
**PLAN DOCUMENT AND
SUMMARY PLAN DESCRIPTION
FOR
CHRISTIAN AND MISSIONARY ALLIANCE**

Effective January 1, 2023

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INTRODUCTION

This Plan was established by The Christian and Missionary Alliance for the benefit of employees who are employed by any denominational employer that elects to participate in the Plan. Denominational employers that are eligible to participate in the Plan include the C&MA National Office, a district office or local church, and any agency, supporting organization, or institution officially related to The Christian and Missionary Alliance.

This Plan is intended to be a “church plan” within the meaning of section 414(e) of the Internal Revenue Code of 1986, as amended, and section 3(33) of the Employee Retirement Income Security Act of 1974 (“ERISA”) and, as such, is exempt from the requirements of ERISA.

This document is a description of Christian and Missionary Alliance Health Care Plan (the Plan). No oral interpretations can change this Plan. The Plan described is designed to protect Plan Participants against certain catastrophic health expenses. This High Definition Health (HDHP) Plan is designed to be used with a Health Savings Accounts (HSA), HSA HDHP.

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

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

To the extent that an item or service is a covered benefit under the Plan, the terms of the Plan shall be applied in a manner that does not discriminate against a health care provider who is acting within the scope of the provider's license or other required credentials under applicable State law. This provision does not preclude the Plan from setting limits on benefits, including cost sharing provisions, frequency limits, or restrictions on the methods or settings in which treatments are provided and does not require the Plan to accept all types of providers as a Network Provider.

Failure to follow the eligibility or enrollment requirements of this Plan may result in delay of coverage or no coverage at all. Reimbursement from the Plan can be reduced or denied because of certain provisions in the Plan, such as coordination of benefits, subrogation, exclusions, timeliness of Continuation Coverage, utilization review or other cost management requirements, lack of Medical Necessity, lack of timely filing of claims or lack of coverage. These provisions are explained in summary fashion in this document; additional information is available from the Plan Administrator at no extra cost.

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

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

It is the intent of this Plan and the Plan Administrator to comply with all applicable Federal and State laws and regulations. In the event of non-compliance with any such law or regulation, the Plan Document will be deemed amended to comply with said law or regulation as of its effective date, and the remainder of the Plan Document will remain in full force and effect. Similarly, in the event a law or regulation applicable to this Plan becomes effective after the initial effective date of this Plan Document, said law or regulation will be deemed included in this Plan Document as of its effective date and without the necessity of an amendment to this Plan Document.

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

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

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

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

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

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

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

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

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

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

Third Party Recovery Provision. Explains the Plan's rights to recover payment of charges when a Covered Person has a claim arising out of an accidental illness or injury, including but not limited to worker's compensation claims.

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

**Notice re U.S. Code §1557 Compliance
Discrimination is Against the Law**

The Christian and Missionary Alliance complies with applicable Federal civil rights laws and does not discriminate on the basis of race, color, national origin, age, disability, or sex.

The Christian and Missionary Alliance does not exclude people or treat them differently because of race, color, national origin, age, disability, or sex.

The Christian and Missionary Alliance:

1. Provides free aids and services to people with disabilities to communicate effectively with us, such as: Qualified sign language interpreters; written information in other formats (large print, audio, accessible electronic formats, other formats)
2. Provides free language services to people whose primary language is not English, such as: Qualified interpreters; Information written in other languages.

If you need these services, contact The Christian and Missionary Alliance.

If you believe that The Christian and Missionary Alliance has failed to provide these services or discriminated in another way on the basis of race, color, national origin, age, disability, or sex you can file a grievance with:

The Christian and Missionary Alliance
ATTN: Ken Baldes
Vice President of Operations/Treasurer
8595 Explorer Drive
Colorado Springs, Colorado 80920-1012
Phone: 719-265-2128
Fax: 719-262-5397
Email address: www.alliancebenefits.org

You can file a grievance in person or by mail, fax, or email. If you need help filing a grievance, (The Christian and Missionary Alliance is available to help you. You can also file a civil rights complaint with the U.S. Department of Health and Human Services, Office for Civil Rights, electronically through the OCR Complaint Portal, available at <https://ocrportal.hhs.gov/ocr/portal/lobby.jsf>, or by mail or phone at:

U.S. Department of Health and Human Services
200 Independence Avenue, SW
Room 509F HHH Building
Washington, D.C. 20201
1-800-368-1019, 800-537-7697 (TDD)

Complaint forms are available at <http://www.hhs.gov/ocr/office/file/index.html>

Spanish (Español): Para obtener asistencia en Español, llame al 1-800-442-7247
Tagalog (Tagalog): Kung kailangan ninyo ang tulong sa Tagalog tumawag 1-800-442-7247
Chinese (中文): 如果需要中文的帮助, 请拨打这个号码 1-800-442-7247
Navajo (Dine): Dinek'ehgo shika at'ohwol ninisingo, kwijigo holne' 1-800-442-7247

SCHEDULE OF BENEFITS

Verification of Eligibility 800-442-7247

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

MEDICAL BENEFITS

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

This document is intended to describe the benefits provided under the Plan but, due to the number and wide variety of different medical procedures and rapid changes in treatment standards, it is impossible to describe all covered benefits and/or exclusions with specificity. Please contact the Plan Administrator if you have questions about specific supplies, treatments or procedures.

BALANCE BILLING

The No Surprises Act, part of Title I of the Consolidated Appropriations Act of 2021, prohibits Physicians, Providers, health care facilities and air ambulance companies from balance billing Covered Persons or otherwise holding Covered Persons liable for any more than the applicable cost sharing amounts they would have owed for Network care. Specifically, these balance billing protections apply when a Covered Person receives Emergency Services from a Non-Network provider or facility, when a Covered Person receives certain non-Emergency Services from a Non-Network provider at Network hospital or ambulatory surgical center, and when a Covered Person receives Emergency Services from a Non-Network air ambulance service.

However, these protections against balance billing do not apply if the Covered Person consents to treatment by a Non-Network provider (this consent exception generally does not apply in emergency situations).

In addition, this Plan generally will cover Emergency Services without precertification; cover Emergency Services by Non-Network providers; base cost sharing amounts on Network benefits; and count any cost sharing amounts for services subject to balance billing protections toward a Covered Person's Network deductible and out-of-pocket limit.

If a Covered Person believes he or she has received a balance bill that is protected under the No Surprises Act, please contact HealthComp Administrators, Inc. at (800) 442-7247 for additional information.

Please visit www.dol.gov/agencies/ebsa/laws-and-regulations/laws/no-surprises-act for additional information regarding the No Surprises Act.

Note: The following services must be precertified or reimbursement from the Plan may be reduced.

- (1) All inpatient Hospital and Skilled Nursing Facility stays.
- (2) Facility based Treatment for Mental or Nervous Disorders or Substance Abuse.
- (3) Home Health Care.
- (4) All Organ and Tissue Transplants, peripheral stem cell replacement and similar procedures.
- (5) Infusion Therapy that includes Specialty Drugs in the specialty pharmacy program, and related services (for each Course of Therapy) in any setting, including, but not limited to: Physician's office, infusion center, outpatient Hospital or clinic, or your home or other residential setting.
- (6) Certain surgical, diagnostic procedures, Durable Medical Equipment and/or prosthetics wherever rendered as specified by Anthem Blue Cross. For a list of current procedures, please contact Anthem Blue Cross toll free at (800) 274-7767.

Please see the Cost Management section in this booklet for details.

The attending Physician does not have to obtain precertification from the Plan for prescribing a maternity length of stay that is 48 hours or less for a vaginal delivery or 96 hours or less for a cesarean delivery.

This Plan has entered into an agreement with certain Hospitals, Physicians and other health care providers, which are called Network Providers. Because these Network Providers have agreed to charge reduced fees to persons covered under the Plan, the Plan can afford to reimburse a higher percentage of their fees.

If the Plan generally requires or allows the designation of a primary care provider, a Covered Person has the right to designate any primary care provider who is a Network Provider and who is available to accept the Covered Person. For children, a Covered Person may designate a pediatrician as the primary care provider if the pediatrician is a Network Provider and is available to accept the child as a patient. A Covered Person does not need prior authorization from the Plan, a primary care provider, or any other person in order to obtain access to obstetrical or gynecological care from a health care professional who specializes in obstetrics or gynecology and who is a Network Provider. However, the health care professional may be required to comply with certain Plan procedures, including obtaining prior authorization for certain services, following a pre-approved treatment plan, or procedures for making referrals.

Therefore, when a Covered Person uses a Network Provider, that Covered Person will receive better benefits from the Plan than when a Non-Network Provider is used. It is the Covered Person's choice as to which Provider to use. Terms of agreements that allow the Plan access to Network Providers and other discounts may differ from provisions of the Plan and will be honored by the Plan as required, except those claims related to dialysis.

Under the following circumstances, the higher In-Network payment will be made for certain Non-Network services:

If a Covered Person has no choice of Network Providers in the specialty that the Covered Person is seeking within the PPO service area.

If a Covered Person has a Medical Emergency requiring immediate care.

If a Covered Person is referred to a Non-Network Provider by an In-Network Provider because the non-emergency service is not available from a Network Provider.

If a covered person has no choice of a Network Provider and receives services by a Non-Network Provider at a network facility.

If a covered person has no choice of a Network Provider within a 50 mile radius, and receives services by a Non-Network Provider at a Network facility.

Additional information about this option, including any rules that apply to designation of a primary care provider, as well as a list of Network Providers, will be given to Plan Participants, at no cost, and updated as needed. This list will include providers who specialize in obstetrics or gynecology.

High Deductible Health Plan

A qualified High Deductible Health Plan (HDHP) with a Health Savings Account provides comprehensive coverage for high cost medical events and a tax-advantaged way to help build savings for future medical expenses. The Plan gives you greater control over how health care benefits are used. A HDHP satisfies certain statutory requirements with respect to minimum deductibles and out-of-pocket expenses for both single and family coverage. These minimum deductibles and limits for out-of-pocket expenses' limit are set forth by the U.S. Department of Treasury and will be indexed for inflation in the future.

There are no copayments.

HSA HDHP MEDICAL BENEFITS SCHEDULE

COVERED CHARGES	NETWORK PROVIDERS	NON-NETWORK PROVIDERS
DEDUCTIBLE, PER CALENDAR YEAR - The Deductible amounts shown below are separate. The Deductible for Network Providers applies only to those charges. The Deductible for Non-Network Providers applies only to those charges. The Deductible is combined with the Prescription Drug Deductible		
Self-only	\$2,000	\$4,000
Family Coverage (aggregate)	\$4,000	\$12,000
No benefits will be paid for any member of a Family Unit until the Family Unit Deductible has been met regardless of the number of participants it takes to meet the Family Deductible.		
MAXIMUM OUT-OF-POCKET AMOUNT, PER CALENDAR YEAR The maximums shown below are separate. The Out-of-Pocket maximum for Network Providers applies only to those charges. The Out-of-Pocket maximum for Non-Network Providers applies only to those charges. The Out-of-Pocket maximum is combined with the Prescription Drug Out-of- Pocket maximum		
Self-only	\$6,300	\$12,600
Family Coverage		
Individual	\$6,300	\$12,600
Per Family Unit	\$12,600	\$37,800
The Plan will pay the designated percentage of Covered Charges until Out-of-Pocket amounts are reached. The Family Out-of-Pocket includes an embedded Out-of-Pocket whereby once an individual reaches the single coverage Out-of-Pocket, the Plan will pay 100% of the remainder of Covered Charges for that individual for the rest of the Calendar Year unless stated otherwise. Once the Family Out-of-Pocket is reached, the Plan will pay 100% of the remainder of Covered Charges for the entire family for the rest of the Calendar Year unless stated otherwise.		
The following charges do not apply toward the Out-of-Pocket maximum and are never paid at 100%. Amounts over the Allowed Amount Cost containment penalties		
COVERED CHARGES		
Note: The maximums listed below are the total for Network and Non-Network expenses. For example, if a maximum of 60 days is listed twice under a service, the Calendar Year maximum is 60 days total which may be split between Network and Non-Network providers.		
Percentage Payable – unless otherwise stated.	80% after deductible	50% after deductible
Ambulance Service	80% after deductible	Same as Network
Autism Spectrum Disorders		
Office Visits and Medication Management	90% after deductible	50% after deductible
Mental Health Psychotherapy	90% after deductible	50% after deductible
Habilitative Therapy	80% after deductible	50% after deductible
Applied Behavioral Analysis Therapy	80% after deductible	50% after deductible
Bariatric Surgery	Covered the same as any other illness based on place and type of service	Covered the same as any other illness based on place and type of service
Biofeedback	80% after deductible	50% after deductible
Birthing Center	80% after deductible	50% after deductible
CT Scans, MRI and PET Scans	80% after deductible	50% after deductible
Diabetes Education	80% after deductible	50% after deductible
Diabetes Supplies/Equipment	80% after deductible	50% after deductible
Dialysis	80% after deductible	50% after deductible
Durable Medical Equipment	80% after deductible	50% after deductible
Emergency Room Visit – Including professional services	80% after deductible	Same as Network
First Stop Health	100% after deductible	Not covered

Hearing Exam and Hearing Aids		
Hearing exam – for fit of aid	80% after deductible 1 exam every 24 months	Not covered
Hearing Aids	80% after deductible \$750 maximum per ear every 24 months	Not covered
Home Health Care - six months lifetime maximum	80% after deductible 40 visits Calendar Year maximum	50% after deductible 40 visits Calendar Year maximum
Hospice Care	80% after deductible	50% after deductible
Bereavement	80% after deductible	50% after deductible
Hospital Services		
Inpatient – the semiprivate room rate	80% after deductible	50% after deductible
Intensive Care Unit - Hospital's ICU Charge	80% after deductible	50% after deductible
Ambulatory/Outpatient Surgery Facilities	80% after deductible	50% after deductible
Outpatient Services	80% after deductible	50% after deductible
Infertility Treatment	80% after deductible	50% after deductible
Includes: care, supplies and services for the diagnosis of infertility, treatment and charges for surgical correction of physiological abnormalities of infertility.		
Jaw Joint Conditions / Temporomandibular Joint Syndrome (TMJ) -diagnostic services and non-surgical treatment	80% after deductible	50% after deductible
Lab & X-ray	80% after deductible	50% after deductible
Marital Counseling – outpatient services only	80% after deductible	50% after deductible
Mental Disorders		
Inpatient – the facility's semiprivate room rate	80% after deductible	50% after deductible
Outpatient	80% after deductible	50% after deductible
Office Setting	90% after deductible	50% after deductible
Residential Treatment Facility	80% after deductible	50% after deductible
Organ Transplants – for recipient and donor.	Contact Optum-Managed Transplant Programs 888-321-0881	
Orthotics	80% after deductible	50% after deductible
Pediatric Extended Care - eight years of age or under	80% after deductible 100 days per Calendar Year maximum	80% after deductible 100 days per Calendar Year maximum
Physician Services		
Inpatient visits	80% after deductible	50% after deductible
Office visits	90% after deductible	50% after deductible
Specialist Office Visits	80% after deductible	50% after deductible
Office Visit Services – including Minor Surgery, Lab, X-ray, and Supplies	80% after deductible	50% after deductible
Surgery (Inpatient and Outpatient)	80% after deductible	50% after deductible
Assistant Surgeon and Anesthesiologists	80% after deductible	50% after deductible
Allergy Injections, and Serum	80% after deductible	50% after deductible
Allergy Testing	80% after deductible	50% after deductible

Pre-Admission Testing	80% after deductible	50% after deductible
Pregnancy	Covered as any other illness based on place and type of service	Covered as any other illness based on place and type of service
Preventive Care – Services as defined by the Patient Protection Affordable Care Act for Network and Non-Network Providers.		
Routine Well Care – All ages	100% deductible waived	Not covered
Note: Cost sharing (deductibles, copayment and coinsurance) will be waived for FDA-approved COVID-19 vaccines for Network and Non-Network providers.		
Prosthetics	80% after deductible	50% after deductible
Rehabilitation/Habilitation		
Occupational and Physical Therapies	80% after deductible 60 visits Calendar Year maximum combined	50% after deductible 60 visits Calendar Year maximum combined
Speech Therapy	80% after deductible 30 visits Calendar Year maximum combined	50% after deductible 30 visits Calendar Year maximum combined
Skilled Nursing Facility – the facility's semiprivate room rate	80% after deductible 60 days Calendar Year maximum	50% after deductible 60 days Calendar Year maximum
Spinal Manipulation Chiropractic, Acupuncture, Massage Therapy, and Naturopathy	80% after deductible 20 visits Calendar Year maximum combined	50% after deductible 20 visits Calendar Year maximum combined
Substance Abuse		
Inpatient – the facility's semiprivate room rate	80% after deductible	50% after deductible
Outpatient	80% after deductible	50% after deductible
Office Setting	90% after deductible	50% after deductible
Urgent Care – includes physician services	85% after deductible	50% after deductible
Voluntary Sterilization		
Female	100% deductible waived	Not covered
Male	80% after deductible	50% after deductible

it is the intent of this Plan to comply with all Federal mandates, for so long as they remain in effect and provide for the screening and testing of patients for COVID-19 as set forth.

Cost sharing (deductibles, copayments and coinsurance) will be waived for medically necessary screening and testing for FDA-approved COVID-19 including hospital, emergency department, urgent care, and provider office visits, including telehealth where the purpose of the visit is to be screened and/or tested for COVID-19 for Network and Non-Network providers. The screening services are included without cost share even if the visit does not result in an order or administration of the COVID-19 test.

HSA HDHP PRESCRIPTION DRUG BENEFIT SCHEDULE

Please refer to the Employee ID card for the Prescription Drug Administrator's phone number.

Please contact the Prescription Drug Administrator for additional information.

PRESCRIPTION DRUG BENEFIT		
	NETWORK	NON-NETWORK
DEDUCTIBLE, PER CALENDAR YEAR - The Deductible is combined with the Medical Deductible		
Self-only	\$2,000	Not applicable
Family Coverage (aggregate)	\$4,000	Not applicable
No benefits will be paid for any member of a Family Unit until the Family Unit deductible has been met regardless of the number of participants it takes to meet the family deductible.		
MAXIMUM OUT-OF-POCKET AMOUNT, PER CALENDAR YEAR - The Out-of-Pocket maximum is combined with the Medical Out-of-Pocket maximum.		
Self-only	\$6,300	Not applicable
Family Coverage		
Individual	\$6,300	Not applicable
Per Family Unit	\$12,600	Not applicable
The Plan will pay the designated percentage of Covered Charges until out-of-pocket amounts are reached. The Family out-of-pocket includes an embedded out-of-pocket whereby once an individual reaches the single coverage out-of-pocket, the Plan will pay 100% of the remainder of Covered Charges for that individual for the rest of the Calendar Year unless stated otherwise. Once the Family out-of-pocket is reached, the Plan will pay 100% of the remainder of Covered Charges for the entire family for the rest of the Calendar Year unless stated otherwise.		
Pharmacy Option (30 Day Supply)		
Generic Drugs	85% after deductible is satisfied	Not covered
Preferred Brand	75% after deductible is satisfied	Not covered
Non-Preferred Brand	85% after deductible is satisfied	Not covered
Formulary Brand Name Drugs – when no Generic is available	75% after deductible is satisfied	Not covered
Formulary Brand Name Drugs – when Generic is available	75% after deductible is satisfied	Not covered
Formulary Brand Name Drug – with generic equivalent	85% after deductible plus cost difference	Not covered
Non-Formulary Brand Name Drugs – when Generic is available	85% after deductible is satisfied	Not covered
Non-Formulary Brand Name Drugs – when no Generic is available	85% after deductible is satisfied	Not covered
Non-Formulary Brand Name Drug – with generic equivalent	85% after deductible plus cost difference	Not covered
Specialty Drugs	75% after deductible is satisfied	Not covered
Mail Order Option (90 Day Supply)		
Generic Drugs	90% after deductible is satisfied	Not Applicable
Preferred Brand	75% after deductible is satisfied	Not covered
Non-Preferred Brand	90% after deductible is satisfied	Not covered

PRESCRIPTION DRUG BENEFIT		
Formulary Brand Name Drugs – when no Generic is available	80% after deductible is satisfied	Not Applicable
Formulary Brand Name Drugs – when Generic is available	80% after deductible is satisfied	Not applicable
Formulary Brand Name Drug – with generic equivalent	90% after deductible plus cost difference	Not covered
Non-Formulary Brand Name Drugs – when Generic is available	90% after deductible is satisfied	Not covered
Non-Formulary Brand Name Drugs – when no Generic is available	90% after deductible is satisfied	Not covered
Non-Formulary Brand Name Drug – with generic equivalent	90% after deductible plus cost difference	Not covered
Refer to the Prescription Drug Section for details on the Prescription Drug benefit.		

In addition, it is the Plan Administrator's intent to comply with federal law regarding preventive care benefits under the Patient Protection and Affordable Care Act. All prescriptions which qualify for the preventive care benefit, as defined by the appropriate federal regulatory agencies, and which are provided by a network-participating pharmacy, will be covered at 100% with no deductible or co-insurance required.

The plan is implementing a specialty pharmacy copay assistance program with SaveOn.

Certain specialty pharmacy drugs are considered non-essential health benefits under the plan and the cost of such drugs will not be applied toward satisfying the participant's out-of-pocket maximum. **Contact the prescription Drug Administrator for a list of these drugs and information to enroll in this Program.** Although the cost of the Program drugs will not be applied towards satisfying a participant's out-of-pocket maximum, the cost of the Program drugs will be reimbursed by the manufacturer at no cost to the participant.

Copays for certain specialty medications may be set to the maximum of the current plan design or any available manufacturer-funded copay assistance.

ELIGIBILITY, FUNDING, EFFECTIVE DATE AND TERMINATION PROVISIONS

A Plan Participant should contact the Plan Administrator to obtain additional information, free of charge, about Plan coverage of a specific benefit, particular drug, treatment, test or any other aspect of Plan benefits or requirements.

ELIGIBILITY

Eligible Classes of Employees. All Active Employees, who qualify under one of the classes below.

New Hires:

- **Regular Full-Time Employees:** Employees designated by the Employer as Regular Full-Time Employees who are scheduled to work at least 30 hours per week. Coverage for Regular Full-Time Employees becomes effective on the first day of the month following completion of the Waiting Period, subject to completion of enrollment requirements.
- **Regular Part-Time Employees:** Employees designated by the Employer as Regular Part-Time Employees who are scheduled to work at least 20 hours per week. Coverage for Regular Part-Time Employees becomes effective on the first day of the month following completion of the Waiting Period, subject to completion of enrollment requirements.

A Waiting Period is the time between the first day of employment as an eligible Employee and the first day of coverage under the Plan unless hired on the first day of the month, then coverage begins on that day.

An Employee's status as a Full-Time or Part-Time Employee will be determined on the basis of the average number of hours worked during an initial or standard measurement period, as applicable, as established by the Plan in accordance with applicable law. The Employee's eligibility (or lack of eligibility) for Plan coverage on the basis of his or her Full-Time or Part-Time status will extend through the stability period established by the Plan in accordance with applicable law. In calculating the average hours worked, the Plan will count hours paid and hours for which the Employee is entitled to payment (such as paid holidays, vacation, pay, etc.). An Employee's status as a Full-Time or Part-Time Employee will be determined on the basis of the Employer's standard employment practices.

Contact the Human Resources Department for additional information.

Eligible Classes of Dependents. A Dependent is any one of the following persons:

- (1) A covered Employee's Spouse.

The term "Spouse" shall mean the person with whom the covered Employee has established a valid marriage under applicable State law but does not include common law marriages. The term "Spouse" shall not include an individual of the same sex as the covered employee, even if they were legally married under the laws of a State or other foreign or domestic jurisdiction. The Plan Administrator may require documentation proving a legal marital relationship.

- (2) A covered Employee's Child(ren).

An Employee's "Child" includes his natural child, stepchild, child for whom the Employee is the legal guardian, adopted child, or a child placed with the Employee for adoption. An Employee's Child will be an eligible Dependent until reaching the limiting age of 26, without regard to student status, marital status, financial dependency or residency status with the Employee or any other person. When the child reaches the applicable limiting age, coverage will end on the last day of the child's birthday month.

The phrase "placed for adoption" refers to a child whom a person intends to adopt, whether or not the adoption has become final, who has not attained the age of 18 as of the date of such placement for adoption. The term "placed" means the assumption and retention by such person of a legal

obligation for total or partial support of the child in anticipation of adoption of the child. The child must be available for adoption and the legal process must have commenced.

The Plan Administrator may require documentation proving eligibility for Dependent coverage, including birth certificates, tax records or initiation of legal proceedings severing parental rights.

- (3) A covered Dependent Child who reaches the limiting age and is Totally Disabled, incapable of self-sustaining employment by reason of mental or physical handicap, primarily dependent upon the covered Employee for support and maintenance and unmarried. The Plan Administrator may require, at reasonable intervals during the two years following the Dependent's reaching the limiting age, subsequent proof of the child's Total Disability and dependency.

After such two-year period, the Plan Administrator may require subsequent proof not more than once each year. The Plan Administrator reserves the right to have such Dependent examined by a Physician of the Plan Administrator's choice, at the Plan's expense, to determine the existence of such incapacity.

These persons are excluded as Dependents: other individuals living in the covered Employee's home, but who are not eligible as defined; the legally separated or divorced former Spouse of the Employee; any person who is on active duty in any military service of any country; or any person who is covered under the Plan as an Employee.

If a person covered under this Plan changes status from Employee to Dependent or Dependent to Employee, and the person is covered continuously under this Plan before, during and after the change in status, credit will be given for deductibles and all amounts applied to maximums.

If both parents are Employees, their eligible Dependent will be covered as the Dependent of one or the other, but not of both.

Eligibility Requirements for Dependent Coverage. A family member of an Employee will become eligible for Dependent coverage on the first day that the Employee is eligible for Employee coverage and the family member satisfies the requirements for Dependent coverage.

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

Court-ordered Coverage for a Child

Federal law requires the Plan, under certain circumstances, to provide coverage for your children. The details of these requirements are summarized below. Be sure you read them carefully.

The Plan Administrator shall enroll for immediate coverage under this Plan any alternate recipient who is the subject of a "medical child support order" ("MCSO") or "national medical support notice" ("NMSN") that is a "qualified medical child support order" ("QMCSO") if the child named in the MCSO is not already covered by the Plan as an eligible dependent, once the Plan Administrator has determined that the order or notice meets the standards for qualification set forth below.

"Alternate recipient" shall mean any child of a Covered Employee who is recognized under a MCSO as having a right to enrollment under this Plan as the Covered Employee's Eligible Dependent. "MCSO" shall mean any judgment, decree or order (including approval of a domestic relations settlement agreement) issued by a court of competent jurisdiction that:

1. Provides for child support with respect to a Covered Employee's child or directs the Covered Employee to provide coverage under a health benefits plan pursuant to a state domestic relations law (including a community property law); or
2. Enforces a law relating to medical child support described in Social Security Act §1908 with respect to a group health plan.

“NMSN” shall mean a notice that contains the following information:

1. Name of an issuing state agency;
2. Name and mailing address (if any) of an employee who is a Participant under the Plan;
3. Name and mailing address of one or more Alternate Recipients (i.e., the child or children of the Covered Employee or the name and address of a substituted official or agency that has been substituted for the mailing address of the alternate recipients(s)); and
4. Identity of an underlying child support order.

“QMCSO” is an MCSO that creates or recognizes the existence of an Alternate Recipient’s right to, or assigns to an Alternate Recipient the right to, receive benefits for which a Covered Employee or Eligible Dependent is entitled under this Plan. In order for such order to be a QMCSO, it must clearly specify the following:

1. The name and last known mailing address (if any) of the Covered Employee and the name and mailing address of each Alternate Recipient covered by the order;
2. A reasonable description of the type of coverage to be provided by the Plan to each Alternate Recipient, or the manner in which such type of coverage is to be determined;
3. The period of coverage to which the order pertains; and
4. The name of this Plan.

In addition, an NMSN shall be deemed a QMCSO if it:

1. Contains the information set forth above in the definition of “NMSN”;
 - a. Identifies either the specific type of coverage or all available group health coverage. If the employer receives an NMSN that does not designate either specific type(s) of coverage or all available coverage, the Employer and the Plan Administrator will assume that all are designated; or
 - b. Informs the Plan Administrator that, if a group health plan has multiple options and the Eligible Dependent is not enrolled, the issuing agency will make a selection after the NMSN is qualified, and, if the agency does not respond within 20 days, the child will be enrolled under the Plan’s default option (if any); and
2. Specifies that the period of coverage may end for the Alternate Recipient(s) only when similarly situated dependents are no longer eligible for coverage under the terms of the Plan, or upon the occurrence of certain specified events.

However, such an order need not be recognized as “qualified” if it requires the Plan to provide any type or form of benefit, or any option, not otherwise provided to Participants without regard to this section, except to the extent necessary to meet the requirements of a state law relating to MCSOs, as described in Social Security Act §1908.

Upon receiving a MCSO, the Plan Administrator shall, as soon as administratively possible:

1. Notify the Covered Employee and each Alternate Recipient covered by the order (at the address included in the order) in writing of the receipt of such order and the Plan’s procedures for determining whether the order qualifies as a QMCSO; and
2. Make an administrative determination if the order is a QMCSO and notify the Participant and each affected Alternate Recipient of such determination.

Upon receiving a NMSN, the Plan Administrator shall:

1. Notify the state agency issuing the notice with respect to the child whether coverage of the child is available under the terms of the Plan and, if so:
 - a. Whether the child is covered under the Plan; and
 - b. Either the effective date of the coverage or, if necessary, any steps to be taken by the custodial parent or by the official of a state or political subdivision to effectuate the coverage; and
2. Provide to the custodial parent (or any state official serving in a substitute capacity) a description of the coverage available and any forms or documents necessary to effectuate such coverage.
3. Permit any Alternate Recipient to designate a representative for receipt of copies of the notices that are sent to the Alternate Recipient with respect to the order.

FUNDING

Cost of the Plan. The cost of Employee and Dependent coverage is determined by each individual Employer.

Contact the Plan Administrator for detailed information.

The level of Employer contributions is set by the Plan Administrator. The level of Employee contributions is set by the Employer. The Plan Administrator reserves the right to change the level of Employer contributions.

ENROLLMENT

Enrollment Requirements. An Employee must enroll for coverage by filling out and signing an enrollment application.

Enrollment Requirements for Newborn Children.

A newborn child of a covered Employee who has Dependent coverage is not automatically enrolled in this Plan. If the newborn child is not enrolled in this Plan within the first 60 days following birth, there will be no payment from the Plan and the parents will be responsible for all costs. Enrollment will have to wait until the yearly open enrollment.

TIMELY ENROLLMENT

- (1) **Timely Enrollment** - The enrollment will be "timely" if the completed form is received by the Plan Administrator no later than 30 days after the person becomes eligible for the coverage, either initially or under a Special Enrollment Period.

If two Employees who are covered under the Plan are the parents of children who are covered under the Plan, and the Employee who is covering the Dependent children terminates coverage, the Dependent coverage may be continued by the other covered Employee with no Waiting Period as long as coverage has been continuous.

SPECIAL ENROLLMENT RIGHTS

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

In addition, in the case of a birth, marriage, adoption or placement for adoption, there may be a right to enroll in this Plan. However, a request for enrollment must be made within 60 days of the birth, adoption or placement for adoption and within 30 days of marriage.

The Special Enrollment rules are described in more detail below. To request Special Enrollment or obtain more detailed information of these portability provisions, contact the Plan Administrator, Christian and Missionary Alliance, 8595 Explorer Drive, Colorado Springs, Colorado, 80920, 800-700-2651.

SPECIAL ENROLLMENT PERIODS

The events described below may create a right to enroll in the Plan under a Special Enrollment Period.

- (1) Losing other coverage may create a Special Enrollment right.** An Employee or Dependent who is eligible, but not enrolled in this Plan, may enroll if the individual loses eligibility for other coverage and loss of eligibility for coverage meets all of the following conditions:

 - (a)** The Employee or Dependent was covered under a group health plan or had health insurance coverage at the time coverage under this Plan was previously offered to the individual.
 - (b)** If required by the Plan Administrator, the Employee stated in writing at the time that coverage was offered that the other health coverage was the reason for declining enrollment.
 - (c)** Either (i) the other coverage was COBRA coverage and the COBRA coverage was exhausted, or (ii) the other coverage was not COBRA coverage, and the coverage was terminated as a result of loss of eligibility for the coverage or because employer contributions towards the coverage were terminated. Coverage will begin no later than the first day of the first calendar month following the date the completed enrollment form is received.
 - (d)** The Employee or Dependent requests enrollment in this Plan not later than 30 days after the date of exhaustion of COBRA coverage or the termination of non-COBRA coverage due to loss of eligibility or termination of employer contributions, described above. Coverage will begin no later than the first day of the first calendar month following the date the completed enrollment form is received.
- (2)** For purposes of these rules, a loss of eligibility occurs if one of the following occurs:

 - (a)** The Employee or Dependent has a loss of eligibility due to the plan no longer offering any benefits to a class of similarly situated individuals (for example: part-time employees).
 - (b)** The Employee or Dependent has a loss of eligibility as a result of legal separation, divorce, cessation of dependent status (such as attaining the maximum age to be eligible as a dependent child under the plan), death, termination of employment, or reduction in the number of hours of employment or contributions towards the coverage were terminated.
 - (c)** The Employee or Dependent has a loss of eligibility when coverage is offered through an HMO, or other arrangement, in the individual market that does not provide benefits to individuals who no longer reside, live or work in a service area, (whether or not within the choice of the individual).
 - (d)** The Employee or Dependent has a loss of eligibility when coverage is offered through an HMO, or other arrangement, in the group market that does not provide benefits to individuals who no longer reside, live or work in a service area, (whether or not within the choice of the individual), and no other benefit package is available to the individual.

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

(3) Acquiring a newly eligible Dependent may create a Special Enrollment right. If:

- (a)** The Employee is a participant under this Plan (or has met the Waiting Period applicable to becoming a participant under this Plan and is eligible to be enrolled under this Plan but for a failure to enroll during a previous enrollment period), and
- (b)** A person becomes a Dependent of the Employee through marriage, birth, adoption or placement for adoption,

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

The Special Enrollment Period for newly eligible Dependents is a period of 30 days that begins after the date of the marriage, and 60 days for a birth, adoption or placement for adoption. To be eligible for this Special Enrollment, the Dependent and/or Employee must request enrollment during this 30 or 60-day period.

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

- (a)** in the case of marriage, the first day of the first month following the date of marriage;
- (b)** in the case of a Dependent's birth, as of the date of birth; or
- (c)** in the case of a Dependent's adoption or placement for adoption, the date of the adoption or placement for adoption.

(4) Eligibility changes in Medicaid or State Child Health Insurance Programs may create a Special Enrollment right. An Employee or Dependent who is eligible, but not enrolled in this Plan, may enroll if:

- (a)** The Employee or Dependent is covered under a Medicaid plan under Title XIX of the Social Security Act or a State child health plan (CHIP) under Title XXI of such Act, and coverage of the Employee or Dependent is terminated due to loss of eligibility for such coverage, and the Employee or Dependent requests enrollment in this Plan within 60 days after such Medicaid or CHIP coverage is terminated.
- (b)** The Employee or Dependent becomes eligible for assistance with payment of Employee contributions to this Plan through a Medicaid or CHIP plan (including any waiver or demonstration project conducted with respect to such plan), and the Employee or Dependent requests enrollment in this Plan within 60 days after the date the Employee or Dependent is determined to be eligible for such assistance.

If a Dependent becomes eligible to enroll under this provision and the Employee is not then enrolled, the Employee must enroll in order for the Dependent to enroll.

Coverage will become effective as of the first day of the first calendar month following the date the completed enrollment form is received unless an earlier date is established by the Employer or by regulation.

EFFECTIVE DATE

Effective Date of Employee Coverage. An Employee will be covered under this Plan as of the first day of the calendar month following the hire date unless hired on the first, then that day.

Active Employee Requirement.

An Employee must be an Active Employee (as defined by this Plan) for this coverage to take effect.

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

TERMINATION OF COVERAGE

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

When Employee Coverage Terminates. Employee coverage will terminate on the earliest of these dates:

- (1) The date the Plan is terminated.
- (2) The last day of the calendar month in which the covered Employee ceases to be in one of the Eligible Classes. This includes death or termination of Active Employment of the covered Employee. It also includes an Employee on disability, leave of absence or other leave of absence, unless the Plan specifically provides for continuation during these periods.
- (3) The end of the period for which the required contribution has been paid if the charge for the next period is not paid when due.
- (4) If an Employee commits fraud, makes an intentional misrepresentation of material fact in applying for or obtaining coverage, or obtaining benefits under the Plan, or fails to notify the Plan Administrator that he or she has become ineligible for coverage, then the Employer or Plan may either void coverage for the Employee and covered Dependents for the period of time coverage was in effect, may terminate coverage as of a date to be determined at the Plan's discretion, or may immediately terminate coverage. If coverage is to be terminated or voided retroactively for fraud or misrepresentation, the Plan will provide written notice at least 30 days in advance of such action.

Leave of Absence. A defined and approved leave of absence period is authorized and extended to an Employee for time away from job responsibilities up to a maximum of 90 days. An Employer should have a process and written documentation in place for any approved length of an Employee's leave of absence and up to a maximum of 90 days for benefit purposes. Benefits under the Plan may not be offered during a leave of absence for more than 90 days. An unpaid or paid leave of absence period must be reported by the Employer to the Plan Administrator within 30 days of change in status for further determination of benefits. If the leave of absence is due to a serious health condition, the Employer must notify the Plan Administrator immediately for review and for possible eligibility of long term disability benefits. If the employee is no longer eligible to continue benefits under their Employer, extended coverage will be offered if the employee has been on the plan for three continuous months or longer as outlined in the Continuation Coverage section of this document.

Rehiring a Terminated Employee. A terminated Employee who is rehired will be treated as a new hire and be required to satisfy all Eligibility and Enrollment requirements to the extent permitted by the terms of the Plan and applicable law.

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

- (1) The maximum period of coverage of a person and the person's covered Dependents under such an election shall be the lesser of:
 - (a) The 24 month period beginning on the date on which the person's absence begins; or
 - (b) The day after the date on which the person was required to apply for or return to a position of employment and fails to do so.
- (2) A person who elects to continue health plan coverage up to 102% of the full contribution under the Plan, except a person on active duty for 30 days or less cannot be required to pay more than the Employee's share, if any, for the coverage.
- (3) An exclusion or Waiting Period may not be imposed in connection with the reinstatement of coverage upon reemployment if one would not have been imposed had coverage not been terminated because of service. However, an exclusion or Waiting Period may be imposed for coverage of any Illness or Injury determined by the Secretary of Veterans Affairs to have been incurred in, or aggravated during, the performance of uniformed service.

If the Employee wishes to elect this coverage or obtain more detailed information, contact the Plan Administrator Christian and Missionary Alliance, 8595 Explorer Drive, Colorado Springs, Colorado, 80920, 800-700-2651. The Employee may also have continuation rights under USERRA. In general, the Employee must meet the same requirements for electing USERRA coverage as are required under COBRA continuation coverage requirements. Coverage elected under these circumstances is concurrent, not cumulative. The Employee may elect USERRA continuation coverage for the Employee and their Dependents. Only the Employee has election rights. Dependents do not have any independent right to elect USERRA health plan continuation.

When Dependent Coverage Terminates. A Dependent's coverage will terminate on the earliest of these dates:

- (1) The date the Plan or Dependent coverage under the Plan is terminated.
- (2) The date that the Employee's coverage under the Plan terminates for any reason including death.
- (3) The date a covered Spouse loses coverage due to loss of eligibility status.
- (4) Coverage will end on the last day of the month in which the Child ceases to meet the applicable eligibility requirements.
- (5) The end of the period for which the required contribution has been paid if the charge for the next period is not paid when due.
- (6) If a Dependent commits fraud or makes an intentional misrepresentation of material fact in applying for or obtaining coverage, or obtaining benefits under the Plan, or fails to notify the Plan Administrator that he or she has become ineligible for coverage, then the Employer or Plan may either void coverage for the Dependent for the period of time coverage was in effect, may terminate coverage as of a date to be determined at the Plan's discretion, or may immediately terminate coverage. If coverage is to be terminated or voided retroactively for fraud or misrepresentation, the Plan will provide written notice at least 30 days in advance of such action.

OPEN ENROLLMENT

Every fall during the Open Enrollment period, covered Employees and their covered Dependents will be able to change some of their benefit decisions based on which benefits and coverages are right for them.

Benefit choices made during the open enrollment period will become effective January 1 of the following year and remain in effect until the next January 1 unless there is a Special Enrollment event or a change in family status during the year (birth, death, marriage, divorce, adoption) or loss of coverage due to loss of a Spouse's employment.

A Plan Participant who fails to make an election during open enrollment will automatically retain his or her present coverages.

Employers and Plan Participants will receive detailed information regarding open enrollment from their Plan Administrator.

MEDICAL BENEFITS

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

DEDUCTIBLE

Deductible Amount. This is an amount of Covered Charges for which no benefits will be paid. Before benefits can be paid in a Calendar Year a Covered Person under self only coverage must meet the self only deductible shown in the Schedule of Benefits. For family coverage, the entire family deductible must be met before benefits will be paid.

Family Coverage. When the maximum amount shown in the Schedule of Benefits has been incurred by members of a Family toward the Calendar Year deductible, the deductibles of all members of that Family will be considered satisfied for that year. In the case of Family Coverage, the entire family deductible must be met before benefits from this Plan will be paid.

BENEFIT PAYMENT

Each Calendar Year, benefits will be paid for the Covered Charges of a Covered Person that are in excess of the deductible. Payment will be made at the rate shown under reimbursement rate in the Schedule of Benefits. No benefits will be paid in excess of the Maximum Benefit Amount or any listed limit of the Plan.

OUT-OF-POCKET LIMIT

Covered Charges are payable at the percentages shown each Calendar Year until the out-of-pocket limit shown in the Schedule of Benefits is met for Self-only coverage. Then, Covered Charges incurred will be payable at 100% (except for any charges excluded as shown in the Schedule of Benefits) for the rest of the Calendar Year.

When a Family Unit reaches the out-of-pocket limit, Covered Charges for that Family Unit will be payable at 100% (except for any charges excluded, as shown on the Schedule of Benefits) for the rest of the Calendar Year. Covered Charges for an individual family member who meets the individual out-of-pocket limit before the out-of-pocket limit for the Family Unit is met will be covered at 100% (except for any charges excluded as shown in the Schedule of Benefits) for the rest of the Calendar Year.

COVERED CHARGES

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

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

Charges for a Private Room will be limited to the semi-private room rate. The private room rate will apply if the facility only has private rooms available.

Charges for an Intensive Care Unit stay are payable.

- (2) Coverage of Pregnancy.** Charges for the care and treatment of Pregnancy are covered the same as any other Sickness.

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

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

- (3) **Skilled Nursing Facility Care.** The room and board and nursing care furnished by a Skilled Nursing Facility will be payable if and when:
- (a) the patient is confined as a bed patient in the facility; and
 - (b) the attending Physician certifies that the confinement is needed for further care of the condition that caused the Hospital confinement; and
 - (c) the attending Physician completes a treatment plan which includes a diagnosis, the proposed course of treatment and the projected date of discharge from the Skilled Nursing Facility.

Covered Charges for a Covered Person's care in these facilities are payable as described in the Schedule of Benefits.

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

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

- (a) If bilateral or multiple surgical procedures are performed by one (1) surgeon, benefits will be determined based on the Allowable Charge that is allowed for the primary procedures; 50% of the Allowable Charge will be allowed for each additional procedure performed through the same incision. Any procedure that would not be an integral part of the primary procedure or is unrelated to the diagnosis will be considered "incidental" and no benefits will be provided for such procedures;
- (b) If multiple unrelated surgical procedures are performed by two (2) or more surgeons on separate operative fields, benefits will be based on the Allowable Charge for each surgeon's primary procedure. If two (2) or more surgeons perform a procedure that is normally performed by one (1) surgeon, benefits for all surgeons will not exceed the Allowable Charge for that procedure; and
- (c) If an assistant surgeon is required, the assistant surgeon's Covered Charge will not exceed 20% of the surgeon's allowance.

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

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

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

Benefit payment for nursing, home health aide and therapy services are subject to the Home Health Care limit shown in the Schedule of Benefits.

A home health care visit will be considered a periodic visit by either a nurse or therapist, as the case may be, or four hours of home health aide services.

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

Covered Charges for Hospice Care Services and Supplies are payable as described in the Schedule of Benefits.

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

- (a) Charges for **acupuncture**.
- (b) **Allergy Extract serum and injections.** Benefits are provided for allergy extract and allergy injections.
- (c) **Allergy testing** consisting of percutaneous, intracutaneous, and patch tests.
- (d) Local Medically Necessary professional land or air **ambulance** service. A charge for this item will be a Covered Charge only if the service is to the nearest Hospital or Skilled Nursing Facility where necessary treatment can be provided unless the Plan Administrator finds a longer trip was Medically Necessary.
- (e) **Anesthetic**; oxygen; blood and blood derivatives that are not donated or replaced; intravenous injections and solutions. Administration of these items is included.
- (f) **Attention Deficit Disorders (ADD) and Attention Deficit Hyperactivity Disorders (ADHD).** Services, supplies, care or treatment to a Covered Person for the diagnosis of Attention Deficit Disorders (ADD) or Attention Deficit Hyperactivity Disorders (ADHD).
- (g) **Autism Spectrum Disorders.** Care and treatment is covered for Autism Spectrum Disorders as shown in the schedule of benefits.
- (h) Office visits and psychotherapy is covered for treatment of **behavioral disorders, and learning disabilities**.
- (i) **Cardiac rehabilitation** as deemed Medically Necessary provided services are rendered (a) under the supervision of a Physician; (b) in connection with a myocardial infarction, coronary occlusion or coronary bypass surgery; and (c) in a Medical Care Facility as defined by this Plan.
- (j) Radiation or **chemotherapy** and treatment with radioactive substances. The materials and services of technicians are included.
- (k) Routine patient care charges for **Clinical Trials.** Coverage is provided only for routine patient care costs for a Qualified Individual in an approved clinical trial for treatment of cancer or other life-threatening disease or condition. For these purposes, a Qualified Individual is a Covered Person who is eligible to participate in an approved clinical trial according to the trial protocol with respect to the treatment of cancer or another life-threatening disease or condition, and either: (1) the referring health care professional is a Network Provider and has concluded that the individual's participation in such trial would be appropriate; or (2) the Covered Person provides medical and scientific information establishing to the satisfaction of the Plan Administrator that the individual's participation in such trial would be appropriate. Coverage is not provided for charges not otherwise covered under the Plan, and does not include charges for the drug or procedure under trial, or charges which the Qualified Individual would not be required to pay in the absence of this coverage.

- (l) Initial **contact lenses** or glasses required for treatment of keratoconus or glaucoma or following cataract surgery.
- (m) Medical facility, anesthesia charges or any fees associated with **dental care** treatment that is determined to be medically necessary will be covered under the medical plan. Following are some examples of medical necessity:
 - (i) The patient is a child (up to 6 years old) with a dental condition that requires repairs of significant complexity (e.g., multiple restorations, pulpal therapy, extractions);
 - (ii) Patients with certain physical, intellectual or medically compromising conditions (e.g., mental retardation, cerebral palsy, epilepsy, cardiac problems, hyperactivity verified by appropriate medical documentation);
 - (iii) Extremely uncooperative, fearful, unmanageable, anxious or uncommunicative patients with substantial dental needs and no expectation that behavior will improve soon;
 - (iv) Patients with dental restorative or surgical needs for whom local anesthesia is ineffective (such as due to acute infection, anatomic variations or allergy);
 - (v) Patients who have sustained extensive orofacial or dental trauma, for which treatment under local anesthesia would be ineffective or compromised.
- (n) **Diabetes Education Program** – an outpatient program of self-management, training and education, including medical nutrition therapy, for the treatment of diabetes. Such outpatient program must be conducted under the supervision of a licensed health care professional with expertise in diabetes. Outpatient diabetes education services will be covered and are based on the certification programs for outpatient diabetes education developed by the American Diabetes Association (ADA).
- (o) **Dialysis treatment.** The Plan will pay dialysis-related claims according to the benefits schedule for the first 3 months after commencement of treatment. Thereafter, the Plan will pay for dialysis-related services at 80% of 125% of the then-current Medicare Allowable for those services in that region, after satisfaction of any deductibles and copayments.

Dialysis treatment shall include hemodialysis or peritoneal dialysis and the supplies utilized to administer under the direction of a Physician in a Hospital, Health Care Facility, Physician's office or at home. Laboratory testing and physician visits will be payable pursuant to the normal plan provisions.

Dialysis charges are excluded from any network provider agreements and are treated as Out-of-Network claims; they are paid at a percentage of the Medicare Allowable rate and may be subject to Medicare rules. This provision applies to charges for dialysis treatment only. Any other applicable provisions, conditions, and exclusions remain in effect, including restrictions on benefits under an Exclusive Provider Only (EPO) Plan, or any dollar maximums applied to non-network claims.

A Covered Person undergoing dialysis should promptly apply for Medicare coverage, regardless of age. Contact the Plan Administrator for information on how to be reimbursed for Medicare Part B premiums.
- (p) Rental of **durable medical or surgical equipment** if deemed Medically Necessary. These items may be bought rather than rented, with the cost not to exceed the fair market value of the equipment at the time of purchase. Repair or replacement will be covered only when required due to growth or development of a dependent child, or deterioration from normal wear and tear if recommended by the attending physician.
- (q) **Enteral nutrition.** Covered charges for Physician-prescribed nutritional supplements, enteral formulae or other enteral supplementation necessary to sustain life for Covered Persons who are or will become malnourished or suffer from disorders, which left untreated

will cause chronic disability or intellectual disability. Covered Expenses include special dietary and therapeutic treatment for Covered Persons with inherited metabolic diseases, such as phenylketonuria (PKU), branched-chain ketonuria, galactosemia and homocystinuria.

- (r) **Genetic testing** for the purpose of determining the need for fetal therapy or to determine a medically necessary intervention for the mother and when Medically Necessary for other conditions.
- (s) **Hearing aids and exams.** Benefits include coverage for an audiometric examination and purchase of hearing aid device, when prescribed by a professional provider.

The hearing aid must be purchased from a contracting supplier.
- (t) **Hearing Device.** Charges for cochlear implants, bone-anchored hearing aid, auditory brainstem implant, or any other surgically implantable device to correct hearing loss or surgery to implant such a device.
- (u) Care, supplies and services for the diagnosis of **infertility**, treatment and charges for surgical correction of physiological abnormalities of infertility.
- (v) Medically Necessary diagnostic and non-surgical services for care and treatment of **jaw joint conditions, including Temporomandibular Joint syndrome (TMJ).**
- (w) **Laboratory studies.** Covered Charges for diagnostic and preventive lab testing and services.
- (x) **Marital Counseling.** Care for outpatient treatment for marital counseling as outlined in the Medical Benefits Schedule.
- (y) Treatment of **Mental Disorders and Substance Abuse** is payable as shown in the Schedule of Benefits.
- (z) Injury to or care of **mouth, teeth and gums.** Charges for Injury to or care of the mouth, teeth, gums and alveolar processes will be Covered Charges under Medical Benefits only if that care is for the following oral surgical procedures:

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

Emergency repair due to Injury to sound natural teeth.

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

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

External incision and drainage of cellulitis.

Incision of sensory sinuses, salivary glands or ducts.

Removal of impacted teeth.

Extraction of teeth in preparation for radiation therapy.

Mandibular staple implant, provided the procedure is not done to prepare the mouth for dentures.

Lingual frenectomy, frenotomy or frenoplasty (to correct tongue-tie).

The correction of a non-dental physiological condition which has resulted in a severe functional impairment.

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.

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

- (aa) **Naturopathy** office visits only. Naturopathic supplements are not covered.
- (bb) **Occupational therapy** by a licensed therapist. Therapy must be ordered by a Physician, result from an Injury or Sickness and improve a body function. Covered Charges do not include recreational programs, maintenance therapy or supplies used in occupational therapy.
- (cc) **Organ transplant.** The terms of this plan document determine how the following are covered under the self-funded health plan:
 - (i) Transplant-related health services received before and after the “benefit period” as defined in the UnitedHealthcare Certificate of Coverage;
 - (ii) Any other transplant-related expenses not covered under the UnitedHealthcare Certificate of Coverage; and
 - (iii) Health care services, received at any time, which are not related to a transplant.
- (dd) **Orthognathic Surgery.**
- (ee) **Orthotic devices.** Purchase, fitting, necessary adjustment, repairs and replacement of a rigid or semi-rigid supportive device which restricts or eliminates motion of a weak or diseased body part.
- (ff) **Pediatric Extended Care Services.** Benefits are provided for care received from a pediatric extended care facility that is licensed by the state and is primarily engaged in providing basic non-residential services to infants and/or young children who have complex medical needs requiring skilled nursing and therapeutic care and who may be technologically dependent.

Services rendered by a pediatric extended care facility pursuant to a treatment plan for which benefits may include one or more of the following:

- (i) Skilled nursing services of a Registered Nurse (RN) or Licensed Practical Nurse (LPN)
- (ii) Physical medicine, speech therapy and occupational therapy
- (iii) Respiratory therapy
- (iv) Medical and surgical supplies provided by the pediatric extended care facility
- (v) Acute health care support
- (vi) Ongoing assessments of health status, growth and development

Pediatric extended care services will be covered for children, pursuant to the attending physician’s treatment plan only when provided in a pediatric extended care facility.

A prescription from the child's attending physician is necessary for admission to such facility.

No benefits are payable after the child has reached the maximum level of recovery possible for his or her particular condition and no longer requires definitive treatment other than routine supportive care.

(gg) Physical therapy must be administered in strict accordance with the referring Physician's orders regarding type of therapy, frequency and duration. The condition treated must also be established as one which receives substantial benefit from short-term therapy.

(hh) Routine Preventive Care. Covered Charges under Medical Benefits are payable for routine Preventive Care as described in the Schedule of Benefits. Standard Preventive Care shall be provided as required by applicable law if provided by a Network Provider. Standard Preventive Care for adults includes services with an "A" or "B" rating from the United States Preventive Services Task Force. Examples of Standard Preventive Care include:

- Screenings for: breast cancer, cervical cancer, colorectal cancer, high blood pressure, Type 2 Diabetes Mellitus, cholesterol, and obesity.
- Immunizations for adults recommended by the Advisory Committee on Immunization Practices of the Centers for Disease Control and Prevention; and
- Additional preventive care and screening for women provided for in the guidelines supported by the Health Resources and Services Administration, including the following:
 - Breastfeeding support, supplies, and counseling.
 - Gestational diabetes screening.

Standard Preventive Care includes women's contraceptives, sterilization procedures, and counseling.

The list of services included as Standard Preventive Care may change from time to time depending upon government guidelines. A current listing of required preventive care can be accessed at:

- www.HealthCare.gov/center/regulations/prevention.html. and
- www.cdc.gov/vaccines/recs/acip/

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

Charges for Routine Well Child Care. Routine well child care is routine care by a Physician that is not for an Injury or Sickness. Standard Preventive Care shall be provided as required by applicable law if provided by a Network Provider. Standard Preventive Care for children includes services with an "A" or "B" rating from the United States Preventive Services Task Force. Examples of Standard Preventive Care include:

- Immunizations for children and adolescents recommended by the Advisory Committee on Immunization Practices of the Centers for Disease Control and Prevention. These may include:
 - Diphtheria,
 - Pertussis,
 - Tetanus,
 - Polio,
 - Measles,
 - Mumps,
 - Rubella,
 - Hemophilus influenza b (Hib),
 - Hepatitis B,
 - Varicella.

- Preventive care and screenings for infants, children and adolescents as provided for in the comprehensive guidelines supported by the Health Resources and Services Administration

The list of services included as Standard Preventive Care may change from time to time depending upon government guidelines. A current listing of required preventive care can be accessed at:

- www.HealthCare.gov/center/regulations/prevention.html. and
- www.cdc.gov/vaccines/recs/acip/

- (ii) The initial purchase, fitting and repair of fitted **prosthetic devices** which replace body parts.
- (jj) **Reconstructive Surgery.** Correction of abnormal congenital conditions and reconstructive mammoplasties will be considered Covered Charges.

This mammoplasty coverage will include reimbursement for:

- (i) reconstruction of the breast on which a mastectomy has been performed,
- (ii) surgery and reconstruction of the other breast to produce a symmetrical appearance, and
- (iii) coverage of prostheses and physical complications during all stages of mastectomy, including lymphedemas,

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

- (kk) **Speech therapy** by a licensed therapist. Therapy must be ordered by a Physician and follow either: (i) surgery for correction of a congenital condition of the oral cavity, throat or nasal complex (other than a frenectomy) of a person; (ii) an Injury; or (iii) a Sickness.
- (ll) **Spinal Manipulation services** by a health care provider acting within the scope of his or her license.
- (mm) **Sterilization** procedures.
- (nn) **Surgical dressings**, splints, casts and other devices used in the reduction of fractures and dislocations.
- (oo) **Telemedicine** for Network and Non-Network providers if applicable. Benefits will be paid in accordance with the benefit currently in place for that type of service.
- (pp) **Tobacco Cessation Programs** shall be covered with no cost sharing as a Standard Preventive Care benefit if provided by In Network Providers.
- (qq) Coverage of **Well Newborn Nursery/Physician Care.**

Charges for Routine Nursery Care. Routine well newborn nursery care is care while the newborn is Hospital-confined after birth and includes room, board and other normal well-baby care for which a Hospital makes a charge.

This coverage is only provided if the newborn child is an eligible Dependent and a parent (1) is a Covered Person who was covered under the Plan at the time of the birth, or (2) enrolls himself or herself (as well as the newborn child if required) in accordance with the Special Enrollment provisions with coverage effective as of the date of birth.

The benefit is limited to charges for routine well-baby nursery care for the newborn child while Hospital confined as a result of the child's birth.

Charges for covered routine nursery care will be applied toward the Plan of the covered parent, provided the newborn child is enrolled on a timely basis.

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

Charges for Routine Physician Care. The benefit is limited to the charges for routine well-baby care made by a Physician for pediatric visits to the newborn child while Hospital confined as a result of the child's birth.

Charges for covered routine Physician care will be applied toward the Plan of the covered parent, provided the newborn child is enrolled on a timely basis.

If the baby is ill, suffers an injury, premature birth, congenital abnormality or requires care other than routine care, benefits will be provided on the same basis as for any other eligible expense provided the child is added to the Plan and coverage is in effect.

(rr) Diagnostic **x-rays**.

COST MANAGEMENT SERVICES

Cost Management Services Phone Number

Please refer to the Employee ID card for the Cost Management Services phone number.

The provider, patient or family member must call this number to receive certification of certain Cost Management Services. This call must be made at least 7 to 10 days in advance of services being rendered or within 48 hours after a Medical Emergency.

Any costs incurred because of reduced reimbursement due to failure to follow cost management procedures will not accrue toward the 100% maximum out-of-pocket payment.

UTILIZATION REVIEW

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

The program consists of:

- (a) Precertification of the Medical Necessity for the following non-emergency services before Medical and/or Surgical services are provided:
 - (i) All inpatient Hospital and Skilled Nursing Facility stays.
 - (ii) Facility based Treatment for Mental or Nervous Disorders or Substance Abuse.
 - (iii) Home Health Care.
 - (iv) All Organ and Tissue Transplants, peripheral stem cell replacement and similar procedures.
 - (v) Infusion Therapy that includes Specialty Drugs in the specialty pharmacy program, and related services (for each Course of Therapy) in any setting, including, but not limited to: Physician's office, infusion center, outpatient Hospital or clinic, or your home or other residential setting.
 - (vi) Certain surgical, diagnostic procedures, Durable Medical Equipment and/or prosthetics wherever rendered as specified by Anthem Blue Cross. For a list of current procedures, please contact Anthem Blue Cross toll free at (800) 274-7767.
- (b) Retrospective review of the Medical Necessity of the listed services provided on an emergency basis;
- (c) Concurrent review, based on the admitting diagnosis, of the listed services requested by the attending Physician; and
- (d) Certification of services and planning for discharge from a Medical Care Facility or cessation of medical treatment.

The purpose of the program is to determine what charges may be Medically Necessary. This program is not designed to be the practice of medicine or to be a substitute for the medical judgment of the attending Physician or other health care provider.

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

The attending Physician does not have to obtain precertification from the Plan for prescribing a maternity length of stay that is 48 hours or less for a vaginal delivery or 96 hours or less for a cesarean delivery.

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

Here's how the program works.

Precertification. Before a Covered Person enters a Medical Care Facility on a non-emergency basis or receives other listed medical services, the utilization review administrator will, in conjunction with the attending Physician, certify the care. Precertification does not confirm or verify eligibility for coverage, nor is it a guarantee of payment. A non-emergency stay in a Medical Care Facility is one that can be scheduled in advance.

The utilization review program is set in motion by a telephone call from, or on behalf of, the Covered Person. Contact the utilization review administrator at the telephone number on your ID card **at least 7 to 10 days before** services are scheduled to be rendered with the following information:

- The name of the patient and relationship to the covered Employee
- The name, employee identification number and address of the covered Employee
- The name of the Employer
- The name and telephone number of the attending Physician
- The name of the Medical Care Facility, proposed date of admission, and proposed length of stay
- The proposed medical services

If there is an **emergency** admission to the Medical Care Facility, the patient, patient's family member, Medical Care Facility or attending Physician must contact the utilization review administrator **within 48 hours** of the first business day after the admission.

The utilization review administrator will precertify the number of days of Medical Care Facility confinement as determined by medical necessity. **Failure to follow this procedure may reduce reimbursement received from the Plan.**

If the Covered Person does not receive precertification as explained in this section, the benefit payment may be reduced by \$500 for Network Providers and \$700 for Non-Network Providers.

Concurrent review, discharge planning. Concurrent review of a course of treatment and discharge planning from a Medical Care Facility are parts of the utilization review program. The utilization review administrator will monitor the Covered Person's Medical Care Facility stay or use of other medical services and coordinate with the attending Physician, Medical Care Facilities and Covered Person either the scheduled release or an extension of the Medical Care Facility stay or extension or cessation of the use of other medical services.

If the attending Physician feels that it is Medically Necessary for a Covered Person to receive additional services or to stay in the Medical Care Facility for a greater length of time than has been precertified, the attending Physician must request the additional services or days.

SECOND AND/OR THIRD OPINION PROGRAM

Certain surgical procedures are performed either inappropriately or unnecessarily. In some cases, surgery is only one of several treatment options. In other cases, surgery will not help the condition.

In order to prevent unnecessary or potentially harmful surgical treatments, the second and/or third opinion program fulfills the dual purpose of protecting the health of the Plan's Covered Persons and protecting the financial integrity of the Plan.

Benefits will be provided for a second (and third, if necessary) opinion consultation to determine the Medical Necessity of an elective surgical procedure. An elective surgical procedure is one that can be scheduled in advance; that is, it is not an emergency or of a life-threatening nature. Benefits for the second (and third, if necessary) opinion will be paid as any other Sickness.

The patient may choose any board-certified specialist who is not an associate of the attending Physician and who is affiliated in the appropriate specialty.

While any surgical treatment is allowed a second opinion, the following procedures are ones for which surgery is often performed when other treatments are available.

Appendectomy	Hernia surgery	Spinal surgery
Cataract surgery	Hysterectomy	Surgery to knee, shoulder, elbow or toe
Cholecystectomy (gall bladder removal)	Mastectomy surgery	Tonsillectomy and adenoidectomy
Deviated septum (nose surgery)	Prostate surgery	Tympanotomy (inner ear)
Hemorrhoidectomy	Salpingo-oophorectomy (removal of tubes/ovaries)	Varicose vein ligation

PREADMISSION TESTING SERVICE

The Medical Benefits percentage payable will be for diagnostic lab tests and x-ray exams when:

- (1) performed on an outpatient basis within seven days before a Hospital confinement;
- (2) related to the condition which causes the confinement; and
- (3) performed in place of tests while Hospital confined.

Covered Charges for this testing will be payable as shown in the Medical Benefits Schedule even if tests show the condition requires medical treatment prior to Hospital confinement or the Hospital confinement is not required.

OUTPATIENT SURGERY

Certain surgical procedures can be performed safely and efficiently outside of a Hospital. Outpatient surgical facilities are equipped for many uncomplicated surgical operations, such as some biopsies, cataract surgeries, tonsillectomies and adenoidectomies, dilation and curettages, and similar procedures.

Charges for covered surgical procedures, when such procedures are performed on an outpatient rather than an inpatient basis, will be paid as shown in the Medical Benefits Schedule.

CASE MANAGEMENT

Case Management. The Plan may elect, in its sole discretion, when acting on a basis that precludes individual selection, to provide alternative benefits that are otherwise excluded under the Plan. The alternative benefits, called "Case Management," shall be determined on a case-by-case basis, and the Plan's determination to provide the benefits in one instance shall not obligate the Plan to provide the same or similar alternative benefits for the same or any other Covered Person, nor shall it be deemed to waive the right of the Plan to strictly enforce the provisions of the Plan.

A case manager consults with the patient, the family and the attending Physician in order to develop a plan of care for approval by the patient's attending Physician and the patient. This plan of care may include some or all of the following:

- personal support to the patient;
- contacting the family to offer assistance and support;
- monitoring Hospital or Skilled Nursing Facility;

- determining alternative care options; and
- assisting in obtaining any necessary equipment and services.

Case Management occurs when this alternate benefit will be beneficial to both the patient and the Plan.

The case manager will coordinate and implement the Case Management program by providing guidance and information on available resources and suggesting the most appropriate treatment plan. The Plan Administrator, attending Physician, patient and patient's family must all agree to the alternate treatment plan.

Once agreement has been reached, the Plan Administrator will direct the Plan to cover Medically Necessary expenses as stated in the treatment plan, even if these expenses normally would not be paid by the Plan. Unless specifically provided to the contrary in the Plan Administrator's instructions, reimbursement for expenses incurred in connection with the treatment plan shall be subject to all Plan limits and cost sharing provisions.

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

Each treatment plan is individually tailored to a specific patient and should not be seen as appropriate or recommended for any other patient, even one with the same diagnosis.

CONTINUITY OF CARE

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

The Plan shall notify the Covered Person that the Provider's contractual relationship with the Plan has terminated, and that the Covered Person has rights to elect continued transitional care from the Provider. If the Covered Person elects in writing to receive continued transitional care, Plan benefits will apply under the same terms and conditions as would be applicable had the termination not occurred, beginning on the date the Plan's notice of termination is provided and ending 90 days later or when the Covered Person ceases to be a continuing care patient, whichever is sooner.

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

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

Note that during continuation, Plan benefits will be processed as if the Provider termination had not occurred and the Covered Person is responsible for their In-Network share of cost.

DEFINED TERMS

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

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

Allowable charge is a charge which is either the network Provider's reduced fee or the Recognized charge for a service or supply.

Ambulatory Surgical Center is a freestanding outpatient surgical facility. It must be licensed as an outpatient clinic according to state and local laws and must meet all requirements of an outpatient clinic providing surgical services. It must also meet accreditation standards of the Joint Commission on Accreditation of Health Care Organizations or the Accreditation Association of Ambulatory Health Care.

Approved Clinical Trials means a phase I, phase II, phase III, or phase IV clinical trial that is conducted in relation to the prevention, detection, or treatment of cancer or other life-threatening disease or condition and is described in any of the following:

- (1) Federally-Funded Trials—The study or investigation is approved or funded (which include funding through in-kind contributions) by one or more of the following:
 - (a) The National Institutes of Health;
 - (b) The Centers for Disease Control and Prevention;
 - (c) The Agency for Health Care Research and Quality;
 - (d) The Centers for Medicare & Medicaid Services;
 - (e) Cooperative group or center of any of the entities described in (a) through (d) or the Department of Defense or Department of Veterans Affairs; or
 - (f) A qualified non-governmental research entity identified in the guidelines issued by the National Institutes of Health for center support grants.
- (2) The study or investigation is conducted under an investigational new drug application reviewed by the Food and Drug Administration.
- (3) The study or investigation is a drug trial that is exempt from having such an investigational new drug application.

Birthing Center means any freestanding health facility, place, professional office or institution which is not a Hospital or in a Hospital, where births occur in a home-like atmosphere. This facility must be licensed and operated in accordance with the laws pertaining to Birthing Centers in the jurisdiction where the facility is located.

The Birthing Center must provide facilities for obstetrical delivery and short-term recovery after delivery; provide care under the full-time supervision of a Physician and either a registered nurse (R.N.) or a licensed nurse-midwife; and have a written agreement with a Hospital in the same locality for immediate acceptance of patients who develop complications or require pre- or post-delivery confinement.

Brand Name means a trade name medication.

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

Certified IDR Entity is an entity responsible for conducting determinations under the No Surprises Act and that has been properly certified by the Department of Health and Human Services, the Department of Labor, and the Department of the Treasury.

Covered Charge(s) means those Medically Necessary services or supplies that are covered under this Plan.

Covered Person is an Employee or Dependent who is covered under this Plan.

Custodial Care is care provided primarily to meet your personal needs. This includes help in walking, bathing or dressing. It also includes: Preparing food or special diets; feeding by utensil, tube or gastrostomy; suctioning and administration of medicine which is usually self-administered or any other care which does not require continuing services of medical personnel.

If Medically Necessary, benefits will be provided for feeding (by tube or gastrostomy) and suctioning.

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

Emergency Medical Condition means a medical screening examination and associated services to treat a condition that requires immediate medical attention that would reasonably expect to result in (a) serious jeopardy to the health of an individual (or in the case of a pregnant person, the health of the unborn child); (b) serious impairment to bodily function; or (c) serious dysfunction of any bodily organ or part. Emergency Services include pre-stabilization services that are provided after a patient is moved out of the emergency department and admitted to a Hospital, as well as any additional services rendered after a patient is stabilized as part of Outpatient observation or an Inpatient or Outpatient stay with respect to the visit in which other Emergency Services are furnished. These services include those provided at an Independent Freestanding Emergency Department as well as a Hospital emergency department. A decision of what constitutes Emergency Services will not be defined solely on the basis of the diagnosis but rather will be a determination that takes into account the reasonableness of each situation as defined by a prudent layperson.

Emergency Services means, with respect to an Emergency Medical Condition, the following:

- (1) An appropriate medical screening examination (as required under section 1867 of the Social Security Act, 42 U.S.C. 1395dd) that is within the capability of the emergency department of a Hospital or of an Independent Freestanding Emergency Department, as applicable, including ancillary services routinely available to the emergency department to evaluate such Emergency Medical Condition; and
- (2) Within the capabilities of the staff and facilities available at the Hospital or the Independent Freestanding Emergency Department, as applicable, such further medical examination and treatment as are required under section 1867 of the Social Security Act (42 U.S.C. 1395dd), or as would be required under such section if such section applied to an Independent Freestanding Emergency Department, to stabilize the patient (regardless of the department of the Hospital in which such further examination or treatment is furnished).

When furnished with respect to an Emergency Medical Condition, Emergency Services shall also include an item or service provided by a Non-Network Provider or Non-Participating Health Care Facility (regardless of the department of the Hospital in which items or services are furnished) after the Participant is stabilized and as part of Outpatient observation or an Inpatient or Outpatient stay with respect to the visit in which the Emergency Services are furnished, until such time as the Provider determines that the Participant is able to travel using non-medical transportation or non-emergency medical transportation, and the Participant is in a condition to, and in fact does, give informed consent to the Provider to be treated as a Non-Network Provider.

Employee means a person who is classified by his Employer as an Active, common law employee.

Employer is any affiliated church or entity of The Christian and Missionary Alliance participating in the Plan.

Essential Health Benefits include, to the extent they are covered under the Plan, ambulatory patient services; emergency services; hospitalization; maternity and newborn care; mental health and substance use disorder services, including behavioral health treatment; prescription drugs; rehabilitative and habilitative services and

devices; laboratory services; preventive and wellness services and chronic disease management; and pediatric services, including oral and vision care.

Experimental procedures are those that are mainly limited to laboratory and/or animal research, but which are not generally accepted as proven and effective procedures within the organized medical community. The Utilization Manager has discretion to make this determination. However, if a Covered Person has a seriously debilitating condition and the Utilization Manager determines the requested treatment is not a Covered Service because it is Experimental, the Covered Person may request an Independent Medical Review.

Family Unit is the covered Employee and the family members who are covered as Dependents under the Plan.

Formulary means a list of prescription medications of safe, effective therapeutic drugs specifically covered by this Plan.

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

Genetic Information means information about the genetic tests of an individual or his family members, and information about the manifestations of disease or disorder in family members of the individual. A "genetic test" means an analysis of human DNA, RNA, chromosomes, proteins or metabolites, which detects genotypes, mutations or chromosomal changes as defined by the *Genetic Information Nondiscrimination Act of 2008 (GINA)*.

Home Health Care Agency is a home health care provider which is licensed according to state and local laws to provide skilled nursing and other services on a visiting basis in your home, and recognized as home health providers under Medicare and/or accredited by a recognized accrediting agency such as the Joint Commission on the Accreditation of Healthcare Organizations.

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

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

Home Infusion Therapy provider is a provider licensed according to state and local laws as a pharmacy, and must be either certified as a home health care provider by Medicare, or accredited as a home pharmacy by the Joint Commission on Accreditation of Health Care Organizations.

Hospice Agency is an agency or organization providing a specialized form of interdisciplinary health care that provides palliative care (pain control and symptom relief) and alleviates the physical, emotional, social, and spiritual discomforts of a terminally ill person, as well as providing supportive care to the primary caregiver and the patient's family. A hospice must be: currently licensed as a hospice pursuant to Health and Safety Code section 1747 or a licensed home health agency with federal Medicare certification pursuant to Health and Safety Code section 1726 and 1747.1.

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

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

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

Hospital is a facility which provides diagnosis, treatment and care of persons who need acute inpatient hospital care under the supervision of physicians. It must be licensed as a general acute care hospital according to state and local laws. It must also be registered as a general hospital by the American Hospital Association and meet accreditation standards of the Joint Commission on Accreditation of Health Care Organizations.

For limited purpose of inpatient care, the definition of hospital also includes: (1) psychiatric health facilities (only for the acute phase of a mental or nervous disorder or substance abuse), and (2) residential treatment centers.

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

Independent Freestanding Emergency Department is a health care facility that is geographically separate and distinct, and licensed separately, from a Hospital under applicable state law, and which provides any Emergency Services.

Infertility means incapable of producing offspring.

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

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

Investigational procedures (Investigational) are those:

- (1) That have progressed to limited use on humans, but which are not generally accepted as proven and effective procedures within the organized medical community; or
- (2) That do not have final approval from the appropriate governmental regulatory body; or
- (3) That are not supported by scientific evidence which permits conclusions concerning the effect of the service, drug or device on health outcomes; or
- (4) That do not improve the health outcome of the patient treated; or
- (5) That are not beneficial as any established alternative; or
- (6) Whose results outside the Investigational setting cannot be demonstrated or duplicated; or
- (7) That are not generally approved or used by Physicians in the medical community.

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

Medical Non-Emergency Care means care which can safely and adequately be provided other than in a Hospital.

Medically Necessary procedures, supplies, equipment or services are those determined to be:

- (1) Appropriate and necessary for the diagnosis or treatment of the medical condition;
- (2) Provided for the diagnosis or direct care and treatment of the medical condition;

- (3) Within standards of good medical practice within the organized medical community;
- (4) Not primarily for your convenience, or for the convenience of your physician or another provider; and
- (5) The most appropriate procedure, supply, equipment or service which can safely be provided. The most appropriate procedure, supply, equipment or service must satisfy the following requirements:
 - (a) there must be valid scientific evidence demonstrating that the expected health benefit from the procedure, supply, equipment or services are clinically significant and produce a greater likelihood of benefit, without a disproportionately greater risk of harm or complications, for you with the particular medical condition being treated than other possible alternatives; and
 - (b) generally accepted forms of treatment that are less invasive have been tried and found to be ineffective or are otherwise unsuitable; and
 - (c) for hospital stays, acute care as an inpatient is necessary due to the kind of services you are receiving or the severity of your condition, and safe and adequate care cannot be received by you as an outpatient or in a less intensified medical setting.

The Plan Administrator has the discretionary authority to decide whether care or treatment is Medically Necessary, and whether an exception to the Medical Necessity requirement is available.

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

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

No Surprises Act (NSA) is the Title I of the Consolidated Appropriations Act of 2021 or any provision or section thereof and which may be amended from time to time.

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

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

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

Participating Health Care Facility is a Hospital, Ambulatory Surgical Center, or other Provider as required by law, which has a direct or indirect contractual relationship with the Plan with respect to the furnishing of a healthcare item or service. A single direct contract or case agreement between a health care facility and a plan constitutes a contractual relationship for purposes of this definition with respect to the parties to the agreement and particular individual(s) involved.

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

Physician means a Doctor of Medicine (M.D.), Doctor of Osteopathy (D.O.), Doctor of Podiatry (D.P.M.), Doctor of Chiropractic (D.C.), Audiologist, Certified Nurse Anesthetist, Licensed Professional Counselor, Licensed Professional Physical Therapist, Master of Social Work (M.S.W.), Midwife, Occupational Therapist, Physiotherapist, Psychiatrist, Psychologist (Ph.D.), Speech Language Pathologist and any other practitioner of the healing arts who is licensed and regulated by a state or federal agency and is acting within the scope of his or her license.

Plan means Christian and Missionary Alliance, which is a benefits plan for certain Employees of The Christian and Missionary Alliance and is described in this document.

Plan Participant is any Employee or Dependent who is covered under this Plan.

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

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

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

Qualifying Payment Amount: The median of the contracted rates recognized by the Plan for the same or a similar item or service provided by a Provider in the same or similar specialty in the same geographic region. If there are insufficient (meaning at least three) contracted rates available to determine a Qualifying Payment Amount, said amount will be determined by referencing a state all-payer claims database or, if unavailable, any eligible third-party database in accordance with applicable law.

Recognized Charge is the lower of:

- (1) The provider's usual charge to provide a service or supply, or
- (2) The charge the Claims Administrator determines to be the recognized charge percentage for the service or supply, or
- (3) The charge the Claims Administrator determines to be appropriate, based on factors such as:
 - (a) The cost of supplying the same or similar service or supply;
 - (b) The manner in which the charges for the service or supply are made;
 - (c) The complexity of the service or supply;
 - (d) The degree of skill needed to provide it;
 - (e) The provider's specialty; and
 - (f) The Recognized Charge in other areas.
- (4) The Qualified Payment Amount.

For Non-Network charges subject to the No Surprises Act, the recognized charge may be the amount deemed payable by a Certified IDR Entity.

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

Skilled Nursing Facility is an institution that provides continuous skilled nursing services. It must be licensed according to state and local laws and be recognized as a skilled nursing facility under Medicare.

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

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

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

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

Urgent Care Services means care and treatment for an illness, injury or condition serious enough that a reasonable person would seek care right away, but not so severe as to require emergency room services.

PLAN EXCLUSIONS

Note: Exclusions related to Prescription Drugs are shown in the Prescription Drug Plan. Contact your Prescription Drug Administrator for additional information.

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

- (1) **Abortion.** Services, supplies, care or treatment in connection with an abortion unless the life of the mother is endangered by the continued Pregnancy.

The Christian and Missionary's statement on abortion can be found at <https://www.cmalliance.org/about/beliefs/perspectives/sanctity-of-life>.
- (2) **Alcohol and Marijuana.** The Christian and Missionary's statement on alcohol and marijuana can be found at <http://www.cmalliance.org/about/beliefs/perspectives/addictive-practices>.
- (3) **Cellular Therapy**, which is the transfer of whole, live cells (modified or unmodified) to produce an immune or other biological response. Cellular therapy includes, but is not limited to, cellular immunotherapies and cancer vaccines. This exclusion does not apply to stem cell transplants that are otherwise covered under the Organ Transplant benefit.
- (4) **Complications of non-covered treatments.** Care, services or treatment required as a result of complications from a treatment not covered under the Plan are not covered. Complications from a non-covered abortion are covered, except as required under the No Surprises Act.
- (5) **Contraceptive Services and Supplies:** Any charge for contraceptive services and supplies abortifacients.
- (6) **Cosmetic Procedures.** Any surgery or procedure, the primary purpose of which is to improve or change the appearance of any portion of the body, but which does not restore bodily function, correct a disease state, or improve a physiological function. Cosmetic Procedures include cosmetic surgery, reconstructive surgery, pharmacological services, nutritional regimens or other services for beautification, or treatment relating to the consequences of, or as a result of, Cosmetic Surgery (including reimplantation). This exclusion includes, but is not limited to, surgery to correct gynecomastia and breast augmentation procedures, and otoplasties. This exclusion does not apply to surgery to restore function if the body area has been altered by injury, disease, trauma, congenital/developmental anomalies, or previous covered therapeutic processes.
- (7) **Court Ordered services.** For otherwise covered services ordered by a court or other tribunal as part of your or your dependent's sentence.
- (8) **Custodial care.** Services or supplies provided mainly as a rest cure, maintenance, Custodial Care or domiciliary care consisting chiefly of room and board.
- (9) **Educational or vocational testing.** Services for educational or vocational testing or training.
- (10) **Excess charges.** The part of an expense for care and treatment of an Injury or Sickness that is in excess of the Recognized Charge.
- (11) **Exercise programs.** Exercise programs for treatment of any condition, except for Physician-supervised cardiac rehabilitation, occupational or physical therapy if covered by this Plan.
- (12) **Experimental / Investigational or not Medically Necessary.** Care and treatment that is either Experimental/Investigational or not Medically Necessary. This exclusion shall not apply to routine patient costs to the extent that the cost is for a Qualified Individual who is a participant in an approved clinical trial with respect to the treatment of cancer or another life-threatening disease or condition. The Plan shall not deny, limit or impose additional conditions on routine patient costs for items and services furnished in connection with participation in the clinical trial.

The following are not included as routine patient costs:

- (a) The investigational item, device, or service itself;
- (b) Items and services that are provided solely to satisfy data collection and analysis needs and that are not used in the direct clinical management of the patient; or
- (c) A service that is clearly inconsistent with widely accepted and established standards of care for a particular diagnosis.

This provision does not require the Plan to pay charges for services or supplies that are not otherwise Covered Charges (including, without limitation, charges which the Qualified Individual would not be required to pay in the absence of this coverage) or prohibit the Plan from imposing all applicable cost sharing and reasonable cost management provisions. For these purposes, a Qualified Individual is a Covered Person who is eligible to participate in an approved clinical trial according to the trial protocol with respect to the treatment of cancer or another life-threatening disease or condition, and either: (1) the referring health care professional is a Network Provider and has concluded that the individual's participation in such trial would be appropriate; or (2) the Covered Person provides medical and scientific information establishing that the individual's participation in such trial would be appropriate.

- (13) **Eye care.** Radial keratotomy or other eye surgery to correct refractive disorders. Also, routine eye examinations, including refractions, lenses for the eyes and exams for their fitting. This exclusion does not apply to aphakic patients and soft lenses or sclera shells intended for use as corneal bandages or as may be covered under the well adult or well child sections of this Plan.
- (14) **Foot care.** Treatment of weak, strained, flat, unstable or unbalanced feet, metatarsalgia or bunions (except open cutting operations), and treatment of corns, calluses or toenails (unless needed in treatment of a metabolic or peripheral-vascular disease).
- (15) **Foot orthotics.** Charges in connection with over-the-counter foot orthotics or arch supports
- (16) **Foreign travel.** Care, treatment or supplies out of the U.S. if travel is for the purpose of obtaining medical services.
- (17) **Gene Therapy,** which is the use of genetic material to modify or manipulate the expression of a gene or alters the biological properties of living cells for therapeutic use.
- (18) **Government coverage.** Care, treatment or supplies furnished by a program or agency funded by any government. This exclusion does not apply to Medicaid or when otherwise prohibited by applicable law.
- (19) **Hair loss.** Care and treatment for hair loss including wigs, hair transplants or any drug that promises hair growth, whether or not prescribed by a Physician.
- (20) **Hearing aids and exams.** Charges for services or supplies in connection with hearing aids or exams for their fitting, except as may be covered under the well adult or well child sections of this Plan.
- (21) **Hospital employees.** Professional services billed by a Physician or nurse who is an employee of a Hospital or Skilled Nursing Facility and paid by the Hospital or facility for the service.
- (22) **Illegal acts.** Charges for services received as a result of Injury or Sickness occurring directly or indirectly, as a result of a Serious Illegal Act, or a riot or public disturbance. For purposes of this exclusion, the term "Serious Illegal Act" shall mean any act or series of acts that, if prosecuted as a criminal offense, a sentence to a term of imprisonment in excess of one year could be imposed. It is not necessary that criminal charges be filed, or, if filed, that a conviction result, or that a sentence of imprisonment for a term in excess of one year be imposed for this exclusion to apply. Proof beyond a reasonable doubt is not required. This exclusion does not apply if the Injury or Sickness resulted

from an act of domestic violence or a medical (including both physical and mental health) condition, or as required under the No Surprises Act.

- (23) **Illegal drugs or medications.** Services, supplies, care or treatment to a Covered Person for Injury or Sickness resulting from that Covered Person's voluntary taking of or being under the influence of any controlled substance, drug, hallucinogen or narcotic not administered on the advice of a Physician. Expenses will be covered for Injured Covered Persons other than the person using controlled substances and expenses will be covered for Substance Abuse treatment as specified in this Plan. This exclusion does not apply if the Injury resulted from an act of domestic violence or a medical (including both physical and mental health) condition, or as required under the No Surprises Act.
- (24) **Immunizations** required for foreign travel or employment.
- (25) **No charge.** Care and treatment for which there would not have been a charge if no coverage had been in force.
- (26) **Non-compliance.** All charges in connection with treatments or medications where the patient either is in non-compliance with medical orders issued while an inpatient at, or is discharged against medical advice from a Hospital or Skilled Nursing Facility, except as required under the No Surprises Act.
- (27) **Non-Medical Emergency Hospital admissions.** Care and treatment billed by a Hospital for non-Medical Emergency admissions on a Friday or a Saturday. This does not apply if surgery is performed within 24 hours of admission.
- (28) **No obligation to pay.** Charges incurred for which the Plan has no legal obligation to pay.
- (29) **No Physician recommendation.** Care, treatment, services or supplies not recommended and approved by a Physician; or treatment, services or supplies when the Covered Person is not under the regular care of a Physician. Regular care means ongoing medical supervision or treatment which is appropriate care for the Injury or Sickness.
- (30) **Not specified as covered.** Non-traditional medical services, treatments and supplies which are not specified as covered under this Plan.
- (31) **Obesity.** Screening and counseling for obesity will be covered to the extent required under Standard Preventive Care. Other care and treatment of obesity, weight loss or dietary control whether or not it is, in any case, a part of the treatment plan for another Sickness is excluded, except for medical and surgical treatment of morbid obesity subject to Utilization Review Administrator's guidelines.
- (32) **Occupational.** Care and treatment of an Injury or Sickness that is occupational -- that is, arises from work for wage or profit including self-employment. This exclusion may apply even if the expenses for the illness or injury are not paid by Worker's Compensation or similar employer's liability insurance.
- (33) **Organ transplant.** Any expenses for organ transplants are excluded under this self-funded health plan. Benefits for organ transplants are payable under the UnitedHealthcare Certificate of Coverage.
- (34) **Personal comfort items.** Personal comfort items or other equipment, such as, but not limited to, air conditioners, air-purification units, over-the-counter humidifiers, electric heating units, orthopedic mattresses, blood pressure instruments, scales, elastic bandages or stockings, nonprescription drugs and medicines, and first-aid supplies and nonhospital adjustable beds.
- (35) **Plan design excludes.** Charges excluded by the Plan design as mentioned in this document.
- (36) **Pre-marital counseling.** Care and treatment for pre-marital counseling.

- (37) **Relative giving services.** Professional services performed by a person who ordinarily resides in the Covered Person's home or is related to the Covered Person as a Spouse, parent, child, brother or sister, whether the relationship is by blood or exists in law.
- (38) **Self-Inflicted.** Any loss due to an intentionally self-inflicted Injury, except as required under the No Surprises Act. This exclusion does not apply if the Injury resulted from an act of domestic violence or a medical (including both physical and mental health) condition.
- (39) **Services before or after coverage.** Care, treatment or supplies for which a charge was incurred before a person was covered under this Plan or after coverage ceased under this Plan.
- (40) **Sex changes.** Care, services or treatment for non-congenital transsexualism, gender dysphoria or sexual reassignment or change. This exclusion includes medications, implants, hormone therapy, surgery, medical or psychiatric treatment.
- (41) **Sexual dysfunctions and inadequacies.** Care, treatment, services, supplies or medication in connection with treatment for sexual dysfunctions and inadequacies.
- (42) **Surgical sterilization reversal.** Care and treatment for reversal of surgical sterilization for men and women.
- (43) **Surrogacy and surrogate mother.** Charges associated with surrogacy, a method of reproduction whereby a woman agrees to become pregnant and deliver a child for a contracted party.
- (44) **Tobacco cessation.** Tobacco cessation care and treatment is excluded except to the extent (1) Medically Necessary due to a severe active lung illness such as emphysema or asthma, or (2) required under Standard Preventive Care.
- (45) **Travel or accommodations.** Charges for travel or accommodations, whether or not recommended by a Physician, except for ambulance charges as defined as a Covered Charge.
- (46) **War.** Any loss that is due to a declared or undeclared act of war.

PRESCRIPTION DRUG BENEFITS

Pharmacy Drug Charge

Participating pharmacies have contracted with the Plan to charge Covered Persons reduced fees for covered Prescription Drugs.

Coinsurance

The coinsurance is applied to each covered pharmacy drug or mail order drug charge and is shown in the schedule of benefits. Any one pharmacy prescription is limited to a 30-day supply. Any one mail order prescription is limited to a 90-day supply. Specialty drugs are limited to a 30-day supply.

Contact the Prescription Drug Administrator for information regarding non-participating pharmacy benefits or benefits at a participating pharmacy when the Covered Person's ID card is not used.

Mail Order Drug Benefit Option

The mail order drug benefit option is available for maintenance medications (those that are taken for long periods of time, such as drugs sometimes prescribed for heart disease, high blood pressure, asthma, etc.). Because of volume buying, the mail order pharmacy is able to offer Covered Persons significant savings on their prescriptions.

Covered Prescription Drugs

- (1) Drugs prescribed by a Physician that require a prescription either by federal or state law. This includes oral contraceptives unless otherwise specifically excluded, but excludes any drugs stated as not covered under this Plan.
- (2) Insulin and other diabetic supplies when prescribed by a Physician.
- (3) Injectable drugs or any prescription directing administration by injection.
- (4) Preauthorized Specialty Drugs as shown in the Prescription Drug Benefit Schedule.

Limits To This Benefit

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

- (1) Refills only up to the number of times specified by a Physician.
- (2) Refills up to one year from the date of order by a Physician.

Expenses Not Covered

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

- (1) **Administration.** Any charge for the administration of a covered Prescription Drug.
- (2) **Appetite suppressants.** A charge for appetite suppressants, dietary supplements or vitamin supplements, except for prenatal vitamins requiring a prescription or prescription vitamin supplements containing fluoride.
- (3) **Compounded Drugs.**
- (4) **Consumed on premises.** Any drug or medicine that is consumed or administered at the place where it is dispensed.

- (5) **Contraceptives.** A charge for Prescription Drugs for contraceptive purposes other than those listed on the preventive drug list; and contraceptives for all abortifacient purposes.
- (6) **Devices.** Devices of any type, even though such devices may require a prescription. These include (but are not limited to) therapeutic devices, artificial appliances, braces, support garments, or any similar device.
- (7) **Experimental.** Experimental drugs and medicines, even though a charge is made to the Covered Person.
- (8) **FDA.** Any drug not approved by the Food and Drug Administration.
- (9) **Immunization.** Immunization agents or biological sera, except as may be required under Standard Preventive Care.
- (10) **Inpatient medication.** A drug or medicine that is to be taken by the Covered Person, in whole or in part, while Hospital confined. This includes being confined in any institution that has a facility for the dispensing of drugs and medicines on its premises.
- (11) **Investigational.** A drug or medicine labeled: "Caution - limited by federal law to investigational use".
- (12) **Medical exclusions.** A charge excluded under Medical Plan Exclusions.
- (13) **No charge.** A charge for Prescription Drugs which may be properly received without charge under local, state or federal programs.
- (14) **No prescription.** A drug or medicine that can legally be bought without a written prescription. This does not apply to injectable insulin or to over the counter drugs that are prescribed by a Physician as required for Standard Preventive Care.
- (15) **Refills.** Any refill that is requested more than one year after the prescription was written or any refill that is more than the number of refills ordered by the Physician.

HOW TO SUBMIT A CLAIM

Benefits under this Plan shall be paid only if the Plan Administrator decides in its discretion that a Covered Person is entitled to them.

When a Covered Person has a Claim to submit for payment that person must:

- (1) Obtain a Claim form from HealthComp's website: <https://www.healthcomp.com> or the Plan Administrator.
- (2) Complete the Employee portion of the form. ALL QUESTIONS MUST BE ANSWERED.
- (3) Have the Physician complete the provider's portion of the form.
- (4) For Plan reimbursements, attach bills for services rendered. ALL BILLS MUST SHOW:
 - Name of Plan
 - Employee's name
 - Name of patient
 - Name, address, telephone number of the provider of care
 - Diagnosis
 - Type of services rendered, with diagnosis and/or procedure codes
 - Date of services
 - Charges
- (5) Send the above to the Claims Administrator at this address:

HealthComp Administrators
P.O. Box 45018
Fresno, California 93718
800-442-7247

WHEN CLAIMS SHOULD BE FILED

Claims should be filed with the Claims Administrator within 12 months of the date charges for the services were incurred. Benefits are based on the Plan's provisions at the time the charges were incurred. Claims filed later than that date may be declined or reduced unless:

- (a) it's not reasonably possible to submit the claim in that time; and
- (b) the claim is submitted within one year from the date incurred. This one year period will not apply when the person is not legally capable of submitting the claim.

The Claims Administrator will determine if enough information has been submitted to enable proper consideration of the claim. If not, more information may be requested from the claimant. The Plan reserves the right to have a Plan Participant seek a second medical opinion.

CLAIMS PROCEDURE

Following is a description of how the Plan processes claims for benefits and reviews the appeal of any claim that is denied. The terms used in this section are defined below.

A "Claim" is defined as any request for a Plan benefit, made by a claimant or by a representative of a claimant, which complies with the Plan's reasonable procedure for filing claims and making benefit claims determinations.

A "Claim" does not include a request for a determination of an individual's eligibility to participate in the Plan.

If a Claim is denied, in whole or in part, or if Plan coverage is rescinded retroactively for fraud or misrepresentation, the denial is known as an "Adverse Benefit Determination."

A claimant has the right to request a review of an Adverse Benefit Determination. This request is an "Appeal." If the Claim is denied at the end of the Appeal process, as described below, the Plan's final decision is known as a "Final Adverse Benefit Determination." If the claimant receives notice of a Final Adverse Benefit Determination, or if the Plan does not follow the Appeal procedures properly, the claimant then has the right to request an independent external review. The External Review procedures are described below.

Both the Claims and the Appeal procedures are intended to provide a full and fair review. This means, among other things, that Claims and Appeals will be decided in a manner designed to ensure the independence and impartiality of the persons involved in making these decisions.

A claimant must follow all Claims and Appeal procedures both internal and external, before he or she can file a lawsuit. However, this rule may not apply if the Plan Administrator has not complied with the procedures described in this Section. If a lawsuit is brought, it must be filed within two years after the final determination of an Appeal. Before a lawsuit can be filed, a claimant must also in good faith adhere to the Peacemaking Principles set forth by The Christian and Missionary Alliance. For details on these Peacemaking Principles, please contact Alliance Peacemaking at (719) 265-2018 or alliancepeacemaking@cmalliance.org.

Any of the authority and responsibilities of the Plan Administrator under the Claims and Appeal Procedures or the External Review Process, including the discretionary authority to interpret the terms of the Plan, may be delegated to a third party. If you have any questions regarding these procedures, please contact the Plan Administrator.

There are different kinds of Claims and each one has a specific timetable for each step in the review process. Upon receipt of the Claim, the Plan Administrator must decide whether to approve or deny the Claim. The Plan Administrator's notification to the claimant of its decision must be made as soon as practical and not later than the time shown in the timetable. However, if the Claim has not been filed properly, or if it is incomplete, or if there are other matters beyond the control of the Plan Administrator, the claimant may be notified that the period for providing the notification will need to be extended. If the period is extended because the Plan Administrator needs more information from the claimant, the claimant must provide the requested information within the time shown on the timetable. Once the Claim is complete, the Plan Administrator must make its decision as shown in the timetable. If the Claim is denied, in whole or in part, the claimant has the right to file an Appeal. Then the Plan Administrator must decide the Appeal and, if the Appeal is denied, provide notice to the claimant within the time periods shown on the timetable. The time periods shown in the timetable begin at the time the Claim or Appeal is filed in accordance with the Plan's procedures. Decisions will be made within a reasonable period of time appropriate to the circumstances, but within the maximum time periods listed in the timetables below. Unless otherwise noted, "days" means calendar days.

The definitions of the types of Claims are:

Urgent Care Claim

A Claim involving Urgent Care is any Claim for medical care or treatment where the Plan conditions receipt of benefits, in whole or in part, on approval in advance of obtaining the care or treatment, and using the timetable for a non-urgent care determination could seriously jeopardize the life or health of the claimant; or the ability of the claimant to regain maximum function; or in the opinion of the attending or consulting Physician, would subject the claimant to severe pain that could not be adequately managed without the care or treatment that is

the subject of the Claim. The Urgent Care Claim rules do not apply to claims involving urgent care where Plan benefits are not conditioned on prior approval. These claims are subject to the rules on Post-Service Claims described below.

A Physician with knowledge of the claimant's medical condition may determine if a Claim is one involving Urgent Care. The Claims Administrator will defer to the attending provider's determination that the Claim involves Urgent Care. If there is no such Physician, an individual acting on behalf of the Plan applying the judgment of a prudent layperson who possesses an average knowledge of health and medicine may make the determination.

In the case of a Claim involving Urgent Care, responses must be made as soon as possible consistent with the medical urgency involved, and no later than the following times:

Notification to claimant of Claim determination	72 hours
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Insufficient information on the Claim, or failure to follow the Plan's procedure for filing a Claim:

Notification to claimant, orally or in writing	24 hours
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Response by claimant, orally or in writing	48 hours
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Benefit determination, orally or in writing	48 hours
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Notification of Adverse Benefit Determination on Appeal	72 hours
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If there is an Adverse Benefit Determination on a Claim involving Urgent Care, a request for an expedited Appeal may be submitted orally or in writing by the claimant. All necessary information, including the Plan's benefit determination on review, may be transmitted between the Plan and the claimant by telephone, facsimile, or other similarly expeditious method. Alternatively, the claimant may request an expedited review under the External Review Process.

Concurrent Care Claims

A Concurrent Care Claim is a special type of Claim that arises if the Plan informs a claimant that benefits for a course of treatment that has been previously approved for a period of time or number of treatments is to be reduced or eliminated. In that case, the Plan must notify the claimant sufficiently in advance of the effective date of the reduction or elimination of treatment to allow the claimant to file an Appeal. This rule does not apply if benefits are reduced or eliminated due to Plan amendment or termination. A similar process applies for Claims based on a rescission of coverage for fraud or misrepresentation.

In the case of a Concurrent Care Claim, the following timetable applies:

Notification to claimant of benefit reduction	Sufficiently prior to scheduled termination of course of treatment to allow claimant to appeal
Notification to claimant of rescission	30 days
Notification of determination on Appeal of Claims involving Urgent Care	24 hours (provided claimant files Appeal more than 24 hours prior to scheduled termination of course of treatment)
Notification of Adverse Benefit Determination on Appeal for non-Urgent Claims	As soon as feasible, but not more than 30 days
Notification of Adverse Benefit Determination on Appeal for Rescission Claims	30 days

Pre-Service Claim

A Pre-Service Claim means any Claim for a benefit under this Plan where the Plan conditions receipt of the benefit, in whole or in part, on approval in advance of obtaining medical care. These are, for example, Claims subject to pre-certification. Please see the Cost Management section of this booklet for further information about Pre-Service Claims.

In the case of a Pre-Service Claim, the following timetable applies:

Notification to claimant of Benefit Determination (whether or not adverse)	15 days
Extension due to matters beyond the control of the Plan	15 days
Insufficient information on the Claim:	
Notification of	15 days
Response by claimant	45 days
Notification, orally or in writing, of failure to follow the Plan's procedures for filing a Claim	5 days
Notification of Adverse Benefit Determination on Appeal	15 days per benefit appeal

Post-Service Claim

A Post-Service Claim means any Claim for a Plan benefit that is not an Urgent Care Claim or a Pre-Service Claim; in other words, a Claim that is a request for payment under the Plan for medical services already received by the claimant.

In the case of a Post-Service Claim, the following timetable applies:

Notification to claimant of Adverse Benefit Determination	30 days
Extension due to matters beyond the control of the Plan	15 days
Extension due to insufficient information on the Claim	15 days
Response by claimant following notice of insufficient information	45 days
Notification of Adverse Benefit Determination on Appeal	30 days per benefit appeal

Notice to claimant of Adverse Benefit Determinations

If a Claim is denied in whole or in part, the denial is considered to be an Adverse Benefit Determination. Except with Urgent Care Claims, when the notification may be oral followed by written or electronic notification within three days of the oral notification, the Plan Administrator shall provide written or electronic notification of the Adverse Benefit Determination. The notice will state in a culturally and linguistically appropriate manner and in a manner calculated to be understood by the claimant:

- (1) Information sufficient to allow the claimant to identify the Claim involved (including date of service, the healthcare provider, and the claim amount, if applicable), and a statement that the diagnosis code and treatment code and their corresponding meanings will be provided to the claimant as soon as feasible upon request.
- (2) The specific reason or reasons for the adverse determination, including the denial code and its corresponding meaning, and a description of the Plan's standard, if any, that was used in denying the Claim. In the case of a Final Adverse Benefit Determination, the description must include a discussion of the decision.
- (3) Reference to the specific Plan provisions on which the determination was based.
- (4) A description of any additional material or information necessary for the claimant to perfect the Claim and an explanation of why such material or information is necessary.
- (5) A description of the Plan's internal and external Appeal procedures. This description will include information on how to initiate the Appeal and the time limits applicable to such procedures.

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

Appeals

When a claimant receives notification of an Adverse Benefit Determination, the claimant generally has 180 days following receipt of the notification in which to file a written request for an Appeal of the decision. However, for Concurrent Care Claims, the Claimant must file the Appeal prior to the scheduled reduction or termination of treatment. For a claim based on rescission of coverage, the claimant must file the Appeal within 30 days. A claimant may submit written comments, documents, records, and other information relating to the Claim.

The Plan Administrator shall provide the claimant, as soon as possible and sufficiently in advance of the time within which a final determination on Appeal is required to allow the claimant time to respond, any new or additional evidence that is relied upon, considered or generated by or at the direction of the Plan. This evidence shall be provided free of charge.

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

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

The period of time within which a benefit determination on Appeal is required to be made shall begin at the time an Appeal is filed in writing in accordance with the procedures of the Plan. This timing is without regard to whether all the necessary information accompanies the filing.

Before the Plan Administrator issues its Final Adverse Benefit Determination based on a new or additional rationale, the claimant must be provided, free of charge, with a copy of the rationale. The rationale must be provided as soon as possible and sufficiently in advance of the time within which a final determination on Appeal is required to allow the claimant time to respond.

The review shall take into account all comments, documents, records, and other information submitted by the claimant relating to the Claim, without regard to whether such information was submitted or considered in the initial benefit determination. The review will not afford deference to the initial Adverse Benefit Determination and will be conducted by a fiduciary of the Plan who is neither the individual who made the adverse determination nor a subordinate of that individual.

If the determination was based on a medical judgment, including determinations with regard to whether a particular treatment, drug, or other item is Experimental, Investigational, or not Medically Necessary or appropriate, the fiduciary shall consult with a health care professional who was not involved in the original benefit determination. This health care professional will have appropriate training and experience in the field of medicine involved in the medical judgment. Additionally, medical or vocational experts whose advice was obtained on behalf of the Plan in connection with the initial determination will be identified.

If the Appeal of a Claim is denied, in whole or in part, the Plan Administrator shall provide written notification of the Adverse Benefit Determination on Appeal. The notice will state, in a culturally and linguistically appropriate manner and in a manner calculated to be understood by the claimant:

- (1) Information sufficient to allow the claimant to identify the Claim involved (including date of service, the healthcare provider, and the claim amount, if applicable), and a statement that the diagnosis code and treatment code and their corresponding meanings will be provided to the claimant as soon as feasible upon request.
- (2) The specific reason or reasons for the adverse determination, including the denial code and its corresponding meaning, and a description of the Plan's standard, if any, that was used in denying the Claim.
- (3) Reference to the specific Plan provisions on which the determination was based.
- (4) A description of any additional material or information necessary for the claimant to perfect the Claim and an explanation of why such material or information is necessary.
- (5) A description of the Plan's internal and external review procedures and the time limits applicable to such procedures.
- (6) A statement that the claimant is entitled to receive, upon request and free of charge, reasonable access to, and copies of, all documents, records, and other information relevant to the Claim.
- (7) If the Adverse Benefit Determination was based on an internal rule, guideline, protocol, or other similar criterion, the specific rule, guideline, protocol, or criterion will be provided free of charge. If this is not practical, a statement will be included that such a rule, guideline, protocol, or criterion was relied upon in making the Adverse Benefit Determination and a copy will be provided free of charge to the claimant upon request.
- (8) If the Adverse Benefit Determination is based on the Medical Necessity or Experimental or Investigational treatment or similar exclusion or limit, an explanation of the scientific or clinical judgment for the determination, applying the terms of the Plan to the claimant's medical circumstances, will be provided. If this is not practical, a statement will be included that such explanation will be provided free of charge, upon request.
- (9) Information about the availability of and contact information for, any applicable office of health insurance consumer assistance or ombudsman established under applicable federal law to assist individuals with the internal claims and appeals and external review process.

If the claimant disagrees with the Adverse Benefit Determination on Appeal, he or she may file a request for a second level of Appeal. This request must be made in writing within 180 days following receipt of the Adverse Benefit Determination on Appeal. The claimant may submit written comments, documents, records, and other information relating to the Claim. The second level of review will be conducted, and written notification of the decision, shall be made in accordance with all of the procedures that apply to the first level of review. If the Claim is denied in whole or in part after this second level of Appeal, the written notification describing the Adverse Benefit Determination is the Final Adverse Benefit Determination.

EXTERNAL REVIEW PROCESS

If a claimant receives a Final Adverse Benefit Determination under the Plan's internal Claims and Appeals Procedures, he or she may request that the Claim be reviewed under the Plan's External Review process. The

External Review process is available only where the Final Adverse Benefit Determination is denied on the basis of (1) a medical judgment (which includes but is not limited to, Plan requirements for medical necessity, appropriateness, health care setting, level of care, or effectiveness of a covered benefit; eligibility for a reasonable alternative under a wellness program; or application of non-quantitative treatment limitations), (2) a determination that a treatment is experimental or investigational, (3) a rescission of coverage, or (4) consideration of whether the Plan is complying with the surprise billing and cost-sharing protections set forth in the No Surprises Act. The request for External Review must be filed in writing within four (4) months after receipt of the Final Adverse Benefit Determination.

The Plan Administrator will determine within five days of receipt whether the Claim is eligible for review under the External Review process. This determination is based on the criteria described above and whether:

- (1) The claimant is or was covered under the Plan at the time the Claim was made or incurred;
- (2) The denial relates to the claimant's failure to meet the Plan's eligibility requirements;
- (3) The claimant has exhausted the Plan's internal Claims and Appeal Procedures; and
- (4) The claimant has provided all the information required to process an External Review.

Within one business day after completion of this preliminary review, the Plan Administrator will provide written notification to the claimant of whether the claim is eligible for External Review.

If the request for review is complete but not eligible for External Review, the Plan Administrator will notify the claimant of the reasons for its ineligibility. The notice will include contact information for the Employee Benefits Security Administration at its toll free number (866-444-3272).

If the request is not complete, the notice will describe the information needed to complete it. The claimant will have 48 hours or until the last day of the 4 month filing period, whichever is later, to submit the additional information.

If the request is eligible for the External Review process, the Plan will assign it to a qualified independent review organization ("IRO"). The IRO is responsible for notifying the claimant, in writing, that the request for External Review has been accepted. The notice should include a statement that the claimant may submit in writing, within 10 business days, additional information the IRO must consider when conducting the review. The IRO will share this information with the Plan. The Plan may consider this information and decide to reverse its denial of the Claim. If the denial is reversed, the External Review process will end.

If the Plan does not reverse the denial, the IRO will make its decision on the basis of its review of all of the information in the record, as well as additional information where appropriate and available, such as:

- (1) The claimant's medical records;
- (2) The attending health care professional's recommendation;
- (3) Reports from appropriate health care professionals and other documents submitted by the plan or issuer, claimant, or the claimant's treating provider;
- (4) The terms of the Plan;
- (5) Appropriate practice guidelines;
- (6) Any applicable clinical review criteria developed and used by the Plan; and
- (7) The opinion of the IRO's clinical reviewer.

The IRO must provide written notice to the Plan and the claimant of its final decision within 45 days after the IRO receives the request for the External Review. The IRO's decision notice must contain:

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

Generally, a claimant must exhaust the Plan's Claims and Procedures in order to be eligible for the External Review process. However, in some cases the Plan provides for an expedited External Review if:

- (1) The claimant receives an Adverse Benefit Determination that involves a medical condition for which the time for completion of the Plan's internal Claims and Appeal Procedures would seriously jeopardize the claimant's life or health or ability to regain maximum function and the claimant has filed a request for an expedited internal review; or
- (2) The claimant receives a Final Adverse Benefit Determination that involves a medical condition where the time for completion of a standard External Review process would seriously jeopardize the claimant's life or health or the claimant's ability to regain maximum function, or if the Final Adverse Benefit Determination concerns an admission, availability of care, continued stay, or health care item or service for which the claimant received emergency services, but has not been discharged from a facility.

Immediately upon receipt of a request for expedited External Review, the Plan must determine and notify the claimant whether the request satisfies the requirements for expedited review, including the eligibility requirements for External Review listed above. If the request qualifies for expedited review, it will be assigned to an IRO. The IRO must make its determination and provide a notice of the decision as expeditiously as the claimant's medical condition or circumstances require, but in no event more than 72 hours after the IRO receives the request for an expedited External Review. If the original notice of its decision is not in writing, the IRO must provide written confirmation of the decision within 48 hours to both the claimant and the Plan.

COORDINATION OF BENEFITS

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

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

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

- (1) Group or group-type plans, including franchise or blanket benefit plans.
- (2) Blue Cross and Blue Shield group plans.
- (3) Group practice and other group prepayment plans.
- (4) Federal government plans or programs. This includes, but is not limited to, Medicare and Tricare.
- (5) Other plans required or provided by law. This does not include Medicaid or any benefit plan like it that, by its terms, does not allow coordination.
- (6) No Fault Auto Insurance, by whatever name it is called, when not prohibited by law.

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

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

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

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

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

- (1) Plans that do not have a coordination provision, or one like it, will pay first. Plans with such a provision will be considered after those without one.
- (2) Plans with a coordination provision will pay their benefits up to the Allowable Charge:
 - (a) The benefits of the plan which covers the person directly (that is, as an employee, member or subscriber) ("Plan A") are determined before those of the plan which covers the person as a dependent ("Plan B").
 - (b) The benefits of a benefit plan which covers a person as an Employee who is neither laid off nor retired are determined before those of a benefit plan which covers that person as a laid-off or Retired Employee. The benefits of a benefit plan which covers a person as a

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

- (c) The benefits of a benefit plan which covers a person as an Employee who is neither laid off nor retired or a Dependent of an Employee who is neither laid off nor retired are determined before those of a plan which covers the person as a COBRA beneficiary.
 - (d) When a child is covered as a Dependent and the parents are not separated or divorced, these rules will apply:
 - (i) The benefits of the benefit plan of the parent whose birthday falls earlier in a year are determined before those of the benefit plan of the parent whose birthday falls later in that year;
 - (ii) If both parents have the same birthday, the benefits of the benefit plan which has covered the parent for the longer time are determined before those of the benefit plan which covers the other parent.
 - (e) When a child's parents are divorced or legally separated, these rules will apply:
 - (i) This rule applies when the parent with custody of the child has not remarried. The benefit plan of the parent with custody will be considered before the benefit plan of the parent without custody.
 - (ii) This rule applies when the parent with custody of the child has remarried. The benefit plan of the parent with custody will be considered first. The benefit plan of the stepparent that covers the child as a Dependent will be considered next. The benefit plan of the parent without custody will be considered last.
 - (iii) This rule will be in place of items (i) and (ii) above when it applies. A court decree may state which parent is financially responsible for medical and dental benefits of the child. In this case, the benefit plan of that parent will be considered before other plans that cover the child as a Dependent.
 - (iv) If the specific terms of the court decree state that the parents shall share joint custody, without stating that one of the parents is responsible for the health care expenses of the child, the plans covering the child shall follow the order of benefit determination rules outlined above when a child is covered as a Dependent and the parents are not separated or divorced.
 - (v) For parents who were never married to each other, the rules apply as set out above as long as paternity has been established.
 - (f) If there is still a conflict after these rules have been applied, the benefit plan which has covered the patient for the longer time will be considered first. This includes situations in which a person who is covered as a dependent child under one benefit plan is also covered as a dependent spouse under another benefit plan. When there is a conflict in coordination of benefit rules, the Plan will never pay more than 50% of Allowable Charges when paying secondary.
- (3) Medicare will pay primary, secondary or last to the extent stated in federal law. If a Plan Participant is Medicare entitled this Plan will base its payment upon benefits that would have been paid by Medicare under Parts A and B regardless of whether or not the person was enrolled under any of these parts. The Plan Administrator will make this determination based on the information available through CMS. If CMS does not provide sufficient information to determine the amount Medicare would pay, the Plan Administrator will make reasonable assumptions based on published Medicare fee schedules.

- (4) If a Plan Participant is under a disability extension from a previous benefit plan, that benefit plan will pay first and this Plan will pay second.
- (5) The Plan will pay primary to Tricare and a State child health plan to the extent required by federal law.

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

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

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

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

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

THIRD PARTY RECOVERY PROVISION

RIGHT OF SUBROGATION AND REFUND

When this provision applies. The Covered Person may incur medical or dental charges due to Injuries which may be caused by the act or omission of a Third Party. In such circumstances, the Covered Person may have a claim for payment of the medical or dental charges. Accepting benefits under this Plan for those incurred medical or dental expenses automatically assigns to the Plan any rights the Covered Person may have to Recover payments from any Third Party or any other insurer or source, including but not limited to, "first party" underinsured or uninsured motorist coverage, worker's compensation, crime victim restitution funds, medical or disability payments, homeowner's plan, renter's plan, medical malpractice plan, or any other liability plan or any other source of coverage.

This Subrogation right allows the Plan to pursue any claim which the Covered Person has against any Third Party, or insurer, whether or not the Covered Person chooses to pursue that claim. The Plan may make a claim directly against the Third Party or insurer, but in any event, the Plan has a lien on any amount Recovered by the Covered Person whether or not designated as payment for medical expenses. This lien shall remain in effect until the Plan is repaid in full.

The Plan Administrator retains sole, full and final discretionary authority to construe, apply, and interpret the language of this provision, to determine all questions of fact and law arising under this provision, and to administer the Plan's subrogation and reimbursement rights. The Plan Administrator also retains the right to delegate this discretionary authority to the Claims Administrator without notice.

The payment for benefits received by a Covered Person under the Plan shall be made in accordance with the assignment of rights by or on behalf of the Covered Person as required by Medicaid.

In any case in which the Plan has a legal liability to make payments for benefits received by a Covered Person, to the extent that payment has been made through Medicaid, the payment for benefits under the Plan shall be made in accordance with any state law that has provided that the state has acquired the rights of the Covered Person to the payments of those benefits.

The Covered Person:

- (1) automatically assigns to the Plan his or her rights against any Third Party or insurer when this provision applies; and
- (2) must repay to the Plan the benefits paid on his or her behalf out of the Recovery made from the Third Party or insurer.

Amount subject to Subrogation or Refund. The Covered Person agrees to recognize the Plan's right to Subrogation and Refund. These rights provide the Plan with a 100%, first dollar priority over any and all Recoveries and funds paid by a Third Party or insurer to a Covered Person relative to the Injury or Sickness, including a priority over any claim for non-medical or dental charges, attorney fees, or other costs and expenses, even if the Covered Person's Recovery is less than the amount claimed, and, as a result, the Covered Person is not made whole. The Covered Person further specifically agrees and acknowledges that the "made whole doctrine" and "common fund" doctrine are completely abrogated under this Plan, and will not affect the Plan's right to 100% Subrogation or Refund for any and all benefits paid. The Plan shall have an equitable lien which supersedes all common law or statutory rules, doctrines, and laws of any state prohibiting assignment of rights which interfere with or compromise in any way the Plan's equitable subrogation lien. Accepting benefits under this Plan for those incurred medical or dental expenses automatically assigns to the Plan any and all rights the Covered Person may have to recover payments from any responsible third party or insurer. Further, accepting benefits under this Plan for those incurred medical or dental expenses automatically assigns to the Plan the Covered Person's Third Party Claims and/or the Covered Person's claims under any other policy of insurance or other coverage.

Notwithstanding its priority to funds, the Plan's Subrogation and Refund rights, as well as the rights assigned to it, are limited to the extent to which the Plan has made, or will make, payments for medical or dental charges as well as any costs and fees associated with the enforcement of its rights under the Plan. The Plan reserves the

right to be reimbursed for its court costs and attorneys' fees if the Plan needs to file suit in order to Recover payment for medical or dental expenses from the Covered Person.

When a right of Recovery exists, the Covered Person will execute and deliver all required instruments and papers as well as doing whatever else is needed to secure the Plan's right of Subrogation as a condition to having the Plan make payments. In addition, the Covered Person will do nothing to prejudice the right of the Plan to Subrogate.

Failure by the Covered Person(s) and/or his attorney to comply with any of these requirements may, at the Plan's discretion, result in forfeiture of payment by the Plan of medical benefits and any funds or payments due under this Plan may be withheld until the Covered Person(s) satisfies his or her obligation.

Conditions Precedent to Coverage. The Plan shall have no obligation whatsoever to pay medical or dental benefits to a Covered Person if a Covered Person refuses to cooperate with the Plan's reimbursement and Subrogation rights or refuses to execute and deliver such papers as the Plan may require in furtherance of its reimbursement and Subrogation rights. Further, in the event the Covered Person is a minor, the Plan shall have no obligation to pay any medical or dental benefits incurred on account of Injury or Sickness caused by a responsible Third Party until after the Covered Person or his authorized legal representative obtains valid court recognition and approval of the Plan's 100%, first dollar reimbursement and Subrogation rights on all Recoveries, as well as approval for the execution of any papers necessary for the enforcement thereof, as described herein.

Defined terms: "Covered Person" means anyone covered under the Plan, including minor dependents.

"Recover," "Recovered," "Recovery" or "Recoveries" means all monies paid to the Covered Person or his designee by way of judgment, settlement, or otherwise to compensate for all losses caused by the Injury or Sickness, whether or not said losses reflect medical or dental charges covered by the Plan. "Recoveries" further includes, but is not limited to, recoveries for medical or dental expenses, attorneys' fees, costs and expenses, pain and suffering, loss of consortium, wrongful death, lost wages and any other recovery of any form of damages or compensation whatsoever.

"Refund" means repayment to the Plan for medical or dental benefits that it has paid toward care and treatment of the Injury or Sickness.

"Subrogation" means the Plan's right to pursue and place a lien upon the Covered Person's claims for medical or dental charges against the other person.

"Third Party" means any Third Party including another person or a business entity.

Rights of Plan Administrator. The Plan Administrator has a right to request reports on and approve of all settlements.

CONTINUATION COVERAGE

WHEREAS, The Christian and Missionary Alliance (C&MA) Benefit Board has approved a plan of employee health benefits (referred to as the "Health Plan," or "Plan" in this section);

WHEREAS, the benefits under the Plan are made available to the employees of The Christian and Missionary Alliance churches (referred to as "Participating Employers") that have been accepted into membership in or affiliation with the C&MA;

WHEREAS, the Plan desires that coverage under the medical, dental, and vision benefits of the Plan (together referred to as the "The Health Plan") be temporarily continued for eligible employees and their dependents in the event of employment termination and certain other events;

NOW, THEREFORE, the following Continuation Coverage is hereby adopted to govern the terms of and conditions upon which the Health Plan Benefits will be continued for eligible employees and their dependents following circumstances that would normally result in termination of those Health Plan Benefits:

- (1) Continuation Coverage is a continuation of Health Plan coverage when coverage would otherwise end because of a life event known as a qualifying event. Specific qualifying events are listed later in this section. After a qualifying event, Continuation Coverage shall be offered to the employee and qualified dependents participating in the Health Plan. Except as otherwise provided by a Participating Employer with respect to its employees or as otherwise stated in this section, qualified beneficiaries who elect Continuation Coverage must pay for that coverage.
- (2) Health Plan benefits of an enrolled employee that commences Short-Term Disability benefits or begins a leave of absence under the Family and Medical Leave Act, or any other leave of absence approved by the plan, will continue on the same basis as if the employee was actively employed (except that the individual's contribution may be on an after-tax basis). This will be applicable for the duration of the individual's Short-Term Disability absence or under an approved leave of absence not to exceed 90 days. If an employee does not return to active employment following a period of Short-Term Disability or expiration of an approved leave of absence, the individual's employment will be considered as terminated for purposes of this continuation coverage (whether or not commencing Long-Term Disability benefits), and remaining eligible months of continuation coverage under this Plan will be available as applicable for coverage in effect immediately prior to employment termination.
- (3) The spouse of an employee will become a qualified beneficiary if the spouse loses any Health Plan coverage due to the qualifying event of the employee's death.
- (4) If an employee has been on this Plan for any length of time, C&MA will offer a minimum of one month Continuation Coverage (even if the employee was on the plan less than one month).

C&MA will offer one month of Continuation Coverage for every month the employee was on the plan as an active employee, up to a maximum of 12 months Continuation Coverage if they have been on the plan as an active employee for 12 months or more.

When Continuation Coverage Is Available. Continuation Coverage for the Health Plan will be offered to qualified beneficiaries only after the Plan Administrator (or its designee) has been notified according to Plan procedures that a qualifying event has occurred. When the qualifying event is the end of employment, the Participating Employer must provide written notice within 30 days of the qualifying event.

If an Employee age 65 or over:

- loses eligibility for the C&MA Plan, either through termination or reduction in hours, continuation of coverage will be offered to any dependents who are under age 65; or
- leaves the C&MA Plan while still eligible (i.e., drops the plan due to Medicare eligibility), continuation coverage will be offered to any dependent who is under 65.

How Continuation Coverage Is Provided. Except as provided in the “Election Period” discussion, below, once the Plan Administrator receives notice that a qualifying event has occurred, Continuation Coverage will be offered to employee and qualified dependents.

Continuation Coverage is a temporary continuation of coverage. Continuation Coverage lasts for up to a maximum of 12 months. In the case of death of a spouse, Continuation Coverage lasts for up to a maximum of 18 months. The maximum period will not be extended if one or more additional qualifying events described above subsequently occurs during the Continuation Coverage period.

Election Period. Once the Plan Administrator (or its designee) is notified of a qualifying event, the Plan’s Continuation Coverage Administrator will notify the employee of the right to elect Continued Coverage and provide an election form to complete and return. The employee will have election rights, and elections must be submitted in writing within 30 days of the later of:

- (1) The date coverage terminates because of the qualifying event, or
- (2) The date the notification and election form is mailed to the qualified.

Election forms that are mailed must be postmarked within the 30-day election period, and submissions of election forms by facsimile or email must bear a transmittal date within the 30-day election period.

Type of Coverage. Continuation Coverage can only be elected for Health Plan benefits in which the qualified beneficiary is enrolled at the time of the qualifying event. At annual enrollment, the qualifying beneficiary already on Continuation Coverage may elect to change or add any Health Plan coverage options with the types of coverage in which they are then enrolled (for example, qualifying beneficiaries under one medical option may elect a different medical option. If the Health Plan benefits change for active employees, such changes shall apply to anyone with Continuation Coverage unless otherwise determined by the Plan Administrator.

Cost of Coverage and Payment. Continuation Coverage is subject to payment by the qualified beneficiaries in the amount determined by the Plan Administrator and set forth in the election notice. Generally, the payment amounts required for each Health Plan benefit will be a function of the contributions charged with respect to active employees in similar circumstances. The contributions are charged on an after-tax basis and will be increased by an additional monthly fee for purposes of covering administrative costs.

Continuation Coverage shall be paid for in monthly installments. The first payment will be retroactive to the date of the loss of coverage due to the qualifying event and will be due no later than 30 days after the later of:

- (1) The date coverage terminates because of the qualifying event, or
- (2) The date the notification and election form is mailed to the qualified beneficiary.

Payments are collected electronically within the first three business days of the month for that month of coverage. Coverage is effective once the initial payment is received. Once payment is received, the participant may re-file claims that may have been denied between the initial benefits termination and the election and payment for Continued Coverage.

After the initial payment, participants on Continued Coverage for more than one month are required to make monthly payments thereafter which are due within the first three business days of the calendar month for which the coverage is to be effective, with a 30-day grace period, or at such other times as the Plan Administrator shall require by advance written notice. If the cost or benefits change in the future for active employees, the changes will also affect those on Continued Coverage except as the Plan Administrator may otherwise determine.

Termination of Continue Coverage. Continuation Coverage automatically ends when the first of the following occurs:

- (1) The applicable coverage period of 12 months ends; or 18 months in the case of death of a spouse, ends;
- (2) The end of the month prior to the employee’s 65th birthday;

- (3) The participant voluntarily elects to end coverage;
- (4) The participant fails to make the required contribution on time;
- (5) All or a portion of the Health Benefits are terminated with respect to all or any category of participants that includes those on Continuation Coverage (in which event, notice of termination will be provided at least 60 days in advance of the effective date); or
- (6) The participant becomes eligible under another group plan (as an employee or otherwise) after the election of Continuation Coverage.

RESPONSIBILITIES FOR PLAN ADMINISTRATION

PLAN ADMINISTRATOR. The Christian and Missionary Alliance is the benefit plan of Christian and Missionary Alliance, the Plan Administrator, also called the Plan Sponsor. An individual or committee may be appointed by The Christian and Missionary Alliance to be Plan Administrator and serve at the convenience of the Employer. If the Plan Administrator or a committee member resigns, dies or is otherwise removed from the position, The Christian and Missionary Alliance shall appoint a new Plan Administrator as soon as reasonably possible.

The Plan Administrator shall administer this Plan in accordance with its terms and establish its policies, interpretations, practices, and procedures. It is the express intent of this Plan that the Plan Administrator shall have maximum legal discretionary authority to construe and interpret the terms and provisions of the Plan, to make determinations regarding issues which relate to eligibility for benefits, to decide disputes which may arise relative to a Plan Participant's rights, and to decide questions of Plan interpretation and those of fact relating to the Plan. The decisions of the Plan Administrator will be final and binding on all interested parties.

DUTIES OF THE PLAN ADMINISTRATOR.

- (1) To administer the Plan in accordance with its terms.
- (2) To interpret the Plan, including the right to remedy possible ambiguities, inconsistencies or omissions.
- (3) To decide disputes which may arise relative to a Plan Participant's rights.
- (4) To prescribe procedures for filing a claim for benefits and to review claim denials.
- (5) To keep and maintain the Plan documents and all other records pertaining to the Plan.
- (6) To appoint a Claims Administrator to pay claims.
- (7) To delegate to any person or entity such powers, duties and responsibilities as it deems appropriate.

PLAN ADMINISTRATOR COMPENSATION. The Plan Administrator serves **without** compensation; however, all expenses for plan administration, including compensation for hired services, will be paid by the Plan.

FORCE MAJEURE. Should the performance of any act required by the Plan be prevented or delayed by reason of any act of nature, strike, lock-out, labor troubles, restrictive governmental laws or regulations, or any other cause beyond a party's control, the time for the performance of the act will be extended for a period equivalent to the period of delay, and non-performance of the act during the period of delay will be excused. In such an event, however, all parties will use reasonable efforts to perform their respective obligations under the Plan.

CLAIMS ADMINISTRATOR IS NOT A FIDUCIARY. A Claims Administrator is **not** a fiduciary under the Plan by virtue of paying claims in accordance with the Plan's rules as established by the Plan Administrator.

COMPLIANCE WITH HIPAA PRIVACY STANDARDS. Certain members of the Employer's workforce perform services in connection with administration of the Plan. In order to perform these services, it is necessary for these employees from time to time to have access to Protected Health Information (as defined below).

Under the Standards for Privacy of Individually Identifiable Health Information (45 CFR Part 164, the "Privacy Standards"), these employees are permitted to have such access subject to the following:

- (1) **General.** The Plan shall not disclose Protected Health Information to any member of the Employer's workforce unless each of the conditions set out in this HIPAA Privacy section is met. "Protected Health Information" shall have the same definition as set out in the Privacy Standards but generally shall mean individually identifiable health information about the past, present or future physical or mental health or condition of an individual, including genetic information and information about treatment or payment for treatment.

- (2) **Permitted Uses and Disclosures.** Protected Health Information disclosed to members of the Employer's workforce shall be used or disclosed by them only for purposes of Plan administrative functions. The Plan's administrative functions shall include all Plan payment and health care operations. The terms "payment" and "health care operations" shall have the same definitions as set out in the Privacy Standards, but the term "payment" generally shall mean activities taken with respect to payment of premiums or contributions, or to determine or fulfill Plan responsibilities with respect to coverage, provision of benefits, or reimbursement for health care. "Health care operations" generally shall mean activities on behalf of the Plan that are related to quality assessment; evaluation, training or accreditation of health care providers; underwriting, premium rating and other functions related to obtaining or renewing an insurance contract, including stop-loss insurance; medical review; legal services or auditing functions; or business planning, management and general administrative activities. However, Protected Health Information that consists of genetic information will not be used or disclosed for underwriting purposes.
- (3) **Authorized Employees.** The Plan shall disclose Protected Health Information only to members of the Employer's workforce who are designated and are authorized to receive such Protected Health Information, and only to the extent and in the minimum amount necessary for these persons to perform duties with respect to the Plan. For purposes of this HIPAA Privacy section, "members of the Employer's workforce" shall refer to all employees and other persons under the control of the Employer.
- (a) **Updates Required.** The Employer shall amend the Plan promptly with respect to any changes in the members of its workforce who are authorized to receive Protected Health Information.
- (b) **Use and Disclosure Restricted.** An authorized member of the Employer's workforce who receives Protected Health Information shall use or disclose the Protected Health Information only to the extent necessary to perform his or her duties with respect to the Plan.
- (c) **Resolution of Issues of Noncompliance.** In the event that any member of the Employer's workforce uses or discloses Protected Health Information other than as permitted by the Privacy Standards, the incident shall be reported to the privacy official. The privacy official shall take appropriate action, including:
- (i) Investigation of the incident to determine whether the breach occurred inadvertently, through negligence, or deliberately; whether there is a pattern of breaches; and the degree of harm caused by the breach;
 - (ii) Applying appropriate sanctions against the persons causing the breach, which, depending upon the nature of the breach, may include, oral or written reprimand, additional training, or termination of employment;
 - (iii) Mitigating any harm caused by the breach, to the extent practicable; and
 - (iv) Documentation of the incident and all actions taken to resolve the issue and mitigate any damages.
- (4) **Certification of Employer.** The Employer must provide certification to the Plan that it agrees to:
- (a) Not use or further disclose the Protected Health Information other than as permitted or required by the Plan documents or as required by law;
 - (b) Ensure that any agent or subcontractor, to whom it provides Protected Health Information received from the Plan, agrees to the same restrictions and conditions that apply to the Employer with respect to such information;
 - (c) Not use or disclose Protected Health Information for employment-related actions and decisions or in connection with any other benefit or employee benefit plan of the Employer;

- (d) Report to the Plan any use or disclosure of the Protected Health Information of which it becomes aware that is inconsistent with the uses or disclosures hereunder or required by law;
- (e) Make available Protected Health Information to individual Plan members in accordance with Section 164.524 of the Privacy Standards;
- (f) Make available Protected Health Information for amendment by individual Plan members and incorporate any amendments to Protected Health Information in accordance with Section 164.526 of the Privacy Standards;
- (g) Make available the Protected Health Information required to provide any accounting of disclosures to individual Plan members in accordance with Section 164.528 of the Privacy Standards;
- (h) Make its internal practices, books and records relating to the use and disclosure of Protected Health Information received from the Plan available to the Department of Health and Human Services for purposes of determining compliance by the Plan with the Privacy Standards;
- (i) If feasible, return or destroy all Protected Health Information received from the Plan that the Employer still maintains in any form, and retain no copies of such information when no longer needed for the purpose of which disclosure was made, except that, if such return or destruction is not feasible, limit further uses and disclosures to those purposes that make the return or destruction of the information unfeasible; and
- (j) Ensure the adequate separation between the Plan and member of the Employer's workforce, as required by Section 164.504(f)(2)(iii) of the Privacy Standards.

The following members of The Christian and Missionary Alliance's workforce are designated as authorized to receive Protected Health Information from The Christian and Missionary Alliance ("the Plan") in order to perform their duties with respect to the Plan: Privacy Officer, and other individuals trained and authorized by the Privacy Officer to receive Protected Health Information.

COMPLIANCE WITH HIPAA ELECTRONIC SECURITY STANDARDS. Under the Security Standards for the Protection of Electronic Protected Health Information (45 CFR Part 164.300 et. seq., the "Security Standards"), the Employer agrees to the following:

- (1) The Plan Administrator agrees to implement reasonable and appropriate administrative, physical and technical safeguards to protect the confidentiality, integrity and availability of Electronic Protected Health Information that the Employer creates, maintains or transmits on behalf of the Plan. "Electronic Protected Health Information" shall have the same definition as set out in the Security Standards, but generally shall mean Protected Health Information that is transmitted by or maintained in electronic media.
- (2) The Plan Administrator shall ensure that any agent or subcontractor to whom it provides Electronic Protected Health Information shall agree, in writing, to implement reasonable and appropriate security measures to protect the Electronic Protected Health Information.
- (3) The Plan Administrator shall ensure that reasonable and appropriate security measures are implemented to comply with the conditions and requirements set forth in Compliance With HIPAA Privacy Standards provisions (3) Authorized Employees and (4) Certification of Employers described above.

FUNDING THE PLAN AND PAYMENT OF BENEFITS

The cost of the Plan is funded as follows:

For Employee and Dependent Coverage: Funding is derived from the funds of the Plan Administrator and contributions made by the covered Employees.

The level of any Employee contributions will be set by the Plan Administrator. These Employee contributions will be used in funding the cost of the Plan as soon as practicable after they have been received from the Employer.

Benefits are paid directly from the Plan through the Claims Administrator.

PLAN IS NOT AN EMPLOYMENT CONTRACT

The Plan is not to be construed as a contract for or of employment.

CLERICAL ERROR

Any clerical error by the Plan Administrator or an agent of the Plan Administrator in keeping pertinent records or a delay in making any changes will not invalidate coverage otherwise validly in force or continue coverage validly terminated. An equitable adjustment of contributions will be made when the error or delay is discovered.

If, an overpayment occurs in a Plan reimbursement amount, the Plan retains a contractual right to the overpayment. The person or institution receiving the overpayment will be required to return the incorrect amount of money. In the case of a Plan Participant, the amount of overpayment may be deducted from future benefits payable.

GENERAL PLAN INFORMATION

TYPE OF ADMINISTRATION

The Plan is a self-funded group health Plan and the administration is provided through a Third Party Claims Administrator. The funding for the benefits is derived from the funds of the Employer and contributions made by covered Employees. The Plan is not insured.

PLAN NAME

The Christian and Missionary Alliance Health Plan

PLAN NUMBER: 501

TAX ID NUMBER: 13-1623940

PLAN EFFECTIVE DATE: January 1, 2004

PLAN YEAR ENDS: December 31

EMPLOYER INFORMATION

Christian and Missionary Alliance
8595 Explorer Drive
Colorado Springs, Colorado 80920
800-700-2651

PLAN ADMINISTRATOR

Christian and Missionary Alliance
8595 Explorer Drive
Colorado Springs, Colorado 80920
800-700-2651

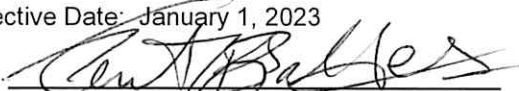
CLAIMS ADMINISTRATOR

HealthComp Administrators
P.O. Box 45018
Fresno, California 93718
800-442-7247

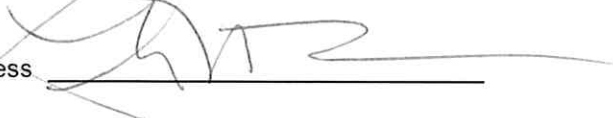
BY THIS AGREEMENT, Christian and Missionary Alliance is hereby adopted as shown.

IN WITNESS WHEREOF, this instrument is executed for Christian and Missionary Alliance on or as of the day and year first below written.

Effective Date: January 1, 2023

By 
Christian and Missionary Alliance

Date 16 March 2023

Witness 

Date 3/16/2023

ACCEPTANCE OF RESPONSIBILITY & CONFIRMATION OF ACCURACY


Pursuant to the terms of your agreement with HealthComp Administrators, Inc. ("HealthComp") we have assisted in the preparation of the enclosed Christian and Missionary Alliance Health Plan. Our assistance has been based upon our understanding of what you, the Plan Sponsor, wish to have incorporated into this document. While we have undertaken to prepare this document to the best of our abilities, responsibility for the accuracy of this document remains that of the Plan Sponsor.

It is imperative that you immediately review this document in detail. You may wish to have legal counsel review this document to ensure that it reflects your plan's objectives in terms of the types and amounts of coverage afforded, exclusions, rights, and other substantive material provisions, and that it meets with all applicable regulatory requirements.

By signing below, you acknowledge your acceptance of responsibility for the contents and accuracy of this document. Please sign and return this form. If you have any questions regarding this document, please immediately contact our office.

We, the Plan Sponsor, recognize that we have full responsibility for the contents of the Christian and Missionary Alliance Health Plan effective January 1, 2023, and that while HealthComp, its employees, agents, and/or sub-contractors may have assisted in the preparation of this document, we are responsible for the final text and meaning. We further certify that the document has been fully read, understood, and describes our intent with regard to our employee welfare plan.

Dated: 16 March 2023

By: 
Authorized Representative of Christian and Missionary Alliance

Print Name: Kenneth E. Baidas

Title: Vice President