pay 80%, and You pay 20%, respectively. Copayments do not reduce the amount of eligible medical expenses subject to Coinsurance.

Out-of-Pocket Maximum - The Medical/Behavioral Health Out-of-Pocket Maximum is comprised of the maximum amount of Deductible, Medical and Behavioral Health Copayments and Coinsurance during any Plan Year (April 1 to March 31) that a Covered Person or Family must pay before the Plan pays 100% of Covered Expenses for the Plan Year (April 1 to March 31). Prescription Drug Copayments accrue to the Prescription Drug Out-of-Pocket Maximum (See Article Four).

Copayments - The copayment is always due when service is rendered. Medical and Behavioral Health copayments accrue to the Medical/Behavioral Health Out-of- Pocket Maximum and Prescription Drug Copayments accrue to the Prescription Drug Out-of-Pocket Maximum.

Physician Office Visits - This is a visit to a Physician who is a family, internist, OB/GYN, or pediatric Physician. These Physicians provide a broad range of preventive medical services and recommend patients to Specialists, Hospitals, and other Providers, as necessary.

Specialist Office Visits - These are visits to Physicians whose practice is limited to treating a specific disease (e.g., oncologists), specific parts of the body (e.g., ear, nose, and throat), a specific age group other than children (e.g., gerontologist), or specific procedures (e.g., oral surgery). You may obtain services directly from a Specialist and do not need to be referred by a Primary Care Physician.

OTHER TERMS YOU SHOULD KNOW

Allowable Charge (also called "Provider's Reasonable Charge") - The dollar amount that Your PPO has determined is reasonable for Covered Services provided under Your program. This is an important term to know if You go outside the Network for care. The amount Your program pays for Non-Network care is based on the Allowable Charge—not the Provider's actual charge.

Autism Spectrum Disorder - Aetna Behavioral Health offers access to Applied Behavioral Analysis (ABA) for Participants (children who have yet to reach 26 years of age) diagnosed with Autism or other pervasive developmental disorders. The Autism benefit covers treatment of Autism through speech therapy, occupational therapy, physical therapy, and applied behavioral analysis. In concert with Your child's physician or psychologist, Aetna's trained clinicians can help You sort through the available treatments and ensure Your child receives the most appropriate care. If Your child has been diagnosed with Autism, please contact Aetna at 1-877-398-5816 for more information on the services available and the steps necessary to receive authorization. ABA services require prior authorization. Aetna will authorize up to 25 hours per week for six months. Additional hours will require additional authorization.

Embold Health Preferred Providers

A subset of Providers within the BCBSF Network, ranked as top-quality doctors.

Embold Health Preferred Providers have been thoroughly evaluated based on appropriateness of care, effectiveness, and cost.

Embold Health Preferred Providers are available for Primary Care, Pediatrics, Cardiology, Endocrinology, Joint Care (Orthopedic), Gastroenterology, Obstetric, Pulmonology, and Spine Care (Orthopedic/Neurosurgical), and Dermatology.

If You see an Embold Preferred Provider, Your office visit copayment is waived.

Total Care Designation - This is a recognized family practice, internal medicine, or pediatric medicine Provider who has demonstrated a commitment to deliver quality patient-centered care by BCBSF and the National Committee on Quality Assurance (www.ncqa.org). Such physicians will display Total Care indicators on the Doctor and Hospital Finder as part of the www.MyHealthToolkitFL.com website. The plan pays 100% of all office visits to a Total Care provider for You and Your enrolled family members if treatment is provided by a Total Care designated family practice, internal medicine, or pediatric physician. Previously branded, Blue Distinction Total Care (BDTC).

Claim - There are three types of Claims You may make on the Plan: Pre-Service Claim, Urgent Care Claim, and Post-Service Claim.

Pre-Service Claim – This is a request for Precertification or prior approval of a Covered Service, which under the terms of Your coverage, must be approved **before** You receive the Covered Service. All Inpatient Services at a Hospital or other facility must be Pre-certified. A Network Provider will take care of the Pre-Service Claim. If You use a Non-Network Provider, You are responsible to submit the Pre-Service Claim.

To ensure that the proposed elective treatment You are scheduling is a covered expense, Your doctor can request a Voluntary Pre-Service Review to help You make better-informed decisions. These are non-life-threatening-non-emergency services that may not be covered under the ICUBA Plan. By asking Your doctor to request a pre-service review, You'll know in advance the costs You may be responsible for. Together You and Your doctor or health care Provider can choose the best approach for Your individual needs. Some of the procedures available for pre-service review include breast reduction mammoplasty, rhinoplasty, and TMJ surgery. Ask Your doctor beforehand!

Urgent Care Claim – This is a Pre-Service Claim that, if decided within the time periods established for making a non-Urgent Care Pre-Service Claim decision could seriously jeopardize Your life, health, or ability to regain maximum function or, in the opinion of a Physician with knowledge of Your medical condition, would subject You to severe pain that cannot be adequately managed without the service.

Post-Service Claim – This is a request for payment or reimbursement of the charges or costs associated with a Covered Service that You have already received. These are typical Claims. If You use a Network Provider, Post-Service Claims will be submitted by the Provider. If You use a Non-Network Provider, You will be responsible for submitting the Post-Service Claim.

Experimental or Investigative - The use of any Experimental or Investigative treatment, service, procedure, facility, equipment, drug, device, or supply (collectively, Intervention) that is determined by The Plan to not be medically effective for the condition being treated will not be covered. The Plan will consider an Intervention to be Experimental or Investigative if: (1) the Intervention does not have FDA approval to be marketed for the specific relevant indication(s); (2) available scientific evidence does not permit conclusions concerning the effect of the Intervention on health outcomes; (3) the Intervention is not proven to be as safe and as effective in achieving an outcome equal to or exceeding the outcome of alternative therapies; (4) the Intervention does not improve health outcomes; or (5) the Intervention is not proven to be applicable outside the research setting. **If an Intervention, as defined above, is determined to be Experimental or Investigative at the time of the service, it will not receive retroactive coverage, even if it is found to be in accordance with the above criteria later.**

The Plan recognizes that situations may occur when You elect to pursue Experimental or Investigative treatment. If You are to receive a service that the Plan may consider to be Experimental or Investigative, You or the Hospital and/or Provider may contact BCBSF's Member Service (1-855-258-9029), BCBSF's Essential Advocate team (1-888-521-2583), and/or Aetna Behavioral Services (1-877-398-5816) to determine whether the Plan considers such service to be Experimental or Investigative. If the Plan determines the treatment is Experimental or Investigative, the treatment will **not** be covered.

Medically Necessary and Appropriate - Services or supplies provided by a Provider are Medically Necessary and Appropriate if the Plan determines they are: (1) appropriate for the symptoms and diagnosis or treatment of Your condition, Illness, disease or Injury; (2) provided for the diagnosis or the direct care and treatment of Your condition, Illness, disease or Injury; (3) provided in accordance with standards of good medical practice; (4) not primarily for Your or Your Provider's convenience; and (5) the most appropriate level of service or supply that can safely be provided to You. When applied to hospitalization, this further means that You require acute care as an Inpatient due to the nature of the services that must be rendered for Your condition, and You cannot receive safe or adequate care as an Outpatient. The Plan reserves the right to determine, in its sole judgment, whether a service is Medically Necessary and Appropriate. No Benefits will be provided unless the Plan determines that the service or supply is Medically Necessary and Appropriate.

Precertification (also referred to as Preauthorization or Prior Authorization) - This is the process through which certain services are pre-approved and the Covered Person is covered for services.

All Inpatient services at a Hospital or other facility must be Pre-certified by calling BCBSF's Admission Notification at 1-888-376-6544.

All Inpatient services at a Behavioral or Substance Use Disorder facility must be Pre-certified by calling Aetna at 1-877-398-5816. To be Pre-certified for Inpatient Adult Rehabilitation for a substance-related disorder, demonstration of alternative levels of care such as Partial Hospitalization must have been attempted and relapse has occurred within 6 months of You or Your Dependent's active participation in such a program.

All Outpatient Diagnostic Imaging including MRI, MRA, CAT, and PET scans received in an Outpatient facility must be Pre-certified by calling BCBSF at 1-866-500-7664.

Some drugs may require prior authorization. You can determine whether prior authorization is required by calling BCBSF at 1-855-258-9029.

Specialty Medications received through the Plan such as medications that are injected or infused by an Outpatient Hospital, Outpatient Facility (such as an infusion center), or at a Provider's office must be Pre-certified by calling 1-888-376-6544. It is Your responsibility to verify precertification has been obtained before You receive treatment or services.

Preferred Provider Organization (PPO) Program - This is a program that does not require the selection of a Primary Care Physician but is based on a Provider Network made up of Physicians, Specialists, Hospitals, and other health care facilities. Using this Provider Network helps ensure that Covered Persons receive maximum coverage for eligible services. All ICUBA medical and behavioral health plans are PPOs.

Teladoc (Telehealth Medical Services) - Teladoc gives You access to quality medical care through phone and video consultations with board certified Internal Medicine, Family Practice or Pediatric physicians 24 hours per day, 365 days per year. Adult and pediatric care is available. You can easily set up an account by visiting www.Teladoc.com. You will need Your BCBSF medical ID card to started, then simply log on to the secure www.Teladoc.com website and click "Set Up Account" then enter Your information, including medical history and prescription history, so that You will save time during Your consultation.

Teladoc may be used when You need immediate care for non-emergent medical issues

To request a consult, visit the Teladoc website, log in to Your account and click “Request a Consult” You can also call Teladoc at 800-835-2362 to consult by phone

Median time for a Physician call back is 10 minutes

There is no time limit for consultations

Teladoc physicians can prescribe short-term medications for a wide range of conditions when medically appropriate (Teladoc does not prescribe medications controlled by the DEA, or other drugs which may be harmful because of their potential for abuse)

When You pick up prescribed medications from the pharmacy, You may use Your prescription drug insurance card to help pay for the medication

It is recommended that You provide consultation information from the Teladoc physician to Your regular doctor – You can download the information from Your online account, or call Teladoc and ask them to mail or fax Your medical record

SCHEDULE OF BENEFITS – PREFERRED PPO

Benefits	Preferred PPO Network Covered Person Pays	Preferred PPO Non-Network Covered Person Pays
Deductible Individual Family	$3,000/$6,000	$4,500/$11,750
Coinsurance	20% after Deductible	40% after Deductible
Lifetime Maximum	NO MAXIMUM	
Out-of-Pocket Maximums *(includes deductible, coinsurance, and medical copayments)* Individual Family	$5,000 $10,000	$8,500 $17,000
Physician Office Visits (Internal Medicine, Family Practice, Pediatrician, OB/GYN)	$15 Copayment; Deductible does not apply	40% after Deductible
Total Care Primary Physician Office Visit (Internal Medicine, Family Practice and Pediatrician only) **Embold Provider Office Visit** (Primary Care, Pediatrician, Cardiology, Obstetrics, Joint Care, Spine Care, Endocrinology, Gastroenterology, and Pulmonology)	$0; Deductible does not apply	N/A
Teladoc Telemedicine Visit	$5 Copayment; Deductible does not apply	N/A
Convenient Care Clinic (Retail) CVS Minute Clinic, Walgreens, etc.	$10 Copayment; Deductible does not apply	NA
Maternity Office Visit[1] (Initial OB visit only)	$15 Copayment; Deductible does not apply	40% after Deductible
Specialist Office Visits	$35 Copayment; Deductible does not apply	40% after Deductible
Independent Clinical Labs Free standing facilities office visits[2] Outpatient Facility (Hospital setting)[3]	$0; Deductible does not apply 20%, Deductible does not apply	40% after Deductible 40% after Deductible
Urgent Care Facility[4]	$30 Copayment; Deductible does not apply	
Preventive Care[5] **Annual Physical and Gynecological Exam**	$0; Deductible does not apply	Not Covered
Preventive Care[5] **Adult and Pediatric Approved Immunizations and Venipunctures**	$0; Deductible does not apply	Not Covered
Pap Tests[2]	$0; Deductible does not apply	Not Covered
Related Wellness Services (e.g., Colorectal Screenings, Colonoscopies, Sigmoidoscopies, Electrocardiograms, Echocardiograms and Bone Mineral Density Tests)	$0; Deductible does not apply	Not Covered
Prostate Cancer Screenings (PSA)[2]	$0; Deductible does not apply	Not Covered
Mammograms and Breast Ultrasounds	$0; Deductible does not apply	Not Covered
Chlamydia and STD tests[2]	$0; Deductible does not apply	Not Covered
Allergy Injections	$0; Deductible does not apply	40% after Deductible

Benefits	Preferred PPO Network Covered Person Pays	Preferred PPO Non-Network Covered Person Pays
General Health Blood Panel, Glucose Test, Lipids Panel, Cholesterol, and ALT/AST[2]	$0; Deductible does not apply	Not Covered
Medical Contraception — IUD devices and tubal ligations	$0; Deductible does not apply	Not Covered
Venipunctures/ Conveyance Fee	$0; Deductible does not apply	Not Covered
Urinalysis [2]	$0; Deductible does not apply	Not Covered
Emergency Room Services[4]	0% after $500 Copayment (waived if admitted); Deductible does not apply	
Medically Necessary Emergency Transportation	0% after $250 copayment; Deductible does not apply	
Hospital Expenses Inpatient[6]	20% after Deductible	40% after Deductible
Hospital Expenses Outpatient	20% after Deductible	40% after Deductible
Outpatient Surgery Office Setting – Physician Office Setting – Specialist Outpatient Facility -- Related Professional Services	 20%; Deductible does not apply 20%; Deductible does not apply 20% after Deductible 20% after Deductible	 40% after Deductible 40% after Deductible 40% after Deductible 40% after Deductible
Infertility Services *(counseling and testing to diagnose)*	20% after Deductible	40% after Deductible
Assisted Fertilization Procedures	**Not Covered**	
Spinal Manipulations	$20; Deductible does not apply	40% after Deductible
	Limit: 60 visits / benefit period	
Diagnostic Services Lab Tests[2] X-ray and other tests	 $0; Deductible does not apply 20% after deductible	 40% after Deductible 40% after Deductible
Outpatient Diagnostic Imaging[10] (MRI, MRA, CAT Scan, PET Scan)	The lesser of allowed charges or $500 Copayment; Deductible does not apply	40% after Deductible
Outpatient Physical Therapy	$20; Deductible does not apply	40% after Deductible
	Limit: 60 visits per benefit period	
Outpatient Speech Therapy *(Restorative only)*	$20; Deductible does not apply	40% after Deductible
	Limit: 60 visits per benefit period	
Outpatient Occupational Therapy	$20; Deductible does not apply	40% after Deductible
	Limit: 60 visits per benefit period	
Cardiac Rehabilitation	20% after Deductible	40% after Deductible
Chemotherapy	20% after Deductible	40% after Deductible
Dialysis Treatment	20% after Deductible	40% after Deductible
Infusion Therapy [11, 12]	20% after Deductible	40% after Deductible
Radiation Therapy	20% after Deductible	40% after Deductible
Respiratory Therapy	20% after Deductible	40% after Deductible
Durable Medical Equipment (Medical Necessity Required)	20% after Deductible	40% after Deductible
Enteral Formulae	20% after Deductible	40% after Deductible
Prosthetic Appliances	20% after Deductible	40% after Deductible
Skilled Nursing Facility[6]	20% after Deductible	40% after Deductible
	Limit: 60 days / benefit period	
Inpatient Rehabilitation[6]	20% after Deductible	40% after Deductible
	Limit: 60 days / benefit period	

Benefits	Preferred PPO Network Covered Person Pays	Preferred PPO Non-Network Covered Person Pays
Home Health Care Medical Necessity Required (unlimited days per Plan Year (April 1 to March 31); 16 hours per day maximum)	20% after Deductible	40% after Deductible
Private Duty Nursing	20% after Deductible	40% after Deductible
Hospice Inpatient and Outpatient Care	0%; Deductible does not apply	40% after Deductible
Transplant Services	20% after Deductible	40% after Deductible
Hearing aid screening/exam	20%; Deductible does not apply	
Hearing Aid	20% after In-Network Deductible Limit: $1,500 / benefit period for exam and hearing aids	
Temporomandibular Joint Disorder (TMJ) (*Medical Necessity required; excludes appliances and orthodontic treatment*)	20% after in-network Deductible	40% after Deductible
EAP, Mental Health, Substance Use Disorder Benefits and Applied Behavioral Analysis (ABA) are administered by Aetna Behavioral Health, You can reach Aetna 24-hours a day at 877-398-5816. **Deductible and Out-of-Pocket for Behavioral Health is combined with Deductible and Out-of-Pocket for Medical through BlueCross BlueShield to meet the benefit year Deductible and Out-of-Pocket listed at the beginning of this Schedule of Benefits.**		
Employee Assistance Program[9] (EAP) Up to six short-term counseling sessions per episode, per year with a licensed clinician (episodes include stress, grief, relationship issues, etc.)	$0	Not covered
Mental Health Inpatient[6]	20% after in-Network Deductible	40% after Deductible
Residential[6] Residential services focus on evaluating and stabilizing the patient. They can help the patient learn effective ways to cope with the symptoms and impact of the patient's illness. Patients typically stay as needed to prepare for a successful transition into outpatient services.	20% after Deductible	40% after Deductible
Mental Health Outpatient professional counseling office visits	$15; Deductible does not apply	40% after Deductible
Psychiatric Medical Evaluation (to determine the necessity for medication)	$15, Deductible does not apply	40% after Deductible
Applied Behavioral Analysis Therapy[6] Behavioral health services related to Autism Spectrum Disorder (ASD) diagnosis. **Requires Authorization.**	$15, Deductible does not apply	40% after Deductible
Partial Hospitalization[6] These programs are longer and more intensive than an Intensive Outpatient Program (IOP), usually 4-6 hours per day, 5-7 days a week. Services are designed to address mental health and/or substance use disorder-related disorders. They include physician and nursing services as well as group, individual, family, or multi- family group psychotherapy, psycho-educational services, and other services.	$15, Deductible does not apply	40% after Deductible

Benefits	Preferred PPO Network Covered Person Pays	Preferred PPO Non-Network Covered Person Pays
(Often used in lieu of an inpatient stay, or as a transition from an inpatient stay.)		
Intensive Outpatient Sessions (IOP) These planned and structured programs are usually 2-3 hours /day (or evening), and 3-7 days per week. Programs are designed to address mental health or a substance use disorder-related disorder. They may include group, individual, family, or multi- family group psychotherapy, psycho-educational services, and other services.	$15, Deductible does not apply	40% after Deductible
AbleTo [13] 8-week program for select conditions	$0	Not covered
Substance Use Disorder Inpatient [6,8]	20% after Deductible	40% after Deductible
Inpatient Detoxification[6] Inpatient detoxification provides 24-hour treatment in a residential or hospital setting for patients who are abusing alcohol or other physically addictive drugs. This level of care provides medical services and physician supervision. Patients typically stay in detoxification only if their withdrawal symptoms require 24-hour medical and nursing services. Detoxification services include preparation for transition to the next level of care in the process of recovery.	20% after Deductible	40% after Deductible
Substance Use Disorder Outpatient Office	$15; Deductible does not apply	40% after Deductible
Outpatient Detoxification These programs offer outpatient services that monitor withdrawal from alcohol or another substance of abuse. Providers can administer medications that assist with detoxification and recovery from addiction.	$15; Deductible does not apply	40% after Deductible

SCHEDULE OF BENEFITS – HIGH DEDUCTIBLE PPO PLAN

Benefits	High Deductible PPO Plan Network	High Deductible PPO Plan Non-Network
	Covered Person Pays	Covered Person Pays
Deductible Individual Family	 $4,500 $9,000	 $8,500 $17,000
Coinsurance	30% after Deductible	50% after Deductible
Lifetime Maximum	No Maximum	
Out-of-Pocket Maximums *(includes deductible, coinsurance, and medical copayments)* Individual Family	 $6,350 $11,700	 $11,700 $23,400
Physician Office Visits (*Internal Medicine, Family Practice, Pediatrician, OB/GYN*)	0% after $15 Copayment; Deductible does not apply	50% after Deductible
Total Care Primary Physician Office Visit *(Internal Medicine, Family Practice, and Pediatrician only)*	0%; Deductible does not apply	N/A
Teladoc Telemedicine Visit	0% after $5 Copayment; Deductible does not apply	N/A
Convenient Care Clinic (Retail) (CVS Minute Clinic, Walgreens, etc.)	0% after $10 Copayment; Deductible does not apply	N/A
Maternity Office Visit[1] (Initial OB visit only)	0% after $15 Copayment; Deductible does not apply	50% after Deductible
Specialist Office Visits	0% after $35 Copayment; Deductible does not apply	50% after Deductible
Independent Clinical Labs Free standing facilities office visits[2] Outpatient Facility (Hospital setting)[3]	 0%; Deductible does not apply 30%, Deductible does not apply	 50% after Deductible 50% after Deductible
Urgent Care Facilty[4]	0% after $30 Copayment; Deductible does not apply	
Preventive Care[5] **Annual Physical and Gynecological Exam**	0%; Deductible does not apply	Not Covered
Preventive Care[5] **Adult and Pediatric Approved Immunizations and Venipunctures**	0%; Deductible does not apply	Not Covered
Pap Tests[2]	0%; Deductible does not apply	Not Covered
Related Wellness Services (e.g., Colorectal Screenings, Colonoscopies, Sigmoidoscopies, Electrocardiograms, Echocardiograms and Bone Mineral Density Tests)	0%; Deductible does not apply	Not Covered
Mammograms and Breast Ultrasounds	0%; Deductible does not apply	Not Covered
Chlamydia and STD tests2	0%; Deductible does not apply	Not Covered
Allergy Injections	0%; Deductible does not apply	50% after Deductible
General Health Blood Panel, Glucose Test, Lipids Panel, Cholesterol, and ALT/AST [2]	0%; Deductible does not apply	Not Covered
Medical Contraception — IUD devices and tubal ligations	0%; Deductible does not apply	Not Covered
Venipunctures/ Conveyance Fee	0%; Deductible does not apply	Not Covered
Urinalysis [2]	0%; Deductible does not apply	Not Covered
Emergency Room Services[4]	0% after $500 Copayment (waived if admitted); Deductible does not apply	
Medically Necessary Emergency Transportation	0% after $250 copayment; Deductible does not apply	

Benefits	High Deductible PPO Plan Network	High Deductible PPO Plan Non-Network
	Covered Person Pays	Covered Person Pays
Hospital Expenses Inpatient[6]	30% after Deductible	50% after Deductible
Hospital Expenses Outpatient	30% after Deductible	50% after Deductible Outpatient Surgery
Office Surgery Office Setting - Physician	0% after $15 Copayment; Deductible does not apply	50% after Deductible
Outpatient Surgery Office Setting - Specialist	0% after $35 Copayment; Deductible does not apply	50% after Deductible
Outpatient Facility	30% after Deductible	50% after Deductible
Related Professional Services	30% after Deductible	50% after Deductible
Infertility Services *(counseling and testing to diagnose)*	30% after Deductible	50% after Deductible
Assisted Fertilization Procedures	Not covered	
Spinal Manipulations	0% after $20 Copayment; Deductible does not apply	50% after Deductible
	Limit: 60 visits / benefit period	
Diagnostic Services Lab tests[2] X-ray and other tests	0%; Deductible does not apply 30% after Deductible	50% after Deductible 50% after Deductible
Outpatient Diagnostic Imaging[10] (MRI, MRA, CAT Scan, PET Scan)	The lesser of allowed charges or $500 Copayment; Deductible does not apply	50% after Deductible
Outpatient Physical Therapy	$20 Copayment; Deductible does not apply	50% after Deductible
	Limit: 60 visits / benefit period	
Outpatient Speech Therapy (restorative services only)	$20 Copayment; Deductible does not apply	50% after Deductible
	Limit: 60 visits / benefit period	
Outpatient Occupational Therapy	$20 Copayment; Deductible does not apply	50% after Deductible
	Limit: 60 visits / benefit period	
Cardiac Rehabilitation	30% after Deductible	50% after Deductible
Chemotherapy	30% after Deductible	50% after Deductible
Dialysis Treatment	30% after Deductible	50% after Deductible
Infusion Therapy[11, 12]	30% after Deductible	50% after Deductible
Radiation Therapy	30% after Deductible	50% after Deductible
Respiratory Therapy	30% after Deductible	50% after Deductible
Durable Medical Equipment (Medical Necessity Required)	$2,000 of the $4,000 Deductible must be satisfied before 30% coinsurance applies.	50% after Deductible
Enteral Formulae	30% after Deductible	50% after Deductible
Prosthetic Appliances	30% after Deductible	50% after Deductible
Skilled Nursing Facility[6]	30% after Deductible	50% after Deductible
	Limit: 60 days / benefit period	
Inpatient Rehabilitation[6]	30% after Deductible	50% after Deductible
	Limit: 60 days / benefit period	

Benefits	High Deductible PPO Plan Network	High Deductible PPO Plan Non-Network
	Covered Person Pays	Covered Person Pays
Home Health Care Medical Necessity Required (unlimited days per Plan Year (April 1 to March 31); 16 hours per day maximum)	30% after Deductible	50% after Deductible
Private Duty Nursing	30% after Deductible	50% after Deductible
Hospice (Inpatient and Outpatient Care)	0%; Deductible does not apply	50% after Deductible
Transplant Services[7]	30% after Deductible	50% after Deductible
Hearing aid screening/exam	30%; Deductible does not apply	
Hearing Aid	30% after **In-Network Deductible** Limit: $1,500 / benefit period for exam and hearing aids	
Temporomandibular Joint Disorder (TMJ) (*Medical Necessity required; excludes appliances and orthodontic treatment*)	30% after Deductible	50% after Deductible
EAP, Mental Health, Substance Use Disorder Benefits and Applied Behavioral Analysis (ABA) are administered by Aetna Behavioral Health, You can reach Aetna 24-hours a day at 877-398-5816. **Deductible and Out-of-Pocket for Behavioral Health is combined with Deductible and Out-of-Pocket for Medical through BlueCross BlueShield to meet the benefit year Deductible and Out-of-Pocket listed at the beginning of this Schedule of Benefits.**		
Employee Assistance Program[9] **(EAP)** Up to six short-term counseling sessions per episode, per year with a licensed clinician (episodes include stress, grief, relationship issues, etc.)	0%; Deductible does not apply 6 face-to-face visits	Not covered
Mental Health Inpatient[6]	30% after Deductible	50% after Deductible
Residential[6] Residential services focus on evaluating and stabilizing the patient. They can help the patient learn effective ways to cope with the symptoms and impact of the patient's illness. Patients typically stay as needed to prepare for a successful transition into outpatient services.	30% after Deductible	50% after Deductible
Mental Health Outpatient professional counseling office visits	0% after $15 Copayment; Deductible does not apply	50% after Deductible
Psychiatric Medical Evaluation (to determine the necessity for medication)	0% after $15 Copayment; Deductible does not apply	50% after Deductible
Applied Behavioral Analysis Therapy[6] Behavioral health services related to Autism Spectrum Disorder (ASD) diagnosis. **Authorization Required.**	0% after $15 Copayment; Deductible does not apply	50% after Deductible
Partial Hospitalization[6] These programs are longer and more intensive than an Intensive Outpatient Program (IOP), usually 4-6 hours per day, 5-7 days a week. Services are designed to address mental health and/or substance use disorder-related disorders. They include physician and nursing services as well as group, individual, family, or multi- family group psychotherapy, psycho- educational services, and other services. (Often used in lieu of an inpatient stay, or as a transition from an inpatient stay.)	0% after $15 Copayment; Deductible does not apply	50% after Deductible

Benefits	High Deductible PPO Plan Network	High Deductible PPO Plan Non-Network
	Covered Person Pays	Covered Person Pays
Intensive Outpatient Sessions (IOP) These planned and structured programs are usually 2-3 hours /day (or evening), and 3-7 days per week. Programs are designed to address mental health or a substance use disorder-related disorder. They may include group, individual, family, or multi- family group psychotherapy, psycho-educational services, and other services.	0% after $15 Copayment; Deductible does not apply	50% after Deductible
AbleTo[13] 8-week program for select conditions	0%; Deductible does not apply	Not covered
Inpatient Detoxification[6] Inpatient detoxification provides 24-hour treatment in a residential or hospital setting for patients who are abusing alcohol or other physically addictive drugs. This level of care provides medical services and physician supervision. Patients typically stay in detoxification only if their withdrawal symptoms require 24-hour medical and nursing services. Detoxification services include preparation for transition to the next level of care in the process of recovery.	30% after Deductible	50% after Deductible
Substance Use Disorder Outpatient	$15 Copayment; Deductible does not apply	50% after Deductible
Outpatient Detoxification These programs offer outpatient services that monitor withdrawal from alcohol or another substance of abuse. Providers can administer medications that assist with detoxification and recovery from addiction.	$15 Copayment; Deductible does not apply	50% after Deductible

PLAN SUMMARY FOOTNOTES

1. For Maternity, a Copayment applies for the first visit only. The Maternity Care program provides confidential, individual support of expectant mothers based on answers to a maternity assessment survey. A maternity nurse will work with You and Your doctor to coordinate Your care and provide You with information to help You make the best decisions for You and Your baby. Covered Persons eighteen years of age and older who enroll in this program will receive a program kit. For more information, call 1-855-838-5897.
2. Quest Diagnostics® is BCBSF's exclusive In-Network Lab Provider. Quest Diagnostics® should be used for all In-Network diagnostic/laboratory services in Florida. For more information on Quest Diagnostics® (i.e., find a location, make an appointment) go to www.questdiagnostics.com or call 1-866-697-8378 (866MyQuest). For questions about laboratory services outside the state of Florida, call 1-855-258-9029.
3. For laboratory services performed at a network physician's office located within a participating Network Hospital or outpatient facility (ex: Moffitt Center, Mayo Clinic), the deductible will not apply.
4. The Office Visit Copayment depends upon the setting. Urgent Care services received in a non-Hospital setting will be subject to a $30 Copayment for the Preferred PPO; Urgent Care services received in the emergency room setting will be subject to an Emergency Room $300 Copayment.
5. Eligible preventive Diagnostic Services include, but are not limited to, laboratory colorectal screenings, bone mineral density tests, sigmoidoscopies, colonoscopies, echocardiograms, electrocardiograms, general health blood panels, adult and pediatric immunizations, mammograms, breast ultrasounds, PAP tests, PSA tests, urinalysis, and venipuncture services. You will not be responsible for the office visit Copayment or Coinsurance when receiving Preventive Care services and the services will be covered at 100%.

6. Precertification is required prior to all planned Inpatient hospital admissions, Skilled Nursing Facilities, Hospitals, and rehabilitation centers. For medical admissions, notification should be provided to BCBSF within 48 hours of an Emergency or maternity-related admission. For Behavioral Health admissions, including mental health and substance use disorder, notification should be provided to Aetna within 48 hours of admission. Please note that in most cases, Participating Providers will obtain Precertification on behalf of the patient, however You should always confirm with BCBSF or Aetna prior to receiving any care that requires Precertification. You will be responsible for obtaining Pre-Certification for Non-Network admissions. If this does not occur and it is later determined that all or part of the Inpatient stay was not Medically Necessary and Appropriate, the patient will be responsible for payment of any costs not covered.
7. Combined limit: $10,000 per transplant for travel, meals and lodging for recipient and travel companion.
8. To be Pre-certified for Inpatient Adult Rehabilitation for a substance-related disorder, demonstration of alternative levels of care such as Partial Hospitalization must have been attempted and relapse has occurred within 6 months of You or Your dependent's active participation in such a program.
9. For Employee Assistance Program (EAP) Benefits, You do not have to be enrolled in a medical plan. All individuals who live in Your household are also eligible for EAP Benefits. Aetna Behavioral Health / Resources for Living is a recognized leader in the behavioral health industry and administers the Plan's mental health, substance use disorder, and EAP benefits. You will find the toll-free phone number (1-877-398-5816) for Aetna Behavioral Health / Resources for Living on the back of Your ID card. All EAP and inpatient admissions require Pre-certification. Each individual may receive up to six free in-person counseling sessions per issue per plan year. Aetna Behavioral Health / Resources for Living is also providing a Meru pilot program for this year, called Meru which combines digital content and human support to offer coaching that focuses on stress, resilience, and mental health prevention. There are face to face interactions through telephonic and texting capabilities and a coach is assigned to work with the member to complete the eight week program. Talkspace is an online therapy platform that makes it easy and convenient for You to connect with a network of 2,500+ licensed therapists from anywhere, anytime. With Talkspace, You can send unlimited text, video, and audio messages to Your dedicated therapist, via web browser or talk through the Talkspace mobile app.

You can find a listing of Network Providers by logging onto:

Behavioral Health: www.Aetna.com – Aetna Member login is personal by member\\

EAP: www.resourcesforliving.com
Username: ICUBA
Password: 8773985816

Meru Health's Coaching Program: 877-398-5816 (same site, username, and password as above).

Talkspace: log onto resourcesforliving.com (same username and password as above). Then go to Services tab and select Talkspace

Covered Persons who are seeking EAP services may call 877-398-5816, 24-hours a day, and speak with a licensed counselor.

10. Preauthorization is required for all Magnetic Resonance Imaging (MRI), Magnetic Resonance Angiography (MRA), Computerized Axial Tomography (CAT) scans, and Positron Emission Tomography (PET) scans in an Outpatient facility (hospital or free standing). You or Your Provider must call BCBSF to obtain approval prior to receiving services. Your Participating Provider is required to contact BCBSF at 1-866-500-7664 to obtain authorization. You are responsible for contacting BCBSF at 1-866-500-7664 to obtain authorization for any services at a Non-Participating Provider.
11. Specific External Ambulatory Insulin Infusion Pumps and Supplies are covered under the Durable Medical Equipment benefit.
12. Preauthorization is required for all Specialty Medications infused or injected at an Outpatient Facility or Participating Provider's office by calling BCBSF at the Preauthorization phone number on the back of Your BCBSF identification card (1-888-376-6544).

Your Participating Provider must obtain Preauthorization from BCBSF before services are received. If Preauthorization is not received, You may be responsible for any costs not covered.

You are responsible for obtaining Preauthorization for Specialty Medications infused or injected at a Non-Participating Provider's office or a Non-Participating Outpatient facility. If Preauthorization is not received, You will be responsible for any costs not covered.

13. AbleTo is a condition management program for patients with specific chronic issues: breast and prostate cancer recovery, heart problems, diabetes, depression, digestive health, pain management, respiratory problems, substance use disorder,

anxiety, postpartum depression, caregiver status (child, elder, autism, etc.), grief/loss, and military transition. You can meet with a therapist and coach via web-based videoconferencing, or over the telephone. Meet with Your therapist once each week to address emotional challenges and meet with Your behavior coach once a week to identify health goals and develop an action plan. Program is eight weeks (16 sessions). You may enroll in the AbleTo program by calling Aetna Behavioral Health at 1-877-398-5816.

SURGERYPLUS

SurgeryPlus is a voluntary program to supplement the ICUBA Plan by providing an alternative solution for ***non-emergent, Medically Necessary*** surgical procedures. SurgeryPlus has located and rigorously screened top surgeons across the United States for the highest quality care, forming an elite group of expert surgeons and is separate from the BCBSF network. You and Your enrolled Dependents are automatically eligible for the SurgeryPlus benefit at no cost to You.

SurgeryPlus provides a concierge benefit which focuses on Medically Necessary, non-emergent surgical cases including but not limited to knee, hip, shoulder, foot & ankle, spine, wrist & elbow, general surgery, gastrointestinal (GI), gynecological (GYN), bariatric, cardiac, and ear, nose, and throat (ENT). **SurgeryPlus does not cover maternity, eye, or brain surgeries.** SurgeryPlus does not cover pre-surgical tests such as imaging (x-ray, MRI, CT scan, etc.) or post-surgical care such as physical therapy or home health care, however they will refer You back to the BCBSF network for these pre- or post-surgical services and the applicable benefit will apply.

Your Benefits

If You utilize the SurgeryPlus benefit Your Deductible and Coinsurance will be waived for the initial consultation, the surgical procedure (including anesthesia and surgical facility fees) and follow up visits with the surgeon for up to 90-days following surgery.

Care Advocates Manage the Entire Process

A dedicated Care Advocate will manage the entire procedure process for You, including locating a surgeon, scheduling appointments, transferring medical records, and arranging all logistics (such as travel). You will work with the same Care Advocate throughout the entire process, so they will know all the details of Your case and ensure Your satisfaction. The Care Advocate will provide You with at least three top quality surgeons for You to review for Your covered procedure. If the surgeon You select requires You to travel, SurgeryPlus will provide You and a companion with a travel allowance.

To learn more, call SurgeryPlus at 1-855-200-2119 or chat with a SurgeryPlus representative online:

1. Activate Your online SurgeryPlus portal by logging in at: http://ICUBAbenefits.org.
2. Click the SurgeryPlus link and then click “register now”
3. Complete Your profile and explore

After the initial activation of Your account, You can easily visit the site by clicking the link on Your ICUBA homepage and You will be automatically logged in to the SurgeryPlus website.

HINGE HEALTH

Hinge Health is a digital exercise therapy program designed to address back, knee, hip, neck, shoulder, and other musculoskeletal pain. These services are available at no cost to all Plan Participants who are 18 years or older. Complete a short online questionnaire about Your pain to learn if You qualify for the program. Hinge Health will review Your questionnaire and will contact You directly if You are eligible to enroll in the program:

Visit hingehealth.com/ICUBA

Complete the questionnaire

Expect a follow up email within 48 hours

If accepted into the program, You can begin the program

Hinge Health provides all the tools You need to get moving again from the comfort of Your home. Here are some of the ways Your treatment could be tailored to You:

Get a personal care team, including a physical therapist and health coach

Schedule personal physical therapy sessions as needed

Receive wearable sensors that give live feedback on Your form in the app

If You don't have pain and are just looking to stay healthy, You can sign up for their app. Recommended exercises will be tailored to You based on Your job and lifestyle.

To learn more, call Hinge Health at 855-902-2777 or send an email to hello@hingehealth.com.

VIRTA

Virta's remote medical team and health coaches can teach You how to change the food You eat so You can naturally lower Your blood sugar. Treatment does not involve surgery, medication, or exercise. Virta is helpful for people living with type 2 diabetes. ICUBA covers the cost of Virta for You and Your eligible family members with type 2 diabetes. There is an online care app, health coaching, testing supplies, custom nutrition plans, recipes, meal plans, and more.

To learn more, check eligibility, and book a consultation, visit virtahealth.com/join/icuba

UTILIZATION REVIEW PROCESS

Precertification (also known as Preauthorization or Prior Authorization) is required for Plan Benefits to be covered. This means that a Covered Person or Provider is required to call the Precertification Provider number on the Participant ID Card (**1-888-376-6544 for Medical; 1-877-398-5816 for Behavioral Health**). The purpose of a Precertification is to determine (1) that an Inpatient stay in the Hospital or other facility service is Medically Necessary and Appropriate and not Experimental or Investigative; (2) that the facility is the appropriate facility for the service; and (3) the standard length of stay allowed for the condition.

CAUTION

Please remember that Precertification does not verify a Covered Person's eligibility for Benefits nor guarantee payment of Benefits under the Plan. It is in the Covered Person's best interest to go through the Precertification process to ensure that the care is Medically Necessary and Appropriate.

Precertification does not constitute a guarantee or warranty of the quality of the medical treatment that a Covered Person will receive. Actual payment of Benefits is governed by the Plan's terms, conditions, limitations, and exclusions.

Please note that a Precertification Claim may be an Urgent Care Claim and will be handled as set forth in Article Eleven - the Claims and Appeals Procedure Section.

To determine that care will be provided in the appropriate setting, BCBSF, Aetna or its designated agent administers a care utilization review program comprised of prospective, concurrent, and/or retrospective reviews. In addition, BCBSF, Aetna or its designated agent assists Hospitals with discharge planning. These activities are conducted via phone or on-site by a Care Coordinator working with a Physician advisor. Here is a brief description of these review procedures:

PROSPECTIVE REVIEW

Prospective review, also known as Precertification or pre-service review, begins upon receipt of treatment information. After receiving the request for care, BCBSF, Aetna or its designated agent:

reviews available information regarding the Covered Person's eligibility for coverage and/or availability of Benefits;

reviews the information provided, including patient demographics, diagnosis, and plan of treatment;

assesses whether care is Medically Necessary and Appropriate;

determines whether the proposed treatment is Experimental or Investigative;

authorizes care or refers the request to a Physician advisor with appropriate training and experience for determination; and

assigns an appropriate length of stay for Inpatient admission.

CONCURRENT REVIEW

Concurrent review may occur during on-going treatment and is used to assess the Medical Necessity and Appropriateness of the length of stay and level of care BCBSF, Aetna or its designated agent:

reviews Your progress and ongoing treatment plan with the facility staff; and

decides, when necessary, to either: extend Your care; offer an alternative level of care; or refer to the Physician advisor for a decision.

DISCHARGE PLANNING

Discharge planning is a process that begins prior to Your scheduled Hospital admission. Working with You, Your family, Your attending Physician(s), and Hospital staff, BCBSF, Aetna or its designated agent will help plan for and coordinate Your discharge to ensure that You receive safe and uninterrupted care when needed at the time of Your discharge. In planning for discharge, BCBSF, Aetna or its designated agent assesses Your:

level of function pre- and post-admission;

ability to perform self-care;

primary caregiver and support system;

living arrangements pre- and post-admission;

special equipment, medication, dietary needs, and safety needs;

obstacles to care;

need for referral to Care Consultant or condition management; and

psychological needs.

RETROSPECTIVE REVIEW

Retrospective review may occur when a service or procedure has been rendered without the required Precertification.

UTILIZATION REVIEW PROCESS INFORMATION

Authorized Representative for Urgent Care Claim

Procedures adopted by the Plan will, in the case of an Urgent Care Claim, permit a Physician or other Professional Provider with knowledge of Your condition to act as Your Authorized Representative. You will need to complete a HIPAA Authorization form to have information released to a third-party. This form can be accessed by logging onto http://icubabenefits.org.

Decisions Involving Requests for Precertification and Other Non-Urgent Care Pre-Service Claims

You will receive written notice of any decision on a request for Precertification or other Pre-Service Claim, whether the decision is adverse or not, within a reasonable period appropriate to the medical circumstances involved. Such period will not exceed 15 days from the date BCBSF, or Aetna, or its designated agent receives the Claim from You or Your Provider. However, this 15-day period may be extended one time by BCBSF or Aetna for an additional 15 days, provided that BCBSF or Aetna determines that the additional time is necessary due to matters outside its control, and notifies You of the extension prior to the expiration of the initial 15-day Pre-Service Claim determination period. If an extension of time is necessary because You failed to submit information necessary for BCBSF or Aetna, or its designated agent to decide on Your Pre-Service Claim, the notice of extension that is sent to You will specifically describe the information that You must submit. In this event, You will have 45 days in which to submit the information before a decision is made on Your Pre-Service Claim.

Decisions Involving Urgent Care Claims

1. If Your request involves an Urgent Care Claim, BCBSF or Aetna, or its designated agent will decide on Your request as soon as possible, considering the medical exigencies involved. You will receive notice of the decision that has been made on Your Urgent Care Claim no later than 72 hours following receipt of the Claim from You or Your Provider.
2. If BCBSF or Aetna, or its designated agent determines in connection with an Urgent Care Claim that You have not provided sufficient information to determine whether or to what extent Benefits are provided under Your coverage, You will be notified of the specific information needed to complete Your Claim within 24 hours following BCBSF's or Aetna's, or its designated agent's receipt of the Claim. You will then be given no less than 48 hours to provide the specific information to BCBSF or Aetna or its designated agent. BCBSF or Aetna or its designated agent will thereafter notify You of its determination on Your Claim as soon as possible but no later than 48 hours after the earlier of (A) its receipt of the

additional specific information, or (B) the date BCBSF or Aetna, or its designated agent informed You that it must receive the additional specific information.

3. In those cases where Your Urgent Care Claim request seeks to extend a previously approved course of treatment and is made at least 24 hours prior to the expiration of the previously approved course of treatment, the timeframe may be shortened. In such a situation, BCBSF or Aetna, or its designated agent will notify You of its decision concerning Your Urgent Care Claim to extend the course of treatment not later than 24 hours following receipt of Your request.

Notices of Determination Involving Precertification Requests and Other Pre-Service Claims

Any time Your request for Precertification or any other Pre-Service Claim is approved, You will be notified in writing that the request has been approved. If Your request for Precertification or approval of any other Pre-Service Claim has been denied, You will receive written notification of that denial which will include, among other items, the specific reason or reasons for the Adverse Benefit Decision and a statement describing Your right to file an appeal. You may only file an appeal once the Claim has been incurred.

For a description of Your right to file an appeal concerning an Adverse Benefit Decision involving a request for Precertification or any other Pre-Service Claim, see Article Eleven (Claims and Appeals Procedures).

ARTICLE FOUR: PRESCRIPTION DRUG BENEFITS

The Prescription Drug Benefits below are covered under each ICUBA Medical Plan through BCBSF. For more specific details regarding excluded Prescription Drugs see below. You may also call BCBSF at 1-855-258-9029.

If the actual cost is less than the Copayment, the Covered Person will pay the actual cost. The prescribing Physician must obtain prior authorization from BCBSF prior to prescribing certain Prescription Drugs. To confirm whether You need clinical prior authorization and/or to request approval, call 1-855-258-9029.

Prescription Drug Copayments are payable in full at the time a prescription is filled.

Copayments		Prescription-Fill Methods*	
Tier	Retail: Up to a 30-day supply	90-Day at Retail Program: Up to a 90-day supply	Mail: Up to a 90-day supply
Preferred generics at the Nova Southeastern University (NSU) pharmacy	$0	$0	N/A
Generic Drugs to treat chronic conditions+	$0	$0	$0
Preferred generics at other network pharmacies	$5	$10	$10
Non-Preferred generics	$10	$20	$20
Preferred brands: brand-name medications on the Preferred Medication List (PML)**	$40	$80	$80
Non-Preferred brands: brand-name medications not on the Preferred Medication List	$75	$150	$150
Preferred specialty	$75***	N/A	N/A
Non-preferred specialty	$75***	N/A	N/A

Prior authorization may be required to ensure safe and effective use of select prescription drugs. Your Physician may be asked to provide additional information to determine Medical Necessity and Appropriateness.

+ Effective 07/01/2020. Prescribed preventive generic medications to treat one of the conditions designated Essential Health Benefit by the Affordable Care Act (In some cases You may have to meet an additional requirement such as age, sex, and diagnosis to qualify for the $0 copay).
** Unless Medically Necessary and Appropriate, the Covered Person will be required to pay the difference in cost between a brand and generic drug if the brand is requested when a generic is available.*
*** The PML is a list of medications preferred by the Plan. You can view the PML online at www.MyHealthToolkitFL.com.*
**** Specialty medications are limited to a 31-day supply. Copayment Assistance Cards are accepted for preferred specialty products.*

Extended Benefit Program: ICUBA participates in the extended benefit program. This program allows You to receive medications that are NOT covered through Your prescription benefits at 100% cost of the discounted rate. You must provide Your prescription card to the pharmacist to participate in this program (not applicable to NSU pharmacy).

GENERAL PRESCRIPTION DRUG PROVISIONS

The Preferred Medication List (PML) is an extensive list of Food & Drug Administration (FDA) approved Prescription Drugs selected for their quality, safety, and effectiveness. It includes products in every major therapeutic category. The PML was developed by the Pharmacy and Therapeutics Committee made up of clinical pharmacists and Physicians and may, from time to time, be revised by the committee. Your program includes coverage for both PML and non-PML drugs at the specific Copayment or Coinsurance amounts listed above.

Prescription Drugs are covered when You purchase them through a Network Pharmacy Provider applicable to Your program. You can choose from more than 62,000 participating pharmacies. For convenience and choice, these Network pharmacies include both major chains and independent stores. Diabetic Supplies including meters, lancing devices, lancets, test strips, control solution, needles, and syringes are covered at 100% with a valid prescription at any Network pharmacy and through the mail service. To obtain more information about diabetic supplies, call BCBSF at 1-855-258-9029.

a. **ICUBAcares Pharmacist Advocate Program**: The ICUBAcares Pharmacist Advocate Program (PAP) is comprised of pharmacists who will assist Covered Persons with closing gaps in care attributed to Prior Authorizations, Quantity Limits, Step Therapy and Generic Drug Requirements; assist Covered Persons with formulary changes; serve as a liaison between doctors, pharmacy and

insurance company; encourage Covered Persons to use therapeutically appropriate, cost-effective therapy; as well as to assist Covered Persons with any medication-related questions. To speak with a Pharmacist Advocate, You can contact ICUBAcares at 1-877-286-3967 M-F 9am-5pm EST.

b. **Mail Service Pharmacy**: By using BCBSF Home Delivery Service Pharmacy or a Retail 90 Network Pharmacy, You will only have to order Your prescription four times per year. We recommend that if You have medications that You take every day, You utilize the 90-day supply to save money and decrease the likelihood of missed doses because You did not remember to go to the pharmacy.

Mail Service: BCBSF Home Delivery will continue to provide this service to You in 2024.

Most current mail-service prescriptions will transfer under Your new benefit around April 1. You will get a letter in the mail if You need to take action.

Retail Pharmacies: Your pharmacy benefit allows You to fill 90-day supplies of long-term, maintenance medications **at any retail pharmacy**. This adds convenience by reducing Your trips to the pharmacy. Ask Your doctor to write Your long-term medication prescription for a 90-day supply and take it to a retail network pharmacy.

Always allow two weeks for Your prescription to arrive.

c. **Online Portal**: Your online portal at myhealthtoolkitfl.com allows You to create an online account to access Your personal information at Your convenience; check eligibility for Yourself and Your Dependents; check Your Benefit coverage and Copayments; search, as well as download, Your plan's drug list; find generic and formulary alternatives; learn more about Your medication; locate a nearby pharmacy in Your plan's Network; review Your prescription history and refill information; and print a temporary ID card.

All pertinent medical and/or prescription information to evaluate the accuracy of the denied request will be objectively and thoroughly reviewed by clinical and/or vocational experts. After the review, You will be informed of the decision in writing. Medical Review Institute of America (MRIOA) or Advanced Medical Reviews (AMR) will conduct the appeal analysis for any external review program. An independent physician expert will review the case and make a recommendation. This recommendation will be submitted to BCBSF, and BCBSF will then notify You and ICUBA of the recommended appeal outcome in writing and the final decision regarding the appeal. MRIOA or AMR will review Your appeal to ensure the treatment is Medically Necessary and Appropriate, meets clinical guidelines, and is not Experimental or Investigative.

d. **Covered Drugs** include:

those which, under Federal law, are required to bear the legend: "Caution: Federal law prohibits dispensing without a prescription;"

legend drugs under applicable state law and dispensed by a licensed pharmacist;

Prescription Drugs listed in Your program's Prescription Drug Preferred Medication List (PML), including compounded medications consisting of a mixture of at least two ingredients other than water, one of which must be a legend drug;

prescribed injectable insulin; and

certain drugs that may require prior authorization from BCBSF.

e. **The following are covered at no cost to You (*i.e.*, at 100%) through Your pharmacy benefit**:

prescribed diabetic supplies including meters, Blood glucose monitors, lancing devices, lancets, test strips, control solution, needles, and syringes;

prescribed over the counter and generic iron supplementation for babies;

prescribed generic oral fluoride supplementation for children;

prescribed over the counter and generic aspirin with a strength of 325mg or less for adults;

prescribed over the counter and generic prenatal vitamins for women planning or capable of pregnancy;

prescribed over the counter and generic folic acid between 0.4 mg and 0.8 mg for women planning or capable of pregnancy;

single-entity and combination vaccines for diphtheria, haemophilus influenza type B (applies to children 6 years of age and under), hepatitis A, hepatitis B, herpes zoster, human papillomavirus (applies to children and adults ages 9 to 26), polio, influenza, measles, mumps, rubella, meningococcal infections, pertussis, pneumococcal infections, rotavirus (applies only to children 8 months and under), tetanus, varicella;

OTC female contraceptive products with the quantity limit of 12 units or days' supply per product per month. Products include female condoms, spermicides (vaginal gel/ foam/ film/ suppositories), sponges;

prescribed contraceptive drugs including; generic oral contraceptives that are monophasic, biphasic, triphasic and extended cycle; branded four-phasic oral contraceptives; branded contraceptive patch with a quantity limit of 3 patches per month; branded contraceptive ring with quantity limit of 1 ring per month; generic injectable contraceptives with quantity limit of 1 injection per 90 days;

prescribed contraceptive devices including; diaphragms (limit 1 per year), cervical caps (limit 1 per year), contraceptive implants;

prescribed generic preparation agents for colorectal cancer screening; and

prescribed preventive generic medications to treat one of the conditions designated Essential Health Benefit by the Affordable Care Act (In some cases You may have to meet an additional requirement such as age, sex, diagnosis of prevention to qualify for the $0 copay).

f. **Tobacco Cessation Benefit**:

All Covered Persons may receive up to two twelve-week courses of treatment for FDA approved or over-the-counter tobacco cessation medication with a Physician's prescription by choosing any or all the following:

Enroll in AHEC tobacco cessation program: www.ahectobacco.com/calendar, or call 1-877-848-6696

Enroll in BCBSF Health Coaching for tobacco cessation: Call 1-855-838-5897

Contact Aetna Resources for Living to request a referral or register for a tobacco cessation seminar: Call 1-877-398-5816

Preferred Medication List: Your Prescription Drug Program follows a select drug list which is referred to as a "Preferred Medication List" (PML). The PML is an extensive list of Food and Drug Administration (FDA) approved Prescription Drugs selected for their quality, safety, and effectiveness. It includes products in every major therapeutic category.

To receive a copy of the Preferred Medication List, call 1-855-258-9029.
You can also look up the PML at www.MyHealthToolkitFL.com.

These listings are subject to periodic review and modification by BCBSF or a designated committee of Physicians and pharmacists.

g. **Quantity Limit Program**: limits the amount of certain medications we cover. For most medications, Your benefit will only cover a set amount within a set time frame. Your doctor can request a medical necessity override to allow a larger amount of some of the drugs in this program.

h. **Preferred Medication List – Formulary Exclusions:** Our pharmacy committee may decide to stop covering some drugs when safe, effective, less costly alternatives are available. You can find the **Excluded Drug List**, and information about how Your doctor can request a formulary exception, at **www.MyHealthToolkitFL.com**. If a drug You are taking is excluded under Your new benefit, we will send You a letter.

i. **Managed Prescription Drug Coverage**: A prescription order or refill that may exceed the manufacturer recommended dosage over a specified period may be denied when presented to the pharmacy Provider. BCBSF may contact the prescribing Physician to determine if the Prescription Drug is Medically Necessary and Appropriate. If it is determined that the prescription is Medically Necessary and Appropriate, the Prescription Drug will be dispensed.

j. **Step-Care and Clinical Prior Authorization Program**: Step-care and prior authorization programs help ensure appropriate drug treatment while managing overall prescription costs. These programs sometimes require extra steps when getting prescriptions filled. To avoid delays, check if Your prescription requires a prior authorization or a step-care plan before getting Your prescription filled on the Preferred Medication List (PML).

The categories/medications that require clinical prior authorization or step-care may include, but are not limited to:

- Acne
- Actiq®
- ADHD/Narcolepsy
- Albuterol Inhalers (Step)
- Anabolic Steroids
- Androgens (Step)
- Antidepressants (Step)
- Angiotensin II Receptor Blockers (Step)
- Antiemetics
- Atypical Antipsychotics (Step)
- Bisphosphonates (Step)
- Duragesics
- Fenofibrates (Step)
- Fentora®
- GLP Inhibitors (*e.g.*, Byetta®, Victoza®) (Step)
- Growth Hormones (Step)
- Hepatitis C (Step)
- Hypnotics – Sleep Aids (Step)
- Impotency Treatment Drugs
- Basal Insulin (Step)
- Intranasal Steroids
- Long-Acting Beta-Agonists (LABA)
- (*e.g.*, Serevent®, Foradil®, Advair®) (Step)
- Lyrica (Step)
- Migraine (Step)
- Multiple Sclerosis (Step)
- Ophthalmic Prostaglandins (Step
- OxyContin®
- Proton Pump Inhibitors (Step)
- Ranexa®
- Statins (Step)
- Symlin®

Note: Drug names are the property of their respective owners.

Clinical prior authorizations must be renewed annually.

You may also confirm whether You need clinical prior authorization or step-care and/or to request approval by calling 1-855-258-9029. Please have available the name of Your medication, Your Physician's name, phone (and fax number, if available), Your member ID number and Your group number (from Your ID Card).

k. **Quality Guidelines**: The purpose of this program is to ensure that certain Prescription Drugs are administered according to Food and Drug Administration (FDA) requirements. FDA requirements can be found on the insert You receive with the drug. Sometimes a medical provider will prescribe the following drugs in a way other than described on the FDA required insert.

The most common Prescription Drugs required to follow this guideline are:

- Acne medications such as Altinac®, Differin®, Epiduo®, Veltin®
- Anabolic steroids such as Deca-Durabolin®, Delatestryl®, Depo-Testosterone®
- Diabetes medications such as Byetta®, Bydureon®, Victoza®, Symlin®
- Immediate release opioids such as Abstral®, Fentora®, Onsolis®
- Angina medications such as Ranexa®
- Fentanyl transdermal systems such as Duragesic®
- Insomnia medications such as Ambien®, Edlluar®, Zolpidem®, Silenor®, Sonata®, Lunesta®, Rozerem®
- Migraine medications such as Amerge®, Axert®, Frova®, Imitrex®, Migranal®, Zomig®, Maxalt®, or Relpax®
- COXII inhibitors such as Celebrex®
- Proton Pump Inhibitors such as Nexium®, Prilosec®, Protonix®, Prevacid®, Zegerid®, Omeprazole®, or Aciphex®
- Oral antifungal agents such as Lamisil® or Sporanox®
- Allergic rhinitis medications such as Singulair®, Accolate®, or Zyflo®
- Central nervous stimulants such as Strattera®

- Opiate dependence medications such as Subutex® or Suboxone®
- Botox injections for migraines

Note: Drug names are the property of their respective owners.

If this occurs Your retail or mail order pharmacist will receive an onscreen computer message requesting that Your medical Provider contact BCBSF clinical staff to determine if Your medical condition warrants that You receive the Prescription Drug. If You have any questions, You may contact BCBSF at 1-855-258-9029for additional information.

l. **Generic Substitution**: Many Brand-Name Drugs are available as Generic Drugs, which are just as effective, but less costly. If Your Physician prescribes a Brand-Name Drug that is available in generic form, and:

- Your Physician requires that only the Brand-Name Drug may be used, You will receive the 30-day supply of the Brand-Name Drug at retail or a 90-day supply of the Brand-Name Drug through retail or mail order.
- Your Physician approves a Generic Drug substitution to be allowed, You will receive the Generic Drug substitution through Retail, or Mail Order. If You still want to receive the Brand-Name Drug, You will be responsible for paying the Brand-Name Drug Copayment plus the difference between the cost of the Brand-Name Drug and the Generic Drug, but in no case more than the cost of the Brand-Name Drug.

m. **Specialty Drugs**: Certain medications used for treating complex health conditions must be obtained through the Specialty Pharmacy Program. The following conditions may require drugs that fall under Specialty Pharmacy, which include, but are not limited to:

- Ankylosing Spondylitis
- Asthma
- Crohn's Disease
- Cystic Fibrosis
- Growth Hormone Deficiency
- Multiple Sclerosis (MS)
- Oral Oncology
- Osteoporosis
- Primary Immunodeficiency Disease
- Psoriasis/Psoriatic Arthritis
- Pulmonary Arterial Hypertension (PAH)
- Rheumatoid Arthritis (RA)
- Respiratory Syncytial Virus (RSV)
- Viral Hepatitis

Prescriptions for these types of drugs will be available through the Specialty Pharmacy program. The Specialty Pharmacy program is provided through BCBSF. The Specialty Pharmacy simplifies Your access to these medications, improves the consistency of Your quality pharmacy care, and helps control rising pharmaceutical costs. Please call BCBSF at 1-855-258-9029 for information.

This means that You will only be able to purchase these specialty medications through BCBSF Specialty Pharmacy. Specialty medications will be limited to a 30-day supply, at the retail cost-sharing amount. The delivery of Your medications will be coordinated and express-delivered to Your home or Physician's office every month. The following list of medications is included in the program and is subject to change based on new drugs being issued in the marketplace.

- Actimmune®
- Apokyn®
- Avonex®
- Baraclude®
- Betaseron®
- Botox
- Cerezyme®
- Copaxone®
- Copegus®
- Depot®
- Eligard®
- Enbrel®
- Etoposide®
- Forteo®
- Fuzeon®
- Genotropin®
- Gleevec®
- Hepsera®
- Humatrope®
- Humira®
- Intrathecal®
- Intron A®
- Kineret®
- Leuprolide®
- Lioresal®
- Lupron®
- Nexavar®
- Norditropin®
- Nutropin®
- Pegasy®
- Peg-Intron®
- Pulmozyme®
- Raptiva®
- Rebetol®
- Rebif®
- Revatio®
- Revlimid®
- Ribasphere®
- Roferon A®
- Saizen®
- Sandostatin®
- Sensipar®
- Serostim®
- Sprycel®
- Sutent®
- Tarceva®
- Targretin®
- Temodar®
- Tev-Tropin®
- Thalomid®
- Tobi®
- VePesid®
- Viadur®
- Xeloda®
- Zoladex®

Zorbtive®

Note: Drug names are the property of their respective owners. In addition to providing access to these medications, Specialty Pharmacy offers:

- A patient Care Coordinator dedicated to Your needs;
- Free overnight delivery of Your medications to Your home or Physician's office;
- Most specialty medication supplies at no charge;
- 24-hour pharmacist and nurse emergency on-call;
- 7-days per week pharmacy hours;
- 8AM - 9PM weekday customer service hours; and
- Monthly refill reminders and free educational items.

You can reach BCBSF Specialty Pharmacy at 1-855-258-9029

n. **Participating/Non-Participating Pharmacies**: You may purchase Prescription Drugs from either a Participating or Non-Participating Pharmacy. If You purchase Your Prescription Drugs at a Non-Participating Pharmacy You will pay 40% Coinsurance. There is no out-of-pocket maximum amount for Non-Participating Pharmacy Prescription Drug Benefits.

o. **Participating Network Pharmacy**: The Rx network consists of more than 62,000 participating chain and independent pharmacies nationwide. Network pharmacies have an arrangement to provide Prescription Drugs to You at an agreed upon price. When You purchase covered drugs from a pharmacy in the Network applicable to Your program, present Your prescription and ID Card to the pharmacist. (Prescriptions that the pharmacy receives by phone from Your Physician or Dentist may also be covered).

You should request and retain a receipt for any amounts that You have paid in case You need the information for income tax or any other purpose. You may also download Your prescription claim history from www.MyHealthToolkitFL.com. To get Your diabetic supplies such as meters, lancing devices, lancets, test strips, control solution, needles, and syringes covered at 100% You must have a prescription from a Provider and use a network pharmacy or mail order. You may also receive these supplies free of charge from Liberty Medical Supply (see (e) above).

p. **ID Card**: If You should forget Your ID Card when You go to a Network Pharmacy to have a prescription filled, the Pharmacy may ask You to pay in full for the prescription. If this happens, call BCBSF at 1-855-258-9029 to confirm eligibility. You may also go to www.MyHealthToolkitFL.com to print an ID card or call the Health Care Advisors for a replacement ID card.

q. **No Deductible**: Prescription Drug Benefits, including Specialty Drugs obtained at Network Pharmacies, are not subject to the overall program Deductibles or Coinsurance.

r. **Out-of-Pocket Maximum**: There is a $2,000 Out-of-Pocket Maximum (individual) and a $4,000 Out-of-Pocket Maximum (family) for Prescription Drugs. Once You have spent $2,000 (individual) or $4,000 (family) in Copayments in a Plan Year, Your Prescription Drugs will be covered at 100% in-Network. There is no out-of-pocket maximum for non-Network.

s. **Non-Participating Pharmacy**: If You are at a Non-Network Pharmacy and are required to pay in full, simply complete a drug reimbursement Claim form. You can request a form online at www.MyHealthToolkitFL.com, or by calling the 1-855-258-9029. Be sure to enclose a copy of Your receipt listing the name of the drug and amount You were charged. You will receive the appropriate reimbursement (typically reimbursed at contracted rate less Copayment/Coinsurance) in three to five weeks.

NINETY (90) DAY PRESCRIPTION DRUG PROGRAM

A Covered Person can order long-term Maintenance Medication drugs at a participating retail pharmacy (Retail 90 Network) or by mail order as described in the Schedule of Benefits. Specialty Drugs are not available through the Maintenance Program. Plan Exclusions are noted below.

Retail Pharmacies: Your pharmacy benefit allows You to fill 90-day supplies of long-term, maintenance medications **at any retail pharmacy**. This adds convenience by reducing Your trips to the pharmacy. Ask Your doctor to write Your long-term medication prescription for a 90-day supply and take it to a retail Network pharmacy.

EXCLUSIONS

a. Services of Your attending Physician, surgeon, or other medical attendant including medications taken by or administered to an individual, in whole or in part, while he or she is a patient in a licensed Hospital, Ambulatory Care Facility, Extended Care Facility, Skilled Nursing Facility, Substance Use Disorder Treatment Facility, Other Facility Provider, or similar institution which operates on its premises, or allows to be operated on its premises, a facility for dispensing pharmaceuticals and Network facilities such as those that include such charges as part of a global rate charged to the Plan.

b. Prescription Drugs dispensed for treatment of an Illness or an Injury for which the group is required by law to furnish Hospital care in whole or in part including, but not limited to state or federal workers' compensation laws, occupational disease laws and other employer liability laws.

c. Cosmetic indications and anti-wrinkle agents (e.g., Botox®, Renova®, etc.).

d. Prescription Drugs to which You are entitled, with or without charge, under a plan or program of any government or governmental body.

e. Charges for therapeutic devices or appliances (e.g., support garments and other non-medicinal substances, etc.).

f. Charges for administration of Prescription Drugs and/or injectable insulin, whether by a Physician or other person.

g. Any charges by any pharmacy Provider or pharmacist except as provided herein.

h. Any drug or medication except as provided herein.

i. Any amounts You are required to pay directly to the pharmacy for each prescription or refill.

j. Charges for a Prescription Drug when such drug or medication is used for unlabeled or unapproved indications and where the Food and Drug Administration (FDA) has not approved use of such drug or medication.

k. Drugs and supplies that are not Medically Necessary and Appropriate or otherwise excluded herein.

l. Any drug or medication which does not meet the definition of a covered Prescription Drug.

m. Any charge for a fertility drug, even if such medication is a Prescription Drug.

n. Pharmacological or hormonal treatment used in conjunction with assisted fertilization.

o. Hair growth stimulants.

p. Food supplements.

q. Any drugs used to abort a pregnancy.

r. Blood products.

s. Antihemophilic drugs.

t. Vitamins, except for generic prenatal vitamins prescribed as Medically Necessary and Appropriate vitamins.

u. Any drugs which are Experimental or Investigative.

v. Any drugs and supplies which can be purchased without a prescription order, unless specifically described as provided herein.

w. Any selected diagnostic agents.

x. Over-the-counter drugs that are not part of a generic substitution program unless aspirin, prenatal vitamins, folic acid, or iron filled with a prescription, which is covered at 100%.

y. Non-legend drugs.

z. Tretinoin topical (e.g., Retin-A®, etc.) for individuals 24 years or older.

aa. Syringes unless accompanied by a prescription order.

bb. Emergency contraceptives.

YOUR PRESCRIPTION DRUG COVERAGE AND MEDICARE

Your Prescription Drug coverage under the Plan is, on average for all Plan Participants, expected to pay out as much as the standard Medicare Prescription Drug coverage will pay and is considered Creditable Coverage. Because Your existing coverage is on average at least as good as standard Medicare Prescription Drug coverage, You can keep this coverage and not pay extra if You later decide to enroll in Medicare Prescription Drug coverage.

Individuals can enroll in a Medicare Prescription Drug plan when they first become eligible for Medicare and each year from October 15 through December 7. Beneficiaries leaving Employer's coverage may be eligible for a Special Enrollment period to sign up for a Medicare Prescription Drug program.

You should compare Your current coverage, including which drugs are covered, with the coverage and cost of the plans offering Medicare Prescription Drug coverage in Your area.

If You decide not to enroll in a Medicare Prescription Drug plan and drop Your coverage under the Plan, be aware that You and Your Dependents may not be able to get this coverage back.

You should also know that if You drop or lose coverage with the Plan and don't enroll in Medicare Prescription Drug coverage after Your current coverage ends, You may pay a penalty to enroll in Medicare Prescription Drug coverage later.

If You go 63 days or longer without Prescription Drug coverage that is at least as good as Medicare's Prescription Drug coverage, Your monthly premium for Medicare Prescription Drug coverage will go up at least 1% per month for every month that You go without such coverage. For example, if You go 19 months without coverage, Your Medicare Prescription Drug premium could be 19% higher than what many other people pay. You will have to pay this premium if You have Medicare Prescription Drug coverage.

For more information about Your options under Medicare Prescription Drug coverage visit www.medicare.gov online or call 1-800-Medicare (1-800-633-4227). TTY users should call 1-877-486-2048.

For people with limited income and resources, extra help paying for Medicare Prescription Drug coverage is available. Information about this extra help is available from the Social Security Administration (SSA) online, at www.socialsecurity.gov, or You may call SSA at 1-800-772-1213 (TTY: 1-800-325-0778).

IMPORTANT NOTICE FROM ICUBA ABOUT YOUR PRESCRIPTION DRUG COVERAGE AND MEDICARE

Please read this notice carefully and keep it where You can find it. This notice has information about Your current prescription drug coverage with ICUBA and about Your options under Medicare's prescription drug coverage. It also explains the options under Medicare prescription drug coverage and can help You decide whether You want to enroll in a Medicare drug plan. If You are considering joining, You should compare Your current coverage, including which drugs are covered at what cost, with the coverage and costs of the plans offering Medicare prescription drug coverage in Your area. At the end of this notice is information about where You can get help to make decisions about Your prescription drug coverage.

There are two important things You need to know about Your current coverage and Medicare's prescription drug coverage:

1. Medicare prescription drug coverage became available in 2006 to everyone with Medicare. You can get this coverage if You join a Medicare Prescription Drug Plan or join a Medicare Advantage Plan (like and HMO or PPO) that offers prescription drug coverage. All Medicare prescription drug plans provide at least a standard level of coverage set by Medicare. Some plans may also offer more coverage for a higher monthly premium.
2. ICUBA has determined that the prescription drug coverage offered by the ICUBA Plan is, on average for all plan participants, expected to pay out as much as standard Medicare Prescription Drug coverage pays and is therefore considered Creditable Coverage.

Because Your existing coverage is Creditable Coverage, You can keep this coverage and not pay a higher premium (a penalty) if You later decide to enroll in Medicare prescription drug coverage.

Individuals can enroll in a Medicare prescription drug plan when they first become eligible for Medicare and each year from October 15 through December 7. Beneficiaries leaving employer/union coverage may be eligible for a Special Enrollment Period to sign up for a Medicare prescription drug plan. You should compare Your current coverage, including which drugs are covered, with the coverage and cost of the plans offering Medicare prescription drug coverage in Your area. If You do decide to enroll in a Medicare prescription

drug plan and drop Your ICUBA prescription drug coverage, be aware that You and Your Dependents may not be able to get this coverage back. Please contact us for more information about what happens to Your coverage if You enroll in a Medicare prescription drug plan.

You should also know that if You drop or lose Your coverage with ICUBA and do not enroll in Medicare prescription drug coverage after Your current coverage ends, You may pay more (a penalty) to enroll in Medicare prescription drug coverage later. If You go 63 days or longer without prescription drug coverage that is at least as good as Medicare's prescription drug coverage (*i.e.*, Creditable Coverage), Your monthly premium will go up at least 1% per month for every month that You did not have that coverage. For example, if You go nineteen months without coverage, Your premium will always be at least 19% higher than what many other people pay. You will have to pay this higher premium if You have Medicare prescription drug coverage. In addition, You may have to wait until the following October to enroll.

For more information about this notice or Your current prescription drug coverage:

Contact Your Division office for further information. You will receive this notice annually and at other times in the future such as before the next period You can enroll in Medicare prescription drug coverage, and if this coverage through ICUBA changes. You also may request a copy at any time. For more information about Your options under Medicare prescription drug coverage: The "Medicare and You" handbook provides detailed information about Medicare plans that offer prescription drug coverage. You will get a copy of the handbook in the mail every year from Medicare. You may also be contacted directly by Medicare prescription drug plans. For more information about Medicare prescription drug plans:

- Visit www.medicare.gov
- Call Your State Health Insurance Assistance Program (see Your copy of the Medicare and Your handbook for their telephone number) for personalized help.
- Call 1-800-MEDICARE (1-800-633-4227). TTY users should call 1-877-486-2048. For people with limited income and resources, extra help paying for Medicare prescription drug coverage is available. Information about this extra help is available from the Social Security Administration (SSA) online at www.socialsecurity.gov or You can call them at 1-800-772-1213 (TTY 1-800-325-0778).

Remember: If You enroll in one of the plans approved by Medicare which offer prescription drug coverage, You may be required to provide a copy of this notice when You join to show that You are not required to pay a higher premium amount.

ARTICLE FIVE: ENROLLMENT AND CONTRIBUTIONS

PARTICIPANT ENROLLMENT AND ELIGIBILITY

I. The "Benefits Effective Date" for an Employee shall be the first day of the month following or coinciding with the date of hire; provided that:

- The Employee meets the requirements for Eligibility and enrolls in the Plan within 30 days of the date of Eligibility; and

- The Employer and Employee make any required contributions toward the cost of coverage for the Participant and any Covered Dependent(s). The formula used for allocating the required contributions shall be determined by such Employee's Employer and the premium to be collected must be approved by the ICUBA Board of Directors. The amount of the respective contributions shall be set forth in notices from the Plan Administrator and may be changed at any time by the ICUBA Board of Directors.

II. Covered Active Employees Age 65 or Over

If You are age 65 or older and Actively at Work, You will remain covered under the Plan and be eligible for the same Benefits that are available to Employees under age 65. In such case, the following shall apply:

- The Plan shall pay all eligible Benefits first.

- Medicare will then pay for Medicare eligible expenses, if any, that were not paid by the Plan.

- If You are age 65 or older and Actively at Work, You may elect not to be covered under the Plan. In such case, Medicare will be Your only coverage. If You choose this option, You will not be eligible for any Benefits under the Plan.

- If You are Actively at Work, Your spouse has the same choices for Benefit coverage as indicated above for an Employee age 65 or older.

- Regardless of the choice made by You or Your spouse, each one of You should apply for Medicare Part A coverage about three months prior to turning age 65. If You choose the Plan as primary, You may wait to enroll in Medicare Part B. You will be able to enroll in Medicare Part B later during special enrollment periods without penalty.

III. The ICUBA Prescription Drug Benefit is Creditable Coverage, which means that You will receive credit towards Medicare Part D upon Your retirement if You choose to enroll in Medicare Part D. Creditable Coverage means that the amount the Plan expects to pay on average for Prescription Drugs for individuals covered under the Plan in the applicable year is the same or more than what standard Medicare Prescription Drug coverage would be expected to pay on average. This is important because the Medicare Modernization Act (MMA) imposes a late enrollment penalty on individuals who do not maintain Creditable Coverage for a period of 63 days or longer following their initial enrollment period for the Medicare Part D Prescription Drug benefit. MMA mandates that certain entities offering Prescription Drug coverage, including employer and union group health plan sponsors, disclose to all Medicare eligible individuals with Prescription Drug coverage under the Plan whether such coverage is "creditable". This information is essential to an individual's decision whether to enroll in a Medicare Part D Prescription Drug plan. The Plan pays for other health expenses in addition to Prescription Drugs. If You or Your Dependent enroll in a Medicare Part D Prescription Drug plan, You and Your eligible Dependents will still be able to receive all Your current health and Prescription Drug benefits under this Plan.

DEPENDENT ENROLLMENT AND ELIGIBILITY

Initial Enrollment. If an Employee enrolls a Dependent within 30 days of his or her date of hire, the Dependent's Benefits Effective Date shall be the same day as the Participant's Benefits Effective Date.

Participant or Dependent Contributions. A Participant or Dependent may be required to make periodic contributions toward the cost of coverage under the Plan in an amount determined by the Employer or the Plan Administrator. The amount of the respective contributions shall be set forth in notices from the Plan Administrator and may be changed from time to time by ICUBA.

SPECIAL ENROLLMENT

The Health Insurance Portability and Accountability Act of 1996 (HIPAA) provides special enrollment opportunities for certain events. If an Employee or the Employee's Dependents are eligible to participate in the Plan, but are not already enrolled in the Plan, the Employee may request Special Enrollment mid-Plan Year (4/1 – 3/31) upon either (1) the loss of other group health plan coverage or (2) the addition of a new Dependent; **provided, however, that the Plan is notified of the Special Enrollment request within 30 days of the event (except as provided in Section E and F under Change in Status below).**

The special enrollment rights provided by HIPPA rules include the right to select among all the benefit options available under the Plan. For example, if an Employee's spouse loses other coverage and qualifies for Special Enrollment, the Employee may add the spouse to the Plan and may elect to switch to another benefits option under the Plan. Similarly, when a covered Employee marries, the Employee may not only add his or her new spouse to the Plan, but the Employee may also select among the Plan's coverage options.

a. **Loss of Other Group Health Plan Coverage.** An Employee or Dependent who is eligible to participate in the Plan, but not enrolled in the Plan, may enroll if the Employee or Dependent was covered under another group health plan or had health insurance coverage at the time he or she became eligible for coverage under this Plan; and

   The other coverage of the Employee or Dependent ended because:

   1. The other coverage was COBRA Continuation Coverage that was exhausted. COBRA Continuation Coverage is considered exhausted when it ceases for any reason other than the person's failure to pay premiums on a timely basis or for improper or illegal acts (such as making a fraudulent claim or an intentional misrepresentation); or

   2. The other health coverage was not COBRA Continuation Coverage and was terminated due to either a loss of eligibility for the coverage (i.e., due to legal separation, divorce, death, termination of employment, or reduction in the number of hours of employment) or because employer contributions for the other coverage were terminated or significant cost increase or decrease occur. An individual will not have Special Enrollment rights if the other coverage ended due to the individual's failure to pay premiums on a timely basis or for cause (e.g., making fraudulent claims or intentional misrepresentations, etc.).

b. **Newly Acquired Dependents**

   1. An Employee's newly-acquired Dependents may enroll in the Plan if: (i) the Employee is a Participant in this Plan or, if not a Participant at the time, the Employee has met the waiting period applicable to becoming a Participant and is eligible to be enrolled under this Plan; and (ii) the person becomes a Dependent of the Employee through marriage, birth, adoption, or placement for adoption (this includes foster children and/or other children in court-ordered custody of the Employee).

   2. If the Employee is not yet a Participant, the Employee must enroll during the Special Enrollment Period for the newly acquired Dependent to be eligible for coverage. In the case of birth or adoption of a child, the spouse and any other Dependent children of the covered Employee may be enrolled as Dependents of the covered Employee if the spouse and other Dependent children are eligible for coverage. The Special Enrollment Period is a period of not more than 30 days that begins on the date of the marriage, birth, adoption, or placement for adoption.

3. The coverage of the Employee or Dependent enrolled during the Special Enrollment Period will be effective: (i) in the case of marriage, from the date of marriage; (ii) in the case of a Dependent's birth, as of the date of birth; (iii) in the case of a Dependent's adoption or placement for adoption, the date of the adoption or placement for adoption; (iv) in the case of foster children, as of the date of placement in the residence; and (v) in the case of children in court-ordered custody of the Employee, as of the date of the order; provided, however, that in each case, the individual is enrolled within 30 days of becoming eligible for such enrollment and the Employee substantiates within that timeframe by providing the necessary documentation to the Plan Administrator or Employer.

4. If a Dependent is acquired other than at the time of birth, due to a court order, decree, or marriage, that Dependent will be considered a Dependent from the date of such court order, decree, or marriage, provided that this new Dependent is properly enrolled as a Dependent within 30 days of the court order, decree, or marriage and proof of the court order, decree, or marriage is provided to the Plan Administrator or Employer within that timeframe.

In order to change benefits mid-Plan Year (April 1 to March 31) due to a Special Enrollment event, You must complete, sign, and return an application to Your Employer or enroll online at http://icubabenefits.org within 30 days after the date of the event. You must provide the Plan Administrator or Your Employer with documentation substantiating the event within the same 30-day period. Once You have provided substantiation of the event, You and/or Your Dependents (as applicable) shall be enrolled in the Plan, effective as of the dates set forth above.

VERY IMPORTANT NOTE: Actual enrollment is necessary for a newborn, adopted child, child placed for adoption, foster child, or other child in court-ordered custody to be covered under the Plan, even if you have other children already covered under the Plan. This means that You must obtain, complete, sign, and return a new enrollment form or make Your election online to add a newborn, adopted child, foster child, or other child in court-ordered custody to the Plan and provide substantiation. If You fail to complete, sign, and return an enrollment form or enroll online within 30-days after the Special Enrollment event, the Dependent will not have coverage or be able to enroll in the Plan until the next Open Enrollment (unless a subsequent Special Enrollment event or Change in Status event occurs).

Claims for maternity expenses or maternity leave do not constitute notification or enrollment of a new Dependent for coverage. If You do not enroll Your Dependent within 30 days from the date of the Special Enrollment event, Your Dependent will not be covered under the Plan and will not have coverage for any conditions other than for the charges covered under the maternity coverage of a newborn's mother.

CHANGE IN STATUS

Once enrollment elections are made, either during the initial or Special Enrollment periods or during the annual Open Enrollment period, those elections may not be changed and will remain in effect for the entire Plan Year. However, there are some important mid-Plan Year exceptions:

A. **Change in Status.** Employees may revoke or modify their enrollment elections mid-Plan Year only if they experience a Change in Status that affects their or their Dependent's eligibility under this Plan. An election change will be approved only if it is consistent with the Change in Status. An election change is "consistent with" a Change in Status if the change is both the result of, and corresponds with, the Change in Status. For example, if a child ceases to be eligible for coverage because of age, it would be consistent with the Change in Status to drop coverage for the child. However, it would not be consistent with the Change in Status to drop coverage for the Employee.

B. **Change in Cost or Coverage.** If the cost of Benefits increases or decreases during a Plan Year, the Plan Sponsor may automatically change Employee premium contributions. When the change in cost is significant, Employees will be given the opportunity to either increase their contributions or elect a less-costly option (if available). If there is a significant overall reduction in the Plan's coverage, Employees may elect another benefit option (if available). If a new Benefit option is added under the Plan, Employees will have the right to change their election to the new Benefit option.

C. **Qualified Medical Child Support Order ("QMCSO").** A child may become eligible for coverage as set forth in a Qualified Medical Child Support Order under ERISA §609(a), including National Medical Support Notice. An Employee may change

his or her Plan enrollment elections if the Employee becomes subject to a QMCSO that requires the Employee to provide (or cancel) health care coverage for the Dependent child; provided, however, that the Plan Administrator shall have sole discretion to determine whether a medical child support order is qualified and for administering the provision of Benefits under the Plan pursuant to a QMCSO. The Plan has procedures for determining whether an order qualifies as a QMCSO. Participants and beneficiaries can obtain, without charge, a copy of such procedures from the Plan Administrator. The Plan Administrator may seek clarification and modification of the order, up to and including, the right to seek a hearing before the court or agency, which issued the order.

D. **Entitlement to Medicare or Medicaid.** An Employee may change his or her elections for Plan coverage if the Employee or any Dependent becomes entitled to or loses Medicare or Medicaid coverage. In such cases, an employee shall be given 60 days for this special enrollment period.

E. **Change in coverage under another employer plan.** An Employee may make a prospective election change that is on account of, and corresponds with, a change made under another employer plan (including a plan of the Policyholder or of another employer) if:

1. The other cafeteria plan or qualified benefits plan permits Participants to make an election change that would be permitted under the applicable provisions of Internal Revenue Code Section 125; or

2. The cafeteria plan permits Participants to make an election for a period of coverage that is different from the period of coverage under the other cafeteria plan or qualified benefits plan.

F. **Loss of coverage under other group health coverage.** An Employee may make an election on a prospective basis to add coverage under the group policy/plan for the Employee or Employee's Dependent if such Employee or Dependent loses coverage under any group health coverage sponsored by a governmental or educational institution, including a:

1. State children's health insurance program under Title XXI of the Social Security Act;

2. Medical care program of an Indian Tribal government, the Indian Health Service, or a tribal organization;

3. A State health benefits risk pool; or

4. A foreign government group health plan.

In such cases, an employee shall be given 60 days for this special enrollment period.

If an Employee experiences an event that allows the Employee to make a mid-Plan Year enrollment change, the Employee must enroll online at http://icubabenefits.org or submit a completed enrollment change form to the Employer no later than 30 days after the event occurs, except for sections (D) and (F) above. If the Employee does not request the coverage change within the specified time limit, the Employee will lose the right to make a change allowed by that event. If approved, the Employee's enrollment change(s) shall take effect on the date of the event.

Consistency Rule: In all cases, any election change because of any change in status must be on account of and correspond with a change in status that affects eligibility for coverage under the plan. For example, if the change in status is the Employee's divorce, annulment or legal separation from a spouse, the death of a spouse or dependent child, or a dependent ceasing to satisfy the eligibility requirements for coverage, an Employee's election to cancel health coverage will apply only to the spouse involved in the divorce, annulment or legal separation, the deceased spouse or dependent child, or the dependent that ceased to satisfy the eligibility requirements.

TERMINATION OF COVERAGE

A Participant's and/or covered Dependent's coverage under the Plan shall terminate on the earliest of the following dates:

- The last day of the month in which the Participant Terminates Employment with the Employer unless the Employer is obligated to continue to make contributions on behalf of the Participant by terms of an employment agreement;

- The last day of the month in which the Participant ceases to be eligible for the Plan due to a reduction in his or her number of hours of employment;

- The last day of the month in which the Participant loses his or her status as a Participant, or a Dependent loses his or her status as a Covered Dependent;

- The last day of the month in which the Participant ceases to be in a class eligible for coverage;

- The date on which this Plan is terminated (or in the case of any Benefit under this Plan, the date of termination of the specific benefit);

- The date following the date the Participant dies; provided, however, that any Covered Dependent may remain a Dependent for the applicable period of COBRA Continuation Coverage set forth in Article Six provided that the Covered Dependent complies with the conditions therein;

- The date the Participant, while on any Approved Leave of Absence, including Approved Disability Leave, or Approved Sabbatical, becomes employed full-time by another employer, or fails to return from such Approved Leave of Absence within 12 months of the date the Approved Leave of Absence commenced;

- The date the Participant fails to timely pay any required contributions; in such case, coverage shall terminate on the last date for which the required contributions were paid by the Employer and or Employee, and as determined by the Plan Administrator;

- The date that the Participant fails to return from a leave of absence under the Family and Medical Leave Act of 1993 after the maximum period allowed under the Act has expired;

- The date that the Participant fails to return from a Leave of Absence under the Uniformed Services Employment and Reemployment Rights Act (USERRA) of 1994 after the maximum period allowed under the Act has expired; or

- The date the Participant's request to revoke or modify coverage due to a Change in Status is approved. The Participant must notify the Plan Administrator or Employer of a Change in Status, either in writing or online, within 30 days of the Change in Status. Coverage is terminated on the last day of the month in which employment ends, or on the effective date of the Change in Status. If coverage is terminated during Open Enrollment, coverage terminates on the last day of the month of the Benefit Plan Year (April 1 to March 31).

LATE ENROLLEES

Late Enrollees may enroll in the Plan only during Open Enrollment as set forth in the Open Enrollment Section. The Benefits Effective Date of the Late Enrollee's coverage is the first day of the Plan Year (April 1 to March 31) following enrollment.

THE GENETIC INFORMATION NON-DISCRIMINATION ACT OF 2008 (GINA)

GINA prohibits discrimination in group health plan coverage based on genetic information. GINA provides that group health plans cannot base premiums for an employee or group of similarly situated individuals on genetic information. GINA also prohibits plans from requesting or requiring an individual to undergo a genetic test. There is a research exception that permits a plan to request but not require that a Participant or Beneficiary undergo a genetic test.

GINA also restricts the Plan from collecting genetic information (including family medical history) prior to or in connection with enrollment. Under GINA, the Plan is generally prohibited from offering rewards in return for collection of genetic information, including family medical history collected as part of a Personal Health Assessment (PHA).

The Plan will not discriminate against Participants or Beneficiaries eligible to participate in the Plan's Wellbeing programs and do not require individuals to meet any standards related to a health factor to obtain a reward, as specified in 29 CFR 2590.702(f)(2)(iii). Rewards for completion of a PHA are available whether the individual answers the questions regarding genetic information (e.g., family history).

If it is unreasonably difficult due to a medical condition for You to achieve the standards of the reward by attending a health fair under this program, call ICUBA at 1-866-377-5102 and we will work with You to develop another way to qualify for the reward.

OPEN ENROLLMENT

The Plan shall conduct an Open Enrollment each year. During Open Enrollment, Participants may make any of the following changes regarding participation in the Plan, subject to other governing provisions of this Plan Document.

- Enroll as a Late Enrollee;
- Add Dependents not able to enroll during the Plan Year of April 1 through March 31 as Special Enrollees; and;
- Make such other changes as permitted by this Plan Document (including dropping coverage).

ELIGIBLE RETIREE'S PARTICIPATION

Retirees must meet a Member Institution's definition of Eligible Retiree to be covered under the ICUBA Retiree Plan. Retirees and their Dependents MUST enroll in medical coverage within 30 days of retirement unless the Eligible Retiree or Dependent chooses COBRA Continuation Coverage in lieu of the Retiree Plan. See Article Six for COBRA Continuation Coverage enrollment rights.

An Eligible Retiree Dependent shall participate in the Plan as of the date of the Eligible Retiree's retirement from a Member Institution, subject to the following:

- If Your Dependent spouse is not a Covered Person at the time You become an Eligible Retiree, Your Dependent spouse may not thereafter become a Covered Person in the Plan unless You and Your spouse acquire a new Dependent by adoption, placement for adoption, or birth (see Dependent Enrollment for further information) or Your Dependent spouse submits a request for Special Enrollment in writing to the Plan Administrator no later than 30 days after the date of a qualifying event (e.g., spouse loss of employer provided coverage);
- During any open enrollment period an Eligible Retiree may elect any ICUBA Retiree Plan if the Eligible Retiree was covered in an ICUBA Retiree Plan prior to the open enrollment period;
- Upon Your death, any Covered Dependent may remain a Dependent for the applicable period of COBRA Continuation Coverage set forth in Article Six, provided that the Covered Dependent complies with the conditions therein; and
- If You terminate participation in the Plan for any reason other than for death, Your eligible Dependents shall terminate participation in the Plan as of Your termination date.

ELIGIBLE RETIREE'S PREMIUM

An Eligible Retiree will be offered coverage at a premium rate, which is based upon attained age at the time of retirement. An Eligible Retiree who is under the age of 65 will be offered the Active Employee Plan at 100% cost. Upon attainment of age 65, the Eligible Retiree shall be the AmWins Medicare Supplement Plan.

The AmWins Medicare Supplement Plan pays secondary to Medicare and is age banded. Upon attainment of an age in a different age band, an Eligible Retiree's premium will change on the first day of the Plan Year following his or her attainment of an age in a new age band.

ARTICLE SIX: CONTINUATION OF COVERAGE

COBRA Continuation Coverage is a temporary extension of group health coverage under the Plan which may allow You and Your family members to continue coverage under certain circumstances when coverage would otherwise end. This Article generally explains COBRA Continuation Coverage, when it may become available to You and Your Family, and what You need to do to protect the right to receive it. When You become eligible for COBRA, You may also become eligible for other coverage options that may cost less than COBRA continuation coverage.

COBRA CONTINUATION COVERAGE

COBRA Continuation Coverage shall be permitted in the following circumstances:

a. **COBRA Continuation Coverage for Employees**. A Participant may elect COBRA Continuation Coverage, at the Participant's own expense at 102% of the total cost of the coverage elected under the Plan, if the Participant's participation under the Plan terminates because of Termination of Employment or reduction of hours with a Member Institution. The COBRA Administrator will not offer COBRA Continuation Coverage where the COBRA Administrator determines that the Termination of Employment was due to gross misconduct.

b. **COBRA Continuation Coverage for Dependents**. A Dependent may elect COBRA Continuation Coverage, at the Dependent's own expense at 102% of the total cost of the coverage elected under the Plan, if the Dependent's participation under the Plan would terminate because of one of the following Qualifying Events:

   - Death of a Participant;
   - A reduction in hours of a Participant;
   - Termination of Employment of a Participant, except for a termination due to gross misconduct;
   - The Participant becomes enrolled in Medicare benefits;
   - Divorce or legal separation of the Participant (If an Employee cancels coverage for his or her spouse in anticipation of a divorce or legal separation, and a divorce or legal separation later occurs, then the divorce or legal separation will be considered a Qualifying Event even though the ex-spouse lost coverage prior to the date of divorce or legal separation. If the ex-spouse notifies the COBRA Administrator within 60 days after the divorce or legal separation and can establish that the Employee canceled the coverage earlier in anticipation of the divorce or legal separation, then COBRA coverage may be available for the period after the divorce or legal separation.);
   - A Dependent child ceases to qualify as a Dependent under the Plan; or
   - Bankruptcy. Sometimes, filing for bankruptcy under Title 11 of the United States Code can be a Qualifying Event. If a bankruptcy is filed by the sponsor of this Plan, and that bankruptcy results in the loss of coverage of any retired Participant under the Plan, the retired Participant is a Qualified Beneficiary with respect to the bankruptcy. The retired Participant's spouse, surviving spouse, and Dependent children will also be Qualified Beneficiaries if bankruptcy results in the loss of their coverage under this Plan.

c. Other individuals who may be Qualified Beneficiaries include:

   - **Recipients under Qualified Medical Child Support Orders**. A child of the Participant who is receiving Benefits under the Plan pursuant to a Qualified Medical Child Support Order received by the COBRA Administrator during the Participant's period of employment with the Employer is entitled to the same rights under COBRA as a Dependent child of the Participant, regardless of whether that child would otherwise be considered a Dependent.

- **Children born to or placed for adoption with a Participant during COBRA period**. Children born to, adopted by, or placed for adoption with a Participant during a period of COBRA Continuation Coverage is a Qualified Beneficiary provided that, if the Participant is a Qualified Beneficiary, the Participant has elected COBRA Continuation Coverage for himself or herself. The child's COBRA coverage begins when the child is enrolled in the Plan, whether through Special Enrollment or Open Enrollment, and it lasts for as long as COBRA Continuation Coverage lasts for other Family members of the Participant. To be enrolled in the Plan, the child must satisfy the otherwise applicable Plan requirements.

- **Tag along of children**. A Participant who enrolls a child during Special Enrollment pursuant to subsection (c)(2) above may at the same time enroll any other Dependent children of the Participant who are not already enrolled in the Plan but who are eligible for coverage. Any such individuals so added shall nonetheless not be Qualified Beneficiaries.

d. **Duty to Notify COBRA Administrator of Qualifying Events**. A Participant or Dependent must timely notify the COBRA Administrator in writing that a Qualifying Event has occurred to be eligible for COBRA Continuation Coverage.

1. Notice must be given by the Member Institution within thirty (30) days of the following events:

    - Termination of Employment of a Participant;
    - Reduction of hours of employment of a Participant;
    - Death of a Participant;
    - Commencement of a bankruptcy by the Member Institution; or
    - Enrollment of a Participant in Medicare.

2. Notice must be given by the Plan Participant or Qualified Beneficiary within sixty (60) days of the following events:

    - Divorce or legal separation of a Participant;
    - Dependent child loses Eligibility for coverage as a Dependent child.

If the following procedures are not observed or if written notice is not provided to the COBRA Administrator within the requisite time, any Spouse or Dependent who loses coverage **WILL NOT BE OFFERED THE OPTION TO ELECT COBRA CONTINUATION COVERAGE.**

Notice Procedures: Any notice that You provide must be in writing. Oral notice, including notice by telephone, is not accepted. You must mail Your notice to the COBRA Administrator at this address:

ICUBA COBRA
c/o Ameriflex COBRA Department
7 Carnegie Plaza
Suite 200
Cherry Hill, NJ 08003
Telephone: 1-866-377-5102, Option 1
Fax: 1-609-257-0136
Email: COBRA@myameriflex.com

If mailed, Your notice must be postmarked no later than the last day of the required notice period. Any notice You provide must state the name of the Plan (Independent Colleges and Universities Benefits Association, Inc. Medical, Behavioral Health and Prescription Drug Plan), the name and address of the Employee covered under the Plan, and

the name(s) and address(es) of the Qualified Beneficiary(ies). Your notice must also name the Qualifying Event and the date it occurred.

The Plan's "Notice of Qualifying Event" form should be used to notify the COBRA Administrator of a Qualifying Event. (A copy of this form can be obtained from the COBRA Administrator.) If the Qualifying Event is a divorce, Your notice must include a copy of the divorce decree.

Your notice of a second Qualifying Event also must name the event and the date it occurred. If the Qualifying Event is a divorce, Your notice must include a copy of the divorce decree.

Your notice of Disability must also include the name of the disabled Qualified Beneficiary, the date when the Qualified Beneficiary became Disabled and the date the Social Security Administration made its determination. Your notice of Disability must include a copy of the Social Security Administration's determination. Qualified Beneficiaries who wish to take advantage of the 11-month Disability extension must notify the COBRA Administrator of the disabled Qualified Beneficiary's Social Security determination. The notice must be provided within 60 days of the Disability determination and prior to the expiration of the initial 18-month period of COBRA coverage. You must also notify the Plan if the Qualified Beneficiary is determined by the Social Security Administration to no longer be Disabled.

The Plan's Notice by Qualified Beneficiary form should be used to notify the COBRA Administrator of a second Qualifying Event, a disability determination, or a determination that a Qualified Beneficiary is no longer disabled. (A copy of this form can be obtained from the COBRA Administrator.)

e. **Electing COBRA Continuation Coverage**. COBRA coverage is retroactive to the first day a Participant is no longer covered by the Plan if elected and paid for by the Qualified Beneficiary. The following rules apply to COBRA elections:

- COBRA Continuation Coverage will begin on the date of the Qualifying Event for each Qualified Beneficiary who timely elects COBRA Continuation Coverage provided that full and timely premium payments are made.
- Each Qualified Beneficiary has an independent right to elect COBRA Continuation Coverage.
- A Qualified Beneficiary must elect coverage in writing within 60 days of being provided a COBRA election notice, using the Plan's "Election Form", and following the procedures specified on the Election Form. This period is measured from the later of the date that coverage was lost or the date the COBRA election notice was provided.
- Written notice of election must be provided to the COBRA Administrator at the address provided on the Plan's Election Form. If mailed, Your election must be postmarked no later than the last day of the 60-day election period.
- A Participant or Dependent may change a prior rejection of COBRA Continuation Coverage at any time during the 60-day period by providing the written notice of election described above.
- A Participant or Dependent who fails to elect COBRA Continuation Coverage within the 60-day election period will lose his or her right to elect COBRA Continuation Coverage.

f. **Length of Continuation Coverage**.

1. **Period of Continuation Coverage for Participants**. A Participant who qualifies for COBRA Continuation Coverage because of Termination of Employment or reduction in hours of employment as described above, may elect COBRA Continuation Coverage for up to 18 months measured from the date of the Qualifying Event.

2. **Coverage under this section may not continue beyond**:

- The last day of the month for which full and timely premium payments have been made in accordance with subsection (f)(4) below;

- The date the Participant becomes entitled to Medicare. However, if Medicare is obtained prior to the COBRA election, COBRA coverage may not be discontinued; or

- The first day the Participant is covered under any other group health plan that is not maintained by ICUBA. However, if other group health coverage is obtained prior to the COBRA election, COBRA coverage may not be discontinued.

3. **Period of COBRA Continuation Coverage for Dependents**. If a Dependent elects COBRA Continuation Coverage under the Plan because of the Participant's Termination of Employment or reduction in hours of employment as described above, Continuation Coverage may be continued for up to 18 months measured from the date of the Qualifying Event. COBRA Continuation Coverage for all other Qualifying Events may continue for up to 36 months. In addition to maximum periods discussed immediately above, Continuation Coverage under this subsection may not continue beyond:

   - The last day of the coverage period for which required contributions have been made, in accordance with subsection (4) below;
   - The date the Dependent becomes entitled to Medicare. However, if Medicare is obtained prior to COBRA election, COBRA coverage may not be discontinued;
   - The first day after the COBRA Continuation Coverage election, when the Participant is covered under any other group health plan that is not maintained by ICUBA. However, if other group health coverage is obtained prior to the COBRA election, COBRA coverage may not be discontinued; or
   - If the Participant elects COBRA Continuation Coverage and, during the period of COBRA Continuation Coverage, a child is born or placed for adoption with the Participant, the Participant has the right to elect COBRA Continuation Coverage for the child, provided the child satisfies the otherwise applicable Plan Eligibility requirements and the Participant notifies the Plan of the birth or placement for adoption within 60 days of the birth or adoption. The period of COBRA Continuation Coverage shall be the same as that for the Participant, or as set forth below.

4. **Contribution Requirements for COBRA Continuation Coverage**. Participants and Dependents who elect COBRA Continuation Coverage because of one of the Qualifying Events specified above must make Continuation Coverage Payments. The first Continuation Coverage Payment is due prior to the first day on which COBRA Continuation Coverage will take effect. However, a Participant or Dependent has 45 days from the date of the affirmative election to pay the Continuation Coverage Payment. This initial Continuation Coverage Payment shall apply to the period between the date coverage under the Plan would otherwise have terminated due to the Qualifying Event and the date the Participant and/or Dependent elects COBRA Continuation Coverage, and to the first month's coverage. The Participant and/or Dependent shall have a 30-day grace period to make the Continuation Coverage Payments due thereafter. Continuation Coverage Payments must be postmarked on or before the completion of the 30-day grace period. If Continuation Coverage Payments are not made on a timely basis, COBRA Continuation Coverage will terminate as of the last day for which required contributions were made. The 30-day grace period shall not apply to the 45-day period for payment of initial COBRA premiums as set out in this subsection. If premiums are not paid by the first day of the period of coverage, the Plan has the option to cancel coverage until payment is received and then reinstate the coverage retroactively to the beginning of the period of coverage if the payment is received within the allowable 30-day grace period.

   - If the amount of the payment made to the Plan is made in error but is not significantly less than the amount due (the lesser of $50 or 10% of the premium amount), the Plan is required to notify You of the deficiency and grant a reasonable period (for this purpose, 30 days is considered reasonable) to pay the difference. The Plan is not obligated to send monthly premium notices. COBRA Qualified Beneficiaries remain subject to the Plan's rules.

5. **Limitation on Participant's Right to COBRA Continuation Coverage**

- If a Dependent loses or will lose coverage under the Plan because of a divorce or ceasing to be a Dependent, the Participant or Dependent is responsible for notifying the COBRA Administrator within 60 days of the divorce or loss of Dependent status. Failure to make timely notification will terminate the Dependent's rights to COBRA Continuation Coverage under this Article.
- A Participant or Dependent must complete, sign, and return the required enrollment materials within 60 days from the later of:
- Loss of coverage, or
- The date the COBRA Administrator or its authorized representative sends notice of eligibility for COBRA Continuation Coverage
- You will be given the option to continue Your Health Care Spending Account (HCSA) through COBRA at 102% of the monthly deposit amount until the end of the current plan year. You will not have the option of increasing or decreasing Your HCSA election amount during the COBRA enrollment period. If Your COBRA coverage continues beyond the current plan year, You will not have the option to elect the HCSA during open enrollment. The Dependent Care Spending account (DCSA) is not eligible for continuation through COBRA.
- You will be given the option to continue Your Health Reimbursement Account (HRA) through COBRA at 102% of the monthly deposit amount. Vesting calculation will end on Your last day of employment even if the HRA is continued through COBRA.
- Failure to enroll for COBRA Continuation Coverage during this 60-day period will terminate all rights to COBRA Continuation Coverage under this Plan. An affirmative election of COBRA Continuation Coverage by a Participant or Participant's spouse shall be deemed to be an election for that Participant's Dependents who would otherwise lose coverage under the Plan.

6. **Multiple Qualifying Events**. If a second Qualifying Event which would entitle the Spouse and Dependents to 36 months of Continuation Coverage occurs during an 18-month extension explained above, coverage may be continued for a maximum of 36 months from the date of the first Qualifying Event provided that the Qualified Beneficiary notifies the Plan Administrator within 60 days of the second Qualifying Event. Such second Qualifying Events include the death of an Employee, divorce from an Employee, an Employee's enrollment in Medicare, or a Dependent child ceasing to be Eligible for coverage as a Dependent under the Plan. You must notify the Plan Administrator within 60 days after the second Qualifying Event using the Notice Procedures described in Section 6 (d). Failure to provide timely notice will result in non-extension of COBRA Continuation Coverage.

7. **Medicare Entitlement**. If a spouse or Dependent loses coverage due to a Qualifying Event, and the Employee later becomes entitled to Medicare, the spouse or Dependent shall be eligible for up to 36 months of coverage measured from the date of the Qualifying Event, which caused the loss of coverage. However, if the Employee was entitled to Medicare within 18 months prior to the Qualifying Event, then spouse or Dependent shall have up to 36 months of coverage measured from the date of entitlement to Medicare.

8. **Extension of COBRA Continuation Period for Disabled Participants**. The period of continuation shall be extended to 29 months (measured from the date of the Qualifying Event) in the event:

   - The Participant is Disabled (as determined by the Social Security Administration) within 60 days after the date of the Qualifying Event, and
   - The individual provides evidence to the COBRA Administrator or its authorized representative of such a determination by the Social Security Administration prior to the earlier of 60 days after the date of the Social Security determination, or the expiration of the initial 18 months of COBRA Continuation Coverage.

In such event, the Plan may charge the individual up to 150% of the cost of the coverage for all months after the 18th month of COBRA coverage. The Participant must notify the Plan Administrator if the Participant is deemed no longer disabled, in which case COBRA Continuation Coverage ends as of the first day of the coverage period that is more than 30 days after the Social Security Administration's determination.

9. **Extension of COBRA Continuation Coverage Period for Disabled Dependents**. The period of continuation shall be extended to 29 months (measured from the date of the Qualifying Event) in the event the Dependent is Disabled as determined by the Social Security Administration within 60 days after the date of the Qualifying Event and the individual provides written evidence to the Plan Administrator or its authorized representative of such Social Security determination 60 days after the date of such determination and prior to the expiration of the initial 18 months of COBRA Continuation Coverage. In such event, the Plan may charge the individual up to 150% of the cost of the coverage from all months after the 18 months of coverage.

g. **Cost of Continuation Coverage**. Generally, each Qualified Beneficiary is required to pay the entire cost of COBRA Continuation Coverage. The amount a Qualified Beneficiary may be required to pay may not exceed 102% of the cost to the group health plan (including both Employer and Employee contributions) for coverage of a similarly situated Plan Participant or Beneficiary who is not receiving COBRA Continuation Coverage (or in the case of an extension of COBRA Continuation Coverage due to a Disability, 150%). COBRA premiums may be increased if the costs to the Plan increase but generally must be fixed in advance of each 12-month premium cycle.

h. **Non-sufficient Funds**.

- If a Participant sends a check for a monthly COBRA premium that is returned for non-sufficient funds (NSF), the Participant is notified by letter and asked to resubmit the payment plus a bank fee of $15. The Participant is advised that an NSF check is considered non-payment of premium and is given 15 days from the date of the letter to send replacement payment. The payment is adjudicated by the postmark.
- If a second check is also returned for Non-Sufficient Funds, the Participant is sent a second letter and asked to re-submit payment plus a fee of $15 within 15 days of the date of the second letter. The Participant is advised that a Non-Sufficient Funds check is considered non-payment, and that their coverage has been cancelled until payment plus the bank fee is received and funds are verified. The Participant is notified that any further NSF checks will result in termination of COBRA coverage with no reinstatement. If there are any further Non-Sufficient Funds payments, coverage is terminated and there is no opportunity for reinstatement of coverage. This notice is sent certified mail/return receipt.

USERRA COVERAGE

Your Rights Under COBRA and USERRA (Uniformed Services Employment and Reemployment Rights Act). Your rights under COBRA and USERRA are similar but not identical. Any election that You make pursuant to COBRA will also be an election under USERRA. COBRA and USERRA will both apply with respect to the continuation coverage elected. If COBRA or USERRA give You or Covered Dependents different rights or protections, the law that provides the greater benefit will apply. USERRA does not provide coverage for Dependents.

The Uniformed Services Employment and Reemployment Rights Act of 1994 (USERRA) established requirements that employers must meet for certain employees who are involved in the Uniformed Services (as defined below). In addition to the rights that You have under COBRA, You are entitled under USERRA to continue the coverage You had under the Plan.

Uniformed Services means the U.S. Armed Services (including the Coast Guard), the Army National Guard and the Air National Guard (when engaged in active duty for training, inactive duty training, or full-time National Guard duty), and the commissioned corps of the Public Health Service. The President is authorized to expand the categories of Uniformed Services through the exercise of emergency or war powers.

Service in the Uniformed Services or Service means the performance of duty on a voluntary or involuntary basis in the Uniformed Services under competent authority, including active duty, active duty for training, initial active duty for training, inactive duty training, full time National Guard duty, and the time necessary for a person to be absent from employment for an examination to determine the fitness of the person to perform any of these duties.

a. **Employee must give advance notice**. A Participant leaving for Service in the Uniformed Services must give the Member Institution/Employer advance notice of the absence from employment for Service. Notices can be written or oral. No such notice is required if the notice is precluded by military necessity or if the giving of notice is impossible or unreasonable under the circumstances.

b. **Employee absence must not exceed 5 years**. The cumulative length of absence and all previous absences from the employment of the current Employer for periods of Service in the Uniformed Services must not exceed 5 years. The 5-year period does not include periods when an individual:

- is required to complete an initial period of obligated service;
- is unable to obtain release orders through no fault of his or her own;
- required to complete specific training requirements;
- is ordered to, or retained on, active duty because of war or national emergency declared by the President or by Congress;
- is ordered to active duty in support of an operational mission or in support of a critical mission; or
- is called into Service as a member of the National Guard.

c. **Employee must report to work within specific timeframes after service ends**. Upon completion of Service in the military, the Employee must notify the Employer of the intention to return to work. The following chart identifies the notification requirements under USERRA:

Period of Absence	Return to Work Requirement
Less than 30 days	Report to work at the beginning of the first regularly scheduled work period following the end of service plus eight hours, or as soon as possible thereafter if satisfying the deadline is unreasonable or impossible through no fault of the Employee.
More than 30 days but less than 181 days	Submit an application for employment not later than 14 days after the completion of the service, or as soon as possible thereafter if satisfying the deadline is unreasonable or impossible through no fault of the Employee.
Period of Absence	**Return to Work Requirement**
More than 180 days	Submit an application for employment not later than 90 days after the completion of the service.
Any period if the absence was for purposes of an examination for fitness to perform service	Report to work at the beginning of the first regularly scheduled work period following the end of service plus eight hours, or as soon as possible thereafter if satisfying the deadline is unreasonable or impossible through no fault of the Employee.
Person who is injured or ill because of (or Injury or Illness was aggravated by) military service	Apply for work or submit application as described above (depending on length of absence) when recovery is complete if recovery time is limited to two years. The two-year period is extended by any minimum time required to accommodate circumstances beyond the Employee's control that makecompliance with these deadlines unreasonable or impossible.

d. **Employee's undesirable conduct**. Rights under USERRA will be terminated if service in the military ends under any of the following circumstances:

- Separation from service with a dishonorable or bad conduct discharge;
- Certain less-than-honorable circumstances as characterized by the Department of Labor;
- For a commissioned officer, dismissal in connection with a court-martial; and
- The dropping of a commissioned officer from the rolls because of an unauthorized absence for at least three months or because of a sentence imposed after a court-martial or a conviction in another court.

e. **USERRA coverage maximum twenty-four (24) months**. When a Participant takes a leave for Service, continued coverage under the Plan, as required by USERRA will begin the day after the Participant loses coverage under the Plan and will continue for up to twenty-four (24) months. There are situations in which USERRA coverage will terminate before the maximum USERRA period expires.

f. **COBRA and USERRA coverage are concurrent**. This means that both COBRA Continuation Coverage and USERRA coverage begin upon commencement of the Participant's leave and continue for up to twenty-four (24) months. COBRA coverage (but not USERRA coverage) may continue for longer, as described in the COBRA section of this Article Six.

g. **If You continue Your medical coverage pursuant to USERRA**, You will be required to pay 102% of the full premium for the coverage elected (the same rate as COBRA). However, if Your Uniformed Service Leave of Absence is less than thirty (30) days, You are not required to pay more than the amount that You pay as an active Participant for that coverage.

h. **USERRA leave time will count toward FMLA eligibility**. A Participant who was called to qualifying military service and is re-employed under USERRA's provisions is credited with the time he or she would have worked, but for his or her military service, when determining eligibility for leave under the Family and Medical Leave Act.

i. **If coverage is not continued during a USERRA Leave of Absence**, when the Employee returns to Actively at Work status no new Waiting Period will apply.

FAMILY AND MEDICAL LEAVE ACT

If an Employee is on a family or medical leave, the Employee may continue coverage in accordance with the Family and Medical Leave Act of 1993 and the Plan will continue coverage, as if the Employee were Actively at Work, if the following conditions are met:

- The required contribution is paid; and
- The Employee has written approval of leave from the Member Institution.

Coverage will be continued for up to the greater of:

- The leave period required by the Family and Medical Leave Act of 1993, and any amendments thereto or regulations promulgated thereunder; or
- The leave period required by applicable state law.

If coverage is not continued during a family or medical leave, when the Employee returns to Actively At Work status no new Waiting Period will apply.

THE NATIONAL DEFENSE AUTHORIZATION ACT

The National Defense Authorization Act of 2008 adds two types of FMLA leave for the families of service members who are called to duty in the Armed Forces. The Service Member Caregiver Leave provides up to 26 weeks of unpaid leave in a single 12-month period for any Eligible Employee who is the spouse, parent or next of kin of a covered service member who suffered a serious Injury or Illness in line of duty while on active duty that renders the service member medically unfit to perform the duties of his/her office, grade, rank, or rating.

An Eligible Employee can take up to 12 weeks of unpaid leave in a 12-month period as the result of any qualifying exigency because the Employee's spouse, son, daughter, or parent is on active duty or has been notified of an impending call of duty in the Armed Forces in support of a "contingency operation."

If an Employee is on a leave provided for under the National Defense Authorization Act, the Employee may continue coverage under the Plan as if the Employee were Actively at Work if the following conditions are met:

- The required contribution is paid; and
- The Employee has written approval of the leave from the Member Institution.

Coverage will be continued for up to the greater of:

- The leave period required by the Family and Medical Leave Act of 1993, and any amendments thereto or regulations promulgated thereunder; or
- The leave period required by applicable state law.

If coverage is not continued during a family or medical leave, when the Employee returns to Actively at Work status no new Waiting Period will apply.

ARTICLE SEVEN: COVERED EXPENSES

COVERED EXPENSES

The Plan provides coverage for a wide range of services called Covered Expenses. The services associated with these Benefits are covered to the extent that they are:

- Medically Necessary and Appropriate;
- Not considered Experimental or Investigative;
- Prescribed by or given by a Physician;
- Reasonable and Customary charges; and
- Provided for care and treatment of a Covered Illness or Injury.

Benefits are payable in accordance with the applicable Deductible, Copayments, and Coinsurance listed in the Schedule of Benefits.

If You receive Services from Network Providers, they have contracted with BCBSF or Aetna to bill specified amounts and automatically meet the Reasonable and Customary charges requirement necessary to be considered a Covered Expense. Covered Expenses are the services listed below, subject to Article Eight ("Limitations and Exclusions") and all other provisions of this Plan:

a. **Ambulance Service**. Hospital or licensed ambulance or air Ambulance Service when Medically Necessary and Appropriate for transportation to a local Hospital or to the nearest Hospital. This service is treated as in-Network and is subject to a copayment of $250. Also included is a transfer to the nearest facility equipped to treat the Emergency, as shown in the Schedule of Benefits. Local transportation by a specially designed and equipped vehicle used only to transport the sick and injured by providing transportation from Your home, the scene of an Accident or medical Emergency to a Hospital; between Hospitals; or between a Hospital and a Skilled Nursing Facility; when such facility is the closest institution that can provide Covered Services appropriate to Your condition. If there is no facility in the local area that can provide Covered Services appropriate for Your condition, then You are covered for Ambulance Service to the closest facility outside Your local area that can provide the necessary service. Local transportation by a specially designed and equipped vehicle used only to transport the sick and injured: from a Hospital to Your home or from a Skilled Nursing Facility to Your home.

b. **Aspirin**. Aspirin covered by the Plan at 100% when purchased with a prescription. You must use the Prescription Drug Plan at a Network Pharmacy or through the mail.

c. **Autism**. Treatment for a Dependent child diagnosed with Autism will be covered, including Applied Behavioral Analysis, Speech Therapy, Occupational Therapy and Physical Therapy.

d. **Bariatric Surgery**. Services provided for surgical treatment for obesity from a Blue Distinction® Provider in Florida. Blue Distinction Centers for Bariatric Surgery provide a full range of bariatric surgery care services, including Inpatient care, post-operative care, Outpatient follow-up care and patient education. To see a list of the specific criteria for the Blue Distinction Centers for Bariatric Surgery, please visit www.bcbs.com/why-bcbs/blue-distinction.

e. **Blood Plasma**. Services and supplies required for the administration of blood transfusions, including blood, blood plasma, and plasma expanders, when not available to the Covered Person without charge.

f. **Breast Implants and Reconstructive Surgery**. Breast Implants and Reconstructive Surgery are covered following a Mastectomy as follows:

- Reconstruction of the breast on which a mastectomy has been performed.
- Surgery and reconstruction of the other breast to produce a symmetrical appearance.

- Prosthesis and treatment of physical complications including lymph edemas.
- External breast prostheses and bras.

Notice. The Women's Health and Cancer Rights Act of 1998

The Plan includes coverage for a Medically Necessary mastectomy and patient-elected reconstruction after the mastectomy. Specifically, for You or Your Dependent who is receiving mastectomy-related Benefits, coverage will be provided in a manner determined in consultation with the attending Physician and the Covered Person for:

1. All stages of reconstruction of the breast on which a mastectomy was performed.
2. Surgery and reconstruction of the other breast to produce a symmetrical appearance.
3. Prostheses treatment of physical complication of all sates of mastectomies, including lymphedema.

The coverage will be subject to the same annual Deductible, Coinsurance, and/or Copayment provisions otherwise applicable under the Plan. If You have any questions about coverage for mastectomies and post-operative reconstructive surgery, please contact the Plan Administrator.

g. **Cardiac Care**. Blue Distinction Centers for Cardiac Care provide a full range of cardiac care services, including Inpatient cardiac care, cardiac rehabilitation, cardiac catheterization, and cardiac surgery (including coronary artery bypass graft surgery). To see a list of the specific criteria for the Blue Distinction Centers for Cardiac Care, please visit www.bcbs.com/why-bcbs/blue-distinction.

h. **Complex Care and Rare Cancers**. Complex and rare cancers comprise approximately fifteen percent (15%) of new cancer cases each year. Blue Distinction Centers for Complex and Rare Cancers are the first in a line of Blue Distinction Centers® focused on cancer treatment. **This initial phase evaluates facilities on patient assessment, treatment planning, complex Inpatient Care, and major surgical treatments for adult, which are all delivered by teams with distinguished expertise and subspecialty training for complex and rare cancers.**

The program focuses on the following thirteen (13) cancers:

- Acute leukemia (inpatient, non-surgical)
- Bladder cancer
- Bone cancer — primary
- Brain cancer — primary
- Esophageal cancer
- Gastric cancer
- Head and neck cancers
- Liver cancer — primary
- Ocular melanoma
- Pancreatic cancer
- Rectal cancer
- Soft tissue sarcoma
- Thyroid cancer — medullary or anaplastic

Facilities designated as Blue Distinction Centers for Complex and Rare Cancers offer comprehensive Inpatient cancer care programs for adults, delivered by multidisciplinary teams with subspecialty training and distinguished clinical expertise in treating complex and rare subtypes of cancer. This initial phase focuses on multi-disciplinary treatment planning and complex, major surgical treatments. Some of the Blue Distinction Facilities for Complex and Rare Cancer are as follows:

- Broward General Medical Center, Ft. Lauderdale
- University of Miami Sylvester Comprehensive Cancer Center, Miami
- Lee Moffitt Cancer Center & Research Institute, Tampa

i. **Consumable Medical Supplies**. Ostomy supplies and urinary tract catheters.

j. **Contact Lenses after Cataract Surgery**. Initial purchase of contact lenses, and/or eyeglasses if required because of cataract surgery.

k. **Cosmetic or Reconstructive Surgery**. Cosmetic or Reconstructive Surgery, only if such surgery is to restore bodily function or correct deformity resulting from an Illness or Injury.

l. **Dental Care Related to Accidental Injury**. Dental services rendered by a Physician or Dentist which are required as the result of accidental Injury to the jaw, sound natural teeth, mouth, or face. Injury caused by chewing or biting will not be considered accidental Injury. Medical expenses for oral surgery:

- When necessitated as the direct result of an Injury to natural teeth or dental prosthesis if treatment begins within 6 months of the date of the Injury (chewing related expenses not covered);
- Other Medically Necessary and Appropriate incision or excision procedures on the gums and tissues of the mouth when not performed in connection with extraction or repair of teeth;
- Care of fractures or complete dislocation of the jaw; or
- Surgical removal of tumors within the oral cavity.

For the purpose of the dental work or oral surgery covered by the terms of this Benefit, Covered Expenses shall be deemed to include fees of a duly licensed Dentist. No other expenses for dental work are included as Covered Expenses. The Plan shall always pay secondary to any other dental coverage.

m. **Diabetes Treatment**. Your program provides coverage for the following when required in connection with the treatment of diabetes and when prescribed by a Physician legally authorized to prescribe such items under the law:

- **Equipment and supplies:** Blood glucose monitors, monitor supplies, insulin infusion devices and insulin pump supplies. To obtain Your prescribed meters, lancing devices, lancets, test strips, control solution, needles, and syringes covered by the Plan at 100%, You must use the Prescription Drug Plan at a Network Pharmacy or through the mail. (Please note: If supplies are obtained under the BCBSF Medical Insurance, deductible and coinsurance will apply.)
- **Outpatient Diabetes Education Program*:** When Your Physician certifies that You require diabetes education as an Outpatient, and coverage is provided through an Outpatient diabetes education program; and visits are Medically Necessary and Appropriate upon the diagnosis of diabetes; and subsequent visits under circumstances whereby Your Physician identifies or diagnoses a significant change in Your symptoms or conditions that necessitates changes in self-management, or identifies, as Medically Necessary and Appropriate, a new medication or therapeutic process relating to the treatment and/or management of diabetes.

** Outpatient Diabetes Education Program – a program of self-management, training, and education, including medical nutrition therapy for the treatment of diabetes. Such program must be conducted under the supervision of a licensed health care professional with expertise in diabetes. Outpatient diabetes education services will be covered subject to Blue Cross Blue Shield of Florida's criteria. These criteria are based on the certification programs for Outpatient diabetes education developed by the American Diabetes Association (ADA).*

n. **Diagnostic Services**. This program covers the following services when ordered by a Professional Provider:

- Diagnostic x-ray consisting of radiology, magnetic resonance imaging (MRI), ultrasound and nuclear medicine;
- Diagnostic pathology consisting of laboratory and pathology tests;
- Diagnostic medical procedures consisting of electrocardiogram (ECG), electroencephalogram (EEG), and other electronic diagnostic medical procedures and physiological medical testing approved by Blue Cross Blue Shield of Florida;
- Allergy testing consisting of percutaneous, intracutaneous, and patch tests; and

- Genetic testing for the purposes of explaining current signs and symptoms of a possible hereditary disease.

o. **Durable Medical Equipment**. The rental or, at the option of Blue Cross Blue Shield of Florida, the purchase, adjustment, repair, and replacement of Durable Medical Equipment when prescribed by a Professional Provider, within the scope of his/her license and required for therapeutic use. Rental costs cannot exceed the total cost of purchase. Prosthetic Devices, Orthopedic Devices and Orthotic Devices are considered Durable Medical Equipment. The Network Provider for durable medical equipment is CareCentrix (1-877-561-9910).

p. **Emergency Care**. Your Outpatient Emergency room visits may be subject to a Copayment, which is waived if You are admitted as an Inpatient. You should use Emergency services only when appropriate. In some situations, such as strains or sprains, fevers, and sore throats, it may make more sense to contact a Network Physician or Urgent Care Facility. Doing this puts You in touch with the person who truly knows Your health history. It can save You hours of waiting in a crowded Emergency room where more critical injuries are being treated. In true Emergency situations, where You must be treated immediately, go directly to Your nearest Hospital Emergency Provider or call "911" or Your area's Emergency number. Once the crisis has passed, call Your Physician to receive appropriate follow-up care.

q. **Enteral Formulae**. Enteral Formulae is a liquid source of nutrition administered under the direction of a Physician that may contain some or all the nutrients necessary to meet minimum daily nutritional requirements and is administered into the gastrointestinal tract either orally or through a tube. Coverage is provided for Enteral Formulae when administered on an Outpatient basis, either orally or through a tube, primarily for the therapeutic treatment of phenylketonuria, branched chain ketonuria, galactosemia, and homocystinuria. This coverage does not include normal food products used in the dietary management of rare hereditary genetic metabolic disorders. Additional coverage for Enteral Formulae is provided when administered on an Outpatient basis, when Medically Necessary and Appropriate for Your medical condition, when considered to be the sole source of nutrition and:

1. When provided through a feeding tube (nasogastric, gastrostomy, jejunostomy, etc.) and utilized instead of regular shelf food or regular infant formulae; or

2. When provided orally and identified as one of the following types of defined formulae:

    - With hydrolyzed (pre-digested) protein or amino acids;

    - With specialized content for special metabolic needs; With modular components; or

    - With standardized nutrients.

Once it is determined that You meet the above criteria, coverage for Enteral Formulae will continue if it represents at least fifty percent (50%) of Your daily caloric requirement. Additional coverage for Enteral Formulae excludes the following:

- Blenderized food, baby food, or regular shelf food when used with an enteral system;
- Milk or soy-based infant formula with intact proteins;
- Any formulae, when used for the convenience of You or Your Family members;
- Nutritional supplements or any other substance utilized for the sole purpose of weight loss or gain, or for caloric supplementation, limitation, or maintenance;
- The following formulae when provided orally: semisynthetic intact protein/protein isolates, natural intact protein/protein isolates, and intact protein/protein isolates; and
- Normal food products used in the dietary management of rare hereditary genetic metabolic disorders.

r. **Genetic Testing**. Genetic testing is a covered benefit for the purposes of explaining current signs and symptoms of a possible hereditary disease. A genetic or genomic test involves an analysis of human chromosomes, deoxyribonucleic acid (DNA), ribonucleic acid (RNA), or gene products (e.g., enzymes and other types of proteins) to detect heritable or

somatic mutations, genotypes, or phenotypes related to disease and health. Additional information regarding genetic or genomic testing can be found on BCBSF's medical coverage guidelines at http://www.cam-policies.com.

s. **Hearing Care Services**. Benefits include coverage for diagnostic testing and the purchase of hearing aid devices, when prescribed by a Professional Provider. The hearing aid must be purchased from an eligible Provider. All eligible Providers are considered in-network.

t. **Home Health Care/ Hospice Care Services**. This program covers the following services You receive from a Home Health Care Agency, Hospice, or a Hospital program for Home Health Care and/or Hospice Care:

- Skilled nursing services of an RN or LPN, excluding private duty nursing services;
- Physical medicine, Occupational Therapy, and speech therapy;
- Medical and surgical supplies provided by the Home Health Care Agency or Hospital program for Home Health Care or Hospice care;
- Oxygen and its administration;
- Medical social service consultations;
- Health aide services when You are also receiving covered nursing or therapy and rehabilitation services; and
- Family counseling related to the Covered Person's terminal condition.

Please note: No Home Health Care/ Hospice benefits will be provided for Dietitian services; Homemaker services; Maintenance therapy; Dialysis treatment; Custodial Care; and Food or home-delivered meals.

u. **Home Infusion Therapy Services**. Services provided by a Home Infusion Therapy Provider in a home setting. This includes pharmaceuticals, pharmacy services, intravenous solutions, medical/surgical supplies, and nursing services associated with Home Infusion Therapy. Specific adjunct non-intravenous therapies are included when administered only in conjunction with Home Infusion Therapy.

v. **Hospice Care**. Hospice Care on either an Inpatient or Outpatient basis as an alternative to Hospitalization for a Terminally Ill person, as shown in the Schedule of Benefits.

Covered Services must be rendered, furnished, and billed by a Hospice Provider and included in a written Hospice Treatment Plan established and periodically reviewed by a Physician. The Hospice Treatment Plan must:

- Certify that the Covered Person is Terminally Ill and has less than a 6-month life expectancy;
- Certify that it is medically advisable for the Covered Person to live at home;
- Certify that Hospital confinement would be required in the absence of Hospice Care; and
- Describe the services and supplies for the palliative care and Medically Necessary and Appropriate treatment to be provided to the Covered Person by the Hospice.

Covered Expenses include:

- An assessment visit and initial testing;
- Room and board, services and supplies furnished by a Hospice while confined therein;
- Patient care provided by home health aides;
- Visits by speech therapists and psychotherapists;
- Intermittent care by a Registered Nurse (R.N.) or Licensed Practical Nurse (L.P.N.);

- Drugs and medicines for the Terminal Illness that are legally obtainable only upon a Physician's written prescription and insulin while receiving Hospice Care on an Inpatient basis only;
- Medical supplies normally used for Hospital Inpatients, such as oxygen, catheters, needles, syringes, dressing, materials used in aseptic techniques, irrigation solutions, intravenous solutions, and other medical supplies including splints, trusses, braces, or crutches;
- Rental of Durable Medical Equipment;
- Family counseling of immediate family members;
- Respite care;
- Professional medical, psychological, social, and pastoral counseling services provided by salaried employees of Hospice; and
- Supportive services to the bereaved immediate family members for up to 3 months following the death of the Covered Person.

In addition to the Limitations and Exclusions Benefits will NOT be provided for any of the following:

- Homemaker or housekeeping services except by home health aides as ordered in the Hospice Treatment Plan;
- Supportive environmental materials such as handrails, ramps, air conditioners, and telephones; Services performed by family members or volunteer workers;
- "Meals on Wheels" or similar food services;
- Separate charges for records, reports, or transportation;
- Expenses for the normal necessities of living, such as food, clothing, and household supplies;
- Services rendered or supplies furnished to other than the Terminally Ill Covered Person except as listed above;
- Any services or supplies not included in the Hospice Treatment Plan or not specifically set forth as a Covered Expense;
- Legal and financial counseling services; or
- Services provided during any period in which the Covered Person is receiving Benefits under this Plan's Home Health Care Benefit.

w. **Hospital Services**. This program covers the following services You receive in a Hospital or facility Provider. Benefits will be covered only when, and so long as, they are determined to be Medically Necessary and Appropriate for the proper treatment of the Covered Person's condition.

Bed, Board and General Nursing Services for:

- A semi-private room;
- A private room. Private room allowance is the average semi-private room charge;
- A bed in a Special Care Unit where intensive care to the critically ill is provided;
- Operating, delivery and treatment rooms and equipment;
- Drugs and medicines provided to You while You are an Inpatient in a facility Provider;
- Whole blood, administration of blood, blood processing, and blood derivatives;
- Anesthesia, anesthesia supplies and services rendered in a facility Provider by an employee of the Hospital or other facility Provider. Administration of anesthesia ordered by the attending Professional Provider and rendered by a Professional Provider other than the surgeon or assistant at surgery;
- Medical and surgical dressings, supplies, casts, and splints; Diagnostic services;

- Therapy and rehabilitation services;
- Surgery; and
- Hospital Services and supplies for Outpatient Surgery including removal of sutures, anesthesia, and anesthesia supplies and services rendered by an Employee of the facility Provider, other than the surgeon or assistant at surgery.

x. **Inpatient Medical Services**. This program covers the following services You receive from a Professional Provider when You are an Inpatient for a condition not related to surgery, pregnancy, or mental Illness:

- Care for a medical condition by a Professional Provider who is not Your surgeon while You are in the Hospital for surgery;
- Care by two or more Professional Providers during one Hospital stay when the nature or severity of Your condition requires the skills of separate Physicians;
- Concurrent care;
- Constant attendance and treatment by a Professional Provider when Your condition requires it for a prolonged period;
- Consultation;
- Consultation by another Professional Provider when requested by the attending Professional Provider;
- Intensive Medical Care;
- Inpatient Medical Care visits;
- Professional Provider visits to examine a newborn infant while the mother is an Inpatient; and Preventive newborn care.

y. **Mastectomy and Breast Cancer Reconstruction**. This program covers a mastectomy performed on an Inpatient or Outpatient basis for the following:

- Surgery to re-establish symmetry or alleviate functional impairment. This includes, but is not limited to, augmentation, mammoplasty, reduction mammoplasty and mastopexy;
- The use of initial and subsequent Prosthetic Devices to replace the removed breast or portions thereof;
- Physical complications of all stages of mastectomy, including lymph edemas; and
- One Home Health Care visit within forty-eight hours after discharge, as determined by Your Physician.

z. **Maternity Care**. If You think You are pregnant, You may contact Your Physician or go to a Network obstetrician or nurse midwife. When Your pregnancy is confirmed, You may continue to receive follow-up care which includes prenatal visits, Medically Necessary and Appropriate sonograms, delivery, postpartum, and newborn care in the Hospital that is covered at the maximum level of Benefits. This program provides services for Normal pregnancy; Complications of pregnancy; and Nursery care.

At the time of confirmation of pregnancy, Your obstetrician may ask You to pre-pay Your portion of anticipated labor and delivery charges. Your doctor may allow You to make partial payments throughout Your pregnancy, sometimes referred to as a global billing plan. The portion You are responsible to pay will be based on where You stand with Your deductible and Your coinsurance percentage. Please see the Maternity Benefits Flyer available through Your member enrollment portal for additional details on the process.

The Newborn's and Mothers' Health Protection Act of 1996 (NMHPA), prohibits the Plan from restricting Your Benefits for any Hospital length of stay in connection with childbirth for the mother or newborn child to less than 48 hours following a vaginal delivery; or less than 96 hours following a cesarean section. However, Federal law generally does not prohibit the mother's or newborn's

attending Provider, after consulting with the mother, from discharging the mother or her newborn earlier than 48 hours (or 96 hours, as applicable). In any case, under Federal law, Your self-insured program can only require that a Provider obtain authorization for prescribing an Inpatient Hospital stay that exceeds 48 hours (or 96 hours).

aa. **Intrauterine Device (IUD)**. IUD is covered when inserted in a Network Provider's office.

bb. **Mental Health Care Services**. Your mental health is just as important as Your physical health. That is why Your Aetna program provides professional, confidential, mental health care that addresses Your individual needs. You have access to a wide range of mental health and substance use disorder Professional Providers, so You can get the appropriate level of responsive, confidential care. See Article Three for more information.

You are covered for a full range of counseling and treatment services. The Aetna program covers the following services You receive from a Provider to treat mental Illness:

- Inpatient facility services;
- Covered Inpatient Hospital Services provided by a Hospital or other facility Provider;
- Inpatient Medical Services;
- Covered Inpatient Medical Services provided by a Professional Provider;
- Individual psychotherapy;
- Group psychotherapy;
- Psychological testing;
- Counseling with family members to assist in Your diagnosis and treatment; and
- Electroshock treatment or convulsive drug therapy including anesthesia when administered concurrently with the treatment by the same Professional Provider.

cc. **Newborn Expenses**. Newborn Expenses for a well-baby shall be paid as part of the mother's delivery expenses, except for expenses related to circumcision.

If the baby has an Illness, suffers Injury, premature birth, congenital abnormality, or requires care other than Preventive Care, Benefits will be provided under the newborn's own Claim on the same basis as any other Covered Expense, provided, however, that coverage is in effect.

The newborn coverage shall include coverage for Injury or Illness, including the necessary care or treatment of medically diagnosed congenital defects, birth abnormalities or prematurity. Covered Expenses include transportation costs of the newborn to and from the nearest Hospital or Other Facility Provider appropriately staffed and equipped to treat the newborn's condition if the transportation is certified by the attending Physician as Medically Necessary and Appropriate to protect the health and safety of the newborn.

dd. **Nutritional Counseling**. Six sessions of Nutritional Counseling for Covered Persons with a diagnosis of Obesity.

ee. **Obesity services**. Lap-Band and Gastric By-pass Surgery. A Covered Person must meet specific prior-authorization criteria to receive approval for this treatment.

ff. **Occupational Therapy**. Occupational Therapy rendered by a licensed occupational therapist or Certified Occupational Therapist Assistant (C.O.T.A.). This care must be prescribed by a Physician.

gg. **Oral surgery**. Benefits are provided for the following limited oral surgical procedures if determined to be Medically Necessary and Appropriate:

- Extraction of impacted third molars when partially or totally covered by bone;

- Extraction of teeth in preparation for radiation therapy;
- Mandibular staple implant when not done to prepare the mouth for dentures;
- Mandibular frenectomy;
- Facility Provider and anesthesia services rendered in conjunction with non-covered dental procedures when determined by the Plan to be Medically Necessary and Appropriate due to the age and/or medical condition of the Covered Person;
- Accidental Injury to the jaw or structures contiguous to the jaw;
- The correction of a non-dental physiological condition which has resulted in a severe functional impairment;
- Treatment for tumors and cysts requiring pathological examination of the jaw, cheeks, lips, tongue, roof, and floor of the mouth; and
- Orthodontic treatment of congenital cleft palates involving the maxillary arch, performed in conjunction with bone graft surgery to correct the bony deficits associated with extremely wide clefts affecting the alveolus.

hh. **Organ Transplant**. Medically Necessary and Appropriate organ or tissue transplant procedures for kidney, cornea, heart, heart/lung, liver, lung, pancreas, or bone marrow (including autologous bone marrow transplants) and all related Covered Expenses when incurred at designated facilities throughout the United States as a BCBSF transplant facility by a Covered Person who is the recipient of such transplant, provided such Organ Transplants are "human to human" and not Experimental Procedures.

Blue Distinction Centers for Transplants have demonstrated their commitment to quality care, resulting in better overall outcomes for transplant patients. Each facility meets stringent clinical criteria, established in collaboration with expert Physicians' and medical organizations' recommendations, including the Center for International Blood and Marrow Transplant Research (CIBMTR), the Scientific Registry of Transplant Recipients (SRTR) and the Foundation for the Accreditation of Cellular Therapy (FACT), and is subject to periodic reevaluation as criteria continue to evolve.

Blue Distinction Centers for Transplants provide a range of services for transplant, including Heart; lung (deceased and living donor); combination heart/lung; liver (deceased and living donor); simultaneous pancreas kidney (SPK); pancreas (PAK/PTA); and bone marrow/stem cell (autologous and allogeneic).

Organ Transplant Coverage is subject to the following conditions and limitations:

- Coverage includes the recipient's medical, surgical and Hospital Services;
- Inpatient immunosuppressive medications; and
- Costs for organ procurement.

Organ procurement costs are limited to costs directly related to the procurement of an organ from a cadaver or live donor and shall consist of the surgery necessary for organ removal, organ transportation, and the transportation, hospitalization, and surgery of the live donor. Compatibility testing undertaken prior to procurement is covered if Medically Necessary. In addition, the Plan will pay, subject to limitations in the Schedule of Medical Benefits, the travel expenses incurred by the Participant or Dependent and one companion to accompany the recipient, for transportation, lodging and food associated with a pre-approved organ/tissue transplant during evaluation, candidacy, transplant event, or post-transplant care. The term companion includes spouse, domestic partner, family member, legal guardian of the Dependent recipient, or any person not related to the recipient but actively involved as a caregiver.

The following conditions also apply:

- When both the recipient and donor are covered by this Plan, services will be covered for each patient;
- When only the recipient is covered by this Plan, Benefits are provided for services for both the recipient and donor, provided Benefits to the donor are not furnished under some other form of surgical/medical coverage; and

- When the recipient is not covered by this Plan and the donor is covered, expenses will be eligible for the donor to the extent that Benefits are not provided under the recipient's program of coverage.

Benefits will be provided for Covered Services furnished by a Hospital that are directly and specifically related to the transplantation of organs, bones, tissue, or blood stem cells.

If a human organ, bone, tissue, or blood stem cell transplant is provided from a living donor to a human transplant recipient when both the recipient and the donor are Covered Persons, each is entitled to the Benefits of this program:

- When only the recipient is a Covered Person, both the donor and the recipient are entitled to the Benefits of this program subject to the following additional limitations: (1) the donor Benefits are limited to only those not provided or available to the donor from any other source, including, but not limited to, other insurance coverage, other BCBSF coverage or any government program; and (2) Benefits provided to the donor will be charged against the recipient's coverage under this program to the extent that Benefits remain and are available under this program after Benefits for the recipient's own expenses have been paid;
- When only the donor is a Covered Person, the donor is entitled to the Benefits of this program, subject to the following additional limitations: (1) the Benefits are limited to only those not provided or available to the donor from any other source in accordance with the terms of this program; and (2) no Benefits will be provided to the non-Covered Person transplant recipient; and
- If any organ, tissue, or blood stem cell is sold rather than donated to the Covered Person recipient, no Benefits will be payable for the purchase price of such organ, tissue, or blood stem cell; however, other costs related to evaluation and procurement are covered up to the Covered Person recipient's program limit.

It is important to have Your Transplant at a Blue Distinction Center for Transplant. To identify a Blue Distinction Transplant Center near You, please contact BCBSF Care Connected Customer Service at 1-855-258-9029.

ii. **Orthotic Devices**. Purchase, fitting, necessary adjustment, repairs, and replacement of a rigid or semi-rigid supportive device that restricts or eliminates motion of a weak or diseased body part. Your Provider will need to provide a prescription and may need to provide documentation for Medical Necessity.

jj. **Outpatient Medical Care Services including Physician Visits**. This program covers the following services:

- Medical Care rendered by a Professional Provider to You, as an Outpatient, for a condition not related to surgery, pregnancy, or mental Illness, except as specifically provided herein; and
- Medical Care visits and consultations to examine, diagnose, and treat an Injury or Illness.

kk. **Partial Hospitalization Mental Health Care Services**. Partial hospitalization for Mental Health Care Services provided by a partial hospitalization program which has been approved by Aetna Behavioral Health. Such programs are subject to periodic review by Aetna Behavioral Health.

ll. **Physical Therapy**. Physical therapy rendered by a licensed Physical Therapist or Physical Therapist Assistant, (P.T.A.) prescribed by a Physician.

mm. **Pre-Admission Testing**. Includes Outpatient tests and studies required in connection with an admission rendered or accepted by a Hospital on an Outpatient basis prior to a scheduled admission to the Hospital as an Inpatient.

nn. **Preventive Care**. Preventive "proactive" care today can help You avoid costly "reactive" care tomorrow. It can also help You establish a healthy lifestyle.

Maintaining Your good health is a major goal of the Independent Colleges and Universities Benefits Association, Inc. Medical, Employee Assistance and Prescription Drug Plan. As such, the Plan provides excellent Network coverage for Your Preventive Care. That is why You are encouraged to take advantage of our extensive Preventive Care Benefits, including periodic physical

examinations, well child visits, immunizations, allergy extract/injections, and a full scope of diagnostic testing. This schedule is reviewed and updated periodically; therefore, the frequency and eligibility of services is subject to change.

- **Adult Care**. Examinations, including a complete medical history, height, and weight measurement, physical examinations (only when performed by a Network Provider), and selected Diagnostic Services based on age, sex, and other criteria (e.g., colonoscopies, bone mineral density test, etc.).
- **Allergy Extract/Injections**. Allergy extract and allergy injections administered in a Network Physician's office are covered by the Plan at 100%.
- **Bone Mineral Density Test and Colonoscopy or Sigmoidoscopy**. The Plan will cover bone mineral density tests, colonoscopies, and sigmoidoscopies at 100%.
- **Echocardiograms and Electrocardiograms**. Echocardiograms and electrocardiograms are covered by the Plan at 100%.
- **Flu Shots**. Flu shots are covered by the Plan at 100%.
- **Lab Work**. Lab In-Network at Quest Diagnostics is covered by the Plan at 100%.
- **Urinalysis**. Urinalyses are covered by the Plan at 100%.
- **Immunizations and Therapeutic Injections**. Immunizations for Covered Persons 18 years of age and older and therapeutic injections required in the diagnosis, prevention, and treatment of an Injury or Illness or for foreign travel if obtained in the United States are covered by the Plan at 100%.
- **Preventive Gynecological Examination and Pap Test**. All female Covered Persons, regardless of age, are covered for preventive gynecological examination, including a pelvic and clinical breast examination. The preventive Papanicolaou smear (pap test) is covered by the Plan at 100%.
- **Venipunctures**. Venipunctures are covered by the Plan at 100%.
- **Blood Stool Tests**. Blood stool tests are covered by the Plan at 100%.
- **Prostate Screening**. PSAs are covered by the Plan at 100%.
- **Mammographic Screening**. Mammography is covered by the Plan at 100%. Ultrasound of the breast when prescribed by a Physician is covered by the Plan at 100%. Mammographic examinations are covered for all Covered Persons regardless of age when such services are prescribed by a Physician. Benefits for mammographic screening are payable only if performed by a mammography service Provider who is properly certified.
- **Skin Cancer Behavioral Counseling**. Counseling for children, adolescents and Young adults who have fair skin about minimizing their exposure to ultraviolet radiation to reduce risk for skin cancer is covered by the Plan at 100%.

oo. **Pediatric Care and Immunizations**. This program covers the following services:

- Preventive physical examinations for Covered Persons who are 18 years of age or Younger, but only when performed by a Network Provider. Selected Diagnostic Services, when appropriate.
- Benefits are provided for a medical history, height and weight measurement, physical examination, and counseling, when appropriate.
- Pediatric immunizations, when performed and billed by a Hospital, facility, Physician or Other Professional Provider, are covered. Benefits are provided to Covered Persons under 21 years of age and Dependent children for those pediatric immunizations, including the immunizing agents, which conform with the standards of the Advisory Committee on Immunization Practices of the Center for Disease Control and U.S. Department of Health and Human Services. Eligible Benefits are covered 100% by the Plan.

pp. **Private Duty Nursing Services**. Services of an actively practicing registered nurse (RN) or licensed practical nurse (LPN) when ordered by a Physician, provided that such nurse does not ordinarily reside in Your home and is not a member of Your immediate family.

For a Covered Person who is an Inpatient in a Hospital or Other Facility Provider, only when BCBSF determines that the nursing services required are of a nature or degree of complexity or quantity that could not be provided by regular nursing staff. For a Covered Person at home, only when BCBSF determines that the nursing services require the skills of an RN or an LPN.

qq. **Prosthetic Appliances**. Purchase, fitting, necessary adjustments, repairs, and replacements of Prosthetic Devices and supplies that:

- Replace all or part of a missing body organ and its adjoining tissues; or
- Replace all or part of the function of a permanently inoperative or malfunctioning body organ.
- Initial and subsequent Prosthetic Devices to replace the removed breast(s) or a portion thereof, are also covered.
- Dental appliances and the replacement of cataract lenses are not covered.

rr. **Scalp Hair Prosthesis**. Purchase of a Scalp Hair Prosthesis when necessitated by hair loss due to the medical condition known as alopecia areata, or as the result of hair loss due to radiation or chemotherapy for diagnosed cancer will be payable as shown in the Schedule of Benefits. Benefits may be provided for the purchase of wigs for hair loss due to alopecia or cancer treatments.

ss. **Skilled Nursing Facility Services**. Services rendered in a Skilled Nursing Facility to the same extent Benefits are available to an Inpatient of a Hospital.

No Benefits are payable:

- After You have reached the maximum level of recovery possible for Your condition and You no longer require definitive treatment other than preventive supportive care;
- When confinement is intended solely to assist You with the Activities of Daily Living or to provide an institutional environment for Your convenience; and
- For treatment of substance use disorder or mental Illness.

tt. **Speech Therapy**. Speech Therapy provided by a speech therapist if all the following conditions are met:

- The service of a speech therapist is required to restore a speech disability that the Covered Person lost as direct result of an Illness or Injury; and
- The services of the therapist are prescribed by a Physician who continues to control and direct the overall treatment of the case, as Medically Necessary and Appropriate to improve the specific defect.

uu. **Spinal Manipulation**. Spinal manipulations for the detection and correction by manual or mechanical means of structural imbalance or subluxation resulting from or related to distortion, misalignment, or subluxation of or in the vertebral column.

vv. **Sterilization**. Elective sterilization regardless of Medical Necessity.

ww. **Substance Use Disorder Services**. The program covers the following services You receive in a Hospital, Other Facility Provider, or from a Professional Provider.

- Inpatient Detoxification, Non-Hospital Residential and Rehabilitation Therapy.
- Outpatient Rehabilitation. Covered Services also include individual and group counseling, psychotherapy and psychological testing, and family counseling for the treatment of substance use disorder.
- Inpatient Rehabilitation. When You are admitted to a facility, You are responsible for contacting Aetna for authorization for Your care.

xx. **Surgical Services**. This program covers the following services You receive from a Professional Provider. If an Inpatient Hospital admission is required, You must contact BCBSF prior to Your admission.

- **Anesthesia**. Administration of anesthesia ordered by the attending Professional Provider and rendered by a Professional Provider other than the surgeon or the assistant at surgery. Benefits will also be provided for the administration of anesthesia for oral surgical procedures in an Outpatient setting when ordered and administered by the attending Network Professional Provider.
- **Assistant at Surgery**. Services of a Physician who actively assists the operating surgeon in performing covered surgery if a house staff member, intern, or resident is not available.
- **Second Surgical Opinion**. A consulting Physician's opinion and related Diagnostic Services to confirm the need for recommended elective surgery.
    i. The second opinion must be from someone other than Your first Physician who recommended the elective surgery;
    ii. Elective surgery means a covered surgery that may be deferred and is not an Emergency; Use of a second surgical opinion is Your option; and
    iii. A third opinion and directly related Diagnostic Services are covered if the first and second opinions conflict.

yy. **Teladoc® (Telemedicine) Services**. Access 24 hours, 7 days a week to a U.S. board-certified doctor through the convenience of phone, video, or mobile phone application. (1-800-TELADOC)

zz. **Therapy and Rehabilitation Services**. This program covers the following services when such services are ordered by a Physician: Radiation therapy; Chemotherapy; Dialysis treatment; Physical medicine; Respiratory therapy; Occupational Therapy; Speech therapy; Infusion therapy; and Cardiac rehabilitation.

aaa. **Tobacco Cessation Benefit**. All enrolled members may receive up to two twelve-week courses of treatment for FDA-approved or over-the-counter tobacco cessation medication with a Physician's prescription by utilizing any of the following programs:

- AHEC tobacco cessation program at: call 1-877-848-6696
- BCBSF Health Coaching for Tobacco Cessation: call 1-855-838-5897
- Aetna Resources for Living to request a referral or to register for a tobacco cessation seminar: call 1-877-398-5816

ELIGIBLE PROVIDERS

Eligible Network Providers include facilities, general practitioners, internists, obstetricians/gynecologists, and a wide range of Specialists:

Hospital;

Psychiatric Hospital;
Rehabilitation Hospital;
Ambulance Service;
Ambulatory surgical facility;
Birthing Center;
Day/night psychiatric facility;
Freestanding dialysis facility;
Freestanding nuclear magnetic resonance facility/magnetic resonance imaging facility;
Home Health Care Agency;
Home infusion therapy Provider;
Hospice;
Outpatient Substance Use Disorder Treatment Facility;
Outpatient physical rehabilitation facility;
Outpatient psychiatric facility;
Pharmacy Provider;
Skilled Nursing Facility; and
Substance Use Disorder Treatment Facili

Professional Providers include:

Audiologist;
Certified registered nurse;
Chiropractor;
Clinical laboratory;
Dentist;
Licensed practical nurse;
Nurse-midwife;
Occupational therapist;
Optometrist;
Physical therapist;
Physician;
Podiatrist;
Psychologist;
Registered nurse;
Respiratory therapist;
Speech-language pathologist; and
Teacher of hearing impaired

ARTICLE EIGHT: LIMITATIONS AND EXCLUSIONS

LIMITATIONS AND EXCLUSIONS

The Plan shall not pay for any service, procedure or supply incurred by a Covered Person, unless it is specifically listed as a Covered Expense under Article Seven, Covered Expenses. Services that are not Medically Necessary and Appropriate, except for those that are for Preventive Care, are not Covered Expenses under the Plan. For example, reports, evaluations, examinations, or hospitalizations not required for health reasons, such as employment, insurance, or government licenses and court ordered forensic or custodial evaluations are not Covered Expenses. The Plan will not provide Benefits for any services, supplies or charges that are:

1. Not Medically Necessary and Appropriate (as determined by BCBSF or Aetna).

2. Not prescribed by, or performed by or upon the direction of, a Professional Provider.

3. Rendered by an entity or individual other than facility Providers, Professional Providers, or other professional Providers, or suppliers.

4. Experimental or Investigative in nature.

5. Rendered prior to Your Benefits Effective Date of coverage.

6. Incurred after the date of termination of Your coverage, except as otherwise provided in the Plan Document.

7. Artificial aids, including, but not limited to, orthopedic shoes, orthotics, arch supports, elastic stockings, dentures, and wigs.

8. For losses sustained or expenses incurred while on active duty as a member of the armed forces of any nation, or losses sustained or expenses incurred because of an act of war, whether declared or undeclared.

9. For which You would have no legal obligation to pay.

10. For services or supplies provided by a non-licensed provider.

11. For non-Prescription Drugs, medications, and supplies, which do not require a Physician's prescription and are not otherwise specifically listed as a Covered Expense.

12. For non-professional care including Medical or surgical care that is not performed according to generally accepted professional standards.

13. For services or supplies that are not Medically Necessary and Appropriate for the diagnosis or treatment of an Illness or Injury, unless covered as a Preventive Benefit.

14. For non-medical ancillary services such as vocational rehabilitation, behavioral training, biofeedback, neurofeedback, hypnosis, hypnotic anesthesia, sleep therapy, employment counseling, back to school, work hardening, driving safety and services, training, and educational therapy. Unless such services are provided as a part of an inpatient treatment for certain mental health conditions.

15. Orthognathic surgery, which means any service or supply for correction of deformities of the jaw. This consists of surgical repositioning of portions of the upper or lower jaws or the bodily repositioning of the entire jaw, unless otherwise listed as a Covered Expense.

16. For Consumable Medical Supplies, other than ostomy supplies and urinary catheters. Excludable supplies include bandages and other disposable medical supplies, and skin preparations.

17. Paid under Medicare when Medicare is primary; however, this exclusion shall not apply when the Plan is obligated by law to offer You all the Benefits of this program and You elect this coverage as primary.

18. For any amounts You are required to pay under the Deductible and/or Coinsurance provisions of Medicare or any Medicare supplemental coverage.

19. For services or supplies for personal comfort or convenience, (e.g., private room, television, telephone, guest trays, etc.).

20. For any Illness or bodily Injury which occurs in the course of employment if benefits or compensation are available, in whole or in part, under the provisions of any federal, state, or local government's workers' compensation, occupational disease, or similar type legislation. This exclusion applies whether You claim the benefits or compensation.

21. Provided to Covered Persons of the armed forces or to patients in Veteran's Administration facilities for service-connected Illness or Injury unless You have a legal obligation to pay.

22. For treatment or services for Injuries resulting from the maintenance or use of a motor vehicle if such treatment or service is paid or payable under a plan or policy of motor vehicle insurance, including a certified or qualified plan of self-insurance, or any fund or program for the payment of extraordinary medical benefits established by law.

23. For Prescription Drugs which were paid or are payable under a freestanding Prescription Drug Program.

24. Submitted by a certified registered nurse and another Professional Provider or Other Professional Provider for the same services performed on the same date for the same Covered Person.

25. Rendered by a Provider who is a member of Your immediate family.

26. Performed by a Professional Provider or Other Professional Provider enrolled in an education or training program when such services are related to the education or training program.

27. For Ambulance Services, which are not Medically Necessary and Appropriate.

28. For operations for cosmetic purposes done to improve the appearance of any portion of the body, and from which no improvement in physiological function can be expected, except as otherwise provided herein. Other exceptions to this exclusion are: (a) surgery to correct a condition resulting from an Accident; (b) surgery to correct a congenital birth defect; and (c) surgery to correct a functional impairment which results from a covered disease or Injury.

29. Charges for failure to keep a scheduled visit or charges for completion of a Claim form.

30. For personal hygiene and convenience items such as, but not limited to, air conditioners, humidifiers, or physical fitness equipment, stair glides, elevators/lifts, or "barrier free" home modifications, whether specifically recommended by a Professional Provider or Other Professional Provider.

31. For lifestyle improvement programs including but not limited to exercise programs, gym memberships, bicycles, treadmills, etc.

32. For foreign travel with the sole purpose of obtaining routine non-Emergency services or procedures outside the United States including foreign travel immunizations. However, foreign travel immunizations obtained in the U.S. are covered.

33. For Experimental Procedures.

34. For eyeglasses, services, or supplies for the purchase or fitting of eyeglasses or lenses except for the first pair of eyeglasses and/or Contact Lenses provided within 1 year of Cataract Surgery.

35. For Inpatient admissions which are primarily for diagnostic studies.

36. For Inpatient admissions which are primarily for physical medicine services.

37. For Custodial Care, domiciliary care, residential care, protective and supportive care, including educational services, rest cures, and convalescent care.

38. For Outpatient therapy and rehabilitation services for which there is no expectation of restoring or improving a level of function or when no additional functional progress is expected to occur, unless Medically Necessary and Appropriate.

39. For respite care.

40. Directly related to the care, filling, removal, or replacement of teeth, the treatment of injuries to or diseases of the teeth, gums, or structures directly supporting or attached to the teeth. These include, but are not limited to, apicoectomy (dental root resection), root canal treatments, soft tissue impactions, alveolectomy and treatment of periodontal disease, except for dental expenses otherwise covered because of accidental bodily Injury to sound natural teeth and for orthodontic treatment for congenital cleft palates as provided herein.

41. For oral surgery procedures, except for the treatment of accidental Injury to the jaw, sound and natural teeth, mouth, or face, except as provided herein.

42. For any service for the treatment of dysfunction or derangement of the temporomandibular join, regardless of cause. This exclusion also applies to orthognathic surgery for the treatment of dysfunction or derangement of the temporomandibular join, regardless of cause, except as specified on the Schedule of Benefits.

43. For palliative or cosmetic foot care including flat foot conditions, supportive devices for the foot, corrective shoes, the treatment of subluxations of the foot, care of corns, bunions, (except capsular or bone surgery), calluses, toenails (except surgery for ingrown toenails), fallen arches, weak feet, chronic foot strain, and symptomatic complaints of the feet, except when such devices or services are related to the treatment of diabetes.

44. For abortion.

45. For acupuncture or acupressure services or supplies.

46. For treatment provided specifically for the purpose of assisted fertilization, including pharmacological or hormonal treatments used in conjunction with assisted fertilization, unless mandated or required by law.

47. For reversal of sterilization.

48. For the treatment of infertility. This includes all forms of infertility treatment, including but not limited to artificial insemination, other artificial methods of conception, in vitro fertilization, in vivo fertilization, services for a surrogate mother, or treatment of sexual dysfunctions not related to organic disease. Cryopreservation of donor sperm and eggs are also excluded from coverage.

49. For eyeglasses or contact lenses and the vision examination for prescribing or fitting eyeglasses or contact lenses (except for the initial pair of contact lenses/glasses prescribed following cataract extraction in place of surgically implanted lenses, or sclera shells intended for use in the treatment of disease or Injury).

50. For the correction of myopia, hyperopia, or presbyopia, including but not limited to corneal microsurgery, such as keratomileusis, keratophakia, radial keratotomy, corneal ring implants, Laser-Assisted in Situ Keratomileusis (LASIK) and all related services.

51. For nutritional counseling, except as provided herein.

52. For weight reduction programs, including all diagnostic testing related to weight reduction programs, unless Medically Necessary and Appropriate.

53. For treatment of obesity, except for medical and surgical treatment of morbid obesity that Blue Cross Blue Shield of Florida, in its sole determination, determines to be Medically Necessary and Appropriate or as otherwise provided in the Plan Document.

54. For physical examinations, the completion of forms, and preparation of specialized reports solely for insurance, licensing, employment, or other non-preventive purposes, such as pre-marital examinations, physicals for school, camp, sports, or travel, which are not Medically Necessary and Appropriate, except as otherwise provided in the Plan Document or as mandated by law.

55. For radial keratotomy, refractive keratoplasty, LASIK, and other procedures performed solely for the correction of vision.

56. For preventive foot care.

57. For self-administered service.

58. For any treatment leading to or in connection with transsexual surgery, except for sickness or Injury resulting from such treatment or surgery unless coverage is provided by Rider in the Riders Section of this document.

59. For any expenses, treatment, or procedure related to sex reassignment or designed to alter physical characteristics to those of the other sex, or any treatment, studies, or expenses related to a transsexual operation sex transformation.

60. For speech therapy unless restorative in nature or administered to a Dependent Child diagnosed with Autism Spectrum Disorder.

61. For charges of State, Federal, or local taxes.

62. For elective procedures such as erectile dysfunction, breast reduction, abdominoplasty, and panniculectomy. Penile implants are covered when an established medical condition is the cause of erectile dysfunction.

63. Immunizations strictly for employment.

64. For treatment of sexual dysfunction not related to organic disease or Injury.

65. For vocational testing, and educational services rendered primarily for training or education purposes.

66. For any care that is related to conditions such as autistic disease of childhood, hyperkinetic syndromes, learning disabilities, behavioral problems, or mental retardation, which extends beyond traditional medical management. Care which extends beyond traditional medical management includes the following:

Services that are primarily educational in nature, such as academic skills training or those for remedial education or those that may be delivered in a classroom-type setting;

Neuropsychological testing, educational testing (such as I.Q., mental ability, achievement, and aptitude testing), except for specific evaluation purposes directly related to medical treatment;

Services provided for purposes of behavioral modification and/or training unless for a Dependent Child diagnosed with Autism Spectrum Disorder;

Services related to learning disorders or learning disabilities, unless for a Dependent Child diagnosed with Autism Spectrum Disorder;

Services provided primarily for social or environmental change unrelated to medical treatment;

Developmental or cognitive therapies that are not restorative in nature but used to facilitate or promote the development of skills which the Covered Person has not yet attained, unless for a Dependent Child diagnosed with Autism Spectrum Disorder; and

Services provided for which, based on medical standards, there is no established expectation of achieving measurable improvement in a reasonable and predictable period.

67. For any care, treatment, or service which has been disallowed under the provisions of Precertification or Utilization Review, or Utilization Management conducted by BCBSF or Aetna or its designated agents.

68. For otherwise Covered Services ordered by a court or other tribunal as part of a Participant's or Dependent's sentence.

69. For counseling such as marriage, job, industrial or sex counseling (including sex addiction, paraphilia, and sex offender counseling) and therapy, unless obtained through the Employee Assistance Program.

70. For any Illness or Injury suffered during the Covered Person's commission of a felony or any illegal activity.

71. For any other medical or dental service or treatment except as provided herein or as mandated by law.

72. For Late Submittal Claims, which are services and/or supplies for which a Claim is submitted 12 months or more after the Date of Service in which charges for such services and/or supplies were incurred.

73. For music therapy, remedial reading, recreational therapy, and other forms of special education.

74. For Cosmetic or Reconstructive Surgery, which are services or and/or supplies for cosmetic or reconstructive surgeries and related treatments, including but not limited to:

Surgical removal or reformation of sagging skin on any part of the body;

Enlargement, reduction, or other changes in appearance of any part of the body, unless specifically covered under Covered Expenses;

Hair plants or removal of hair by electrolysis;

Chemical face peels or skin abrasions; and

Surgical treatments of scarring secondary to acne or chicken pox including, but not limited to, dermabrasion, chemical peel, salabrasion, and collagen injections.

This exclusion shall not apply to Cosmetic or Reconstructive Surgery specifically as listed as a Covered Expense, or as deemed Medically Necessary and Appropriate in connection with an Illness or Injury.

75. For genetic screening, including the evaluation of genes to determine if You are a carrier of an abnormal gene that puts You at risk for a condition, except as provided under the "What Is Covered?" section.

76. Mental Health treatment for a stay in a facility for treatment for dementia and amnesia without a behavior disturbance that necessitates mental health treatment.

77. Mental Health treatment for sexual deviations and disorders except for gender dysphoria.

78. Mental Health treatment for tobacco use disorders, except as described for Tobacco Cessation services listed as Covered Service in Article Seven.

79. Mental Health treatment for pathological gambling, kleptomania, and pyromania.

80. Mental Health treatment for school and/or education service, including special education, remedial education, or any such related or similar programs except where such services are incidental to Mental Health Treatment for a Covered Dependent.

81. Mental Health services for transportation.

82. Educational services provided by a school or education service, including special education, remedial education, or any such related or similar programs except where such services are incidental to Mental Health Treatment for a Covered Dependent..

83. For complications that occur because the Covered Person did not follow the course of treatment prescribed by a Provider, including complications that occur because a Covered Person left a Hospital against medical advice.

84. For complications from a Covered Person's receipt or use of services, Medical Supplies, or other treatment that are not covered Benefits, including complications arising from a Covered Person's use of Discount Services.

85. For accounts payable (whether in the form of initiation fees, annual dues, or otherwise) for membership or use of any gym, work out center, fitness center, club, golf course, weakness center, health club, weight control organization or other similar entity or payable to a trainer of any type, except as specified on the Schedule of Benefits.

86. For any outpatient services that are not preauthorized. If Preauthorization is not received for an otherwise Covered Expense related to an outpatient service. Benefits may be reduced as set forth in the Schedule of Benefits.

87. For any service that requires Preauthorization, the penalty for not obtaining Preauthorization may vary from state to state, depending on the contractual agreements between BCBSF or Aetna and the Providers in that state. Generally, this is a penalty to the Provider, but in some cases, the Covered Person may be held liable.

88. For all charges for MRIs MRAs CAT scans or PET scans in an office or outpatient facility when the required Preauthorization is not obtained.

COVERED PERSON'S RIGHT TO CHOOSE

The Plan does not limit a Covered Person's right to choose his or her own Medical Care. If a medical expense is not a Covered Expense, or is subject to a Limitation or Exclusion, a Covered Person still has the right and privilege to receive such medical service or supply at the Covered Person's own personal expense. Similarly, if the Provider is Non-Network, the Covered Person still has the right and privilege to utilize such Provider at the Plan's reduced Coinsurance level with the Covered Person being responsible for a larger percentage of the total medical expense.

ARTICLE NINE: COORDINATION OF BENEFITS

How are benefits from this Plan coordinated with other plans?

When two or more plans, including Medicare, may be paying benefits in a specific situation, there are rules, called coordination of benefits rules, which establish the order of payment.

The coordination of benefits will be on a Non-Duplication basis: the claims administrator determines what would have been paid had they been the primary claims administrator then subtracts the other claims administrator's paid amount. Both participating Providers and Non-Network Providers are processed based on the in-network level of benefits.

The term *benefit plan* as used in this section means this Plan or any one of the following plans:

Group or group-type plans, including franchise or blanket benefit plans

Group practice and other group prepayment plans

Federal government plans or programs, including Medicare

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

No fault auto insurance, by whatever names it is called, when not prohibited by law.

If coverage is provided under two or more plans, coordination of benefits ("COB") determinates which plan is primary and which plan is secondary:

Plans that do not have a coordination provision will pay first. Plans that have a coordination provision will pay their benefits by the following rules, up to the allowable charges:

The plan that covers the person directly (that is, as an employee, member, or subscriber) ("Plan A") will determine its benefits before the plan that covers the person as a Dependent ("Plan B")

- Note: If the person covered directly is a Medicare beneficiary, and Medicare is secondary to Plan B and primary to Plan A (for example, if the person is retired), then Plan B will pay before Plan A.

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

The benefits of a benefit plan that covers a person as an employee who is neither laid off nor retired or as a Dependent of an employee who is neither laid off nor retired are determined before those of a plan that covers the person as a COBRA beneficiary

When a child is covered as a Dependent and the parents are not separated or divorced, these rules will apply:

The benefit plan of the parent whose birthday falls earlier in a year will determine benefits before the benefit plan of the parent whose birthday falls later in that year

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

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

If there is a court decree that states which parent is financially responsible for medical and dental benefits of the child, the benefit plan of that parent will be considered before other plans that cover the child as a Dependent. If the court decree states that the parents will share joint custody, without stating which one is responsible for the healthcare expenses of the child, the plans covering the child will follow the rules that would apply if the parents were not separated or divorced

The benefit plan of the parent with custody will be considered before the benefit plan of the parent without custody, if the parent with custody has not remarried

The benefit plan of the parent with custody will be considered first if that parent has remarried. The benefit plan of the stepparent that covers the child as a Dependent will be considered next. The benefit plan of the parent without custody will be considered last

If there is still a conflict after these rules have been applied, the benefit plan which has covered the patient longer will be considered first.

Medicare will pay primary, secondary or last to the extent stated in federal law. When Medicare is to be the primary payer, this Plan will base its payment upon benefits that would have been paid by Medicare under Parts A and B, regardless of whether the person was enrolled under both or either of these parts. Generally, coverage under this Plan will be primary if the plan member is an active employee or the Spouse of an active employee (except for patients with end-stage renal disease (ESRD), in which case coverage under this Plan will be primary only during the first 30 months of Medicare coverage). Coverage under this Plan will generally be secondary if the plan member has been entitled to benefits under Medicare for more than 30 months for ESRD or is a retired employee or the Dependent of a retired employee

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

Finally, if none of the above rules determines which plan is primary or secondary, the allowable expenses shall be shared equally between the plans meeting the definition of Plan. In addition, this Plan will not pay more than it would have paid had it been the primary Plan.

What is an allowable charge under coordination of benefits?

For a charge to be allowable under the coordination of benefits rules, it must be covered under this Plan. Here are some other limitations that apply:

HMOs. In the case of HMO (Health Maintenance Organization) plans, this Plan will not consider any charges more than what an HMO provider has agreed to accept as payment in full. Also, when an HMO pays its benefits first, this Plan will not consider as an allowable charge any charge that would have been covered by the HMO if the patient had used the services of an HMO provider

PPOs. In the case of plans that utilize an in-network provider organization (PPO), this Plan will not consider any charges more than the PPO's contracted rates

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

Vehicle insurance. When medical payments are available under vehicle insurance, this Plan will pay excess benefits only, without reimbursement for vehicle plan deductibles. This Plan will always be considered the secondary carrier regardless of Your election under PIP (personal injury protection) coverage with the auto carrier

When This Plan is Secondary

If this Plan is secondary, it determines the amount it will pay for a Covered Health Service by following the steps below.

The Plan determines the amount it would have paid based on the allowable expense.

The Plan pays the entire difference between the allowable expense and the amount paid by the primary plan – if this amount is not more than the Plan would have paid had it been the only plan involved.

You will be responsible for any Coinsurance or Deductible payments as part of the COB payment. The maximum combined payment You may receive from all plans cannot exceed 100% of the total allowable expense. See the textbox below for the definition of allowable expense.

Determining the Allowable Expense If This Plan is Secondary

If this Plan is secondary, the allowable expense is the primary plan's Network rate. If the primary plan bases its reimbursement on reasonable and customary charges, the allowable expense is the primary plan's reasonable and customary charge. If both the primary plan and this Plan do not have a contracted rate, the allowable expense will be the greater of the two plans' reasonable and customary charges.

When the Provider is an In-network Provider for both the primary plan and this Plan, the allowable expense is the primary plan's network rate. When the Provider is an In-network Provider for the primary plan and a Non-Network Provider for this Plan, the allowable expense is the primary plan's network rate. When the Provider is a Non-Network Provider for the primary plan and an In-network Provider for this Plan, the allowable expense is the reasonable and customary charges allowed by the primary plan. When the Provider is a Non-network Provider for both the primary plan and this Plan, the allowable expense is the greater of the two Plans' reasonable and customary charges.

What if some expenses are covered by Workers' Compensation?

This Plan does not replace or affect any requirement for coverage by a Workers' Compensation or Occupational Disease Act law. If benefits are paid by this Plan and the Plan determines that You should have received Workers' Compensation for the same incident,

this Plan has the right to recover the payments it made as described under the "**Subrogation"** section of this SPD. This Plan reserves its right to exercise its recovery rights even if:

The Workers' Compensation benefits are in dispute or are made by means of settlement or compromise

No final determination is made that bodily injury or sickness was sustained during or resulted from the plan member's employment

The amount of Workers' Compensation due to medical or healthcare is not agreed upon or defined by the plan member or the Workers' Compensation carrier

The medical or healthcare benefits are specifically excluded from the Workers' Compensation settlement or compromise.

When a Covered Person Qualifies for Medicare

Determining Which Plan is Primary

To the extent permitted by law, this Plan will pay Benefits second to Medicare when You become eligible for Medicare, even if You don't elect it. There are, however, Medicare-eligible individuals for whom the Plan pays Benefits first and Medicare pays benefits second:

Employees with active current employment status age 65 or older and their Spouses age 65 or older (however, Domestic Partners are excluded as provided by Medicare); and

Individuals with end-stage renal disease, for a limited period; and

Disabled individuals under age 65 with current employment status and their Dependents under age 65.

Determining the Allowable Expense When This Plan is Secondary to Medicare

If this Plan is secondary to Medicare, the Medicare approved amount is the allowable expense, if the Provider accepts Medicare. If the Provider does not accept Medicare, the Medicare limiting charge (the most a Provider can charge You if they don't accept Medicare) will be the allowable expense. Medicare payments, combined with Plan Benefits, will not exceed 100% of the total allowable expense.

If You are eligible for, but not enrolled in, Medicare, and this Plan is secondary to Medicare, or if You have enrolled in Medicare but choose to obtain services from a Provider that does not participate in the Medicare program, Benefits will be paid on a secondary basis under this Plan and will be determined as if You timely enrolled in Medicare and obtained services from a Medicare participating Provider. When calculating the Plan's secondary Benefits in these circumstances, for administrative convenience the claims administrator in its sole discretion may treat the Provider's billed charges as the allowable expense for both the Plan and Medicare, rather than the Medicare approved amount or Medicare limiting charge.

What is the benefit period for determining coordination?

Benefits will be coordinated on a calendar year basis. This is called the claims determination period.

What else should I know about coordination of benefits?

To make coordination of benefits work, this Plan may give or obtain needed information from another insurer or any other organization or person. This information may be given or obtained without the consent of or notice to any other person. You must give this Plan the information it asks for about other plans and their payment of allowable charges. If You do not provide the information needed to apply these rules and determine the benefits payable, Your claim for benefits will be denied.

Facility of payment

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

Right to Recover Benefit Overpayments and Other Erroneous Payments

If, for any reason, any benefit under the Plan is erroneously paid or exceeds the amount appropriately payable under the Plan to a Participant, the Participant shall be responsible for refunding the overpayment to the Plan. In addition, if the Plan makes any payment that, according to the terms of the Plan, should not have been made, the insurer, the Plan Administrator or ICUBA (or designee) may recover that incorrect payment, whether it was made due to the insurer's or Plan Administrator's (or its designee's) own error, from the person to whom it was made or from any other appropriate party. The Participant will cooperate with the Plan Administrator, the insurer, or ICUBA in the repayment of any benefit overpayment or erroneous payment. As may be permitted in the sole discretion of the Plan Administrator, the refund or repayment may be in one or a combination of the

following methods: (a) in the form of a single lump-sum payment, (b) as a reduction of the amount of future benefits otherwise payable under the Plan, (c) as automatic deductions from pay, or (d) any other method as may be required or permitted in the sole discretion of the Plan Administrator or the insurer. The Plan may also seek recovery of the erroneous payment or benefit overpayment from any other appropriate party.

Prohibition on Assignments

Except as otherwise expressly permitted in the sections governing qualified medical child support orders, certain disability and life insurance benefits, and the Plan's subrogation and reimbursement rights, no right or benefit under the Plan shall be subject to alienation, sale, transfer, assignment, pledge, or encumbrance or charge, voluntary or involuntary, by operation of law or otherwise, and any attempt at such transaction(s) shall be void. Neither You nor Your Dependent may assign any of Your rights, benefits, or any other interest under this Plan (including any right to assert benefit claims, statutory violations, or fiduciary breach claims) to any third party, including any providers. Any attempt to assign Your rights and benefits under this Plan shall be null and void. This Plan will, in its discretion, make payments directly to healthcare providers as a courtesy. The payment of benefits directly to a healthcare provider, if any, will be done as a convenience to You and Your covered Dependent(s) and will not constitute an assignment of rights, benefits or any other interest under the Health Plan or the Plan or a waiver of this anti-assignment provision.

SUBROGATION

RIGHT OF SUBROGATION, REIMBURSEMENT, AND OFFSET

The Plan has a right to subrogation and reimbursement. References to "You" or "Your" in this Right of Subrogation, Reimbursement, and Offset Section include You (or Your Dependents), Your estate, Your heirs, and Your beneficiaries unless otherwise stated.

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

The right to reimbursement means that if it is alleged that any third party caused, or is responsible for, an Illness or Injury for which You receive a settlement, judgment, or other recovery from any third party, You must use those proceeds to fully return to the Plan 100% of any benefits You receive for that Illness or Injury. The right of reimbursement will apply to any benefits received at any time until the rights are extinguished, resolved, or waived in writing.

The following persons and entities are examples of those considered to be third parties:

A person or entity alleged to have caused You to suffer an Illness, Injury, or damages, or who is legally responsible for the Illness, Injury, or damages.

Any insurer or other indemnifier of any person or entity alleged to have caused or who caused the Illness, Injury, or damages.

The Plan Sponsor in a Workers' Compensation case or other matter alleging liability.

Any person or entity who is or may be obligated to provide benefits or payments to You or on Your behalf, including benefits or payments for underinsured or uninsured motorist protection, no-fault or traditional auto insurance (including where no third party may be liable), medical payment coverage (auto, homeowners,' or otherwise), Workers' Compensation coverage, other insurance carriers, or third-party administrators.

Any group health plan (other than this Plan) responsible or obligated to provide benefits or benefit payments to You or on Your behalf.

Any person or entity against whom You may have any claim for professional and/or legal malpractice arising out of or connected to an Illness, or Injury You allege or could have alleged were the responsibility of any third party.

Any person or entity that is liable for payment to You on any equitable or legal liability theory.

You agree as follows:

You will cooperate with the Plan in protecting the Plan's legal and equitable rights to subrogation and reimbursement in a timely manner, including, but not limited to:

- Notifying the Plan, in writing, of any potential legal claim(s) You may have against any third party for acts that caused benefits to be paid or become payable.
- Providing any relevant information requested by the Plan.

- Signing and/or delivering such documents as the Plan or our agents (including attorneys) reasonably request to secure the subrogation and reimbursement claim.
- Responding to requests for information about any accident or Injuries.
- Making court appearances.
- Obtaining our consent or our agents' consent before releasing any party from liability or payment of medical expenses.
- Complying with the terms of this section.

Your failure to cooperate with the Plan is considered a breach of the Plan. As such, the Plan has the right to terminate or deny future benefits, take legal action against You, and/or set off from any future benefits the value of benefits the Plan has paid relating to any Illness or Injury alleged to have been caused or caused by any third party to the extent not recovered by the Plan due to You or Your representative not cooperating with the Plan. If the Plan incurs attorneys' fees and costs to collect third party settlement funds held by You or Your representative, the Plan has the right to recover those fees and costs from You. You will also be required to pay interest on any amounts You hold that should have been returned to the Plan.

The Plan has a priority right to receive payment on any claim against a third party before You (or Your attorney or other representative) receive payment from that third party. Further, our priority right to payment is superior to all claims, debts, or liens asserted by any medical providers, including, but not limited to, Hospitals or Emergency treatment facilities, that assert a right to payment from funds payable from or recovered from an allegedly responsible third party and/or insurance carrier.

The Plan's subrogation and reimbursement rights apply to full and partial settlements, judgments, or any other recoveries paid or payable to You, Your representative, Your estate, Your heirs, or Your beneficiaries, no matter how those proceeds are captioned or characterized. Payments include, but are not limited to, insurance payments, benefit payments, economic damages (e.g., loss of future earnings, medical expenses, and benefits), non-economic damages (e.g., pain and suffering, reputational damage, loss of enjoyment of activities, mental anguish), pecuniary damages (e.g., loss of wages, property damage), damages for loss of consortium, punitive damages, and attorney's fees or expenses. The Plan is not required to help You to pursue Your claim for damages or personal Injuries and no amount of associated costs, including attorneys' fees, will be deducted from our recovery without the Plan's express written consent. No so-called "fund doctrine" or "common-fund doctrine" or "attorney's fund doctrine" will defeat this right, and neither those doctrines nor any other state laws have any applicability to the Plan's rights hereunder.

Regardless of whether You (or Your attorney or other representative) have been fully compensated or made whole, the Plan may collect from You the proceeds of any full or partial recovery that You or Your legal representative obtain, whether in the form of a settlement (either before or after any determination of liability) or judgment or by lawsuit, mediation, arbitration, award, order, insurance payment or otherwise, no matter how those proceeds or recoveries are captioned or characterized. Proceeds from which the Plan may collect include, but are not limited to, insurance payments, benefit payments, attorney's fees, and expenses, and economic, non-economic, pecuniary, and punitive damages. No "collateral source" rule, any "made-whole doctrine" or "make-whole doctrine," claim of unjust enrichment, nor any other equitable limitation will limit our subrogation and reimbursement rights, and neither those doctrines nor any other state laws have any applicability to the Plan's rights hereunder.

Benefits paid by the Plan may also be benefits advanced. This means that if the Plan previously paid benefits to You or on Your behalf, You must reimburse the Plan for those amounts.

If You receive any payment from any third party because of Illness or Injury, and the Plan alleges some or all those funds are due and owed to the Plan, You and/or Your representative will hold those funds in trust, either in a separate bank account in Your name or in Your representative's trust account.

By participating in, and accepting benefits from, the Plan, You agree that:

- Any amounts recovered by You from any third party constitute Plan assets (to the extent of the amount of Plan Benefits provided on behalf of the Covered Person);
- The Plan has established an equitable lien against any money or property or other recovery You or Your representative (including Your attorney) recover;
- You and Your representative (including Your attorney) will be fiduciaries of the Plan with respect to such amounts; and
- You will be liable for, and agree to pay, any costs and fees (including reasonable attorneys' fees) Incurred by the Plan to enforce its reimbursement rights.

The Plan's rights to recovery will not be reduced due to Your own negligence.

Upon the Plan's request, You will assign to the Plan all rights of recovery against third parties, to the extent of the Covered Expenses the Plan has paid for the Illness or Injury.

The Plan may, at its option, take necessary and appropriate action to preserve the Plan's rights under these provisions, including, but not limited to, providing or exchanging medical payment information with an insurer, the insurer's legal representative, or other third party; filing an ERISA reimbursement lawsuit to recover the full amount of medical benefits You receive for the Illness or Injury out of any settlement, judgment, or other recovery from any third party; and filing suit in Your name (or Your Dependent's name) or Your estate's name, which does not obligate the Plan in any way to pay You part of any recovery the Plan might obtain. Any ERISA reimbursement lawsuit stemming from a refusal to refund benefits as required under the terms of the Plan is governed by a six-year statute of limitations.

You may not accept any settlement that does not fully reimburse the Plan, without its prior written approval.

The Plan has the authority and discretion to resolve all disputes regarding the interpretation of the language stated herein.

In the case of Your death, giving rise to any wrongful death or survival claim, the provisions of this Section apply to Your estate, the personal representative of Your estate, and Your heirs or beneficiaries. In the case of Your death, the Plan's right of reimbursement and right of subrogation will apply if a claim can be brought on behalf of You or Your estate that can include a claim for past medical expenses paid by the Plan or damages. The obligation to reimburse the Plan is not extinguished by a release of claims or settlement agreement of any kind.

No allocation of damages, settlement funds, or any other recovery, by You, Your estate, the personal representative of Your estate, Your heirs, Your beneficiaries, or any other person or party will be valid if it does not reimburse the Plan for 100% of its interest unless the Plan provides written consent to the allocation.

The provisions of this Section apply to the parents, guardian, or other representative of a Dependent Child who incurs an Illness or Injury caused by any third party. If a parent or guardian may bring a claim for damages arising out of a minor's Illness or Injury, the terms of this subrogation and reimbursement clause will apply to that claim.

If any third party causes or is alleged to have caused You to suffer an Illness or Injury or is otherwise responsible for payment in connection with that Illness or Injury (e.g., no fault auto insurance) while You are covered under this Plan, the provisions of this Section continue to apply, even after You are no longer covered.

In the event that You do not abide by the terms of the Plan pertaining to reimbursement, the Plan may terminate benefits to You, Your Dependents, or the subscriber; deny future benefits; take legal action against You; and/or set off from any future benefits the value of Benefits the Plan has paid relating to any Illness or Injury alleged to have been caused or caused by any third party (or in the event of no fault insurance where no third party may be liable) to the extent not recovered by the Plan due to Your failure to abide by the terms of the Plan. If the Plan incurs attorneys' fees and costs to collect third party settlement funds or any other recovery held by You or Your representative, the Plan has the right to recover those fees and costs from You. You will also be required to pay interest on any amounts You hold that should have been returned to the Plan.

The Plan and all administrators administering the terms and conditions of the Plan's subrogation and reimbursement rights have such powers and duties as are necessary to discharge their duties and functions, including the exercise of its discretionary authority to (1) construe and enforce the terms of the Plan's subrogation and reimbursement rights and (2) make determinations with respect to the subrogation amounts and reimbursements owed to the Plan.

RELEASE OF INFORMATION

For determining the applicability of, and implementing, the terms of the above provisions of this Plan or any similar provision of an Other Plan, BCBSF or Aetna may, without the consent of, or notice to, any Covered Person, release to, or obtain from, any other insurance company or other organization or individuals, any information concerning any Covered Person that is necessary for those purposes. Any person receiving Benefits under this Plan must furnish to BCBSF or Aetna information about other coverage, which may be involved in applying the Coordination of Benefits' provisions.

ICUBA's Right of Recovery

If, for any reason, any Benefit under the Plan is erroneously paid or exceeds the amount appropriately payable under the Plan to a Covered Person, the Covered Person shall be responsible for refunding the overpayment to the Plan. In addition, if the Plan makes any payment that, according to the terms of the Plan, should not have been made, the insurer, the Plan Administrator, or ICUBA (or designee) may recover that incorrect payment, whether it was made due to the insurer's or Plan Administrator's (or its designee's) own error, from the person to whom it was made or from any other appropriate party. The Covered Person will cooperate with the Plan Administrator, the insurer, or ICUBA in the repayment of any benefit overpayment or erroneous payment. As may be permitted in the sole discretion of the Plan Administrator, the refund or repayment may be in one or a combination of the following methods: (a) in the

form of a single lump-sum payment, (b) as a reduction of the amount of future benefits otherwise payable under the Plan, (c) as automatic deductions from pay, or (d) any other method as may be required or permitted in the sole discretion of the Plan Administrator or the insurer. The Plan may also seek recovery of the erroneous payment or benefit overpayment from any other appropriate party.

ICUBA's Right to Use Your Social Security Number for Administration of Benefits

ICUBA retains the right to use Your Social Security number for benefit administration purposes, including tax reporting. If a state law restricts the use of Social Security numbers for benefit administration purposes, ICUBA generally takes the position that ERISA preempts such state laws.

Disclaimer

Your eligibility for Benefits is determined by the Plan. ICUBA and/or the Plan Administrator, as applicable, has the discretionary authority to interpret the Plan to make eligibility and benefit determinations as it may determine in its sole discretion. The Plan Administrator also has the discretionary authority to make factual determinations as to whether any individual is entitled to receive any benefits under the Plan. ICUBA may delegate responsibilities for the operation and administration of the Plan and its benefits and may designate fiduciaries other than those named in the Plan and may allocate or reallocate fiduciary responsibilities under the Plan.

Every effort has been made to accurately describe the plans/benefits in this SPD. However, if there should be a discrepancy or inconsistency between this SPD and federal laws and regulations, the appropriate federal laws and regulations will control.

ICUBA reserves the right to act through its Board of Directors or through a designee of either to amend, modify, suspend, or terminate a plan/benefit, in whole or in part, at any time, at its discretion, with or without advance notice to Participants, for any reason, subject to applicable law.

ICUBA also reserves the right to change the amount of required Participant contributions for coverage under the Plans at any time, with or without advance notice to Participants.

All terms of the Plan (including this SPD) are legally enforceable. However, this SPD does not constitute a contract of employment or guarantee of any particular benefit or term of employment.

ARTICLE TEN: COORDINATION OF BENEFITS WITH MEDICARE

ELIGIBILITY FOR MEDICARE

A Participant may have coverage under the Plan and under Medicare. Medicare means benefits offered under Title XVII of the Social Security Act and includes all the benefits provided by Parts A and B of Medicare. When a Participant has coverage under both the Plan and Medicare, the Plan will pay Benefits primary to Medicare for:

An active Employee who is age 65 or over;

An active Employee's covered spouse who is age 65 or over;

An active Employee or covered spouse who is under age 65 and entitled to Medicare because of a Disability; or

The first 30 months of treatment for end stage renal disease received by any Participant.

If a Participant does not fall into one or more of the categories above, the Plan will pay Benefits secondary to Medicare. When the Plan pays secondary to Medicare, the Participant must first submit a claim to Medicare. After Medicare makes payment, the Participant may submit the Claim to the Plan for payment.

When a Participant files for Social Security benefits, the Participant automatically becomes eligible for Medicare Part A Hospital coverage, which has no premium expense. A Participant must voluntarily enroll in Medicare Part B medical coverage and pay premiums.

ELECTION BY PARTICIPANT

A Participant who is covered under Medicare and the Plan, and who falls into one of the categories above, may elect to waive coverage under the Plan. If coverage is waived under the Plan, the Plan will no longer provide coverage for that person. If a Participant waives coverage under the Plan, the Participant may later reapply for coverage under the Plan during Open Enrollment as a Late Enrollee. However, the rules governing Late Enrollees will apply. If a Participant elects Medicare as the primary coverage, the Participant will have no further coverage under this Plan.

HEALTH CARE FINANCING ADMINISTRATION REGULATION

This Article is based on regulations issued by the Health Care Financing Administration (HCFA) now known as Centers for Medicare and Medicaid Services (CMS) and may be amended or changed at any time. It is the intent of the Plan to abide by the Medicare Secondary Payer rules. The Plan will coordinate with Medicare to the fullest extent permitted by applicable law. If the Plan in any way conflicts with regulations issued by CMS, the Plan will pay Benefits in accordance with CMS regulations.

COORDINATION OF MEDICARE WITH THE ICUBA MEDICAL PLAN

Active Employees and Dependents

An Employee who is over the age of 65 and enrolled in Medicare will be Covered under the Plan as the primary payer if that Employee is still Actively at Work. Medicare is secondary to the Plan for these Actively at Work Employees. You must supply the social security number of any dependent over the age of 45 at the time of enrollment.

Medicare uses a Coordination of Benefits (COB) Contractor which consolidates the activities that support the collection, management, and reporting of other insurance coverage for Medicare beneficiaries. The purposes of the COB program are to identify the health benefits available to a Medicare beneficiary and to coordinate the payment process to prevent mistaken payment of Medicare benefits. The COB Contractor does not process claims, nor does it handle any mistaken payment recoveries or claims-specific inquiries. The Medicare intermediaries and carriers are responsible for processing claims submitted for primary or secondary payment. Medicare's Coordination of Benefits Agreement Program establishes a nationally standard contract between the Center for Medicare and Medicaid Services (CMS) and other health insurance organizations that defines the criteria for transmitting enrollee eligibility data and Medicare adjudicated claim data. The CMS will transfer the claims crossover functions from individual Medicare contractors to a national claims crossover contractor, the Coordination of Benefits Contractor (COBC). This consolidation will allow for the establishment of unique identifiers (COBC IDs) to be associated with each contract and create a national repository for COB information. You

Retirees

Note: The Plan requires that all retired Covered Persons eligible for Medicare enroll in Medicare Parts A and B and pay any associated premiums. The Plan will pay Benefits based on the premise that the retired Covered Person has elected coverage under Medicare Parts A and B, regardless of whether the retired Covered Person has done so.

Plan coverage is available for Eligible Retirees. If You retire before the attaining age 65, You will be provided with the opportunity to remain covered under the Plan. Upon attaining age 65, You will be offered the AmWins Retiree Supplemental Plan and You have thirty (30) days to enroll. The premium for the AmWins Plan is age banded and Your premium will change the first day of the plan year following Your birthday if Your birthday results in a change of Your age band.

Under the comprehensive benefits program, health care Benefits are provided under one integrated program. These Benefits include coverage for Hospital Services, Physician services, and many other Covered Services. Most Benefits are subject to Deductible and Coinsurance provisions which require You to share a portion of the medical costs. Below are the specific Benefit levels. These Benefits will be applied after Medicare Parts A and B have paid their portion for Covered Services.

As a Medicare Participant, You have a right to access and to review a fee schedule with a complete listing of fees used by Medicare to pay doctors or other providers/suppliers. This comprehensive listing of fee maximums is used to reimburse a Physician and/or other Providers on a fee-for-service basis. CMS develops fee schedules for Physicians, Ambulance Services, clinical laboratory services, and Durable Medical Equipment, prosthetics, orthotics, and supplies. **This fee schedule is available at** http://www.cms.hhs.gov/FeeScheduleGenInfo/.

The ICUBA Prescription Drug benefit is Creditable Coverage, so You will receive credit towards Medicare Part D upon Your retirement if You choose to elect Medicare Part D. Creditable Coverage means that the amount the Plan expects to pay on average for Prescription Drugs for individuals covered under the Plan in the applicable year is the same or more than what standard Medicare Prescription Drug coverage would be expected to pay on average. This is important because the Medicare Modernization Act (MMA) imposes a late enrollment penalty on individuals who do not maintain Creditable Coverage for a period of 63 days or longer following their initial enrollment period for the Medicare Prescription Drug benefit. MMA mandates that certain entities offering Prescription Drug coverage, including employer and union group health plan sponsors, disclose to all Medicare eligible individuals with Prescription Drug coverage under the plan whether such coverage is 'creditable." This information is essential to an individual's decision whether to enroll in a Medicare Part D Prescription Drug plan. The Plan pays for other health expenses in addition to Prescription Drugs. If You or Your Dependent enroll in a Medicare Prescription Drug plan, You and Your eligible Dependents will still be able to receive all Your current health and Prescription Drug Benefits.

ARTICLE ELEVEN: CLAIMS AND APPEALS PROCEDURES

HOW TO FILE A CLAIM

Participating Providers have agreed to file Claims for services they rendered to You. However, in the event a Provider does not file a Claim for such services, it is Your responsibility to file the claim. If You choose to use a Non-Network Provider, You are responsible for filing Your Claim.

The only time You must pay a Participating Provider is when You have a Benefit Year Deductible, Coinsurance, Copayment or when the services or supplies provided are not Covered Expenses under Your Plan of Benefits.

The procedure is simple. Just take the following steps:

a. **Know Your Benefits**. Review this information to see if the services You received are eligible under the Plan.

Get an

Itemized Bill. Itemized bills must include:

The name and address of the service Provider;

The Covered Person's full name;

The Date of Service or supply;

A description of the service/supply;

The amount charged for each service/supply rendered;

The diagnosis or nature of the Illness;

For Durable Medical Equipment, the Physician's certification;

For Private Duty Nursing Services, the nurse's license number, charge per day, and shift worked; and

For Ambulance Services, the total mileage.

Please note: If You have already made payment for the services You received, You must also submit proof of payment (receipt from the Physician) with Your Claim form. Cancelled checks, cash register receipts, or personal itemizations are not acceptable as itemized bills.

b. **Copy Itemized Bills**. You must submit originals, so You should make copies for Your records. Once Your Claim is received, itemized bills cannot be returned.

c. **Complete a Claim Form**. Make sure all information is completed properly then sign and date the Claim form.

Medical Claim forms can be obtained by contacting BCBSF Member Service at 1-855-258-9029.

Behavioral Health and Substance Use Disorder Claim forms can be obtained by contacting Aetna at 1-877-398-5816.

d. **Attach Itemized Bills to the Claim Form and Mail**. After You complete the above steps, attach all itemized bills to the Claim form and mail everything to the address on the form.

e. **Remember**: Multiple services for the same Covered Person can be filed with one Claim form. However, a separate Claim form must be completed for each Covered Person.

f. **Remember**: Your Claims must be submitted within 12 (twelve) months from the Date of Service, or Your Claim will be denied as untimely.

YOUR EXPLANATION OF BENEFITS STATEMENT (EOB)

Once Your Claim is processed, You will receive an Explanation of Benefits (EOB) statement. This statement lists: the Provider's charge; the Allowable Charge; the Copayment, Deductible, and Coinsurance amounts, if any, You are required to pay; the total Benefits payable; and the total amount You owe.

ADDITIONAL INFORMATION ON HOW TO FILE A CLAIM

a. **Covered Person Inquiries:** General inquiries regarding Your eligibility for coverage and Benefits that do not involve the filing of a Claim should be made by directly contacting BCBSF Member Service for Medical at 1-855-258-9029 or Aetna for Behavioral Health at 1-877-398-5816.

b. **Filing Benefit Claims**:

Authorized Representatives: When You see a Network Provider, they will usually bill us directly. When You see a Non-Network Provider, we may choose to pay You or to pay the Provider directly. Unless prohibited by law or with regards to the Plan's subrogation/reimbursement rights, You may not assign your rights, benefits or any other interest to a Network or Non-Network provider or any other third-party or individual. The payment of benefits directly to a Provider, if any, will be done as a convenience to You and will not constitute an assignment of rights, benefits or any other interest under this Plan or a waiver of this anti-assignment provision.

Requests for Precertification and Other Pre-Service Claims: For a description of how to file a request for Precertification or other Pre-Service Claim, and for a description of the time frames in which such requests will be determined by BCBSF or Aetna, as applicable, and the notice that You will receive concerning its decision (whether adverse or not), see the Utilization Review Process Information Section in Article Three. Please review the Covered Expenses as detailed in Article 7 prior to requesting Precertification or Pre-Service Claims to ensure that the procedure You are planning is a Covered Expense under the Plan. If the planned procedure is listed under the Limitations and Exclusions in Article 8, the procedure will not be covered except as otherwise explained herein. If the Plan does not require Precertification for the Claim for which the approval is being requested, it is not a "claim for benefits" governed by ERISA and the Department of Labor Regulations.

Requests for Reimbursement and Other Post-Service Claims: When a Participating Provider (e.g., Hospital, Physician, etc.) submits its own reimbursement Claim, the amount paid to that Participating Provider will be determined in accordance with the Participating Provider's agreement with BCBSF, the local Blue Cross Blue Shield Plan or Aetna serving Your area. BCBSF or Aetna will notify You of the amount that was paid to the Participating Provider. Any remaining amounts that You are required to pay in the form of a Copayment, Coinsurance, or program Deductible will also be identified in that Explanation of Benefits (EOB) or notice. If You believe that the Copayment, Coinsurance, or Deductible amount identified in that EOB or notice is not correct, or that any portion of those amounts are covered under Your Benefit program, You should contact BCBSF Member Service at 1-855-258-9029 for Medical/Rx or Aetna at 1-877-398-5816 for Behavioral Health/Substance Use Disorder.

c. **Deadline**: To be eligible for coverage, You must submit all requests for reimbursement and other Post-Service Claims within 12 (twelve) months from the Date of Service.

DEFINITIONS

1. **Claim**. A Claim is any request for a Plan Benefit or Benefits made in accordance with these Claims and Appeals Procedures. A communication regarding Benefits that is not made in accordance with these Claims and Appeals Procedures will not be treated as a Claim. Any request for Plan Benefits that is not made in accordance with these Claims and Appeals Procedures is called an Incorrectly Filed Claim.

2. **Claimant**. A Claimant is an individual who makes a request for a Plan Benefit or Benefits in accordance with these Claims and Appeals Procedures.

3. **Incorrectly Filed Claim**. Any request for Benefits that is not made in accordance with these Claims and Appeals Procedures is called and Incorrectly Filed Claim.

4. **Day**. When used in these Claims and Appeals Procedures, the term Day means a calendar day.

5. **Authorized Representative**. When You see a Network Provider, they will usually bill us directly. When You see a Non-Network Provider, we may choose to pay You or to pay the Provider directly. Unless prohibited by law or with regards to the Plan's subrogation/reimbursement rights, You may not assign your rights, benefits or any other interest to a Network or Non-Network provider or any other third-party or individual. For Urgent Care Claims, the Plan will recognize a health care Professional with knowledge of the Claimant's medical condition (i.e., the treating Physician) as the Claimant's Authorized Representative unless the Claimant provides specific written direction otherwise. The payment of benefits

directly to a Provider, if any, will be done as a convenience to You and will not constitute an assignment of rights, benefits or any other interest under this Plan or a waiver of this anti-assignment provision.

TYPES OF CLAIMS

There are different categories of Claims, each with different Claims and Appeal rules. The Department of Labor Regulations set forth different requirements based on the type of Claim involved. The primary difference is the timeframe within which Claims and Appeals must be determined.

1. **Pre-Service Claim**. A Claim is a Pre-Service Claim if the Plan Document specifically conditions receipt of the Benefit, in whole or in part, on receiving approval in advance of obtaining the Medical Care, Behavioral Health Services or Substance Abuse Disorder care unless the Claim involves Urgent Care, as defined below. Benefits under this Plan that require approval in advance are specifically noted in this Plan Document as being subject to Precertification. For benefits not noted as being subject to Pre-Certification, no advance approval is necessary, and any request for advance approval will not be treated as a Claim.

2. **Urgent Care Claim**. An Urgent Care Claim is a special type of Pre-Service Claim. A Claim involving Urgent Care is any Pre-Service Claim for Medical Care, Behavioral Health Services or Substance Abuse Disorder care or treatment with respect to which the application of the time periods that otherwise apply to Pre-Service Claims could seriously jeopardize the Claimant's life or health or ability to regain maximum function or would, in the opinion of a Physician with knowledge of the Claimant's condition, subject the Claimant to severe pain that cannot be adequately managed without the care or treatment that is the subject of the Claim.

The prudent layperson standard applies to these determinations. If a treating Physician determines the Claim involves Urgent Care, the Claim shall be treated as an Urgent Care Claim. However, to file an Urgent Care Claim, You must be requesting to have a procedure which is a Covered Expense as defined in Article 7 of this Plan Document. The procedure must not be a procedure that is a Limitation or Exclusion as defined in Article 8 of this Plan Document.

On receipt of a Pre-Service Claim, BCBSF or Aetna will make a determination of whether it involves Urgent Care; provided, however, that if a Physician with knowledge of the Claimant's condition determines that a Claim involves Urgent Care, the Claim shall be treated as an Urgent Care Claim.

3. **Post-Service Claim**. A Post-Service Claim is any Claim for a Benefit under this Plan that is not a Pre-Service Claim or an Urgent Care Claim. Post-Service Claims are Claims that involve only the payment or reimbursement of the cost for Medical Care, Behavioral Health Services or Substance Abuse Disorder care that has already been provided.

4. **Concurrent Care Claim**. A Concurrent Care Claim occurs where the Plan approves an ongoing course of treatment to be provided over a period of time or for a specified number of treatments. There are two types of Concurrent Care Claims:

Where reconsideration of the approval results in a reduction or termination of the initially approved period of time or number of treatments; and

Where an extension is requested beyond the initially approved period of time or number of treatments.

5. **Disability Claim**. A Disability Claim is any Claim for a Disability Benefit under this Plan.

6. **Change in Claim Type**. The Claim type is determined initially when the Claim is filed. However, if the nature of the Claim changes as it proceeds through these Claims and Appeals Procedures, the Claim may be re-characterized. For example, a Claim may initially be an Urgent Care Claim. If the urgency subsides, it may be re-characterized as a Pre-Service Claim.

7. **Questions about Claim Type**. If You have any questions regarding what type of Claim and/or what Claims and Appeals Procedure to follow, contact the Plan Administrator.

TIMEFRAME FOR DECIDING INITIAL BENEFIT CLAIMS

1. **Pre-Service Claims**. BCBSF or Aetna shall decide an initial Pre-Service Claim within a reasonable time appropriate to the medical circumstances, but no later than 15 days after the Plan's receipt of the Pre-Service request for authorization. If the Plan does not require Precertification for the Claim for which the approval is being requested, it is not a "claim for benefits" governed by ERISA and the Department of Labor regulations.

2. **Urgent Care Claims**. BCBSF or Aetna shall decide an initial Urgent Care Claim as soon as possible, considering the medical exigencies, but no later than 72 hours after the Plan's receipt of the Claim.

3. **Concurrent Care Extension Request**. If a Claim is a request to extend a Concurrent Care Claim (defined above) involving Urgent Care and if the Claim is made at least 24 hours prior to the end of the initially approved period of time or number of treatments, the Claim shall be decided within no more than 24 hours after the Plan's receipt of the Claim. Any other request to extend a Concurrent Care Claim shall be decided in the otherwise applicable timeframes for Pre-Service, Urgent Care, or Post-Service Claims.

4. **Concurrent Care Early Termination**. A decision by BCBSF or Aetna to reduce or terminate an initially- approved course of treatment is an Adverse Benefit Decision that may be appealed by the Claimant under these Claims and Appeals Procedures, as explained below. Notification to the Claimant of a decision to reduce or terminate an initially approved course of treatment shall be provided sufficiently in advance of the reduction or termination to allow the Claimant time to appeal the Adverse Benefit Decision and receive a decision on review under these Claims and Appeals Procedures prior to the reduction or termination.

5. **Post-Service Claim**. BCBSF or Aetna shall decide an initial Post-Service Claim within a reasonable time but no later than 30 days after the Plan's receipt of the Claim.

6. **Disability Claim**. An initial Disability Claim decision will be rendered within a reasonable time but no later than 45 days after receipt of the claim by the Plan.

7. **When Extensions of Time Are Permitted**. Despite these specified timeframes, nothing prevents the Claimant from voluntarily agreeing to extend the above timeframes. In addition, if BCBSF or Aetna, due to matters beyond their control, are not able to decide a Pre-Service Claim, a Post-Service Claim, or a Disability Claim, as applicable, within the above timeframes, one 15-day extension of the applicable timeframe is permitted (up to two 30-day extensions in the case of a Disability Claim), provided that the Claimant is notified in writing of the need for the extension prior to the beginning of any such extension period. The extension notice shall include (i) a description of the matters beyond the Plan's control that justify the extension and (ii) the date by which a decision is expected, and in the case of a Disability Claim, (iii) the standards governing entitlement to a benefit, (iv) any unresolved issues that prevent a decision on the Claim, and (v) additional information the Plan needs to resolve those issues. The Claimant shall be given at least 45 days to provide such additional information, if applicable. No extension is permitted for Urgent Care Claims.

8. **Incomplete Claims**. If any information needed to process a Claim is missing, the Claim shall be treated as an Incomplete Claim.

9. **How Incomplete Urgent Care Claims Are Treated**. If an Urgent Care Claim is incomplete, BCBSF or Aetna shall notify the Claimant as soon as possible, but no later than 24 hours following the Plan's receipt of the Incomplete Claim. The notification may be made orally to the Claimant, unless the Claimant requests written notice, and it shall describe the information necessary to complete the Claim and shall specify a reasonable time, no less than 48 hours, within which the Claim must be completed. The Plan shall decide the Claim as soon as possible, but no later than 48 hours after the earlier of:

Receipt of the specified information; or

The end of the period of time provided to submit the specified information.

10. **How Other Incomplete Claims Are Treated**. If a Pre-Service or Post-Service Claim is incomplete, BCBSF or Aetna may deny the Claim or may take an extension of time, as described above. If BCBSF or Aetna takes an extension of time, the

extension notice shall include a description of the missing information and shall specify a timeframe, no less than 45 days, in which the necessary information must be provided. The timeframe for deciding the Claim shall be suspended from the date the extension notice is received by the Claimant until the date the missing necessary information is provided to BCBSF or Aetna. If the requested information is provided, BCBSF or Aetna shall decide the Claim within the extension period specified in the extension notice. If the requested information is not provided within the time specified, the Claim may be decided without that information.

NOTIFICATION OF INITIAL BENEFIT DECISION

1. **Pre-Service and Urgent Care**. Written notification of BCBSF's or Aetna's decision on a Pre-Service or Urgent Care Claim shall be provided to the Claimant whether the decision is Adverse.

2. **Definition of Adverse**. A decision on a Claim is "Adverse" if it is

A denial, reduction, or termination of; or

A failure to provide or make payment (in whole or in part) for a Benefit.

3. **Notification of Adverse Benefit Decision (Initial Claim Denial)**. Written or electronic notification shall be provided to the Claimant of the Plan's Adverse Benefit Decision on a Claim and shall include the following, in a manner calculated to be understood by the Claimant (including, if necessary, in a culturally and linguistically appropriate manner according to applicable requirements):

Information sufficient to identify the Claim involved (e.g., the Date of Service, the health care Provider, the Claim amount when applicable, and a statement describing the availability, upon request, of the diagnosis code, the treatment code, and the corresponding meanings of the codes);

The specific reasons(s) for the Adverse Benefit Decision, including the denial code and its meaning and any Plan standard used in denying the Claim;

Reference(s) to the specific Plan provision(s) on which the decision is based;

A description of any additional material or information necessary to perfect the Claim and why such information is necessary;

A description of the Plan's Claim review procedures, including any internal or external appeals available, how to initiate the appeals, the applicable time limits and an explanation of the expedited review procedure for certain types of Claims (for example, certain Urgent Care Claims);

A statement that You have a right to bring a civil action in federal court if Your Claim has been denied after You have asked for and received a review of the initial denial;

A description of any additional materials necessary to perfect Your Claim, and an explanation of why those materials are necessary;

Reference to any rule, guideline, protocol, or similar document or criteria relied on in making the initial determination, and a statement that a copy of such rule, guideline, or protocol may be obtained upon request at no cost to You;

If the decision is based on a matter of judgment (for example, it was determined that Your treatment was Experimental or was not Medically Necessary), the Notice will also contain an explanation of the scientific or clinical judgment on which the determination was based or a statement that a copy of such explanation can be obtained upon written request at no charge to You;

In the case of an Urgent Care Claim, an explanation of the expedited review methods available for such Claim. Notification of the Plan's Adverse Benefit Decision on an Urgent Care Claim may be provided orally, but written notification shall be furnished no later than 3 days after the oral notice.

If the Adverse Benefit Decision is based on a standard, the notice will include a description of the standard; and

A disclosure of the availability of, and contact information for, any applicable office of health insurance consumer assistance or ombudsman available to assist You with the Plan's internal Claims and appeals and external review process.

YOUR RIGHT TO APPEAL

A Claimant has a right to appeal an Adverse Benefit Decision under these Claims and Appeals Procedures. After an initial benefit decision has been made with regard to a Claim by BCBSF or Aetna, as applicable, then an appeals process is offered under the Plan

which has two levels (each level is referred to as a "level of review") with the exception of Urgent Care Claims (which are subject to one level of review): (1) the first level of review (Your first opportunity to appeal an Adverse Benefit Decision); and (2) the second level of review (Your second opportunity to appeal an Adverse Benefit Decision). Medical Claim Appeals are the responsibility of BCBSF and Behavioral and Substance Use Disorder Claims are the responsibility of Aetna. If you are appealing an Adverse Benefit Decision associated with a mental health parity claim under the MHPAEA, then your Claim appeal will be the responsibility of the ICUBA Plan Administrator.

HOW TO APPEAL AN ADVERSE BENEFIT DECISION

First Level of Review. If the Claimant is dissatisfied with an Adverse Benefit Decision by BCBSF or Aetna, the Claimant may request a first level of review by BCBSF or Aetna, as applicable. The first level of review is Your first opportunity to appeal the Adverse Benefit Decision.

How to File Your Appeal. Except for Urgent Care Claims, discussed below, the first level of review of an Adverse Benefit Decision is filed when a Claimant (or Authorized Representative) submits a written request for review to BCBSF or Aetna at the address listed below:

BCBSF
Columbia Service Center
Attention: Appeals Coordinator AX-830
P. O. Box 100121
Columbia, SC 29202-3121

Aetna
P.O. Box 14079
Lexington, KY 40512 4079

To file an appeal for a first level of review of an Adverse Benefit Decision, the request must pertain to a Covered Expense as detailed in Article 7 of the Plan and not listed as a Limitation or Exclusion as detailed in Article 8 of the Plan. The Claimant should state why the appeal should be approved and include any information supporting the appeal. The appeal will be reviewed, and the decision made by a Claims reviewer not involved in the initial decision. Appeals involving Medical Necessity or clinical appropriateness will be considered by a health care Professional.

Important Deadline to Request First Level of Review. The **appeal of an Adverse Benefit Decision must be filed within 180 days following the Claimant's receipt of the notification of Initial Adverse Benefit Decision**, except that the appeal of a decision by the Plan to reduce or terminate an initially approved course of treatment (see the definition of Concurrent Care Claim) must be filed within 30 days of the Claimant's receipt of the notification of the Plan's decision to reduce or terminate. Failure to comply with these important deadlines shall cause the Claimant to forfeit any right to any further review of an Adverse Benefit Decision under these Claims and Appeals Procedures or in a court of law.

Urgent Care Appeals. Considering the expedited timeframes for decision of Urgent Care Claims, an appeal for an Urgent Care Claim may be submitted to BCBSF Member Services at 1-855-258-9029 for Medical/Rx or to Aetna at 1-877-398-5816 for Behavioral Health. The appeal should include at least the following information:

The identity of the Claimant;

A specific medical condition or symptom;

A specific treatment, service or product for which approval or payment is requested; and

Any reasons why the appeal should be processed on a more expedited basis.

Second Level of Review. If the Claimant is dissatisfied with the outcome of the first level of review, **the Claimant may voluntarily initiate** an additional, second level of review upon receipt of an Adverse Benefit Decision from BCBSF or Aetna. The Claimant will receive a notice from the Plan addressing how to initiate a second level of review and the deadline for making such a request.

Court Review and Failure of the Claimant to Follow These Internal Review Procedures

All decisions following a review by the Claims Administrator are final and binding for purposes of the Plan's internal Claim review procedures. If no review is sought, the decision of the Claims Administrator is final and binding upon the expiration of the time period for seeking internal review. If Your Claim is denied in whole or in part after all stages of the internal review procedures have been completed (except any voluntary levels of review), You have the right to seek to have Your Claim paid by filing a request for external review (if Your Claim is eligible), or a civil action in federal court, but You will not be able to do so unless You have completed all of the levels of the internal review process (except any voluntary levels) required under the Plan.

If Your Claim is eligible for external review and You wish to file a request for external review, You must do so within four months after You receive a final Notice of Denial on Review. If You do not follow and complete these procedures, Your request may be ineligible for

external review. If You wish to file Your Claim in court, You must do so within one year of the date of the Notice of the Denial on Review, or if later, within one year of the date of the final decision on external review. If You do not follow and complete these procedures, a review of Your Claim in court will be subject to dismissal for Your failure to exhaust Your Claim and review rights under this Plan.

HOW YOUR APPEAL WILL BE DECIDED

The first level of review of an Adverse Benefit Decision will be performed by the BCBSF or Aetna appeals board, as applicable, which may include a medical director or other Clinician. If the Claimant's appeal under the first level of review results in another Adverse Benefit Decision by BCBSF or Aetna, as applicable, the Claimant may then request a second level of review by an Independent Review Organization (IRO) or BCBSF or Aetna, as applicable.

If the Claimant is appealing an Adverse Benefit Decision based on a mental health parity claim under the MHPAEA, such Claimant must directly notify the ICUBA Plan Administrator. Such mental health parity claim shall be referred to an Independent Review Organization (IRO).

Generally, the person(s) who reviews and decides an appeal will be a different individual than the person who made the initial Adverse Benefit Decision and will not be a subordinate of the person who made the initial Adverse Benefit Decision. If applicable, under the second level of review, the procedures to be followed by an IRO regarding claims submitted for external review will be carried out in accordance with applicable law.

Independent External Review

For adverse benefit determination involving medical judgment, consideration of whether the Plan is complying with the surprise billing and cost-sharing protections set forth in the No Surprises Act, or a rescission, you or your authorized representative may make a request for an independent external review or expedited external review of an adverse benefit determination or final internal adverse benefit determination by an independent review organization (IRO).

Requesting an External Review

Within four months after the date of receipt of a final Notice of Denial on Review from the Claims Administrator, you or your authorized representative must file your request for standard (or "independent") external review. If there is no corresponding date four months after the date of receipt of such a notice, then the request must be filed by the first day of the fifth month following the receipt of the notice. For example, if the date of receipt of the notice is October 30, because there is no February 30, the request must be filed by March 1. If the last filing date would fall on a Saturday, Sunday, or federal holiday, the last filing date is extended to the next day that is not a Saturday, Sunday, or federal holiday.

Preliminary Review

Within five business days following the date of receipt of the external review request, the Claims Administrator must complete a preliminary review of the request to determine whether your request is eligible for external review.

You will be notified within one business day after the preliminary review is completed if your request is eligible or if further information or documents are needed. You will have the remainder of the four- month appeal period (or 48 hours following receipt of the notice), whichever is later, to perfect the appeal request. If your claim is not eligible for external review, the reasons it is ineligible and contact information for the Department of Labor's Employee Benefits Security Administration (toll-free number 866-444-EBSA (3272)) will be outlined in the notice.

Referral to Independent Review Organization

When an eligible request for external review is completed within the time period allowed, the Claims Administrator will assign the matter to an independent review organization (IRO).

Within five business days after the date of assignment of the IRO, the Claims Administrator must provide to the assigned IRO the documents and any information considered in making the adverse benefit determination or final internal adverse benefit determination. The IRO will then notify you of your acceptance for external review and your right to submit additional information to the IRO within 10 business days following your receipt of the notification.

Upon receipt of any information submitted by you or your authorized representative, the assigned IRO must within one business day forward the information to the Claims Administrator. Upon receipt of any such information, the Claims Administrator may reconsider its adverse benefit determination or final internal adverse benefit determination that is the subject of the external review.

If the Claims Administrator reverses its decision based on this information, the Claims Administrator will provide you and the IRO with notice of the reversal within 1 business day of making the determination. The IRO will then terminate the external review process.

If the Claims Administrator does not reverse this determination, the IRO will continue the external review process and provide you with written notice of the final external review decision.

Reversal of Plan's Decision

Upon receipt of a notice of a final external review decision reversing the adverse benefit determination or final internal adverse benefit determination, the Claims Administrator immediately must provide coverage or payment (including immediately authorizing or immediately paying benefits) for the claim.

Expedited External Review

Request for Expedited External Review

The Claims Administrator must allow you or your authorized representative to make a request for an expedited external review with the Claims Administrator for claims that otherwise qualify for external review at the time you receive:

- an adverse benefit determination that involves a medical condition of the claimant for which the timeframe for completion of an expedited internal appeal under the interim final regulations would seriously jeopardize your life or health or would jeopardize your ability to regain maximum function and you have filed a request for an expedited internal appeal; or
- a final internal adverse benefit determination, if the claimant has a medical condition where the timeframe for completion of an independent external review would seriously jeopardize your life or health or would jeopardize your ability to regain maximum function, or if the final internal adverse benefit determination concerns an admission, availability of care, continued stay, or health care item or service for which you received emergency services, but have not been discharged from a facility.

Preliminary Review

Immediately upon receipt of the request for expedited external review, the Claims Administrator must determine whether the request qualifies for external review and provide you with notice.

Referral to Independent Review Organization

Upon a determination that a request is eligible for external review following the preliminary review, the Claims Administrator will assign an IRO. The Claims Administrator must provide or transmit all necessary documents and information considered in making the adverse benefit determination or final internal adverse benefit determination to the assigned IRO electronically or by telephone or facsimile or any other available expeditious method.

The assigned IRO, to the extent the information or documents are available and the IRO considers them appropriate, must consider the information or documents described above under the procedures for standard review. In reaching a decision, the assigned IRO must review the claim de novo and is not bound by any decisions or conclusions reached during the Claims Administrator's internal claims and appeals process.

Notice of Final External Review Decision

The IRO will provide notice of the final external review decision as expeditiously as your medical condition or circumstances require, but in no event more than 72 hours after the IRO receives the request for an expedited external review. If the notice is not in writing, within 48 hours after the date of providing that notice, the assigned IRO must provide written confirmation of the decision to the Claims Administrator and you or your authorized representative.

TIMEFRAMES FOR DECIDING BENEFIT CLAIM APPEALS

1. **Pre-Service Claims**. An appeal of a Pre-Service Claim shall be decided within a reasonable time appropriate to the medical circumstances but no later than 30 days after receipt by the Plan of the Request for Review Form.

2. **Urgent Care Claims**. An appeal of an Urgent Care Claim shall be decided as soon as possible, considering the medical exigencies, but no later than 72 hours after receipt by the Plan of the Request for Review Form.

3. **Post-Service Claims**. An appeal of a Post-Service Claim shall be decided within a reasonable period but no later than 60 days after receipt by the Plan of the Request for Review Form.

4. **Concurrent Care Claims**. An appeal of a decision by the Plan to reduce or terminate an initially approved course of treatment (see the definition of Concurrent Care Claim) shall be decided before the proposed reduction or termination takes place. An appeal of a denied request to extend a Concurrent Care Claim shall be decided in the appeal timeframe for Pre-Service, Urgent Care, or Post-Service Claims described above, as appropriate to the request.

5. **Disability Claims**. An appeal of a denied Disability Claim shall be decided within a reasonable period but no later than 45 days after receipt by the Plan of the Request for Review Form. If the Plan determines that special circumstances require additional time for processing the claim, it can extend the response period by an additional 45 days by notifying the Claimant in writing, prior to the end of the initial 45-day period, that an additional period is required. The notice of extension must set forth the special circumstances and the date by which the Plan expects to make the review decision.

Mental Health Parity Claims Procedure

The MHPAEA, as amended by the Affordable Care Act, generally requires that the Plan ensure that the financial requirements and treatment limitations on MH/SUD benefits it provides are no more restrictive than those on Medical benefits. This is commonly referred to as providing MH/SUD benefits in parity with Medical benefits. An appeal of an Adverse Determination Decision based on a mental health parity claim must be brought to the Plan Administrator, which will send such claim to an IRO for a review and ruling. A Participant may file both a mental health parity claim and a Behavioral Health/Substance Use Disorder claim at the same time. Each claim will be handled independently as described in these appeal procedures. A mental health parity appeal may be an appeal of a Pre-Service Claim, an Urgent Care Claim, a Post-Service Claim, or a Concurrent Care Claim. Only one level of appeal is available for a mental health parity claim and it will be handled by an IRO. For purposes of these Claim Appeal procedures, the Plan Administrator is also the Claim Administrator.

NOTIFICATION OF DECISION ON APPEAL

Written notification of the decision on appeal shall be provided to the Claimant regardless of whether the decision is an Adverse Benefit Decision. Written notification shall be provided to the Claimant of an Adverse Benefit Decision and shall include the following, written in a manner calculated to be understood by the Claimant:

The specific reason(s) for the appeal decision;

A reference to the specific Plan provision(s) on which the decision is based;

A statement that the Claimant is entitled to receive, free of charge, reasonable access to any document: (1) relied on in making the review decision; (2) submitted, considered, or generated while making the review decision; or (3) that demonstrates compliance with the administrative processes and safeguards required in making the determination;

A statement of the second level of appeals procedures of the Plan, if applicable, and the Claimant's right to receive information about such procedures;

A copy of the specific internal rules, guidelines, protocol, or similar criterion relied upon in making the Adverse Benefit Decision (or a statement that such rules, guidelines, protocols, standards, or other similar Plan criteria do not exist);

In the case of a Disability Claim, a discussion of the Plan's decision, including (for example) an explanation of the basis for disagreeing with or not following the views presented by the Claimant to the Plan of health care Professionals treating the Claimant and vocational professionals who evaluated the Claimant, or a Disability determination regarding the Claimant by the Social Security Administration;

If the adverse determination is based on medical necessity or experimental treatment or a similar exclusion or limit, either an explanation of the scientific or clinical judgment, applying the terms of the Plan to the Claimant's medical circumstances, or a statement that this will be provided without charge upon request; and

A statement of the Claimant's right to bring a civil action under Section 502(a) of ERISA, which, in the case of a Disability Claim, includes a description of any contractual limitations period relevant to the Claimant's right to bring the action, including the calendar date on which the contractual limitations period expires for the claim.

If the appeal was based on a mental health parity claim under the MHPAEA, the specific reasons for any denial of benefits relating to MH/SUD benefits will be disclosed upon request and will be considered in the Adverse Benefit Appeal Decision.

Notification of an Adverse Benefit Decision on appeal of an Urgent Care Claim may be provided orally, but written notification shall be furnished no later than 3 days after the oral notice.

Information for all Types of Claims

You are entitled to a full and fair review.

As part of providing an opportunity for a full and fair review during the internal claims and appeals process, this Plan shall provide You, free of charge, with any new or additional evidence considered, relied upon, or generated by this Plan (or at the discretion of this Plan) in connection with Your claim. **This includes any specific evidence related to any applicable Mental Health Parity non-qualitative analysis related to your claim; however, such claims are handled under a separate Mental Health Parity Claims Procedure that is administered by the Plan Administrator rather than the Plan's Behavioral Health and Substance Use Disorder claims administrator, Aetna (see Section above)**. Such evidence shall be provided as soon as possible and sufficiently in advance of the date on which the notice of the internal appeal determination is required to be provided to give You a reasonable opportunity to respond prior to that date.

Before an internal appeal determination is made based on a new or additional rationale, the Plan shall provide Your, free of charge, with rationale. The rationale shall be provided as soon as possible and sufficiently in advance of the date on which the notice for the internal appeal determination is required to be provided to give You a reasonable opportunity to respond prior to that date.

What if there is a misstatement on a claim?

If there is a misstatement of any fact affecting Your coverage under the Plan, the correct information will be used to determine the coverage or Benefits due.

Do I have the right to take legal action regarding disputed claims?

Yes. However, You must exhaust the mandatory claims appeal procedure described above before filing suit.

Neither You nor Your dependent may bring any legal action until the Plan's mandatory claims and appeals procedures explained in the sections above have been timely exhausted in their entirety. Note that different claims and appeals procedures apply, based on the type of benefits at issue or the type of claim. You and Your dependent must follow the Plan's required claims and appeal procedures carefully and completely. Failure to timely exhaust those procedures will cause You and/or Your dependent to give up important legal rights and will bar any subsequent lawsuit.

Statute of Limitations and Venue

Any legal actions filed in court seeking to recover benefits, enforce or clarify any rights under the Plan (including any rights under ERISA Section 502 or 510), or filed under any other provision of the law, must be filed within certain deadlines.

For self-funded benefits offered under the Plan, any legal action filed in court must be filed on or before the later of:

One year from the date a final adverse benefit determination is issued or should have been issued in accordance with the Plan's mandatory claims appeal/review procedures;

One year from the date on which You or Your dependent shall be deemed to have exhausted the Plan's internal appeal/review procedures under applicable federal law; or

One year from the date the service or treatment was provided or the date the claim arose, whichever is earlier.

The failure to file a legal action in court before these deadlines expire will bar Your lawsuit. If You do not file a civil action before the applicable deadline expires, You will not be allowed to pursue a civil action with respect to Your Claim. Any civil action related to the Plan must be filed in the United States District Court for the Middle District of Florida.

The applicable insurance certificates or insurance contracts will set forth the statute of limitations deadlines for filing lawsuits involving fully insured benefits. In the event the applicable insurance certificate or insurance contract is silent and does not contain an express statute of limitations period, the above limitations periods (for the self-funded benefits) shall apply and any action must be filed in the United States District Court for the Middle District of Florida.

Limitations of Damages

In the event You or Your dependent sue the Plan, Plan fiduciaries, Plan Sponsor or Administrator, or any other agents of the Plan for a determination of coverage and/or benefits entitlement, any recoverable damages are limited to those benefits that would have been paid and/or available under the terms of the Plan. In the event You or Your dependent prevail in a lawsuit, damages shall not exceed the amount of benefits that otherwise would have been payable under the terms of the Plan.

ARTICLE TWELVE: HIPAA PRIVACY NOTICE

INDEPENDENT COLLEGES AND UNIVERSITIES BENEFITS ASSOCIATION, INC. MEDICAL, BEHAVIORAL HEALTH, AND PRESCRIPTION DRUG PLAN

NOTICE OF PRIVACY PRACTICES

Effective Date of Notice: April 2024

The Independent Colleges and Universities Benefits Association, Inc. Medical, Behavioral Health and Prescription Drug Plan (the "Plan") is required by law to take reasonable steps to ensure the privacy of Your personally identifiable health information and to inform You about:

the Plan's uses and disclosures of Protected Health Information (PHI); Your privacy rights with respect to Your PHI;

Your right to file a complaint with the Plan and with the Secretary of the U.S. Department of Health and Human Services; and

the person or office to contact for further information about the Plan's privacy practices.

The term "Protected Health Information" (PHI) includes all individually identifiable health information transmitted or maintained by the Plan, regardless of form (oral, written, or electronic).

The American Recovery and Reinvestment Act of 2009, (the Act) requires that the Plan provide notice within 60 days to affected individuals if there is a breach involving unsecured protected health information that is PHI which is not secured using a technology or methodology specified by the Secretary of Health and Human Services (HHS). The notice must contain:

a description of what happened; the types of PHI involved;

the steps that You should take to protect Yourself; and

the steps that the Plan is taking to investigate and mitigate harm; and contact information for follow-up questions.

If You have any questions about this Notice, please address them to:

Privacy and Security Officer ICUBA
P.O. Box 616927
Orlando, FL 32861

WHO WILL FOLLOW THIS NOTICE?

This Notice describes the PHI practices of the Plan and that of any third-party that assists in the administration of Plan Claims.

OUR PLEDGE REGARDING PHI

We understand that Your health information is personal, and we are committed to protecting Your health information. We create a record of the health care claims reimbursed under the Plan for Plan administration purposes. This Notice applies to all the medical records we maintain. Your personal doctor or health care Provider may have different policies or notices regarding the doctor's use and disclosure of Your health information created in the doctor's office or clinic.

This Notice will tell You about the ways in which we may use and disclose Your PHI. It also describes our obligations and Your rights regarding the use and disclosure of Your PHI.

We are required by law to:

Make sure that health information that identifies You is kept private;

Give You this Notice of our legal duties and privacy practices with respect to health information about You; and

Follow the terms of the Notice that is currently in effect.

HOW WE MAY USE AND DISCLOSE YOUR PHI

The following categories describe different ways that we may use and disclose Your PHI. For each category of uses or disclosures we will explain what we mean and present some examples. Not every use or disclosure in a category will be listed. However, all the ways we are permitted to use and disclose information will fall within one of the categories.

For Treatment (as described in applicable regulations). We may use or disclose Your PHI to facilitate medical treatment or services by Providers. We may disclose Your PHI to Providers, including doctors, nurses, technicians, medical students, or other hospital personnel who are involved in taking care of You. For example, we might disclose information about Your prior prescriptions to a pharmacist to determine if a pending prescription is contraindicative with prior prescriptions. Likewise, we might disclose information about Your prior treatment to Your campus wellness program or health center if medical history is necessary to determine a course of treatment.

For Payment (as described in applicable regulations). We may use and disclose Your PHI to determine Your eligibility for Plan Benefits, to facilitate payment for the treatment and services You receive from health care Providers, to determine benefit responsibility under the Plan, or to coordinate Plan coverage. For example, we may tell Your health care Provider about Your medical history to determine whether a particular treatment is experimental, investigational, or Medically Necessary and Appropriate or to determine whether the Plan will cover the treatment.

We may also share Your PHI for utilization review, the adjudication or subrogation of health claims, or to another medical plan to coordinate benefit payments.

For Health Care Operations (as described in applicable regulations). We may use and disclose Your PHI for health care operations. These uses and disclosures are necessary to run the Plan and include, but are not limited to, quality assessment and improvement; reviewing competence or qualifications of health care professionals; underwriting, premium rating, and other insurance activities relating to creating or renewing insurance contracts; submitting claims for stop-loss (excess loss) coverage; conducting or arranging for medical review, legal services, and auditing functions, including fraud and abuse compliance programs; business planning and development such as cost management; and business management and general Plan administrative activities. For example, the Plan may use information about Your claims to refer You to a disease management program, project future benefit costs or audit the accuracy of its claims processing functions. The Plan is prohibited from using or disclosing Your PHI that is genetic information for underwriting purposes.

As Required By Law. We will disclose Your PHI when required to do so by federal, state, or local law. For example, we may disclose medical information when required by a court order in a litigation proceeding such as a malpractice action.

To Avert a Serious Threat to Health or Safety. We may use and disclose Your PHI when necessary to prevent a serious threat to the health and safety of the public or another person. Any disclosure, however, would only be to someone able to help prevent the threat. For example, we may disclose medical information about You in a proceeding regarding the licensure of a physician.

SPECIAL SITUATIONS

In certain cases, Your PHI can be disclosed without authorization to a family member, close friend, or other person You identify who is involved in Your care or payment for Your care. Information describing Your location, general condition, or death may be provided to a similar person (or to a public or private entity authorized to assist in disaster relief efforts). You will generally be given the chance to agree or object to these disclosures (although exceptions may be made, for example if You are not present or if You are incapacitated). In addition, Your PHI may be disclosed without authorization to Your legal representative.

The Plan is also allowed to use or disclose Your PHI without Your written authorization for uses and disclosures required by law, for public health activities, and other specified situations, including the following:

Disclosure to Employer Member Institutions. There are few limited situations where information may be disclosed to any of the Member Institutions of ICUBA. First, information may be disclosed to another medical plan maintained by the Member Institution for purposes of facilitating claims under that plan. Second, information may be disclosed to a Member Institution's personnel solely for purposes of administering benefits under the Plan. Third, the Plan may disclose enrollment/disenrollment information to the Member Institution for enrollment and disenrollment purposes only. Information will only be disclosed to a Member Institution if it has established certain safeguards and firewalls to limit the classes of employees who will have access to Your PHI and to limit the use of Your PHI to Plan purposes and not for non-permissible purposes.

Organ and Tissue Donation. If You are an organ donor, we may release medical information to organizations that handle organ procurement or organ, eye, or tissue transplantation or to an organ donation bank, as necessary to facilitate organ or tissue donation and transplantation.

Military and Veterans. If You are a member of the armed forces, we may release Your PHI as required by military command authorities. We may also release medical information about foreign military personnel to the appropriate foreign military authority.

Workers' Compensation. We may release Your PHI for workers' compensation or similar programs. These programs provide benefits for work-related injuries and Illness.

Public Health Risks. We may disclose Your PHI for public health activities. These activities generally include the following:

To prevent and control disease, Injury, or disability;

To report births and deaths;

To report child abuse or neglect;

To report reactions to medications or problems with products;

To notify people of recalls of products they may be using;

To notify a person who may have been exposed to a disease or may be at risk for contracting or spreading a disease or condition; and

To notify the appropriate government authority if we believe a patient has been the victim of abuse, neglect, or domestic violence. We will only make this disclosure if You agree or when required or authorized by law.

Health Oversight Activities. We may disclose Your PHI to a health oversight agency for activities authorized by law; these oversight activities include, for example, audits, investigations, inspections, and licensure. These activities are necessary for the government to monitor the health care system, government programs, and compliance with civil rights laws.

Lawsuits and Disputes. If You are involved in a lawsuit or a dispute, we may disclose Your PHI in response to a court or administrative order. We may also disclose Your PHI in response to a subpoena, discovery request, or other lawful process by someone else involved in the dispute, but only if efforts have been made to tell You about the request or to obtain an order protecting the requested information.

Law Enforcement. We may release PHI if asked to do so by a law enforcement official:

In response to a court order, subpoena, warrant, summons, or similar process;

To identify or locate a suspect, fugitive, material witness, or missing person;

About the victim of a crime if, under certain limited circumstances, we are unable to obtain the person's agreement;

About a death we believe may be result of a criminal conduct;

About criminal conduct at the hospital; and

In emergency circumstances to report a crime; the location of the crime or victims; or the identity, description or location of the person who committed the crime.

Coroners, Medical Examiners, and Funeral Directors. We may release PHI to a coroner or medical examiner. This may be necessary, for example, to identify a deceased person or to determine the cause the death. We may also release medical information about patients of the hospital to funeral directors as necessary to carry out their duties.

National Security and Intelligence Activities. We may release Your PHI to authorized federal officials for intelligence, counterintelligence, and other national security activities as required by law.

Inmates. If You are an inmate of a correctional institution or under the custody of a law enforcement official, we may release Your PHI to the correctional institution or law enforcement official. This release would be necessary:

For the institution to provide You with Medical Care;

To protect Your health and safety or the health and safety of others; or

For the safety and security of the correctional institution.

Important Note. Except as described in this Notice, other uses and disclosures will be made only with Your written authorization. For example, You may wish the Member Institution / Campus Human Resources office to assist You with a Claim. We have provided a form to each Human Resource office for this purpose. If You provide us permission to use or disclose Your PHI, You may revoke that permission, in writing, at any time. If You revoke Your permission, we will no longer use or disclose Your PHI for the reasons covered by Your written authorization. However, You cannot revoke Your authorization if the Plan has acted relying on Your authorization. In other words, You cannot revoke Your authorization with respect to disclosures the Plan has already made.

YOUR RIGHTS REGARDING YOUR PHI

You have the following rights regarding the PHI we maintain about You:

Right to Inspect and Copy. You have a right to inspect and obtain a copy of Your PHI that may be used to make decisions about Your Plan Benefits; provided, however, You submit Your request in writing to the Privacy Official. If You request a copy of the information, we may charge a fee for the costs of copying, mailing, or other supplies associated with Your request.

We may deny Your request to inspect and copy in certain very limited circumstances. If You are denied access to Your PHI, You may request that the denial be reviewed.

Right to Amend. If You feel the PHI we have about You is incorrect or incomplete, You may ask us to amend the information. You have the right to request an amendment for as long as the information is kept by the Plan.

To request an amendment, Your request must be made in writing and submitted to the Privacy Official. In addition, You must provide a reason that supports Your request.

We may deny Your request for an amendment if it is not in writing or does not include a reason to support the request. In addition, we may deny Your request if You ask us to amend information that:

Is not part of the PHI kept by or for the Plan;

Was not created by us, unless the person or entity that created the information is no longer available to make the amendment;

Is not part of the information which You would be permitted to inspect and copy; or

Is accurate and complete.

Right to Receive an Accounting of PHI Disclosures. You have the right to request an "accounting of disclosures" by the Plan of Your PHI during the six (6) year period prior to the date of Your request. However, such accounting need not include PHI disclosures made to carry out treatment, payment, or health care operations to You about Your own PHI prior to April 14, 2003 or based on Your written authorization.

To request this list or accounting of disclosures, You must submit Your request in writing to the Privacy Official. Your request must state a time period, which may not be longer than six years and may not include dates before April 14, 2003. Your request should indicate in what form You want the list (for example, paper or electronic). The first list You request within a 12-month period will be free. If You request more than one list within a 12-month period, we may charge You a reasonable cost-based fee for each subsequent list. We will notify You of the cost involved and You may choose to withdraw or modify Your request at that time before any costs are incurred.

Right to Request Restrictions. You have the right to request a restriction or limitation on the PHI we use or disclose about You for treatment, payment, or health care operations. You also have the right to request a limit on the PHI we disclose about You to someone who is involved in Your care or the payment for Your care, like a family member or friend. For example, You could ask that we not use or disclose information about a surgery that You had. We are not required to agree to Your request.

To request restrictions, You must make Your request in writing. In Your request, You must tell us:

What information You want to limit;

Whether You want to limit our use, disclosure, or both; and

To whom You want the limits to apply (for example, disclosures to Your spouse).

Right to Request Confidential Communications. You have the right to request that we communicate with You about medical matters in a certain way or at a certain location. For example, You can ask that we only contact You at work or by mail. To request confidential communications, You must make Your request in writing to the Privacy Official and must specify how or where You wish to be contacted. We will not ask You the reason for Your request and will accommodate all reasonable requests.

Right to a Paper Copy of This Notice. You have the right to a paper copy of this Notice upon request. You may ask us to give You a copy of this Notice at any time. Even if You have agreed to receive this Notice electronically, You are still entitled to a paper copy of this Notice. You may obtain a copy of this Notice on the Internet. To obtain a paper copy of this Notice, please contact the Privacy Official for further information.

CHANGES TO THIS NOTICE

The Plan must abide by the terms of the Notice currently in effect. This Notice took effect on April 14, 2024. However, the Plan reserves the right to change the terms of its privacy policies as described in this Notice at any time and to make new provisions effective for all PHI that the Plan maintains. This includes health information that was previously created or received, not just health information created or received after the policy is changed. If changes are made to the Plan's privacy policies described in this Notice, You will be provided with a revised Privacy Notice. We will post a copy of the current notice on the Plan website. The Notice will contain the effective date on the first page.

COMPLAINTS

If You believe that Your privacy rights have been violated, You may complain to the Plan in care of the Privacy Officer:

Privacy and Security Officer ICUBA
P.O. Box 616927
Orlando, FL 32861

In addition, You may file a complaint with the Secretary of the U.S. Department of Health and Human Services, Hubert H. Humphrey Building, 200 Independence Avenue, S.W., Washington, D.C. 20201.

The Plan will not retaliate against You for filing a complaint.

WHOM TO CONTACT AT THE PLAN FOR MORE INFORMATION

If You have any questions regarding this Notice or the subjects addressed in it, You may address them to the Privacy Officer:

Privacy and Security Officer ICUBA
P.O. Box 616927
Orlando, FL 32861

OTHER USES OF PHI

Other uses and disclosures of PHI not covered by this Notice or the laws that apply to us will be made only with Your written permission.

CONCLUSION

PHI use and disclosure by the Plan is regulated by a federal law known as HIPAA (the Health Insurance Portability and Accountability Act of 1996 as amended_. You may find these rules at 45 Code of Federal Regulations Parts 160 and 164. This Notice attempts to summarize the regulations. The regulations will supersede any discrepancy between the information in this notice and the regulations.

ARTICLE THIRTEEN: YOUR RIGHTS UNDER ERISA

STATEMENT OF PARTICIPANTS RIGHTS

As a Participant in the Plan, You are entitled to certain rights under the Employee Retirement Income Security Act of 1974 (ERISA). ERISA provides that all Plan Participants are entitled to:

a. The right to receive information about Your Plan and Benefits, including the right to examine, without charge, at the Plan Administrator's office and at other specified locations, such as worksites, all documents governing the Plan, including insurance contracts and a copy of the latest annual report (Form 5500 Series) filed by the Plan with the U.S. Department of Labor and available at the Public Disclosure Room of the Employee Benefits Security Administration.

b. The right to obtain, upon written request to the Plan Administrator, copies of documents governing the operation of the Plan, including insurance contracts and copies of the latest annual report (Form 5500 Series) and an updated Summary Plan Description (SPD). The Plan Administrator may make a reasonable charge for the copies.

c. The right to receive a summary of the Plan's annual financial report.

d. The right to continue group health plan coverage under COBRA should You, Your Spouse, or Your Dependent lose coverage because of a Qualifying Event. You or Your Dependents may have to pay for such coverage. Review this SPD and the documents governing the Plan regarding the rules about 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 Plan. The people who operate the Plan, called "fiduciaries" of the Plan have a duty to do so prudently, and in the sole interest of You and other Plan Participants and Beneficiaries. No one, including Your employer, or any other person, can terminate You or otherwise discriminate against You in any way to prevent You from obtaining a Plan Benefit or exercising Your rights under ERISA.

HOW TO ENFORCE YOUR RIGHTS

a. If Your Claim for a Benefit is denied or ignored, in whole or in part, You have a right to know why this was done, to obtain copies of documents relating to the decision without charge, and to appeal any denial, all within certain time schedules and as set forth within this Plan Document.

b. Under ERISA, there are steps You can take to enforce Your above-listed rights. For instance, if You request a copy of Plan documents or the latest annual report (Form 5500) materials from the Plan and do not receive them within 30 days, You may file suit in a federal court. In such a case, the court may require the Plan Administrator to provide the materials and pay You up to $110 a day until You receive the materials, unless the materials were not sent because of reasons beyond the control of the Plan Administrator.

If You have a Claim for Benefits which is denied or ignored, in whole or in part, and **if You have exhausted the Claims Procedures available** to You under the Plan, You may file suit in a federal court after You have exhausted the appeal procedures described in this SPD. **Any suit must be brought in the United States District Court for the Middle District of Florida**. In addition, if You disagree with the Plan Administrator's decision or lack thereof concerning the qualified status of a medical child support order, You may file suit in a federal court

c. If 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 that Your Claim is frivolous.

d. If You have any questions about Your 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 contact 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 at 866-444-3272.

ARTICLE FOURTEEN: GENERAL PLAN PROVISIONS

RIGHT OF RECOVERY

If, for any reason, any Benefit under the Plan is erroneously paid or exceeds the amount appropriately payable under the Plan to a Covered Person, the Participant shall be responsible for refunding the overpayment to the Plan. In addition, if the Plan makes any payment that, according to the terms of the Plan, should not have been made, the insurer, the Plan Administrator, or ICUBA (or designee) may recover that incorrect payment, whether it was made due to the insurer's or Plan Administrator's (or its designee's) own error, from the person to whom it was made or from any other appropriate party. The Covered Person will cooperate with the Plan Administrator, the insurer, or ICUBA in the repayment of any benefit overpayment or erroneous payment. As may be permitted in the sole discretion of the Plan Administrator, the refund or repayment may be in one or a combination of the following methods: (a) in the form of a single lump-sum payment, (b) as a reduction of the amount of future Benefits otherwise payable under the Plan, (c) as automatic deductions from pay, or (d) any other method as may be required or permitted in the sole discretion of the Plan Administrator or the insurer. The Plan may also seek recovery of the erroneous payment or benefit overpayment from any other appropriate party.

VERIFICATION

The Plan Administrator shall be entitled to require reasonable information to verify any Claim or the status of any person as a Covered Person. If the Covered Person does not supply the requested information within the applicable time limits or provide a release for such information, such Covered Person shall not be entitled to Benefits under the Plan.

LIMITATION OF RIGHTS

Nothing appearing in, or done pursuant to, the Plan shall be held or construed:

a. To give any person any legal or equitable right against a Member Institution, ICUBA, the Board of Directors of ICUBA, or any of their employees, or person connected therewith, except as provided by law; or

b. To give any person any legal or equitable right to any assets of the Plan or any related Trust, except as expressly provided herein or as provided by law.

SEVERABILITY

If any provision of the Plan is held invalid or unenforceable, its validity or unenforceability shall not affect any other provision of the Plan, and the Plan shall be construed and enforced as if such provision had not been included herein.

CAPTIONS

The captions contained herein are inserted only as a matter of convenience and for reference and in no way define, limit, enlarge or describe the scope or intent of the Plan nor in any way shall affect the Plan or the construction of any provision thereof.

CONSTRUCTION

Any words herein used in the masculine shall also include the feminine and neutral where they would so apply. Words in the singular shall also include the plural and vice versa where they would so apply.

ENTIRE PLAN

This document constitutes the entire Plan and there are no oral items or conditions to the contrary. Any change, modification or amendment to the Plan must be in writing.

NON-GUARANTEE EMPLOYMENT

Nothing contained in the Plan shall be construed as a contract of employment between ICUBA or a Member Institution and any Participant, or as a right of any Participant to continue in the employment of ICUBA or a Member Institution, or as a limitation of the right of ICUBA or a Member Institution to discharge any Participant, with or without cause.

ARTICLE FIFTEEN: PLAN ADMINISTRATOR DUTIES AND POWERS

APPOINTMENT OF PLAN ADMINISTRATOR

ICUBA shall appoint a Plan Administrator to administer the Plan and keep records of proceedings and Claims. The Plan Administrator will serve until resignation or dismissal by ICUBA, and any vacancy or vacancies shall be filled in the same manner as the original appointments. ICUBA may dismiss any person or persons serving as Plan Administrator at any time with or without cause. If ICUBA chooses to appoint more than one (1) person to act as Plan Administrator, a majority vote of such persons shall be necessary for the transaction of business. In the event only two (2) persons are named as Plan Administrator, the transaction of business shall require the unanimous vote of both parties.

POWERS OF PLAN ADMINISTRATOR

Subject to the limitations of the Plan, the Plan Administrator will from time to time establish rules for the administration of the Plan and transaction of its business. The Plan Administrator will rely on the records of ICUBA or the Member Institutions, as applicable, with respect to all factual matters dealing with the employment and Eligibility of an Employee. The Plan Administrator will resolve any factual dispute, giving due weight to all evidence available to it. The Plan Administrator shall have such powers and duties as may be necessary to discharge its functions hereunder, including, but not limited to, the sole and absolute discretion to:

a. Construe, interpret and apply the Plan provisions; and

b. Determine the amount, manner, and time of payment of any Benefits to any Covered Person.

The Plan Administrator has the discretionary authority to control and manage the operation and administration of the Plan. The Plan Administrator shall have the exclusive right to interpret the provisions of the Plan to make eligibility and benefit determinations as to whether any individual is entitled to receive or eligible for any benefits under the Plan and to determine any questions arising hereunder or in connection with the administration of the Plan, including the remedying of any omission, inconsistency, or ambiguity, and making all factual determinations. The Plan Administrator's decisions and actions shall be conclusive and binding on all persons.

The Plan gives the Plan Administrator absolute and final discretion to determine eligibility for participation in or coverage under the Plan, to determine entitlement to benefits, to construe the terms of the Plan, and to resolve any factual issues or disputes relevant to participation in or coverage under the Plan or benefits enrollment or entitlement. In particular, the Plan Administrator shall have full discretionary authority to: interpret all plan documents; resolve and clarify inconsistencies, ambiguities and/or omissions in all plan documents; determine eligibility for and entitlement to benefits; make all interpretive and factual determinations as to whether any individual is entitled to receive any benefits under the terms of the Plan; determine benefit amounts; make decisions regarding questions of coverage; employ, appoint or designate persons to help or advise in connection with the performance of any administrative function; and exercise all other power and authority contemplated by ERISA with respect to the Plan. Any construction of the terms of any plan document and any determination of fact adopted by the Plan Administrator shall be final and legally binding on all parties.

In certain instances, the Plan Administrator has delegated its discretionary authority under the Plan. For insured benefits offered under the Plan, the Plan Administrator has delegated its fiduciary duties to interpret the insurance contracts (and the Plan, if applicable) and to make all interpretive and factual determinations as to whether any individual is entitled to receive any benefits under the terms of the insurance contract (or certificate of insurance) and/or the Plan. These delegates have the full extent of the Plan Administrator's authority and duties with respect to those responsibilities delegated to them.

For the self-funded benefits offered under the Plan, the Plan Administrator has delegated its fiduciary duties with respect to certain initial claim determinations, and in some cases, final claim determinations, to the applicable Claims Administrator. These delegates have the full extent of the Plan Administrator's authority and duties with respect to those responsibilities delegated to them. The Plan Administrator may delegate any of its duties and responsibilities to one or more persons or entities.

OUTSIDE ASSISTANCE

The Plan Administrator may employ such counsel, accountants, Claims Administrators, consultants, actuaries and other person or persons, as the Plan Administrator shall deem advisable. ICUBA shall pay the compensation of such counsel, accountants, and other person or persons and any other reasonable expenses incurred by the Plan Administrator in the administration of the Plan.

DELEGATION OF POWERS

In accordance with the provisions hereof, the Plan Administrator has been delegated certain administrative functions relating to the Plan with all powers necessary to enable the Plan Administrator to properly carry out such duties. The Plan Administrator as such shall have no power in any way to modify, alter, add to, or subtract from any provisions of the Plan other than expressly provided in this Article.

Clerical errors

Clerical errors by the Plan Administrator or the claims processor will not invalidate coverage that is valid or continue coverage that has been terminated. Equitable adjustments will be made as soon as any error is discovered. If the Plan makes an overpayment due to a clerical error, the Plan has the right to that overpayment, which may be deducted from future benefit payments.

Misrepresentations

In the absence of fraud, all statements made by a plan member relating to eligibility for coverage in this Plan will be deemed to be representations and not warranties. No such representations will void the benefits or be used in defense to a claim under the Plan unless a copy of the document that contains the representation is or has been furnished to the plan member or to a beneficiary, if any.

ARTICLE SIXTEEN: AMENDMENTS, TERMINATIONS AND MERGERS

RIGHT TO AMEND, MERGE OR CONSOLIDATE

ICUBA reserves the right to merge or consolidate the Plan, and to make any amendment or amendments to the Plan periodically, including those which are retroactive in effect. Such amendments may be applicable to any Covered Person. However, no amendment shall authorize or permit any part of the Trust Fund to be used or diverted to any purpose other than to the exclusive benefit of the Participants.

RIGHT TO TERMINATE

The Plan is intended to be permanent, but ICUBA may at any time terminate the Plan in whole or in part.

ARTICLE SEVENTEEN: YOUR RIGHTS AND PROTECTIONS AGAINST SURPRISE MEDICAL BILLS

When You get emergency care or get treated by a Non-Network Provider at a Network hospital or ambulatory surgical center, You are protected from surprise billing or balance billing under the Medical Benefit Program.

What is "Balance Billing" (sometimes called "Surprise Billing")?

When You see a doctor or other health care Provider, You may owe certain out-of-pocket costs, such as a copayment, coinsurance, and/or a deductible. You may have other costs or have to pay the entire bill if You see a Provider or visit a health care facility that isn't in Your health plan's Network.

"Non-Network" describes Providers and facilities that haven't signed a contract with Your health plan. Non-Network Providers may be permitted to bill You for the difference between what Your plan agreed to pay and the full amount charged for a service. This is called "balance billing." This amount is likely more than in-Network costs for the same service and might not count toward Your annual out-of-pocket limit.

"Surprise billing" is an unexpected balance bill. This can happen when You can't control who is involved in Your care—like when You have an emergency or when You schedule a visit at an in-Network facility but are unexpectedly treated by a Non-Network Provider.

You Are Protected from Balance Billing For:

Emergency services

If You have an emergency medical condition and get emergency services from a Non-Network Provider or facility, the most the Provider or facility may bill You is Your plan's in-Network cost-sharing amount (such as copayments and coinsurance). You can't be balance billed for these emergency services. This includes services You may get after You're in stable condition, unless You give written consent and give up Your protections not to be balanced billed for these post-stabilization services.

Certain services at an in-Network hospital or ambulatory surgical center

When You get services from an in-Network hospital or ambulatory surgical center, certain Providers there may be Non-Network. In these cases, the most those Providers may bill You is Your plan's in-Network cost-sharing amount. This applies to emergency medicine, anesthesia, pathology, radiology, laboratory, neonatology, assistant surgeon, hospitalist, or intensivist services. These Providers can't balance bill You and may not ask You to give up Your protections not to be balance billed.

If You get other services at these in-Network facilities, Non-Network Providers can't balance bill You, unless You give written consent and give up Your protections.

You're never required to give up Your protections from balance billing. You also aren't required to get care at a Non-Network Provider or facility. You can choose a Provider or facility in Your plan's Network.

When Balance Billing Isn't Allowed, You Also Have the Following Protections:

- You are only responsible for paying Your share of the cost (like the copayments, coinsurance, and deductibles that You would pay if the Provider or facility was in-Network). Your health plan will pay Non-Network Providers and facilities directly.
- Your health plan generally must:
    - Cover emergency services without requiring You to get approval for services in advance (prior authorization).
    - Cover emergency services by Non-Network Providers.
    - Count any amount You pay for emergency services or Non-Network services toward Your deductible and out-of-pocket limit.

If You believe You've been wrongly billed, You may contact the nearest office of the Employee Benefits Security Administration (EBSA), 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, DC 20210.

Visit www.dol.gov/ebsa for more information about Your rights under federal law.

ARTICLE EIGHTEEN: ERISA PLAN INFORMATION

NAME OF THE PLAN	Independent Colleges and Universities Benefits Association, Inc. Medical, Behavioral Health and Prescription Drug Plan
TYPE OF PLAN	Welfare benefit plan
NAMED FIDUCIARY AND PLAN ADMINISTRATOR	**The Board of Directors of the Independent Colleges and Universities Benefits Association, Inc.**
CLAIMS ADMINISTRATION AND PLAN FUNDING	Blue Cross Blue Shield of Florida (BCBSF) is the claims administrator and processes claims under the Medical program through BCBSF. BCBSF is the pharmacy benefit manager under the Prescription Drug program. Aetna is the claims administrator and processes behavioral health claims. BCBSF and Aetna Behavioral Health do not serve as insurers, but as claims processors and Network Providers. Claims are paid out of the assets of ICUBA, which receives contributions from Member Institutions and Participants, and holds those assets in trust for the exclusive benefit of Beneficiaries. Aetna Resources for Living provides Employee Assistance Program Services on a capitated fee basis.
ADDRESS OF PLAN	ICUBA 4850 Millenia Blvd., Suite 329 Orlando, FL 32839
AGENT FOR SERVICE OF LEGAL PROCESS	Mark S. Weinstein, President & CEO 4850 Millenia Blvd., Suite 329 Orlando, FL 32839
PLAN NUMBER	501
PLAN SPONSOR	Independent Colleges and Universities Benefits Association, Inc.
EMPLOYER IDENTIFICATION NUMBER (EIN)	42-1576411
PLAN EFFECTIVE DATE	April 1, 2003, as amended and restated as of April 1, 2024
PLAN RENEWAL DATE	April 1 of each year
PLAN YEAR (APRIL 1 TO MARCH 31) END	March 31 of each year
MEDICAL PRECERTIFICATION PROVER	Blue Cross Blue Shield of Florida P.O. Box 100121, Columbia, SC 29202 1-855-258-9029 www.MyHealthToolkitFL.com
MENTAL HEALTH PRECERTIFICATION PROVIDER	Aetna Behavioral Health P.O. Box 14079, Lexington, KY 40512-4079 1-877-398-5816 www.aetna.com

PARTICIPATING INSTITUTIONS

Barry University (effective 1/1/2006)
Beacon College (effective 10/1/2005)
The Bolles School (effective 7/1/2010)
Central Florida Area Health Education Center (effective 4/1/2011)
Corbett Preparatory School of IDS (effective 12/1/2012)
Edward Waters University (effective 11/1/2003)
Everglades Area Health Education Center (effective 4/1/2011)
Florida Institute of Technology (effective 4/1/2003)
Good Shepherd Episcopal School (effective 12/1/2011)
Grace Episcopal Day School (effective 9/1/2014)
Jacksonville Country Day School (effective 9/1/2013)
Nova Southeastern University (effective 4/1/2003)
Palm Beach Atlantic University (effective 4/1/2003)
The Poynter Institute (effective 1/1/2011)
Rollins College (effective 4/1/2003)
Saint Edward's School (effective 9/1/2009)
Saint Leo University (effective 6/1/2003)
Saint Paul's School (effective 7/1/2010)
Saint Stephen's Episcopal School (effective 4/1/2016)
St. Thomas University (effective 4/1/2023)
San Jose Episcopal Day School (effective 7/1/2010)
Tampa Preparatory School (effective 5/1/2011)
Unity School (effective 4/1/2016)
The University of Tampa (effective 6/1/2003)
Warner University (effective 7/1/2018)
Westminster Christian Private School, Inc. (effective 1/1/2017)

BOARD OF DIRECTORS

Executive Officers

Chairperson: Jennifer Addleman, Director, Benefits & Wellbeing, Rollins College

Vice-Chairperson: Jennifer Boyd–Pugh, Vice President for University Administration, Barry University

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Shelli Greaves, Director of Human Resources, Saint Edward's School

Tom Hartnett, Chief Financial Officer, Saint Stephen's Episcopal Day School

"THE BENEFITS AND COVERAGES DESCRIBED HEREIN ARE PROVIDED THROUGH A TRUST. THE TRUST IS ESTABLISHED AND FUNDED BY A GROUP OF EMPLOYERS AND IS NOT PROTECTED BY A GUARANTY FUND IN THE EVENT OF INSOLVENCY. PARTICIPATING EMPLOYERS ARE ASSESSABLE FOR ANY LOSSES INCURRED BY THE TRUST."

GLOSSARY: DEFINITIONS

The following terms, as used in the Plan, shall have the meaning specified in this Glossary, unless a different meaning is clearly required by the context in which it is used:

ACA is the Affordable Care Act of 2010, as amended.

Accident shall mean a non-occupational, unexpected, unforeseen, and unintended event that may result in Injury or Illness.

Accreditation shall mean certification that an organization meets the reviewing organization's standards. Examples: Accreditation of HMOs by the National Committee on Quality Assurance (NCQA) or Accreditation of Hospitals by the Joint Commission on Accreditation of Healthcare Organizations.

Actively at Work shall mean performing the Employee's job at the location where the Employee generally reports to work. If such Employee is on vacation, Approved Leave of Absence, Approved Sabbatical, Approved Disability Leave, or is off due to a holiday or other reason approved by the Employer, the Employee will be deemed Actively At Work if the Employee was Actively At Work on the day immediately prior to such vacation, Approved Leave of Absence, Approved Sabbatical, Approved Disability, holiday, or other approved reason.

Activities of Daily Living shall refer to the following, with or without assistance:

- Bathing, which is the cleansing of the body in either a tub or shower, or by sponge bath;
- Dressing, which is to put on, take off, and secure all necessary and appropriate items of clothing and any necessary braces or artificial limbs;
- Toileting, which is to get to and from the toilet, get on and off the toilet, and perform associated personal hygiene;
- Transferring, which is to move in and out of a bed, chair, wheelchair, tub, or shower;
- Mobility, which is to move from one place to another, with or without the assistance of equipment;
- Eating, which is getting nourishment into the body by any means other than intravenous; and
- Continence, which is voluntarily maintaining control of bowel and/or bladder function; in the event of incontinence, maintaining a reasonable level of personal hygiene.

Adjudication shall mean the administrative procedure used to process a Claim for a Covered Expense.

Adverse Benefit Decision (or Determination) shall mean a denial, reduction, termination of, or failure to provide or make payment (in whole or in part) for a claim for Benefits, including any such denial, reduction, termination, or failure to provide or make payment that is based on a determination of a Covered Person's eligibility to participate in the Plan, and including, a denial, reduction or termination of, or failure to provide or make payment (in whole or in part) for a Benefit which results from the application of any utilization review as well as a failure to cover an item or services for which Benefits are otherwise provided because it is determined to be Experimental or Investigative, or not Medically Necessary and Appropriate. An Adverse Benefit Determination includes any cancellation or discontinuance of coverage that has retroactive effect (whether there is an adverse effect on any Benefit), except to the extent attributable to a failure to pay any required premiums or Employee contributions.

Allowable Charge shall mean the amount BCBSF or Aetna agrees to pay a Provider as payment in full for a service, procedure, supply, or equipment. Additionally:

- The Allowable Charge shall not exceed the Maximum Payment; and,

- In addition to the Covered Person's liability for Benefit Year Deductibles, Copayments and/or Coinsurance, the Covered Person may be balance billed by the Non-Participating Provider for any difference between the Allowable Charge and the Billed Charge.

Ambulatory Surgical Center is a licensed facility that:

- Has permanent facilities and equipment for the primary purpose of performing surgical procedures on an outpatient basis;
- Provides treatment by or under the supervision of licensed medical doctors or oral surgeons and provides nursing services when the Covered Person is in the facility;
- Does not provide inpatient accommodations; and,
- Is not, other than incidentally, a facility used as an office or clinic for private practice of a licensed medical doctor or oral surgeon.

Authorized Representative is an individual (including a Provider) whom the Member designates in writing to act on his or her behalf.

Ambulance Services shall mean services provided by a mobile unit designed to carry an ill or injured Covered Person to a Hospital.

Ambulatory Care shall mean services provided in an Ambulatory Care Facility, which do not involve admission to an Inpatient Hospital bed. Visits to a Physician's office are a type of Ambulatory Care.

Ambulatory Care Facility shall mean a facility that provides Outpatient Care.

Approved Disability Leave shall mean an approved leave of absence due to Disability. For purposes of this definition, the term "Disability" shall mean that the Employee is unable to perform the duties of his or her regular occupation with the Member Institution, as determined in the sole discretion of the Plan Administrator. Coverage under an Approved Disability Leave shall terminate upon the earlier of:

- the date the Employee completes 12-consecutive months of Approved Disability Leave; or
- the date the Employee becomes eligible for Medicare. If You are covered under Medicare prior to Your Approved Disability Leave, Your coverage will end on the date You complete 12-consecutive months of Approved Disability Leave.

Approved Leave of Absence shall mean an Approved Leave of Absence for a period not to exceed 12-consecutive months, with the stated intention of returning to full-time employment with the Member Institution. For purposes of this document the term Approved Leave of Absence shall not refer to leave under the Family and Medical Leave Act or the Uniformed Services Employment and Reemployment Rights Act. The service member caregiver leave provides up to 26 weeks of unpaid leave of absence in a single 12-month period for any Eligible Employee who is the spouse, parent, or next of kin of a covered service member who suffered a serious Injury or Illness incurred in the line of duty while on active duty that renders the service member medically unfit to perform the duties of his/her office, grade, rank, or rating. An Eligible Employee can take up to 12 weeks of unpaid Leave of Absence in a 12-month period because of any qualifying exigency because the Employee's spouse, son, daughter, or parent is on active duty or has been notified of an impending call of duty in the Armed Forces in support of a "contingency operation."

Approved Sabbatical shall mean an approved paid sabbatical or fellowship for a period not to exceed twelve consecutive months. A Participant must be covered prior to the effective date of such Approved Sabbatical.

Autism Spectrum Disorder shall mean pervasive developmental disorders with origin specific to childhood that fall under the Autism diagnoses. The Autism benefit covers Autistic Disorder, Asperger's Syndrome, and Pervasive Developmental Disorder not otherwise defined in the most recent edition of the Diagnostic and Statistical Manual of Mental Disorders of the American Psychiatric Association. You will see the diagnosis code on Your Physician's billing statement. Autism Spectrum Disorder Diagnosis to the fifth digit with Descriptors include:

- 299.00 Autistic Disorder Current of Active
- 299.01 Autistic Disorder Residual State
- 299.10 Childhood Disintegrative Disorder Current or Active
- 299.11 Childhood Disintegrative Disorder Residual State
- 299.80 Other Specified Pervasive Developmental Disorder
- 299.81 Other Specified Pervasive Developmental Disorder Residual State
- 299.90 Unspecified Pervasive Developmental Disorder Current or Active Status
- 299.91 Unspecified Pervasive Developmental Disorder Residual State

Beneficiary shall mean a person who is Eligible to receive Benefits under the Plan. Sometimes "Beneficiary" is used for Eligible Dependents enrolled under the Plan; "Beneficiary" can also be used to mean any person Eligible for Benefits, including Employees, Retirees, and Eligible Dependents.

Benefits shall mean Medical Care, Mental Health Care Services, or Medical Supplies that are the portion of the cost of Covered Services paid by the Plan and are:

- Medically Necessary and Appropriate;
- Preauthorized (when required under this Plan of Benefits or the Schedule of Benefits);
- Included in Article Seven of this Plan of Benefits; and
- Not limited or excluded under the terms of this Plan of Benefits.

For example, if the Plan pays the remainder of a Physician's bill after an office visit Copayment has been made, the amount that the Plan pays is the "Benefit." Or, if the Plan pays 80% of the Reasonable and Customary cost of Covered Services, that 80% payment is the "Benefit."

Benefits Effective Date shall mean the first day of coverage under this Plan for Participants and Dependents as set forth in Article Five, "Enrollment and Contributions."

Billed Charges shall mean the actual charges as billed by the Provider.

Brand-Name Drug shall mean a drug manufactured by a pharmaceutical company, which has chosen to patent the drug's formula and register its brand name.

Breast Implant shall mean an insertion of a silicone bag (prosthesis) under the breast (sub-mammary) or under the breast and chest muscle (subpectoral) and then filling the bag with saline (salt water) or silicone.

Care Coordination is available through BCBSF aiding a Participant who is at risk of developing medical complexities or for whom a health incident has precipitated a need for rehabilitation or additional health care support. The program strives to attain a balance between quality-and cost-effective care while maximizing the Participant's quality of life. It typically involves coordination of services to help meet a Participant's health care needs, usually when the Participant has a condition which requires multiple services from multiple Providers. This term is also used to refer to coordination of care during and after a Hospital stay.

Change in Status shall mean the ability to modify or revoke elections mid-Plan Year due to one of the following events:

- Change in legal marital status, including marriage, death of spouse, divorce, legal separation, or annulment;

- Change in number of Dependents, including birth, adoption, placement for adoption, and death of a spouse or other Dependent;

- A Dependent satisfying or ceasing to satisfy the requirements for coverage due to age;

- Change in employment status of the Employee, the Employee's spouse or other Dependent, including termination or commencement of employment, taking, or returning from an unpaid leave of absence, change in work site, change in full-time or part-time status, change in hourly or salaried status; or

- Change in residence by the Employee, the spouse or Dependent.

Claim shall mean a request for payment under the terms of the Plan.

Claims Administrator shall mean the person or persons appointed by the Plan to determine Benefit eligibility and to adjudicate Claims under the Plan.

Claims Appeal shall mean the process used by a Participant or Provider to request re-consideration of an Adverse Benefit Decision.

Claim Status shall mean the state of a Claim. The various states are paid, Pended, denied, and received-not-yet-processed.

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

COBRA Administrator shall mean ICUBA's designee at 1-866-377-5102, Option 1.

COBRA Continuation Coverage shall mean the continuation of health care Benefits for Participants and Dependents on the occurrence of a Qualifying Event as defined by COBRA, and as further set forth in the Continuation of Coverage section.

Code shall mean the Internal Revenue Code of 1986, as amended.

Coinsurance or Coinsurance Percentage shall mean the sharing of the Allowable Charge between the Covered Person and the Plan after any applicable Deductible is met. The Plan will pay the percentage of Allowable Charges as set forth on the Schedule of Benefits. The Covered Person is responsible for the remaining percentage of the Allowable Charge. Coinsurance is calculated after any applicable Benefit Year Deductible or Copayment is subtracted from the allowable Charged, based upon the Network charge or the lesser charge of the Provider.

Concurrent Care shall mean an ongoing course of treatment to be provided over a period of time or number of treatments.

Consumable Medical Supplies shall mean supplies that are non-durable medical supplies and that are usually disposable in nature; cannot withstand repeated use by more than one individual; are primarily and customarily used to serve a medical purpose; generally, are not useful to a person in the absence of Illness or Injury; and may be ordered and/or prescribed by a Physician.

Contact Lenses after Cataract Surgery shall mean contact lenses provided after a surgeon has removed a cataract, in which the surgeon must remove the entire lens of the eye. As a result, after surgery, without a lens, the eye cannot focus. There are four ways to provide an artificial form of focus: glasses, contact lenses, plastic lens implants inside the eye (intraocular lenses) or, less commonly, a procedure which uses donor corneas from deceased individuals fashioned as a "human contact lens" which is permanently sewn onto the surface of the eye (epikeratophakia).

Continuation Coverage Payments shall mean the payments required for COBRA Continuation Coverage.

Coordination of Benefits shall mean a provision in a contract that applies when a person is covered under more than one group health benefits program. It requires that payment of Benefits be coordinated by all plans and/or programs to eliminate over-insurance or duplication of Benefits.

Copayment (Co-pay) shall mean the Covered Person's portion of the payment for Benefits indicated in the Schedule of Benefits. It represents the fixed dollar amount You are required to pay each time a particular service is used. This payment may be requested at the time of service. Copayments do not count toward the satisfaction of Deductibles.

Covered Expenses shall mean those expenses listed as covered in Article Seven of this Plan Document.

Covered Person shall mean a Participant or Dependent covered under the Plan.

Covered Services shall mean Hospital, Medical, Behavioral Health Care, and other health care services, behavioral health services, and/or substance use disorder services incurred by a Covered Person that are entitled to a payment of Benefits under the Plan. The term defines the type and amount of expense that will be considered in the calculation of Benefits.

Custodial Care shall mean non-medical aid consisting of services and supplies, provided to an individual in or out of an institution, primarily to assist such person in Activities of Daily Living, whether Disabled. The care is not meant to be curative or providing medical treatment.

Date of Service shall mean the date a service or treatment was provided to a Covered Person as specified on the Claim and should be the date such service or treatment was received.

Day Treatment or Partial Hospitalization shall mean an Outpatient treatment program that offers intensive, multidisciplinary services not otherwise offered in an Outpatient setting, twenty or more daytime hours or 12 or more evening hours per week. The program is designed to treat patients with serious mental, nervous and chemical dependency disorders and offers major diagnostic, psycho-social, and prevocational modalities. Such programs must be in a less restrictive, less expensive alternative to Inpatient treatment.

Deductible shall mean a flat amount a Covered Person must pay before the Plan will make any Benefit payments associated with specific plan provisions.

Dentist shall mean an individual licensed as a Dentist in the jurisdiction where services are provided.

Dependent shall mean a person Eligible for coverage because of that person's relationship to a Participant. For purposes of coverage under this Plan, if both parents are Participants, a Dependent shall only be covered as a Dependent under this Plan by one parent.

A Dependent may be one of the persons described below.

1. The legally recognized spouse of a Participant. A spouse that is legally separated or divorced from the Participant shall not be a Dependent, except for purposes of COBRA Continuation Coverage.

2. A child who is:

A natural child;

A legally adopted child, which shall be defined as a child adopted or placed for adoption with the Participant before the child reaches age 18. A child is considered placed for adoption when the Participant provides Support, and the child resides with the Participant (defined below) in anticipation of adoption. The child's placement for adoption ends upon the termination of the legal obligation;

A stepchild;

A child of a Participant required to be covered in accordance with applicable requirements of any Qualified Medical Child Support Order as defined by ERISA Section 609;

A child with proof of legal guardianship by the Participant where the Participant provides Support, and the child resides with the Participant;

A foster child or other child in court-ordered temporary or other custody of the Participant; or

A child over age 26 who is continuously incapable of self-support because of a Disability (see Disabled Child).

A child shall be deemed a Dependent until the date in which such child:

Reaches the end of the calendar year in which the age of twenty-six was attained;

Becomes a Participant;

Serves on extended active duty in the Armed Forces; or

Is over 26 years of age and is no longer continuously incapable of self-support because of a Disability

A child of a Participant shall be deemed a Dependent until the last day of calendar year in which such child attains 26 years of age. The child may be married, live outside the home, and/or be employed.

Diabetes Treatment shall mean treatment that is to provide insulin therapy in a manner that mimics the natural pancreas.

Disability (or Disabled) shall mean any congenital or acquired physical or mental Illness, defect, or characteristic preventing or restricting an individual from participating in normal life or limiting the individual's capacity to work. Such Disability must be certified by a Physician. The Participant must provide proof of such Disability within the 30-day period after the date the child would otherwise lose Dependent status.

Diagnostic Services shall mean services ordered by a Physician to help diagnose or monitor a Covered Person's condition or disease. Diagnostic Services include radiology, ultrasound, nuclear medicine, laboratory, and pathology services or tests.

Disabled Child shall mean an unmarried enrolled Dependent child with a mental or physical disability which reaches age 26, when coverage would otherwise end on December 31st following the child's 26th birthday, the Plan will continue to cover the child, if:

the child is unable to be self-supporting due to a mental or physical disability;

the child depends mainly on You for support;

You provide to ICUBA proof of the child's incapacity and dependency within 31 days of the date coverage would have otherwise ended because the child reached age 26 during the calendar year; and

You provide proof, upon ICUBA's request, that the child continues to meet these conditions.

The proof will include a recent examination and certification by the treating physician of a child's continued disability. However, You will not be asked for this information more than once a year. If You do not supply such proof within 30 days, the Plan will no longer pay Benefits for that child.

Coverage will continue, if the enrolled Dependent is incapacitated and dependent upon You, unless coverage is otherwise terminated in accordance with the terms of the Plan.

Durable Medical Equipment shall mean equipment prescribed by a Physician, which meets all the following requirements:

Is Medically Necessary and Appropriate;

Is primarily and customarily used to serve a medical purpose;

Is designed for prolonged and repeated use;

Is for a specific therapeutic purpose in the treatment of an Illness or Injury;

Would have been covered in a Hospital;

Does not include appliances that are provided solely for the Covered Person's comfort or convenience;

Is not useful to a Covered Person in the absence of Illness or Injury; and

Is a standard, non-luxury item (as determined by the Plan).

Prosthetic Devices, Orthopedic Devices and Orthotic Devices are considered Durable Medical Equipment. The Network Provider for Durable Medical Equipment is CareCentrix (1-877-561-9910).

Hearing Aids shall not be treated as Durable Medical Equipment subject to the limits set forth in the Schedule of Benefits but will be subject to a separate limit set forth in the Schedule of Medical Benefits.

Effective Date shall mean the first day of coverage for Participants and Dependents under this Plan as set forth in the Enrollment and Contributions section.

Eligible Dependent shall mean a Dependent who qualifies for coverage under the Plan.

Eligible Employee shall mean an Employee who qualifies for coverage under the Plan.

Eligible Retiree shall mean each Employee who:

1. is a Participant in the Plan during the 3-month period immediately prior to retirement from a Member Institution;
2. was Actively At Work on the day prior to retirement; and
3. meets the following age and service requirements:

is at least 55 years of age and has 10 years of continuous service with a Member Institution;

is at least 56 years of age and has 9 years of continuous service with a Member Institution;

is at least 57 years of age and has 8 years of continuous service with a Member Institution;

is at least 58 years of age and has 7 years of continuous service with a Member Institution;

is at least 59 years of age and has 6 years of continuous service with a Member Institution; or

is at least 60 years of age and has at least 5 years of continuous service with a Member Institution.

Eligibility shall mean the provisions within the Plan that specify who qualifies for coverage under the Plan and when coverage becomes effective.

Emergency shall mean a serious medical condition, which arises suddenly and requires immediate care and treatment to avoid jeopardy to the life and health of the person. Emergencies are covered 24 hours a day, seven days a week, no matter where You are.

Employee shall mean:

An Employee regularly scheduled to work at a position for a minimum of 75% of a workweek as defined by the Member Institution and shall not be less than 28 hours per week;

A faculty member under an academic contract for a minimum of eighteen undergraduate semester credit hours annualized, or equivalent, during the academic year with a Member Institution or equivalent;

An Employee on an Approved Leave of Absence;

An Employee on an Approved Sabbatical; or

An Employee on an Approved Disability Leave.

The term Employee shall not include:

Leased employees;

Collectively bargained employees, unless an agreement between the Member Institution and the collectively bargained group specifies coverage for such individuals;

Temporary employees;

A member of the Member Institution's Board of Directors, unless engaged in the conduct of the business on a full-time basis;

An independent contractor or consultant who is paid other than a regular wage or salary by the Member Institution;

A student employee; or

Adjunct faculty.

Employer or Member Institution shall mean the independently governed and operated institutions of education in the State of Florida, who are members of ICUBA, and who are approved for membership as set forth in ICUBA's Articles of Incorporation and Bylaws. The term Member Institution shall also mean any affiliated foundation or other entity associated with such institutions, and any other entity adopting the Plan with the approval of its governing body and ICUBA as set forth in ICUBA's Articles of Incorporation and Bylaws.

If a Member Institution merges or is otherwise consolidated with any affiliate, the successor shall, as to the group of Member Institutions covered by the Plan immediately before such merger or consolidation, be the Member Institution as defined hereunder, unless ICUBA specifies to the contrary. In the case of any other merger or consolidation, the successor shall not be the Member Institution except to the extent that it acts, with the approval of ICUBA, to adopt the Plan.

Enrollment Date shall mean the date a Participant first becomes covered under the Plan. It is the date of hire for new Employees, the Change in Status date for Special Enrollees, and the beginning of the Plan Year (April 1 to March 31) for Employees who enroll during Open Enrollment.

Enteral Formulae shall mean food administered through a tube placed in the nose, the stomach, or the small intestine. A tube in the nose is called a nasogastric tube or nasoenteral tube. A tube that goes through the skin into the stomach is called a gastrostomy or percutaneous endoscopic gastrostomy (PEG). A tube into the small intestine is called a jejunostomy or percutaneous endoscopic jejunostomy (PEJ) tube.

ERISA shall mean the Employee Retirement Income Security Act of 1974, as amended from time to time.

Essential Advocates shall mean a team of BCBSF health experts comprised of nurses, plan benefit specialists and community resources professionals that can assist You in pricing services and resolving claims. Essential Advocates are available 24 hours a day by calling 1-888-521-2583.

Exclusions shall mean specific conditions or services that are not covered under the Plan.

Experimental or Investigative shall have the meaning set forth in the Section entitled "Other Terms You Should Know" in Article Three.

Experimental or Investigational Procedure shall mean any drug, device, procedure, service, or treatment that is the subject of ongoing Phase I or II clinical trials to determine maximum tolerated dose, toxicity, safety, efficacy, or efficacy as compared to other treatments. A drug, device, procedure, service, or treatment will not be considered experimental if it is the subject of ongoing Phase III clinical trials and the Covered Person meets the Phase III protocol requirements to participate. A drug, device, procedure, service, or treatment will be the subject of ongoing Phase I or II clinical trials to determine maximum tolerated dose, toxicity, safety, efficacy, or efficacy as compared to other treatments unless all the following criteria are met:

The drug, device, procedure, service, or treatment must have approval from the appropriate government regulatory bodies.

A drug, device, procedure, service, or treatment must have Food and Drug Administration (FDA) approval for those specific indications and methods of use for which such drug, device, procedure, service, or treatment is sought to be provided.

Any drugs, devices, procedures, services, or treatments, which at the time sought to be provided are not approved by the Center for Medicare and Medicaid Services for reimbursement under Medicare, are considered Experimental Procedures.

Drugs are considered experimental if they are not commercially available for purchase and are not approved by FDA for general use. The phrase "approved by FDA for general use" refers to permission for commercial distribution. Any other approvals that are granted as an interim step in the FDA regulatory process, subject to the Phase III Exception above are considered Experimental Procedures.

Drugs and tests approved by the FDA for a specific disease, Injury, Illness, or condition, but which are sought to be provided for another disease, Injury, Illness, or condition, are considered Experimental Procedures.

Drugs that are without at least one ingredient that constitutes a controlled substance as defined by the FDA are considered Experimental Procedures.

The scientific evidence must permit conclusions concerning effect of the drug, device, procedure, service, or treatment on health outcomes.

The evidence must consist of well-designed and well-conducted investigations published in peer-review journals. The quality of the body of studies and the consistency of the results are considered in evaluating the evidence.

The evidence must demonstrate that the drug, device, procedure, service, or treatment can measure or alter the sought-after changes related to the disease, Injury, Illness, or condition. In addition, there must be evidence, or a convincing argument based on established medical facts that such measurement or alteration affects that health outcome.

Opinions and evaluations by national medical associations, consensus panels or other technology evaluation bodies are evaluated according to the scientific quality of the supporting evidence and rationale.

The drug, device, procedure, service, or treatment must improve or contribute to the improvement of the net health outcome.

The drug, device, procedure, service, or treatment's beneficial effects on health outcomes must outweigh any harmful effects on health outcomes.

The drug, device, procedure, service, or treatment be as beneficial as any established alternatives.

The technology must improve the net health outcome as much or more than established alternatives.

The improvement must be attainable outside the investigational settings.

When used under the usual conditions of medical practice, the drug, device, procedure, service, or treatment must reasonably be expected to satisfy criteria (a) and (b).

Notwithstanding any other provision contained herein, these criteria will be the sole means to construe and determine whether any drug, device, procedure, service, or treatment constitutes "Experimental Procedures."

Explanation of Benefits (EOB) shall mean a statement provided by the applicable Claims Administrator that explains the Covered Expenses, the allowable reimbursement amounts, any Deductibles, Coinsurance, or other adjustments taken, and the net amount paid. A Participant typically receives an Explanation of Benefits with a Claim reimbursement check or as confirmation that a Claim has been paid directly to the Provider.

Extended Care Facility shall mean an institution which:

Is duly licensed as an extended care facility, convalescent facility, or Skilled Nursing Facility and operates in accordance with governing laws and regulations;

Regularly provides Inpatient Skilled Nursing Care for payment during the active or convalescent stage of an Injury or Illness;

Is staffed with a Physician or registered nurse on duty 24 hours a day;

Operates in accordance with medical policies, whereby such policies are supervised and established by a Physician other than the Covered Person's own Physician;

Regularly maintains a daily medical record for each Covered Person;

Is not, other than incidentally, a place for the aged, a place for individuals addicted to drugs or alcohol, or a place for Custodial Care; and

Is recognized as an Extended Care Facility or a Skilled Nursing Facility under Medicare. Family shall mean a Covered Person and his or her Covered Dependents.

Foreign Travel shall mean travel outside of the United States. You are automatically covered for Emergency services outside the U.S. Preventive Care is not covered outside the United States.

Generic Drug shall mean a Prescription Drug that has the same active-ingredient formula as a Brand Name Drug. A Generic Drug is known only by its formula name and its formula is available to any pharmaceutical company. Generic Drugs are rated by the Food and Drug Administration (FDA) to be as safe and as effective as Brand Name Drugs and are typically less costly.

Genetic Information shall mean a condition that relates to genetics.

Genetic Information Nondiscrimination Act of 2008 (GINA) shall mean a federal law that outlines requirements that employer sponsored health plans may not require or discriminate due to Genetic Information.

Health Insurance Portability and Accountability Act (HIPAA) shall mean a federal law that outlines the requirements that employer-sponsored group insurance plans, insurance companies, and managed care organizations must satisfy to provide health insurance coverage in the individual and group healthcare markets.

Hearing Care Services shall mean services provided to assist in hearing.

Home Health Care Agency shall mean any of the following:

A Home Health Care Agency licensed by the jurisdiction in which it is located;

A Home Health Care Agency as defined by the Social Security Administration; or

An organization licensed in the jurisdiction in which it is located which is an appropriate Provider of home health services, and which meets the following requirements:

- Has a full-time administrator;
- Keeps written medical records; and
- Has at least one Registered Nurse (R.N.) on staff, or the services of an R.N. available.

Home Health Care or Home Health Care Services shall mean the following care provided to a Covered Person at such Covered Person's home or a Home Health Care Agency on recommendation of a Physician:

Intermittent care by a:

- Registered Nurse (R.N.)

- Licensed Practical Nurse (L.P.N.)
- Home Health Aide
- Occupational and Physical Therapist
- Licensed Vocational Nurse (L.V.N.)
- Physical Therapist Assistant (P.T.A.)
- Certified Occupational Therapist Assistant (C.O.T.A.);

Private duty nursing services of a Registered Nurse (R.N.) or Licensed Practical Nurse (L.P.N.);

Social work; and

Nutrition services, including special meals.

Home Infusion Therapy shall mean services that introduce a solution into the body through a vein. An infusion is the therapeutic introduction of a fluid other than blood into a vein.

Hospice shall mean a public agency or a private organization, which provides care and services for Terminally Ill persons and their families. Such agency or organization must be qualified to receive Medicare payments, or satisfy the following requirements:

Provides and has available 24 hours per day:

- Palliative and supportive care for Terminally Ill persons;
- Services which encompass the physical, psychological, and spiritual needs of Terminally Ill persons and their families; and
- Acute Inpatient Care, Outpatient Care, and Home Health Care. Care and counseling must be furnished directly by, or under the arrangement of, such agency or organization.

Has a medical director who is a Physician;

Has an interdisciplinary team to coordinate care and services, which includes at least one Physician, one R.N., and one social worker; and

Is licensed or accredited as a Hospice if the laws of the jurisdiction in which it is located allow for the licensing or accreditation of Hospices.

Hospice Care shall mean care rendered by a Hospice in response to the special physical, psychological, and spiritual needs of Terminally Ill Covered Persons and/or their family members.

Hospital shall mean an institution, which makes charges and is engaged primarily in providing Medical Care to sick and injured persons on an Inpatient basis at the Participant's expense which fully meets all the requirements set forth below:

It is an institution operating in accordance with the law of the jurisdiction in which it is located pertaining to institutions identified as Hospitals. It is primarily engaged in providing Medical Care of injured and sick persons by or under the supervision of a staff of Physicians or surgeons for compensation from its patients on an Inpatient basis. It continuously provides 24-hour nursing services by Registered Nurses and maintains facilities on the premises for major operative surgery. It is not, other than incidentally, a nursing home, a place for rest, a place for the aged, a place for the mentally ill or emotionally disturbed, or a place for the treatment of substance use disorder.

It is accredited by the Joint Commission on Accreditation of Hospitals (JCAH) or is recognized by the American Hospital Association (AHA) and is qualified to receive payments under the Medicare program.

It is a psychiatric Hospital, as defined by Medicare, which is qualified to participate in and is eligible to receive payments under and in accordance with the provisions of Medicare.

Hospital Services shall mean services provided in a Hospital.

ID Card shall mean an identification card provided to all Covered Persons for proper identification under the Plan. ID Card information helps Providers verify Covered Persons' Eligibility for coverage.

Illness shall include disease, mental, emotional, or nervous disorders, and pregnancy.

Injury shall mean only bodily injury.

Inpatient shall mean a registered bed Covered Person in a Hospital or Other Facility Provider and for whom a room and board charge is made. A person is not an Inpatient on any day on which he or she is on leave or otherwise gone from the Hospital, whether a room and board charge is made.

Inpatient Care shall mean Medical Care given to a Covered Person admitted to a Hospital, Extended Care Facility, nursing home, or other facility.

Late Enrollee shall mean a Participant or Dependent who (or a Dependent for whom the responsible Participant) fails to enroll during the periods set forth in the Enrollment and Contributions section of this Plan Document. A Special Enrollee shall not be considered a Late Enrollee.

Maintenance Medication shall mean medications that are prescribed for long-term treatment of chronic conditions, such as diabetes, high blood pressure, high cholesterol, or asthma. Maintenance Medications are available through Mail Service or the 90-day retail program. Oral contraceptives are considered Maintenance Medications.

Maximum Benefit shall mean the maximum amount to be paid by the Plan on behalf of a Covered Person for Covered Expenses, which are incurred while such Covered Person is covered under the Plan.

Medical Care shall mean Professional services rendered by a Physician or Other Professional Provider for the treatment of an Illness or Injury.

Medically Necessary/Medical Necessity refers to a course of treatment accepted as the most successful course of the medical symptoms You are experiencing. The course of treatment is determined jointly by You, Your health professional and the Plan using United States standards, health care services that a Provider, exercising prudent clinical judgment, would provide to a patient for the purpose of preventing, evaluating, diagnosing, or treating an illness, injury, disease, or its symptoms, and that are:

In accordance with generally accepted standards of medical or behavioral health practice;

Clinically appropriate, in terms of type, frequency, extent, site and duration and considered effective for the Covered Person's illness, injury, or disease;

Not primarily for the convenience of the Covered Person, Covered Person's caregiver(s) or Provider; and

Not more costly than an alternative service or sequence of services at least as likely to produce equivalent therapeutic or diagnostic results as to the diagnosis or treatment of that Covered Person's Illness, Injury, or disease.

All requirements of the above-referenced definition must be met for a health care service to be deemed Medically Necessary and Appropriate. The failure of a health care service to meet any one of the above referenced requirements means, in the discretion of the BCBSF or Aetna, the health care service does not meet the definition of Medically Necessary and Appropriate.

For the purposes of determining Medical Necessary and Appropriate:

BCBSF and Aetna have the discretion to utilize and rely upon any medical and behavioral health (which includes substance use and mental health) standards, policies, guidelines, criteria, protocols, manuals, publications, studies, or literature (herein collectively referred to as "criteria"), whether developed by them or others, which, in their discretion, are determined to be generally accepted by the medical and/or behavioral health community;

"Generally accepted standards of medical or behavioral health practice" means United States standards that are based on credible scientific evidence published in peer-reviewed medical and/or behavioral health literature generally recognized by the relevant United States medical or behavioral health community, physician, or behavioral health specialty society recommendations, and/or any other factors deemed relevant in the discretion of BCBSF or Aetna; and,

BCBSF and Aetna may use the following materials, including but not limited to, Corporate Administrative Medical ("CAM") Policies, Technology Evaluation Center ("TEC") Assessments, Behavioral Health Care Utilization Management Criteria and/or any Care Guidelines or criteria by MCG Health, LLC or affiliated companies which reflect clinically appropriate health care services and generally accepted standards of medical and behavioral health practice. MCG Health, LLC and/or its affiliated companies are independent companies that develop evidence-based guidelines and criteria for medical, behavioral health and insurance industries to interpret clinical determinations and determine the medical necessity and appropriateness of requested services, procedures, devices, and supplies.

Medicare Part A shall mean Hospital insurance provided by Medicare that can help pay for Inpatient Hospital care, Medically Necessary Inpatient Care in a Skilled Nursing Facility, Home Health Care, Hospice Care, and end-stage renal disease treatment.

Medicare Part B shall mean Medicare-administered medical insurance that helps pay for certain Medically Necessary practitioner services and Outpatient Hospital Services and supplies not covered by Part A Hospital insurance of Medicare coverage. Physicians' services are covered under Part B even if they are provided to a Covered Person in an Inpatient setting.

Medicare Part D shall mean retail Prescription Drug benefits available to Medicare-eligible beneficiaries.

Mental disorder as defined in the most recent edition of the *Diagnostic and Statistical Manual of Mental Disorders* (DSM) of the American Psychiatric Association is a syndrome characterized by clinically significant disturbance in an individual's cognition, emotion regulation, or behavior that reflects a dysfunction in the psychological, biological, or developmental processes underlying mental functioning. **Mental disorders** are usually associated with significant distress or disability in social, occupational, or other important activities.

Mental Health Care Services shall mean services provided to treat a mental or nervous disorder such as neurosis, psychoneurosis, psychopathy, psychosis, or psychiatric-related disease, or disorder of any kind, including personality disorders. **Note**: Although a Physician or Other Professional Provider may have prescribed treatment, such treatment may not be considered Medically Necessary and Appropriate within this definition. Disorders, such as Autism, is a Covered Service so long as such condition has as its standard and accepted course of treatment such as the taking of Prescription Drugs. Learning disabilities, behavioral problems, or attention-deficit disorders are covered with a diagnosis of autism spectrum disorder. Psychiatric disorders resulting from specific external factors, such as grief, are classed as mental or nervous disorders. Dementia (presenile and arteriosclerotic) is not a Covered Benefit.

Mental Health Parity shall mean the Mental Health Parity and Addiction Equity Act of 2008 (MHPAEA) which refers to a federal law that provides participants who already have benefits under mental health and substance use disorder (MH/SUD) coverage parity with benefits limitations under their medical/surgical coverage.

Newborn Expenses shall mean expenses incurred by a newborn child.

Network shall mean any Participating Provider or managed care network under contract with BCBSF and/or Aetna, as applicable.

Network Benefits shall mean the services or supplies provided by a Participating Provider or authorized by any of ICUBA's contracted managed care networks.

Network Preventive Care Benefits shall mean mammograms, bone mineral density screenings, colorectal cancer screenings, colonoscopies, sigmoidoscopies, venipunctures, glucose testing, lipid panels, ALT/AST screenings, cholesterol screenings, electrocardiograms, urinalysis, echocardiograms, pap tests, prostate cancer screenings, chlamydia and other sexually transmitted disease screenings, adult immunizations, well-child exams, skin cancer behavioral counseling, and flu shots.

Non-Network shall mean the use of health care Providers not contracted with BCBSF and/or Aetna Behavioral Health. This includes drugs, devices, procedures, services, treatments, or supplies, which are not provided by a BCBSF Participating Provider and/or Aetna Participating Provider.

Non-Network Benefits shall mean Benefits the Plan provides to Covered Persons for Covered Services obtained outside of the Network service area.

Non-Network Provider shall mean the use of health care Providers not contracted with BCBSF or Aetna Behavioral Health..

Occupational Therapy shall mean treatment to restore a physically Disabled person's ability to perform Activities of Daily Living.

Open Enrollment shall mean the period when Eligible persons can enroll, terminate, or change coverage in the Plan. Open Enrollment occurs annually and is meant for enrollment in the new Plan Year (04/01 – 03/31).

Organ Transplant shall mean services that provide for Medically Necessary and Appropriate organ or tissue transplant procedures for kidney, cornea, heart, heart/lung, liver, lung, pancreas, or bone marrow.

Orthopedic Device shall mean any ridged or semi-ridged leg, arm, back or neck brace and casting materials that are eliminating motion in a diseased or injured part of the body.

Orthotic Devices shall include any device to mechanically assist, restrict or control function of a moving part of the Covered Person's body such as shoe inserts that can relieve stress and stretching of the plantar fascia while standing and walking.

Other Facility Provider shall mean any of the following: Ambulatory Care Facility, Substance Use Disorder Treatment Facility, free-standing dialysis facility, Outpatient psychiatric facility, psychiatric Day Treatment facility, psychiatric Hospital, Hospice, Extended Care Facility, or rehabilitation facility, which is licensed as such in the jurisdiction in which it is located.

Other Professional Provider or Professional Provider shall mean the following persons or practitioners, including Physicians, acting within the scope of such Provider's license, which is certified and licensed in the jurisdiction in which the services are provided:

Audiologist

Anesthesiologist

Certified Nurse Practitioner

Clinical Social Worker

Dental Practitioner

Emergency medical technician

Independent laboratory technician

Licensed Practical Nurse

Nurse Midwife

Occupational Nurse

Pharmacist

Physical Therapist

Physician Assistants

Registered Nurse

Respiratory Therapist

Speech - Language Pathologist or Audiologist

Out-of-Pocket Expense shall mean any amount of Deductible, Copayment and Coinsurance that a Covered Person pays for any Covered Expense.

Out-of-Pocket Limit or Out-of-Pocket Maximum shall mean the maximum amount of Deductible, Copayment and Coinsurance during any Plan Year (April 1 to March 31) that a Covered Person or Family shall pay before the Plan shall pay 100% of Covered Expenses for that Plan Year (April 1 to March 31). There are separate Out-of-Pocket limits for Network and Non-Network services. There is also a separate Out-of-Pocket Limit for Prescription Drugs. Each benefit plan option has its own Out-of-Pocket limits.

Outpatient shall mean a Covered Person who receives drugs, devices, procedures, services, treatments, or supplies while not confined as an Inpatient.

Outpatient Care shall mean any health care service provided to a Covered Person who is not admitted to an Inpatient facility. Outpatient Care may be provided in a Physician's office, clinic, a Covered Person's home, or Hospital outpatient department.

Outpatient Surgery shall mean surgical services provided to a Covered Person while such Covered Person is an Outpatient.

Participant shall mean an Employee or Eligible Retiree who meets the requirements for Eligibility, properly enrolls in the Plan, and continuously meets the requirements for Eligibility.

Participating Physician shall mean a duly licensed Physician under contract with BCBSF or Aetna Behavioral Health.

Participating Provider shall mean any Hospital, Physician, pharmacy, Other Professional Provider, Other Facility Provider, or other entity under contract BCBSF or Aetna. Refer to the Provider Directory for a listing of the Participating Providers. Contact BCBSF at the toll free number (1-855-258-9029), or log onto the website at www.MyHealthToolkitFL.com; contact Aetna at the toll free number (1-877-398-5816), or log onto the website at www.aetna.com.

Pended Claim shall mean a Claim that requires additional information prior to completing the Adjudication process due to a specific reason.

Personal Health Assessment (PHA) is a voluntary health questionnaire used to provide individuals with an evaluation of their health risks and quality of life. The PHA incorporates an extended questionnaire (including biometric data), a risk calculation score, and feedback (often face-to-face with a health advisor).

Personal Health Record is a health record initiated and maintained by an individual that provides a complete and accurate summary of the health and medical history of an individual by gathering data from many sources and making this information accessible online to anyone who has the necessary electronic credentials to view the information. Physician shall mean a properly licensed person holding the degree of Physician of Medicine (M.D.), Physician of Osteopathy (D.O.), Physician of Podiatry (D.P.M.), or Physician of Chiropractic (D.C.).

Physical Therapy shall mean rehabilitation concerned with restoration of function and prevention of physical Disability following disease, Injury, or loss of body part.

Plan, The Plan, or This Plan shall mean the Independent Colleges and Universities Benefits Association, Inc. Medical, Behavioral Health, and Prescription Drug Plan.

Plan Administrator shall mean the Board of Directors of ICUBA.

Plan Year shall mean April 1 through March 31 of each year.

Precertification shall mean the pre-approval of a Covered Expense for all Inpatient and some Outpatient services, as illustrated in Article Seven of this Plan Document.

Preferred Medication List (PML) shall mean a list of preferred, commonly prescribed Prescription Drugs.

Prescription Drugs shall mean drugs or medicines obtainable only upon a Physician's written prescription, including any medication compounded by the pharmacist that contains a prescription legend drug, insulin, and insulin needles and syringes.

Preventive Care shall mean medical services aimed at early detection and intervention.

Primary Care shall mean the basic, comprehensive, preventive level of health care typically provided by a person's general or family practitioner, internist, or pediatrician.

Primary Care Physician (PCP) shall mean a Physician, usually a family or general practitioner, internist, or pediatrician, who provides a broad range of preventive medical services and recommends patients to Specialists, Hospitals, and other Providers, as necessary. OB-GYN is considered a PCP.

Private Duty Nursing Services shall mean nursing services rendered at home by Registered Nurses (RNs) or Licensed Practical Nurses (LPNs), in accordance with Physician orders.

Prosthetic Devices shall mean a device that replaces all or a part of the human body because a part of the body is permanently damaged, is absent or is malfunctioning.

Provider shall mean any person or entity licensed by the appropriate state regulatory agency and legally entitled to practice within the scope of such person or entity's license in the practice of any of the following:

Medicine;

Dentistry;

Optometry;

Podiatry;

Chiropractic services;

Behavioral health;

Physical therapy;

Oral surgery;

Speech therapy;

Occupational therapy; or

Osteopathy.

The term Provider also includes a Hospital; a Rehabilitation Facility; a Skilled Nursing Facility; a physician assistant; nurses practicing in expanded roles (such as pediatric nurse practitioners, family practice nurse practitioners and certified nurse midwives) when supervised by a licensed medical doctor or oral surgeon; and Behavioral Health Services when performed by a Behavioral Health Provider, licensed professional counselor, masters level licensed social worker, licensed marriage and family therapist or other licensed Behavioral Health Provider approved by the Corporation. The term Provider does not include interns, residents, in-house physicians, physical trainers, lay midwives or massage therapists.

Provider Directories shall mean listings of Providers who have contracted with BCBSF or Aetna to provide care to its Covered Persons. Covered Persons may refer to the directories to select Network Providers. The Provider Directory for Medical is available at www.MyHealthToolkitFL.com, for Behavioral Health at www.aetna.com.

Provider Network shall mean a panel of Providers contracted by BCBSF or Aetna.

Provider Services shall include the following services:

A. When performed by a Provider or Behavioral Health Provider within the scope of his or her license, training, and specialty and within the scope of generally acceptable medical standards as determined by BCBSF, or Aetna:

Office visits, which are for the purpose of seeking or receiving care for a preventive service, Illness, or Injury;

Basic diagnostic services and machine tests; or,

Behavioral Health Services.

B. When performed by a licensed medical doctor, osteopath, podiatrist, or oral surgeon:

Benefits rendered to a Covered Person in a Hospital or Skilled Nursing Facility;

Benefits rendered in a Covered Person's home;

Surgical Services;

Anesthesia Services, including the administration of general or spinal block anesthesia;

Radiological examinations;

Laboratory tests; and

Maternity services, including consultation, prenatal care, conditions directly related to pregnancy, delivery and postpartum care, and delivery of one or more infants. Provider Services also include maternity services performed by certified nurse midwives when supervised by a licensed medical doctor.

Qualified Beneficiary shall refer to an individual covered by a group health plan on the day before a Qualifying Event who is either an Employee, the Employee's spouse, or an Employee's Dependent child. In certain cases, a retired Employee, the retired Employee's spouse, and the retired Employee's Dependent children may be Qualified Beneficiaries. In addition, any child born to or placed for adoption with a covered Employee during the period of COBRA Continuation Coverage is considered a Qualified Beneficiary.

Qualifying Event shall refer to certain events that would cause an individual to lose health coverage. The type of Qualifying Event will determine who the Qualified Beneficiaries are and the amount of time that the Plan must offer the health coverage to them under COBRA.

Reasonable and Customary shall mean those charges made for medical services and/or supplies essential to the care of a Covered Person which will be considered reasonable and customary if they are the amount normally charged by the Provider for similar services and supplies and do not exceed the amount ordinarily charged by most Providers for comparable services and supplies in the locality where the services or supplies are received. In determining whether charges are Reasonable and Customary, consideration will be given to the nature or severity of the Illness or Injury being treated and any medical complications, degree of professional skill or unusual circumstances which require additional time, skill, or experience. All Network Provider charges are deemed to be Reasonable and Customary.

Rehabilitation Facility shall mean a licensed facility operated for the purpose of assisting Covered Persons with neurological or other physical injuries to recover as much restoration of function as possible.

Rehire shall mean an Employee who is terminated and then re-employed.

Retail Health Clinic shall mean a facility usually located at a Retail Pharmacy or other retail environment. Services are furnished by Providers trained to diagnose, treat, and write prescriptions (when clinically appropriate) for a variety of common family illnesses.

Scalp Hair Prosthesis shall mean an artificial substitute for scalp hair.

Schedule of Benefits shall mean the pages of this Plan Document, so titled, which specify the coverage provided and the applicable Copayments, Coinsurance, Plan Year Deductibles and Benefit limitations.

Secondary Plan shall mean a plan that is not the Primary Plan. When this Plan of Benefits constitutes a Secondary Plan, availability of Benefits is determined after those of the other plan and may be reduced because of benefits payable under the other plan.

Service Area shall mean the geographical area covered by BCBSF or Aetna Behavioral Health.

Skilled Nursing Care shall mean service provided by a Registered Nurse (R.N.), Licensed Practical Nurse (L.P.N.), or Licensed Vocational Nurse (L.V.N.), provided the care is Medically Necessary and Appropriate and the treating Physician has prescribed such care.

Skilled Nursing Facility shall mean an institution which:

Is duly licensed as an Extended Care Facility or convalescent facility, and operates in accordance with governing laws and regulations;

Regularly provides Inpatient Skilled Nursing Care for payment during the active or convalescent stage of an Injury or Illness;

Is staffed with a Physician or Registered Nurse on duty 24 hours a day;

Operates in accordance with medical policies supervised and established by a Physician other than the Covered Person's own Physician;

Regularly maintains a daily medical record for each Covered Person;

Is not, other than incidentally, a place for the aged, a Substance Use Disorder Treatment Facility, or a place for Custodial Care; and

Is recognized as an Extended Care Facility or a Skilled Nursing Facility under Medicare.

Special Enrollee shall mean an Employee or Dependent who is entitled to and who requests Special Enrollment as described in the Enrollment Contributions section of this Plan Document.

Specialists shall mean Providers whose practices are limited to treating a specific disease (e.g., oncologists, etc.), specific parts of the body (e.g., ear, nose, and throat, etc.), a specific age group: other than children (e.g., gerontologist, etc.), or specific procedures (e.g., oral surgery, etc.). A chiropractor (D.C.) is considered a Specialist.

Speech Therapy shall mean services provided by a speech therapist when all the following conditions are met:

The service of a speech therapist is required to restore a speech Disability that the Covered Person lost as a direct result of an Illness or Injury, unless being treated under the diagnosis of autism spectrum disorder, in which the service of a speech therapist is covered.

The services of the therapist are prescribed by a Physician who continues to direct the overall treatment of the case as Medically Necessary and Appropriate to improve the specific defect.

Spinal Manipulation Treatment shall mean office visits or treatment, which involve manipulation (with or without the application of treatment such as heat, water, or cold therapy, diathermy, or ultrasound) of the spinal skeletal system and surrounding tissues to allow free movement of joints, alignment of bones, or enhancement of nerve functions.

Sterilization shall mean a planned surgical procedure resulting in the inability to reproduce.

Substance related disorder shall mean addictive disorder, or both, as defined in the Diagnostic and Statistical Manual of Mental Disorders (DSM) published by the American Psychiatric Association.

Substance Use Disorder Treatment Facility shall mean a facility, other than an acute care Hospital, established to care and treat those who need Inpatient Medical Care due to alcoholism or drug abuse. The institution must have permanent facilities on the premises for Inpatient Medical Care. The institution must be licensed, registered, or approved by the appropriate authority of the jurisdiction in which it is located, or it must be accredited by the American Hospital Association. It must keep daily medical records on all patients. A Substance Use Disorder Treatment Facility shall not include an institution, or part of one, used mainly for rest care, nursing care, care of the aged, or Custodial Care.

Surgical Services shall mean services received and performed by a Professional Provider.

Telemedicine is the remote diagnosis and treatment of patients by means of telecommunications technology.

Temporomandibular Joint Dysfunction Services (TMJ) shall mean services rendered for the dysfunction of the temporal bone and mandible.

Terminal Illness or Terminally Ill shall mean a life expectancy of six months or less.

Termination Of Employment or Terminates Employment shall mean the severance of an Employee's employment relationship with a Member Institution and all other affiliates, or the expiration of an Approved Leave of Absence, Approved Sabbatical, or leave mandated by the Family and Medical Leave Act or the Uniformed Services Employment and Reemployment Rights Act from a Member Institution without the Employee returning to the employment of such Member Institution or any affiliate.

Therapy and Rehabilitation Services shall mean services ordered by a Physician to stimulate growth and development of the individuals enrolled.

Transplant Services shall mean services where the Covered Person has new organs or body tissue transferred to replace the diseased or malfunctioning organs.

Urgent Care shall mean when prompt medical attention is needed.

Urgent Care Claims shall have the meaning set forth in the "Types of Claims" section of Article Eleven.

Waiting Period shall mean the period that must pass under this Plan before an Employee or Dependent is eligible to enroll in the Plan (or other medical plan as the case may be). Notwithstanding the foregoing, if an Employee or Dependent enrolls as a Late Enrollee or Special Enrollee on a Special Enrollment Date, any period before such late or Special Enrollment is not a Waiting Period.

You, Your, or Yourself shall mean a Participant in the Plan.

RIDERS TO THE INDEPENDENT COLLEGES AND UNIVERSITIES BENEFITS ASSOCIATION, INC. MEDICAL, BEHAVIORAL HEALTH, AND PRESCRIPTION DRUG PLAN DOCUMENT

Twenty-seven riders accompany this Plan.

Depending upon Your Employer, these riders may or may not apply to You.

It is important that You read the riders and determine whether they apply to You or not.

RIDER 1 – INDEMNIFICATION

The Following Rider to The Independent Colleges and Universities Benefits Association, Inc. Medical, Behavioral Health, and Prescription Drug Plan Document amends the coverages of the Plan for the Participants, Dependents, and Beneficiaries for All Member Institutions:

Barry University, Beacon College, The Bolles School, Central Florida AHEC, Corbett Preparatory School of IDS, Edward Waters University, Everglades AHEC, Florida Institute of Technology, Good Shepherd Episcopal School, Grace Episcopal Day School, Jacksonville Country Day School, Nova Southeastern University, Palm Beach Atlantic University, The Poynter Institute, Rollins College, Saint Edward's School, Saint Paul's School, Saint Leo University, Saint Stephen's Episcopal School, San Jose Episcopal Day School, St. Thomas University, Tampa Preparatory School, Unity School, The University of Tampa, Warner University and Westminster Christian Private School, Inc.

PURPOSE OF RIDER: This Rider amends the Plan to specify the indemnification provisions that apply between ICUBA and the Member Institutions. For purposes of this Rider, ICUBA and each Member Institution are referred to individually as a "Party" and collectively as the "Parties."

I. **INDEMNIFICATION.**

A. INDEMNIFICATION BY THE MEMBER. Notwithstanding anything to the contrary contained in the Membership and Adoption Agreement between the Parties (the "Agreement") or any Plan documents and without prejudice to other rights that ICUBA or the Board may have under the Agreement, Plan documents, or applicable law, the Member (the "Member Indemnifying Party") shall defend, indemnify and hold ICUBA, its officers, directors, employees and agents, the Board and its respective directors, and the Plan (each, an "ICUBA Indemnified Party" and collectively, the "ICUBA Indemnified Parties"), harmless from any and all liabilities and claims, including but not limited to damages, court costs, reasonable legal fees and costs of investigation, which arise from the Member Indemnifying Party's (i) failure to perform (whether in whole or in part) any obligation required to be performed by the Member Indemnifying Party (or any person or representative designated by the Member Indemnifying Party) under the Agreement or any of the Plan documents; (ii) incorrect or incomplete data provided by the Member Indemnifying Party (or any person or representative designated by the Member Indemnifying Party) to ICUBA with regard to its Participants; (iii) a failure to follow the terms of the Plan or any of the Plan documents; or (iv) any breach of the Health Insurance Portability and Accountability Act ("HIPAA") that occurs as a result of the Member Indemnifying Party's actions or inactions; provided however, that (a) the Member Indemnifying Party shall not indemnify the ICUBA Indemnified Parties for any indirect, special consequential, or exemplary damages; and (b) the Member Indemnifying Party shall not indemnify the ICUBA Indemnified Parties for any Indemnified Damages that result from the ICUBA Indemnified Parties' own fraud, misconduct, or gross negligence.

B. INDEMNIFICATION BY ICUBA. Notwithstanding anything to the contrary contained in the Agreement or any Plan documents and without prejudice to other rights that the Member may have under the Agreement, Plan documents, or applicable law, ICUBA (the "ICUBA Indemnifying Party") shall defend, indemnify and hold the Member, its officers, directors, employees and agents (each, a "Member Indemnified Party" and collectively, the "Member Indemnified Parties"), harmless from any and all liabilities and claims, including but not limited to damages, court costs, reasonable legal fees and costs of investigation, which arise from the ICUBA Indemnifying Party's (i) a failure to perform (whether in whole or in part) any obligation required to be performed by the ICUBA Indemnifying Party (or any person or representative designated by the ICUBA Indemnifying Party) under the Agreement; (ii) a failure to follow the terms of the Plan or any of the ICUBA Plan documents; or (iii) any breach of HIPAA that occurs as a result of the ICUBA Indemnifying Party's actions or inactions (collectively, the "Indemnified Damages"); provided, however, that (a) the ICUBA Indemnifying Party shall not indemnify the Member Indemnified Parties for any indirect, special consequential, or exemplary damages; (b) the ICUBA Indemnifying Party shall not indemnify the Member Indemnified Parties for any Indemnified Damages that result from the Member Indemnified Parties' own fraud, misconduct, or gross negligence; and (c) the amount of any Indemnified Damages payable to the Member Indemnified Parties shall not exceed the amount, if any, that is recovered by ICUBA from insurance so that none of ICUBA's assets are utilized in the payment of any such Indemnified Damages.

C. INDEMNIFICATION CONDITIONS. A party seeking indemnification pursuant to the terms of this Section 1 (an "Indemnified Party") must: (i) promptly notify the other party (the "Indemnifying Party") in writing of the claim; (ii) grant the Indemnifying Party sole control of the defense and settlement of the claim, provided that the Indemnified Party has the right to reasonably approve the terms of any settlement before being bound by it, such approval not to be unreasonably withheld or delayed; and (iii) provide the Indemnifying Party, at such party's expense, with all assistance, information and authority reasonably required for the defense and settlement of the claim.

II. **RIGHT TO INSPECT RECORDS.** ICUBA and its Authorized Representatives, at reasonable times and upon reasonable advance written notice, shall have the right to inspect, to audit, to examine, and to make copies of, or extracts from, all the Member's Records (as defined below) pertaining to (i) its Participants' eligibility to participate in the Plan; or (ii) such other data as is reasonably necessary to administer the Plan, whether in written or electronic format. Such records shall include, but not be limited to accounting records; written policies and procedures; reimbursement records; enrollment documents; employee census data; insurance documents; payroll documents; and any supporting or underlying documents or materials relating to the Agreement and/or the Plan that are not otherwise protected by any applicable state or federal law and that are not confidential employment records (collectively, the "Records"). During the term of the Agreement and for a period of five (5) years after termination of the Agreement, the Member shall maintain the Records. The Member shall have no obligation to make available any Records that are protected by law unless otherwise ordered by a court of competent jurisdiction over the subject matter in issue.

III. **COSTS AND EXPENSES OF INSPECTION**. The expenses and costs incurred from any audits conducted under the authority of this right to audit, and not specifically allocated, shall be borne by ICUBA. However, if the audit determines that there has occurred material and substantive instances of fraud, misrepresentation, or nonperformance, then the Member shall reimburse ICUBA for all reasonable expenses and costs, including reasonable attorneys' fees as necessary to enforce this provision.

SURVIVAL. All Sections of this Rider shall survive the termination of the Agreement and the Plan.

RIDER 22 – COVERED EXPENSES: EMERGENCY CONTRACEPTIVES

The Following Rider to The Independent Colleges and Universities Benefits Association, Inc. Medical, Behavioral Health, and Prescription Drug Plan Document amends the coverages of the Plan for the Participants, Dependents, and Beneficiaries for the following Institutions:

Beacon College, The Bolles School, Central Florida AHEC, Corbett Preparatory School of IDS, Edward Waters University, Everglades AHEC, Florida Institute of Technology, Grace Episcopal Day School, Jacksonville Country Day School, Nova Southeastern University, The Poynter Institute, Rollins College, Saint Stephen's Episcopal School, San Jose Episcopal Day School, Tampa Preparatory School, Unity School, The University of Tampa, and Westminster Christian Private School, Inc.

PURPOSE OF RIDER: This Rider amends the Covered Expenses under the Plan.

Generic emergency contraceptives with a quantity limit of two courses per plan year shall be covered at no out- of-pocket cost to eligible members.

RIDER 23 – LIMITATIONS AND EXCLUSIONS: ABORTION

The Following Rider to The Independent Colleges and Universities Benefits Association, Inc. Medical, Behavioral Health, and Prescription Drug Plan Document amends the coverages of the Plan for the Participants, Dependents, and Beneficiaries for the following Institutions:

Beacon College, The Bolles School, Central Florida AHEC, Everglades AHEC, Florida Institute of Technology, Nova Southeastern University, The Poynter Institute, Rollins College, Tampa Preparatory School, Unity School, and The University of Tampa

PURPOSE OF RIDER: The Plan recognizes a limited number of issues are of a sensitive political, theological, or academic nature. The Plan allows the individual Member Institutions to elect coverages with respect to these issues.

ARTICLE EIGHT, LIMITATIONS AND EXCLUSIONS (ABORTION)

This Rider allows the coverage of abortions which otherwise meet the definition of a Covered Expense by deleting Limitations and Exclusions: forty-four

RIDER 24 - ELIGIBILITY FOR TRANSGENDER OR GENDER REASSIGNMENT SURGERY

The Following Rider to The Independent Colleges and Universities Benefits Association, Inc. Medical, Behavioral Health, and Prescription Drug Plan Document amends the coverages of the Plan for the Participants, Dependents, and Beneficiaries for the following Institutions:

Barry University, Central Florida AHEC, Edward Waters University, Everglades AHEC, Florida Institute of Technology, Grace Episcopal Day School, Nova Southeastern University, The Poynter Institute, Rollins College, Tampa Preparatory School, and The University of Tampa

PURPOSE OF RIDER: This Plan recognizes a limited number of issues are of a sensitive political, theological, or academic nature. The Plan allows individual Member Institutions to elect coverages with respect to these issues.

Eligibility for transgender or gender reassignment surgery requires that the following conditions are met:

1. Covered member must complete at least twelve consecutive months of living, dressing, and working full-time as the preferred gender. During this period, regular and consistent attendance in a program of counseling and behavior therapy is required.

2. An additional twelve consecutive months of living, dressing, and working full-time as the preferred gender with the addition of hormone supplementation consistent with the preferred gender is required. During this period coverage regular and consistent attendance in a program of counseling and behavior therapy is also required.

3. After documented completion of step one and two above, the requested surgical alteration will be covered subject to non-discriminatory medical necessity.

Transgender Surgery

Transgender or Gender Reassignment surgery is considered a covered benefit when all the following criteria are met:

The individual is at least 21 years of age;

The individual has been diagnosed with the gender disorder of transsexualism based on DSM-V criteria and established by comprehensive independent behavioral health evaluation;

The individual has successfully lived and worked within the desired gender role full-time for at least 12 months (real-life experience) without returning to the original gender;

In addition to living and working with the desired gender role full-time for at least 12 months, and minimum of an additional twelve continuous months of hormone replacement therapy must occur; and

After the minimum of twenty-four continuous months of living and working within the desired gender role full- time and hormone replacement therapy the individual should undergo repeat comprehensive independent behavioral health evaluation.

Behavioral health evaluation and support services are provided through Aetna Behavioral Health and Resources for Living.

RIDER 26 – RELAXED DEADLINES FOR COVID 19 PANDEMIC

The Following Rider to The Independent Colleges and Universities Benefits Association, Inc. Medical, Behavioral Health, and Prescription Drug Plan Document amends the coverages of the Plan for the Participants, Dependents, and Beneficiaries for the following Institutions:

Barry University, Beacon College, The Bolles School, Central Florida AHEC, Corbett Preparatory School of IDS, Edward Waters University, Everglades AHEC, Florida Institute of Technology, Good Shepherd Episcopal School, Grace Episcopal Day School, Jacksonville Country Day School, Nova Southeastern University, Palm Beach Atlantic University, The Poynter Institute, Rollins College, Saint Edward's School, Saint Paul's School, Saint Leo University, Saint Stephen's Episcopal School, San Jose Episcopal Day School, Tampa Preparatory School, Unity School, The University of Tampa, Warner University and Westminster Christian Private School, Inc.

PURPOSE OF RIDER: This Rider amends the Plan to specify relaxed deadlines for certain enrollments, claims submissions, appeals and COBRA-related events due to the COVID Pandemic.

Relaxed deadlines for certain enrollments, claim submissions, appeals and COBRA-related events Due to the COVID Pandemic:

On April 28, 2020, the federal authorities who regulate our welfare benefits plans issued guidance expanding Your rights under those plans, particularly our healthcare plans. This guidance might be helpful to You.

As You might know, the plans impose a variety of deadlines by which plan enrollees must make certain requests for coverage, elect COBRA continuation coverage, pay for COBRA coverage, notify the plan about certain COBRA qualifying events (like divorce or legal separation), file claims for benefits, notify the plan of an appeal of a claim that had been denied in whole or in part, and similar notifications.

The recent guidance requires the plans to provide You with additional flexibility or grace periods regarding these elections, notice, payments, etc. due to the coronavirus pandemic. When determining what Your deadline is for these events, the plans must simply disregard the period from March 1, 2020, to the date that is 60 days after the coronavirus national emergency declaration expires. This period is called the "outbreak period."

The outbreak period is disregarded for purpose of determining the deadline for the following elections, payments, and notices:

Your 30- or 60-day period to exercise HIPAA special enrollment rights.

The 60-day period to elect COBRA continuation of coverage, following a loss of Your employer-sponsored coverage due to specific COBRA qualifying events.

Your 45-day grace period to make Your first COBRA premium payment following the election of COBRA continuation coverage, as well as the normal 30-day grace periods for making monthly COBRA premium payments.

The date by which You must notify the plan when You experience a COBRA qualifying event and are determined to have been disabled as of the date of that event or within the following 60 days.

The date by which You or a healthcare Provider on Your behalf must file a claim for benefits under the plan.

The date by which You must file an appeal after having a claim denied in whole or in part.

The date by which claimants must request external review after having certain medical claims denied in whole or in part.

The ICUBA Medical, Behavioral Health and Prescription Drug Plan to which the federal guidance applies are deemed amended to reflect these requirements, for as long as the requirements are in effect.

For more information related to how these extensions may affect Your situation, contact You Human Resources Department.

HIPAA special enrollment events generally include loss of eligibility for other coverage, or acquisition of a new dependent due to marriage, birth, adoption, or placement for adoption.

COBRA qualifying events include voluntary or involuntary termination of employment, reduction in hours below plan eligibility requirements, divorce or legal separation, death of a covered employee, and loss of dependent child status.

This rider ends May 11th per the National COVID-19 Public Health Emergency transition with a 60 day run out.