

Congregational Employee Plan for Mennonite Church USA

Summary Plan Description

Plan Information

This summary plan description (and accompanying ID card) is issued only to eligible employees of Mennonite Church USA, 3145 Benham Ave., Suite 1, Elkhart, IN 46517. Credentialed pastors and non-credentialed employees of participating area conference offices and participating congregations are considered to be employees of Mennonite Church USA for purposes of this plan.

Plan sponsor: Mennonite Church USA, 3145 Benham Ave., Suite 1, Elkhart, IN 46517; (574) 294-7523

Type of benefit plan: Group health plan

Plan number: 510

Plan year: Jan. 1 – Dec. 31

Denomination's plan effective date: Sept. 1, 1994

Denomination's plan revision date: Jan. 1, 2020

Plan administrator, plan representative, trustee, and agent for service of legal process: Mennonite Church USA, 3145 Benham Ave., Suite 1, Elkhart, IN 46517; (574) 294-7523

Claims administrator: Highmark Blue Cross Blue Shield, P.O. Box 1210, Pittsburgh, PA 15230-1210;
(800) 226-2239

Plan agent: Everence Association, Inc., a fraternal benefit society, P.O. Box 483, Goshen, IN 46527; (574) 533-9511 or
(800) 348-7468

Type of plan administrator: Contract administrator

The plan sponsor reserves the right to modify, suspend, or end the plan at any time.

Table of Contents

Schedule of Benefits.....	3
Part I, Introduction	5
Part II, Definitions.....	5
Part III, Participation — Who Can Be Covered	11
Part IV, Enrollment — When Coverage Starts.....	13
Part V, Basis of Coverage — What Coverage Costs.....	15
Part VI, How Your Health Coverage Works.....	15
Part VII, Preferred Provider Organization Program	16
Part VIII, Precertification and Claims Management	18
Part IX, Covered Services	20
Part X, Exceptions & Limitations — What Is Not Covered.....	32
Part XI, About Your Identification Card.....	35
Part XII, How to File a Claim	35
Part XIII, Appeal Procedures	36
Part XIV, When Coverage Ends.....	40
Part XV, Continuation of Coverage	41
Part XVI, Coordination of Benefits.....	44
Part XVII, Highmark Member Services Support	46
Part XVIII, Administration of the Plan	48
Part XIX, Provision of Protected Health Information to Plan Sponsor	49
Part XX, Other Important Points	51

Schedule of Benefits

Medical benefits under this plan are provided through the Highmark Blue Cross Blue Shield Preferred Provider Organization (PPO) Program. It is your responsibility to make sure that a health care provider is a network provider before medical treatment is received. The health care provider that you select can assist with this information.

Plan Information	
Minimum employment requirement	<ul style="list-style-type: none"> • Credentialed pastors – working at least 20 hours per week. • Non-credentialed employees – employed and paid for at least 30 hours per week.

Plan Requirements	In-Network	Out-of-Network
Calendar-year deductible	\$1,400 for single (self-only) coverage; \$2,800 for family coverage.	\$2,800 for single (self-only) coverage; \$5,600 for family coverage.
Calendar-year coinsurance	Not applicable.	
Office visit copayment	Not applicable.	
Total annual out-of-pocket maximum	\$1,400 for single (self-only) coverage; \$2,800 for family coverage.	\$2,800 for single (self-only) coverage; \$5,600 for family coverage.
Precertification	You are responsible to contact Highmark Health Care Management Services 7-10 days prior to a planned inpatient admission or within 48 hours of an emergency admission.	
Filing claims	PPO provider files claims.	You are responsible to file claims.

Medical Benefits	In-Network	Out-of-Network ¹
<i>Inpatient Facility Services</i>		
• Hospital services ²	You pay in-network deductible.	You pay out-of-network deductible.
• Skilled nursing facility care ² , up to 100 days per calendar year	You pay in-network deductible.	You pay out-of-network deductible.
<i>Outpatient Services</i>		
<ul style="list-style-type: none"> • Physician/specialist services • Urgent care facility services • Allergy testing and shots • Chemotherapy, radiation therapy, and kidney dialysis • Maternity care (physician fees) • Home health care • Health education programs • Medical supplies and equipment • Cardiac rehabilitation programs • Durable medical equipment and prosthetics • Outpatient surgery in hospital, outpatient surgical center, or physician office • X-ray, lab, and diagnostic services • Spinal manipulations, up to 20 visits per year • Physical medicine, up to 20 visits per year • Speech therapy, up to 20 visits per year • Occupational therapy, up to 20 visits per year 	You pay in-network deductible.	You pay out-of-network deductible.
• Amwell virtual physician visits	You pay in-network deductible.	No plan benefit outside the Amwell network of physicians
<i>Emergency Services</i>		
<ul style="list-style-type: none"> • Ambulance • Hospital emergency room care 	You pay in-network deductible.	
<i>Hospice Services</i>		
<ul style="list-style-type: none"> • Inpatient services² • Outpatient services 	You pay in-network deductible.	You pay out-of-network deductible.

Medical Benefits	In-Network	Out-of-Network¹
<i>Adult Preventive Care Services³</i>		
<ul style="list-style-type: none"> • Routine physical exams • Well-woman visits to obtain preventive services • Routine gynecological exam and pap test • Routine diagnostic screenings, including a complete blood count (CBC) and urinalysis • Mammograms – routine screenings • Annual routine prostate specific antigen test and/or digital rectal exam • As prescribed, FDA-approved contraceptive methods (including sterilization) for all women with reproductive capacity • Preventive care screenings and services for pregnant women • Breastfeeding (lactation) counseling and support, including costs of breastfeeding equipment • Services for prevention of obesity, heart disease, and diabetes • Routine adult immunizations 	Plan pays 100%.	No plan benefit.
• Immunizations required for foreign travel	Plan pays 100%.	
<i>Pediatric Preventive Care Services³</i>		
<ul style="list-style-type: none"> • Routine physical exams • Routine pediatric immunizations • Routine diagnostic screenings • Services for prevention of obesity and heart disease 	Plan pays 100%.	No plan benefit.
• Immunizations required for foreign travel	Plan pays 100%.	
<i>Mental Health Services</i>		
<ul style="list-style-type: none"> • Inpatient treatment² • Outpatient treatment 	You pay in-network deductible.	You pay out-of-network deductible.
<i>Substance Abuse Services</i>		
<ul style="list-style-type: none"> • Inpatient detoxification² • Inpatient rehabilitation² • Outpatient treatment 	You pay in-network deductible.	You pay out-of-network deductible.
<i>Outpatient Prescription Drugs⁴ (provided through CVS Caremark Pharmacy Network)</i>		
• Drugs purchased at a retail pharmacy	You pay in-network deductible; 30-day supply if purchased at a participating retail pharmacy/90-day supply if purchased at a CVS retail pharmacy.	No plan benefit if purchased outside of CVS Caremark Pharmacy Network.
• Drugs purchased through mail order	You pay in-network deductible; 90-day supply if purchased through CVS Caremark Mail Service Program.	No plan benefit if purchased outside of CVS Caremark Mail Service Program.
• Specialty pharmaceuticals	You pay in-network deductible if purchased from a Caremark specialty pharmacy, as directed by CVS; 90-day supply.	No plan benefit if not purchased from a Caremark specialty pharmacy, as directed by CVS Caremark.

¹Plan payments for services received from an out-of-network provider are based on the allowable charge for the type of care, service, or treatment received. If the provider's charges are more than the allowable charge, you will be responsible for paying the difference. Any of these extra amounts you have to pay will not count toward your calendar-year deductible requirement or the total annual out-of-pocket maximum.

²Precertification required. If this does not occur and it is later determined that all or part of the inpatient stay was not medically necessary or appropriate, the patient will be responsible for payment of any costs not covered.

³The schedule of covered preventive services is outlined in Highmark's *Preventive Schedule* and *Women's Health Preventive Schedule*, which are updated periodically based on changes in clinical practice guidelines.

⁴At a participating retail, specialty, or mail order pharmacy, you pay the entire cost for your prescription drug, at the discounted rate CVS Caremark has negotiated, until your calendar-year deductible requirement is met. Prior authorization is required for compound drugs costing \$300 or more, any drug costing \$5,000 or more, and all specialty pharmaceuticals.

Part I, Introduction

This summary plan description describes the medical benefits provided by the Congregational Employee Plan for Mennonite Church USA, a self-funded plan from Mennonite Church USA for eligible employees of Mennonite Church USA. It will tell you how you can be covered by the plan, how to file a claim, and other important information about how the plan works. Please read it carefully.

You have joined a church-based network of employees to provide you with an excellent package of benefits.

If you have questions about the plan or about points in the plan that aren't covered in the summary plan description, please talk to Everence Association, Inc., a fraternal benefit society (Everence), the agent of the plan, or call the Highmark Member Service number on the back of your ID card.

Claims for the plan will be handled by a claims administrator who is trained in the benefits offered by the plan. The claims administrator's name, address, and phone number are:

Highmark Blue Cross Blue Shield (Highmark)
P.O. Box 1210
Pittsburgh, PA 15230-1210
(800) 226-2239

Part II, Definitions

The following words and terms are used in this summary plan description. When used, this is what they mean:

Allowable charge — The dollar amount that Highmark has determined is reasonable for covered services provided under this plan. The amount the plan pays for covered services is based on the allowable charge, not the provider's actual charge.

Ambulatory surgical facility — A licensed public or private establishment that:

1. Has an organized medical staff of physicians;
2. Has permanent facilities to provide chiefly elective surgical care, continuous physician services, and nursing services;
3. Is properly licensed by all applicable regulatory agencies;
4. Maintains medical records for each patient;
5. Does not have facilities for patients to stay overnight; and
6. Does not exist for the purpose of terminating pregnancies.

Amwell — A program provided through Highmark to members that offers 24/7/365 (on demand) access from any location in the U.S. to a national network of physicians and pediatricians who provide virtual medical consultations to treat non-emergency conditions via telephone, computer, or mobile applications (iPhone, iPad, etc.).

Ancillary provider — Includes the following:

1. Ambulance service,
2. Clinical laboratory,
3. Diabetes prevention provider,
4. Home infusion therapy provider,
5. Independent diagnostic testing facility (IDTF),
6. Suite infusion therapy provider, and
7. Suppliers.

Calendar year — The 12-month period from Jan. 1 through Dec. 31 of any year.

Claim — A request for precertification or other approval of a covered service, or a request for payment or reimbursement of the charges or costs associated with a covered service. Claim includes the following:

1. Pre-service claim – A request for precertification or prior approval of a covered service which, under the terms of the plan, must be approved in advance of obtaining medical care.
2. Post-service claim – A request for payment or reimbursement of the charges or costs associated with a covered service a member has received.
3. Urgent Care claim – A pre-service claim where failing to make a determination quickly could seriously jeopardize an individual's life, health, or ability to regain maximum function, or, in the opinion of a physician with knowledge of the individual's medical condition, would subject the individual to severe pain that could not be managed without the

requested treatment. Any claim that a physician with knowledge of an individual's condition considers an urgent care claim becomes an urgent care claim.

Complications of pregnancy — Includes the following:

1. Conditions requiring medical treatment before or after the termination of pregnancy whose diagnoses are distinct from pregnancy, but which are adversely affected by pregnancy or caused by pregnancy, such as acute nephritis; cardiac decompensation; missed abortion; disease of the vascular, hematopoietic, nervous, or endocrine systems; and similar medical and surgical conditions of comparable severity;
2. Hyperemesis gravidarum and pre-eclampsia requiring hospital confinement, ectopic pregnancy which is terminated, and spontaneous termination of pregnancy that occurs during a period of gestation in which a viable birth is not possible;
3. An emergency or non-scheduled cesarean section; and
4. Treatment to stop premature labor and birth.

Contracting Suppliers (for the sale or lease of) — Include, but are not limited to:

1. Durable medical equipment,
2. Supplies,
3. Orthotics, and
4. Prosthetics.

Creditable coverage — Includes coverage under any of the following:

1. A group health plan;
2. Health insurance coverage;
3. Part A or Part B of Title XVIII of the Social Security Act;
4. Title XIX of the Social Security Act, other than coverage consisting solely of benefits under Section 1928;
5. Chapter 55 of Title 10, United States Code;
6. A medical care program of the Indian Health Service or of a tribal organization;
7. A state health benefits risk pool;
8. A health plan offered under Chapter 89 of Title 5, United States Code;
9. A public health plan established or maintained by a state, the U.S. government, a foreign country, or any political subdivision of a state, the U.S. government, or a foreign country that provides health coverage to individuals who are enrolled in the plan;
10. A health benefit plan under Section 5(e) of the Peace Corps Act (22 U.S.C. 2504(e)); and
11. Title XXI of the Social Security Act, State Children's Health Insurance Program (S-CHIP).

Creditable coverage does not include:

1. Coverage only for accident or disability income insurance, or any combination thereof;
2. Coverage issued as a supplement to liability insurance;
3. Liability insurance, including general liability insurance and automobile liability insurance;
4. Workers' compensation or similar insurance;
5. Automobile medical payment insurance;
6. Credit-only insurance;
7. Coverage for on-site medical clinics; and
8. Other similar insurance coverage under which benefits for medical care are secondary or incidental to other insurance benefits.

Custodial care — Any type of service that is designed to assist you or your covered dependent, whether disabled or not, in the activities of daily living. Such services include assistance in walking or getting in and out of bed, bathing, dressing, feeding, preparation of special diets, and supervision over medication that can normally be self-administered.

Deductible — The specific dollar amount you or your covered dependent must pay for eligible expenses each calendar year before benefits are payable, in whole or in part, under this plan.

Diabetes education program — An outpatient program of self-management, training, and education (including medical nutrition therapy) for the treatment of diabetes. The program must be conducted under the supervision of a licensed health care professional with expertise in diabetes.

Diabetes prevention program — A 12-month program using curriculum approved by the Centers for Disease Control to deliver a prevention lifestyle intervention for those at high risk of developing type 2 diabetes. The program includes behavioral and motivational content focusing on moderate changes in both diet and physical activity.

Diabetes prevention provider — An entity that offers a diabetes prevention program based on an in-person/onsite or digital model and that has an agreement with Highmark. If the program is based on an in-person/onsite model, the program must offer services through a participating member association which has a contract with the YMCA.

Elective surgery — A covered surgery that may be deferred and is not an emergency.

Emergency — A medical condition manifesting itself (including injuries) by acute signs or symptoms that could reasonably result in placing a covered person's life or limb in danger if immediate medical attention is not provided.

Employee — Credentialed pastors working for a participating institution and non-credentialed employees employed and paid by a participating institution, as outlined in *Part III, Section A*.

Enteral formulae — A liquid source of nutrition administered under the direction of a physician that is administered into the gastrointestinal tract either orally or through a tube and which may contain some or all of the nutrients necessary to meet minimum daily nutritional requirements. Enteral formulae is intended for the specific dietary management of a disease or condition for which distinctive nutritional requirements are identified through medical evaluation.

Experimental or investigative medical treatment — Any treatment, service, procedure, facility, equipment, drug, device, or supply (intervention) that is not determined by Highmark to be medically effective for the condition being treated. An intervention is considered to be experimental or investigative if:

1. The intervention does not have approval from the U.S. Food and Drug Administration (FDA) 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 identified above, is determined to be experimental or investigative at the time the service is rendered, it will not receive retroactive coverage, even if it is found to no longer be experimental or investigative within the above criteria at a later date.

Highmark recognizes that situations may occur when you elect to pursue experimental or investigative treatment. If you are planning to receive a service that Highmark may consider to be experimental or investigative, you, the hospital, or the professional provider may contact Highmark Member Service to determine whether Highmark considers the service to be experimental or investigative.

Facility provider — A health care institution or service that is approved by Highmark and is licensed to render health care services authorized by Highmark. Facility providers include the following:

1. Ambulatory surgical facility,
2. Birthing facility,
3. Day/night psychiatric facility,
4. Freestanding dialysis facility,
5. Freestanding nuclear magnetic resonance facility/magnetic resonance imaging facility,
6. Home health care agency,
7. Home infusion therapy provider,
8. Hospice,
9. Hospital,
10. Outpatient physical rehabilitation facility,
11. Outpatient psychiatric facility,
12. Outpatient substance abuse treatment facility,
13. Pharmacy provider,
14. Psychiatric hospital,
15. Rehabilitation hospital,
16. Residential treatment facility,
17. Skilled nursing facility,
18. Substance abuse treatment facility, and
19. Urgent care facility.

Home health care agency — An agency that specializes in giving nursing and other therapeutic services in the home. The home health care agency provides services prescribed by the covered person's attending physician in a formal treatment plan

for the individual's care. The agency must be approved as such by the state in which it is located, have a full-time administrator, and maintain a complete record on each individual.

Hospice care agency — An agency that provides counseling, medical services, and room and board to individuals and their families during the final stages of a terminal illness and during bereavement. A hospice care agency must:

1. Be licensed as such by the state in which it is located;
2. Provide services 24 hours a day, seven days a week;
3. Exist mainly to provide hospice services;
4. Be directly supervised by a physician;
5. Have a full-time administrator, a licensed social service coordinator, and a registered nurse coordinator; and
6. Maintain written records of its services provided to the patient.

Hospital — A legally operating institution that:

1. Provides — for a fee — diagnostic, medical, and surgical care and treatment of ill or injured persons;
2. Has a staff of one or more physicians on call at all times;
3. Provides 24-hour nursing services under the full-time supervision of a registered nurse (R.N.);
4. Has inpatient facilities; and
5. Is accredited as a hospital by the Joint Commission, the American Osteopathic Association, or the Commission on the Accreditation of Rehabilitative Facilities.

The term *hospital* **does not** include a clinic, rest home, extended care facility, convalescent nursing home, home for the aged, or a place that provides chiefly custodial care.

Illness — A physical or mental disorder or infirmity that interferes with normal bodily functions. It includes pregnancy and pregnancy-related conditions. It does not include any condition a member develops as the result of work for wage or profit and which is covered by workers' compensation.

Immediate family — A member's spouse, child, parent, sibling, or in-law.

Infertility — The presence of a demonstrated condition recognized by a licensed physician or surgeon that prevents conception or carrying a pregnancy to term. The inability to conceive may be due to either the male or female partner.

Injury — Bodily damage caused by accidental, unexpected, external means while this plan is in effect. It does not include injuries a member receives in connection with his or her job or any other occupation for which the member is paid (including self-employment).

Late enrollee — An eligible individual who does not enroll in the plan within his or her respective enrollment or special enrollment period.

Medically necessary and appropriate — Services, supplies, or covered medications that a provider, exercising prudent clinical judgment, would provide to a patient for the purpose of preventing, evaluation, diagnosing, or treating an illness, injury, disease or its symptoms, and that are:

1. In accordance with generally accepted standards of medical practice;
2. Clinically appropriate, in terms of type, frequency, extent, site and duration, and considered effective for the patient's illness, injury or disease; and
3. Not primarily for the convenience of the patient, physician, or other health care 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 patient's illness, injury, or disease.

Highmark reserves the right, utilizing the criteria set forth in this definition, to render the final determination as to whether a service, supply, or covered medication is medically necessary and appropriate. No benefits will be provided under this plan unless Highmark determines that the service, supply, or covered medication is medically necessary and appropriate.

Medicare — Title XVIII of the Social Security Act of 1965 as amended.

Member — Any employee or dependent who meets all applicable eligibility requirements, as outlined in *Part III*, and is enrolled in and receiving benefits under this plan.

Mental illness — A neurosis, psychoneurosis, psychopathy, psychosis, or mental or emotional disease or disorder of any kind that is generally believed in the medical community to be treatable.

National BlueCard® Preferred Provider Organization (PPO) Network — A network of physicians, hospital or facility providers, professional providers, and other health professionals or facilities that have contracted to provide covered

medical, mental health, or substance abuse treatment, services, and supplies at negotiated fees under the Highmark Blue Cross Blue Shield Preferred Provider Organization Program.

Network provider — An ancillary provider, professional provider or facility provider furnishing medical services and supplies as part of the Highmark Blue Cross Blue Shield Preferred Provider Organization (PPO) Program. Eligible network providers include facilities, general practitioners, internists, obstetricians/gynecologists, and a wide range of specialists.

You may call (800) 810-BLUE (2583) or go to the Blue Cross Blue Shield website at www.bcbs.com, choose the “Find a Doctor or Rx” tab and click on “Find a doctor, hospital or other medical provider” to locate the network provider nearest you or to verify that your current provider is in the network.

Using a network provider when receiving medical treatment, services, or supplies assures that members receive maximum benefits under this plan.

Other coverage — The amount of any benefits paid or value received from other insurance or benefit plans for the same loss.

Partial hospitalization — A distinct and organized intensive ambulatory treatment service. It is less than 24-hour daily care specifically designed for the diagnosis and active treatment of an individual’s mental illness or substance abuse (as defined in this document) when there is a reasonable expectation for improvement or to maintain the individual’s functional level and to prevent relapse or hospitalization. It may include day, night, evening, or weekend care. This intensive ambulatory psychiatric treatment includes the major diagnostic, medical, psychiatric, psychosocial, and prevocational treatment modalities usually found in a comprehensive hospital program. Partial hospitalization may include group and family therapies, individual therapy, pharmacotherapy, psychodrama, and occupational/recreational therapies in a distinct, structured therapeutic environment. Partial hospitalization operates in a hospital, is medically supervised, and is at least three hours in duration per patient visit. Admission to or release from partial hospitalization must be approved by a qualified physician.

Participating institution — A conference office or congregation that is enrolled in and participating in this plan.

Physical medicine — When prescribed by a physician, the medically necessary and appropriate outpatient treatment of illness or injury by physical agents such as heat, cold, light, electricity, or the use of mechanical devices. The intention of treatment is restoration or maintenance, not enhancement, of bodily function. Physical medicine includes, but is not limited to:

1. Physical therapy,
2. Cognitive therapies,
3. Biofeedback, and
4. Sports medicine.

Physical medicine does not include:

1. Membership fees for exercise facilities and health spas;
2. Payment for exercise-type equipment;
3. Spinal manipulations; or
4. Treatment programs not administered by a professional provider.

Physician (doctor) — A person legally qualified and licensed to practice medicine or osteopathy. This definition does not include you, a member of your immediate family, or co-workers.

Plan — The Congregational Employee Plan for Mennonite Church USA which provides coverage for employees of participating institutions of Mennonite Church USA and their dependents who:

1. Meet the eligibility requirements outlined in *Part III*; and
2. Are enrolled in the plan.

Plan administrator — The person or entity that maintains the records of the plan, administers the plan, has discretionary authority to interpret the provisions of the plan, and makes all decisions necessary or proper to carry out the terms of the plan. The plan administrator may delegate its responsibilities to other persons or entities. The plan administrator for this plan is Mennonite Church USA.

Plan year — The plan’s fiscal year. It is the 12-month period beginning each Jan. 1 and ending the following Dec. 31.

Precertification — The process through which certain services are pre-approved by Highmark and the member is covered for services.

Preferred Provider Organization (PPO) Program — A program based on a provider network made up of physicians, specialists, hospitals, and other health care facilities. Using this provider network helps assure that members receive maximum coverage for eligible services.

Prescription drug — A drug or compound that can only be purchased with a physician's prescription from a legally licensed pharmacist.

Pre-transplant stabilization — An inpatient stay to medically stabilize a covered person for purposes of, or preparation for, a later transplant, whether or not the transplant occurs.

Professional provider — A person, practitioner, or entity engaged in the delivery of health services and licensed or certified, when required, to perform services within the scope of such licensure or certification. Professional providers include the following:

1. Audiologist,
2. Certified registered nurse*,
3. Certified registered nurse midwife,
4. Certified registered nurse practitioner (CRNP),
5. Chiropractor,
6. Dentist,
7. Dietician-nutritionist,
8. Licensed practical nurse,
9. Licensed social worker,
10. Marriage and family therapist,
11. Naturopathic physician,
12. Occupational therapist**,
13. Optometrist,
14. Physical therapist,
15. Physician,
16. Physician's assistant,
17. Podiatrist,
18. Professional counselor,
19. Psychologist,
20. Registered nurse,
21. Respiratory therapist**,
22. Speech-language pathologist,
23. Teacher of the hearing impaired.

*Excluded from eligibility are registered nurses employed by a health care facility or by an anesthesiology group.

**Covered services must be prescribed by a physician. Services of an occupational therapist and respiratory therapist are only reimbursable through a facility provider.

Qualified Medical Child Support Order (QMCSO) — A medical child support order that:

1. Creates or recognizes the existence of a child's right to, or assigns to a child, the right to receive benefits for which a participant is eligible under the plan;
2. States the name and last known mailing address of the participant and the name and mailing address of each child (alternate recipient) covered by the order;
3. Contains a reasonable description of the type of coverage to be provided;
4. Specifies the period to which such order applies;
5. Identifies the plan to which such order applies; and
6. Does not require the plan to provide any type or form of benefit or any option not otherwise provided under the plan, except to the extent necessary to meet the requirements of a state law as described in Section 1908 of the Social Security Act, as added by Section 13822 of the Omnibus Budget Reconciliation Act of 1993.

Spouse — The individual legally married to the employee (as determined under applicable laws of the state in which the marriage was validly entered into, regardless of the current state of domicile) while the employee is enrolled in this plan. *Spouse* does not include an individual who is legally separated from the employee.

Substance abuse — Any use of alcohol or other drugs that produces a pattern of pathological use causing impairment in social or occupational functioning or produces physiological dependency evidenced by physical tolerance or withdrawal.

Transplant — One complete series of a transplant including the pre-transplant evaluation, harvesting, stabilization, and the transplant itself. It does not include a second transplant if the first was not successful.

Urgent care facility — A freestanding facility that:

1. Is engaged primarily in providing minor emergency and episodic medical care to a member;
2. Is either accredited by the Joint Commission or licensed by the state in which it is located;
3. Includes x-ray and laboratory equipment and a life support system as part of the facilities; and
4. Is not located on or in conjunction with and is not in any way a part of a regular hospital.

You, your — The employee working for or employed and paid by a participating institution who is enrolled in this plan and to whom this summary plan description is issued.

Part III, Participation — Who Can Be Covered

A. Employees

You can be covered by this plan if you are a:

1. Pastor of a participating institution (see definition in *Part II*) who is:
 - a. Credentialed for ministry (ordained, licensed toward ordination, or licensed for specialized ministry) by an area conference of Mennonite Church USA or by a recognized and approved credentialing process as determined by the plan sponsor for pastors of participating institutions that are not formally affiliated with Mennonite Church USA; and
 - b. Working at least 20 hours per week in ministry to the congregation; **or**
2. Non-credentialed employee of a participating institution who is employed and paid for at least 30 hours per week.

Non-credentialed employees of participating institutions who were enrolled in the Congregational Employee Plan for Mennonite Church USA on Dec. 31, 2009, and regularly paid for at least 20 but less than 30 hours per week at that time may continue enrollment in this plan until employment ends or the number of hours of employment is reduced to less than 20 hours per week, whichever occurs first.

To be covered by this plan, you must follow all enrollment procedures outlined in *Part IV*.

FMLA Leave

Under any leave of employment that qualifies under the Family and Medical Leave Act of 1993 (FMLA), your coverage will be maintained under the plan on the same conditions as coverage would have been provided if you had been continuously working. This means that the same level of benefits and type of coverage available to similarly situated working employees will be available to you. You must pay the same level of premium contribution you were paying as an active employee.

If you do not return to work as an active employee working the applicable minimum employment requirement for non-credentialed employees and credentialed pastors listed above and performing the normal duties of your job on the first business day that follows the end of an FMLA leave, coverage under this plan will terminate, unless you elect continuation of coverage (see *Part XV*).

Sabbaticals

You remain eligible for coverage if you are on a sabbatical approved by your participating institution according to the participating institution's written sabbatical policy in effect at the time of the sabbatical. The terms of the sabbatical must be within the Mennonite Church USA sabbatical guidelines in effect at the time of the sabbatical and the employee must agree to provide a minimum one year of service to the congregation following the sabbatical, as indicated in the Mennonite Church USA sabbatical guidelines.

If you do not return to work as an active employee working the applicable minimum employment requirement for non-credentialed employees and credentialed pastors listed above and performing the normal duties of your job on the first business day that follows the last day of an approved sabbatical, coverage under this plan will terminate, unless you elect continuation of coverage (see *Part XV*).

Military Leave

Employees and their dependents who are covered under this plan on the day the employee leaves employment for military service will have plan rights as mandated by the Uniformed Services Employment and Re-employment Rights Act (USERRA). These rights include the following:

1. The right to elect up to 24 months of extended plan coverage beginning on the day the employee would otherwise lose plan coverage because of entering military service*; and

2. Immediate plan coverage with no pre-existing conditions waiting periods or exclusions applied when the employee is re-employed by the participating institution upon return from military service, except for injuries or illnesses determined by the Secretary of Veterans' Affairs to have been incurred or aggravated during military service.

*If the period of military service is 30 days or less, the employee is responsible to pay the same level of premium contribution he or she was paying as an active employee. If the period of military service is 31 days or more, the employee is responsible to pay the entire cost of coverage plus a reasonable administration fee.

This provision is mandated by the Uniformed Services Employment and Re-employment Rights Act (USERRA) for all public and private employers. For more information, contact the plan administrator.

B. Dependents

As long as you are covered under this plan, your dependents may also be covered by the plan if all eligibility and enrollment requirements in *Part III* and *Part IV* have been met. A *dependent* is:

1. Your spouse (see definition in *Part II*), provided you are not divorced or legally separated;
2. Your children** under the age of 26. Your child's marital status, financial dependency, employment, residency, student status, or voluntary service status will not be considered in determining eligibility for plan coverage to age 26.
3. Any biological or legally adopted children of your dependents as defined in #2 as long as they are principally dependent on you for support and maintenance. You may be required to provide proof of this support.

A dependent also includes a child for whom you are required to provide medical coverage pursuant to a Qualified Medical Child Support Order (see definition in *Part II*).

**For the purposes of plan coverage, the word *children* means your biological children, children placed in your home for adoption, or stepchildren who meet the age requirements. The word *children* also includes a minor for whom you have accepted legal guardianship.

To be eligible for dependent coverage, proof that dependents meet the above definition may be required.

C. Dependents Who Are Disabled

Dependents who are physically or mentally disabled can continue to be covered under this plan after they reach age 26 if all of the following conditions apply:

1. Because of the disability, the child is not able to earn a living;
2. The child must have become disabled before his or her 26th birthday;
3. The child must be entirely dependent on you for support and maintenance; and
4. You provide Everence with a written notice from your physician that documents your child's disability within 30 days after your child's 26th birthday.

After the child's 26th birthday, Everence may ask you to provide written proof from your physician once a year certifying your child's continuing disability. You will have to pay the full cost of any required proof or certification.

The premium charged for a disabled dependent will be the same as any other adult covered person age 26 or older who is not an employee.

Plan coverage for a disabled dependent will continue as long as you are covered by the plan or until the earliest of the following events:

1. Your child is no longer disabled;
2. Your child is no longer entirely dependent on you for support and maintenance;
3. You do not provide proof of your child's continuing disability when Everence asks for it; or
4. Your child gets married.

D. Dependents of Medicare Enrollees

If you, as an eligible employee, terminate coverage in this plan and enroll in Medicare as your primary coverage, your eligible dependents may remain enrolled in this plan as long as you continue to be an employee otherwise eligible for coverage under the plan.

If you are already enrolled in Medicare as your primary coverage when you first become eligible for coverage under this plan and you choose to remain enrolled in Medicare as your primary coverage, your eligible dependents may enroll in this plan.

If you are enrolled in Medicare as your primary coverage and any of your dependents become eligible for Medicare while they are enrolled in the plan under this provision, they must also enroll in Medicare as their primary coverage unless they have other rights under the Medicare Secondary Payer Law.

E. General Provisions

If more than one family member works for a participating institution, plan benefits will be identical to those you would receive if only one family member works for a participating institution. If both you and your spouse are employees of the same participating institution, your children will be enrolled either as your dependents or your spouse's dependents but not under both.

It is very important for Everence to have correct, up-to-date information about you and your dependents. **Be sure to let Everence know when your address or any other personal information changes that may affect your coverage**, such as your marital status, the number of your dependents, their names and birth dates, etc. Changes must be reported to Everence within 30 days following the change. This information helps ensure that all individuals are properly enrolled and have the appropriate coverage.

Part IV, Enrollment — When Coverage Starts

A. When Coverage Begins

Coverage begins for employees and their dependents (if properly enrolled when first eligible for coverage) as follows:

1. For employees and dependents enrolling at the time of an employer's initial group formation, on the date of the formation.
2. For new employees (and their dependents) hired after initial group formation who are not transferring coverage from another participating institution, on the first day of employment.
3. For new employees (and their dependents) hired after initial group formation who are transferring coverage from another participating institution, on the first day of the month following the first day of employment.
4. For dependents added later as a result of marriage, birth, or adoption, on the first day they qualify as a dependent. See *Section C* in this *Part IV*.

B. Initial Enrollment

In order to be covered by this plan, you must enroll yourself and each of your qualified dependents (if you want dependent coverage) by completing and returning the *Employee Enrollment for Health Coverage* form to Everence. If you are not enrolling someone in your family who is eligible for coverage, you must complete the waiver section of the *Employee Enrollment for Health Coverage* form.

You and your dependents can enroll in the plan as part of the hiring process or any time within the 90-day enrollment period that immediately follows your first day of employment. You will not have to provide proof of good health if you and your dependents enroll within this 90-day enrollment period.

C. Enrolling New Dependents

New dependents can be enrolled in the plan any time during the 90-day enrollment period that immediately follows the date a dependent first becomes eligible for coverage through birth, placement for adoption, adoption, or marriage.

Coverage for new dependents added through marriage begins on the day of marriage if they are enrolled in the plan within the 90-day enrollment period and additional premium is paid, if required.

Coverage for a newborn child begins on the day of birth if the newborn is enrolled in the plan within the 90-day enrollment period that immediately follows the day of birth and additional premium is paid, if required.

Coverage for a newly-adopted child begins on the earlier of the date of adoption or placement in your home if the newly-adopted child is enrolled in the plan within the 90-day enrollment period that immediately follows the date of adoption or placement for adoption and additional premium is paid, if required.

You can enroll new dependents in the plan by contacting Everence. If you are already enrolled in the plan when you add your first dependent, you will get a new ID card showing your dependent coverage.

D. Special Enrollment Periods

Waiver of Coverage

If you and/or your dependents are eligible for coverage under this plan but waive coverage due to enrollment in other creditable coverage (see definition in *Part II*), you and/or your dependents may enroll in this plan later without being considered a late enrollee if employer contributions toward the other creditable coverage terminate or if eligibility for the other creditable coverage ends as a result of:

1. Termination of employment;
2. Involuntary termination of the other health plan;
3. Reduction in the number of hours of employment;
4. Legal separation, divorce, or death of a spouse;
5. Discontinuance of dependent coverage by the other health plan; or
6. Marriage.

You and/or your dependents must enroll in this plan within the 90-day special enrollment period that immediately follows the day the other creditable coverage ends (or employer contributions terminate). You will not have to provide proof of good health if you and/or your dependents enroll within the 90-day special enrollment period.

The effective date of coverage for an eligible individual who loses other creditable coverage will be the day after the other creditable coverage ends (or employer contributions terminate) as long as he or she enrolls in the plan within the 90-day special enrollment period.

You must inform Everence and complete the waiver section of the *Employee Enrollment for Health Coverage* form if you are waiving coverage for yourself or any dependent.

Special Enrollment Period When New Dependents Become Eligible for Coverage

An eligible employee who has not enrolled in the plan, can also enroll at the same time a new dependent becomes eligible for coverage through marriage, birth, or adoption. Both the employee and the new dependent must enroll within the 90-day special enrollment period that immediately follows the date the new dependent becomes eligible to enroll in the plan.

Similarly, an eligible spouse who has not enrolled in the plan can enroll at the same time as a newborn or newly-adopted child. Both the spouse and the new dependent must enroll within the 90-day special enrollment period that immediately follows the date the new dependent becomes eligible to enroll in the plan.

The effective date of coverage will be the date of marriage, birth, placement for adoption, or adoption, whichever is relevant.

Special Enrollment Periods Required by the Children's Health Insurance Program (CHIP) Reauthorization Act of 2009

If you and/or your dependents are eligible for coverage under this plan but waive coverage because you and/or your dependents are enrolled in Medicaid or a state Children's Health Insurance Program (CHIP), you and/or your dependents may enroll in this plan later without being considered a late enrollee if Medicaid or CHIP coverage ends because of loss of eligibility.

In addition, if you and/or your dependents are eligible for coverage under this plan but choose not to enroll, you and/or your dependents may enroll in this plan later without being considered a late enrollee if you and/or your dependents become eligible for a state group health plan premium assistance subsidy under Medicaid or CHIP which provides help in paying for coverage under this plan.

You and/or your dependents must enroll in this plan within the 90-day special enrollment period that immediately follows the date coverage under Medicaid or CHIP terminates or the date it is determined that you and/or your dependents are eligible for a state premium assistance subsidy, whichever applies.

The effective date of coverage will be the day after Medicaid or CHIP coverage terminates or the date you and/or your dependents become eligible for the state premium assistance subsidy, whichever applies.

E. Change in Hours

If you are already an employee of a participating institution, but have not been eligible for plan coverage, you may enroll immediately following your first eligibility. For example, if you are a credentialed pastor and increase your hours so you work at least 20 hours per week on a regular basis or if you are a non-credentialed employee and increase your hours so you are paid for at least 30 hours per week on a regular basis, you are eligible for plan coverage.

You and your eligible dependents can then enroll in the plan during the 90-day enrollment period that immediately follows your change in hours. As long as you enroll in the plan during the 90-day enrollment period, you do not have to provide proof of good health. Coverage will be effective on the same day as your change in hours.

F. Late Enrollment

Any eligible individual who does not enroll in the plan within his or her respective 90-day enrollment or special enrollment period becomes a late enrollee. A late enrollee has the following opportunities to enroll in the plan:

Annual Open Enrollment Period

A late enrollee is eligible to enroll in the plan during the annual open enrollment period. Late enrollees who enroll during the annual open enrollment period do not need to provide proof of good health and may not be denied coverage if all eligibility and enrollment requirements are met.

The annual open enrollment period begins Nov. 1 and ends Dec. 31. Coverage for a late enrollee who enrolls during the open enrollment period will be effective Jan. 1.

Proof of Good Health

In addition, a late enrollee age 19 or older may enroll in the plan outside of the annual open enrollment period if the individual provides proof of good health and is approved for coverage by Everence. To facilitate the determination of good health, the late enrollee must complete and submit a *Statement of Physical Condition* with the enrollment form. Everence will notify the late enrollee in writing when the approval process is completed and if the late enrollee has been approved for coverage. If approval is granted, coverage will be effective the first day of the month that follows the date the individual is approved for coverage. If, in the approval process, the late enrollee is required to obtain records from a physician or the late enrollee is required to have a physical exam, the late enrollee is responsible for the cost.

A late enrollee who is denied enrollment in the plan will need to wait until the next open enrollment period to enroll in the plan, unless the individual experiences a qualifying event for special enrollment, as outlined above in *Section D* of this *Part IV*.

Part V, Basis of Coverage — What Coverage Costs

This plan is currently funded by contributions made by participating institutions and employees. Each participating institution will contribute at least 50 percent of total funding for employees and dependents covered under the plan. All payments are the responsibility of each participating institution. The participating institution is responsible for informing employees of their premium contribution share. This information must be on file with Everence. The employee's premium contribution share is to be paid to the participating institution. Everence will notify participating institutions monthly of premium contributions due.

Plan participants who elect continuation of coverage (see *Part XVI*) must pay the entire cost of their coverage.

Employees who continue coverage during a leave of absence that qualifies under the Family and Medical Leave Act of 1993 (FMLA) or an approved sabbatical must pay the same level of premium contribution they were paying as an active employee.

Plan participants who extend plan coverage while on military leave (see *Part III, Section A*), must pay the same level of premium contribution they were paying as an active employee if the period of military service is 30 days or less. For periods of military service that exceed 30 days, the plan participant must pay the entire cost of coverage plus a reasonable administrative fee.

In addition to these contributions, all plan participants are responsible for paying:

1. Deductibles;
2. Charges that exceed the allowable charge, when receiving services from an out-of-network provider; and
3. Charges for care, services, treatment, and supplies not covered by the plan.

Part VI, How Your Health Coverage Works

You need to know:

1. If you receive care from an out-of-network provider, plan payments for provider services are based on the allowable charge which is the dollar amount Highmark Blue Cross Blue Shield has determined is reasonable for the care, service, or treatment received by a member.

If the provider charges are more than the allowable charge, the member will be responsible for payment of the difference. Any of these extra amounts the member is required to pay will not count toward the calendar-year deductible requirement or the total annual out-of-pocket maximum.

2. The plan does not pay charges for treatment of an illness or injury a member may receive or develop as the result of any work for wage or profit (including self-employment). This provision applies to any illness or injury covered by workers' compensation, occupational disease, or similar law. However, if specific coverage for such an illness or injury is not in effect and is not required by law, this plan will cover eligible charges for treatment of the illness or injury.

A. Calendar-year Deductible

The calendar-year deductible is the specific dollar amount you are required to pay for covered services each calendar year before the plan pays for all or a portion of the remaining expenses. Deductibles for single (self-only) and family coverage are listed in the *Schedule of Benefits*. You are responsible for paying all of the charges to which the deductible applies until you have paid the deductible requirement.

If you are the only person covered under this plan, you have met your deductible when you have paid eligible expenses equal to the deductible for single (self-only) coverage listed in the *Schedule of Benefits*.

If your family is covered under this plan, you have met your deductible when the combined eligible expenses you have paid for all covered family members is equal to the deductible for family coverage listed in the *Schedule of Benefits*. **If only one family member has medical expenses, that person must meet the entire deductible for family coverage before benefits are payable by the plan.**

Your deductible requirement remains as listed in the In-Network column in the *Schedule of Benefits* if you or your dependents receive care from network providers. If you or your dependents receive care from out-of-network providers, your deductible requirement will be the amount listed in the Out-of-Network column in the *Schedule of Benefits*.

Only expenses eligible under this plan can be applied toward meeting the deductible requirement.

The accumulation period for the deductible amount is a calendar year, beginning Jan. 1 and ending the following Dec. 31.

B. Total Annual Out-of-Pocket Maximum

The total annual out-of-pocket maximum is the total amount (deductible) you must pay for eligible health care expenses each calendar year before the plan begins to pay 100 percent of all additional eligible health care expenses for the remainder of the calendar year. The total annual out-of-pocket maximum is listed in the *Schedule of Benefits*. The total annual out-of-pocket maximum does not include expenses for care, services, treatment, and supplies not covered by the plan or amounts in excess of the provider's allowable charge.

C. Maximum Benefits

The benefits provided by this plan are not subject to an overall calendar-year or lifetime dollar maximum for any covered person.

Some benefits have calendar-year maximum limits on the number of days or number of services covered by this plan. These maximums are listed in the *Schedule of Benefits* and described in *Part IX*.

Part VII, Preferred Provider Organization Program

Your health coverage under this plan is arranged through the Highmark Blue Cross Blue Shield Preferred Provider Organization (PPO) Program. The PPO program allows you to get the medical care you want from the provider you select. When you or a covered dependent need medical care, you can choose between two levels of health care services – network care or out-of-network care.

Whether you or your covered dependents choose network care or out-of-network care, you are responsible to contact Healthcare Management Services (HMS) to precertify the patient's care or verify that the provider has precertified the care according to the precertification requirements outlined in *Part VIII*. The provider will not automatically do this for you.

A. Benefits When Choosing Network Care

Network care is care you receive from providers in the national BlueCard® PPO network. This network includes physicians, a wide range of specialists, community and specialty hospitals, mental health and substance abuse providers, and laboratories in your community and across the country. You and your covered dependents must select a provider in the national BlueCard® PPO network in order to receive the maximum benefits payable under this plan.

When you choose a provider in the national BlueCard® PPO network, your deductible remains as listed in the In-Network column in the *Schedule of Benefits*. The network provider will submit the claim for you.

You may call (800) 810-BLUE (2583) or go online at www.highmarkbcbs.com, choose the “Find a Doctor or Rx” tab and click on “Find a doctor, hospital or other medical provider” to locate the network provider nearest you or verify that your current provider is in the network.

B. Reduced Benefits When Choosing Out-of-Network Care

Out-of-network care is care you receive from providers that are not in the national BlueCard® PPO network.

If you or your covered dependents receive out-of-network care for services other than preventive care services or emergency services provided by a hospital, emergency room, or ambulance, even if you are referred to an out-of-network provider by a network provider, benefits will be reduced. The deductible requirement will be two times the amount listed in the In-Network column in the *Schedule of Benefits*. You will also be responsible to pay all charges that exceed the allowable charge for eligible services received.

If you or your covered dependents receive preventive care services (other than immunizations required for foreign travel) from a provider outside the PPO network, there are no plan benefits and you will be responsible to pay the charges. Immunizations required for foreign travel are paid by the plan as an in-network benefit, even if provided by an out-of-network provider.

If you or your dependents receive out-of-network care, you are still responsible to follow all precertification requirements outlined in *Part VIII*. You are also responsible to make sure a claim form is completed and submitted to the address on your ID card.

C. Out-of-Area Care

The PPO program also covers care when you or your covered dependents are traveling or otherwise away from home. Services received from providers across the country who are part of the national BlueCard® PPO network will be paid at the in-network benefit level. If you receive services from an out-of-network provider, benefits will be reduced as outlined in *Section B* above.

You or your dependents do not need to receive care through a network provider in the event of an emergency or if urgent injury or illness occurs. In this case, you should seek treatment from the nearest hospital or emergency room.

If the illness or injury is not a true emergency and you receive care from an out-of-network provider, benefits will be reduced as outlined in *Section B* above.

If the illness or injury is a true emergency, eligible services received will be paid as in-network benefits, regardless of whether the provider is a network provider. If the treatment results in an inpatient admission, you are responsible to contact Healthcare Management Services (HMS) at the precertification number on your ID card to precertify the patient’s care according to the precertification requirements outlined in *Part VIII*. This must be done within 48 hours after the emergency admission.

If emergency treatment is being provided by a hospital or other facility provider outside the national BlueCard® PPO network, the patient may be required — when medically appropriate — to transfer to a hospital or facility provider that is part of the PPO network.

If you or your dependents do not transfer to a provider that is part of the PPO network as requested when medically appropriate, benefits will be reduced as outlined in *Section B* above.

D. Blue Cross Blue Shield Global Core Program

When you travel abroad, your coverage travels with you. The Blue Cross and Blue Shield symbols on your ID card are recognized around the world. The PPO program provides all of the services of the Blue Cross Blue Shield Global Core

Program. These services include access to a worldwide network of health care providers. Medical assistance services are also provided. You can access these services by calling (800) 810-BLUE (2583) or logging onto www.bcbsglobalcore.com.

The Blue Cross Blue Shield Global Core Program provides the following services to members:

1. Making referrals and appointments for you with nearby physicians and hospitals;
2. Verbal translation from a multilingual service representative;
3. Providing assistance if special help is needed;
4. Making arrangements for medical evacuation services; and
5. Processing inpatient hospitalization claims.

For outpatient or professional services received abroad, you should pay the provider, then complete a Blue Cross Blue Shield Global Core International claim form and send it with the provider's itemized bill(s) to the Service Center address on the claim form to initiate claims processing. The claim form is available from Highmark, the Service Center, or online at www.bcbsglobalcore.com. For assistance with submission of claims, call the Service Center at (800) 810-BLUE (2583) or call collect at (804) 673-1177, 24 hours a day, seven days a week.

E. Outpatient Prescription Drugs

Pharmacies are not part of the national BlueCard® PPO network. See *Part IX, Section P*, of this summary plan description for guidelines when purchasing outpatient prescription drugs.

Part VIII, Precertification and Claims Management

In order for benefits to be paid under this plan, the services, treatment, or supplies must be considered medically necessary and appropriate. Healthcare Management Services (HMS), a division of Highmark Blue Cross Blue Shield, is responsible for determining that care is medically necessary and provided in the appropriate setting.

This plan requires that you notify HMS in advance if you or your covered dependents need inpatient care. You can contact HMS at the toll-free Member Service number on the back of your ID card.

Through this process HMS can help reduce costs without sacrificing the quality of care. All rules and guidelines for this are given below. Please read all the instructions carefully.

Whether you are admitted to a network facility or an out-of-network facility, you are responsible to contact HMS to precertify the patient's care or verify that the provider has precertified the care. The provider will not automatically do this for you.

A. Initial Precertification of Hospitalization and Other Inpatient Treatment

You or your representative must notify HMS **7-10 days** prior to any non-emergency planned admission to an inpatient facility, including a:

1. Hospital (including admission for treatment of mental illness or substance abuse);
2. Skilled nursing facility;
3. Rehabilitative center; or
4. Other inpatient facility.

You need to notify HMS **within 48 hours** or as soon as reasonably possible following an emergency admission to any inpatient facility.

You do not need to notify HMS prior to an inpatient admission for delivery of a child if the inpatient stay is no longer than 48 hours for a vaginal delivery or 96 hours for a cesarean delivery. If the inpatient admission extends beyond 48 hours for a vaginal delivery or 96 hours for a cesarean delivery, you must notify HMS in advance of the extended stay.

HMS must be notified of any inpatient admission required for pre- or postnatal care not directly related to the delivery of a child.

An HMS nurse will complete a review of the request for inpatient admission to ensure it is:

1. Appropriate for the symptoms and diagnosis or treatment of the patient's condition, illness, disease, or injury;
2. Provided for the patient's diagnosis or the direct care and treatment of the patient's condition, illness, disease, or injury;
3. Not primarily for the convenience of the patient or the health care provider;
4. In accordance with standards of good medical practice; and

5. The most appropriate supply or level of service that can safely be provided to the patient. When applied to hospitalization, this means the patient requires acute care as an inpatient due to the nature of services required for the patient's condition and the patient cannot receive safe or adequate care as an outpatient.

B. HMS Care/Utilization Review Process

In order to assess that care is provided in the appropriate setting, HMS administers a care utilization review program comprised of prospective, concurrent, and/or retrospective reviews. In addition, HMS assists hospitals with discharge planning. These review procedures are as follows:

Prospective Review

Prospective review, also known as precertification or pre-service review, begins upon receipt of treatment information. After receiving the request for inpatient admission, HMS:

1. Reviews available information regarding the patient's eligibility for coverage and/or availability of benefits;
2. Reviews the information provided, including patient demographics, diagnosis, and plan of treatment;
3. Assesses whether the inpatient stay is medically necessary and appropriate for the symptoms and diagnosis or treatment of the patient's condition, illness, disease, or injury;
4. Authorizes care or refers the request to a physician advisor for determination; and
5. Assigns an appropriate length of stay for the inpatient admission.

Concurrent Review

Concurrent review may occur during the course of ongoing inpatient treatment to assess the medical necessity and appropriateness of the length of stay and level of care. HMS will:

1. Review the patient's progress and ongoing treatment plan with the facility staff; and
2. Decide, when necessary, to either:
 - a. Extend the patient's care;
 - b. Offer an alternative level of care; or
 - c. Refer to the physician advisor for a decision.

This plan will not pay for an inpatient stay that extends beyond the number of days HMS has initially authorized — unless the attending physician requests extension of an authorized stay and HMS determines the extended stay is medically necessary and appropriate.

Discharge Planning

Discharge planning is a process that begins prior to the patient's scheduled inpatient admission. HMS will work with the patient, the patient's family, the attending physician, and hospital staff to help plan and coordinate the patient's discharge to ensure that the patient receives safe and uninterrupted care when needed at the time of discharge.

In planning for discharge, HMS assesses the patient's:

1. Level of function pre- and post-admission;
2. Ability to perform self-care;
3. Primary caregiver and support system;
4. Living arrangements pre- and post-admission;
5. Special equipment, medication, dietary, and safety needs;
6. Obstacles to care;
7. Need for referral to case management or condition management; and
8. Psychological needs.

Retrospective Review

Retrospective review may occur when a service or procedure has been rendered without the required precertification. HMS will review the service or procedure to determine if it was medically necessary and appropriate. If it was determined not to be medically necessary and appropriate, the charges will not be covered by the plan and you will be responsible to pay the charges.

Case Management Services

If you experience a serious injury or illness, or need assistance in coordinating your care needs, the Case Management program may be able to provide assistance.

If you are accepted into the program and give your permission, the Case Management program will:

1. Work collaboratively with you, your family or significant others, and your providers to coordinate and implement a plan of care that meets your holistic needs;
2. Help identify community-based support and educational services to assist with your ongoing health care needs; and

3. Assist in the coordination of benefits and alternative resources.

C. Initial Precertification and Other Pre-Service Claims Decisions

Pre-service Claims

A precertification or other pre-service claim (see definition in *Part II*) will be decided by HMS, whether the decision is adverse or not, within a reasonable period of time appropriate to the medical circumstances involved. That period of time will not exceed 15 days from the date Highmark receives the claim. However, this 15-day period of time may be extended once for an additional 15 days if Highmark determines additional time is necessary due to circumstances beyond its control. In this case, Highmark will notify you of the extension in writing prior to the expiration of the initial 15-day pre-service claim determination period. The notification will include the reason for the delay and the date a determination is expected.

If an extension of time is necessary because additional information is needed from you to decide the precertification or other pre-service claim, the extension notice will describe the specific information you need to submit to the plan. In this event, you will be given at least 45 days from the day you receive the extension notice to provide the information before a decision is made on your precertification or other pre-service claim. When HMS receives the information, HMS will make a determination of your claim within 15 days following receipt of the information and will notify you in writing whether or not your initial precertification or other pre-service claim is approved.

Urgent Care Claims

A precertification or other pre-service claim that is an urgent care claim (see definition in *Part II*) will be decided by HMS on an expedited basis, but no later than 72 hours following receipt of the claim. If HMS is unable to make a determination because of insufficient or incomplete information, HMS will notify you within 24 hours of receipt of the claim, specifying what information is needed to complete the claim. You will be given at least 48 hours to provide the information to HMS. When the information is received, HMS will make a determination of your urgent care claim as soon as possible, but no later than 48 hours after the earlier of HMS's receipt of the information or the end of the period given to you to provide the additional information. You will be notified in writing whether or not your initial urgent care claim is approved.

In addition, the 72-hour time frame may be shortened in those cases where your urgent care claim request seeks extension of a previously approved course of treatment and the request is made at least 24 hours prior to the end of the previously approved course of treatment. In this case, HMS will make a determination of your urgent care claim request to extend the course of treatment no later than 24 hours after HMS receives your request.

D. Failure to Follow Required Precertification Procedures

If you or your authorized representative fail to follow the plan's precertification procedures when making an urgent care, precertification, or other pre-service claim, HMS will notify you of the failure and the proper procedures to be followed. Notice will be provided to you as soon as possible following the failure, but no later than five days for a precertification or other pre-service claim or 24 hours for an urgent care claim. Notification may be provided to you orally unless you or your representative request a written notice. This only applies when you fail to follow plan procedures for a precertification or other pre-service claim that:

1. Is received by the department of Highmark customarily responsible for handling benefit matters (HMS); and
2. Names a specific claimant, a specific medical condition or symptom, and a specific treatment, service, or product for which precertification is requested.

E. If an Initial Precertification and Other Pre-Service Claim is Denied

If your request for precertification or approval of a pre-service claim is denied by HMS, the written notice informing you of the denial will include information about the adverse benefit determination and your right to file an appeal, as outlined in *Part XIII*.

Everence Association, Inc. (Everence) will notify you of any initial preauthorization determination or concurrent care review that results in an adverse benefit determination, as outlined in *Part XIII, Section A*, when a request for preauthorization of specialty pharmaceuticals, compound prescription drugs costing \$300 or more, or drugs costing \$5,000 or more is denied.

The plan will not cover any charges in connection with a precertification, preauthorization, or other pre-service claim that is denied.

Part IX, Covered Services

This plan covers the allowable charges (see definition in *Part II*) for services or supplies that are medically necessary and appropriate for the treatment of an injury or illness, provided these charges are not listed under *Part X*.

All covered charges are subject to the deductible, except where noted otherwise. In addition, you are required to precertify an inpatient admission according to the precertification procedures outlined in *Part VIII*.

A. Ambulance Services

The plan covers local transportation by a specially designed and equipped vehicle used only to transport the sick and injured:

1. From the patient's home to a hospital;
2. From the scene of an accident or medical emergency to a hospital;
3. Between hospitals; or
4. Between a hospital and a skilled nursing facility.

Local transportation is covered to the closest hospital or facility that can provide services appropriate to the patient's condition.

The plan also covers local transportation by a specially designed and equipped vehicle used to transport the sick and injured:

1. From a hospital to the patient's home; and
2. From a skilled nursing facility to the patient's home.

B. Amwell Virtual Physician Visits

This plan covers Amwell virtual medical consultations provided by physicians who are part of the Amwell physician network. Amwell allows members to access Amwell physicians via telephone, computer, or mobile applications (iPhone, iPad, etc.) for most routine, non-emergency medical conditions (such as cold and flu symptoms, allergies, sinus problems, yeast or urinary tract infections, etc.). Amwell virtual physician visits are available 24 hours a day, seven days a week from any location within the United States. Through an Amwell virtual physician visit, the physician can diagnose and treat your non-emergency illness and prescribe medications when appropriate (some states may require a video visit for an Amwell physician to prescribe medications).

To access Amwell, visit the Amwell website at www.amwell.com and follow the instructions to create an account and download the mobile app. After an account is set up, a virtual physician visit with an Amwell physician may be requested by logging onto your online account through the Amwell website or the Amwell mobile app. You may also call 1-844-SEE-DOCS (1-844-733-3627) to request a virtual physician visit with an Amwell physician.

Amwell will collect payment for a virtual physician visit from you via credit card or debit card at the time the virtual physician visit is requested. The amount you are required to pay is applied toward your calendar-year deductible requirement.

C. Clinical Trials

The plan covers routine patient costs for items and services furnished to a qualified individual in connection with an approved clinical trial.

For the purposes of this provision, the following definitions apply:

Approved clinical trial is a Phase I, Phase II, Phase III, or Phase IV clinical trial that is:

1. Conducted in connection with the prevention, detection, or treatment of cancer or other life-threatening disease or condition and is federally funded through a variety of entities or departments of the federal government;
2. Conducted in connection with an investigational new drug application reviewed by the U.S. Food and Drug Administration; or
3. Exempt from investigational new drug application requirements.

Life-threatening condition is a disease or condition likely to result in death unless the course of the disease or condition is altered.

Qualified individual is a group health plan participant who is eligible, according to the trial protocol, to participate in an approved clinical trial for the treatment of cancer or other life-threatening disease or condition and either:

1. The referring health care professional is a participating provider and has concluded that the participant's participation in the clinical trial would be appropriate; or
2. The participant provides medical and scientific information establishing that the individual's participation in the clinical trial would be appropriate.

Routine patient costs include items and services covered by the plan for a plan participant not enrolled in a clinical trial. Such items and services do not include the following:

1. The investigational item, device, or service itself;
2. Items and services not included in the direct clinical management of the patient, but provided in connection with data collection and analysis; or
3. A service clearly not consistent with widely accepted established standards of care for the particular diagnosis.

D. Dental Services

The plan covers charges for the dental services listed below which are rendered by a physician or dentist and are medically necessary and appropriate:

1. Dental services required as a result of accidental injury to the jaw, sound natural teeth, mouth, or face. Injury caused by chewing or biting is not considered accidental injury.
2. Oral surgical procedures as follows:
 - a. Extraction of partially or completely unerupted bony, impacted teeth;
 - b. Extraction of teeth in preparation for radiation therapy;
 - c. Mandibular staple implant when not done to prepare the mouth for dentures;
 - d. Lingual frenectomy, frenotomy, or frenoplasty (to correct tongue-tie);
 - e. Facility provider and anesthesia services rendered in conjunction with non-covered dental procedures when determined by Highmark to be medically necessary and appropriate due to the patient's age and/or medical condition;
 - f. Treatment of accidental injury to the jaw or structures contiguous to the jaw;
 - g. Correction of a non-dental physiological condition which has resulted in a severe functional impairment;
 - h. Treatment of tumors and cysts requiring pathological examination of the jaw, cheeks, lips, tongue, roof, and floor of the mouth; and
 - i. 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.
3. Administration of anesthesia for outpatient oral surgical procedures when ordered and administered by the attending professional provider.

E. Diabetes Treatment

The plan covers the following when required in connection with the treatment of diabetes and when prescribed by a physician legally authorized to prescribe such items:

1. Equipment and supplies, such as blood glucose monitors, monitor supplies, and insulin infusion devices; and
2. Diabetes education when the attending physician certifies that the patient requires diabetes education as an outpatient and services are provided through a diabetes education program (see definition in *Part II*). The following services are covered when provided under a diabetes education program:
 - a. Medically necessary and appropriate visits upon the initial diagnosis of diabetes; and
 - b. Subsequent visits when the attending physician:
 - 1) Identifies or diagnoses a significant change in the patient's symptoms or condition that requires changes in self-management; or
 - 2) Identifies, as medically necessary and appropriate, a new medication or therapeutic process relating to the treatment and/or management of diabetes.

Outpatient diabetes education services will be covered subject to Highmark Blue Cross Blue Shield's criteria which is based on certification programs for outpatient diabetes education developed by the American Diabetes Association (ADA).

F. Diagnostic Services

The plan covers the following diagnostic services when ordered by a professional provider:

1. Computed tomography (CT), computed tomographic angiography (CTA), magnetic resonance imaging (MRI), magnetic resonance angiography (MRA), positron emission tomography (PET scan), and positron emission tomography/computed tomography (PET/CT scan);
2. Diagnostic x-rays, ultrasound, and mammography for medical purposes;
3. Diagnostic pathology consisting of laboratory and pathology tests;
4. Diagnostic medical services consisting of electrocardiogram (ECG), electroencephalogram (EEG), and other electronic diagnostic medical procedures and physiological medical testing; and
5. Allergy testing consisting of percutaneous, intracutaneous, and patch tests.

G. Enteral Formulae

The plan covers the following enteral formulae (see definition in *Part II*) when administered on an outpatient basis:

1. Amino acid-based elemental medical formulae ordered by a physician for infants and children for food protein allergies, food protein-induced enterocolitis syndrome, eosinophilic disorders, and short bowel syndrome;
2. Nutritional supplements administered under the direction of a physician for the therapeutic treatment of phenylketonuria, branched-chain ketonuria, galactosemia, and homocystinuria;
3. Enteral formulae prescribed by a physician, considered to be the sole source of nutrition and provided:
 - a. Through a feeding tube (nasogastric, gastrostomy, jejunostomy, etc.) and utilized instead of regular shelf food or regular infant formulas; or
 - b. Orally and identified as one of the following types of defined formulae with: hydrolyzed (pre-digested) protein or amino acids, specialized content for special metabolic needs, modular components, or standardized nutrients.

Once it is determined that the above criteria have been met, coverage for enteral formulae will continue as long as it represents at least 50 percent of the individual's daily caloric requirement.

Coverage for enteral formulae **does not** include the following:

1. Blenderized food, baby food, or regular shelf food;
2. Milk or soy-based infant formulae with intact proteins;
3. Any formulae, when used for the convenience of you or your family members;
4. Nutritional supplements or any other substance utilized for the sole purpose of weight loss or gain, or for caloric supplementation, limitation, or maintenance;
5. Semisynthetic intact protein/protein isolates, natural intact protein/protein isolates, and intact protein/protein isolates, when provided orally; or
6. Normal food products used in the dietary management of the disorders outlined above.

H. Home Health Care/Hospice Care Services

The plan covers the following services provided by a home health care agency, hospice care agency, or a hospital program for home health care and/or hospice care:

1. Skilled nursing services of a registered nurse or licensed practical nurse*, excluding private duty nursing services;
2. Physical medicine, occupational therapy, and speech therapy, subject to the limitations outlined in *Part IX, Section Y*;
3. Medical and surgical supplies provided by the home health care agency or hospital program for home health care or hospice care;
4. Oxygen and its administration;
5. Medical social service consultations;
6. Health aide services when the patient is also receiving covered nursing or therapy and rehabilitation services; and
7. Family counseling related to the patient's terminal condition.

*The services of a licensed practical nurse will be made available only when the services of a registered nurse are not available and only when medically necessary and appropriate. Services of a licensed practical nurse are only reimbursable through a facility provider.

Exclusions

The plan will not provide home health care/hospice benefits for the following:

1. Dietitian services;
2. Homemaker services;
3. Maintenance therapy;
4. Dialysis treatment;
5. Custodial care;
6. Private duty nursing services; and
7. Food or home-delivered meals.

I. Home Infusion and Suite Infusion Therapy Services

The plan covers services provided by a home infusion therapy and/or suite infusion therapy provider at an infusion suite or in a home setting. Covered charges include pharmaceuticals, pharmacy services, intravenous solutions, medical/surgical supplies, and nursing services associated with infusion therapy. Specific adjunct non-intravenous therapies are covered when administered only in conjunction with infusion therapy.

J. Hospital Services

The plan covers the following inpatient and outpatient services received in a hospital or other facility provider.

Covered Outpatient Hospital Services

1. Operating, recovery, treatment, and emergency rooms and equipment;
2. Outpatient emergency treatment of an accidental injury or a medical condition manifesting itself by acute symptoms that require immediate attention;
3. Whole blood, administration of blood, blood processing, and blood derivatives;
4. Medical and surgical supplies such as casts, dressings, splints, etc.;
5. X-rays, laboratory tests, and other diagnostic services prescribed by the attending physician, including outpatient pre-admission testing prior to a scheduled admission to the hospital as an inpatient;
6. Hospital services and supplies for outpatient surgery including removal of sutures, anesthesia, anesthesia supplies, and services rendered by an employee of the hospital or facility provider. Administration of anesthesia ordered by the attending physician and rendered by a professional provider other than the surgeon or assistant surgeon;
7. Surgical pathology; and
8. Outpatient therapy and rehabilitation services. Charges for occupational therapy, speech therapy, and physical medicine are subject to the limitations in *Part IX, Section Y*.

Covered Inpatient Hospital Services

1. Room and board while confined in a semiprivate room of a hospital.
2. Room and board while confined in a special care unit where intensive care to the critically ill is provided.
3. Room and board while confined in a private room of a hospital. Private room allowance is the hospital's most common daily **semiprivate** room charge for each day of confinement in a private room.
4. Other services and supplies prescribed by the attending physician, such as:
 - a. General nursing services;
 - b. Operating, delivery, treatment, and recovery rooms and equipment;
 - c. Anesthesia, anesthesia supplies, and services rendered in a hospital or facility provider by an employee of the hospital or facility provider. Administration of anesthesia ordered by the attending physician and rendered by a professional provider other than the surgeon or assistant surgeon;
 - d. Special diets;
 - e. X-rays, laboratory tests, and other diagnostic services;
 - f. Drugs and medicines;
 - g. Oxygen;
 - h. Whole blood, administration of blood, blood processing, and blood derivatives;
 - i. Medical and surgical supplies such as casts, dressings, splints, etc.; and
 - j. Therapy and rehabilitation services.

When a member is admitted to a hospital, you are responsible to contact HMS to precertify the patient's care according to the precertification requirements outlined in *Part VIII*. The hospital or attending physician will not automatically do this for you.

K. Infertility Testing and Treatment

The plan covers diagnostic testing and treatment of the underlying cause of male sterility and female infertility (see definition in *Part II*). Diagnostic procedures include, but are not limited to, sperm count, endometrial biopsy, hysterosalpingography, and diagnostic laparoscopy.

The plan does not cover treatment provided specifically for the purpose of assisted fertilization (see item #56 in *Part X*).

L. Maternity Services

The plan covers maternity charges for any member in connection with a pregnancy or complications of pregnancy (see definition in *Part II*). All eligible maternity charges, including prenatal visits, medically necessary and appropriate sonograms, delivery, postpartum care, and routine newborn care in the hospital, that are incurred on or after the effective date of coverage will be covered by the plan regardless of when the pregnancy began.

Coverage for the mother and newborn includes 48 hours of inpatient care following normal vaginal delivery and 96 hours of inpatient care following a cesarean section, as provided in the Newborns' and Mothers' Health Protection Act of 1996 which applies to this plan. The inpatient stay can be shorter if the physician, in consultation with the mother, determines that medical criteria for an earlier discharge is met.

If medical criteria for safe discharge is met and discharge occurs prior to 48 hours following normal vaginal delivery or 96 hours following a cesarean section, the plan will pay for one home health care visit within 48 hours after discharge by a licensed network health care provider whose scope of practice includes postpartum care. The home health care visit includes parent education, assistance, and training in breast and bottle feeding, infant screening and clinical tests, and the

performance of any necessary maternal and neonatal physical assessments. At the mother's request, the visit may occur at the office of the licensed network health care provider.

Physician, hospital, and testing charges are covered as described in those sections of this summary plan description. Remember to enroll the new baby in the plan within the 90-day enrollment period that immediately follows the date of birth. To do this, contact Everence.

If you are pregnant, now is the time to enroll in the Baby BluePrints® Maternity Education and Support Program offered by Highmark. See Part XVII, Section E, for more information.

M. Mental Health Care Services

The plan covers inpatient and outpatient mental health care services provided by a professional provider for treatment of mental illness if the member is confined in a hospital, residential treatment facility, or other facility provider specializing in such treatment. The plan covers the following services:

1. Inpatient hospital services provided by a hospital, residential treatment facility, or other facility provider;
2. Partial hospitalization received through a partial hospitalization program;
3. Individual psychotherapy;
4. Group psychotherapy;
5. Psychological testing;
6. Counseling with family members to assist in the patient's diagnosis and treatment;
7. Medication checks;
8. Biofeedback;
9. Medical hypnotherapy; and
10. Electroshock treatment or convulsive drug therapy, including anesthesia when administered concurrently with the treatment by the same professional provider.

Inpatient and outpatient mental health care are covered as any other illness.

When a member is admitted to a hospital, residential treatment facility, or other facility provider for inpatient treatment of mental illness, you are responsible to contact HMS to precertify the patient's care according to the precertification requirements outlined in Part VIII. The hospital, residential treatment facility, other facility provider, or attending physician will not automatically do this for you.

N. Morbid Obesity

The plan covers surgery for morbid obesity if the following conditions are met:

1. The patient must be at least 18 years of age;
2. The patient must have a five-year history of morbid obesity with weight loss attempts documented by a physician;
3. The patient's body mass index (BMI) must be 40 or greater or 35 or greater with at least two serious medical conditions exacerbated or caused by the obesity. The BMI is calculated by dividing the patient's weight (in kilograms) by height (in meters) squared; and
4. The surgery must be medically necessary and appropriate.

If the above conditions are met, the plan will also cover drug therapy in lieu of surgery, according to the terms of the prescription drug benefit in Section P. The drug therapy program must be approved by Everence and will be authorized for six months. The plan will cover an additional six months of drug therapy if documentation of weight loss monitoring is provided by the attending physician and a 10 percent weight loss has been documented at the end of the first six months. In no case will drug therapy be approved for more than 12 months.

O. Orthotic Devices

The plan covers purchase, fitting, necessary adjustment, repairs, and replacement of rigid or semi-rigid supportive devices that restrict or eliminate motion of a weak or diseased body part. Orthotic devices covered by the plan include, but are not limited to casts, splints, trusses, braces, and orthopedic shoes when part of a leg brace. The plan does not cover foot orthotic devices when not part of a leg brace.

P. Prescription Drugs

Coverage under this plan includes prescription drugs and medicines prescribed by a licensed physician in connection with the treatment of an illness or injury covered by the plan. This benefit is administered through CVS Caremark.

The plan only covers drugs available to the public with a prescription written by a physician, dentist, or practitioner licensed to do so, identified by a prescription number, and dispensed by a licensed pharmacist.

This coverage includes:

1. insulin, insulin syringes, glucose test strips, and lancets; and
2. Self-administered specialty pharmaceuticals (prior approval is required as outlined below).

Coverage does not include:

1. Over-the-counter drugs;
2. Drugs that can be purchased without a prescription;
3. Drugs used to terminate a pregnancy;
4. Drugs that are considered experimental or investigative; and
5. Drugs not approved by the U.S. Food and Drug Administration for sale in the U.S.

Preventive drug measures prescribed by a physician (including select generic statin drugs for prevention of cardiovascular disease); and oral contraceptive drugs, transdermal contraceptive patches, and contraceptive devices available only by prescription that are required to be covered by the Patient Protection and Affordable Care Act of 2010 (ACA) are covered under the Adult Preventive Care Services provision outlined in *Part IX, Section Q*.

Prescription Drug Card

You have been given a prescription drug card which allows you to purchase prescription drugs at preferred prices. To take advantage of this arrangement, you must purchase prescription drugs with your prescription drug card at participating pharmacies. You can find the nearest participating pharmacy on the CVS Caremark website, www.caremark.com. **This plan will not pay for any prescription drugs when purchased without the prescription drug card or at a non-participating pharmacy.** When you purchase prescription drugs using your prescription drug card under this plan, benefits are not coordinated with other prescription drug coverage you may have.

You may also purchase prescription drugs by mail through the CVS Caremark Mail Service Program. To sign up for this service you must complete and mail an order form to CVS Caremark at the address on the order form for your first prescription. Refills can then be ordered by calling CVS Caremark at (800) 966-5772 or following the instructions on the CVS Caremark website, www.caremark.com.

When you use your prescription drug card to purchase prescription drugs, you do not need to file a claim to receive benefits.

Compound Prescription Drugs

The plan will not cover compound prescription drugs that cost less than \$300 and include an ingredient not approved by the U.S. Food and Drug Administration.

In addition, compound prescription drugs costing \$300 or more require preauthorization through CVS Caremark to ensure the medical necessity and appropriateness of the prescription.

You or your physician may call CVS Caremark at (800) 294-5979 to determine if a specific compound drug costs \$300 or more and requires preauthorization prior to purchase at a participating pharmacy or through mail order. If a compound prescription drug requires preauthorization, your physician must obtain authorization through CVS Caremark at (800) 294-5979 prior to the dispensing of the drug. If the compound prescription drug is determined by CVS Caremark to be medically necessary and appropriate, the drug will be covered by the plan.

If you purchase a compound prescription drug that is not covered by the plan or if you do not obtain prior approval for a compound drug costing \$300 or more through CVS Caremark, there are no plan benefits and you will be responsible for the total cost of the drug.

Prescription Drugs Costing \$5,000 or More

All prescription drugs costing \$5,000 or more require preauthorization through Everence Association, Inc. (Everence) to ensure the medical necessity and appropriateness of the drug. This requirement does not apply to specialty pharmaceuticals which are required to be approved through CVS Caremark as outlined below, regardless of the cost.

You or your physician may call Everence at (800) 348-7468 to determine if a specific prescription drug costs \$5,000 or more and requires preauthorization prior to purchase at a participating pharmacy or through mail order. If a prescription drug requires preauthorization, your physician must obtain authorization from Everence at (800) 348-7468 prior to the dispensing of the drug. If the prescription drug is determined by Everence to be medically necessary and appropriate, the drug will be covered by the plan.

If you do not obtain prior approval for a prescription drug costing \$5,000 or more through Everence or if the drug is not covered by the plan, there are no plan benefits and you will be responsible for the total cost of the drug.

Specialty Pharmaceuticals

Specialty pharmaceuticals include oral, injectable, and infused medications that are biopharmaceuticals (bioengineered proteins), blood-derived products, and complex molecules. In general, specialty pharmaceuticals include, but are not limited to blood modifiers and drugs prescribed for the treatment of respiratory syncytial virus (RSV), growth hormone deficiency, Crohn's disease, hepatitis C, hemophilia, Gaucher's disease, cystic fibrosis, multiple sclerosis, rheumatoid arthritis, asthma, enzyme replacement, immune deficiencies, pulmonary arterial hypertension, and other chronic low prevalence diseases.

You may call Everence Member Services at (800) 348-7468 or (574) 533-9511 to determine if the drugs you or your covered dependent need are specialty pharmaceuticals.

You or your physician must obtain approval for all specialty pharmaceuticals through CVS Caremark at (800) 237-2767 before treatment initially begins and the drugs are purchased. You must purchase specialty pharmaceuticals from a Caremark specialty pharmacy as directed by CVS Caremark in order for the drugs to be covered by the plan.

If you do not obtain prior approval for specialty pharmaceuticals through CVS Caremark or if you do not purchase the drugs from a Caremark specialty pharmacy as directed by CVS Caremark, there are no plan benefits and you will be responsible for the total cost of the drugs.

Cost Sharing

When you purchase prescription drugs, you are responsible for paying the pharmacy in full at the time of purchase until you have met your calendar-year deductible requirement.

Maximum Quantity at Purchase

The maximum quantity you may purchase at one time when using your prescription drug card is limited to:

1. A 30-day supply – if you purchase prescription drugs other than specialty pharmaceuticals at a participating pharmacy;
2. A 90-day supply – if you purchase prescription drugs other than specialty pharmaceuticals through the CVS Caremark Mail Service Program or at a CVS retail pharmacy (a 90-day supply of prescription drugs purchased at a CVS retail pharmacy will receive mail order pricing); or
3. A 30-day supply – if you purchase specialty pharmaceuticals as directed by CVS Caremark from a Caremark specialty pharmacy.

75 percent of a prescription must be used before refill is allowed.

Q. Preventive Care Services

The schedule of covered preventive care services is outlined in Highmark's *Preventive Schedule* and *Women's Health Preventive Schedule* and is based on the requirements of the Patient Protection and Affordable Care Act of 2010 (ACA), recommendations of organizations such as Bright Futures/American Academy of Pediatrics, the U.S. Preventive Services Task Force, the Advisory Committee on Immunization Practices, and the Health Resources and Services Administration (HRSA). The schedules are updated periodically, based on changes in clinical practice guidelines. For a current schedule of covered services, log onto the Highmark member website, www.highmarkbcbs.com or call Member Service at the phone number listed on the back of your ID card. Covered preventive care services are not subject to the deductible requirement of the plan.

You must receive eligible preventive care services from a network provider for the charges to be covered by the plan. **If preventive care services (other than immunizations required for foreign travel) are received from an out-of-network provider, there are no plan benefits and you will be responsible to pay the charges.**

Adult Preventive Care Services (for adults ages 19+)

Adult preventive care services covered by the plan include, but are not limited to the following:

1. Routine physical examinations, including a complete medical history, height and weight measurement, only when performed by a network provider; and selected routine diagnostic screenings as listed in Highmark's *Preventive Schedule*, including a complete blood count (CBC) and urinalysis.
2. One routine gynecological examination per calendar year, including a pelvic and clinical breast examination, for female members, regardless of age.
3. Pap test for female members, as listed in Highmark's *Preventive Schedule*.
4. Routine mammographic screenings (only if performed by a properly certified mammography service provider) as follows:
 - a. One routine mammographic screening per calendar year for female members age 40 and over; and

- b. Routine mammographic screening as based on a physician's recommendation for all female members regardless of age.
- 5. Well-woman visits to obtain recommended preventive services, as listed in Highmark's *Preventive Schedule* and *Women's Health Preventive Schedule*.
- 6. Routine prostate cancer screening, including an annual prostate specific antigen test and/or digital rectal exam.
- 7. Immunizations and therapeutic injections required for the diagnosis, prevention, and treatment of an injury or illness. The plan covers immunizations required for foreign travel but does not cover immunizations required for employment.
- 8. Services for prevention of obesity, heart disease, and diabetes for adults with a body mass index (BMI) of 25+, as listed in Highmark's *Preventive Schedule*.
- 9. Diabetes prevention program (see definition in *Part II*) delivered by a diabetes prevention provider (see definition in *Part II*) for adults meeting certain medical criteria for having a high risk of developing type 2 diabetes, as listed in Highmark's *Preventive Schedule*.
- 10. Tobacco cessation counseling and medication.
- 11. Preventive care services, screenings, and procedures for pregnant women, as listed in Highmark's *Preventive Schedule* and *Women's Health Preventive Schedule*.
- 12. Breast-feeding (lactation) counseling and support, including costs of breastfeeding equipment.
- 13. As prescribed, risk reducing breast cancer medications (Tamoxifen or Raloxifene) for women ages 35 and older without a cancer diagnosis who are determined by their physician to be at increased risk for breast cancer and at low risk for adverse medication effects.
- 14. Preventive drug measures when prescribed by a physician, including select generic statin drugs for prevention of cardiovascular disease, as listed in Highmark's *Preventive Schedule*.
- 15. As prescribed, all FDA-approved contraceptive methods (including sterilization, oral contraceptive drugs, transdermal contraceptive patches, contraceptive injectables, contraceptive implants, and contraceptive devices) for all women with reproductive capacity, as listed in Highmark's *Women's Health Preventive Schedule*.

Pediatric Preventive Care Services (for children under age 19)

Pediatric preventive care services covered by the plan include, but are not limited to the following:

- 1. Routine physical examinations, including a complete medical history, height and weight measurement; and selected routine diagnostic screenings as listed in Highmark's *Preventive Schedule*.
- 2. Pediatric immunizations, including immunizing agents, when performed and billed by a hospital, facility provider, physician, or other professional provider. The schedule of immunizations will conform with the standards of the Advisory Committee on Immunization Practices of the Center for Disease Control and the U.S. Dept. of Health and Human Services. The plan covers immunizations required for foreign travel but does not cover immunizations required for employment.
- 3. Oral fluoride for children ages 6 months to 16 years whose primary water source is deficient in fluoride, when prescribed by a physician.
- 4. Services for prevention of obesity and heart disease for children with a body mass index in the 85th to 98th percentile, as listed in Highmark's *Preventive Schedule*.

R. Private Duty Nursing Services

The plan covers private duty nursing ordered by a physician that is provided by a registered nurse or licensed practical nurse who is not an immediate family member and who does not normally live with the member. The plan covers private duty nursing for a member:

- 1. Who is an inpatient in a hospital or other facility provider only when Highmark determines that the nursing services required are of a nature or degree of complexity or quantity that cannot be provided by the regular nursing staff; and
- 2. At home only when Highmark determines that the nursing services require the skills of a registered nurse or licensed practical nurse.

S. Professional Provider Services

The plan covers the following services received from a professional provider (see definition in *Part II*):

- 1. Medical care to any member while a hospital inpatient. The plan will cover:
 - a. Care for a medical condition by a professional provider who is not your surgeon while you are in the hospital for surgery;
 - b. Care by two or more professional providers during the same hospital stay when the nature or severity of the patient's condition requires the skills of separate physicians;
 - c. Consultation by another professional provider qualified by special training or experience when requested by the attending professional provider to help diagnose or treat the patient's condition, not including staff consultations which are required by the facility provider's rules and regulations;
 - d. Inpatient medical care visits;
 - e. Intensive medical care and treatment when the patient's condition requires it for a prolonged period of time; and

- f. Routine newborn care to examine the newborn while the mother is an inpatient.
2. Outpatient medical care visits and consultations to examine, diagnose, and treat an illness or injury.

T. Prosthetic Appliances

The plan covers the following:

1. Purchase, fitting, necessary adjustments, repairs, and replacement of prosthetic devices and supplies that replace all or part of:
 - a. A missing body organ and its adjoining tissues; or
 - b. The function of a permanently inoperative or malfunctioning body organ.
2. Initial and subsequent prosthetic devices to replace a removed breast or a portion thereof.

The plan covers the initial set of cataract lenses needed after cataract surgery but does not cover dental appliances or the replacement of cataract lenses.

U. Skilled Nursing Facility Services

The plan covers charges for room, board, and general nursing care while confined in a skilled nursing facility. Skilled nursing facility services must be ordered by a physician and determined to be medically necessary and appropriate.

Skilled nursing facility services will be covered by the plan up to 100 days per calendar year.

The plan does not cover charges for skilled nursing facility services:

1. After the patient has reached the maximum level of recovery possible for his or her specific condition and no longer requires definitive treatment other than routine supportive care;
2. When confinement in a skilled nursing facility is intended solely to assist the patient with activities of daily living or to provide an institutional environment for the patient's convenience; or
3. For treatment of mental illness or substance abuse.

When a member is admitted to a skilled nursing facility, you are responsible to contact HMS to precertify the patient's care according to the precertification requirements outlined in *Part VIII*. The skilled nursing facility or attending physician will not automatically do this for you.

V. Spinal Manipulations

The plan covers 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.

Spinal manipulations and other treatment received in conjunction with spinal manipulations are covered by the plan up to 20 visits per calendar year.

W. Substance Abuse Services

Inpatient Substance Abuse Services

The plan covers detoxification and non-hospital residential and rehabilitation therapy services received in a hospital, substance abuse treatment facility, non-hospital residential treatment facility, other facility provider, or from a professional provider for treatment of substance abuse.

Inpatient substance abuse services are covered as any other illness.

When a member is admitted to a hospital, substance abuse treatment facility, residential treatment facility, or other facility provider for inpatient treatment of substance abuse, you are responsible to contact HMS to precertify the patient's care according to the precertification requirements outlined in *Part VIII*. The hospital, substance abuse treatment facility, residential treatment facility, other facility provider, or attending physician will not automatically do this for you.

Outpatient Substance Abuse Services

The plan covers the following outpatient rehabilitation services for treatment of substance abuse provided by an outpatient hospital or substance abuse treatment facility:

1. Individual counseling;
2. Group counseling;
3. Partial hospitalization;
4. Psychotherapy;
5. Psychological testing; and

6. Family counseling.

Outpatient substance abuse services are covered as any other illness.

X. Surgical Services

A covered surgery is one that is medically necessary and appropriate and is performed by a professional provider in connection with the treatment of an illness or injury which is not work related. The plan covers charges for the following:

1. Surgery performed by a professional provider, including pre- and post-surgery visits;
2. Assistant surgeon fees, only if medically necessary and appropriate;
3. Facility charges for the operating and recovery rooms and miscellaneous medical supplies, such as dressings and bandages;
4. Anesthesia and anesthesia supplies;
5. Administration of anesthesia if ordered by the attending professional provider and administered by a professional provider other than the surgeon or assistant surgeon; and
6. Second surgical opinion provided by a consulting physician and related diagnostic services to confirm the need for recommended elective surgery. Elective surgery is covered surgery that may be deferred and is not an emergency. Please keep in mind that:
 - a. Use of a second surgical opinion is your option;
 - b. The second surgical opinion must be provided by someone other than the physician who recommended the elective surgery;
 - c. A third surgical opinion and directly related diagnostic services are covered if the first and second surgical opinions conflict;
 - d. If the consulting opinion is against elective surgery and you decide to have the elective surgery, the surgery will be covered by the plan. In this case, the patient will be eligible for a maximum of two such consulting opinions involving the elective surgical procedure in question but limited to one consultation per consultant.

When more than one surgical procedure is performed at the same time by the same professional provider, the total benefits payable by the plan will be the allowable charge for the highest paying procedure and no payment will be made for additional surgical procedures, unless approved by the plan.

Mastectomy and Reconstructive Surgery Following a Mastectomy

The plan will cover a mastectomy and breast reconstruction in connection with a mastectomy. Eligible charges include:

1. A mastectomy performed on an inpatient or outpatient basis. If the mastectomy is performed on an inpatient basis and discharge occurs within 48 hours after admission for a mastectomy, the plan will cover one home health care visit within 48 hours after discharge, as determined necessary by the attending physician.
2. Reconstruction of the breast on which the mastectomy was performed, including initial and subsequent prosthetic devices to replace the removed breast or portions thereof.
3. Surgery and reconstruction of the other breast to produce a symmetrical appearance. This includes, but is not limited to, augmentation mammoplasty, reduction mammoplasty, and mastopexy.
4. Treatment of physical complications of all stages of the mastectomy, including lymphedemas.

The benefits under this provision will be provided in a manner determined in consultation with the attending physician and the patient, and as provided in the Women's Health and Cancer Rights Act of 1998 which applies to this plan.

Y. Therapy and Rehabilitation Services

The plan covers charges for the following therapy and rehabilitation services when ordered by a physician:

1. Radiation therapy;
2. Chemotherapy;
3. Dialysis treatment;
4. Physical medicine (see definition in *Part II*), limited to 20 visits per calendar year when received on an outpatient basis;
5. Respiratory therapy;
6. Occupational therapy, limited to 20 visits per calendar year when received on an outpatient basis;
7. Speech therapy, limited to 20 visits per calendar year when received on an outpatient basis;
8. Infusion therapy; and
9. Cardiac rehabilitation.

The plan does not cover 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.

Z. Transplant Services

Charges for medically necessary and appropriate human organ, bone marrow, blood stem cell, and tissue transplants will be covered as any other illness if the following conditions are met:

1. The procedure or organ transplant is not considered experimental or investigational in nature by any appropriate technological assessment body established by any state or federal government; and
2. Such expenses are not covered under any government or other insurance program.

Organ, bone marrow, and blood stem cell transplants include the following procedures:

1. Heart transplants;
2. Heart/lung transplants;
3. Kidney transplants;
4. Pancreas transplants;
5. Liver transplants;
6. Bone marrow transplants (autologous, allogeneic) or other method of stem cell support, if it is not experimental;
7. Lung transplants (single or double); and
8. Kidney/pancreas transplants from the same donor.

Inpatient Transplant Expenses

Covered charges for transplants are limited to charges that would qualify as inpatient covered expenses under this *Part IX* for:

1. Pre-transplant evaluation,
2. Pre-transplant harvesting,
3. Pre-transplant stabilization,
4. The transplant itself, and
5. Follow-up biopsies and anti-rejection medication.

If a human organ, tissue, or blood stem cell transplant is provided from a living donor to a human transplant recipient, the following guidelines apply:

1. When both the recipient and the donor are members covered under this plan, each is entitled to the benefits of this plan.
2. When only the recipient is a member, both the donor and the recipient are entitled to the benefits of this plan, subject to the following limitations:
 - a. The donor benefits are limited to only those that are not provided or available to the donor from any other source, including, but not limited to, other insurance coverage, other Blue Cross Blue Shield coverage, or any government program; and
 - b. Benefits provided to the donor will be charged against the recipient's coverage under this plan to the extent that benefits remain and are available under this plan after benefits for the recipient's own expenses are paid.
3. When only the donor is a member, the donor is entitled to the benefits of this plan, subject to the following limitations:
 - a. The donor benefits are limited to only those that are not provided or available to the donor from any other source in accordance with the terms of this plan; and
 - b. No benefits are provided to the non-member transplant recipient.
4. If any organ, tissue, or blood stem cell is sold rather than donated to the member 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 of the organ, tissue, or blood stem cell are covered by the plan.

Travel, Lodging, and Food Expenses

If a covered organ, bone marrow, or blood stem cell transplant is performed in a network facility, the plan will cover the following travel, lodging, and food expenses in connection with the transplant:

1. Transportation for the member recipient and one adult to accompany the member recipient to and from the transplant facility;
2. Lodging at or near the transplant facility for the adult who accompanied the member recipient, while the member recipient is confined at the transplant facility; and
3. Food expenses.

Transportation, lodging, and food expenses for the accompanying adult will be limited to \$5,000 per covered transplant at the transplant facility.

This transportation, lodging, and food will be provided for:

1. Pre-transplant evaluation, harvesting, and stabilization, and
2. The transplant itself.

These costs will be considered as additional covered expenses. In addition, there will be no deductible amount applied to these expenses.

Travel, lodging, and food benefits are not available for tissue transplants.

Exclusions

No benefits will be paid for human organ, bone marrow, blood stem cell, and tissue transplant charges:

1. That exceed the allowable charges;
2. For animal to human transplants;
3. For artificial or mechanical devices designed to replace human organs temporarily or permanently;
4. For procurement or transportation of the organ or tissue unless expressly provided for in this provision;
5. To keep a donor alive for the transplant operation; and
6. That are excluded in *Part X* of this summary plan description.

AA. Other Covered Charges

The plan will cover the following types of care, service, and treatment given to a covered person in connection with a covered illness or injury:

1. Charges for medical care, treatment, services, and supplies listed below, when prescribed by the attending physician:
 - a. Use of radium or other radioactive substances.
 - b. Whole blood or blood derivatives, blood processing, and administration of blood.
 - c. Heart pacemaker.
 - d. Canes, crutches, and walkers.
 - e. Colostomy or ileostomy bags and related supplies.
 - f. Allergy extract and allergy injections.
 - g. Rental or purchase (at the option of Highmark), adjustment, repair, and replacement of durable medical equipment required for therapeutic use when prescribed by a professional provider, within the scope of his or her license. Examples of durable medical equipment include:
 - a wheelchair
 - a hospital bed
 - an inhalation device
 - a home or portable dialysis system.
 - h. Oxygen and equipment for its administration.
2. Charges for elective sterilization for covered males, regardless of medical necessity and appropriateness. Elective sterilization for females is covered under the Adult Preventive Care Services provision outlined in *Part IX, Section Q*.

Part X, Exceptions & Limitations — What Is Not Covered

Although the plan covers charges for most illnesses and injury, there are some conditions and charges it does **not** cover. These are:

A. Illness, Injuries and Other Services

The plan does **not** cover charges for:

1. Services, treatment, or supplies received prior to a member's effective date of coverage under this plan or after a member's coverage under this plan terminates.
2. Services, treatment, or supplies not prescribed by or performed by or upon the direction of a professional provider.
3. Services or treatment that are submitted by a certified registered nurse and another professional provider for the same services performed on the same date for the same member.
4. Services or treatment rendered by other than ancillary providers, facility providers, professional providers, or contracting suppliers (see definitions in *Part II*).
5. Services or treatment performed by a professional provider enrolled in an education or training program when such services are related to the education or training program.
6. Services, treatment, or supplies that are not medically necessary and appropriate as determined by Highmark Blue Cross Blue Shield.
7. Services, treatment, or supplies that are experimental or investigative for the condition being treated. That is, procedures and drugs that have not been adopted for general, clinical use and have not been approved by the appropriate boards or are not accepted by the medical community as safe, effective treatment.
8. Charges billed with inappropriate or non-standard codes, as determined by Highmark according to accepted industry billing standards.

9. Services, treatment, or supplies for which you would have no legal obligation to pay if you didn't have coverage under this plan.
10. Telephone consultations, except as specifically provided for Amwell virtual physician visits, as outlined in *Part IX, Section B*.
11. Completion of claim forms or failure to keep a scheduled appointment.
12. Treatment of a condition, illness, or injury resulting from or prolonged by a member's involvement in an illegal occupation, performance of, or attempted performance of an assault or other felony.
13. Personal, non-medical services or supplies while hospitalized — for example, television, haircuts, telephone, and newspapers.
14. Personal hygiene and convenience items such as, but not limited to, air conditioners, humidifiers, physical fitness equipment, stair glides, elevators/lifts or "barrier free" home modifications, whether or not specifically recommended by a professional provider.
15. Reversal of an elective sterilization.
16. A hospital admission in connection with surgery that begins on a Fri., Sat., or Sun. — unless surgery is performed the next day. If a covered person is going to have surgery on Mon., the plan will cover an admission that begins on Sun.
17. Inpatient admissions that are primarily for diagnostic studies.
18. Inpatient admissions that are primarily for physical medicine services.
19. Transplant services other than those listed under *Part IX, Section Z*, unless approved by Highmark.
20. Loss sustained or expenses incurred while on active duty as a member of the armed forces of any nation, and loss sustained or expenses incurred as a result of an act of war, whether declared or undeclared. This includes service with military forces as a civilian whose duties do not include combat.
21. Treatment of a condition, illness, or injury that results from participating in a civil insurrection or riot.
22. Treatment required as a result of any illness or injury that occurs in the course of employment or any work for wage or profit (including self-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, except as provided in *Part VI*. This exclusion applies whether or not you claim the benefits or compensation.
23. Custodial care, domiciliary care, residential care, protective care, and supportive care, including educational services, rest cures, convalescent care, and care that is chiefly for the purpose of meeting personal needs and could be provided by persons without professional skills or training.
24. Respite care.
25. Services, treatment, or supplies provided to you or a covered dependent by a provider who is a member of your immediate family or someone who ordinarily lives with you.
26. Services, treatment, or supplies provided by a dental or medical department maintained, in whole or in part, by or on behalf of an employer, mutual benefit association, labor union, trust, or similar type of entity.
27. Services, treatment, or supplies to the extent benefits are provided to members of the armed forces or to patients in a hospital or other facility operated by any U.S. governmental agency, including Veteran's Administration facilities for service-connected illness or injury, unless you are obligated by law to pay the charges.
28. Services, treatment, or supplies to the extent payment has been made under Medicare when Medicare is primary.
29. Services or treatment 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.
30. Ambulance services, except as specifically provided in *Part IX, Section A*.
31. Services, treatment, or supplies 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. Exceptions to this exclusion are dental expenses specifically covered in *Part IX, Section D*.
32. Oral surgical procedures, except as specifically covered in *Part IX, Section D*.
33. Tooth implantology.
34. Treatment of temporomandibular joint syndrome (TMJ) with intra-oral prosthetic devices, or any other method to alter vertical dimensions and/or restore or maintain the occlusion; and treatment of TMJ not caused by documented organic joint disease or physical trauma.
35. Cosmetic surgery performed to improve the appearance of any portion of the body and from which no improvement in physiological function can be expected, except as specifically provided in this plan. Other exceptions include cosmetic surgery to correct:
 - a. A condition resulting from an accident;
 - b. A congenital defect; and
 - c. A functional impairment that results from a covered disease or injury.
36. Palliative, or cosmetic foot care, including but not limited to flat foot conditions; supportive devices for the foot; corrective shoes; 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.
37. Routine hearing services.
 38. Hearing aids, tinnitus maskers, or examinations for the prescription or fitting of hearing aids.
 39. Routine optometric vision examinations.
 40. Eyeglasses, contact lenses, and vision examination for prescribing or fitting eyeglasses or contact lenses. Exceptions to this exclusion are:
 - a. The initial pair of contact lenses/glasses prescribed following cataract extraction in place of surgically implanted lenses; and
 - b. Sclera shells intended for use in the treatment of illness or injury.
 41. 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.
 42. Routine or periodic physical examinations not necessary for the treatment of an injury or illness, except as specifically provided in *Part IX, Section Q*. The plan does not cover the completion of forms and preparation of specialized reports solely for insurance, licensing, employment, or other non-preventive purposes, such as employment physicals, pre-marital examinations, and physicals for school, camp, sports, or travel, which are not medically necessary and appropriate.
 43. Preventive care services and wellness services or programs, except as specifically provided in *Part IX, Section Q*.
 44. Well-baby care visits, except as specifically provided in *Part IX, Section Q*.
 45. Nicotine cessation support programs and/or classes, except as specifically provided in *Part IX, Section Q*.
 46. Any care related to conditions such as autism, hyperkinetic syndromes, learning disabilities, behavioral problems, or intellectual disabilities that extends beyond traditional medical management. Care that extends beyond traditional medical management includes the following:
 - a. Services that are primarily educational in nature;
 - b. Neuropsychological testing and educational testing (such as I.Q., mental ability, achievement, and aptitude testing), except for specific evaluation purposes directly related to medical treatment;
 - c. Services related to learning disorders or learning disabilities;
 - d. Services provided primarily for social or environmental change unrelated to medical treatment;
 - e. Developmental or cognitive therapies that are not restorative in nature but used to facilitate or promote the development of skills which the member has not yet attained; and
 - f. Services provided for which, based on medical standards, there is no established expectation of achieving measurable improvement in a reasonable and predictable period of time.
 47. Treatment for conditions that do not meet the level of impairment or symptoms required to be medically necessary such as, but not limited to:
 - a. Partnership relationship problems;
 - b. Marital counseling (if no mental health diagnosis);
 - c. Parent-child problems; and
 - d. Academic problems.
 48. Methadone hydrochloride treatment for which no additional functional progress is expected to occur.
 49. Services or treatment ordered by a court or other judicial proceedings as part of the member's sentence, even if otherwise covered by the plan.
 50. Services, treatment, or supplies that have been disallowed under the provisions of the Healthcare Management Services (HMS) precertification program.
 51. Elective abortions for any reason other than to preserve the person's life upon whom the abortion is performed.
 52. Immunizations required for employment.
 53. Surrogate pregnancy.
 54. Treatment leading to or in connection with transsexual surgery.
 55. Treatment of sexual dysfunction not related to organic disease or injury.
 56. Treatment provided specifically for the purpose of assisted fertilization such as, but not limited to:
 - a. Artificial insemination;
 - b. In-vitro fertilization (IVF);
 - c. Gamete intrafallopian transfer (GIFT);
 - d. Zygote intrafallopian transfer (ZIFT); and
 - e. Pharmacological or hormonal treatments used in conjunction with assisted fertilization.
 57. Acupuncture.
 58. Drugs not approved by the U.S. Food and Drug Administration for sale in the U.S.
 59. Nutritional counseling, except as specifically provided in *Part IX, Section Q*, for prevention of obesity.
 60. Food including, but not limited to, enteral formulae, infant formulas, supplements, substances, products, enteral solutions, or compounds used to provide nourishment through the gastrointestinal tract whether ingested orally or

provided by tube, whether utilized as a sole or supplemental source of nutrition, and when provided on an outpatient basis, except as specifically provided for enteral formulae in *Part IX, Section G*.

61. Medical or surgical treatment of obesity or morbid obesity, even if prescribed or provided by a physician, except as specifically provided for morbid obesity in *Part IX, Section N*.
62. Supplies, instructions, programs, and activities for weight reduction (including all diagnostic testing related to weight reduction programs), weight control, or physical fitness, even if prescribed or provided by a physician.
63. Hair growth stimulants.
64. Drugs prescribed for cosmetic purposes only.
65. Drugs and supplies that can be purchased without a prescription, except as specifically provided by this plan.
66. Prescription drugs and medications used for unlabeled or unapproved indications, where such use has not been approved by the Food and Drug Administration (FDA).
67. Health services provided in a foreign country, unless required as emergency health services.
68. Treatment for complications arising from, or connected in any way with, a surgical or medical treatment or procedure that is not covered by this plan, whether or not the patient was covered by this plan at the time the non-covered surgery, treatment, or procedure was performed.
69. Any other medical or dental service or treatment except as specifically provided by this plan.

B. Claims Submitted After Loss of Dependent Eligibility

Claims will not be paid for dependents who are no longer eligible to be covered under this plan as your dependents. Please read *Part III, Section B*, and *Part XIV* for more information on dependent eligibility and when coverage ends under this plan.

Part XI, About Your Identification Card

The Blue Cross and Blue Shield symbols on your Highmark PPO identification (ID) card are recognized throughout the country and around the world. You should carry your ID card with you at all times, destroy any previously issued medical ID cards, and show this card to the hospital, physician, or other professional provider whenever you or your covered dependents need medical care.

When you or one of your covered dependents receives health care services, you need to show your ID card to the hospital, physician, or other professional provider and ask the provider to file the claim for you.

The following information is displayed on your ID card:

1. Your name;
2. Your identification number;
3. Group number;
4. Member Service toll-free number (on back of the card);
5. Precertification toll-free number (on back of card); and
6. “PPO in Suitcase” symbol.

There is a logo of a suitcase with “PPO” inside it on your ID card. This “PPO suitcase” lets hospitals, physicians, and other professional providers know that you are a member of a Blue Cross and Blue Shield PPO and that you have access to PPO providers nationwide.

If your card is lost or stolen, please contact Highmark Member Service immediately. To request additional ID cards, you may contact Highmark Member Service or request cards online by logging onto www.highmarkbcbs.com.

Part XII, How to File a Claim

A. When Receiving Services from a Network Provider

If services are received from a network provider, you will not have to file a claim. You need to make sure you show the member’s ID card to the provider. The provider will take the information needed and will then bill the plan. Any ineligible and unpaid services will be billed to you by the network provider.

B. When Receiving Services from an Out-of-Network Provider

If services are received from an out-of-network provider, you or your provider must file a paper claim form before the plan can pay charges for a member’s care, service, or treatment. You cannot combine claims for more than one family member on the same claim form. A separate claim form will need to be submitted for each member with a claim. Multiple services for the same member can be filed on the same claim form.

It is your responsibility to make sure that appropriate claim forms are properly completed, signed and dated and mailed to Highmark at the address listed on the back of your ID card. You can get paper claim forms from the Human Resources Department, Highmark Member Service, or the Highmark website at www.highmarkbcbs.com. If you have questions about how to fill out the form, please talk to the Human Resources Department.

To be considered for payment, all paper claims must be filed within one year from the end of the year in which the service took place. Claims filed more than one year after the end of the year in which the service took place are not eligible for coverage.

When you submit a claim form, you must attach the itemized bill. **It is important to send in original bills. “Balance due” statements, paid receipts, or canceled checks cannot be used because they do not give Highmark enough information to process the claim correctly.** The following information must be included on the itemized bill:

1. The name and address of the provider;
2. The patient’s full name;
3. The date of the service or supply;
4. A description of the service or supply;
5. The amount charged;
6. The diagnosis of the illness, injury, or condition;
7. For durable medical equipment, the physician’s certification;
8. For private duty nursing, the nurse’s license number, charge per day, shift worked, and signature of provider prescribing the service; and
9. For ambulance services, the total mileage.

If you have already made payment for the services received, you must also submit proof of payment (receipt from the provider) with the claim form.

C. Initial Post-Service Claim Determination

Highmark will notify you in writing of its determination of your post-service claim within a reasonable period of time, but no later than 30 days after Highmark receives the claim. However, Highmark may extend the review period once for an additional 15 days if Highmark determines additional time is necessary due to special circumstances beyond its control. If an extension of time is required, Highmark will notify you of the extension prior to the end of the initial 30-day post-service claim determination period. This extension notification will be communicated to you in writing and will include the reason for the delay and the date a determination is expected.

If an extension of time is necessary because Highmark needs additional information from you to decide the post-service claim, the extension notice will describe the specific information you need to submit to the plan to complete the claim. In this event, you will be given at least 45 days from the day you receive the extension notice to provide the required information before a decision is made on your post-service claim. The 45-day extended time frame in which Highmark is required to make a determination on your post-service claim will not include the days from the date of the extension notice to the earlier of:

1. The date Highmark receives the requested information; or
2. The date the requested information is required to be provided to Highmark.

After a post-service claim is processed, you will receive an *Explanation of Benefits* (EOB) statement in writing. Please read it carefully so you will understand how the claim has been paid. This form lists:

1. The provider’s actual charges;
2. The allowable amount, as determined by Highmark;
3. Deductible amounts you are required to pay, if any;
4. Total benefits payable by the plan; and
5. The total amount you are required to pay.

If a post-service claim is denied (in whole or in part), you will receive written notification of the adverse benefit determination which will include specific information about the denied claim and the plan’s appeal procedures, as outlined in *Part XIII*.

Part XIII, Appeal Procedures

A. Notification of Initial Adverse Benefit Determination

You will be notified of an initial adverse benefit determination in writing when:

1. A pre-service or post-service claim for benefits is denied (either in whole or in part);

2. A concurrent care request for extension of a previously approved admission or treatment is denied;
3. A concurrent care review decision is made to reduce or terminate previously approved benefits provided over a period of time; and
4. Plan coverage is rescinded, as outlined in *Part XX, Section F*, except for rescission of coverage due to failure to timely pay required premium contributions.

You will be notified orally of any initial adverse benefit determination involving an urgent care claim for benefits. In this case, written confirmation of the decision will be provided to you within three days after the oral notification.

The notification of an initial adverse benefit determination will include the following information:

1. The specific reason or reasons for the adverse benefit determination;
2. Reference to the specific plan provisions on which the adverse benefit determination was based;
3. A description of any additional material or information necessary for you to complete the claim and an explanation of why such material or information is necessary;
4. A description of the plan's appeal procedures and the time limits applicable to such procedures;
5. Your right to receive a copy of the internal rule, guideline, protocol, or similar criteria, free of charge upon request, if an internal rule, guideline, protocol, or similar criteria was relied on in making the adverse benefit determination;
6. Your right to receive an explanation of any scientific or clinical judgment of the plan in applying the terms of the plan to your medical circumstances, free of charge upon request, if the adverse benefit determination is based on medical necessity, experimental treatment, or other similar exclusion; and
7. An explanation of the plan's expedited review process for an urgent care claim.

If the reason for an initial adverse benefit determination is unclear to you, please contact Highmark for clarification if the initial adverse benefit determination relates to medical services and contact Everence Association, Inc. (Everence) if the initial adverse benefit determination relates to prescription drugs.

B. First Level Appeal of Initial Adverse Benefit Determination

If, after talking with Highmark or Everence, your question or concern about the adverse benefit determination is not addressed to your satisfaction, or if you do not agree with the initial adverse benefit determination, you may appeal the decision. You have the right to designate an individual to act on your behalf as your authorized representative in connection with any claim for coverage or benefits. Highmark and Everence reserve the right to establish reasonable procedures for determining whether an individual has been authorized to act on your behalf.

To appeal an initial adverse benefit determination, you or your authorized representative must submit a written request for review of the adverse benefit determination to Highmark or Everence. The written appeal must be received by Highmark or Everence within the following applicable timeframe after you receive notice of the initial adverse benefit determination:

1. 180 days for a pre-service, urgent care, or post-service claim; or rescission of coverage appeal; and
2. Prior to the termination of the admission or treatment for a concurrent care claim.

To expedite the review of an adverse benefit determination involving an urgent care claim, you or your authorized representative may telephone Highmark or Everence to request the review instead of submitting a written appeal.

You will be provided with a full and fair review of the initial adverse benefit determination. This means:

1. The review will be conducted by a representative from the Highmark Appeal Review Department or Everence who was not involved in any previous decision to deny the claim which is the subject of your appeal or the subordinate of any individual who was involved in that decision;
2. The independence and impartiality of those involved in the review will be maintained;
3. The claim and all documentation supporting it will be re-examined during the review and the Highmark Appeal Review Department or Everence will afford no deference to any prior adverse decision on the claim which is the subject of your appeal;
4. If you are appealing an adverse benefit determination that was based on a medical judgment, including whether a requested benefit is medically necessary and appropriate or experimental or investigative, the Highmark Appeal Review Department or Everence will consult with a physician of the same or similar specialty. The physician must not be the same individual who was consulted in connection with the initial determination or a subordinate of that individual;
5. Upon your request, you will be provided with the identity of any medical or vocational expert whose advice was obtained in connection with the initial adverse benefit determination;
6. You will be given the opportunity to submit written comments, documents, records, etc., with regard to your claim for benefits. All information you submit will be taken into account during the review, regardless of whether it was reviewed as part of the initial determination
7. You are entitled to receive upon request and free of charge, copies of all documents, records, and information relevant to your claim for benefits; and

8. Any new or additional evidence or rationale considered or relied on in denying the claim will be provided to you sufficiently in advance of the due date for the Highmark Appeal Review Department or Everence's decision to allow you sufficient time to respond prior to the decision.

You will be notified of the review decision as soon as possible after Highmark or Everence receives your appeal of the adverse benefit determination, but no later than:

1. 72 hours for an urgent care claim;
2. 30 days for a non-urgent pre-service claim;
3. 30 days for a post-service claim;
4. 30 days for a rescission of coverage appeal; and
5. Prior to termination of the admission or treatment for a concurrent care claim.

The notification will be provided in writing for a pre-service, concurrent care, or post-service claim; or rescission of coverage appeal; and orally for an urgent care claim. When the notification is provided orally, written confirmation of the decision will be provided to you within three days after the oral notification.

C. Notification of First Level Appeal Adverse Benefit Determination

If the review of your appeal of an initial adverse benefit determination again results in an adverse benefit determination, the notification to you will include the following information:

1. The specific reason or reasons for the adverse benefit determination on review;
2. Reference to the specific plan provisions on which the adverse benefit determination is based;
3. Notification of your right to receive, free of charge upon request, any document:
 - a. Relied on in making the determination;
 - b. Submitted, considered, or generated in the course of making the determination;
 - c. That demonstrates compliance with the administrative processes and safeguards required in making the determination; or
 - d. That constitutes a statement of policy or guidance with respect to the plan concerning the denied treatment without regard to whether the statement was relied on.
4. Your right to receive a copy of the internal rule, guideline, protocol, or similar criteria free of charge upon request, if an internal rule, guideline, protocol, or similar criteria was relied on in making the adverse benefit determination;
5. Your right to receive an explanation of any scientific or clinical judgment of the plan in applying the terms of the plan to your medical circumstances, free of charge upon request, if the adverse benefit determination is based on medical necessity, experimental treatment, or other similar exclusion; and
6. Notification of your right to file a second level appeal.

D. Second Level Appeal of First Level Appeal Adverse Benefit Determination

If your first level appeal of an initial adverse benefit determination is denied, you have the right to request a second level review. The second level review will be facilitated by Everence and will be decided by the plan administrator according to the full and fair review procedures outlined in *Section B* above. To request a second level appeal, you must submit a written request for a second level claim review to Everence within 30 days after the date you receive notice of the first level review decision.

Everence will provide you with written notification of the plan administrator's review decision of your second level appeal within 30 days after the second level appeal is received by Everence.

E. Notification of Second Level Appeal Adverse Benefit Determination

If the plan administrator's review of your second level appeal of a first level appeal adverse benefit determination again results in an adverse benefit determination, the notification to you will include the information listed in items #1 through #5 in *Section C* above. The notification will also include information about your right to request external review of the adverse benefit determination, as outlined in *Section F*, including contact information for requesting external review.

You cannot file a lawsuit on any adverse benefit determination unless you have exhausted the appeal procedures outlined above. You also cannot file a lawsuit on any adverse benefit determination more than three years after the care, service, or treatment has been given to you or your covered dependent.

F. External Review

If you have exhausted the plan's internal appeal procedures and your second level appeal of an adverse benefit determination is denied by the plan administrator, you may have the right to further appeal the denial through the independent external review process established under the Patient Protection and Affordable Care Act (ACA).

External review is available if the final adverse benefit determination of a second level appeal is based on medical necessity, appropriateness, health care setting, level of care, effectiveness of a covered benefit, a determination that treatment is experimental or investigational, or a determination by the plan administrator to rescind plan coverage. External review is not available if the adverse benefit determination is based on a plan participant's failure to meet eligibility requirements under the terms of the plan (other than eligibility disputes related to rescission of coverage), explicit benefit exclusions, or defined benefit limits.

You must file your request for external review with Highmark (medical services) or Everence (prescription drugs) within four months after you receive notification of the final adverse benefit determination of your second level appeal. For pre-service claims, the four-month period begins to run from the date you received notification of the initial adverse benefit determination. The external review will be conducted by an independent review organization that is not affiliated with the plan.

Preliminary Review

Highmark or Everence will conduct a preliminary review of your external review request within five business days following the date the request is received. The preliminary review will determine whether:

1. You were covered by the plan at all relevant times;
2. The adverse benefit determination relates to your failure to meet the plan's eligibility requirements;
3. You exhausted the plan's internal appeal process outlined above; and
4. You submitted all required information or forms necessary for processing the external review.

You will be notified of the results of the preliminary review within one business day following completion of the review. If your request is complete but not eligible for external review the notification will include the reasons for ineligibility. If your request is not complete, the notification will describe the information or materials needed to complete the request. You will have the remainder of the four-month filing period or if later, 48 hours from receipt of the notifications, whichever is later, to complete your request for external review.

Referral to Independent Review Organization (IRO)

If your request for external review is found to be acceptable following preliminary review, one of at least three IROs will randomly or by rotation be selected to perform an external review of your claim. The IRO will be accredited by a nationally-recognized accrediting organization. Within five business days thereafter, Highmark or Everence will provide the IRO with documents and information the plan administrator considered when making the final internal adverse benefit determination. The IRO may reverse the plan administrator's final adverse benefit determination if the documents and information are not provided to the IRO within the five-day timeframe. If the IRO does so, it will notify you and the plan within one business day after making the decision.

The IRO will timely notify you in writing of the eligibility of your request for external review and will provide you with at least 10 business days following receipt of the notice to provide additional information for the IRO to consider in its external review.

The IRO will review all information and documents that are timely received. In reaching its decision, the IRO will review your claim *de novo*. This means the IRO will not be bound by any decisions or conclusions reached during the plan's internal claims and appeal process outlined above.

The assigned IRO must provide written notice of its final external review decision within 45 days after the date the IRO received the request for external review. The IRO will deliver its notice of final external review decision to you and Highmark or Everence. The IRO's notice will include the following:

1. A general description of the reason for the external review request, including information sufficient to identify the claim;
2. The date it received the assignment to conduct the review and the date of its decision;
3. References to the evidence or documentation, including specific coverage provisions and evidence-based standards, considered in reaching its decision;
4. A discussion of the principal reason(s) for its decision, including the rationale for its decision and any evidence-based standards that were relied on in making its decision;
5. A statement that the determination is binding except to the extent that other remedies may be available under state or federal law to either you or your plan;
6. A statement that judicial review may be available to you; and
7. Current contact information, including phone number, for any applicable office of health insurance consumer assistance or ombudsman established under Section 2793 of the Public Health Service Act.

Coverage or payment for the requested benefits will be paid immediately upon Highmark or Everence's receipt of the IRO's notice of a final external review decision from the IRO that reverses the plan administrator's prior final internal adverse benefit determination.

Expedited External Review

You are entitled to external review as described above on an expedited basis if:

1. The final adverse benefit determination involves a medical condition for which the timeframe for completion of an expedited internal appeal would seriously jeopardize your life or your health or would jeopardize your ability to regain maximum function and you filed a request for an expedited internal appeal;
2. You have a medical condition where the timeframe for completion of a standard external review of a final internal adverse benefit determination would seriously jeopardize your ability to regain maximum function; or
3. 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 you have not been discharged from the facility rendering emergency services.

In the above circumstances, Highmark or Everence will immediately conduct a preliminary review and will immediately notify you if your request is not eligible. If your request is not complete, the notification will describe the information or materials needed to complete the request. You will then have 48 hours from receipt of the notice to complete your request for external review.

If your request for external review on an expedited basis is found to be acceptable following the preliminary review, the external review will be conducted by the IRO according to the same procedures outlined above for external review that is not expedited. However, the assigned IRO must provide notice of its final external review decision as expeditiously as possible, but in no event more than 72 hours from the time the IRO received the request for external review. The IRO must provide written notice of its final external review decision to you and to Highmark or Everence, if not originally in writing, within 48 hours of its original decision. The IRO's written notice will inform you of the same information listed above for the final external review decision of a non-expedited external review.

Coverage or payment for the requested benefits will be paid immediately upon Highmark or Everence's receipt of the IRO's notice of a final expedited external review decision from the IRO that reverses the plan administrator's prior final internal adverse benefit determination.

Part XIV, When Coverage Ends

Plan coverage will end at midnight on the first of the following events:

1. The last day of the month in which you are no longer an employee working for or employed and paid by a participating institution;
2. The last day of the month in which you are no longer an employee eligible for these benefits because:
 - a. The number of hours you regularly work for a participating institution as a credentialed pastor is reduced to less than 20 hours per week; or
 - b. The number of hours you are employed and paid by a participating institution as a non-credentialed employee is reduced to less than 30 hours per week (20 hours per week, if you were enrolled in the plan that was in effect on Dec. 31, 2009 and working at least 20 but less than 30 hours per week as of that date).
3. The last day of the month in which you do not return to work as an active employee regularly working at least 20 hours per week (if you are a credentialed pastor) or employed and paid for at least 30 hours per week (if you are a non-credentialed employee) and performing the normal duties of your job on the first business day that follows the last day of a leave of absence that qualifies under the Family and Medical Leave Act of 1993 (FMLA) or an approved sabbatical;
4. The day immediately preceding the day you become covered under Medicare as your primary coverage (see paragraph entitled *Enrollment in Medicare* in this *Part XIV*);
5. The day the plan sponsor cancels this medical plan for all plan participants;
6. The last day of coverage for which your participating institution paid the required funding contribution; or
7. The last day of the month in which your participating institution terminates participation in this plan.

Coverage for your dependents will end the same day your coverage terminates or if earlier, the last day of the month in which they no longer qualify as dependents; for example, if a dependent child reaches the age limit outlined in *Part III*. In the event of an employee's death, coverage for the employee's dependents will end the last day of the month in which the employee's death occurs.

However, if you are an active employee who has chosen Medicare as your primary coverage and your dependents are covered under this plan, coverage for your dependents will end at midnight on the last day of the month in which you are no longer an employee otherwise eligible for coverage under this plan (see *Part III, Section D*).

Plan coverage will end as described above unless you or your dependents choose to continue coverage entirely at your own cost as allowed under *Part XV*.

Enrollment in Medicare

If you are covered under this plan when you become eligible for Medicare and you continue to be an employee eligible for this plan's benefits, you may choose either Medicare or this plan as your primary coverage. If you choose Medicare as your primary coverage, benefits under this plan will end and you will not be able to continue enrollment in this plan. In this case, continuation coverage is not available to you. Your spouse and dependent children may remain covered under this plan as long as you are an employee otherwise eligible for coverage.

If you choose Medicare as your primary coverage, you can at your own choice, purchase a Medicare supplement plan at your own expense. Your participating institution cannot pay your Medicare or Medicare supplement premiums for you. Contact Everence for more details.

Part XV, Continuation of Coverage

You and your dependents may choose to continue coverage under this plan, at your own expense, under certain circumstances that would ordinarily end your coverage (see *Part XIV*).

When group health plan coverage under this plan ends and you become eligible for continuation of coverage, you may also be eligible for other coverage options that may cost less than continuation coverage, as outlined in *Section F* of this *Part XV*.

A. Eligibility Requirements

You and your covered dependents can choose to continue coverage if group health coverage under this plan terminates as a result of either of the following qualifying events:

1. You are no longer an employee working for or employed and paid by a participating institution for any reason other than acts of "gross misconduct";
2. You do not return to work as an active employee working the applicable minimum employment requirement and performing the normal duties of your job on the first business day that follows the last day of a leave of absence that qualifies under the Family and Medical Leave Act of 1993 (FMLA) or an approved sabbatical; or
3. You are no longer an employee eligible for these benefits because:
 - a. The number of hours you regularly work for a participating institution as a credentialed pastor is reduced to less than 20 hours per week; or
 - b. The number of hours you are employed and paid by a participating institution as a non-credentialed employee is reduced to less than 30 hours per week.

You are not eligible to continue coverage under this plan if:

1. Coverage ended because you failed to make a required premium contribution;
2. You replace this coverage with other coverage;
3. You become eligible for other group coverage; or
4. You are enrolled in or eligible to enroll in Medicare.

Your covered dependents may also choose to continue coverage if they are no longer eligible for group health coverage under this plan as a result of any of the following qualifying events:

1. Your death;
2. You and your spouse divorce or legally separate;
3. You are covered under Medicare as primary coverage and are no longer an employee otherwise eligible for coverage under this plan; or
4. Your child no longer qualifies as an eligible dependent, according to the terms of the plan.

Your dependent who is enrolled in Medicare or eligible to enroll in Medicare at the time one of the qualifying events listed above occurs is not eligible for continuation coverage under this plan.

B. Employee and Participating Institution Rights and Responsibilities

The plan will offer continuation coverage to you and your covered dependents only after the plan has been notified that a qualifying event has occurred.

Your participating institution is required to notify the plan within 30 days after coverage for an employee and his or her covered dependents would end because of any of the following qualifying events:

1. An employee no longer works for or is employed and paid by a participating institution for any reason other than acts of “gross misconduct”.
2. Failure of an employee to return to work as an active employee working the applicable minimum employment requirement and performing the normal duties of his or her job on the first business day that follows the last day of a leave of absence that qualifies under the Family and Medical Leave Act of 1993 (FMLA) or an approved sabbatical;
3. An employee is no longer eligible for plan coverage because:
 - a. The number of hours the employee regularly works for a participating institution as a credentialed pastor is reduced to less than 20 hours per week; or
 - b. The number of hours the employee is employed and paid by a participating institution as a non-credentialed employee is reduced to less than 30 hours per week.
4. Death of an employee.

The employee or the employee’s dependent is responsible to notify the plan as soon as possible, but no later than 30 days after plan coverage for the employee’s dependent would end because of any of the following qualifying events:

1. The employee and spouse divorce;
2. The employee and spouse legally separate; or
3. A child no longer qualifies as the employee’s dependent, according to the terms of the plan.

You or your dependent must provide notice of a qualifying event to the plan by completing and returning the required cancellation form to Everence. This form can be obtained from Everence. If you or your dependent do not provide notice of a qualifying event to Everence within 30 days after coverage would otherwise end because of the qualifying event, you and your dependents will lose all continuation coverage rights under the plan.

Within 14 days after receiving notice that a qualifying event has occurred, continuation coverage will be offered to all eligible individuals. You and/or your eligible dependents have a maximum of 30 days from the date of loss of coverage or the date of notification of continuation coverage rights, whichever is later, to elect continuation coverage. Continuation coverage will begin on the day plan coverage would otherwise end due to the qualifying event for each eligible individual who elects continuation coverage within the 30-day election period. If an eligible individual does not elect continuation coverage within the 30-day election period, group health coverage under this plan will end and the individual will lose all continuation coverage rights under the plan.

Each eligible individual has an independent right to elect continuation coverage. However, if not otherwise indicated when you elect continuation coverage, the election will be deemed to be an election on behalf of all eligible individuals who would have lost coverage because of the qualifying event giving rise to the election.

You are responsible to keep your participating institution informed of all events that they might otherwise not be aware of (such as information about your dependents) regarding your family’s continuation coverage rights. In order to protect your family’s rights, you should also keep your participating institution informed of any changes in the address of family members. You should keep a copy of any notices you send to your participating institution for your records.

C. Length and Level of Coverage

Continuation coverage will be the same coverage that the plan provides to other plan participants who are not receiving continuation coverage. Each individual who elects continuation coverage will have the same rights and benefits under the plan as other plan participants, including special enrollment rights.

You and/or your dependent can continue coverage for a limited period of time. Plan coverage will end at midnight on the earliest of the following events:

1. Eighteen months following the date continued coverage became effective;
2. The day the plan sponsor terminates the plan for all plan participants;
3. The day the participating institution terminates participation in this plan;
4. The day the participating institution ceases to be eligible to participate in this plan;
5. The end of the last month for which you made a required premium payment;
6. The day you or your dependent become covered under any other group or individual health plan;
7. The day you or your dependent become entitled to Medicare benefits; or
8. The day your ex-spouse remarries and becomes covered under another group or individual health plan.

D. Cost of Continuation Coverage

Generally, each individual electing continuation coverage is required to pay the entire cost of continuation coverage plus a two percent surcharge for administrative expenses. The amount an individual is required to pay may not exceed 102 percent of the cost to the group health plan (including both participating institution and employee contributions) for coverage of a similarly-situated plan participant who is not receiving continuation coverage.

The notice telling you about continued coverage will also include the monthly cost. The cost of coverage is determined each year just before the beginning of the plan year (Jan. 1). It is based on the amount paid for claims during the year, stop-loss insurance costs, and the cost to administer the plan. Plan costs are adjusted once each year and remain the same for the entire plan year.

E. Payment of Premium

If you and/or your covered dependents elect continuation coverage, payment for continuation coverage is not required to be sent with the election form. However, the first payment for continuation coverage must be made within 45 days after the date of election. If the election form is returned by mail, the date of election is considered to be the post-marked date. If you or your dependents do not make the first payment for continuation coverage within 45 days after the date of election, you and/or your dependents will lose all continuation coverage rights under the plan.

The first payment must cover the cost of continuation coverage from the day coverage under the plan would otherwise have ended up to the time the first payment is made. The amount of the first payment, the due date, and the address where payment must be sent will be listed on the election form. You or your dependents are responsible to make sure the amount of the first payment is enough to cover this entire period. You may contact Everence to confirm the correct amount of the first payment.

After the first payment is made, continuation coverage is required to be paid on a monthly basis. Payment for continuation coverage is due on the first day of each month. If payment is made on or before the due date, coverage under the plan will continue for that month without any break. Everence will send a monthly premium notice that lists the amount of the required payment and the due date. The monthly payment should be sent to the address on the premium notice.

Although payment for continuation coverage is due on the first day of each month, you and/or your dependents will be given a grace period of 30 days to make each monthly payment. Coverage will continue during the grace period as long as the monthly payment is made before the end of the grace period. If a monthly payment is paid later than the due date but before the end of the grace period for that payment, continuation coverage will be suspended as of the due date and then retroactively reinstated back to the due date when the payment is made. This means that any claim for benefits submitted while coverage is suspended may be denied and may have to be resubmitted once coverage is reinstated.

If you or your covered dependents fail to make a monthly payment before the end of the grace period for that payment, coverage will end and you and/or your dependents will lose all rights to continuation coverage under the plan.

F. Other Coverage Options

When group health plan coverage ends and you become eligible for continuation coverage, you and your family may also be eligible for other coverage options. For example, you may be eligible to buy an individual plan through the Health Insurance Marketplace. By enrolling in coverage through the Marketplace, you may qualify for lower costs on your monthly premiums and lower out-of-pocket costs and you can see what your premium, deductibles, and out-of-pocket costs will be before you make a decision to enroll. Being eligible for continuation coverage does not limit your eligibility for coverage or for a tax credit through the Marketplace. Through the Marketplace you'll also learn if you qualify for free or low-cost coverage from Medicaid or the Children's Health Insurance Program (CHIP). Some of these coverage options may cost less than continuation coverage. You can learn more about many of these options at www.healthcare.gov.

Additionally, you may qualify for a 30-day special enrollment period for another group health plan for which you are eligible (such as a spouse's plan), even if that plan generally doesn't accept late enrollees.

G. Other Information

This benefit requires your participating institution to keep careful records on all employees and their dependents. Remember, it is your responsibility to let your participating institution know when any of your personal information changes, such as your address, the number of dependents you have, their names and birth dates, your marital status, etc.

If you and/or your dependent do not elect continuation coverage, group health coverage under this plan will end.

If you have any questions about continuation coverage, please contact Everence. For more information about your rights under the Health Insurance Portability and Accountability Act (HIPAA), the Patient Protection and Affordable Care Act (Affordable Care Act), and other laws affecting group health plans, visit the nearest Regional or District Office of the U.S. Dept. of Labor's Employee Benefits Security Administration (EBSA) in your area or visit the EBSA website at www.dol.gov/ebsa/consumer_info_health.html. (Addresses and phone numbers of Regional and District EBSA Offices are available through the EBSA website.) For more information about the Health Insurance Marketplace, visit www.healthcare.gov.

Part XVI, Coordination of Benefits

If you or someone in your family are covered by this plan and another health plan or any other insurance, the two plans coordinate benefits. If more than two plans are involved, all plans will be taken into account. The intent is to avoid paying twice on the same service while providing covered individuals with the benefits outlined in this summary plan description.

To coordinate benefits, one plan (the primary plan) pays benefits first, and the other plan (the secondary plan) pays if there are allowable expenses not paid by the first plan.

A. Definition of Plan

To coordinate benefits, a plan is defined as providing benefits, treatment, or services for medical or dental care. It includes the following:

1. Group insurance or group-type coverage, whether insured or uninsured. This includes prepayment, group practice, or individual practice coverage. It also includes coverage other than school accident-type coverage.
2. Coverage under a governmental plan, or coverage required or provided by law. This does not include a state plan under Medicaid (Title XIX, grants to states for Medical Assistance Programs of the U.S. Social Security Act, as amended from time to time).
3. Motor vehicle insurance (including no-fault auto insurance).

Each contract or other arrangement for coverage under #1, #2, or #3 is a separate plan. Also, if an arrangement has two parts and coordination of benefit rules apply to only one of the two, each of the parts is a separate plan.

Medicaid is not a plan under this provision.

B. Determining Which Plan is Primary

The following plans or programs will be deemed to be primary:

1. Plans that do not have a coordination of benefits provision;
2. Coverage that is required by law; and
3. Motor vehicle insurance coverage.

Otherwise, one of the following rules will apply.

If Covered under One Plan as an Employee and Another Plan as a Dependent

If you are covered by one plan as an employee, member, or subscriber, and by another plan as a dependent, the plan you are covered by as an employee will be the primary plan.

If you are covered under a retiree plan, are on Medicare, and also have coverage as a dependent on your working spouse's plan, then:

1. The plan covering you as a dependent on your spouse's plan is the primary plan;
2. Medicare pays second; and
3. The plan covering you as a retiree pays last.

Active/Inactive Employee

The benefits of a plan that covers a person as an employee who is neither laid off nor retired are determined before those of a plan which covers that person as a laid off or retired employee. The same would hold true if a person is a dependent of a person covered as a retiree and as an employee. If the plan does not have this rule, and if, as a result, the plans do not agree on the order of benefits, this rule is ignored.

Continuation Coverage

If a person whose coverage is provided under a right of continuation provided by federal or state law is also covered under another plan, the order of benefits will be determined as follows:

1. First, the benefits of a plan covering the person as an employee, member, or subscriber (or as that person's dependent);

2. Second, the benefits under the continuation coverage.

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

Length of Coverage

If none of the above rules determines the order of benefits, the benefits of the plan that covered an employee, member, or subscriber longer is the primary plan.

If a Dependent Is living with Both Parents and Has Coverage under Both Parents' Plans

1. The plan of the parent whose birthday falls earlier in a year will be the primary plan.
2. If the parents have the same birthday, the plan that has covered the parent the longest will be the primary plan.

If a Dependent's Parents are Divorced or Separated and the Dependent Has Coverage under Two Plans

Determining the primary plan is done in the following order:

1. If a court has decreed that one parent is responsible for the health care expenses of the child, that parent's plan will be primary;
2. If a court has awarded joint custody without specifying who has responsibility for the child's health care expenses, the birthday rule will apply;
3. If there is no court ruling as stated in #1 and #2, the plan of the parent with custody will be primary;
4. Next, the plan of the spouse of the parent with custody will be primary;
5. Finally, the plan of the parent not having custody will be primary.

C. When This Is the Primary Plan

Benefits will be paid as described in this summary plan description.

D. When This is the Secondary Plan

The plan will pay benefits only on allowable expenses that have not already been paid by the primary plan.

E. General Provisions

Definition of Allowable Expenses

An allowable expense means a necessary, reasonable, and customary item of expense for health care; when the item of expense is covered at least in part by one or more plans covering the person for whom the claim is made. The following are not included as allowable expenses:

1. Outpatient prescription drugs; and
2. The primary plan's deductible, if all plans covering the person are qualified high-deductible health plans.

When a plan provides benefits in the form of services, the reasonable cash value of each service rendered will be considered both an allowable expense and a benefit paid.

When benefits are reduced under a primary plan because a covered person does not comply with the plan provisions, the amount of such reduction will not be considered an allowable expense. Examples of such provisions are those related to second surgical opinions, precertification of admissions or services, and preferred provider arrangements.

Claim Determination Period

The claim determination period is a calendar year. However, it does not include any part of a year during which a person has no coverage under this plan, or any part of a year before the date this coordination provision or a similar provision takes effect.

Right to Exchange Information with the Other Plan

To coordinate benefits, Highmark has the right to exchange information with the other plan and require you to supply any information needed. In addition, Highmark may pay other plans any amounts found necessary and deem these payments as paid benefits.

Benefits Other than Cash

If the primary plan offers benefits other than cash, Highmark will assign these a reasonable cash value and regard them a paid benefit.

Overpayment of Benefits

If as a result of this coordination of benefits provision, the amount of benefits paid by this plan on behalf of you or your dependents is more than should have been paid, Highmark may recover the overpayment on behalf of this plan. Highmark may recover the overpayment from:

1. You,
2. Your dependents,
3. Insurance companies, or
4. Other organizations.

Part XVII, Highmark Member Services Support

A. Member Service

If you need help with a claim or have a question about your benefits under this plan, you can call the toll-free Member Service number on the back of your ID card or log onto the Highmark Blue Cross Blue Shield website at www.highmarkbcbs.com. For TTY/TDD hearing impaired service, dial 711 and the toll-free Member Service number on the back of your ID card. A Highmark Blue Cross Blue Shield Member Service representative can also help you with any coverage inquiry. Representatives are trained to answer your questions quickly, politely, and accurately.

As a Highmark member, you have access to a wide range of readily available health education tools and support services, all geared to help you “Have a greater hand in your health”.

B. Blues On CallSM – 24/7 Health Decision Support

Call 1-888-BLUE-428 (1-888-258-3428) to be connected to a specially-trained wellness professional. You can talk to a Health Coach whenever you like, any time of the day, any day of the week.

Health Coaches are specially-trained registered nurses, dietitians and respiratory therapists who can help you make more informed health care and self-care (when appropriate) decisions. They can assist with a health symptom assessment, provide health-related information, and discuss your treatment options. Please be assured that your discussions with your Health Coach are kept strictly confidential.

Help with Common Illnesses, Injuries and Questions

Health Coaches can address any health topic that concerns you:

- Everyday conditions, such as a rash, an earache or a sprain
- A recent diagnosis you’ve received
- A scheduled medical test
- Planned surgery or other medical procedure
- Questions to ask your doctor at your next appointment
- How to care for a child or elder

You don’t have to be ill to talk to a Health Coach Call to learn about programs and other resources to help you manage:

- Stress
- Personal nutrition
- Weight management
- Physical activities
- Insomnia
- Depression

Help with Chronic Conditions

If you have diabetes, asthma, congestive heart failure, chronic obstructive pulmonary disease or coronary artery disease, you need to manage your condition every day in order to stay healthy and avoid hospital stays. That means keeping track of medications, tests, doctor appointments and your diet. Your Blues On Call Health Coach can help you work more closely with your doctor and get more involved in taking good care of yourself.

You can even establish a relationship with a specific Health Coach and schedule time to talk about your concerns and conditions.

C. myCare NavigatorSM – 24/7 Health Advocate Support

Getting the right care and finding the right doctor and wellness services for you and your family is now as quick and easy as calling myCare Navigator at 1-888-BLUE-428 (1-888-258-3428).

Your dedicated health advocate can help you and your family members:

1. Locate a primary care physician or get an appointment with a hard-to-reach specialist;
2. Get your medical records transferred;
3. Get a second opinion;
4. Understand your health care options;
5. Locate wellness resources, such as services for your special needs child or quality elder care for a parent; or
6. Handle billing questions and make the most of your care dollars.

Get the help you need to navigate the health care system easily and effectively. The same number that connects you to Blues On Call now connects you to your health advocate, myCare Navigator. Call 1-888-BLUE-428 (1-888-258-3428) for *total* care support.

D. Highmark Website

As a Highmark member, you have a wealth of health information at your fingertips. It's easy to access all your online offerings. Whether you are looking for a health care provider, managing your claims, want to make informed health care decisions on treatment options, or lead a healthier lifestyle, Highmark can help with online resources.

Go to www.highmarkbcbs.com. Then log in to your Member Home page to take advantage of resources available to help you understand your health status. Then, take steps toward real health improvement.

E. Baby BluePrints[®] Maternity Education and Support Program

If You Are Pregnant, Now is the Time to Enroll in Baby Blueprints

If you are expecting a baby, this is an exciting time for you. It's also a time when you have many questions and concerns about your and your developing baby's health.

To help you understand and manage every stage of pregnancy and childbirth, Highmark offers the Baby BluePrints Maternity Education and Support Program.

By enrolling in this free program, you will have access to online information on all aspects of pregnancy and childbirth. Baby BluePrints will also provide you with personal support from a nurse health coach available to you throughout your pregnancy.

Easy Enrollment

Just call toll-free at 1-866-918-5267. You can enroll at any time during your pregnancy. We encourage you to enroll early in your pregnancy to take full advantage of this program.

F. Information for Non-English-Speaking Members

Non-English-speaking members have access to clear benefits information. They can call the toll-free Member Service number on their ID card to be connected to a language services interpreter line. Highmark Member Service representatives are trained to make the connection.

G. Registration Information

Highmark is a registered mark of Highmark, Inc.

Blues On Call and myCare Navigator are service marks of the Blue Cross Blue Shield Association, an association of independent Blue Cross and Blue Shield companies.

Baby BluePrints, BlueCard, Blue Cross, BlueShield, and the Cross and Shield symbols are registered service marks of the Blue Cross Blue Shield Association.

Blue Cross Blue Shield Global is a trademark of the Blue Cross Blue Shield Association.

The Blue Cross Blue Shield Association is an independent company that does not provide Highmark Blue Cross Blue Shield products and services.

Part XVIII, Administration of the Plan

Any authority or responsibility allocated to or reserved by the plan administrator shall be exercised by Mennonite Church USA. The plan administrator may delegate its responsibilities to other persons or entities.

A. Plan Administrator

Mennonite Church USA is the plan administrator of this plan and as such shall administer this plan in accordance with its terms and establish its policies, interpretations, practices, and procedures. It is the express intent of this plan that the plan administrator shall have maximum legal discretionary authority to construe and interpret eligibility for benefits, to decide disputes which may arise relative to a plan participant's rights, and to decide questions of plan interpretation and those of fact relating to the plan. The decisions of the plan administrator will be applied in the same way to all plan participants regardless of special circumstances and will be final and binding on all interested parties.

The duties of the plan administrator include, but are not limited to the following:

1. Requiring any plan participant to furnish such information as it may reasonably request for the purpose of the proper administration of the plan as a condition to receiving any benefit under the plan;
2. Keeping and maintaining plan documents, accounts showing the fiscal transactions of the plan, and all other records pertaining to the plan;
3. Ratifying or establishing practices and procedures relevant to the plan;
4. Implementing the amendment or termination of the plan;
5. Supplying plan participants with plan information (such as this summary plan description);
6. Administering the plan in accordance with its terms and conditions;
7. Interpreting all provisions of the plan and remedying ambiguities, inconsistencies, errors, or omissions;
8. Hearing and deciding all eligibility and enrollment questions and appeals concerning the plan;
9. Hearing and deciding all second level appeals of adverse benefit determinations for the plan;
10. Performing all necessary reporting;
11. Directing all payments to be made pursuant to the plan;
12. Securing legal review of plan documents, as necessary;
13. Securing all legal determinations relating to the implementation and administration of the plan, as necessary and appropriate;
14. Contracting with third party providers to provide services deemed appropriate under the plan and monitoring their performance; and
15. Exercising all other functions not specifically delegated to others by the terms of the plan as may be necessary for the operation of the plan.

B. Participating Institution

The duties of the participating institution shall include, but are not limited to the following:

1. Establishing, communicating, and implementing procedures to determine whether a medical child support order is qualified;
2. Reporting to Everence any change in the enrollment status of an employee within 90 days following an employment or special enrollment event that makes an employee eligible to enroll in the plan and within 30 days following an employment event that causes an employee to lose eligibility for plan coverage. Such events include, but are not limited to commencement or termination of employment (voluntary or involuntary), death of an employee, increase or decrease in an employee's hours of employment, commencement or termination of a leave of absence, etc.;
3. Reporting to Everence the enrollment of an employee's new dependents added through marriage, birth, or adoption within 90 days following the date of marriage, birth, or adoption;
4. Reporting to Everence the enrollment of an employee's dependent(s) as a result of special enrollment rights within 90 days following the special enrollment qualifying event; and
5. Reporting to Everence the termination of plan coverage for an employee's dependent within 30 days following the date of loss of eligibility.

The plan is responsible for all benefits paid by Highmark on behalf of a covered person that are incurred after the individual's termination date of coverage but prior to the date Highmark is notified of the termination.

C. Claims Administrator

The claims administrator shall be appointed by the plan and shall have the authority and responsibility to provide administrative services in connection with the payment of claims. Highmark is under contract with the plan as claims administrator and as such shall perform the duties outlined in the *Preferred Provider Organization Network Program Agreement*. These duties include, but are not limited to the following:

1. Enrollment of eligible employees and dependents in the plan upon notification of enrollment by the participating institution through Everence;
2. Termination of plan coverage for plan participants upon notification of termination by the participating institution through Everence;
3. Issuing an identification card to each plan participant upon enrollment in the plan;
4. Administering the utilization management and case management procedures of the plan according to Highmark's internal policies and procedures in compliance with applicable law;
5. Processing and payment of claims submitted to the plan in accordance with the terms of the plan, Highmark's administrative practices, and PPO network rules;
6. Preparing and issuing *Explanation of Benefits* for claims submitted to the plan that have been processed by Highmark;
7. Hearing and deciding first level appeals of adverse benefit determinations for the plan. If a plan participant requests review of the claims administrator's denial of a first level adverse benefit determination, the second level appeal will be facilitated by Everence and decided by the plan administrator;
8. Facilitating requests for external review of second level adverse benefit determinations with an independent review organization;
9. Maintaining current plan data;
10. Providing and/or certifying all information necessary for filing reports; and
11. Seeking subrogation recoveries on behalf of the plan.

Highmark does not guarantee the payment of any benefits under this plan and does not assume any financial risk or obligation with respect to claims submitted to the plan.

D. Role of Everence Association, Inc.

Everence Association, Inc., a fraternal benefit society, (Everence) is not the insurer or the claims administrator of this plan. The plan has appointed Everence to act as exclusive agent on the plan's behalf in performing the plan's duties under the terms and provisions of the *Preferred Provider Organization Network Program Agreement*. The administrative duties of Everence are outlined in the *Administrative Services Agreement* between the plan and Everence and include the following:

1. Developing the summary plan description for the plan (which describes the terms and benefits of the plan) and other enrollment and cancellation forms required to administer the plan;
2. Developing a *Summary of Benefits and Coverage* for each plan option, as required by the Patient Protection and Affordable Care Act. Of 2010 (ACA);
3. Determining the eligibility of employees and their dependents to enroll in the plan;
4. Providing notification to Highmark of the enrollment of new plan participants, upon timely notification by the participating institution;
5. Providing notification to Highmark of the termination of coverage for plan participants, upon timely notification by the participating institution;
6. Preparing and issuing a *Certificate of Group Health Plan Coverage* to each plan participant upon termination of plan coverage;
7. Facilitating second level appeals of adverse benefit determinations;
8. Billing, collecting, and forwarding to Highmark all reimbursements and administrative fees paid by participating employers;
9. Filing claims with insurance companies providing excess loss insurance coverage to the plan; and
10. Providing all written, verbal, and electronic communications between the plan and Highmark.

Everence Association, Inc., does not guarantee the payment of any benefits under this plan and does not assume any financial risk or obligation with respect to claims submitted to the plan.

Part XIX, Provision of Protected Health Information to Plan Sponsor

A. Permitted and Required Uses and Disclosure of Protected Health Information (PHI)

Unless otherwise permitted by law, and subject to the conditions of disclosure outlined in *Section B* of this *Part XIX* and obtaining written certification pursuant to *Section C* of this *Part XIX*, the plan may disclose PHI or electronic PHI to the plan

sponsor, provided the plan sponsor uses or discloses such PHI or electronic PHI only to perform plan administration functions which the plan sponsor performs on behalf of the plan.

Plan administration functions do not include functions performed by the plan sponsor in connection with any other benefit or benefit plan of the plan sponsor or any employment-related actions or decisions. Enrollment and disenrollment functions performed by the plan sponsor are performed on behalf of plan participants and beneficiaries and are not plan administration functions. Enrollment and disenrollment information held by the plan sponsor is held in its capacity as an employer and is not PHI.

Notwithstanding the provisions of this plan to the contrary, in no event shall the plan sponsor be permitted to use or disclose PHI or electronic PHI in a manner that is inconsistent with 45 CFR §164.504(f).

B. Conditions of Disclosure for Plan Administration Purposes

Protected Health Information (PHI)

The plan sponsor agrees that with respect to any PHI disclosed to it by the plan (other than enrollment/disenrollment information, summary health information, and information disclosed pursuant to a signed authorization that complies with the requirements of 45 CFR §164.508 which are not subject to these restrictions), the plan sponsor shall:

1. Not use or further disclose the PHI other than as permitted or required by the plan documents or as required by law.
2. Ensure that any agents, including a subcontractor, to whom it provides PHI received from the plan, agree to the same restrictions and conditions that apply to the plan sponsor with respect to such PHI.
3. Not use or disclose the PHI for employment-related actions and decisions or in connection with any other benefit or employee benefit plan of the plan sponsor.
4. Report to the plan any use or disclosure of the PHI that is inconsistent with the uses or disclosures provided for of which it becomes aware.
5. Make available to a plan participant who requests access, the plan participant's PHI in accordance with 45 CFR §164.524.
6. Make available to a plan participant who requests an amendment, the plan participant's PHI and incorporate any amendments to the plan participant's PHI in accordance with 45 CFR §164.526.
7. Make available to a plan participant the information required to provide an accounting of disclosures in accordance with 45 CFR §164.528.
8. Make its internal practices, books, and records relating to the use and disclosure of PHI received from the plan available to the Secretary of Health and Human Services for purposes of determining compliance by the plan with 45 CFR §164.504(f).
9. If feasible, return or destroy all PHI received from the plan that the plan sponsor still maintains in any form and retain no copies of such information when no longer needed for the purpose for which the disclosure was made, except that, if such return or destruction is not feasible, limit further uses and disclosures to those purposes that make the return or destruction of the information infeasible.
10. Ensure that the adequate separation between the plan and the plan sponsor (i.e., the firewall) required by 45 CFR §164.504(f)(2)(iii) is established.

Electronic Protected Health Information (PHI)

The plan sponsor further agrees that if it creates, receives, maintains, or transmits electronic PHI (other than enrollment/disenrollment information and summary health information and information disclosed pursuant to a signed authorization that complies with the requirements of 45 CFR §164.508, which are not subject to these restrictions) on behalf of the plan, the plan sponsor will:

1. Implement administrative, physical, and technical safeguards that reasonably and appropriately protect the confidentiality, integrity, and availability of the electronic PHI that it creates, receives, maintains, or transmits on behalf of the plan;
2. Ensure that the adequate separation between the plan and the plan sponsor (i.e., the firewall), required by 45 CFR §164.504(f)(2)(iii), is supported by reasonable and appropriate security measures;
3. Ensure that any agent, including a subcontractor, to whom it provides electronic PHI agrees to implement reasonable and appropriate security measures to protect such PHI; and
4. Report to the plan any security incident with respect to electronic PHI of which it becomes aware.

C. Certification of Plan Sponsor

The plan shall disclose PHI to the plan sponsor only upon the receipt of a certification by the plan sponsor that the plan has been amended to incorporate the provisions of 45 CFR §164.504(f)(2)(ii), and that the plan sponsor agrees to the conditions of disclosure set forth in *Section B* of this *Part XIX*.

D. Permitted Uses and Disclosure of Summary Health Information

The plan or a health insurance issuer or HMO with respect to the plan, may disclose summary health information to the plan sponsor, provided the plan sponsor requests such summary health information for the purpose of:

1. Obtaining premium bids from health plan providers for providing health insurance coverage under the plan; or
2. Modifying, amending, or terminating the plan.

E. Adequate Separation Between the Plan and the Plan Sponsor

The plan sponsor shall only allow the Director of the Corinthian Plan to have access to PHI. No other individual shall have access to PHI.

Such individual shall only have access to and use of PHI to the extent necessary to perform the plan administration functions that the plan sponsor performs for the plan. In the event that such individual does not comply with the provisions of this *Part XIX*, the individual shall be subject to disciplinary action by the plan sponsor for non-compliance pursuant to the plan sponsor's employee discipline and termination procedures.

The plan sponsor will ensure that the provisions of this *Part XIX* are supported by reasonable and appropriate security measures to the extent the individual designated in this *Section E* creates, receives, maintains, or transmits electronic PHI on behalf of the plan.

F. Definitions

For purposes of this *Part XIX*, the following terms shall have the meaning set forth below unless otherwise provided by the plan:

Electronic protected health information (electronic PHI) — PHI that is transmitted by or maintained in any electronic media.

Plan sponsor — The plan sponsor of the plan is Mennonite Church USA.

Protected health information (PHI) — Information that is created or received by the plan and relates to the past, present, or future physical or mental health or condition of a member; the provision of health care to a member; or the past, present, or future payment for the provision of health care to a member; and that identifies the member or for which there is a reasonable basis to believe the information can be used to identify the member. PHI includes information of persons living or deceased.

The following components of a member's information also are considered PHI: a) names; b) street address, city, county, precinct, zip code; c) dates directly related to a member, including birth date, health facility admission and discharge date, and date of death; d) telephone numbers, fax numbers, and electronic mail addresses; e) Social Security numbers; f) medical record numbers; g) health plan beneficiary numbers; h) account numbers; i) certificate/license numbers; j) vehicle identifiers and serial numbers, including license plate numbers; k) device identifiers and serial numbers; l) Web Universal Resource Locators (URLs); m) biometric identifiers, including finger and voice prints; n) full face photographic images and any comparable images; and o) any other unique identifying number, characteristic, or code.

Summary health information — Information: a) that summarizes the claims history, claims expenses, or type of claims experienced by individuals for whom a plan sponsor has provided health benefits under a group health plan; and b) from which the information described at 45 CFR §164.514(b)(2)(i) has been deleted, except that the geographic information except that the geographic information described in 45 CFR §164.514(b)(2)(i)(B) need only be aggregated to the level of a five-digit zip code.

Part XX, Other Important Points

A. Subrogation

Subrogation means the plan's right to reimbursement — for loss under this summary plan description — for amounts you or any covered person recover for the same loss from any person or organization. No person shall take or do anything to defeat the plan's rights of subrogation.

Subrogation applies to all claims, demands, actions, and rights of recovery you or any covered person may have against a third party or parties and the third party's insurers for a covered person's illness or injury. The plan's subrogation rights

apply to your own or any covered person's uninsured motorist, underinsured motorist, or no-fault automobile insurance coverage, too. You or any covered person must reimburse the plan on whatever amount of money is received.

If the plan pays any benefits for a covered person because of an injury or illness that was caused by a third party, then the plan will pay benefits on the condition and with the agreement and understanding that the covered person will reimburse the plan for the amount of benefits paid (including costs and legal or attorney's fees in recovering the money) from the amount you or any covered person recover from the third party.

The plan shall be reimbursed in full in first priority from any monies to the extent of any and all benefits paid by the plan. You will not be required to reimburse the plan for more than you or any covered person receive by way of settlement or recovery on a judgement. If you or any covered person recover less than the plan has paid, you will not have to pay any additional money out of your pocket. If you or any covered person recover more than the plan has paid, you will be entitled to keep the difference between what was recovered and what the plan has paid.

If you or any covered person have a claim against a third party for an illness or injury, do not sign any releases or other papers that may compromise the plan's right to reimbursement or subrogation. **Be sure to check with Highmark before any papers are signed.** Any covered person must not hinder the plan's attempts to recover or resolve the claim with the third party unless Highmark gives prior written consent. Because of payments the plan makes on behalf of plan participants, all plan participants have an obligation to cooperate fully with Highmark in their efforts to seek reimbursement from a third party.

B. Overpayment

If for some reason the plan pays you more than you are entitled to, the plan has the right to subtract the overpayment from payments made to the provider on your behalf in the future.

C. Periodic Information Requests

In order to keep plan information up-to-date, Highmark may request basic information about you or your covered dependents that is required to pay claims according to plan provisions.

D. Assignment

The benefits provided by the plan are intended to provide for your family's health care needs. Therefore, you may not assign any of the benefits to which you may be entitled under the plan to any person or organization unless that person or organization has provided health care services to you or a covered member of your family.

E. Payment of Claims

The plan may require proof of payment before reimbursing you for claims that were not assigned to a health care provider.

If Highmark determines that a valid release cannot be given for payment of plan benefits, Highmark may, at its discretion, pay the individual who has assumed responsibility for your principal support and care. Because he or she has paid for your support and care, it is only fair for the plan to make payment to him or her.

If you should die before benefit payments have been made, Highmark may honor assignments you made before your death.

Any payment made by Highmark in accordance with this provision shall fully satisfy its liability for payment.

F. Misrepresentation

If you or your dependent intentionally misrepresent a material fact (either verbally or in writing) or commit fraud and because of that intentional misrepresentation or fraud, coverage is given to an individual who would otherwise not be eligible for coverage, the plan has the right to rescind coverage from the date it became effective and pursue recovery of any benefits received. At least 30 days advance notice will be provided before plan coverage is rescinded.

Likewise, if a covered person knowingly makes a statement, either verbally or in writing, which is not true and because of that statement, a claim that would otherwise not be eligible for payment is paid, the plan has the right to pursue recovery of benefits received by the covered person as a result of the claim.

G. Clerical Error

Any clerical error by the plan administrator or an agent of the plan administrator in keeping records pertaining to plan coverage or delays in making any changes will not invalidate coverage otherwise validly in force or continue coverage validly terminated. An equitable adjustment will be made when the error or delay is discovered.

In addition, any clerical error or delay by the plan administrator or an agent of the plan administrator in enrolling an individual as required by the terms of the plan will not invalidate coverage for which an individual would otherwise be eligible.

H. Enforceability

The plan (as described in this summary plan description and related documents which together constitute the plan) is maintained for the exclusive benefit of the employees of participating institutions. As a participant in this plan, your rights to its coverage and any particular benefit that it provides are legally enforceable.

I. Amendment of the Plan

The plan sponsor reserves the right to amend the plan at any time without prior notice to plan participants. Any amendments to the plan will be in writing and shall be made by resolution of the person or persons who have been duly authorized by the plan sponsor to take such action.

Properly executed amendments shall be delivered to the plan and the claims administrator (Highmark). Plan participants will be notified of any amendment of the plan, in writing, by the plan administrator.

J. Termination of the Plan

The plan sponsor intends to maintain this plan indefinitely; however, it reserves the right to terminate the plan at any time, either in whole or in part, by an instrument properly executed and delivered to the plan and the claims administrator (Highmark). Any such termination of the plan shall be made by resolution of the person or persons who have been duly authorized by the plan sponsor to take such action. Plan participants will be notified of any termination of the plan, in writing, by the plan administrator.

In the event the plan is terminated altogether, plan liability for payment of claims shall be limited to payment of those claims incurred as of the date the plan is terminated. Neither the plan nor the plan sponsor shall have any liability for charges, fees, or expenses that are incurred after the effective date of the termination of the plan.