PLAN DOCUMENT AMENDMENT #1

FOR

UNIVERSITY OF THE INCARNATE WORD

GROUP HEALTH PLAN

EFFECTIVE JUNE 1, 2021

NOTICE IS HEREBY GIVEN that the University of the Incarnate Word Group Health Plan document is amended effective June 1, 2021.

CHANGE 1. The fourth bullet which appears under the "Maximum Allowable Charge" definition in the section entitled "DEFINITIONS" is hereby deleted in its entirety and replaced with the following:

- Crosswalk pricing (prices established by CMS utilizing standard Medicare payment methods for items in alternate settings based on Medicare rates provided for similar services and/or supplies paid to similarly skilled and trained providers of care in traditional settings), in conjunction with the Scheduled Benefit Amount, as defined below;

CHANGE 2. The item "Medically Necessary or Medical Necessity" which appears in the section entitled "DEFINITIONS" is hereby deleted in its entirety and replaced with the following:

Medically Necessary or Medical Necessity: Describes medical treatment, as determined by the Plan Administrator, that:

1. Is appropriate and consistent with the diagnosis;

2. In accordance with accepted medical standards, would not have been omitted without adversely affecting the patient's condition or the quality of medical care rendered;

3. Is not primarily Custodial Care;

4. As to institutional care, could not have been provided in a Physician's office, in the Outpatient department of a Hospital or in a lesser facility without adversely affecting the patient's condition or the quality of medical care rendered; and

5. Are rendered in the least intensive setting that is appropriate for the delivery of the services and supplies. Where applicable, the Plan may compare the cost-effectiveness of alternative services, settings, or supplies when determining least intensive setting.

CHANGE 3. The subsection "Eligibility Restrictions," which appears in the section entitled "PERSONS COVERED AND EFFECTIVE DATES" is hereby deleted in its entirety and replaced with the following:

Eligibility Restrictions

- You may not be covered under this Plan as both an employee and as a dependent.
- If both parents of a Child are Covered Employees, a Dependent Child can be covered under this Plan by either parent, but not by both parents.
- You may not enroll your dependents without enrolling yourself in the Plan.
- You and your dependents must enroll in the same plan option.
- Your dependent may not reside outside of the United States on a full-time basis. For purposes of the Plan, the United States includes U.S. territories.

CHANGE 4. The section entitled "HOW THE PLAN WORKS" is hereby deleted in its entirety and replaced with the following:

HOW THE PLAN WORKS

This Plan is a Reference-Based Pricing (RBP) plan that bases payments to facility and professional providers on the Medicare fee schedule plus an incentive bonus over and above current Medicare allowable amounts. Therefore, there is no medical provider network and Members may choose any provider. The Plan will pay covered charges up to the Maximum Allowable Charge, less any amount that the Member must pay due to application of deductibles, copayments, out-of-pocket expenses, or other cost-sharing provisions.

Each Participant has a free choice of any provider, and the Participant, together with his or her provider, is ultimately responsible for determining the appropriate course of medical treatment, regardless of whether the Plan will pay for all or a portion of the cost of such care.

Patient Advocates
The Plan has selected Zelis, as the Patient Advocacy program partner. As patient advocates, Zelis can assist Members in several ways by:

- Offering guidance and assistance with referrals to facility and professional providers that will accept the Plan's reimbursement rate as payment in full;
- Educating Members and providers about the Plan's payment methodology;
- Advocating on the Member's behalf as a liaison between the Member and his or her providers;
- Making outreach to providers in an effort to gain acceptance of the Plan's reimbursement as payment in full;
- Providing assistance and support should Members receive a balance bill from a provider.

Members may contact a Zelis Patient Advocate by calling the toll-free number on the ID card.

Finding a Provider
Because there is no medical provider network, you may see any provider you choose and covered services will be paid up to the Maximum Allowable Charge. However, it is advisable to contact your provider in advance to verify they will accept a percentage of Medicare reimbursement as payment in full. If a provider will not agree to accept the Medicare reference-based reimbursement as payment in full, then the Member should contact a Zelis Patient Advocate at the toll-free number on the ID card. A Patient Advocate can help by reaching out to providers or assisting Members in finding another provider that will accept the Plan's compensation as payment in full.

Balance Billing
Although most providers will accept the Plan's reimbursement as payment in full, some providers may invoice Members for the balance of the billed charges remaining after the Plan has paid the Maximum Allowable Charge. This is called balance billing. Members who receive a balance bill should call Gilsbar, LLC at the number on the back of the ID card. Gilsbar, LLC will ask the Member to fax or email a copy of the bill from the provider so that Gilsbar can review the bill to make sure it is a balance bill and not attributable to the Member's cost-sharing responsibility (such as copays, deductibles, or coinsurance). If the bill is determined to be a balance bill, it will be forwarded to Zelis Patient Advocacy for handling. A Zelis Patient Advocate will contact the provider on the Member's behalf to help resolve the bill and will keep the Member informed on the status of the balance bill.

MDLIVE
MDLIVE provides access to a national network of board-certified doctors and pediatricians who are available on-demand 24 hours a day, 7 days a week, 365 days a year to diagnose, treat and prescribe medication (when necessary) for many medical issues via mobile app, telephone or online video consultations. MDLIVE does not replace existing primary care Physician relationships, but supplements them as a convenient, affordable alternative for medical care. Refer to the website located at www.mygilsbar.com for more details.

Asserta Health
The Plan has contracted with Asserta Health to negotiate pre-payment of certain covered services. Members using Asserta Health may have their share of costs (deductible, copayments, and/or coinsurance) greatly reduced or completely eliminated per a shared savings arrangement.

The per episode shared savings available to a Covered Member is up to 100% of the Member's out-of-pocket costs when sufficient savings is generated through utilization of the Asserta Health pre-payment program. Savings are calculated relative to a reference price of 200% of Medicare and are limited to procedures with a reference price greater than or equal to $7,500.

The Plan Participant must contact Asserta Health before any services are rendered or scheduled. Some of the services Asserta Health may be used for are:

- General Surgery
- Orthopedic Surgery

- Advanced Imaging
- Cardiac Surgery
- Spinal Surgery
- Women's procedures

Asserta's medEcash℠ payment platform stages funds that come directly from the Plan and the Member in advance, then pays 100% of transparent cash prices to each provider in real time on the day of service. Providers are paid immediately without the need to file a claim, and the member is not billed later. The entire transaction is completed on the date of service.

Plan Participants can contact Asserta Health at 866-996-5835 to determine if the health plan service needed is available under this program.

CHANGE 5. The second paragraph under the subsection "The Plan Adminstrator" which appears in the section entitled "PLAN ADMINSTRATION" is hereby deleted in its entirety.

Copies of the Plan document and this Plan document amendment are maintained on file by the Plan Administrator and by the Benefit Services Manager.

This Group Health Plan document amendment is hereby adopted in its entirety.

PLAN DOCUMENT AMENDMENT #2

FOR

UNIVERSITY OF THE INCARNATE WORD

GROUP HEALTH PLAN

EFFECTIVE JUNE 1, 2021

NOTICE IS HEREBY GIVEN that the University of the Incarnate Word Group Health Plan document is amended effective June 1, 2021.

CHANGE 1. The item "Medically Necessary or Medical Necessity" which appears in the section entitled "DEFINITIONS" is hereby deleted in its entirety and replaced with the following:

Medically Necessary or Medical Necessity: Describes medical treatment, as determined by the Plan Administrator, that:

1. Is appropriate and consistent with the diagnosis;
2. In accordance with accepted medical standards, would not have been omitted without adversely affecting the patient's condition or the quality of medical care rendered;
3. Is not primarily Custodial Care;
4. As to institutional care, could not have been provided in a Physician's office, in the Outpatient department of a Hospital or in a lesser facility without adversely affecting the patient's condition or the quality of medical care rendered; and
5. Are rendered in the least intensive setting that is appropriate for the delivery of the services and supplies. Where applicable, the Plan may compare the cost-effectiveness of alternative services, settings, or supplies when determining least intensive setting.

The mere fact that the service is furnished, prescribed or approved by a Physician does not mean that it is "medically necessary." In addition, the fact that certain services are excluded from coverage under this Plan because they are not "medically necessary" does not mean that any other services are deemed to be "medically necessary."

Copies of the Plan document and this Plan document amendment are maintained on file by the Plan Administrator and by the Benefit Services Manager.

This Group Health Plan document amendment is hereby adopted in its entirety.

PLAN DOCUMENT AMENDMENT #3

FOR

UNIVERSITY OF THE INCARNATE WORD

GROUP HEALTH PLAN

EFFECTIVE JUNE 1, 2022

NOTICE IS HEREBY GIVEN that the University of the Incarnate Word Group Health Plan document is amended effective June 1, 2022.

CHANGE 1. The section entitled "NOTICE REGARDING WELLNESS PROGRAM AND NOTICE OF REASONABLE ALTERNATIVES" has been deleted in its entirety.

CHANGE 2. The item "Behavioral/Mental Health and Substance Use Disorders – Outpatient" which appears in the subsection "Schedule of Medical Benefits" in the section entitled "HIGHLIGHTS OF THE GROUP HEALTH PLAN" is hereby deleted in its entirety and replaced with the following:

BENEFIT DESCRIPTION	BRONZE PLAN		SILVER PLAN	
	YOU PAY	PLAN PAYS	YOU PAY	PLAN PAYS
Behavioral/Mental Health and Substance Use Disorders – Outpatient (Includes Partial Hospitalization services)	$25 copay, deductible waived	100%	Deductible, then 0%	100% after deductible

CHANGE 3. The item "Emergency Services in an Emergency Room" which appears in the subsection "Schedule of Medical Benefits" in the section entitled "HIGHLIGHTS OF THE GROUP HEALTH PLAN" is hereby deleted in its entirety and replaced with the following:

<table>
<tr><th rowspan="2">BENEFIT DESCRIPTION</th><th colspan="2">BRONZE PLAN</th><th colspan="2">SILVER PLAN</th></tr>
<tr><th>YOU PAY</th><th>PLAN PAYS</th><th>YOU PAY</th><th>PLAN PAYS</th></tr>
<tr><td rowspan="2">Emergency Services in an Emergency Room</td><td>$150 copay, deductible waived</td><td>100%</td><td rowspan="2">Deductible, then 0%</td><td rowspan="2">100% after deductible</td></tr>
<tr><td colspan="2">Copay is waived if you are admitted directly to the Hospital from the Emergency Room</td></tr>
<tr><td colspan="5">For Emergency Services not performed in the emergency department of a Hospital or in an Independent Freestanding Emergency Department (IFED), refer to the applicable service for benefit. For IFEDs that bill as an urgent care facility, refer to the "Urgent Care Facility" benefit.</td></tr>
</table>

CHANGE 4. The item "Urgent Care Facility" which appears in the subsection "Schedule of Medical Benefits" in the section entitled "HIGHLIGHTS OF THE GROUP HEALTH PLAN" is hereby deleted in its entirety and replaced with the following:

BENEFIT DESCRIPTION	BRONZE PLAN		SILVER PLAN	
	YOU PAY	PLAN PAYS	YOU PAY	PLAN PAYS
Urgent Care Facility (includes all covered charges billed by facility)	$50 copay, deductible waived	100%	Deductible, then 0%	100% after deductible
Includes charges for Emergency Services Incurred in an urgent care facility that is authorized to perform Emergency Services (and is therefore considered an Independent Freestanding Emergency Department (IFED)).				

CHANGE 5. The subsection "Schedule of Prescription Drug Benefits" in the section entitled "HIGHLIGHTS OF THE GROUP MEDICAL PLAN" is hereby deleted in its entirety and replaced with the following:

Schedule of Prescription Drug Benefits
The following schedule summarizes amounts paid by the Plan. Please refer to the Prescription Drug Benefits section for a description of covered expenses and benefit exclusions and limitations.

BENEFIT DESCRIPTION	BOTH PLANS
PRESCRIPTION DRUG DEDUCTIBLE, PER CALENDAR YEAR	
Per Member	No deductible applies
Per Family	No deductible applies
PRESCRIPTION DRUG OUT-OF-POCKET MAXIMUM, PER CALENDAR YEAR	
Per Member	Medical out-of-pocket maximum applies
Per Family	Medical out-of-pocket maximum applies
BRAND-NAME PENALTY	
If your Physician authorizes the use of a Generic drug, but you choose to use the Brand Name drug, you must pay the difference between the actual cost of the Generic and Brand Name in addition to the Brand Name copayment.	
USING A NON-NETWORK PHARMACY	
If you fill your prescription using a Non-Network retail pharmacy…	Purchases at a non-participating *pharmacy* require you to pay in full then submit a claim form for reimbursement and are subject to an additional 30% coinsurance. Non-network *mail order* prescriptions are not covered.
RETAIL PHARMACY OPTION (30-day supply)	
Prescribed Preventive Medications as recommended by federal law*	No charge
Generic drug	$10
Preferred Brand Name drug	$25
Non-Preferred Brand Name drug	$50
Generic or Brand Name drugs over $1,250	Not covered

BENEFIT DESCRIPTION	BOTH PLANS
SPECIALTY DRUGS (30-day supply)	
All specialty drugs are excluded; however, the Plan may cover a specialty drug at the applicable copay listed above for one 30-day period during a Calendar Year for each specialty drug when an urgent fill of medication is required, unless otherwise excluded elsewhere in the Plan.	Copay follows above categories, when covered
MAIL ORDER OPTION (90-day supply; available only through a Network pharmacy)	
Prescribed Preventive Medications as recommended by federal law*	No charge
Generic drug	$15
Preferred Brand Name drug	$37.50
Non-Preferred Brand Name drug	$75
Generic or Brand Name drugs over $3,750	Not covered

*****Contraceptives are covered as recommended by the ACA and are payable at the applicable Generic and Brand Name copays shown above.

Brand Name means a trade name medication.

Generic drug means a prescription drug that 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.

Preferred Brand Name drug means a trade name prescription medication that is on the Formulary Brand Name drug list, compiled by the third party payor, of safe, effective therapeutic drugs specifically covered by this Plan.

Non-Preferred Brand Name drug means a trade name prescription medication that is not on the Formulary Brand Name drug list.

Specialty drugs means those federal legend drugs that are any drug, regardless of route of administration, which are classified by the pharmacy benefit manager as "specialty" medications. A drug is considered a "specialty" medication if it includes one or more of the following characteristics:

- Requires patient participation in a medical management program that includes review of medication use, patient training, coordination of care and management of successful use.
- Continual monitoring and training is needed
- A FDA-mandated Risk Evaluation and Mitigation Strategy program is utilized in order to approve medication
- Medication has particular handling, distribution, and/or administration requirements
- Medication has a high cost
- Medication is administered orally, inhaled, infused or injected
- Medication is used to target chronic or complex diseases
- Medication can be produced through biological processes
- Medication is used to treat rare diseases and is referred to as orphan drugs

CHANGE 6. The following definitions are hereby ADDED to the section entitled "DEFINITIONS" replacing any such definitions that currently appear with the same name:

Air Ambulance Service: Medical transport by helicopter or airplane for Participants.

Cost Sharing: The amount a Participant is responsible for paying for a covered item or service under the terms of the Plan. Cost sharing generally includes co-payments, coinsurance, and amounts paid towards deductibles, but does not include amounts paid towards premiums, balance billing by non-Participating Providers, or the cost of items or services that are not covered under the Plan.

Emergency Services: Emergency Services include all of the following—

1. **Initial Services**. A medical screening examination within the capability of a Hospital emergency department or an Independent Freestanding Emergency Department, including ancillary services routinely available to the emergency department to evaluate an Emergency Medical Condition.

2. **Stabilization Services**. Such further medical examination and treatment within the capabilities of the staff and facilities available at the Hospital or Independent Freestanding Emergency Department to stabilize the Participant.

3. **Post-stabilization Services**. Additional services covered under the Plan that are furnished by a non-Participating Provider or emergency non-Participating Facility after a Participant is stabilized and as part of Outpatient observation or an Inpatient or Outpatient stay with respect to the visit in which the Initial and Stabilization Services were provided. See the "Provider Information and Patient Advocacy" section for additional details.

An Emergency Medical Condition is a medical condition, including a mental health condition or substance use disorder, manifesting itself through acute symptoms of sufficient severity (including severe pain) that a prudent layperson with an average knowledge of health and medicine could reasonably expect the absence of immediate medical attention to result in serious jeopardy to the individual's health (or with respect to a pregnant woman, the health of the woman or her unborn child), impairment to bodily functions, or serious dysfunction of bodily organ or part.

Examples of Emergency Medical Conditions are:

- Chest pain
- Heart attack
- Head injuries
- Strokes (cerebrovascular accidents)
- Poisoning
- Convulsions
- Severe bleeding
- Fractures
- Vomiting blood
- Extreme difficulty breathing
- Sudden severe pain anywhere in the body
- Threat of bodily harm to self or others

If you believe you are experiencing an Emergency Medical Condition, call 911 (or the appropriate emergency number in your area) or go immediately to the nearest appropriate medical facility.
Independent Freestanding Emergency Department (IFED): A health care facility that:

1. Is geographically separate and distinct and licensed separately from a Hospital under applicable state law; and

2. Provides any Emergency Services as described in the Emergency Services definition.

Maximum Allowable Charge: The benefit payable for a specific coverage item or benefit under the Plan. The Maximum Allowable Charge will always be a negotiated rate, if one exists.

If the billed charge is for services included under the protections of the Consolidated Appropriations Act (CAA) (which includes Emergency Services, non-emergency services performed by non-Participating Providers in Participating Facilities, and Air Ambulance Services), and if no negotiated rate exists, the Maximum Allowable Charge, for purposes of determining the Participant's Cost Sharing, is the lesser of the billed charge or the recognized amount/Qualifying Payment Amount (QPA) as determined by specific processes outlined in the CAA. The Plan will pay the non-Participating Provider in accordance with the processes permitted by the CAA. If the Plan and non-Participating Provider disagree on the amount paid, a negotiation process may be initiated, which may result in an "Independent Dispute Resolution (IDR)" entity determining the amount paid by the Plan to the provider.

If none of the factors above is applicable, the Maximum Allowable Charge will be determined and established by the Plan, at the Plan Administrator's discretion, using normative data and submitted information such as, but not limited to, any one or more of the following, in the Plan Administrator's discretion:

- Medicare reimbursement rates (presently utilized by the Centers for Medicare and Medicaid Services ["CMS"]), in conjunction with the Scheduled Benefit Amount, as defined below;
- Medicare Equivalency tables (prices established by CMS utilizing standard Medicare Payment methods and/or based upon supplemental Medicare pricing data for items Medicare doesn't cover based on data from CMS), in conjunction with the Scheduled Benefit Amount, as defined below;
- Approximation tools (prices established by CMS utilizing standard Medicare payment methods and/or based upon prevailing Medicare rates in the community for non-Medicare facilities for similar services and/or supplies provided by similarly skilled and trained providers of care), in conjunction with the Scheduled Benefit Amount, as defined below;
- Crosswalk pricing (prices established by CMS utilizing standard Medicare payment methods for items in alternate settings based on Medicare rates provided for similar services and/or supplies paid to similarly skilled and trained providers of care in traditional settings), in conjunction with the Scheduled Benefit Amount, as defined below;
- Medicare cost data as reflected in the applicable individual provider's cost report(s);

- The fee(s) which the provider most frequently charges the majority of patients for the service or supply;
- Amounts the provider specifically agrees to accept as payment in full either through direct negotiation or through a preferred provider organization (PPO) network;
- Average wholesale price (AWP) and/or manufacturer's retail pricing (MRP);
- Medicare cost-to-charge ratios or other information regarding the actual cost to provide the service or supply;
- The prevailing range of fees charged in the same "area" (defined as a metropolitan area, county, or such greater area as is necessary to obtain a representative cross-section of providers, persons or organizations rendering such treatment, services, or supplies for which a specific charge is made) by providers of similar training and experience for the service or supply.

The Plan Administrator may in its discretion, taking into consideration specific circumstances, deem a greater amount payable than the lesser of the aforementioned amounts. The Plan Administrator may take any or all of such factors into account but has no obligation to consider any particular factor. The Plan Administrator may also account for unusual circumstances or complications requiring additional or a lesser amount of time, skill and experience in connection with a particular service or supply, industry standards and practices as they relate to similar scenarios, and the cause of Injury or Illness necessitating the service(s) and/or charge(s).

In all instances, the Maximum Allowable Charge will be limited to an amount which, in the Plan Administrator's discretion, is charged for services or supplies that are not unreasonably caused by the treating provider, including errors in medical care that are clearly identifiable, preventable, and serious in their consequence for patients. A finding of provider negligence and/or malpractice is not required for services or fees to be considered ineligible pursuant to this provision.

The determination that fees for services are includable in the Maximum Allowable Charge will be made by the Plan Administrator, taking into consideration, but not limited to, the findings and assessments of the following entities: (a) The National Medical Associations, Societies, and organizations; and (b) The Food and Drug Administration. To be includable in the Maximum Allowable Charge, services and fees must be in compliance with generally accepted billing practices for unbundling or multiple procedures.

The Plan Administrator has the discretionary authority to decide if a charge is covered under this Plan. The Maximum Allowable Charge will not include any identifiable billing mistakes including, but not limited to, up-coding, duplicate charges, and charges for services not performed.

When applicable, the "Scheduled Benefit Amount" will be determined based on multiplying the most applicable of the following by 120%:

- For inpatient hospital expenses, the Medicare Diagnosis Related Group ("DRG") scheduled dollar conversion amounts based upon the CMS weighted values
- For outpatient hospital expenses, the CMS Ambulatory Payment Classification (APC) based upon the CMS weighted values, or the current Medicare allowable fee for the appropriate area;
- For physicians and other eligible providers, the current Medicare allowable fee for the appropriate area; or
- For Ambulatory Surgical Centers (ASC), the current Medicare allowable fee for the appropriate area.

Participating Facility and/or Participating Provider: Any provider or facility that has a contractual relationship directly or indirectly with the Plan setting forth the terms and conditions on which a relevant item or service is provided to Participants under the Plan. A single case agreement between a facility or provider and the Plan that is used to address unique situations constitutes a contractual relationship for purposes of this definition and is limited to the parties to the agreement.

CHANGE 7. The section entitled "HOW THE PLAN WORKS" is renamed to "PROVIDER INFORMATION AND PATIENT ADVOCACY".

CHANGE 8. The subsection "Patient Protections Related to Surprise Medical Bills", shown below, is hereby ADDED to the section entitled "PROVIDER INFORMATION AND PATIENT ADVOCACY".

Patient Protections Related to Surprise Medical Bills

The Consolidated Appropriations Act (CAA) of 2021 was passed to prevent excessive out-of-pocket costs to Members from surprise billing and balance billing. Surprise billing happens when Members unknowingly get care from providers that are not Participating Providers. Balance billing happens when a provider charges a Member the remainder of what the Plan does not pay and is currently

prohibited in both Medicare and Medicaid. The CAA expands the protections to employer-sponsored group health plans. These protections apply to Emergency Services, certain non-emergency services, and Air Ambulance Services, and are described below.

A. Emergency Services. The Plan will cover Emergency Services, as defined in the Definitions section, subject to a number of conditions, described below.

1. No prior authorization. The services will be covered without the need for any prior authorization.
2. No contractual relationship requirement. If the Plan provides benefits for Emergency Services, the services will be covered without regard to whether the provider is a Participating Provider or the facility is a Participating Facility.
3. Limited restrictions for providers without a contractual relationship. If the services are provided by a non-Participating Provider or Facility, then the following apply:
    a. The Plan will not impose any administrative requirement or coverage limitation that is more restrictive than the requirements or limitations that apply to Emergency Services received at a Participating Provider or Facility.
    b. Cost Sharing will not be greater than the Cost Sharing that would apply if the services were provided by a Participating Provider or Facility.
    c. The Member's Cost Sharing will be calculated as if the total amount charged for such services is no greater than the "Qualifying Payment Amount", as described in the CAA.
4. Use of diagnosis codes. The Plan will not use final diagnosis codes as the sole basis for limiting coverage required under the regulatory definition of an Emergency Medical Condition.
5. Limited terms or conditions. The services are covered for all Participants without regard to any other term or condition of coverage under the Plan (e.g., exclusions for certain diagnoses), other than Coordination of Benefits, any applicable waiting period, or any applicable Cost Sharing.
6. Notice-and-Consent Exception. If the Member is treated by a non-Participating Provider or is treated at a non-Participating Facility, the Plan is not required to apply the expanded protections as described above for Emergency Services, and a provider is not prohibited from balance billing, in certain limited circumstances for Post-stabilization Services when all conditions described below have been met.

a. The Member's attending Physician must determine that the Member can travel using non-medical or non-emergency medical transportation to an available Participating Provider or Facility located within a reasonable travel distance, taking into account the Member's medical condition, and

b. The Member must be in a condition to receive the information and must give informed consent to treatment by the Participating Provider or Facility after having received specified disclosures as outlined in the Consolidated Appropriations Act (CAA), including any regulatory or sub-regulatory guidance.

c. If the non-Participating Provider or Facility has determined that the notice-and-consent exception applies, then the non-Participating Provider or Facility must notify the Plan when transmitting the bill for services since, under these circumstances, the Plan need not apply the expanded patient protections for Emergency Services.

The notice-and-consent exception does not apply to items or services furnished as a result of unforeseen, urgent medical needs arising at the time an item or service is provided, regardless of whether the non-Participating Provider or Facility has satisfied the notice-and-consent criteria. Note: The Plan may be unaware that notice-and-consent was obtained when the claim is first received and adjudicated by the Plan. This may result in the reprocessing of the claim to no longer follow the Consolidated Appropriations Act (CAA) procedures if notification of notice-and-consent is received after the initial adjudication of the claim.

B. Non-Emergency Services Performed by non-Participating Providers in Participating Facilities. Expanded patient protections will also apply to items or services other than Emergency Services that are provided by a non-Participating Provider with respect to a "visit" at a "participating health care facility". For services covered under this provision, the non-Participating Provider is generally prohibited from balance billing the Member for charges exceeding the Member's Cost Sharing obligation under the Plan. The following rules apply:

1. No contractual relationship requirement. If the Plan provides benefits with respect to a "visit", the services will be covered without regard to whether the provider is a Participating Provider.

2. Limited restrictions for providers without a contractual relationship. If the services are provided by a non-Participating Provider in a "participating health care facility", then the following apply:

   a. Cost Sharing will not be greater than the Cost Sharing that would apply if the services were provided by a Participating Provider or Facility.

b. The Member's Cost Sharing will be calculated as if the total amount charged for such services is no greater than to the "Qualifying Payment Amount" as described in the CAA.

3. Notice-and-Consent Exception for Certain Services. If the provider has obtained the Participant's consent to treatment after providing a notice satisfying certain criteria as described in the CAA, then the Plan will not apply the expanded Cost Sharing protections and the non-Participating Provider is not prohibited from balance billing. This exception does not apply to ancillary services or to items or services furnished as a result of unforeseen, urgent medical needs arising at the time an item or service is provided. Note: The Plan may be unaware that notice-and-consent was obtained when the claim is first received and adjudicated by the Plan. This may result in the reprocessing of the claim to no longer follow the Consolidated Appropriations Act (CAA) procedures if notification of notice-and-consent is received after the initial adjudication of the claim.

   a. Ancillary services include:

      i. Items and services related to emergency medicine, anesthesiology, pathology, radiology, and neonatology, whether provided by a Physician or non-Physician practitioner;

      ii. Items and services provided by assistant surgeons, hospitalists, and intensivists;

      iii. Diagnostic services, including radiology and laboratory services;

      iv. Items and services provided by a non-Participating Provider if there is no Participating Provider who can furnish such item or service at such facility.

4. Definitions. For the purposes of this provision, the following definitions apply:

   a. Visit: A visit for purposes of these requirements encompasses items and services furnished to an individual at a health care facility that include equipment and devices, telemedicine services, imaging services, laboratory services, preoperative and postoperative services, and such other items and services as may be specified by guidance, regardless of whether or not the provider furnishing such items or services is at the facility.

   b. Participating health care facility: A "health care facility" that is a Participating Facility; it has a direct or indirect contractual relationship with the Plan with respect to the furnishing of the item or service at the facility.

   c. Health care facility: A hospital, a hospital outpatient department, a critical access hospital, an ambulatory surgical center, and any other facility as may be specified by

guidance that provides items or services for which coverage is provided under the Plan.

5. Irrespective of the CAA rules outlined in "B" above, this Plan will apply the "Qualifying Payment Amount" to <u>any</u> covered service provided by a non-Participating Provider in any Participating Facility, except when the Plan receives notification that Notice-and-Consent was obtained.

C. Air Ambulance Services. Expanded patient protections will also apply to Air Ambulance Services. For services covered under this provision, the non-Participating Provider is prohibited from balance billing the Member for charges exceeding the Member's Cost Sharing obligation under the Plan. The following rules apply:

1. <u>No contractual relationship requirement</u>. If the Plan provides benefits for Air Ambulance Services, the services will be covered without regard to whether the provider is a Participating Provider.
2. <u>Limited restrictions for providers without a contractual relationship</u>. If the services are provided by a non-Participating Provider, then the following apply:
   a. Cost Sharing will not be greater than the Cost Sharing that would apply if the services were provided by a Participating Provider or Facility.
   b. The Member's Cost Sharing will be calculated as if the total amount charged for such services is no greater than to the "Qualifying Payment Amount", as described in the CAA.

CHANGE 9. The subsection "Continuity of Care", shown below, is hereby ADDED to the section entitled "PROVIDER INFORMATION AND PATIENT ADVOCACY".

Continuity of Care
If your provider ceases to be a Participating Provider, you are eligible to continue care with that provider. Specifically, if eligible charges for benefits under the Plan would otherwise begin to be paid as if the provider was a non-Participating Provider due to the following reasons:

a. The contractual relationship between the Plan and provider or facility is terminated (unless termination is due to failure to meet quality standards or fraud), or
b. Benefits provided under the Plan with respect to the provider or facility are terminated because of a change in the terms of participation of the provider or facility,

Then, eligible charges will continue to be paid as if the contractual relationship with the Plan had not terminated for 90 days following the date the contractual relationship between the provider or facility and the Plan is terminated.

CHANGE 10. The subsection "Balance Billing", which appears in the section entitled "PROVIDER INFORMATION AND PATIENT ADVOCACY" is hereby deleted in its entirety and replaced with the following:

Balance Billing for Services Not Included Under the CAA Protections
For services not included under the CAA protections described in the subsection "Patient Protections Related to Surprise Medical Bills", although most providers will accept the Plan's reimbursement as payment in full, some providers may invoice Members for the balance of the billed charges remaining after the Plan has paid the Maximum Allowable Charge. This is called balance billing. Members who receive a balance bill should call Gilsbar, LLC at the number on the back of the ID card. Gilsbar, LLC will ask the Member to fax or email a copy of the bill from the provider so that Gilsbar can review the bill to make sure it is a balance bill and not attributable to the Member's cost-sharing responsibility (such as copays, deductibles, or coinsurance). If the bill is determined to be a balance bill, it will be forwarded to Zelis Patient Advocacy for handling. A Zelis Patient Advocate will contact the provider on the Member's behalf to help resolve the bill and will keep the Member informed on the status of the balance bill.

CHANGE 11. Item #1, which appears in the subsection entitled "Covered Medical Expenses" under the section "MEDICAL BENEFITS" is hereby deleted in its entirety and replaced with the following:

1. Transportation by a professional **ambulance** service to a local Hospital or convalescent facility for Inpatient care, if Medically Necessary, or to the nearest Hospital for Emergency Services. Transportation by ambulance to a non-medical facility will be covered only if Medically Necessary. Expenses for transportation by air will be covered only if Air Ambulance Service is Medically Necessary.

CHANGE 12. Item #17, which appears in the subsection entitled "Covered Medical Expenses" under the section "MEDICAL BENEFITS" is hereby deleted in its entirety and replaced with the following:

17. Treatment of **Mental/Emotional** Disorders, including Applied Behavior Analysis.

CHANGE 13. Item #44, shown below, is hereby ADDED to the subsection entitled "Covered Medical Expenses" under the section "MEDICAL BENEFITS":

44. Care and treatment for an **Emergency Medical Condition.** See the "Provider Information and Patient Advocacy" section for more important details about this benefit.

CHANGE 14. Item #22, "Specialty drugs," is hereby ADDED to the subsection "Exclusions and Limitations" in the section entitled "PRESCRIPTION DRUG BENEFITS":

22. **Specialty drugs** and any other prescription drugs over $1,250 for a 30-day supply and over $3,750 for a 90-day supply. However, the Plan may cover a specialty drug for one 30-day period during a Calendar Year for each specialty drug when an urgent fill of medication is required, unless otherwise excluded elsewhere in the Plan.

CHANGE 15. The section "WELLNESS PROGRAM BENEFITS" has been deleted in its entirety.

CHANGE 16. Item #19, which appears in the section entitled "GENERAL EXCLUSIONS AND LIMITATIONS" is hereby deleted in its entirety and replaced with the following:

19. **Education**, training, bed and board while confined to an institution that is primarily a school Or other institution for training, or instruction in alternate life patterns, except for diabetes self-management training, listed in the Medical Benefits section. Additionally, LEAP, TEACCH, Denver and Rutgers programs are excluded.

CHANGE 17. The subsection "Procedure for External Review" is hereby ADDED to the section entitled "CLAIMS PAYMENT AND APPEALS":

Procedure for External Review

If the Participant's claim continues to be denied or if the Participant does not receive a timely decision, he or she may request an external review of the claim by an independent review organization (IRO), except where such request is limited by applicable law, that will review the denial and issue a final decision. This request for external review must be made within 4 months from the date of receipt of the notice of final internal Adverse Benefit Determination or by the first of the fifth month following receipt of such notice, whichever occurs later.

In order for a claim to be eligible for external review, it must be a claim that involves:

1. Consideration of whether the Plan is complying with the surprise billing and cost-sharing protections of the Consolidated Appropriations Act (CAA) of 2021; or

2. Items or services within the scope of such CAA requirements for Emergency Services, non-emergency services performed by non-Participating Providers in a Participating Facility, and Air Ambulance Services and also involve:

    a. Medical judgment (including, but not limited to, those based on the Plan's requirements for Medical Necessity, appropriateness, health care setting, level of care, or effectiveness of a covered benefit; its determination that a treatment is Experimental or Investigational) as determined by the external reviewer;

    b. Consideration of whether a Participant or beneficiary is entitled to a reasonable alternative standard for a reward under a wellness program;

    c. Consideration of whether the Plan is complying with the nonquantitative treatment limitation provisions of the Mental Health Parity and Addiction Equity Act, which generally requires, among other things, parity in the application of medical management techniques;

    d. A rescission of coverage (whether or not the rescission has any effect on any particular benefit at that time).

The Participant will be notified in writing within six business days as to whether their request is eligible for external review and whether additional information is necessary to process the request. If the Participant's request is determined ineligible for external review, the notice will include the reasons

for ineligibility and contact information for the appropriate oversight agency. If additional information is required to process the Participant's request, he or she may submit the additional information within the four-month filing period, or within 48 hours, whichever occurs later.

The Participant will receive written notice from the assigned IRO of the Participant's right to submit additional information to the IRO and the time periods and procedures to submit this additional information. The IRO will make a final determination and provide written notice to the Participant and the Plan no later than 45 days from the date the IRO receives a request for external review. The notice from the IRO will contain the reason(s) for the decision, including any applicable evidence-based standards used, and references to evidence or documentation considered in reaching its decision. If the IRO decides the claim is payable, the Plan will pay the claim but may seek later judicial review.

Copies of the Plan document and this Plan document amendment are maintained on file by the Plan Administrator and by the Benefit Services Manager.

This Group Health Plan document amendment is hereby adopted in its entirety.

By: _____ Date: _____
Plan Administrator

GROUP HEALTH PLAN
FOR EMPLOYEES OF UNIVERSITY OF THE INCARNATE WORD

PLAN DOCUMENT AND
SUMMARY PLAN DESCRIPTION

**DOCUMENT CONTAINS CONFIDENTIAL PROPRIETARY
OR TRADE SECRET INFORMATION**

ESTABLISHMENT OF THE PLAN; ADOPTION OF THE PLAN DOCUMENT AND SUMMARY PLAN DESCRIPTION

THIS PLAN DOCUMENT AND SUMMARY PLAN DESCRIPTION, made by University of the Incarnate Word (the "Company" or the "Plan Sponsor") as of June 1, 2020, hereby amends and restates the Group Health Plan (the "Plan"), which is a form of a group health plan sponsored and maintained by the Company and was originally adopted by the Company, effective June 1, 2018.

Effective Date

The Plan Document is effective as of the date first set forth above, and each amendment is effective as of the date set forth therein (the "Effective Date").

Adoption of the Plan Document

The Plan Sponsor, as the settlor of the Plan, has adopted this Plan Document as the written description of the Plan. This Plan Document represents both the Plan Document and the Summary Plan Description. This Plan Document amends and replaces any prior statement of the health care coverage contained in the Plan or any predecessor to the Plan.

IN WITNESS WHEREOF, this adoption document has been executed by or on behalf of the Plan Sponsor, duly authorized, effective on the day and year stated above.

UNIVERSITY OF THE INCARNATE WORD

GROUP HEALTH PLAN SUMMARY PLAN DESCRIPTION

This Summary Plan Description is intended to describe the provisions of the Group Health Plan, which is a form of a group health plan sponsored and maintained by University of the Incarnate Word. The terms of this Summary Plan Description are effective as of June 1, 2020 and govern the administration and payment of claims Incurred on or after that date. **Please review the following information carefully; it supersedes any prior written information about the Plan.**

GRANDFATHERED STATUS

This group health plan believes this plan is a "grandfathered health plan" under the Patient Protection and Affordable Care Act (the Affordable Care Act). As permitted by the Affordable Care Act, a grandfathered health plan can preserve certain basic health coverage that was already in effect when that law was enacted. Being a grandfathered health plan means that your plan may not include certain consumer protections of the Affordable Care Act that apply to other plans, for example, the requirement for the provision of preventive health services without any cost sharing. However, grandfathered health plans must comply with certain other consumer protections in the Affordable Care Act, for example, the elimination of lifetime limits on benefits.

Questions regarding which protections apply and which protections do not apply to a grandfathered health plan and what might cause a plan to change from grandfathered health plan status can be directed to the Plan Administrator at 4301 Broadway, CPO 320, San Antonio, TX 78209, or by phone at (210) 829-6019. You may also contact the U.S. Department of Health and Human Services at www.healthreform.gov.

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NOTICE OF SPECIAL ENROLLMENT RIGHTS

IMPORTANT NOTICE

(PLEASE READ THOROUGHLY)

for employees of University of the Incarnate Word

Regarding Your Rights Concerning Special Enrollment Period under the Health Insurance Portability and Accountability Act of 1996 (HIPAA)

If you are declining enrollment for yourself or your dependents (including your spouse) because of other health insurance or group health plan coverage, you may be able to enroll yourself and your dependents in this plan if you or your dependents lose eligibility for that other coverage (or if the employer stops contributing towards you or your dependents' other coverage). However, you must request enrollment within 31 days after you or your dependents' other coverage ends (or after the employer stops contributing towards the other coverage).

If you have a new dependent as a result of marriage, birth, adoption, or placement for adoption, you may be able to enroll yourself and your dependents. However, you must request enrollment within 31 days after the marriage, birth, adoption, or placement for adoption.

In addition, if you and your dependent are covered under Medicaid or a state children's health insurance program and you lose eligibility for such coverage, you may request coverage for yourself and your dependent child, and you may be able to enroll yourself and your dependent in this Plan if you request enrollment within 60 days of losing such coverage.

If you or your dependents (including your spouse) become eligible for a state premium assistance subsidy from Medicaid or through a state children's health insurance program with respect to coverage under this plan, you may be able to enroll yourself and your dependents in this plan. However, you must request enrollment within 60 days after your or your dependents' determination of eligibility for such assistance.

To request special enrollment or obtain more information, contact your Plan Administrator at 4301 Broadway, CPO 320, San Antonio, TX 78209, (210) 829-6019.

NOTICE OF RIGHTS CONCERNING RECONSTRUCTIVE SURGERY FOLLOWING A MASTECTOMY

IMPORTANT NOTICE

(PLEASE READ THOROUGHLY)

Regarding Your Rights Concerning Reconstructive Surgery Following a Mastectomy Under the

Women's Health and Cancer Rights Act of 1998

Dear Plan Participant:

If you have had or are going to have a mastectomy, you may be entitled to certain benefits under the Women's Health and Cancer Rights Act of 1998 (WHCRA). For individuals receiving mastectomy-related benefits, coverage will be provided in a manner determined in consultation with the attending physician and the patient, for:

- all stages of reconstruction of the breast on which the mastectomy was performed;
- surgery and reconstruction of the other breast to produce a symmetrical appearance;
- prostheses; and
- treatment of physical complications of the mastectomy, including lymphedema.

Note: These benefits will be provided subject to the same deductibles and coinsurance applicable to other medical and surgical benefits provided under this plan. If you would like more information on WHCRA benefits, contact your Plan Administrator at 4301 Broadway, CPO 320, San Antonio, TX 78209, (210) 829-6019.

NOTICE OF PRIVACY PRACTICES

Your Information. Your Rights. Our Responsibilities.

This notice describes how medical information about you may be used and disclosed and how you can get access to this information.
Please review it carefully.

Your Rights

When it comes to your health information, you have certain rights. This section explains your rights and some of our responsibilities to help you.

Get a copy of your health and claims records	• You can ask to see or get a copy of your health and claims records and other health information we have about you. Ask us how to do this. • We will provide a copy or a summary of your health and claims records, usually within 30 days of your request. We may charge a reasonable, cost-based fee.
Ask us to correct health and claims records	• You can ask us to correct your health and claims records if you think they are incorrect or incomplete. Ask us how to do this. • We may say "no" to your request, but we'll tell you why in writing within 60 days.
Request confidential communications	• You can ask us to contact you in a specific way (for example, home or office phone) or to send mail to a different address. • We will consider all reasonable requests, and must say "yes" if you tell us you would be in danger if we do not.

continued on next page

Your Rights *continued*

Ask us to limit what we use or share	• You can ask us **not** to use or share certain health information for treatment, payment, or our operations. • We are not required to agree to your request, and we may say "no" if it would affect your care.
Get a list of those with whom we've shared information	• You can ask for a list (accounting) of the times we've shared your health information for six years prior to the date you ask, who we shared it with, and why. • We will include all the disclosures except for those about treatment, payment, and health care operations, and certain other disclosures (such as any you asked us to make). We'll provide one accounting a year for free but will charge a reasonable, cost-based fee if you ask for another one within 12 months.
Get a copy of this privacy notice	• You can ask for a paper copy of this notice at any time, even if you have agreed to receive the notice electronically. We will provide you with a paper copy promptly.
Choose someone to act for you	• If you have given someone medical power of attorney or if someone is your legal guardian, that person can exercise your rights and make choices about your health information. • We will make sure the person has this authority and can act for you before we take any action.
File a complaint if you feel your rights are violated	• You can complain if you feel we have violated your rights by contacting us using the information on page 1. • You can file a complaint with the U.S. Department of Health and Human Services Office for Civil Rights by sending a letter to 200 Independence Avenue, S.W., Washington, D.C. 20201, calling 1-877-696-6775, or visiting **www.hhs.gov/ocr/privacy/hipaa/complaints/.** • We will not retaliate against you for filing a complaint.

Your Choices

For certain health information, you can tell us your choices about what we share. If you have a clear preference for how we share your information in the situations described below, talk to us. Tell us what you want us to do, and we will follow your instructions.

In these cases, you have both the right and choice to tell us to:	• Share information with your family, close friends, or others involved in payment for your care • Share information in a disaster relief situation • Contact you for fundraising efforts *If you are not able to tell us your preference, for example if you are unconscious, we may go ahead and share your information if we believe it is in your best interest. We may also share your information when needed to lessen a serious and imminent threat to health or safety.*
In these cases we *never* share your information unless you give us written permission:	• Marketing purposes • Sale of your information

Our Uses and Disclosures

How do we typically use or share your health information? We typically use or share your health information in the following ways.

Help manage the health care treatment you receive	• We can use your health information and share it with professionals who are treating you.	***Example:*** *A doctor sends us information about your diagnosis and treatment plan so we can arrange additional services.*
Run our organization	• We can use and disclose your information to run our organization and contact you when necessary. • **We are not allowed to use genetic information to decide whether we will give you coverage and the price of that coverage.** This does not apply to long term care plans.	***Example:*** *We use health information about you to develop better services for you.*
Pay for your health services	• We can use and disclose your health information as we pay for your health services.	***Example:*** *We share information about you with your dental plan to coordinate payment for your dental work.*
Administer your plan	• We may disclose your health information to your health plan sponsor for plan administration.	***Example:*** *Your company contracts with us to provide a health plan, and we provide your company with certain statistics to explain the premiums we charge.*

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How else can we use or share your health information? We are allowed or required to share your information in other ways – usually in ways that contribute to the public good, such as public health and research. We have to meet many conditions in the law before we can share your information for these purposes. For more information see: **www.hhs.gov/ocr/privacy/hipaa/understanding/consumers/index.html.**

Help with public health and safety issues	• We can share health information about you for certain situations such as:
	  • Preventing disease
	  • Helping with product recalls
	  • Reporting adverse reactions to medications
	  • Reporting suspected abuse, neglect, or domestic violence
	  • Preventing or reducing a serious threat to anyone's health or safety

Do research	• We can use or share your information for health research.
Comply with the law	• We will share information about you if state or federal laws require it, including with the Department of Health and Human Services if it wants to see that we're complying with federal privacy law.
Respond to organ and tissue donation requests and work with a medical examiner or funeral director	• We can share health information about you with organ procurement organizations. • We can share health information with a coroner, medical examiner, or funeral director when an individual dies.

Address workers' compensation, law enforcement, and other government requests	• We can use or share health information about you:
	  • For workers' compensation claims
	  • For law enforcement purposes or with a law enforcement official
	  • With health oversight agencies for activities authorized by law
	  • For special government functions such as military, national security, and presidential protective services

Respond to lawsuits and legal actions	• We can share health information about you in response to a court or administrative order, or in response to a subpoena.

Our Responsibilities

- We are required by law to maintain the privacy and security of your protected health information.
- We will let you know promptly if a breach occurs that may have compromised the privacy or security of your information.
- We must follow the duties and privacy practices described in this notice and give you a copy of it.
- We will not use or share your information other than as described here unless you tell us we can in writing. If you tell us we can, you may change your mind at any time. Let us know in writing if you change your mind.

For more information see: **www.hhs.gov/ocr/privacy/hipaa/understanding/consumers/noticepp.html.**

Changes to the Terms of This Notice

We can change the terms of this notice, and the changes will apply to all information we have about you. The new notice will be available upon request, on our web site, and we will mail a copy to you.

NOTICE OF PREMIUM ASSISTANCE UNDER MEDICAID AND THE CHILDREN'S HEALTH INSURANCE PROGRAM (CHIP)

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

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

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

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

If you live in one of the following states, you may be eligible for assistance paying your employer health plan premiums. The following list of states is current as of January 31, 2020. Contact your State for more information on eligibility –

ALABAMA – Medicaid	COLORADO – Health First Colorado (Colorado's Medicaid Program) & Child Health Plan Plus (CHP+)
Website: http://myalhipp.com/ Phone: 1-855-692-5447	Health First Colorado Website: https://www.healthfirstcolorado.com/ Health First Colorado Member Contact Center: 1-800-221-3943/ State Relay 711 CHP+: https://www.colorado.gov/pacific/hcpf/child- health-plan-plus CHP+ Customer Service: 1-800-359-1991/ State Relay 711

ALASKA – Medicaid	FLORIDA – Medicaid
The AK Health Insurance Premium Payment Program Website: http://myakhipp.com/ Phone: 1-866-251-4861 Email: CustomerService@MyAKHIPP.com Medicaid Eligibility: http://dhss.alaska.gov/dpa/Pages/medicaid/default.aspx	Website: http://flmedicaidtplrecovery.com/hipp/ Phone: 1-877-357-3268
ARKANSAS – Medicaid	**GEORGIA – Medicaid**
Website: http://myarhipp.com/ Phone: 1-855-MyARHIPP (855-692-7447)	Website: https://medicaid.georgia.gov/health-insurance-premium-payment-program-hipp Phone: 678-564-1162 ext 2131
CALIFORNIA – Medicaid	**INDIANA – Medicaid**
Website: https://www.dhcs.ca.gov/services/Pages/TPLRD_CAU_cont.aspx Phone: 1-800-541-5555	Healthy Indiana Plan for low-income adults 19-64 Website: http://www.in.gov/fssa/hip/ Phone: 1-877-438-4479 All other Medicaid Website: http://www.indianamedicaid.com Phone 1-800-403-0864
IOWA – Medicaid and CHIP (Hawki)	**NEBRASKA – Medicaid**
Medicaid Website: https://dhs.iowa.gov/ime/members Medicaid Phone: 1-800-338-8366 Hawki Website: http://dhs.iowa.gov/Hawki Hawki Phone: 1-800-257-8563	Website: http://www.ACCESSNebraska.ne.gov Phone: 1-855-632-7633 Lincoln: 402-473-7000 Omaha: 402-595-1178
KANSAS – Medicaid	**NEVADA – Medicaid**
Website: http://www.kdheks.gov/hcf/default.htm Phone: 1-800-792-4884	Medicaid Website: http://dhcfp.nv.gov Medicaid Phone: 1-800-992-0900
KENTUCKY – Medicaid	**NEW HAMPSHIRE – Medicaid**
Kentucky Integrated Health Insurance Premium Payment Program (KI-HIPP) Website: https://chfs.ky.gov/agencies/dms/member/Pages/kihipp.aspx Phone: 1-855-459-6328 Email: KIHIPP.PROGRAM@ky.gov KCHIP Website: https://kidshealth.ky.gov/Pages/index.aspx Phone: 1-877-524-4718 Kentucky Medicaid Website: https://chfs.ky.gov	Website: https://www.dhhs.nh.gov/oii/hipp.htm Phone: 603-271-5218 Toll free number for the HIPP program: 1-800-852-3345, ext 5218
LOUISIANA – Medicaid	**NEW JERSEY – Medicaid and CHIP**
Website: www.medicaid.la.gov or www.ldh.la.gov/lahipp Phone: 1-888-342-6207 (Medicaid hotline) or 1-855-618- 5488 (LaHIPP)	Medicaid Website: http://www.state.nj.us/humanservices/dmahs/clients/medicaid/ Medicaid Phone: 609-631-2392 CHIP Website: http://www.njfamilycare.org/index.html CHIP Phone: 1-800-701-0710

MAINE – Medicaid	NEW YORK – Medicaid
Website: http://www.maine.gov/dhhs/ofi/public-assistance/index.html Phone: 1-800-442-6003 TTY: Maine relay 711	Website: https://www.health.ny.gov/health_care/medicaid/ Phone: 1-800-541-2831
MASSACHUSETTS – Medicaid and CHIP	**NORTH CAROLINA – Medicaid**
Website: http://www.mass.gov/eohhs/gov/departments/masshealth/ Phone: 1-800-862-4840	Website: https://medicaid.ncdhhs.gov/ Phone: 919-855-4100
MINNESOTA – Medicaid	**NORTH DAKOTA – Medicaid**
Website: https://mn.gov/dhs/people-we-serve/children-and-families/health-care/health-care-programs/programs-and-services/medical-assistance.jsp [Under ELIGIBILITY tab, see "what if I have other health insurance?"] Phone: 1-800-657-3739	Website: http://www.nd.gov/dhs/services/medicalserv/medicaid/ Phone: 1-844-854-4825
MISSOURI – Medicaid	**OKLAHOMA – Medicaid and CHIP**
Website: http://www.dss.mo.gov/mhd/participants/pages/hipp.htm Phone: 573-751-2005	Website: http://www.insureoklahoma.org Phone: 1-888-365-3742
MONTANA – Medicaid	**OREGON – Medicaid**
Website: http://dphhs.mt.gov/MontanaHealthcarePrograms/HIPP Phone: 1-800-694-3084	Website: http://healthcare.oregon.gov/Pages/index.aspx http://www.oregonhealthcare.gov/index-es.html Phone: 1-800-699-9075
PENNSYLVANIA – Medicaid	**RHODE ISLAND – Medicaid and CHIP**
Website: https://www.dhs.pa.gov/providers/Providers/Pages/Medical/HIPP-Program.aspx Phone: 1-800-692-7462	Website: http://www.eohhs.ri.gov/ Phone: 1-855-697-4347, or 401-462-0311 (Direct RIte Share Line)
SOUTH CAROLINA – Medicaid	**VIRGINIA – Medicaid and CHIP**
Website: https://www.scdhhs.gov Phone: 1-888-549-0820	Website: https://www.coverva.org/hipp/ Medicaid Phone: 1-800-432-5924 CHIP Phone: 1-855-242-8282
SOUTH DAKOTA - Medicaid	**WASHINGTON – Medicaid**
Website: http://dss.sd.gov Phone: 1-888-828-0059	Website: https://www.hca.wa.gov/ Phone: 1-800-562-3022
TEXAS – Medicaid	**WEST VIRGINIA – Medicaid**
Website: http://gethipptexas.com/ Phone: 1-800-440-0493	Website: http://mywvhipp.com/ Toll-free phone: 1-855-MyWVHIPP (1-855-699-8447)
UTAH – Medicaid and CHIP	**WISCONSIN – Medicaid and CHIP**
Medicaid Website: https://medicaid.utah.gov/ CHIP Website: http://health.utah.gov/chip Phone: 1-877-543-7669	Website: https://www.dhs.wisconsin.gov/publications/p1/p10095.pdf Phone: 1-800-362-3002
VERMONT– Medicaid	**WYOMING – Medicaid**
Website: http://www.greenmountaincare.org/ Phone: 1-800-250-8427	Website: https://wyequalitycare.acs-inc.com/ Phone: 307-777-7531

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

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

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

OMB Control Number 1210-0137 (expires 1/31/2023)

NOTICE REGARDING WELLNESS PROGRAM AND NOTICE OF REASONABLE ALTERNATIVES

This Wellness Program is a voluntary wellness program available to all employees. The program is administered according to federal rules permitting employer-sponsored wellness programs that seek to improve employee health or prevent disease, including the Americans with Disabilities Act of 1990, the Genetic Information Nondiscrimination Act of 2008, and the Health Insurance Portability and Accountability Act, as applicable, among others. If you choose to participate in the wellness program you will be asked to complete a voluntary health risk assessment or "HRA" that asks a series of questions about your health-related activities and behaviors and whether you have or had certain medical conditions (e.g., cancer, diabetes, or heart disease). You will also be asked to complete a biometric screening, which will include a blood test for a basic metabolic panel, including but not limited to, testing of cholesterol, triglycerides, and blood glucose. The biometric screening will also include weight, height, and waist measurements. You are not required to complete the HRA or to participate in the blood test or other medical examinations.

However, employees who choose to participate will receive an incentive which is the ability to earn points redeemable for rewards in this Wellness Program for completing certain wellness activities. Although you are not required to complete these components, only employees who do so will have the ability to earn points which are redeemable for rewards in this Wellness Program.

Additional incentives called “rewards” consisting of gift cards may be available for employees who participate in certain health-related activities outlined later in this document in the section entitled Wellness Program Benefits. If you are unable to participate in any of the health-related activities or achieve any of the health outcomes required to earn an incentive, you may be entitled to a reasonable accommodation or an alternative standard. You may request a reasonable accommodation or an alternative standard by contacting University of the Incarnate Word at 4301 Broadway, CPO 320, San Antonio, TX 78209, (210) 829-6019.

The information from your HRA and the results from your biometric screening will be used to provide you with information to help you understand your current health and potential risks and may also be used to offer you services through the wellness program, such as health coaching and workshops. You also are encouraged to share your results or concerns with your own doctor.

Protections from Disclosure of Medical Information

We are required by law to maintain the privacy and security of your personally identifiable health information. Although the wellness program and University of the Incarnate Word may use aggregate information it collects to design a program based on identified health risks in the workplace, the Plan Administrator will never disclose any of your personal information either publicly or to the employer, except as necessary to respond to a request from you for a reasonable accommodation needed to participate in the wellness program, or as expressly permitted by law. Medical information that personally identifies you that is provided in connection with the wellness program will not be provided

to your supervisors or managers and may never be used to make decisions regarding your employment.

Your health information will not be sold, exchanged, transferred, or otherwise disclosed except to the extent permitted by law to carry out specific activities related to the wellness program, and you will not be asked or required to waive the confidentiality of your health information as a condition of participating in the wellness program or receiving an incentive. Anyone who receives your information for purposes of providing you services as part of the wellness program will abide by the same confidentiality requirements. The only individual(s) who will receive your personally identifiable health information is (are) registered nurses and health coaches to provide you with services under the wellness program.

In addition, all medical information obtained through the wellness program will be maintained separate from your personnel records, information stored electronically will be encrypted, and no information you provide as part of the wellness program will be used in making any employment decision. Appropriate precautions will be taken to avoid any data breach, and in the event a data breach occurs involving information you provide in connection with the wellness program, we will notify you immediately.

You may not be discriminated against in employment because of the medical information you provide as part of participating in the wellness program, nor may you be subjected to retaliation if you choose not to participate.

If you have questions or concerns regarding this notice, or about protections against discrimination and retaliation, please contact University of the Incarnate Word at 4301 Broadway, CPO 320, San Antonio, TX 78209, (210) 829-6019.

Notice of Reasonable Alternatives

Your health plan is committed to helping you achieve your best health. Rewards for participating in a wellness program are available to all employees. If you think you might be unable to meet a standard for a reward under this Wellness Program, you might qualify for an opportunity to earn the same reward by different means. Contact us at 4301 Broadway, CPO 320, San Antonio, TX 78209, (210) 829-6019, and we will work with you (and, if you wish, with your doctor) to find a wellness program with the same reward that is right for you considering your health status.

HIGHLIGHTS OF THE GROUP HEALTH PLAN

This Plan is maintained for the purpose of providing benefits for Eligible Employees and their Eligible Dependents. Although it has no present intention to do so, the Plan Sponsor has reserved the right to amend or even terminate the Plan. Examples of amendments include, but are not limited to, the inclusion of additional cost containment features, increases in deductibles and out-of-pocket expense amounts, and changes in the benefits provided under this Plan. In addition, your Employer may require you to pay a portion of the cost of coverage (employee only or family coverage). Your share of the cost is determined annually, or more frequently if deemed appropriate, by the Plan Administrator.

Eligible Employee

The term "Eligible Employee" shall mean an employee who worked or is regularly scheduled to work at least 30 hours a week for the Employer. An employee is not a retired employee, a temporary or leased employee, or an independent contractor.

In accordance with the Patient Protection and Affordable Care Act as well as IRS rules and guidelines in the Internal Revenue Code, Section 4980H (as amended), the Plan may use a Monthly Measurement Method or a Look-Back Measurement Method, or a combination of the two methods for determining the full-time status of employees. All New Employees who are not expected to work full-time at the time of hire, including variable hour and seasonal workers, may be subject to an Initial Measurement Period not to exceed twelve months.

If the Look-Back Measurement Method is used, then the term "Eligible Employee" shall also include a Variable Hour Employee who has averaged at least 130 hours per month for a complete Measurement Period and is currently in a Stability Period, or Administrative Period (if applicable), as determined by the Plan Sponsor. An employee who continues employment during the Stability Period will remain eligible throughout the Stability Period and Administrative Period (if applicable), regardless of a change in employment status (including, but not limited to, a reduction in hours).

For details and information about the Measurement Periods and, if applicable, Stability Periods and Administrative Periods, see your Personnel or Human Resources department.

The Plan Administrator determines status as an Eligible Employee hereunder.

Eligible Dependent

The Plan Administrator determines status as an Eligible Dependent hereunder and reserves the right to require such documentation as it deems satisfactory that a dependent is an Eligible Dependent under the Plan. The term "Eligible Dependent" shall mean any one or more of the following except

that no Participant covered as an employee shall also be covered as a dependent, regardless of eligibility.

1. The Spouse, as defined by the Plan in the Definitions section, of an Eligible Employee until the date of legal separation or divorce, whichever occurs first.

   A common law spouse is eligible for coverage under the Plan, if the common law marriage is legally recognized in the jurisdiction in which the employee has his or her principal residence.

   A domestic partner is not eligible for coverage under the Plan, even in a state where domestic partnership is recognized.

2. Any Child of an Eligible Employee who is:

   a. under the age of 26; or

   b. incapable of sustaining his or her own living due to mental or physical disability, provided such disability commenced prior to attainment of age 26. Such Child must be unmarried and have had continuous coverage as a dependent prior to attainment of such age and have remained covered continuously thereafter. The Plan Administrator may require proof of prior coverage. Additionally, at reasonable intervals during the two years following the dependent's reaching limiting age, the Plan Administrator may require subsequent proof of the Child's disability and continued incapability of self-sustaining employment. After such two-year period, the Plan Administrator may not require proof more than once each year.

   "Child" includes:

   a. a biological child; or

   b. a legally adopted child; or

   c. a child legally placed in the employee's home for the purpose of adoption by the employee; or

   d. a stepchild; or

   e. a child of a covered common law Spouse; or

   f. a foster child; or

   g. a child under the legal guardianship of the employee; or

h. a grandchild if the child's parent is also a Covered Dependent or if the Covered Employee has legal custody of the child; or

i. a child of the employee for whom the employee is required to provide health benefits pursuant to a Qualified Medical Child Support Order (QMCSO) in accordance with procedures adopted by the Plan Administrator. (Special rules apply to QMCSOs. Contact the Plan Administrator in situations of divorce and child custody for information regarding QMCSOs.)

Eligibility Date

(See "Persons Covered and Effective Dates" section for enrollment details and effective dates.)

Employee: The first day of the month coinciding with or after you meet the Plan's definition of an Eligible Employee.

Dependent: The same as the employee's Eligibility Date, if you have Eligible Dependents when you first become eligible to participate in the Plan.

Open Enrollment

(See "Persons Covered and Effective Dates" section for enrollment details.)

The Open Enrollment period is during the months of April and/or May. Coverage for a Participant enrolling during Open Enrollment is effective on the first day of June following enrollment.

Special Coverage Provisions for Coronavirus

In accordance with the Families First Coronavirus Response Act (FFCRA) and the Coronavirus Aid, Relief, and Economic Security (CARES) Act, this Plan will waive all applicable deductibles, copayments, and coinsurance, and will not impose prior authorization requirements or other medical management techniques for the following services for all covered Members until the end of the declared public health emergency or as required by any extension, amendment, or addition of applicable law:

a. Diagnostic testing products designed to detect COVID-19 or SARS-COV-2 that are FDA-approved as well as tests that are:
    - Subject to an emergency use authorization;
    - Those for which the developer has requested or intends to request emergency use authorization, unless the emergency use authorization has been denied or the developer fails to submit a request within a reasonable timeframe;

- Those developed in and authorized by a State that notified the Secretary of HHS of its intention to review tests intended to diagnose COVID-19; and
- Any other test that the Secretary of HHS determines appropriate in guidance.

b. Services or items furnished to covered Members during an office visit (including in-person or telehealth* visits), urgent care center visits, and emergency room visits that result in an order for or administration of diagnostic testing as described in (a) above.

In addition to the required coverage under the FFCRA and the CARES Act listed above, the Plan will also waive all applicable deductibles, copayments and coinsurance for the following services until December 31, 2020 or for as long as the testing requirements of the FFCRA and the CARES Act are in effect, whichever occurs first:

a. Treatment of COVID-19 or SARS-COV-2, including Outpatient treatment, Inpatient confinements, and prescription drugs.

Services covered under this provision are available through any provider. The Maximum Allowable Charge for testing will be the negotiated rate. If there is no negotiated rate, then the Maximum Allowable Charge will be that which is required by applicable law irrespective of other payment provisions of the Plan.

*Telehealth services are covered under this provision, even if the Plan does not otherwise provide telehealth services.

Services and items not listed above are payable as shown in other sections of the Plan Document and Summary Plan Description.

In addition to the coverage described above, this Plan will be deemed to automatically comply with the requirements of future legislation regarding the novel coronavirus (COVID-19).

Schedule of Medical Benefits

This is only a summary of the Plan's benefits and is not intended to be all-inclusive. Important information is contained in other sections, including benefit exclusions and limitations. Payment for any of the expenses listed below is subject to all Plan exclusions, limitations, and provisions. You may find the *Definitions* section helpful in understanding some of the capitalized terms used throughout this Summary Plan Description, and within certain sections where a term is defined and used there. In addition, the Plan has other requirements and provisions that may affect benefits, such as those described in the sections for *Utilization Management* and *How the Plan Works*, and it is strongly recommended that you read the entire Summary Plan Description to ensure a complete

understanding of the Plan provisions. You also may contact Gilsbar, L.L.C., the Benefit Services Manager, or the Plan Administrator for assistance.

For any benefit subject to a Calendar Year and/or Lifetime maximum, covered expenses that accumulate toward the benefit limit include any ancillary covered expenses associated with that benefit, including but not limited to office visits, lab tests, X-rays, physician services, etc.

Any benefit limits listed in the schedule below refer to the maximum amount the Plan will pay for covered services. All maximums are per Member, unless specifically noted as per family.

Eligible office visit expenses for any covered diagnosis will pay at the Physician Services – Office Visits benefit level unless otherwise specifically noted.

BENEFIT DESCRIPTION	BRONZE PLAN		SILVER PLAN	
	YOU PAY	PLAN PAYS	YOU PAY	PLAN PAYS
OVERALL CALENDAR YEAR MAXIMUM	N/A	Unlimited	N/A	Unlimited
HEALTH FUND CONTRIBUTIONS, PER CALENDAR YEAR	N/A		The first $500 of eligible expenses are paid at 100%, deductible waived for each covered Participant. Once the $500 is exhausted, the cost-sharing listed below applies.	
DEDUCTIBLE, PER CALENDAR YEAR				
Individual Only Coverage	$1,500	N/A	$1,000	N/A
All Other Coverage Levels Embedded Per Person Deductible	$1,500	N/A	$1,000	N/A
Overall Family Deductible	$3,000	N/A	$2,000	N/A
Note: No deductible or coinsurance will apply to covered charges billed by the Christus Santa Rosa Health System (including facilities, physician groups, and ancillary providers).				

BENEFIT DESCRIPTION	BRONZE PLAN		SILVER PLAN	
	YOU PAY	PLAN PAYS	YOU PAY	PLAN PAYS
MAXIMUM OUT-OF-POCKET EXPENSES PER CALENDAR YEAR				
Individual Only Coverage	$4,000	N/A	$1,000	N/A
All Other Coverage Levels Embedded Per Person Maximum	$4,000	N/A	$1,000	N/A
Overall Family Maximum	$12,000	N/A	$2,000	N/A
NOTE: The following charges do not apply toward the out-of-pocket expense amount and are never paid at 100%: • Premiums, Amounts above the Maximum Allowable Charge, and Non-covered Services • Utilization Management and Prescription drug card Brand Name penalties				
ASSERTA HEALTH				
The Plan has contracted with Asserta Health to negotiate pre-payment of certain covered services. Members using Asserta Health may have their share of costs (deductible, copayments, and/or coinsurance) greatly reduced or completely eliminated per a shared savings arrangement. Asserta's medEcash℠ payment platform stages funds that come directly from the Plan and the Member in advance, then pays 100% of transparent cash prices to each provider in real time on the day of service. Providers are paid immediately without the need to file a claim, and the member is not billed later. The entire transaction is completed on the date of service. Refer to the *Using the Provider Network* section for more details.				
MDLIVE				
The Plan offers MDLIVE, a service providing access to a national network of board-certified doctors who are available on-demand 24 hours a day, 7 days a week, 365 days a year to diagnose, treat, and prescribe medication (when necessary) for many non-emergency medical issues via mobile app, video, or phone. By using this service, you can avoid the inconvenience and potentially high costs of going to the emergency room or urgent care center, and necessary prescriptions can be sent directly to your local pharmacy. For more details, refer to the Physician Services benefit later in this Schedule of Benefits, refer to the Medical Benefits section, or visit www.mygilsbar.com.				
UTILIZATION MANAGEMENT PENALTY				
$200 additional deductible for failure to precertify Inpatient admissions and organ transplants. See the Utilization Management section for details or a list of services or supplies that must be Precertified.				
COPAYMENTS AND BENEFIT PERCENTAGES				
Ambulance	Deductible, then 30%	70%	Deductible, then 0%	100%

BENEFIT DESCRIPTION	BRONZE PLAN		SILVER PLAN	
	YOU PAY	PLAN PAYS	YOU PAY	PLAN PAYS
Bariatric Surgery	Not covered			
Behavioral/Mental Health and Substance Use Disorders – Inpatient (Precertification required) (Includes residential treatment)	$250 copay per day for up to 5 days, deductible then 30%	70%	Deductible, then 0%	100%
Behavioral/Mental Health and Substance Use Disorders – Outpatient (Includes Partial Hospitalization services) (Applied Behavior Analysis is excluded)	$25 copay, deductible waived	100%	Deductible, then 0%	100%
Chemotherapy & Radiation Therapy	Deductible, then 30%	70%	Deductible, then 0%	100%
Chiropractic Treatment (Limited to 60 visits per Calendar Year) (Office visit and X-ray charges do not apply to the maximum. Refer to the *Physician Services – Office Visit* benefit for those services.)	$45 copay, deductible waived	100%	No charge	100%
Convenience Care (Alternative to Physician office visits for unscheduled, non-emergency Illness and Injuries)	$25 copay, deductible waived	100%	Deductible, then 0%	100%
Diabetes Self-Management Training	Deductible, then 30%	70%	Deductible, then 0%	100%
Diagnostic Testing (Advanced Imaging – MRI, CAT, PET, nuclear stress tests, etc.) – Inpatient	Refer to **Physician Services – Inpatient** and **Hospital/Facility Inpatient Expenses** for professional and facility benefits			

BENEFIT DESCRIPTION	BRONZE PLAN		SILVER PLAN	
	YOU PAY	PLAN PAYS	YOU PAY	PLAN PAYS
Diagnostic Testing (Advanced Imaging – MRI, CAT, PET, nuclear stress tests, etc.) – Outpatient Professional and Facility Components	Deductible, then 30%	70%	Deductible, then 0%	100%
Diagnostic Testing (X-ray, lab) – Professional Component (Refer to "Hospital/Facility" for the facility component)				
Inpatient	Deductible, then 30%	70%	Deductible, then 0%	100%
Outpatient Hospital and Standalone Facility X-ray	$45 copay, deductible waived	100%	Deductible, then 0%	100%
Lab	No charge	100%	Deductible, then 0%	100%
Office X-ray	Refer to **Physician Services – Office Visits**	Refer to **Physician Services – Office Visits**	Deductible, then 0%	100%
Lab	No charge	100%	Deductible, then 0%	100%
Durable Medical Equipment	Deductible, then 30%	70%	Deductible, then 0%	100%
Emergency Services in an Emergency Room	$150 copay, deductible waived	100%	Deductible, then 0%	100%
	Copay is waived if you are admitted directly to the Hospital from the Emergency Room			
Extended Care/Skilled Nursing Facility (Limited to 100 days per Calendar Year) (Precertification required)	$250 copay per day for up to 5 days, deductible waived	100%	Deductible, then 0%	100%

BENEFIT DESCRIPTION	BRONZE PLAN		SILVER PLAN	
	YOU PAY	PLAN PAYS	YOU PAY	PLAN PAYS
Foot Conditions (other than routine foot care)	Refer to applicable service for benefits			
Home Health Care (Limited to 120 visits per Calendar Year)	No charge	100%	Deductible, then 0%	100%
Hospice Care				
Outpatient	Deductible, then 30%	70%	Deductible, then 0%	100%
Inpatient	$250 copay per day for up to 5 days, deductible waived	100%	Deductible, then 0%	100%
Hospital/Facility Inpatient Expenses (Precertification required)	$250 copay per day for up to 5 days, deductible, then 30%	70%	Deductible, then 0%	100%
Room and board is limited to the semi-private room rate, or if the Hospital has private rooms only, the private room rate billed. Eligible charge for ICU is the ICU charge.				
Hospital/Facility Outpatient Expenses	Deductible, then 30%	70%	Deductible, then 0%	100%
Infertility/Sterility (Only diagnosis and treatment of the underlying medical condition is covered; comprehensive infertility services are not covered)	Refer to applicable service for benefits			
Massage Therapy	Not covered			
Maternity				
Prenatal care	Refer to **Preventive Care**	Refer to **Preventive Care**	Refer to **Preventive Care**	Refer to **Preventive Care**
Delivery charges	$250 copay per day for up to 5 days, deductible	100%	Deductible, then 0%	100%

BENEFIT DESCRIPTION	BRONZE PLAN		SILVER PLAN	
	YOU PAY	PLAN PAYS	YOU PAY	PLAN PAYS
Maternity-related expenses for dependent Children are covered.				
Newborn Care – Routine Inpatient	Deductible, then 30%	70%	Deductible, then 0%	100%
Organ Transplants (Precertification required)	Refer to applicable service for benefits			
Orthotics/Prosthetics	Deductible, then 30%	70%	Deductible, then 0%	100%
Physician Services				
Inpatient Visits	Deductible, then 30%	70%	Deductible, then 0%	100%
Inpatient Surgery	Deductible, then 30%	70%	Deductible, then 0%	100%
Outpatient Visits	Deductible, then 30%	70%	Deductible, then 0%	100%
Outpatient Surgery	Deductible, then 30%	70%	Deductible, then 0%	100%
Office Visits Primary Care Physician	$25 copay, deductible waived	100%	Deductible, then 0%	100%
Specialist	$45 copay, deductible waived	100%	Deductible, then 0%	100%
All other eligible expenses rendered during an office visit that are not covered under the copay or listed elsewhere	Deductible, then 30%	70%	Deductible, then 0%	100%
Copay is per provider and applies only to office visit charge, x-ray, allergy testing, allergy treatment (including allergy injections), and contraceptive injections (birth control related only). Primary Care Physicians are Family Practitioners, Internists, Pediatricians, and General Practitioners.				

BENEFIT DESCRIPTION	BRONZE PLAN		SILVER PLAN	
	YOU PAY	PLAN PAYS	YOU PAY	PLAN PAYS
MDLIVE (Call 877-953-4955, visit www.mygilsbar.com, or use the MDLIVE App on your mobile device to receive general health care and pediatric care information for a Participant's condition. The MDLIVE program is available 24/7/365. See the Medical Benefits section for more details about this benefit.)	No charge	100%	No charge	100%
Prescription Drugs (Inpatient)	Refer to **Hospital/Facility Inpatient Expenses**			
Prescription Drugs (Outpatient)	Refer to **Schedule of Prescription Drug Benefits** subsection			
Preventive Care				
• Female sterilization • Contraceptive injections (non-birth control related) • Contraceptive implants • Female contraceptive generic prescription drugs and devices provided, administered, or removed by a Physician during an office visit ▪ (Refer to the Schedule of Prescription Drug Benefits for items purchased through the Prescription Drug program) ▪ (Over-the-counter items are not covered)	Deductible, then 30%	70%	Deductible, then 0%	100%
• Contraceptive injections (birth control related)	Refer to **Physician Services – Office Visits**		Deductible, then 0%	100%
• Contraceptive pills and all other covered contraceptives	Refer to **Schedule of Prescription Drug Benefits** subsection		Deductible, then 0%	100%

BENEFIT DESCRIPTION	BRONZE PLAN		SILVER PLAN	
	YOU PAY	PLAN PAYS	YOU PAY	PLAN PAYS
• Female contraceptive counseling (limited to 2 visits per calendar year) • Prenatal care • All other Preventive Care as described below*	No charge	100%	No charge	100%
*This benefit includes Preventive Care, as defined in the Definitions section, as well as the following once annually or as recommended by the Affordable Care Act (ACA): routine physical exam, prostatic/testicular exam, routine eye exam (1 every 2 calendar years and includes refraction and glaucoma testing), and routine hearing exam (including audiometric hearing exam 1 every 2 calendar years).				
Private Duty Nursing (Limited to Inpatient only) (Limited to (70) 8-hour shifts per Calendar Year; each period of private duty nursing of up to 8 hours will be deemed one shift)	Deductible, then 30%	70%	Deductible, then 0%	100%
Rehabilitation Services & Habilitation Services (Cardiac Rehab, Pulmonary, Occupational, Physical, Speech, & Vision Therapies)	Deductible, then 30%	70%	Deductible, then 0%	100%
Physical, Occupational, & Speech therapy are limited to a combined maximum of 60 visits per Calendar Year. Pulmonary Rehab is limited to 36 visits per Calendar Year. Habilitation services are limited to the treatment of autism and are subject to the Calendar Year maximum listed above for physical, occupational, and speech therapy. Vision therapy is not covered.				
Sleep Disorders Sleep studies	Deductible, then 30%	70%	Deductible, then 0%	100%
Other eligible expenses	Refer to applicable service for benefits	Refer to applicable service for benefits	Refer to applicable service for benefits	Refer to applicable service for benefits

BENEFIT DESCRIPTION	BRONZE PLAN		SILVER PLAN	
	YOU PAY	PLAN PAYS	YOU PAY	PLAN PAYS
Sterilization Vasectomy	Deductible, then 30%	70%	Deductible, then 0%	100%
Female sterilization as recommended by the ACA	Refer to **Preventive Care**	Refer to **Preventive Care**	Refer to **Preventive Care**	Refer to **Preventive Care**
Temporomandibular Joint Syndrome	Refer to applicable service for benefits			
Urgent Care Facility (includes all covered charges billed by facility)	$50 copay, deductible waived	100%	Deductible, then 0%	100%
Wig after chemotherapy (Limited to 1 wig up to $300 per Lifetime)	Deductible, then 0%	100%	Deductible, then 0%	100%
Other Covered Expenses	Deductible, then 30%	70%	Deductible, then 0%	100%

Schedule of Prescription Drug Benefits

The following schedule summarizes amounts paid by the Plan. Please refer to the Prescription Drug Benefits section for a description of covered expenses and benefit exclusions and limitations.

BENEFIT DESCRIPTION	BOTH PLANS
PRESCRIPTION DRUG DEDUCTIBLE, PER CALENDAR YEAR	
Per Member	No deductible applies
Per Family	No deductible applies
PRESCRIPTION DRUG OUT-OF-POCKET MAXIMUM, PER CALENDAR YEAR	
Per Member	Medical out-of-pocket maximum applies
Per Family	Medical out-of-pocket maximum applies
BRAND-NAME PENALTY	
If your Physician authorizes the use of a Generic drug, but you choose to use the Brand Name drug, you must pay the difference between the actual cost of the Generic and Brand Name in addition to the Brand Name copayment.	
PRESCRIPTION UTILIZATION MANAGEMENT	
Some covered drugs may have additional requirements or limits on coverage. These requirements and limits may include: • Prior Authorization: The Pharmacy Benefits Manager (PBM) requires you or your Physician to get prior authorization for certain drugs. This means that you will need to get approval from the PBM before you fill your prescriptions. If you don't get approval, the PBM may not cover the drug. • Quantity Limits: For certain drugs, the PBM limits the amount of the drug that they will cover. This promotes appropriate dispensing by aligning quantities with FDA-approved dosage guidelines and other medical evidence. • Step Therapy: In some cases, the PBM requires you to first try certain drugs to treat your medical condition before they will cover another drug for that condition. For example, if Drug A and Drug B both treat your medical condition, the PBM may not cover Drug B unless you try Drug A first. If Drug A does not work for you, the PBM will then cover Drug B. You can also get more information about the restrictions applied to specific covered drugs by visiting the PBM's website. They have posted online documents that explain the above restrictions. You may also ask them to send you a copy by calling the number listed on your ID card.	
USING A NON-NETWORK PHARMACY	
If you fill your prescription using a Non-Network retail pharmacy…	Purchases at a non-participating *pharmacy* require you to pay in full then submit a claim form for reimbursement and are subject to an additional 30% coinsurance. Non-network *mail order* prescriptions are not covered.

BENEFIT DESCRIPTION	BOTH PLANS
RETAIL PHARMACY OPTION (30-day supply)	
Prescribed Preventive Medications as recommended by federal law*	No charge
Generic drug	$10
Preferred Brand Name drug	$25
Non-Preferred Brand Name drug	$50
SPECIALTY DRUGS (30-day supply)	
Specialty drugs must be obtained through Maxor Specialty Pharmacy or they will not be covered	Copay follows above categories
MAIL ORDER OPTION (90-day supply; available only through a Network pharmacy)	
Prescribed Preventive Medications as recommended by federal law*	No charge
Generic drug	$15
Preferred Brand Name drug	$37.50
Non-Preferred Brand Name drug	$75

*****Contraceptives are covered as recommended by the ACA and are payable at the applicable Generic and Brand Name copays shown above.

Brand Name means a trade name medication.

Generic drug means a prescription drug that 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.

Preferred Brand Name drug means a trade name prescription medication that is on the Formulary Brand Name drug list, compiled by the third party payor, of safe, effective therapeutic drugs specifically covered by this Plan.

Non-Preferred Brand Name drug means a trade name prescription medication that is not on the Formulary Brand Name drug list.

Specialty drugs means prescription medications that require special handling, administration or monitoring. These drugs are high-cost injectable, infused, oral, or inhaled drugs that generally require special storage or handling and close monitoring of the patient's drug therapy. Specialty drugs are used to treat complex, chronic and often costly conditions, such as cancer, chronic kidney failure,

post-transplant anti-rejection, multiple sclerosis, rheumatoid arthritis, hepatitis C, and hemophilia. These drugs may have a limited distribution or may need prior authorization to have them ordered through a specialty pharmacy.

MAXOR Specialty Pharmacy

Experience how our patient-focused services can help you enjoy a better, fuller life. We make ordering and managing your chronic injectables or specialty medications as easy as possible.

As a full-service specialty pharmacy, we help patients manage all of their specialty conditions. We have a special clinical focus in the following areas:

- Ankylosing Spondylitis
- Bronchiectasis
- Cancer
- Crohn's Disease
- Cystic Fibrosis
- Enzyme Deficiencies and Lysosomal Storage Disorders
- Growth Hormone Deficiency
- Hemophilia/Bleeding Disorders
- Hepatitis C
- HIV
- Infertility
- Juvenile Arthritis
- Multiple Sclerosis
- NTM
- Osteoarthritis
- Psoriasis
- Respiratory Syncytial Virus (RSV)
- Rheumatoid Arthritis
- Transplant

We go beyond just dispensing products. We provide customized programs and specialty services that improve patient outcomes using the following methods:

Realizing every patient is unique, our pharmacist-led clinical team works directly with your physician to coordinate all aspects of your care. We proactively contact you regularly to remind you about refills, answer any questions, provide additional education and support, or check on how you are progressing with your therapy.

Best of all, you can always speak directly with one of our specialty pharmacists 24/7/365. Call us toll free at (866) 629-6779.

DEFINITIONS

For this Summary Plan Description, the following terms have the meanings given them in this section, unless otherwise defined elsewhere in the Summary Plan Description for the purpose of specific provisions. **These definitions are not an indication that charges for particular care, supplies or services are eligible for payment under the Plan; please refer to the appropriate sections of this Summary Plan Description for that information.**

Accident: An unintentional, unforeseeable and undesirable happening that results in bodily Injury for which medical treatment is required.

Actively at Work and Active Work: Actually performing the regular duties of the employee's occupation at an Employer-designated work site. For a vacation, holiday or scheduled non-working day (e.g., weekend, etc.), Actively at Work and Active Work mean the capacity to perform the regular duties of the employee's occupation at an Employer-designated work site. An employee will be deemed Actively at Work if the employee is absent from work due to a health factor.

Administrative Period: A period of time selected by the Employer beginning immediately following the end of the Measurement Period and ending immediately before the start of the associated Stability Period. This period of time may be used by the Employer to determine if a Variable Hour Employee averaged at least 30 hours per week during the Measurement Period and, if so, to make an offer of coverage. Any applicable Administrative Period will not exceed 90 days.

Assignment of Benefits: An arrangement whereby a Participant of the Plan, at the discretion of the Plan Administrator, assigns their right to seek and receive payment of eligible Plan benefits, less deductibles, co-payments and coinsurance amounts, to a medical provider. If a provider accepts said arrangement, the provider's rights to receive Plan benefits are equal to those of the Participant, and are limited by the terms of this Plan Document. A provider that accepts this arrangement indicates acceptance of an Assignment of Benefits and deductibles, co-payments, and coinsurance amounts, as consideration in full for treatment rendered. The Plan Administrator may revoke an assignment of benefits at its discretion and treat the Participant as the sole beneficiary.

Benefit Services Manager: Gilsbar, L.L.C., the entity that performs certain contracted nondiscretionary administrative services for the Plan pursuant to the terms of the Benefit Services Management Agreement.

Calendar Year: A period of twelve months commencing January 1 and ending December 31 of the same year.

Chiropractic Treatment: Skeletal adjustments, modalities, spinal/cerebral manipulation or other treatment in connection with the detection and correction, by manual means, of structural imbalance

or subluxation of the human body. Such treatment is done to remove interference resulting from, or related to, distortion, misalignment or subluxation of, or in, the vertebral column.

COBRA: The Consolidated Omnibus Budget Reconciliation Act of 1985, as amended.

Continuous Period of Confinement: All periods of confinement due to the same or a related cause or condition, unless periods are separated by one month during which the Member was not confined in either a Hospital or an Extended Care Facility or Skilled Nursing Facility.

Cosmetic or Cosmetic Surgery: Services or supplies designed to improve appearance, or surgery performed to reshape normal structures of the body to improve the patient's appearance and self-esteem.

Covered Dependent: A dependent covered pursuant to the eligibility requirements of the Plan; however, a dependent eligible as a dependent of more than one Covered Employee may not be a Covered Dependent of more than one employee.

Covered Employee: An employee covered pursuant to the eligibility requirements of the Plan, except that no employee may be covered simultaneously as an employee and a dependent.

Custodial or Custodial Care: Care or confinement provided primarily for the maintenance of the Participant, essentially designed to assist the Participant, whether or not Totally Disabled, in the activities of daily living, which could be rendered at home or by persons without professional skills or training. This care is not reasonably expected to improve the underlying medical condition, even though it may relieve symptoms or pain. Such care includes, but is not limited to, bathing, dressing, feeding, preparation of special diets, assistance in walking or getting in and out of bed, and supervision over medication which can normally be self-administered and all domestic activities.

Elective Surgical Procedure: Any non-Emergency surgical procedure which may be scheduled at the convenience of the patient or the surgeon without jeopardizing the patient's life or causing serious impairment to the patient's bodily functions.

Eligibility Date: The day on which employees and dependents of employees become eligible to participate in the Plan.

Eligible Dependent: (See Highlights section.)

Eligible Employee: (See Highlights section.)

Emergency Medical Condition: A severe medical condition of recent onset that would lead a reasonably prudent and knowledgeable layperson to believe that failure to obtain immediate medical

attention could result in serious jeopardy to health or serious impairment to bodily function or to any bodily organ or part.

Examples of Emergency medical conditions are:

- Chest pain
- Heart attack
- Head injuries
- Strokes (cerebrovascular accidents)
- Poisoning
- Convulsions
- Severe bleeding
- Fractures
- Vomiting blood
- Extreme difficulty breathing
- Sudden severe pain anywhere in the body
- Threat of bodily harm to self or others

If you believe you are having a medical emergency, call 911 (or the appropriate emergency number in your area) or go immediately to the nearest appropriate medical facility.

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

1. A 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, including ancillary services routinely available to the emergency department to evaluate such Emergency Medical Condition; and

2. Such further medical examination and treatment, to the extent they are within the capabilities of the staff and facilities available at the hospital, as are required under section 1867 of the Social Security Act (42 U.S.C. 1395dd) to stabilize the patient.

Employer: University of the Incarnate Word, including any affiliate or subsidiary thereof.

Essential Health Benefits: Under section 1302(b) of the PPACA, those health benefits to include at least the following general categories and the items and services covered within the categories: ambulatory patient services; Emergency Services; hospitalization; maternity and newborn care; mental health and Substance Abuse 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 or Investigational: Any treatment, equipment, new technology, drug, procedure or supply, which:

1. is not recognized by the state or national medical communities;

2. does not have final approval from the appropriate government regulatory bodies of the United States;

3. is not supported by conclusive, scientific evidence regarding the effect on health outcome; or

4. is not considered standard medical treatment for the patient's specific condition when compared with established, more conventional or widely recognized treatment alternatives.

Any treatment, equipment, new technology, drug, procedure or supply may be considered Experimental or Investigational within this definition, even if a Physician has previously prescribed, ordered, recommended or approved such treatment. The Plan Administrator determines what is considered Experimental or Investigational.

Extended Care or Skilled Nursing Facility: A licensed facility operating pursuant to law which is primarily engaged in providing (for compensation from its patients) skilled nursing care on an Inpatient basis during the convalescent stage of Illness or Injury under 24-hour-a-day supervision of a Physician or registered graduate Nurse, and which maintains permanent facilities for the care of ten or more bed patients. Such a facility must maintain complete medical records on each patient and have established methods and procedures for the dispensing and administering of drugs. In no event shall the term include a facility that is primarily:

1. A rest home, retirement home or home for the aged;

2. A school or similar institution;

3. Engaged in the care and treatment of Substance Abuse, or of mentally ill or senile persons; or

4. Engaged in Custodial Care.

Full-time Employee or Full-Time Employment: With respect to a calendar month, an employee who is employed an average of at least 30 hours of service per week with the Employer.

HIPAA: The Health Insurance Portability and Accountability Act of 1996, as amended.

Home Health Care Agency: An agency that:

1. Is primarily engaged in providing skilled nursing and other therapeutic services to the patient in his or her home;

2. Is duly licensed or approved by the appropriate governmental body if such licensing or approval is legally required;

3. Has policies established by a professional group associated with the organization, including at least one Physician and at least one registered Nurse to govern the services provided;

4. Provides for full-time supervision of such services by a Physician or by a registered Nurse; and

5. Maintains a complete medical record of each patient.

Home Health Care Expenses: Expenses made by a health care agency for the following necessary services or supplies furnished to the Member in such individual's home in accordance with the home health care plan for care for which the patient would otherwise have been hospitalized:

1. Part-time or intermittent nursing care by or under the supervision of a registered Nurse;

2. Part-time or intermittent home health care aide services that consist primarily of caring for the patient;

3. Physical therapy, Occupational Therapy and speech therapy provided by the Home Health Care Agency; and/or

4. Medical supplies, drugs and medications prescribed by a Physician and laboratory services by or on behalf of a certified Home Health Care Agency, to the extent such items would have been covered under any other provisions of the Plan had the Member been confined in a Hospital.

Hospice: A licensed service that offers a coordinated program of home care and Inpatient care for a Terminally Ill patient and the patient's family. The program provides supportive care to meet the special needs from the physical, psychological, spiritual, social and economic stresses often experienced during the final stages of life.

Hospital: An institution operated pursuant to law that is accredited by the appropriate national regulatory body for Hospital accreditation. It must be primarily engaged in providing (for compensation from its patients) medical, diagnostic and surgical facilities for the care and treatment of sick and injured persons on an Inpatient basis. It must also provide such facilities under the

supervision of a staff of Physicians and with 24-hour-a-day nursing service by registered graduate Nurses. In addition, the definition of a Hospital shall include the following:

1. A surgery center;

2. A rehabilitation hospital, if it provides medical supervision by a Physician, 24-hour-a-day nursing services by registered graduate Nurses and treatment programs developed by a staff of professionals who specialize in rehabilitative care, and has transfer arrangements with at least one other Hospital providing acute care and surgical facilities;

3. A Substance Abuse treatment center that is licensed by the state or federal government, subject to any exclusions and limitations on such treatment contained in this Plan.

The definition of a Hospital shall not include any institution or part thereof which is used principally as a rest facility, Extended Care Facility, nursing facility, facility for the aged or for Custodial Care, or a halfway house.

Illness: A bodily disorder or Mental/Emotional Disorder of any kind of any Participant. Illness includes pregnancy for the purpose of benefit determination. Illness also includes Injury where appropriate to the context.

Incurred or Incurred Date: The actual date a specific service is rendered or the supply is obtained. With respect to a course of treatment or procedure which includes several steps or phases of treatment, expenses are incurred for the various steps or phases as the services related to each step are rendered and not when services relating to the initial step or phase are rendered.

Injury: A bodily injury resulting from an Accident sustained by any Participant. All injuries sustained by a Participant in one Accident will be considered one Injury.

Inpatient: A person who is confined in a Hospital, Extended Care Facility or Skilled Nursing Facility as a registered bed patient and who is charged at least one day's room and board by the facility.

Late Enrollee: A Participant who enrolls in the Plan other than:

1. during the first period in which the individual is eligible to enroll under the Plan; or

2. during a special enrollment period.

Lifetime Maximum Benefit: The Lifetime Maximum Benefit is the absolute limit on what this Plan will pay for each Participant's covered expenses, even if other provisions of the Plan appear to entitle the Participant to more. “Lifetime” shall mean while covered under this Plan or any other plan maintained by the Employer.

Marriage or Married: A union that is legally recognized as a Marriage under the state law where such Marriage was performed.

Maximum Allowable Charge: The benefit payable for a specific coverage item or benefit under the Plan. The Maximum Allowable Charge will always be a negotiated rate, if one exists; if no negotiated rate exists, the Maximum Allowable Charge will be determined and established by the Plan, at the Plan Administrator's discretion, using normative data and submitted information such as, but not limited to, any one or more of the following, in the Plan Administrator's discretion:

- Medicare reimbursement rates (presently utilized by the Centers for Medicare and Medicaid Services ["CMS"]), in conjunction with the Scheduled Benefit Amount, as defined below;
- Medicare Equivalency tables (prices established by CMS utilizing standard Medicare Payment methods and/or based upon supplemental Medicare pricing data for items Medicare doesn't cover based on data from CMS), in conjunction with the Scheduled Benefit Amount, as defined below;
- Approximation tools (prices established by CMS utilizing standard Medicare payment methods and/or based upon prevailing Medicare rates in the community for non-Medicare facilities for similar services and/or supplies provided by similarly skilled and trained providers of care), in conjunction with the Scheduled Benefit Amount, as defined below;
- Prices established by CMS utilizing standard Medicare payment methods for items in alternate settings based on Medicare rates provided for similar services and/or supplies paid to similarly skilled and trained providers of care in traditional settings, in conjunction with the Scheduled Benefit Amount, as defined below;
- Medicare cost data as reflected in the applicable individual provider's cost report(s);
- The fee(s) which the provider most frequently charges the majority of patients for the service or supply;
- Amounts the provider specifically agrees to accept as payment in full either through direct negotiation or through a preferred provider organization (PPO) network;
- Average wholesale price (AWP) and/or manufacturer's retail pricing (MRP);
- Medicare cost-to-charge ratios or other information regarding the actual cost to provide the service or supply;
- The prevailing range of fees charged in the same "area" (defined as a metropolitan area, county, or such greater area as is necessary to obtain a representative cross-section of providers, persons or organizations rendering such treatment, services, or supplies for which a specific charge is made) by providers of similar training and experience for the service or supply.

The Plan Administrator may in its discretion, taking into consideration specific circumstances, deem a greater amount payable than the lesser of the aforementioned amounts. The Plan Administrator may take any or all of such factors into account but has no obligation to consider any particular factor. The Plan Administrator may also account for unusual circumstances or complications requiring additional or a lesser amount of time, skill and experience in connection with a particular service or supply, industry standards and practices as they relate to similar scenarios, and the cause of Injury or Illness necessitating the service(s) and/or charge(s).

In all instances, the Maximum Allowable Charge will be limited to an amount which, in the Plan Administrator's discretion, is charged for services or supplies that are not unreasonably caused by the treating provider, including errors in medical care that are clearly identifiable, preventable, and serious in their consequence for patients. A finding of provider negligence and/or malpractice is not required for services or fees to be considered ineligible pursuant to this provision.

The determination that fees for services are includable in the Maximum Allowable Charge will be made by the Plan Administrator, taking into consideration, but not limited to, the findings and assessments of the following entities: (a) The National Medical Associations, Societies, and organizations; and (b) The Food and Drug Administration. To be includable in the Maximum Allowable Charge, services and fees must be in compliance with generally accepted billing practices for unbundling or multiple procedures.

The Plan Administrator has the discretionary authority to decide if a charge is covered under this Plan. The Maximum Allowable Charge will not include any identifiable billing mistakes including, but not limited to, up-coding, duplicate charges, and charges for services not performed.

When applicable, the "Scheduled Benefit Amount" will be determined based on multiplying the most applicable of the following by 120%:

- For inpatient hospital expenses, the Medicare Diagnosis Related Group ("DRG") scheduled dollar conversion amounts based upon the CMS weighted values
- For outpatient hospital expenses, the CMS Ambulatory Payment Classification (APC) based upon the CMS weighted values, or the current Medicare allowable fee for the appropriate area;
- For physicians and other eligible providers, the current Medicare allowable fee for the appropriate area; or
- For Ambulatory Surgical Centers (ASC), the current Medicare allowable fee for the appropriate area.

Measurement Period: A period of time selected by the Employer during which a Variable Hour Employee's hours of service are tracked to determine if they average at least 30 hours during this period. The beginning dates and the lengths of each Measurement Period are set by the Plan Sponsor and will be applied uniformly to each category of employees.

- Initial Measurement Period: For a newly-hired Variable Hour Employee, this Measurement Period may start at any time from the date of hire to the first day of the month after the employee begins working and end no later than after the first 12 months of service.

- Standard Measurement Period: For Ongoing Employees, this Measurement Period will start on the same day each year and will last no longer than 12 months.

Medically Necessary or Medical Necessity: Describes medical treatment, as determined by the Plan Administrator, that:

1. Is appropriate and consistent with the diagnosis;

2. In accordance with accepted medical standards, would not have been omitted without adversely affecting the patient's condition or the quality of medical care rendered;

3. Is not primarily Custodial Care; and

4. As to institutional care, could not have been provided in a Physician's office, in the Outpatient department of a Hospital or in a lesser facility without adversely affecting the patient's condition or the quality of medical care rendered.

The mere fact that the service is furnished, prescribed or approved by a Physician does not mean that it is "medically necessary." In addition, the fact that certain services are excluded from coverage under this Plan because they are not "medically necessary" does not mean that any other services are deemed to be "medically necessary."

Medicare: All parts of Health Insurance for the Aged provided by Title XVIII of the Federal Social Security Act of 1965, as now constituted or as hereafter amended.

Mental/Emotional Disorder: Any disorder characterized by abnormal functioning of the mind or emotions and in which psychological, intellectual, emotional or behavioral disturbances are the dominant feature. Mental/Emotional Disorders include mental disorders, mental Illnesses, psychiatric Illnesses, mental conditions and psychiatric conditions, whether organic or non-organic, whether of biological, non-biological, genetic, chemical or non-chemical origin, and irrespective of cause, basis or inducement.

New Employee: An employee who has not been employed for at least one complete Standard Measurement Period, or who is treated as a New Employee following a period during which the employee was credited with zero hours of service.

Nurse: A licensed Registered Nurse (RN) or Licensed Practical Nurse (LPN) or Licensed Vocational Nurse (LVN) who does not usually live with the patient and is not a member of his or her family.

Occupational Therapy: The therapeutic use of self-care, work or other therapy activities for the sole purpose of reducing disability and restoring function and motor skills following an Injury or Illness.

Ongoing Employee: An employee who has been employed by the Employer for at least one complete Standard Measurement Period.

Outpatient: A person who is not admitted as an Inpatient but who receives medical care.

Outpatient Surgery: Surgery performed on an Outpatient basis at a Hospital, ambulatory surgical facility, or Physician's office. An ambulatory surgical facility is defined as a licensed, specialized facility, within or outside the Hospital facility, that meets all the following criteria:

1. Is established, equipped and operated in accordance with the applicable laws in the jurisdiction in which it is located and primarily for the purpose of performing surgical procedures;

2. Is operated under the supervision of a Medical Doctor (M.D.) who is devoting full time to such supervision;

3. Provides at least two operating rooms and one post anesthesia recovery room;

4. Provides the full-time service of one or more Registered Nurses for patient care in the operating rooms;

5. Maintains a written agreement with at least one or more Hospitals in the area for immediate acceptance of patients who develop complications;

6. Maintains an adequate medical record for each patient. The medical record must contain an admitting diagnosis including, for all patients except those undergoing a procedure under local anesthesia, a preoperative examination report, medical history and laboratory tests and/or X-rays, an operative report and a discharge summary.

Partial Hospitalization: A structured Hospital-based program. Patients receive intense treatment usually between the hours of 8 a.m. and 5 p.m., Monday through Friday, and are capable of remaining in their home environment in the evenings. Individual, group or family therapy is provided a minimum of four hours a day, three times a week.

Participant: Any Eligible Employee or Eligible Dependent who has elected coverage under this Plan. Participant, covered individual, covered person, and member have the same meaning.

Physician: A duly licensed Doctor of Medicine (M.D.), Osteopath, Podiatrist, Doctor of Dental Surgery or Dental Medicine (D.D.S. or D.M.D.), Doctor of Optometry, Chiropractor and auxiliary personnel which can include clinical psychologists, board-certified social workers, licensed professional

counselors, Family Nurse Practitioners, Physician Assistants, Certified Registered Nurse Anesthetists, Nurse midwives, physical and occupational therapists or any other licensed practitioner of the healing arts if he or she performs a covered service:

1. within the scope of the license; and

2. applicable state law requires such practitioner to be licensed.

Plan: The arrangement created by this Plan Document and Summary Plan Description, and which may be amended from time to time.

Plan Administrator: University of the Incarnate Word.

Plan Document: This Plan Document and Summary Plan Description.

Plan Sponsor: University of the Incarnate Word.

Plan Year: A period of twelve consecutive months commencing on either the effective date of the Plan or on the day following the end of the first Plan Year if the first Plan Year is a short year.

Preventive Care: Care consisting of measures taken to prevent diseases, rather than curing them or treating their symptoms. For purposes of the Plan, and in accordance with recommendations and guidelines, Preventive Care consists of the following:

1. Evidence-based items or services rated A or B in the United States Preventive Services Task Force (USPSTF) recommendations;

2. Recommendations of the Advisory Committee on Immunization Practices adopted by the Director of the Centers for Disease Control and Prevention (CDC);

3. Comprehensive guidelines for infants, children, and adolescents supported by the Health Resources and Services Administration (HRSA); and

4. Comprehensive guidelines for women supported by the Health Resources and Services Administration (HRSA).

For more information, contact the Plan Administrator.

Reasonable and Customary: For the purposes of the plan generally, a charge is considered Reasonable and Customary:

1. If the charge is made for medical or dental services or supplies essential to the care of the Participant; and

2. If the charge is in the amount normally charged by the provider for similar services and supplies; and

3. If the charge does not exceed the amount ordinarily charged by most providers of comparable services and supplies in the geographic area where the services or supplies are received.

Whether a charge is Reasonable and Customary may be established by the Plan Administrator by use of any customary or accepted method. See also, "Maximum Allowable Charge".

Reconstructive Surgery: Surgery performed to restore function by reshaping abnormal structures of the body caused by Illness, Injury, congenital defects or developmental abnormalities.

Residential Treatment Center: A facility that provides treatment 24 hours a day and can usually serve more than twelve people at a time. Treatment may include individual, group and family therapy; behavior therapy; special education; recreation therapy; or medical services. Residential treatment is usually more long-term than Inpatient Hospitalization. Residential treatment is for (1) severe and persistent mental illness that results in the person being unable to maintain independent functioning without support and continued treatment for an indefinite period of time or (2) Substance Abuse in which the patient is at a high risk for relapse.

Routine Physical Exam: Exam by doctor not required because of Illness or Injury.

Second Surgical Opinion: A written report from a qualified Physician, who is not financially or professionally associated with the first Physician, as to the Medical Necessity of a future surgical procedure that was recommended by another Physician. This will include all Outpatient tests and diagnostic procedures Medically Necessary to render such opinion.

Sound, Natural Tooth: Any tooth that is sufficiently supported by its surrounding natural structures and is not decayed or weakened by previous dental work to the extent that it is more susceptible to damage. This susceptibility includes, but is not limited to, a tooth that is restored by a multi-surface restoration or a tooth that has had root canal therapy.

Spouse: An individual who is legally Married to a Covered Employee.

Stability Period: A period selected by the Employer that immediately follows, and is associated with, a Standard Measurement Period or an Initial Measurement Period (and, if elected by the Employer, the Administrative Period associated with that Standard Measurement Period or Initial Measurement Period), and is used by the Employer as part of the look-back measurement method. The Stability Period is a period of time equal to the Measurement Period in which the Variable Hour Employee's eligibility status is fixed.

Substance Abuse: The regular, excessive and compulsive drinking of alcohol and/or physical, habitual dependence on drugs that results in a chronic disorder affecting physical health and/or personal or

social functioning. This does not include dependence on tobacco and ordinary caffeine-containing drinks.

Summary Plan Description: This Plan Document and Summary Plan Description.

Temporomandibular Joint (TMJ) Syndrome: One or more jaw joint problems including conditions of structures linking the jaw bone and skull and the complex of muscles, nerves and other tissues related to the temporomandibular joint. Care and treatment shall include, but is not limited to, orthodontics, crowns, inlays, physical therapy and any appliance that is attached to or rests on the teeth.

Terminally Ill: Someone who has a life expectancy of approximately six months or less, as certified in writing by the Physician who is in charge of the patient's care and treatment.

Variable Hour Employee: An employee is considered a Variable Hour Employee if, based on the facts and circumstances at the employee's start date, the Employer cannot determine whether the employee is reasonably expected to be employed on average at least 30 hours of service per week during the Initial Measurement Period because the employee's hours are variable or otherwise uncertain.

PERSONS COVERED AND EFFECTIVE DATES

Election of Coverage

If you are eligible to become covered under the Plan as outlined in the Highlights section, you may elect coverage under the Plan by submitting a completed, valid enrollment form which you may obtain from the Plan Administrator. You may elect coverage for yourself only, you and your Spouse, you and your dependent children, or your whole family. The application process involves electing coverage and paying the required contribution, if any, for the type of coverage you've chosen. The Plan Administrator determines annually or more frequently if deemed appropriate, whether (and to what extent) employees will be required to contribute towards the cost of coverage under the Plan. Contributions may be required to obtain employee and/or dependent coverage.

Effective Date of Employee Coverage

Your Eligibility Date is listed in the Highlights section. This is the earliest date that you may become covered under the Plan. If you choose not to enroll within 31 days of your Eligibility Date, you will be considered a Late Enrollee. You will also be considered a Late Enrollee if you do not enroll within 31 days of a special enrollment event described later in this section.

Your coverage is effective as follows:

1. If you are an Eligible Employee, at 12:01 A.M. on your Eligibility Date, if you enroll within 31 days of becoming eligible; or

2. If you are a Late Enrollee, at 12:01 A.M. on the first day of June following the date of the request for enrollment (see Open Enrollment Period later in this section).

If you are enrolling during a special enrollment period, see the subsection below entitled Special Enrollment Periods.

If you are not required to make a contribution to the cost of your coverage (that is, it is non-contributory), it is effective at 12:01 A.M. on your Eligibility Date. However, you must complete an enrollment form for your claims to be paid promptly.

If, for reasons not related to a health condition, you are not Actively at Work on the date you would otherwise become covered under the Plan, your coverage will not begin until the day you return to Active Work.

Effective Date of Dependent Coverage

Your dependents may be covered under the Plan only if you are a Covered Employee and if the dependents meet the Plan's requirements for Eligible Dependents. If you have Eligible Dependents when you first become eligible to participate in the Plan, the Eligibility Date for these dependents is

the same as your Eligibility Date. Any dependent not enrolled within 31 days of the Eligibility Date is considered a Late Enrollee. A dependent will also be considered a Late Enrollee if not enrolled within 31 days of a special enrollment event described later in this section.

Dependent coverage is effective as follows:

1. If you are an Eligible Employee, at 12:01 A.M. on the Eligibility Date, if you apply for dependent coverage within 31 days of becoming an Eligible Employee; or

2. If you or your dependent is a Late Enrollee, at 12:01 A.M. on the first day of June following the date of the request for enrollment (see Open Enrollment Period later in this section).

If you are enrolling your dependent during a special enrollment period, see the subsection below entitled Special Enrollment Periods.

If dependent coverage is non-contributory, coverage is effective at 12:01 A.M. on the Eligibility Date. Your dependents must be listed on your enrollment form for claims to be paid promptly.

If you did not have an Eligible Dependent when you first became eligible to participate in the Plan, but you later acquire one, coverage for this dependent is effective as described above. However, in this case the Eligibility Date is the date the Eligible Dependent was acquired. For a newborn child, the Eligibility Date is the date of birth. For an adopted child (under age 18), the Eligibility Date is the date of adoption or the date of placement in your home while you are covered under this Plan.

Contributory coverage for a newborn child is effective on the date of birth only if application is made within 31 days after this date. Contributory coverage for an adopted child (under age 18) is effective on the date of adoption or the date of placement in your home if application is made within 31 days after this date. These are exceptions to provision (1) above.

Special Enrollment Periods

The employee must make a request for special enrollment to the Plan Administrator within 31 days of Marriage, birth, adoption or the loss of other coverage (other than Medicaid or a State Children's Health Insurance Program). The request must be made in writing to the Plan Administrator.

Coverage is effective as follows:

1. For Marriage, the first day of the month following enrollment.

2. For loss of other coverage, the first day of the month following enrollment.

3. For birth or adoption, the date of birth or adoption, or the date the child is placed in the home for adoption.

Special enrollment rights are also available for employees and/or their dependents who lose coverage under Medicaid or a State Children's Health Insurance Program (SCHIP) or become eligible for a premium assistance subsidy from Medicaid or SCHIP as provided for in the Children's Health Insurance Program Reauthorization Act of 2009 (CHIPRA). In these cases, the employee must make a request for special enrollment to the Plan Administrator within 60 days of loss of Medicaid or SCHIP coverage, or notice of eligibility for a premium assistance subsidy, whichever applies. Coverage will become effective no later than the first day of the month after application is made to the Plan Administrator.

If an employee or a dependent does not enroll within 31 days of Marriage, birth or adoption or the loss of other coverage, and requests coverage later, he is considered a Late Enrollee and may enroll only during the Open Enrollment Period.

Open Enrollment Period

The Open Enrollment Period and the corresponding coverage effective date are shown in the Highlights section.

During the Open Enrollment Period only:

- The Plan allows an Eligible Employee (and/or his or her Eligible Dependents) who is not currently enrolled and who has completed any waiting period (i.e., a Late Enrollee) to elect coverage;

- Eligible Employees who are currently enrolled may also elect to change their plan selection, add or drop dependents, or drop coverage altogether.

Eligibility Restrictions

- You may not be covered under this Plan as both an employee and as a dependent.

- If both parents of a Child are Covered Employees, a Dependent Child can be covered under this Plan by either parent, but not by both parents.

- You may not enroll your dependents without enrolling yourself in the Plan.

- You and your dependents must enroll in the same plan option.

- Your dependent may not reside outside of the United States on a full-time basis.

Change in Family Status

Once you are in the Plan, you must notify the Plan Administrator within 31 days of <u>any</u> family status change, such as a newborn baby, or when your first family member becomes eligible, or when you

no longer need coverage for a certain family member, or when they are no longer eligible as defined in the Plan.

Change in Coverage Status

If your coverage status changes from dependent to employee or from employee to dependent, all individual deductibles, benefit maximums, and out-of-pocket expense amounts applicable to your individual coverage will carry over as if there had been no change in status.

When Both Spouses Are Covered Employees

When both you and your Spouse are Covered Employees and you have family coverage for dependent children, one Spouse will be treated as a dependent for billing purposes and in calculating the family deductible and out-of-pocket expense amount (when applicable). This provision allows families in which both Spouses are Covered Employees to get the full benefit of their family coverage. The Spouse who was hired last will be the one treated as a dependent for the purposes stated in this section unless the Plan Administrator determines otherwise.

Election of Coverage Regarding Medicare

Medicare regulations applicable to employers with twenty or more employees require that any active Participant who has reached age 65 and is eligible for Medicare must choose one of the following coverage options:

1. Primary coverage under this Plan (Plan benefits will be paid without regard to Medicare), or

2. Sole coverage under Medicare (coverage under this Plan will terminate).

When eligible, Plan Participants must enroll in Medicare coverage in a timely manner to assure maximum coverage.

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. 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.

"GINA"

"GINA" shall mean the Genetic Information Nondiscrimination Act of 2008 (Public Law No. 110-233), which prohibits group health plans, issuers of individual health care policies, and employers from discriminating on the basis of genetic information.

The term "genetic information" means, with respect to any individual, information about:

1. Such individual's genetic tests;

2. The genetic tests of family members of such individual; and

3. The manifestation of a disease or disorder in family members of such individual.

The term "genetic information" includes participating in clinical research involving genetic services. Genetic tests would include analysis of human DNA, RNA, chromosomes, proteins, or metabolite that detects genotypes, mutations, or chromosomal changes.

Therefore, this Plan will not discriminate in any manner with its Participants on the basis of such genetic information.

HOW THE PLAN WORKS

This is an open network, open access plan. The member is not restricted to use specific providers because there is no medical provider network. The plan will pay covered charges up to the Maximum Allowable Charge, less any amount that the Member must pay due to application of deductibles, copayments, out-of-pocket expenses, or other cost-sharing provisions.

The Plan has selected OccuNet, LLC dba Fairos, to reprice claims, perform Member Advocacy and provide pricing appeal resolution. With this Plan, facility and professional providers are reimbursed based on the Medicare fee schedule plus a specific percentage over and above current Medicare allowable amounts for services rendered to the Member. When Medicare does not apply to the services rendered, Fairos will reprice the claim according to its proprietary data about the services rendered and the market in which the services were rendered.

The provider is balance billing a Member when they attempt to collect more than is allowed by the Plan for the services rendered as is indicated on the Member's Explanation of Benefits (EOB).

Members who receive a balance bill should contact Gilsbar, LLC at the number on the back of the ID card. Gilsbar, LLC will ask the Member to fax or email a copy of the bill from the provider so that Gilsbar can review the bill to ensure it is a balance bill and not attributable to the Member's cost-sharing responsibility (such as copays, deductibles, or coinsurance).

If Gilsbar determines a Member's bill is truly a balance bill, the bill will be forwarded to Fairos for Member Advocacy. Fairos will serve as a liaison between the Member and his or her providers. Fairos will make outreach to providers in order to gain acceptance of the Plan's reimbursement rate as payment in full and address any issues or questions related to pricing of the Member's claims. Fairos will engage consultants, legal counsel or other specialists when it is deemed necessary in review and resolution of the appeal and when appropriate, Fairos may direct contract with the provider for the services rendered to the Member.

The Fairos Member Advocate will keep the Member informed of progress and status their balance bill and its resolution.

Each Member has a free choice of any provider, and the Member, together with his or her provider, is ultimately responsible for determining the appropriate course of medical treatment, regardless of whether the Plan will pay for all or a portion of the cost of such care.

MDLIVE

MDLIVE provides access to a national network of board-certified doctors and pediatricians who are available on-demand 24 hours a day, 7 days a week, 365 days a year to diagnose, treat and prescribe medication (when necessary) for many medical issues via mobile app, telephone or online video

consultations. MDLIVE does not replace existing primary care Physician relationships, but supplements them as a convenient, affordable alternative for medical care. Refer to the website located at www.mygilsbar.com for more details.

Asserta Health

The Plan has contracted with Asserta Health to negotiate pre-payment of certain covered services. Members using Asserta Health may have their share of costs (deductible, copayments, and/or coinsurance) greatly reduced or completely eliminated per a shared savings arrangement.

The per episode shared savings available to a Covered Member is up to 100% of the Member's out-of-pocket costs when sufficient savings is generated through utilization of the Asserta Health pre-payment program. Savings are calculated relative to a reference price of 200% of Medicare and are limited to procedures with a reference price greater than or equal to $7,500.

The Plan Participant must contact Asserta Health before any services are rendered or scheduled. Some of the services Asserta Health may be used for are:

- General Surgery
- Advanced Imaging
- Spinal Surgery
- Orthopedic Surgery
- Cardiac Surgery
- Women's procedures

Asserta's medEcash℠ payment platform stages funds that come directly from the Plan and the Member in advance, then pays 100% of transparent cash prices to each provider in real time on the day of service. Providers are paid immediately without the need to file a claim, and the member is not billed later. The entire transaction is completed on the date of service.

Plan Participants can contact Asserta Health at 866-996-5835 to determine if the health plan service needed is available under this program.

DEDUCTIBLES, COPAYMENTS, AND OUT-OF-POCKET EXPENSES

Deductibles and out-of-pocket expenses represent the portion that the Participant pays of covered expenses. This section describes generally these cost-sharing provisions of the Plan. The Plan Sponsor determines these amounts.

Calendar Year Deductible

The Calendar Year deductible is the amount of covered expenses Incurred by an individual during the Calendar Year for which no benefits will be paid by the Plan. After you or a Covered Dependent has satisfied the Calendar Year deductible, the Plan pays a certain percentage of the covered expenses for that individual that are Incurred during the rest of the Calendar Year. Deductible accumulation period is January 1 through December 31. After the accumulation period has ended, the deductible amount starts over. Copayments do not accrue toward the deductible.

Family Calendar Year Deductible

This Plan has an embedded family Deductible. An embedded deductible is an individual deductible for each Covered Person that is embedded within the overall family deductible. If the dollar amount of the embedded Calendar Year deductible shown in the Schedule of Medical Benefits is satisfied by a Covered Person in the family, the Plan will begin to pay for covered services for that family member, regardless of whether the higher family deductible has been satisfied. Once a Covered Person has satisfied the embedded deductible amount, no additional covered expenses for that person will be counted toward the overall family deductible amount.

Additionally, if several members of the family cumulatively satisfy the overall family deductible, the Plan will begin to pay for covered services for the entire family.

Penalty Per Inpatient Confinement (Utilization Management)

If you do not pre-certify your Inpatient stay with the Utilization Management organization, covered expenses billed by the facility and Incurred during that confinement will be subject to the Utilization Management Penalty shown in the Schedule of Medical Benefits in addition to the Calendar Year deductible and any other applicable deductibles. Other services or supplies, if any, that require precertification will be subject to the same Utilization Management Penalty for failure to precertify. Refer to the Utilization Management section for details on how to pre-certify a scheduled Hospital admission and what to do when you are admitted to the Hospital unexpectedly.

Office Visit Copayments

The copayment amount and the applicable benefit percentage for Physician office visits are shown in the Schedule of Medical Benefits. A Participant is required to pay only the listed copay amount for

same-day office visit services and, if applicable, the copay amount for same-day services by a laboratory. The copay applies to the services outlined in the Schedule of Medical Benefits.

The following charges are specifically excluded from the copay benefit associated with the original office visit:

1. Services rendered on a different day;
2. Services rendered outside the Physician's office (except as otherwise listed in the Schedule of Medical Benefits);
3. Services rendered in conjunction with any surgical procedure;
4. Services billed as a separate facility fee.

Such charges will be considered for payment by other applicable benefit provisions of the Plan. After the copay, the Plan will apply the applicable benefit percentage to the remaining covered expenses up to the maximum office visit limit, if any, and then the appropriate deductibles, benefit percentages and other Plan limits apply.

Copayments for Other Applicable Benefits

The copayment amounts (if any) and the applicable benefit percentages are shown in the Schedule of Medical Benefits. A Participant is required to pay the listed copay amount for covered services. After the copay, the Plan will apply the applicable deductible and benefit percentage to the remaining expenses up to the benefit maximum, if any.

Out-of-Pocket Expense

Out-of-pocket expense is the amount of covered expenses you must pay before certain benefits begin to be paid by the Plan at one hundred percent (100%).

If during the Calendar Year your out-of-pocket covered expenses satisfy the out-of-pocket expense amount, the rate of payment by the Plan for certain covered charges will be increased to a full one hundred percent (100%). The one hundred percent (100%) will continue for covered expenses Incurred during the remainder of that Calendar Year. You must satisfy your out-of-pocket amount before these benefits will be paid at one hundred percent (100%).

Family Out-of-Pocket Expense

This Plan has an embedded family out-of-pocket expense amount. An embedded out-of-pocket expenses amount is an individual out-of-pocket amount that is embedded within the overall family out-of-pocket expense amount. If the dollar amount of the embedded Calendar Year out-of-pocket expense amount shown in the Schedule of Medical Benefits is satisfied by a Covered Person in the family, no additional out-of-pocket expense amount is required to be satisfied by that Covered Person

for covered expenses Incurred during the remainder of the Calendar Year. Once a Member has satisfied the embedded out-of-pocket expense amount, no additional covered expenses for that person will be counted toward the overall family out-of-pocket expense amount.

Additionally, if several members of the family cumulatively satisfy the overall family out-of-pocket expense amount, no additional out-of-pocket expense amount is required to be satisfied by the Members of that family for covered expenses Incurred during the remainder of the Calendar Year.

MEDICAL BENEFITS

Covered Medical Expenses

Covered expenses (sometimes identified as covered charges, eligible charges, eligible expenses or similar terms) include only charges that:

1. Are Medically Necessary for the care and treatment of Illness or Injury of a Participant; and

2. Are recommended by an attending Physician; and

3. Do not exceed the Maximum Allowable Charge; and

4. Are not excluded by other provisions applicable to this coverage.

The following expenses are covered by the Plan provided they meet the requirements for covered medical expenses described above and are not excluded elsewhere in the Plan. Reimbursement is based upon the Lifetime and Calendar Year limits, benefit percentages and other limitations previously described in the Schedule of Medical Benefits.

1. Transportation by a professional **ambulance** service to a local Hospital or convalescent facility for Inpatient care, if Medically Necessary, or to the nearest Hospital for Emergency care. Transportation by ambulance to a non-medical facility will be covered only if Medically Necessary. Expenses for transportation by air will be covered only if an air ambulance is Medically Necessary.

2. Services and supplies used in the administration of **anesthesia**, when not duplicated in the Hospital charges.

3. Services and supplies for treatment of **attention deficit**/hyperactivity disorder.

4. **Blood** and blood derivatives that are not donated or replaced.

5. **Cardiac rehabilitation**.

6. **Chiropractic** treatment.

7. Expenses Incurred at **convenience care clinics** for:
    a. Care of treatment of unscheduled, non-emergency Illnesses and Injuries;
    b. The administration of certain immunizations administered within the scope of the clinic's license; and
    c. Individual screening and counseling services to aid in:

i. Tobacco use cessation;

ii. Weight reduction due to obesity (as recommended by the ACA).

Charges Incurred for services and supplies furnished in a group setting for screening and counseling services are not covered under this benefit.

8. **Diabetes** self-management training.

9. Rental of **durable medical equipment** when such equipment is deemed Medically Necessary, including, but not limited to, a wheelchair, hospital-type bed, respirator, and equipment for the administration of oxygen. Such equipment may be purchased if, in the judgment of the Plan Administrator, purchase of the equipment would be less expensive than rental or the equipment is not available for rental. If purchased, the Plan will cover replacement only after a five-year period.

10. Room, board and supplies (other than drugs and medicines) billed by an **Extended Care Facility** or Skilled Nursing Facility. Benefits are payable only if the confinement is required due to a need for extended medical care and not for Custodial Care.

11. **Home health** care, if prescribed by a Physician as a plan of treatment. The Physician must certify that the proper treatment of the Injury or Illness would require continued confinement as an Inpatient in a Hospital or Skilled Nursing Facility in the absence of the services and supplies provided as part of the home health care plan. Each visit by a member of a Home Health Care Agency shall be considered as one home health care visit and four hours of home health aide service shall be considered as one home health care visit.

12. **Hospice** care. Covered charges are as follows:

    a. Inpatient Hospice care;

    b. Services of a Physician;

    c. At-home care including part-time nursing care, use of medical equipment, rental of wheelchairs and hospital-type beds;

    d. Emotional support services and physical/chemical therapies; and

    e. Bereavement counseling sessions for covered family members following the death of a Terminally Ill Participant.

13. **Hospital** room and board, at the rate shown in the Schedule of Medical Benefits. If Medical Necessity requires an intensive care unit or intermediate care unit, the Plan will cover the room and board up to the maximum listed in the Schedule of Benefits.

14. Other **Hospital** services and supplies furnished by the Hospital for medical care during confinement, exclusive of Physician's and other professional services.

15. Services and supplies to diagnose **infertility**. Treatment of infertility is not covered.

16. Medical **laboratory** charges in connection with treatment of an Illness or Injury.

17. Treatment of **Mental/Emotional** Disorders, specifically excluding Applied Behavior Analysis.

18. Routine Hospital and Physician care for a **newborn child** prior to discharge from the Hospital. Such care may not be less than 48 hours following a normal delivery or 96 hours following a cesarean section. Refer to "Pregnancy" later in this section for details of the Newborns' and Mothers' Health Protection Act of 1996. The maximum benefit is also 48 hours and 96 hours, respectively. Charges for routine newborn care will be covered under the mother's claim if she is covered under the Plan. For a newborn child to receive this benefit, the child must be enrolled in the Plan within 31 days after birth.

19. Screening and counseling services to aid in weight reduction due to **obesity**. Coverage includes:

    a. Preventive counseling visits and/or risk factors reduction intervention;

    b. Nutritional counseling; and

    c. Healthy diet counseling visits provided in connection with Hyperlipidemia (high cholesterol) and other known risk factors for cardiovascular and diet-related chronic disease.

20. **Occupational therapy** performed by a licensed occupational therapist and ordered by a Physician, including habilitative and rehabilitative therapy that is Medically Necessary due to an Illness or Injury or due to surgery for an Illness or Injury. Rehabilitative therapy must be to restore or rehabilitate due to an Illness or Injury or due to surgery for an Illness or Injury. Habilitative therapy is covered only for the treatment of autism spectrum disorders. Any therapy must be considered progressive therapy, not maintenance therapy, and must not be performed for the purpose of vocational rehabilitation. Covered expenses do not include either recreational programs or supplies used in Occupational Therapy.

21. Covered medical expenses Incurred for care and treatment due to an **organ transplant** are subject to the following:

    a. The recipient must be a Participant in the Plan;

    b. Covered organ transplants are limited to transplants of the kidney, cornea, bone marrow and/or stem cell, heart, heart/lung, liver, lung, and pancreas or other organ transplant

approved by the FDA that is not Experimental or Investigational. Bone marrow and/or stem cell transplants are considered organ transplants for the purposes of this Plan;

c. Charges for obtaining donor organs are covered under the Plan when the recipient is a Participant and the charges are not covered under another plan. Donor charges include those for:

   i. evaluating the organ;

   ii. removing the organ from the donor; and

   iii. transportation of the organ to the place where the transplant is to be performed.

d. Except as provided under (c) above, organ procurement does not include donor-related expenses while the Participant is awaiting the transplant, unless the donor is covered under this Plan.

Prior to undergoing the procedures, the Participant who is the recipient of the transplant must receive two opinions with regard to the need for transplant surgery. Each opinion must be in writing by a board-certified specialist in the involved field of surgery. The specialist must certify that alternative procedures, services, or course of treatment would not be effective in the treatment of the Participant's condition.

22. The initial purchase, fitting and repair of an **orthotic appliance** such as a brace, splint or other appliance required for support of a malfunctioning or deformed limb as a result of Injury, Illness or a disabling congenital condition. The Plan will cover subsequent repair, modification or replacement of the appliance only if the attending Physician certifies in writing that it is Medically Necessary due to:

    a. a physical change in the condition of the patient's site of attachment;

    b. the normal, physical growth of a dependent child; or

    c. the fact that the existing orthosis is unusable and cannot be repaired or modified to achieve proper fit and function.

    This benefit does not include the following: corrective or orthopedic shoes, arch supports or other similar, corrective foot devices or appliances.

23. **Outpatient Surgery** charges for necessary services and supplies for surgical procedures performed on an Outpatient basis at a Hospital, ambulatory surgical facility, or Physician's office, provided that benefits for such charges would be payable if the procedure were performed during a Hospital confinement.

24. **Physician's** fees for medical care and treatment of an Illness or Injury covered under the terms of this Plan. Services provided by MDLIVE include general health care and pediatric

care information for a Participant's condition. Services are provided by doctors and pediatricians through online video over the internet, over the phone, or through secure email. MDLIVE can be used in the following circumstances:

a. When the Participant is considering using the emergency room or urgent care facility for non-emergency use;

b. The primary care doctor is not available;

c. Traveling and in need of medical care;

d. During or after normal business hours, night, weekends and holidays; or

e. To request prescriptions or get refills. MDLIVE doctors provide prescriptions only if they deem it is necessary and MDLIVE does not prescribe DEA medications.

25. **Physical therapy** by a licensed physical therapist, including habilitative and rehabilitative therapy that is Medically Necessary due to an Illness or Injury or due to surgery for an Illness or Injury. Rehabilitative therapy must be to restore or rehabilitate due to an Illness or Injury or due to surgery for an Illness or Injury. Habilitative therapy is covered only for the treatment of autism spectrum disorders.

26. **Preadmission testing** ordered by a Physician, done on an Outpatient basis and related to the condition for which the patient is to be hospitalized. These tests must be performed at a Hospital, ambulatory surgical facility, or Physician's office prior to confinement as an Inpatient. No benefits will be payable if the same tests are repeated after Hospital admission, unless Medically Necessary.

27. **Pregnancy** expenses. Under the Newborns' and Mothers' Health Protection Act of 1996, group health plans and health insurance issuers generally may not 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).

28. **Prescription drugs** necessary for the treatment of an Illness or Injury, if obtainable only on a Physician's written prescription and dispensed by a licensed pharmacist (see Prescription Drug Benefits section).

29. **Preventive** care services, as listed in the Schedule of Medical Benefits. This benefit also includes breast pump supplies and rental of breast pumps for female Participants during breastfeeding. Breast pumps may be purchased if, in the judgment of the Plan Administrator,

purchase would be less expensive than rental or a breast pump is not available for rental; if purchased, the Plan will cover replacement only once per Calendar Year.

30. **Private duty nursing** care done only on an Inpatient basis if prescribed by a Physician as Medically Necessary and if performed by a registered Nurse or a licensed practical Nurse.

31. Replacement of a natural eye or limb with an artificial one (**prosthesis**), and subsequent repair, modification or replacement if it is Medically Necessary. Subsequent replacement is covered only if the attending Physician certifies in writing that such replacement is Medically Necessary due to:

    a. a physical change in the condition of the patient's site of attachment;

    b. the normal, physical growth of a dependent child; or

    c. the fact that the existing prosthesis is unusable and cannot be repaired or modified to achieve proper fit and function.

32. **Radiological tests** (X-rays), radium treatments, and treatments with other radioactive substances.

33. **Reconstructive surgery** of the breast on which a **mastectomy** was performed, surgery and reconstruction of the other breast to produce a symmetrical appearance, and prostheses and physical complications from all stages of a mastectomy, including lymphedemas, in a manner determined in consultation with the attending Physician and the Participant. Reimbursement will be made according to the Schedule of Medical Benefits section by type of service.

34. **Rehabilitation Hospital** charges, provided all the following conditions are met:

    a. The Participant has a physical disability, and his or her medical condition and functional performance can realistically be improved through the intensive rehabilitation program offered by the Hospital;

    b. Other treatment programs offering less intensive care or Outpatient treatment would not achieve the realistic goals sought by the Participant through the Hospital's rehabilitation program; and

    c. The Participant requires close medical care by a Physician and 24-hour-a-day nursing supervision.

    The Utilization Management company should be notified of the intended stay.

35. **Second Surgical Opinion** charges to confirm that recommended surgery is needed. The Physician who provides the second opinion must be board-certified for the medical condition for which surgery is advised. He must not be scheduled to perform the surgery or be in partnership with or have any financial affiliation with the first Physician in order for the surgical opinion benefit to be paid. If the second Physician disagrees with the first Physician, the Plan will cover a third surgical opinion.

36. Treatment of **sleep disorders**. Sleep studies are covered when the Participant shows clinical signs and symptoms for obstructive sleep apnea, according to a Physician. The PSG test (Type I) is covered only if performed in a certified sleep lab facility. Home sleep study monitors (Type II, III, and IV) are covered only if the Participant shows clinical signs and symptoms for obstructive sleep apnea, according to a Physician.

37. **Speech therapy** by a qualified speech therapist, including habilitative and rehabilitative therapy that is Medically Necessary due to an Illness or Injury or due to surgery for an Illness or Injury. Rehabilitative therapy must be to restore or rehabilitate speech loss due to an Illness or Injury or due to surgery for an Illness or Injury. If speech loss is due to a congenital anomaly, surgery to correct the anomaly must have been performed prior to therapy. Habilitative therapy is covered only for the treatment of autism spectrum disorders.

38. Elective surgery for **sterilization**, including tubal ligation, female sterilization by any other FDA-approved method, and vasectomy.

39. Treatment of **Substance Abuse**.

40. Medical **supplies** that are Medically Necessary for treatment, including, but not limited to, an electronic heart pacemaker, surgical dressings, casts, splints, and crutches.

41. **Surgeon's** fees for the performance of surgical procedures, including necessary related postoperative care by a Physician, subject to the Maximum Allowable Charge. Charges for **multiple surgical procedures** are subject to the following provisions:

    a. If bilateral or multiple surgical procedures are performed by one surgeon, benefits will be determined based on the Maximum Allowable Charge that is allowed for the primary procedures; 50% of the Maximum 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 or more surgeons on separate operative fields, benefits will be based on the Maximum Allowable Charge for each surgeon's primary procedure. If two or more surgeons perform a procedure that is

normally performed by one surgeon, benefits for all surgeons will not exceed the Maximum 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 primary surgeon's allowance.

42. Treatment of **Temporomandibular Joint syndrome**, whether surgical or nonsurgical.

43. **Wig** after chemotherapy.

UTILIZATION MANAGEMENT

Utilization Management Company Phone Number
Please refer to the employee ID card for the Utilization Management company's phone number.

The Participant or family member must call this number to receive certification of certain cost management services. This call must be made at least 2 days in advance of services being rendered, or within 48 hours or on the first business day after an Emergency.

Failure to precertify required medical services will result in the application of the Utilization Management Penalty, if any, shown in the Schedule of Medical Benefits.

Any reduced reimbursement due to failure to follow cost management procedures will not accrue toward the maximum out-of-pocket amount.

Utilization Management
Utilization Management ("UM") is a program designed to help ensure that all Participants 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:

Inpatient Confinements
Organ Transplants

(b) Concurrent review, based on the admitting diagnosis, of the listed services requested by the attending Physician;

(c) Certification of services and planning for discharge from a medical care facility or cessation of medical treatment; and

(d) Retrospective review of the Medical Necessity when precertification or concurrent review/discharge planning has not been secured.

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 the Plan will not consider that course of treatment as appropriate for the maximum reimbursement under the Plan.

The Utilization Management company's staff cannot and does not verify benefits or eligibility. The Utilization Management company's staff cannot and does not ensure that all plan requirements are met or will be met on the date services are rendered. The Utilization Management program's purpose is strictly the verification of Medical Necessity and the appropriateness of care.

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 your benefits, please read the following provisions carefully.

Here's how the program works.

Precertification
Before a Participant enters a medical care facility on a non-emergency basis, the Utilization Management administrator will, in conjunction with the attending Physician, certify the care as appropriate for Plan reimbursement. A non-emergency stay in a medical care facility is one that can be scheduled in advance.

The Utilization Management program is set in motion by a telephone call from the Participant or the Participant's attending Physician. Contact the Utilization Management company at the telephone number on the Participant's ID card **at least 2 days before** services are scheduled to be rendered with the following information:

- The name of the Participant and relationship to the Covered Employee;
- The name, Social Security 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; and
- The diagnosis and/or type of surgery.

If there is an **Emergency** admission to the medical care facility, the Participant, Participant's family member, medical care facility or attending Physician must contact the Utilization Management company **within 48 hours** or on the first business day after the admission.

It is important to remember that, if a Participant needs medical care for a condition which could seriously jeopardize his or her life, there is no need to contact the Plan for prior approval. The Participant should obtain such care without delay.

The Utilization Management administrator will determine the number of days of medical care facility confinement authorized for Medical Necessity.

Precertification is designed to assist with your hospital stay, not to determine which benefits will be payable. To find out which benefits are payable, please refer to the appropriate sections of this Summary Plan Description.

Under the Newborns' and Mothers' Health Protection Act of 1996, 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 following a vaginal delivery, or 96 hours following a cesarean section. Notification is still encouraged at the time of admission, and is **required** for any Hospital stay that is in excess of the minimum length of stay. Failure to notify the Utilization Management company of any stay that is in excess of the minimum length of stay will result in application of the penalty shown in the Schedule of Medical Benefits to the Hospital expenses for the excess days not certified.

Concurrent Review, Discharge Planning

Concurrent review of a course of treatment and discharge planning from a medical care facility are parts of the Utilization Management program. The Utilization Management administrator will monitor the Participant's medical care facility stay or use of other medical services and coordinate with the attending Physician, medical care facilities and Participant 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 Participant 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.

Case Management

Case Management is a program whereby a Case Manager monitors Participants and explores, discusses and recommends coordinated and/or alternate types of appropriate Medically Necessary care. The Case Manager consults with the Participant, the family and the attending Physician in order to develop a plan of care for approval by the Participant's attending Physician and the Participant. This plan of care may include some or all of the following:

- personal support to the Participant;
- contacting the family to offer assistance and support;

- monitoring Hospital or Skilled Nursing Facility;
- determining alternative care options; or
- 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 will consider care outside its normal benefit limitations if the use of an alternative treatment plan results in savings for the Plan and is endorsed by the Participant. The objective of this service is to direct the Participant toward the most appropriate care in a cost-effective environment. The Plan Administrator, attending Physician, Participant and, in some circumstances, the Participant's family must all agree to the alternate treatment plan.

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

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

Retrospective Review for Medical Necessity

When precertification for the services listed earlier in this section or continued stay review/discharge planning has not been secured, the Utilization Management company may elect to use Retrospective Review for Medical Necessity. Retrospective Review for Medical Necessity is the process by which the Utilization Management company uses the established medical criteria to evaluate and determine Medical Necessity and appropriateness of the care or treatment plan retrospectively for services requiring precertification or for continued stay reviews/discharge plans which were not reviewed prior to services being rendered. Any penalty assessed due to non-precertification still applies.

PRESCRIPTION DRUG BENEFITS

Using Your Prescription Drug Benefits

As a Participant in the Plan, you will receive an ID card that allows you to purchase prescription drugs through the Pharmacy Benefits Manager's pharmacy network. If you present this card to a network retail pharmacy when buying prescription drugs covered by the Plan or purchase eligible prescription drugs through the network mail-order pharmacy, you will be charged as shown in the Schedule of Prescription Drug Benefits.

A current list of network pharmacies is available, without charge, through www.myGilsbar.com. If you do not have access to a computer at your home, you may access this website at your place of employment. If you have any questions about how to do this, please contact your Employer. If you do not have your prescription drug card with you when buying eligible prescription drugs from a network pharmacy or if you purchase prescription drugs from a non-network retail pharmacy, you must pay the full price of the prescription drug and submit a claim form to the pharmacy benefits manager for reimbursement. These expenses are reimbursable only by the pharmacy benefits manager. Claim forms may be obtained from your Personnel or Human Resources Department. Any claim submitted to Gilsbar, L.L.C. for these expenses will be returned to you for reimbursement by the pharmacy benefits manager.

Outpatient prescription drugs purchased from a Non-Network mail order pharmacy are not covered under the Plan.

Covered Prescription Drug Expenses

Drugs and medicines are eligible for coverage only if they are used to treat an Illness or Injury of a Participant in the Plan and can be obtained from a licensed pharmacist with a written or electronic prescription from a Physician and do not exceed the Maximum Allowable Charge. They are limited to the following:

1. Prescription drugs, including, but not limited to, pre-natal vitamins and vitamins with fluoride;

2. Injectable insulin, including insulin syringes and needles, and diabetic supplies furnished on written prescription of a Physician.

Covered expenses may not exceed a 30-day supply when you purchase prescription drugs from a retail pharmacy, or a 90-day supply when you are purchasing a maintenance drug through the mail-order program. The amount may not be more than the amount normally prescribed by your Physician.

An expense will be considered to be Incurred, for purposes of this benefit, at the time the drug or medication is received from the pharmacist.

Exclusions and Limitations

Charges for the following are excluded from the Prescription Drug Benefits unless required by federal law, specifically covered by the Plan, or otherwise noted below:

1. **Administration**: Any charge for the administration or injection of any drug or medication.

2. **Anorexiants** or any drug or medication used as an appetite suppressant.

3. **Blood** or blood plasma.

4. **Compounded drugs** and medications.

5. **Consumed on site**: Any drug or medication which is consumed or administered at the place where it is dispensed.

6. **Contraceptives** or contraceptive devices of any kind, except as recommended by the Affordable Care Act or as specifically covered by this Plan.

7. **Cosmetic purposes**: Drugs used for cosmetic purposes, such as hair growth stimulants or growth hormones; also, Retin-A for a Participant over age 25.

8. **Devices** of any type, even though they may require a prescription order (including but not limited to therapeutic devices, artificial appliances, support garments and other similar devices, regardless of their intended use).

9. **Diagnostic** agents.

10. **Experimental/investigational**: Drugs labeled: "Caution–limited by federal law to investigational use," or experimental drugs even though a charge is made to the Participant.

11. **FDA**: Any drug that is not approved by the FDA or that is prescribed for non-FDA-approved uses.

12. **Immunization** agents or biological sera, except for immunizations covered by the Plan that are recommended by the Affordable Care Act.

13. **Impotence**: Drugs for erectile dysfunction or organic impotence.

14. **Infertility**: Any drug or medication related to or used in the treatment of infertility.

15. **Injectables** & supplies: A charge for hypodermic syringes and/or needles, injectable medications or any prescription directing administration by injection for any medication or

treatment other than insulin, preventive immunizations, female contraceptives as recommended by the Affordable Care Act, or as specifically covered under the Specialty Drug benefit or otherwise herein.

16. **Inpatient medication**: Any drug or medication which is to be taken by or administered to the Participant, in whole or in part, while he is a patient in a Hospital, rest home, sanitarium, Skilled Nursing or Extended Care Facility, convalescent Hospital, nursing home or similar institution which operates on its premises a facility for dispensing pharmaceuticals.

17. **Medical exclusions**: Any drug or medication otherwise excluded by the medical portion of the Plan.

18. **No charge**: Any drug or medication which may be properly received without charge under any local, state or federal program, including Worker's Compensation.

19. **No prescription**: Any drug or medication lawfully obtainable without a prescription order of a Physician, except insulin.

20. **Refills**: Filling or refilling of a prescription in excess of the number prescribed by the Physician, or the filling or refilling of a prescription after one year from the order of the Physician.

21. **Vitamins**, except pre-natal vitamins and vitamins with fluoride that require a prescription.

WELLNESS PROGRAM BENEFITS

University of the Incarnate Word believes that our most valuable asset is our employees. To that end, we have put together a comprehensive wellness program designed to help you reach your healthy goals. This section outlines the details of the program and how you can earn points and rewards and become your best self.

Definitions

The capitalized words in this section have the following meanings:

Dependent: A married or unmarried child up to age 26; and, an unmarried, incapacitated child who (1) is age 26 or over; (2) is not able to support himself; and (3) depends on you for support, if the incapacity occurred before age 26. The child may be the Employee's natural child, stepchild, legally adopted child, child placed in the home in anticipation of adoption or, another child for whom the Employee has permanent legal custody.

In all cases, the child must also qualify as your dependent for purposes of Sections 105 and 106 of the Internal Revenue Code.

Eligible Employee: An Employee of the Employer who is eligible to participate in this Wellness Program.

Participant: An individual who is an Eligible Employee and who is participating in this Wellness Program. Participant, member, covered individual, and covered person have the same meaning.

Spouse: means an individual who is legally married to an Eligible Employee as determined under applicable state law (and who is treated as a spouse under the Code).

Wellness Program: The University of the Incarnate Word Wellness Program as set forth herein and as amended from time to time. Wellness Program and Plan have the same meaning.

Eligibility to Participate

An individual is an Eligible Employee and may participate in this Plan if the individual is employed by the Employer and is a Participant in the medical plan sponsored by the Employer.

Spouses are eligible to participate in the Wellness Program's events and activities, but Spouses do not receive any incentives for such participation.

Dependents are not eligible to participate in the Wellness Program's events and activities.

Enrollment When First Eligible

All Eligible Employees that meet the Plan's eligibility requirements as set forth above will become enrolled as Participants in this Plan on the same day they become eligible and can commence earning incentives. All Spouses become enrolled as Participants when they first participate in any wellness activity. Once enrolled, Participants will remain enrolled; however, the incentives and eligibility for the incentives may change periodically. Any changes will be communicated to all Participants.

Benefits Offered

When an Eligible Employee becomes a covered Participant, such Participant will be eligible to receive Benefits under any of the wellness benefit programs described below. Spouses may be able to participate in some of the benefits, however, only the Eligible Employee can earn points. See each section for specific participation limitations.

1. *Wellness Center*. The online Wellness Center provides a comprehensive, NCQA-certified suite of health and wellness resources. The Wellness Center is designed to help you work towards and gain better health in a positive, productive way. This highly flexible system provides you with the ability to efficiently manage your wellness goals and will provide you with a personalized health experience based on your specific risks and needs. The Wellness Center is your customized and personal online portal. It is full of helpful resources and tools, including nutritional and exercise trackers, healthy recipes, educational webinars, and much more. The Wellness Center is also the secure storehouse for all of your health reports, and you'll be able to access, save, and print your information at your convenience. Visit www.myGilsbar.com to help track your progress.

2. *Biometric Screening*. The following screenings are performed annually: Total Cholesterol, LDL, HDL, Triglycerides, Glucose, and cotinine testing. The biometric screening includes blood pressure, weight, Body Mass Index (BMI) and hip and waist measurements. You will receive immediate results along with immediate confidential consultation.

3. *Health Assessment*. This is a personalized assessment that provides a profile of your present health and a glimpse of where you might be heading. This assessment is used to provide you with an evaluation of your health risks and quality of life. It covers areas such as diet, exercise, smoking, and blood pressure. These results will empower you to better manage your personal health and will also serve as a tool for dialogue with your healthcare providers.

4. *Health Coaching*. Employees are able to call and speak with a health coach on topics such as stress management, weight management, life balance, ergonomics, and tobacco cessation. Call 866.284.5268 for telephonic coaching and to make an appointment.

5. *Wellness Newsletters*. Monthly educational newsletters.

6. *Online Workshops*. Online Workshops are available for education on diabetes prevention, exercise activity, healthy eating, heart disease prevention, smoking cessation, stress management and weight management. The goal of the workshops is to provide you with education and a personal plan to help you achieve health and wellness goals in one or more of these areas.

Rewards for Participating in the Wellness Program

The Employer shall have the option to provide rewards for participation in this program. A reward can relate to one or more of the Benefits. Any reward will be in the form and amount selected by the Employer. The form of the reward can include, but is not limited to, Employee contribution discounts to other Employer-sponsored group Employee benefit plans, reductions in a deductible or copayment under Employer-sponsored group Employee benefit plans, cash payments or Employer contributions to another arrangement (such as a health reimbursement arrangement or health flexible spending account sponsored by the Employer). The form and amount of any available reward shall be as set forth from time to time in the SPD or other communications to Participants. The Employer may take all necessary actions to address the taxation of a reward, including but not limited to treating the amounts as taxable income on reports and, to the extent consistent with other applicable laws or policies of University of the Incarnate Word, withholding amounts from an Employee's wages to pay for taxes owed by the Employee with respect to the rewards. The Employer may withhold or modify rewards, alter the requirements for obtaining a reward, and take whatever other steps it deems reasonably necessary to ensure that the rewards are provided in accordance with all applicable laws.

Earning Points and Redeeming Points for Rewards

Eligible Employees may earn up to 300 points by participating in wellness activities and events. Earn points August 15 through May 31. Points do not carry over from one year to the next.

1. *Earning points*: Participants will earn points by participating in various activities and challenges offered throughout the year. To get started, complete the required activities as listed in Eligibility and Enrollment. See the Wellness Activities grid below for ways to earn points.
2. *Redeeming points*: Employees may redeem points at the end of the Plan Year each year. Points may be redeemed for gift cards. Unused points are forfeited upon termination.

3. *Wellness Activities*

Activity	points
Biometric Screening (automatic) • Earn points just by completing the biometric screening.	100 points

Activity	points
Health Assessment (automatic) • Participation in the Health Assessment	100 points
Challenges (automatic)	25 points each / 50 points max
Completion of Online Workshops (automatic) • You can participate in one workshop at a time, and you will be awarded points upon completion.	15 points each
Telephonic Health Coaching (automatic) • Telephonic coaching connects you with a health coach to discuss stress management, weight management, life balance, ergonomics, and tobacco cessation. You may enroll at any time by calling (866) 284-5268 but are limited to one program at a time. Program length varies by health need.	50 points each
Online Exercise Steps Tracking (automatic) • Earn 1 points daily for utilization in the Wellness Center or the mobile app.	1 points daily / 60 points max
Non-Tobacco-Use Declaration (self-reported) • You can earn points for not using tobacco. Just make your tobacco-free declaration.	20 points annually
Tobacco Cessation Program (self-reported) • If you are not tobacco free, complete a tobacco cessation program in order to earn points.	50 points annually

GENERAL EXCLUSIONS AND LIMITATIONS

Note: Refer to the Prescription Drug Benefits section for additional exclusions and limitations specifically related to those expenses.

This section applies to all benefits provided under any section of this Summary Plan Description. This Plan excludes or limits coverage as described for the following, unless specifically covered by the Plan.

Charges for services, surgery, supplies or treatment for the following are not covered:

1. **Abortion**: Elective abortions unless the life of the mother is endangered by the continued pregnancy or the pregnancy is the result of rape or incest.

2. **Acupuncture/Acupressure**: Needle puncture or application of pressure at specific points, whether used to cure disease, to relieve pain or as a form of anesthesia for surgery.

3. **Administrative fees**, interest or penalties.

4. **Bariatric Surgery**: Unless mandated by federal legislation, a charge for bariatric surgery (including, but not limited to gastric bypass, intestinal bypass, lap band, Roux-en-Y gastroenterostomy, adjustable gastric restrictive procedure, sleeve gastrectomy, gastroplasty, liposuction, or similar surgeries, including the normal pre-surgery and post-surgery care related to those procedures) is excluded.

5. **Blood** and blood derivatives that are donated or replaced, including fees for administration.

6. **Claim filed late**: Charges for which the claim is received by the Plan after the maximum period allowed under this Plan for filing claims has expired.

7. **Claim form**: Completion of a claim form.

8. **Complications from non-covered services**: Charges that result from complications arising from a non-covered Illness or Injury, or from a non-covered procedure unless otherwise required by law.

9. **Contraceptive** substances or devices, except those recommended by the Affordable Care Act.

10. **Controlled substances**: Injury or Illness resulting from a Participant'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 Participants other

11. than the person using controlled substances and expenses will be covered for Substance Abuse treatment as specified in this Plan.

12. **Coordination of benefits**: Benefits available under the Plan that may be reduced or eliminated based upon the coordination of benefits or subrogation rules.

13. **Contraceptive** substances or devices.

14. **Cosmetic or Cosmetic Surgery**: Charges in connection with Cosmetic Surgery and other services and supplies that are for Cosmetic purposes are excluded unless they are:
    a. Incurred as a result of accidental Injury;
    b. For correction of a congenital anomaly; or
    c. For reconstruction of the breast on which a mastectomy was performed, or for surgery and reconstruction of the other breast to produce a symmetrical appearance, and prostheses and physical complications from all stages of a mastectomy, including lymphedemas, in a manner determined in consultation with the attending Physician and the Participant.

15. **Coverage not in force**: Charges incurred while coverage is not in force under the Plan.

16. **Custodial** care.

17. **Deductible**: Charges that are not payable due to the application of any specified deductible, copayment, or coinsurance provision of this Plan.

18. **Durable medical equipment**: Replacement of durable medical equipment within five years unless approved by the Plan Administrator.

19. **Education**, training, bed and board while confined to an institution that is primarily a school or other institution for training, or instruction in alternate life patterns, except for diabetes self-management training, listed in the Medical Benefits section. Additionally, Applied Behavior Analysis**,** LEAP, TEACCH, Denver and Rutgers programs are excluded.

20. **Electrical power**, water supply, sanitary waste disposal systems, saunas, hot tubs or swimming pools or their installation, or any similar expense associated with a residence.

21. **Equipment**: Air conditioners, dehumidifiers, air purifiers, heating pads, hot water bottles, home enema equipment, rubber gloves and any equipment or supplies not Medically Necessary.

22. **Excess of Maximum Allowable Charge**: The portion of any charge for any services or supplies that are in excess of the Maximum Allowable Charge, as determined by the Plan Administrator, is excluded.

23. **Experimental or Investigational**: Treatment, services, equipment, new technology, drugs, procedures or supplies considered Experimental or Investigational at the time the procedure is performed or service or supply is provided.

24. **Family member**: Services or supplies provided by a member of the Participant's immediate family or by an individual residing in the Participant's home.

25. **Fertilization**: Any means of artificial fertilization, including but not limited to artificial insemination, in-vitro fertilization or gamete intra-fallopian transfer. Services of a surrogate mother are also excluded.

26. **Foot Conditions**: Physicians' services in connection with corns, calluses or toenails are excluded, unless the charges are for the partial or complete removal of the nail roots.

    Charges for corrective or orthopedic shoes, arch supports or other corrective devices or appliances are excluded.

27. **Foreign Travel**: Care, treatment or supplies out of the U.S. if travel is for the purpose of obtaining medical services.

28. **Genetic testing** or treatment, unless the results are specifically required for a medical treatment decision on the member.

29. **Government Plan**: Services or supplies furnished by or on behalf of the United States Government or any other government are excluded unless, as to such other government, payment of the charge is legally required.

    Services or supplies are excluded to the extent benefits for them are provided by any law or governmental program under which the Participant is or could be covered, unless payment of the charge is legally required.

30. **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, except for wigs after chemotherapy.

31. **Hearing Aids**: Examinations to determine the need for, or the proper adjustments of, hearing aids are excluded. Also, the purchase of hearing aids is excluded.

32. **Hypnosis** (except where used in lieu of anesthesia), biofeedback, somnambular or environmental therapy.

33. **Infertility**: All specific treatments to correct infertility.

34. **Injury Due to Act of War**: Any Illness or Injury due to war, declared or undeclared, or any act of war is excluded.

35. **Marriage** counseling.

36. **Medicare**: Benefits available under the Plan that may be reduced or eliminated based upon the coordination of benefits with Medicare when Medicare is the primary payor. This limitation may apply to Participants aged 65 or older, and is subject to federal regulation.

37. **Mouth and Teeth Conditions**: Medical Benefits for mouth conditions due to periodontal or periapical disease, or involving any of the teeth, their surrounding tissue or structure or the alveolar process are excluded unless the charges are for the following:
    a. Treatment or removal of malignant or benign tumors or surgical removal of impacted wisdom teeth;
    b. Treatment of an accidental Injury to a Sound, Natural Tooth, or for the setting of a jaw fracture or dislocation if the treatment begins within three months of the Accident; or
    c. Hospital services, supplies and anesthesia for oral surgical procedures for which a doctor (M.D., D.O. or D.D.S.) provides satisfactory certification to the Plan Administrator that hospitalization is Medically Necessary.

38. **Newborn care**: Hospital care or Physician care of a newborn prior to discharge from Hospital, except in cases of Illness or as specifically listed for coverage under this Plan.

39. **Not legally required to pay**: Any item for which the Participant is not legally required to pay, or for which a charge would not have been made if the Participant did not have this coverage.

40. **Not listed**: Any items not listed in the Covered Medical Expenses subsection.

41. **Not necessary**: Diagnostic services or treatments performed in connection with research studies, pre-marital examinations or any examination not necessary for the diagnosis of an Illness or Injury, unless specifically listed and included for coverage under this Plan.

42. **Occupational Illness or Injury**: Any Illness or Injury arising out of, or in the course of, employment with the Participant's employer or self-employment, or Illness or Injury covered under the Worker's Compensation Law or any similar legislation, are excluded.

43. **Oral statements**: Charges which are Incurred based upon oral statements made by anyone involved in the administration of the Plan that are in conflict with the benefits described in this Summary Plan Description.

44. **Organ transplants**: Organ transplants other than those specified as covered under the Plan; or organ transplants that are Experimental or Investigational or which are not approved by the FDA; and

    Donor-related health care services and supplies, except as otherwise specifically listed and included for coverage under the Plan or unless the donor is a covered Participant under the Plan.

45. **Outpatient Well Baby or Well Child Care**: Routine well baby or well child care is excluded except as otherwise specifically listed and included for coverage under this Plan.

46. **Personal** or convenience items.

47. **Physical Fitness**: programs, services, or equipment related to physical conditioning or weight loss (including but not limited to, surgical procedures, medical treatments, weight control/loss programs, dietary regimens and supplements, appetite suppressants and other medications, food or food supplements, exercise programs, or exercise-related equipment, and other services and supplies that are primarily intended to control weight, or for the purpose of weight reduction) are excluded, regardless of whether the above would also treat any other Injury or Illness. This exclusion does not apply to any coverage provided under Obesity listed in the Medical Benefits section.

48. **Prior to or after coverage**: Services or supplies that were rendered or received prior to or after any period of coverage under this Plan, except as specifically provided in this Summary Plan Description.

49. **Prison**: Charges for services received while confined in a prison, jail or other penal institution.

50. **Radioactive contamination**: An Injury or Illness caused as a result of radioactive contamination.

51. **Room and board** for any other room at the same time the patient is being charged for use of a special care unit.

52. **Routine or Preventive Care**: Routine or preventive care is excluded except as otherwise specifically listed and included for coverage under this Plan.

53. **Sales tax** on prescription drugs or on any other covered items.

54. **Scheduled visit**: Failure to keep a scheduled medical visit.

55. **Sexual dysfunctions**, impotence, penile implants, sex transformations, gender dysphoria or inadequacies, and sex therapy.

56. **Sterilization reversal**: Reversal of previous sterilization treatments or surgeries.

57. **Telephone** conversations with a Physician when care and treatment are not rendered. This exclusion does not apply to telehealth services performed in lieu of a physical visit with a Physician.

58. **Travel expenses**, even if prescribed by a Physician.

59. **Unnecessary Services or Supplies**: Any services or supplies not Medically Necessary for the care of the Participant's Illness or Injury are excluded. Charges made by a Hospital to the extent that they are allocated to scholastic education or vocational training of the patient are also excluded. The Plan Administrator determines whether a service, treatment or supply is Medically Necessary.

60. **VAX-D therapy**.

61. **Violation of law**: The sale, use or administration of any supplies, services or treatment, which is in violation of the law, regardless of whether it would otherwise be an eligible expense under the Plan.

62. **Vision Care**: Medical benefits for Physicians' services in connection with eye refractions or any other examinations to determine the need for, or the proper adjustment of, eyeglasses or contact lenses are excluded, unless for the initial examination following cataract surgery. The charges for eyeglasses or contact lenses are excluded, unless for the initial set following cataract surgery. Radial keratotomy, LASIK, and any surgical procedures to improve refractive errors such as nearsightedness, etc., are also excluded. This exclusion does not apply to any services otherwise covered under vision benefits, if any.

63. **Vision therapy** (nonsurgical treatment to the eye muscles).

64. **Vitamins** (except pre-natal vitamins prescribed by a Physician), minerals, nutritional food supplements, or any over-the-counter items, whether or not prescribed by a Physician, unless specifically covered herein.

65. **Weekend Admissions**: If admitted to the Hospital on a Friday, Saturday or Sunday, charges for these days will be excluded unless admitted due to an Emergency or if surgery is performed within 24 hours of admission.

With respect to any Injury which is otherwise covered by the Plan, the Plan will not deny benefits provided for treatment of the Injury if the Injury results from an act of domestic violence or a medical condition (including both physical and mental health conditions).

WHEN YOU HAVE A CLAIM

Before submitting a claim, review this Summary Plan Description and the bills you have accumulated. Be sure you are submitting itemized bills for which benefits are payable.

The Benefit Services Manager may periodically request a General Information Verification Form to verify continued eligibility for benefits. If you need a General Information Verification Form, you may download one from the Gilsbar web site at www.myGilsbar.com or you may notify your Personnel or Human Resources Department.

If you or a Covered Dependent has to go to the Hospital, get duplicate Medical/Dental Family Claim Forms from your Personnel Department or Gilsbar's web site in advance. Sign the forms and send them to the Benefit Services Manager at the address listed on your ID card.

Keep a separate running record of expenses for yourself and each Covered Dependent.

Save all bills, including those being accumulated to satisfy a deductible. In most instances, they will serve as evidence of your claim.

Submit the original bill, not a copy. Each bill must be complete and itemized and should show the Participant's full name, date or dates the service was rendered or purchase was made, nature of the Illness or Injury, and type of service or supply furnished. Drug store cash register receipts or labels from containers are not sufficient proof of a claim.

Attach all itemized bills to the fully completed claim form and send all claims Incurred to the name and address shown on your ID card.

All claims, including those first mailed to the Preferred Provider Organization, must be received by Gilsbar, L.L.C. no later than 365 days after the date the expense is Incurred. A claim received after this deadline will be covered only if the Plan Administrator, or Benefit Services Manager acting on the instructions of the Plan Administrator, finds that there was a reasonable cause for the delay. Contact Gilsbar, L.L.C. to be sure the Claims Department has received all submitted claims.

CLAIMS PAYMENT AND APPEALS

Assignments

The Plan Administrator may revoke an Assignment of Benefits at its discretion and treat the Participant as the sole beneficiary. Benefits for medical expenses covered under this Plan may be assigned by a Participant to the provider as consideration in full for services rendered; however, if those benefits are paid directly to the Participant, the Plan will be deemed to have fulfilled its obligations with respect to such benefits. The Plan will not be responsible for determining whether any such assignment is valid. Payment of benefits which have been assigned may be made directly to the assignee unless a written request not to honor the assignment, signed by the Participant, has been received before the proof of loss is submitted, or the Plan Administrator – at its discretion – revokes the assignment.

No Participant shall at any time, either during the time in which he or she is a Participant in the Plan, or following his or her termination as a Participant, in any manner, have any right to assign his or her right to sue to recover benefits under the Plan, to enforce rights due under the Plan or to any other causes of action which he or she may have against the Plan or its fiduciaries.

A medical provider which accepts an Assignment of Benefits, in accordance with this Plan, does so as consideration in full for services rendered and is bound by the rules and provisions set forth within the terms of this document.

Claims Procedure

A description of the Plan's process for handling claims and appeals for health benefits follows. The times listed are maximum times only. A period of time begins at the time the claim is filed in accordance with the Plan's procedures, which are described below. "Days" means calendar days.

There are three types of health claims under this Plan and each has a specific timetable for approvals or denials: Pre-service Claim, Concurrent Claim, and Post-service Claim. The definitions and procedures for the three types of health claims are:

Pre-service Claim – a claim for a benefit under the Plan where prior approval for any part of the benefit is a condition to receiving the benefit. If a Participant makes a request for information on a charge or benefit (or a request for a determination of Medical Necessity) for which prior approval is not required by the Plan, that informational request or determination is not a pre-service claim. If a Participant needs medical care for a condition which could seriously jeopardize his or her life, health or ability to regain maximum function or which would subject him to severe pain that cannot be adequately managed without care or treatment, there is no need to seek or obtain approval in advance of obtaining medical care. The Participant should obtain such care without delay and contact the Utilization Management (UM) organization within 48 hours, or on the first business day following a Hospital admission.

Concurrent Claim – a claim that arises when the Plan has approved the Medical Necessity of an on-going course of treatment to be provided over a period of time or number of treatments, and either:

1. the Plan determines that the course of treatment should be reduced or terminated, or
2. the Participant requests extension of the course of treatment beyond that which was approved.

Remember, if the Plan does not require approval, then there is no need to contact the UM organization to request an extension of that treatment.

Pre-service and Concurrent Claims are deemed to be filed with the Plan when the request for approval is made and received by the UM organization or Benefit Services Manager in accordance with the Plan's procedures.

Post-service Claim – a request for a Plan benefit or benefits that is a request for payment under the Plan for covered medical services already received by the Participant.

A Post-service Claim is deemed to be filed with the Plan on the date it is received by the Benefit Services Manager, containing the following information:

1. A properly completed Form HCFA or Form UB92 or successor forms, or an Electronic Data Interchange (EDI) file or other standard billing format;
2. The date of service;
3. The name, address, telephone number and tax identification number of the provider of the services or supplies;
4. The place where the services were rendered;
5. The diagnosis and procedure codes;
6. The amount of charges and repricing information;
7. The name of the Plan;
8. The name of the Covered Employee;
9. The name of the patient; and
10. Any Physician's notes, accident details, employment status, coordination of benefits information, or other information needed to adjudicate the claim.

When the information referenced above is provided, the claim is considered a "Clean Claim". The Plan will determine if enough information has been submitted to enable proper consideration of the claim. If the claim is not a Clean Claim, the Plan may deny the claim or may take an extension of time in order to request additional information. This additional information must be received by the Benefit Services Manager within 45 days from the date the Participant or the authorized representative

receives the request. **Failure to respond within this time period may result in claims being denied or reduced.**

"Adverse Benefit Determination" is defined as a denial, reduction, or termination of, or a failure to provide or make payment (in whole or in part) for a benefit. It includes any reduction or failure to make payment resulting from the application of any utilization review, the application of any Plan exclusions, and the failure to cover an item or service for which benefits are otherwise provided because it is determined to be Experimental or Investigational or not Medically Necessary.

Timing of Notice of Benefit Determinations:
Pre-service Claim:

1. If the Participant has provided all the information needed to determine the Medical Necessity of the treatment, the Plan will notify the Participant of a benefit determination in a reasonable period of time appropriate to the medical circumstances, but not later than 15 days after receipt of the claim, unless an extension has been requested, then prior to the end of the 15-day extension period.

2. If the Participant has not provided all the information needed to determine the Medical Necessity of the treatment, the Participant may be notified as to what specific information is needed as soon as possible, but not later than 15 days after receipt of the claim. The Participant will be notified of a determination of benefits in a reasonable period of time appropriate to the medical circumstances, either prior to the end of the extension period (if additional information was requested during the initial processing period), or by the date agreed to by the Plan and the Participant (if additional information was requested during the extension period).

3. If the Participant has failed to follow the Plan's procedures for filing a Pre-service Claim, the Participant will be notified of the failure and the proper procedures to be followed as soon as possible, but not later than 5 days following the failure.

4. Extensions. This period may be extended by the Plan for up to 15 days, provided that the Plan Administrator both determines that such an extension is necessary due to matters beyond the control of the Plan and notifies the Participant, prior to the expiration of the initial 15-day processing period, of the circumstances requiring the extension of time and the date by which the Plan expects to render a decision.

Concurrent Claim:

1. Plan Notice of Reduction or Termination. If the Plan Administrator is notifying the Participant of a reduction or termination of a course of treatment (other than by Plan amendment or

termination), it will do so before the end of such period of time or number of treatments. The Participant will be notified sufficiently in advance of the reduction or termination to allow the Participant to appeal and obtain a determination on review of that Adverse Benefit Determination before the benefit is reduced or terminated.

2. Request by Participant for Extension of Treatment. If the Plan Administrator receives a request from the Participant to extend the course of treatment beyond the period of time or number of treatments, the request will be treated as a new Pre-service Claim or Post-service Claim and decided within the timeframe appropriate to that type of claim.

Post-service Claim:

1. If the Participant has provided all the information needed to process the claim, the Plan will notify the Participant of an Adverse Benefit Determination in a reasonable period of time, but not later than 30 days after receipt of the claim, unless an extension has been requested, then prior to the end of the 15-day extension period.

2. If the Participant has not provided all the information needed to process the claim and additional information is requested during the initial processing period, the Participant may be notified of an Adverse Benefit Determination prior to the end of the extension period, unless additional information is requested during the extension period; then, the Participant will be notified of the determination by a date agreed to by the Plan Administrator and the Participant.

3. Extensions. This period may be extended by the Plan for up to 15 days, provided that the Plan Administrator both determines that such an extension is necessary due to matters beyond the control of the Plan and notifies the Participant, prior to the expiration of the initial 30-day processing period, of the circumstances requiring the extension of time and the date by which the Plan expects to render a decision.

Form of Notice to Participant of Adverse Benefit Determinations

Once the claim has been decided, the Plan Administrator will provide written or electronic notification of any Adverse Benefit Determination. The notice will state:

1. The reason or reasons for the Adverse Benefit Determination;
2. Reference to the Plan provisions on which the determination was based;
3. A description of any additional material or information necessary for the Participant to perfect the claim and an explanation of why such material or information is necessary;
4. A description of the Plan's appeal procedures, incorporating any voluntary appeal procedures offered by the Plan and the time limits applicable to such procedures. This will include a statement of the Participant's right to bring a civil action following a denial of the appeal;

5. A statement that the Participant is entitled to request the diagnostic and treatment codes used and their meaning;
6. A statement that any rule, guideline, protocol, or criterion that was relied upon in making the Adverse Benefit determination will be provided free of charge to the Participant upon request;
7. If the denial is based on Medical Necessity, Experimental/Investigational Treatment or a similar exclusion or limit, either an explanation of the scientific or clinical judgment for the determination or a statement that such explanation will be provided free of charge upon request.

Procedure for Internal Appeals

When a Participant receives an Adverse Benefit Determination, the Participant has the right to a full and fair review of the claim and Adverse Benefit Determination. More specifically, the Participant has 180 days following receipt of the notification in which to appeal the decision. The Participant must submit a written request for appeal to the Benefit Services Manager, including any written comments, documents, records, and other information relating to the claim. If the Participant so requests, he or she will be provided, free of charge, reasonable access to, and copies of, all documents, records, and other information relevant to the claim that is in the possession of the Plan Administrator or the Benefit Services Manager.

A document, record, or other information will 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. Demonstrates 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 Participants; or
4. Constitutes a statement of policy or guidance with respect to the Plan concerning the denied treatment option or benefit for the individual's diagnosis, without regard to whether such advice or statement was relied upon in making the benefit determination.

The period of time within which a benefit determination on review is required to be made shall begin at the time an appeal is deemed to be filed in accordance with the procedures of the Plan, which are described in this section. It is the Participant's responsibility to submit proof that the claim for benefits is covered and payable under the Plan's provisions. Any appeal must include the following:

1. The name of the Covered Employee/Participant;
2. The Covered Employee's/Participant's Social Security number or Participant ID number (PID);

3. The group name or identification number;
4. All facts and theories supporting the claim for benefits, whether or not presented or available at the initial benefit decision. **Failure to include any theories or facts in the appeal will result in their being deemed waived. In other words, the Participant will lose the right to raise factual arguments and theories which support this claim if the Participant fails to include them in the appeal;**
5. A statement in clear and concise terms of the reason or reasons for disagreement with the handling of the claim; and
6. Any material or information that the Participant has which indicates that the Participant is entitled to benefits under the Plan.

The review shall take into account all comments, documents, records, and other information submitted by the Participant relating to the claim, without regard to whether such information was submitted or considered in the initial benefit determination. The review will not rely on the initial Adverse Benefit Determination and will be conducted by an independent party who is neither the individual who made the Adverse Benefit 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 Benefit Services Manager will consult with a health care professional who was not involved in the original benefit determination or the subordinate of that individual. 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 upon request.

In the event of an Adverse Benefit Determination on review, the Participant will receive written or electronic notice of determination. The notice will meet the requirements as described above.

The Plan Administrator will notify the Participant of the Plan's benefit determination on review within the following timeframes:

Pre-service and Concurrent Claims: Within a reasonable period of time appropriate to the medical circumstances, but not later than 30 days after receipt of the appeal.

This Plan does not require prior approval for a Participant to receive urgent care; therefore, all urgent care claims will be handled as Concurrent or Post-service claims.

Post-service Claims: Within a reasonable period of time, but not later than 60 days after receipt of the appeal.

Responsibility for Deciding Claims and Appeals

The Plan Administrator shall be ultimately and finally responsible for adjudicating claims and for providing full and fair review of the decision on such claims in accordance with the provisions in this section. Benefits under the Plan will be paid only if the Plan Administrator decides in its discretion that the Participant is entitled to them. Processing claims in accordance with the Plan Document and Summary Plan Description may be delegated to Gilsbar, L.L.C.

Decision on Appeal to be Final

The decision by the Plan Administrator or other appropriate named fiduciary of the Plan on review will be final, binding and conclusive and will be afforded the maximum deference permitted by law.

No suit concerning the claim may be commenced until the appeal process set forth herein has been completed and the decision on the appeal has been rendered by the Plan Administrator. The Participant has one year from that time to file suit. Suit may not be brought after the one-year period has passed.

Summary of Claims Procedure Timetables

This chart of the timetables is included for your convenience only. Details concerning any applicable time limits are contained elsewhere in this section, and we recommend that you review this section and applicable subsections carefully for complete information regarding the timetables that apply to your claim.

Time Limits	Type of Claim			
	Pre-service	**Concurrent: To end or reduce treatment prematurely**	**Concurrent: To deny your request to extend treatment**	**Post-service**
You'll be notified of determination as soon as possible, but no later than…	15 days from receipt of claim	Notification to end or reduce will allow time to finalize appeal before end of treatment	Treated as any other Pre-service or Post-service claim	30 days from receipt of claim
Extension period allowed for circumstances beyond the Benefit Services Manager's control…	15 days	n/a	Treated as any other Pre-service or Post-service claim	15 days
If additional information is needed, you must provide it within…	45 days of date of extension notice	n/a	Treated as any other Pre-service or Post-service claim	45 days of date of extension notice

Time Limits	Type of Claim			
	Pre-service	Concurrent: To end or reduce treatment prematurely	Concurrent: To deny your request to extend treatment	Post-service
You must file your appeal within…	180 days of claim denial	Denial letter will specify filing limit	Treated as any other Pre-service or Post-service claim	180 days of claim denial
You'll be notified of the appeal decision as soon as possible but no later than…	30 days from receipt of appeal	15 days from receipt of appeal	Treated as any other Pre-service or Post-service claim	60 days from receipt of appeal

Appointment of Authorized Representative

A Participant is permitted to appoint an authorized representative to act on his or her behalf with respect to a benefit claim or appeal of a denial. An assignment of benefits by a Participant to a provider will not constitute appointment of that provider as an authorized representative. To appoint such a representative, the Participant must complete a form which can be obtained from Gilsbar, L.L.C. In the event a Participant designates an authorized representative, all future communications from the Plan will be with the representative, rather than the Participant, unless the Participant directs the Plan Administrator, in writing, to the contrary.

An Appointment of Authorized Representative Form may be obtained from www.myGilsbar.com or by calling the number below. Forms must be submitted to:

Gilsbar, L.L.C.
Attention: Claims Dept.
P.O. Box 998
Covington, LA 70433
Phone: 1-888-472-4352
Fax: 985-898-1529

Right of Recovery

Occasionally, benefits are paid more than once, are paid based upon improper billing or a misstatement in a proof of loss or enrollment information, or are not paid according to the Plan's terms, conditions, limitations or exclusions. Whenever the Plan pays benefits exceeding the amount of benefits payable under the terms of the Plan, the Plan Administrator has the right to recover any such erroneous payment directly from the person or entity who received such payment and/or from the covered person on whose behalf such payment was made.

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

The person or entity receiving an erroneous payment may not apply such payment to another expense. The Plan Administrator shall have the sole discretion to choose who will repay the Plan for an erroneous payment and whether such payment shall be reimbursed in a lump sum or deducted from future claims presented by the covered person for processing.

Providers and any other person or entity accepting payment from the Plan, in consideration of such payments, agree to be bound by the terms of this Plan and agree to submit claims for reimbursement in strict accordance with their state's health care practice acts, ICD-10 or CPT standards, Medicare guidelines, HCPCS standards, or other standards approved by the Plan Administrator or insurer. Any payments made on claims for reimbursement not in accordance with the above provisions shall be repaid to the Plan within 30 days of discovery or demand or incur prejudgment interest of 1.5% per month. If court action is necessary to recover any erroneous payment, the Plan shall be entitled to recover its litigation costs and actual attorneys' fees incurred.

Subrogation, Reimbursement, and Third Party Recovery Provision

Payment Condition

The Plan, in its sole discretion, may elect to conditionally advance payment of benefits in those situations where an Injury, Illness, disease or disability is caused in whole or in part by, or results from the acts or omissions of, Participants and/or their dependents, beneficiaries, estate, heirs, guardian, personal representative, or assigns (collectively referred to hereinafter in this section as "Participant(s)") or a third party, where any party besides the Plan may be responsible for expenses arising from an incident, and/or other funds are available, including but not limited to no-fault, uninsured motorist, underinsured motorist, medical payment provisions, third party assets, third party insurance, and/or guarantor(s) of a third party (collectively "Coverage").

Participant(s), his or her attorney, and/or legal guardian of a minor or incapacitated individual agrees that acceptance of the Plan's conditional payment of medical benefits is constructive notice of these provisions in their entirety and agrees to maintain 100% of the Plan's conditional payment of benefits or the full extent of payment from any one or combination of first and third party sources in trust, without disruption except for reimbursement to the Plan or the Plan's assignee. The Plan shall have an equitable lien on any funds received by the Participant(s) and/or their attorney from any source and said funds shall be held in trust until such time as the obligations under this provision are fully satisfied. The Participant(s) agrees to include the Plan's name as a co-payee on any and all settlement drafts. Further, by accepting benefits the Participant(s) understands that any recovery obtained

pursuant to this section is an asset of the Plan to the extent of the amount of benefits paid by the Plan and that the Participant shall be a trustee over those Plan assets.

In the event a Participant(s) settles, recovers, or is reimbursed by any Coverage, the Participant(s) agrees to reimburse the Plan for all benefits paid or that will be paid by the Plan on behalf of the Participant(s). When such a recovery does not include payment for future treatment, the Plan's right to reimbursement extends to all benefits paid or that will be paid by the Plan on behalf of the Participant(s) for charges Incurred up to the date such Coverage or third party is fully released from liability, including any such charges not yet submitted to the Plan. If the Participant(s) fails to reimburse the Plan out of any judgment or settlement received, the Participant(s) will be responsible for any and all expenses (fees and costs) associated with the Plan's attempt to recover such money. Nothing herein shall be construed as prohibiting the Plan from claiming reimbursement for charges Incurred after the date of settlement if such recovery provides for consideration of future medical expenses.

If there is more than one party responsible for charges paid by the Plan, or may be responsible for charges paid by the Plan, the Plan will not be required to select a particular party from whom reimbursement is due. Furthermore, unallocated settlement funds meant to compensate multiple injured parties of which the Participant(s) is/are only one or a few, that unallocated settlement fund is considered designated as an "identifiable" fund from which the plan may seek reimbursement.

Subrogation

As a condition to participating in and receiving benefits under this Plan, the Participant(s) agrees to assign to the Plan the right to subrogate and pursue any and all claims, causes of action or rights that may arise against any person, corporation and/or entity and to any Coverage to which the Participant(s) is entitled, regardless of how classified or characterized, at the Plan's discretion, if the Participant(s) fails to so pursue said rights and/or action.

If a Participant(s) receives or becomes entitled to receive benefits, an automatic equitable lien attaches in favor of the Plan to any claim, which any Participant(s) may have against any Coverage and/or party causing the Sickness or Injury to the extent of such conditional payment by the Plan plus reasonable costs of collection. The Participant is obligated to notify the Plan or its authorized representative of any settlement prior to finalization of the settlement, execution of a release, or receipt of applicable funds. The Participant is also obligated to hold any and all funds so received in trust on the Plan's behalf and function as a trustee as it applies to those funds until the Plan's rights described herein are honored and the Plan is reimbursed.

The Plan may, at its discretion, in its own name or in the name of the Participant(s) commence a proceeding or pursue a claim against any party or Coverage for the recovery of all damages to the full extent of the value of any such benefits or conditional payments advanced by the Plan.

If the Participant(s) fails to file a claim or pursue damages against:

a. The responsible party, its insurer, or any other source on behalf of that party,
b. Any first party insurance through medical payment coverage, personal injury protection, no-fault coverage, uninsured or underinsured motorist coverage,
c. Any policy of insurance from any insurance company or guarantor of a third party,
d. Workers' compensation or other liability insurance company,
e. Any other source, including but not limited to crime victim restitution funds, any medical, disability or other benefit payments, and school insurance coverage,

the Participant(s) authorizes the Plan to pursue, sue, compromise and/or settle any such claims in the Participant's/Participants' and/or the Plan's name and agrees to fully cooperate with the Plan in the prosecution of any such claims. The Participant(s) assigns all rights to the Plan or its assignee to pursue a claim and the recovery of all expenses from any and all sources listed above.

Right of Reimbursement

The Plan shall be entitled to recover 100% of the benefits paid or payable benefits Incurred, that have been paid and/or will be paid by the Plan, or were otherwise Incurred by the Participant(s) prior to and until the release from liability of the liable entity, as applicable, without deduction for attorneys' fees and costs or application of the common fund doctrine, made whole doctrine, or any other similar legal or equitable theory, and without regard to whether the Participant(s) is fully compensated by his or her recovery from all sources. 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 interferes with or compromises in any way the Plan's equitable lien and right to reimbursement. The obligation to reimburse the Plan in full exists regardless of how the judgment or settlement is classified and whether or not the judgment or settlement specifically designates the recovery or a portion of it as including medical, disability, or other expenses and extends until the date upon which the liable party is released from liability. If the Participant's/Participants' recovery is less than the benefits paid, then the Plan is entitled to be paid all of the recovery achieved. Any funds received by the Participant are deemed held in constructive trust and should not be dissipated or disbursed until such time as the Participant's obligation to reimburse the Plan has been satisfied in accordance with these provisions. The Participant is also obligated to hold any and all funds so received in trust on the Plan's behalf and function as a trustee as it applies to those funds until the Plan's rights described herein are honored and the Plan is reimbursed.

No court costs, experts' fees, attorneys' fees, filing fees, or other costs or expenses of litigation may be deducted from the Plan's recovery without the prior, express written consent of the Plan.

The Plan's right of subrogation and reimbursement will not be reduced or affected as a result of any fault or claim on the part of the Participant(s), whether under the doctrines of causation, comparative fault or contributory negligence, or other similar doctrine in law. Accordingly, any lien reduction statutes, which attempt to apply such laws and reduce a subrogating Plan's recovery, will not be applicable to the Plan and will not reduce the Plan's reimbursement rights.

These rights of subrogation and reimbursement shall apply without regard to whether any separate written acknowledgment of these rights is required by the Plan and signed by the Participant(s).

This provision shall not limit any other remedies of the Plan provided by law. These rights of subrogation and reimbursement shall apply without regard to the location of the event that led to or caused the applicable Illness, Injury, disease or disability.

Participant is a Trustee Over Plan Assets

Any Participant who receives benefits and is therefore subject to the terms of this section is hereby deemed a recipient and holder of Plan assets and is therefore deemed a trustee of the Plan solely as it relates to possession of any funds which may be owed to the Plan as a result of any settlement, judgment or recovery through any other means arising from any injury or accident. By virtue of this status, the Participant understands that he or she is required to:

a. Notify the Plan or its authorized representative of any settlement prior to finalization of the settlement, execution of a release, or receipt of applicable funds;
b. Instruct his or her attorney to ensure that the Plan and/or its authorized representative is included as a payee on all settlement drafts;
c. In circumstances where the Participant is not represented by an attorney, instruct the insurance company or any third party from whom the Participant obtains a settlement, judgment or other source of Coverage to include the Plan or its authorized representative as a payee on the settlement draft;
d. Hold any and all funds so received in trust, on the Plan's behalf, and function as a trustee as it applies to those funds, until the Plan's rights described herein are honored and the Plan is reimbursed.

To the extent the Participant disputes this obligation to the Plan under this section, the Participant or any of its agents or representatives is also required to hold any/all settlement funds, including the entire settlement if the settlement is less than the Plan's interests, and without reduction in consideration of attorneys' fees, for which he or she exercises control, in an account segregated from their general accounts or general assets until such time as the dispute is resolved.

No Participant, beneficiary, or the agents or representatives thereof, exercising control over plan assets and incurring trustee responsibility in accordance with this section will have any authority to accept any reduction of the Plan's interest on the Plan's behalf.

Release of Liability

The Plan's right to reimbursement extends to any incident related care that is received by the Participant(s) (Incurred) prior to the liable party being released from liability. The Participant's/ Participants' obligation to reimburse the Plan is therefore tethered to the date upon which the claims were Incurred, not the date upon which the payment is made by the Plan. In the case of a settlement, the Participant has an obligation to review the "lien" provided by the Plan and reflecting claims paid by the Plan for which it seeks reimbursement, prior to settlement and/or executing a release of any liable or potentially liable third party, and is also obligated to advise the Plan of any incident related care incurred prior to the proposed date of settlement and/or release, which is not listed but has been or will be incurred, and for which the Plan will be asked to pay.

Excess Insurance

If at the time of Injury, Sickness, Disease or disability there is available, or potentially available any Coverage (including but not limited to Coverage resulting from a judgment at law or settlements), the benefits under this Plan shall apply only as an excess over such other sources of Coverage, except as otherwise provided for under the Plan's Coordination of Benefits section.

The Plan's benefits shall be excess to any of the following:

a. The responsible party, its insurer, or any other source on behalf of that party.
b. Any first party insurance through medical payment coverage, personal injury protection, no-fault coverage, uninsured or underinsured motorist coverage.
c. Any policy of insurance from any insurance company or guarantor of a third party.
d. Workers' compensation or other liability insurance company.
e. Any other source, including but not limited to crime victim restitution funds, any medical, disability or other benefit payments, and school insurance coverage.

Separation of Funds

Benefits paid by the Plan, funds recovered by the Participant(s), and funds held in trust over which the Plan has an equitable lien exist separately from the property and estate of the Participant(s), such that the death of the Participant(s), or filing of bankruptcy by the Participant(s), will not affect the Plan's equitable lien, the funds over which the Plan has a lien, or the Plan's right to subrogation and reimbursement.

Wrongful Death

In the event that the Participant(s) dies as a result of his or her Injuries and a wrongful death or survivor claim is asserted against a third party or any Coverage, the Plan's subrogation and reimbursement rights shall still apply, and the entity pursuing said claim shall honor and enforce these Plan rights and terms by which benefits are paid on behalf of the Participant(s) and all others that benefit from such payment.

Obligations

It is the Participant's/Participants' obligation at all times, both prior to and after payment of medical benefits by the Plan:

a. To cooperate with the Plan, or any representatives of the Plan, in protecting its rights, including discovery, attending depositions, and/or cooperating in trial to preserve the Plan's rights.

b. To provide the Plan with pertinent information regarding the Sickness, Disease, disability, or Injury, including accident reports, settlement information and any other requested additional information.

c. To take such action and execute such documents as the Plan may require to facilitate enforcement of its subrogation and reimbursement rights.

d. To do nothing to prejudice the Plan's rights of subrogation and reimbursement.

e. To promptly reimburse the Plan when a recovery through settlement, judgment, award or other payment is received.

f. To notify the Plan or its authorized representative of any incident related claims or care which may be not identified within the lien (but has been Incurred) and/or reimbursement request submitted by or on behalf of the Plan.

g. To notify the Plan or its authorized representative of any settlement prior to finalization of the settlement.

h. To not settle or release, without the prior consent of the Plan, any claim to the extent that the Participant may have against any responsible party or Coverage.

i. To instruct his or her attorney to ensure that the Plan and/or its authorized representative is included as a payee on any settlement draft.

j. In circumstances where the Participant is not represented by an attorney, instruct the insurance company or any third party from whom the Participant obtains a settlement to include the Plan or its authorized representative as a payee on the settlement draft.

k. To make good faith efforts to prevent disbursement of settlement funds until such time as any dispute between the Plan and Participant over settlement funds is resolved.

If the Participant(s) and/or his or her attorney fails to reimburse the Plan for all benefits paid, to be paid, Incurred, or that will be Incurred, prior to the date of the release of liability from the relevant entity, as a result of said Injury or condition, out of any proceeds, judgment or settlement received, the Participant(s) will be responsible for any and all expenses (whether fees or costs) associated with the Plan's attempt to recover such money from the Participant(s).

The Plan's rights to reimbursement and/or subrogation are in no way dependent upon the Participant's/Participants' cooperation or adherence to these terms.

Offset

If timely repayment is not made, or the Participant and/or his or her attorney fails to comply with any of the requirements of the Plan, the Plan has the right, in addition to any other lawful means of recovery, to deduct the value of the Participant's amount owed to the Plan. To do this, the Plan may refuse payment of any future medical benefits and any funds or payments due under this Plan on behalf of the Participant(s) in an amount equivalent to any outstanding amounts owed by the Participant to the Plan. This provision applies even if the Participant has disbursed settlement funds.

Minor Status

In the event the Participant(s) is a minor as that term is defined by applicable law, the minor's parents or court-appointed guardian shall cooperate in any and all actions by the Plan to seek and obtain requisite court approval to bind the minor and his or her estate insofar as these subrogation and reimbursement provisions are concerned.

If the minor's parents or court-appointed guardian fail to take such action, the Plan shall have no obligation to advance payment of medical benefits on behalf of the minor. Any court costs or legal fees associated with obtaining such approval shall be paid by the minor's parents or court-appointed guardian.

Language Interpretation

The Plan Administrator retains sole, full and final discretionary authority to construe 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 with respect to this provision. The Plan Administrator may amend the Plan at any time without notice.

Severability

In the event that any section of this provision is considered invalid or illegal for any reason, said invalidity or illegality shall not affect the remaining sections of this provision and Plan. The section shall be fully severable. The Plan shall be construed and enforced as if such invalid or illegal sections

had never been inserted in the Plan.

COORDINATION WITH OTHER PLANS

The Plan contains a provision to prevent double payment for covered expenses. This provision works by coordinating the benefits under this Plan with other similar plans under which a Participant is covered, so the total benefits available will not exceed one hundred percent (100%) of the Maximum Allowable Charge. The expenses for services and supplies must be covered, at least in part, by one of the coordinating plans. This provision is commonly called "coordination of benefits." Benefits payable under other similar plans include the benefits that would have been payable had proper claim been made for them.

If this Plan provides coverage for eligible retirees, and you are a covered retiree, and you or a Covered Dependent are entitled to Medicare coverage (whether or not you are enrolled for such coverage), this Plan will be the secondary payor and will coordinate its benefits (as described in this section) with Medicare benefits as permitted by law.

As permitted by law, this Plan also will be the secondary payor and will coordinate its benefits with Medicare for Participants who are eligible to enroll in Medicare due to disability or End Stage Renal Disease (whether or not you are enrolled for such coverage). For Participants with End Stage Renal Disease, the Plan will pay the Maximum Allowable Charge for the first 90 days. After the first 90 days, the Plan will pay according to Medicare's published fee schedule.

For the purposes of this coordination provision, the term "plan" means the following types of medical care benefits:

1. Coverage under a governmental plan or required or provided by law, including no fault coverage to the extent required in policies or contracts by a motor vehicle insurance statute or similar legislation; and

2. Group insurance or other coverage for a group of individuals, other than school accident-type coverage for elementary school, high school and college students. This does not include any law or plan where benefits are provided after those provided by other plans.

In the event of a motor vehicle Accident, this Plan shall not be primary to any auto coverage such as medical, no fault, casualty or liability insurance that by its terms is immediately payable without the necessity of a finding of liability on the part of a third party. The Participant shall be responsible for identifying the motor vehicle Accident as the source of the Injury and completing any requested Accident report forms.

When a claim is made, the primary plan (as described below) pays its benefits without regard to any other plans. The secondary plans adjust their benefits so that the total benefits available will not exceed the Maximum Allowable Charge. No plan pays more than it would otherwise pay without this coordination provision.

A plan without a coordination of benefits provision is always the primary plan. If all plans have such a provision:

1. The plan covering the patient as an active Participant (e.g., employee, member, subscriber) or a dependent of an active Participant, rather than as an inactive Participant (e.g., COBRA beneficiary, retiree, or TRICARE participant) or a dependent of an inactive Participant, is primary and the others are secondary (if the other plan does not have this provision and, as a result, the plans do not agree on the order of benefits, this provision is ignored);

2. If a child is covered under both parents' plans, the parent whose birthday falls earlier in the Calendar Year is primary, or, if both parents have the same birthday, the plan covering the parent longer is primary; but when the parents are separated or divorced, their plans pay in this order:

    a. the plan of the parent with custody of the child;

    b. the plan of the Spouse of the parent with custody of the child;

    c. the plan of the parent not having custody of the child; and

    d. the plan of the Spouse of the parent not having custody of the child.

However, if a Qualified Medical Child Support Order (QMCSO) has established financial responsibility for the child's health care expenses, the benefits of that plan are determined first.

If none of the preceding provisions determine the order of benefits, the benefits of the plan that covered a Participant longer are determined first.

If none of the preceding provisions of this section make it able to determine which plan is primary, the Maximum Allowable Charge shall be shared equally between the plans.

TERMINATION OF COVERAGE

Coverage will terminate for an employee at 11:59 P.M. on the earliest of the following:

1. Date the Plan terminates;

2. Last day of the month in which employment terminates;

3. Date employee ceases to be an Eligible Employee for a reason other than termination of employment (unless the employee is in a Stability Period or Administrative Period);

4. Last day of the employee's current Stability Period or the Administrative Period (if applicable), if the employee does not meet the requirements for future coverage as determined by the current Standard Measurement Period;

5. Date the employee chooses Medicare as his or her sole coverage;

6. The end of the last period for which any required contribution was received;

7. Date of the employee's death; or

8. The date on which an employee or his or her dependent submits, or has knowledge of the submission of, a fraudulent claim or any fraudulent information or intentional misrepresentation of a material fact to the Plan, including enrollment information.

Coverage for a dependent will cease at 11:59 P.M. on the earliest of the following:

1. Date the Plan terminates;

2. Date the employee's coverage terminates;

3. Date the dependent enters active service with armed forces of any country;

4. Date the dependent ceases to be an Eligible Dependent (for any reason other than attaining the applicable age limit);

5. Date the dependent chooses Medicare as his or her sole coverage;

6. For a dependent Spouse, on the date of divorce or legal separation;

7. For a dependent child/children, the end of the month of attainment of the applicable age limit;

8. The end of the last period for which any required contribution was received; or

9. The date on which an employee or his or her dependent submits, or has knowledge of the submission of, a fraudulent claim or any fraudulent information or intentional misrepresentation of a material fact to the Plan, including enrollment information.

An employee or dependent whose coverage has terminated as described here may have rights to the continued coverage described in the next section, Continuation of Benefits.

CONTINUATION OF BENEFITS

Continuation of Benefits other than COBRA

If a Covered Employee ceases active employment or is otherwise no longer able to meet the eligibility requirements of the Employer, participation may be continued for so long as the Employer reasonably believes it is obligated to provide the Covered Employee with leave under the application of its leave policies, the federal Family and Medical Leave Act, the Americans with Disabilities Act, or any applicable federal or state law, as such laws are amended from time to time.

These rules are applied pursuant to procedures adopted by the Plan Administrator and applied on a basis uniformly applicable to all employees similarly situated.

Reinstatement of Coverage

A terminated employee who is rehired will be treated as a new hire and be required to satisfy all Eligibility and Enrollment requirements. If the employee is returning to work directly from the Plan's COBRA coverage, the waiting period will not apply provided he meets all the other requirements of the definition of an Eligible Employee. Participants whose coverage is reinstated under this provision will receive credit for any portion of the Calendar Year deductible and other cost sharing amounts that were met for that year while previously covered under the Plan. Benefit maximums for such Participants will be reduced by any amount paid by the Plan while the Participants were previously covered.

Notwithstanding the above, this Plan will comply at all times with the Affordable Care Act with regard to rehire provisions.

Continuation During Family and Medical Leave

The Family and Medical Leave Act of 1993 ("FMLA") requires employers to provide unpaid, job-protected leave during any 12-month period to eligible employees for certain family and medical reasons. This Plan will comply with the law at all times. Please see the Plan Administrator for details of the FMLA policy adopted by the Employer when you need to take FMLA leave.

COBRA Continuation of Coverage

The right to COBRA Continuation Coverage was created by a federal law, the Consolidated Omnibus Budget Reconciliation Act of 1985, as amended ("COBRA"). COBRA Continuation Coverage can become available to you when you otherwise would lose your group health coverage. It also can become available to other members of your family who are covered under the Plan when they otherwise would lose their group health coverage. The entire cost (plus a reasonable administration fee) must be paid by the Covered Employee. Coverage will end in certain instances, including if you

or your dependents fail to make timely payment of premiums. You should check with your employer to see if COBRA applies to you and your dependents.

What is COBRA Continuation Coverage?

"COBRA Continuation Coverage" is a continuation of Plan coverage when coverage otherwise would end because of a life event known as a "Qualifying Event." Life insurance, accidental death and dismemberment benefits and weekly income or long-term disability benefits (if a part of your employer's plan) are not considered for continuation under COBRA.

What is a Qualifying Event?

Specific Qualifying Events are listed below. After a Qualifying Event, COBRA Continuation Coverage must be offered to each person who is a "Qualified Beneficiary." You, your Spouse, and your dependent children could become Qualified Beneficiaries if coverage under the Plan is lost because of the Qualifying Event.

If you are a Covered Employee (meaning that you are an employee and are covered under the Plan), you will become a Qualified Beneficiary if you lose your coverage under the Plan because either one of the following Qualifying Events happens:

1. Your hours of employment are reduced, or

2. Your employment ends for any reason other than your gross misconduct.

If you are the Spouse of a Covered Employee, you will become a Qualified Beneficiary if you lose your coverage under the Plan because any of the following Qualifying Events happens:

1. Your Spouse dies;

2. Your Spouse's hours of employment are reduced;

3. Your Spouse's employment ends for any reason other than his or her gross misconduct;

4. Your Spouse becomes entitled to Medicare benefits (under Part A, Part B, or both); or

5. You become divorced or legally separated from your Spouse.

Your dependent children will become Qualified Beneficiaries if they lose coverage under the Plan because any of the following Qualifying Events happens:

1. The parent-Covered Employee dies;

2. The parent-Covered Employee's hours of employment are reduced;

3. The parent-Covered Employee's employment ends for any reason other than his or her gross misconduct;

4. The parent-Covered Employee becomes entitled to Medicare benefits (Part A, Part B, or both);

5. The parents become divorced or legally separated; or

6. The child stops being eligible for coverage under the plan as a "dependent child."

The Employer must give notice of some Qualifying Events

When the Qualifying Event is the end of employment, reduction of hours of employment, death of the Covered Employee, or the Covered Employee's becoming entitled to Medicare benefits (under Part A, Part B, or both), the Employer must notify the Plan Administrator of the Qualifying Event.

You must give notice of some Qualifying Events

Each Covered Employee or Qualified Beneficiary is responsible for providing the Plan Administrator with the following notices, in writing, either by U.S. First Class Mail, hand delivery, or by facsimile to (210) 829-3847:

1. Notice of the occurrence of a Qualifying Event that is a divorce or legal separation of a Covered Employee (or former employee) from his or her Spouse;

2. Notice of the occurrence of a Qualifying Event that is an individual's ceasing to be eligible as a dependent under the terms of the Plan;

3. Notice of the occurrence of a second Qualifying Event after a Qualified Beneficiary has become entitled to COBRA Continuation Coverage with a maximum duration of 18 (or 29) months;

4. Notice that a Qualified Beneficiary entitled to receive Continuation Coverage with a maximum duration of 18 months has been determined by the Social Security Administration ("SSA") to be disabled at some time before the 60th day of Continuation Coverage; and

5. Notice that a Qualified Beneficiary, with respect to whom a notice described in paragraph (4) above has been provided has subsequently been determined by the SSA to no longer be disabled.

The Plan Administrator is:

University of the Incarnate Word
Plan Administrator
4301 Broadway, CPO 320
San Antonio, TX 78209
(210) 829-6019

A form of notice is available, free of charge, from the Plan Administrator and must be used when providing the notice.

Deadline for providing the notice

For Qualifying Events described in (1), (2) or (3) above, the notice must be furnished by the date that is 60 days after the latest of:

1. The date on which the relevant Qualifying Event occurs;

2. The date on which the Qualified Beneficiary loses (or would lose) coverage under the Plan as a result of the Qualifying Event; or

3. The date on which the Qualified Beneficiary is informed, through the furnishing of the Plan's SPD or the general notice, of both the responsibility to provide the notice and the Plan's procedures for providing such notice to the Plan Administrator.

For the disability determination described in (4) above, the notice must be furnished by the date that is 60 days after the latest of:

1. The date of the disability determination by the SSA;

2. The date on which a Qualifying Event occurs;

3. The date on which the Qualified Beneficiary loses (or would lose) coverage under the Plan as a result of the Qualifying Event; or

4. The date on which the Qualified Beneficiary is informed, through the furnishing of the Plan's SPD or the general notice, of both the responsibility to provide the notice and the Plan's procedures for providing such notice to the Plan Administrator.

In any event, this notice must be furnished before the end of the first 18 months of Continuation Coverage.

For a change in disability status described in (5) above, the notice must be furnished by the date that is 30 days after the later of:

1. The date of the final determination by the SSA that the Qualified Beneficiary is no longer disabled; or

2. The date on which the Qualified Beneficiary is informed, through the furnishing of the Plan's SPD or the general notice, of both the responsibility to provide the notice and the Plan's procedures for providing such notice to the Plan Administrator.

The notice must be postmarked (if mailed), or received by the Plan Administrator (if hand delivered), by the deadline set forth above. If the notice is late, the opportunity to elect or extend COBRA Continuation Coverage is lost, and if you are electing COBRA Continuation Coverage, your coverage under the Plan will terminate on the last date for which you are eligible under the terms of the Plan, or if you are extending COBRA Continuation Coverage, such Coverage will end on the last day of the initial 18-month COBRA coverage period.

Who can provide the notice

Any individual who is the Covered Employee (or former employee), a Qualified Beneficiary with respect to the Qualifying Event, or any representative acting on behalf of the Covered Employee (or former employee) or Qualified Beneficiary, may provide the notice, and the provision of notice by one individual shall satisfy any responsibility to provide notice on behalf of all related Qualified Beneficiaries with respect to the Qualifying Event.

Required contents of the notice

The notice must contain the following information:

1. Name and address of the Covered Employee or former employee;

2. If you already are receiving COBRA Continuation Coverage and wish to extend the maximum coverage period, identification of the initial Qualifying Event and its date of occurrence;

3. A description of the Qualifying Event (for example, divorce, legal separation, cessation of dependent status, entitlement to Medicare by the Covered Employee or former employee, death of the Covered Employee or former employee, disability of a Qualified Beneficiary or loss of disability status);

4. In the case of a Qualifying Event that is divorce or legal separation, name(s) and address(es) of Spouse and dependent child(ren) covered under the Plan, date of divorce or legal separation, and a copy of the decree of divorce or legal separation;

5. In the case of a Qualifying Event that is Medicare entitlement of the Covered Employee or former employee, date of entitlement, and name(s) and address(es) of Spouse and dependent child(ren) covered under the Plan;

6. In the case of a Qualifying Event that is a dependent child's cessation of dependent status under the Plan, name and address of the child, reason the child ceased to be an eligible dependent (for example, attained limiting age);

7. In the case of a Qualifying Event that is the death of the Covered Employee or former employee, the date of death, and name(s) and address(es) of Spouse and dependent child(ren) covered under the Plan;

8. In the case of a Qualifying Event that is disability of a Qualified Beneficiary, name and address of the disabled Qualified Beneficiary, name(s) and address(es) of other family members covered under the Plan, the date the disability began, the date of the SSA's determination, and a copy of the SSA's determination;

9. In the case of a Qualifying Event that is loss of disability status, name and address of the Qualified Beneficiary who is no longer disabled, name(s) and address(es) of other family members covered under the Plan, the date the disability ended and the date of the SSA's determination; and

10. A certification that the information is true and correct, a signature and date.

If you cannot provide a copy of the decree of divorce or legal separation or the SSA's determination by the deadline for providing the notice, complete and provide the notice, as instructed, by the deadline; however, you must submit a copy of the decree of divorce or legal separation or the SSA's determination within 30 days after the date you have provided the notice. The notice will be timely if you do so. However, no COBRA Continuation Coverage, or extension of such Coverage, will be available until you have provided a copy of the decree of divorce or legal separation or the SSA's determination.

Please note, if the notice does not contain all of the required information, the Plan Administrator may request additional information. If the individual fails to provide such information within the time period specified by the Plan Administrator in the request, the Plan Administrator may reject the notice if it does not contain enough information for the Plan Administrator to identify the plan, the Covered Employee (or former employee), the Qualified Beneficiaries, the Qualifying Event or disability, and the date on which the Qualifying Event, if any, occurred.

Electing COBRA Continuation Coverage

Complete instructions on how to elect COBRA Continuation Coverage will be provided by the Plan Administrator within 14 days of receiving the notice of your Qualifying Event. You then have 60 days

in which to elect COBRA Continuation Coverage. The 60-day period is measured from the later of the date coverage terminates or the date of the notice containing the instructions. If COBRA Continuation Coverage is not elected in that 60-day period, then the right to elect it ceases.

Each Qualified Beneficiary will have an independent right to elect COBRA Continuation Coverage. Covered Employees may elect COBRA Continuation Coverage on behalf of their Spouses, and parents may elect COBRA Continuation Coverage on behalf of their children.

In the event that the Plan Administrator determines that the Participant is not entitled to COBRA Continuation Coverage, the Plan Administrator will provide to the Participant an explanation as to why he or she is not entitled to COBRA Continuation Coverage.

How long does COBRA Continuation Coverage last?

COBRA Continuation Coverage will be available up to the maximum time period shown below. Multiple Qualifying Events which may be combined under COBRA will not continue coverage for more than 36 months beyond the date of the original Qualifying Event. When the Qualifying Event is "entitlement to Medicare," the 36-month continuation period is measured from the date of the original Qualifying Event. For all other Qualifying Events, the continuation period is measured from the date of the Qualifying Event, not the date of loss of coverage.

When the Qualifying Event is the death of the Covered Employee (or former employee), the Covered Employee's (or former employee's) becoming entitled to Medicare benefits (under Part A, Part B, or both), your divorce or legal separation, or a dependent child's losing eligibility as a dependent child, COBRA Continuation Coverage lasts for up to a total of 36 months.

When the Qualifying Event is the end of employment or reduction of the Covered Employee's hours of employment, and the Covered Employee became entitled to Medicare benefits less than 18 months before the Qualifying Event, COBRA Continuation Coverage for Qualified Beneficiaries other than the Covered Employee lasts until 36 months after the date of Medicare entitlement. For example, if a Covered Employee becomes entitled to Medicare 8 months before the date on which his or her employment terminates, COBRA Continuation Coverage for his or her Spouse and children can last up to 36 months after the date of Medicare entitlement, which is equal to 28 months after the date of the Qualifying Event (36 months minus 8 months).

Otherwise, when the Qualifying Event is the end of employment (for reasons other than gross misconduct) or reduction of the Covered Employee's hours of employment, COBRA Continuation Coverage generally lasts for only up to a total of 18 months. There are two ways in which this 18-month period of COBRA Continuation Coverage can be extended.

Disability extension of 18-month period of COBRA Continuation Coverage

If you or anyone in your family covered under the Plan is determined by the SSA to be disabled and you notify the Plan Administrator as set forth above, you and your entire family may be entitled to receive up to an additional 11 months of COBRA Continuation Coverage, for a total maximum of 29 months. The disability would have to have started at some time before the 60th day of COBRA Continuation Coverage and must last at least until the end of the 18-month period of COBRA Continuation Coverage. An extra fee may be charged for this extended COBRA Continuation Coverage.

Second Qualifying Event extension of 18-month period of COBRA Continuation Coverage

If your family experiences another Qualifying Event while receiving 18 months of COBRA Continuation Coverage, the Spouse and dependent children in your family can get up to 18 additional months of COBRA Continuation Coverage, for a maximum of 36 months, if notice of the second Qualifying Event properly is given to the Plan as set forth above. This extension may be available to the Spouse and any dependent children receiving COBRA Continuation Coverage if the Covered Employee or former employee dies, becomes entitled to Medicare benefits (under Part A, Part B, or both), or gets divorced or legally separated, or if the dependent child stops being eligible under the Plan as a dependent child, but only if the event would have caused the Spouse or dependent child to lose coverage under the Plan had the first Qualifying Event not occurred. An extra fee may be charged for this extended COBRA Continuation Coverage.

Does COBRA Continuation Coverage ever end earlier than the maximum periods above?

COBRA Continuation Coverage also may end before the end of the maximum period on the earliest of the following dates:

1. The date your employer ceases to provide a group health plan to any employee;

2. The date on which coverage ceases by reason of the Qualified Beneficiary's failure to make timely payment of any required premium;

3. The date that the Qualified Beneficiary first becomes, after the date of election, covered under any other group health plan (as an employee or otherwise), or entitled to either Medicare Part A or Part B (whichever comes first). However, a Qualified Beneficiary who becomes covered under a group health plan which has a Pre-existing condition limit must be allowed to continue COBRA Continuation Coverage for the length of a Pre-existing condition or to the COBRA maximum time period, if less; or

4. The first day of the month that begins more than 30 days after the date of the SSA's determination that the Qualified Beneficiary is no longer disabled, but in no event before the

end of the maximum coverage period that applied without taking into consideration the disability extension.

Payment for COBRA Continuation Coverage

Once COBRA Continuation Coverage is elected, you must pay for the cost of the initial period of coverage within 45 days. Payments then are due on the first day of each month to continue coverage for that month. If a payment is not postmarked (if mailed) or received by the Plan Administrator (if hand delivered) within 30 days of the due date, COBRA Continuation Coverage will be canceled and will not be reinstated.

Two provisions under the Trade Act affect the benefits received under COBRA. First, certain eligible individuals who lose their jobs due to international trade agreements may receive a 72.5% tax credit for premiums paid for certain types of health insurance, including COBRA premiums. Second, eligible individuals under the Trade Act who do not elect COBRA Continuation Coverage within the election period will be allowed an additional 60-day period to elect COBRA Continuation Coverage. If the Qualified Beneficiary elects COBRA Continuation Coverage during this second election period, the coverage period will run from the beginning date of the second election period. You should consult the Plan Administrator if you believe the Trade Act applies to you.

Additional Information

Additional information about the Plan and COBRA Continuation Coverage is available from the Plan Administrator, who is:

University of the Incarnate Word
Plan Administrator
4301 Broadway, CPO 320
San Antonio, TX 78209
(210) 829-6019

Current Addresses

In order to protect your family's rights, you should keep the Plan Administrator (who is identified above) informed of any changes in the addresses of family members.

USERRA Continuation of Coverage

May I continue participation while I am absent under USERRA?

The Uniformed Services Employment and Reemployment Rights Act of 1994 ("USERRA") is a federal law, under which you may elect to continue coverage under the Plan for yourself and your Covered

Dependents, where:

1. They were Participants in the Plan immediately prior to your leave of absence for uniformed service; and

2. The reason for your leave of absence is due to active service in the uniformed services.

In addition, you must meet the following requirements:

1. You (or an appropriate officer of the uniformed service) must give advance written or verbal notice of your service to your Employer. This notice will not be required if giving it is precluded by military necessity or is otherwise impossible or unreasonable;

2. The cumulative length of this absence and all previous absences with your Employer by reason of your service in the uniformed service does not exceed five years (although certain exceptions apply to this five-year maximum requirement); and

3. You comply with the notice requirements set forth in "When will coverage continued through USERRA terminate?"

The law requires your Employer to allow you to elect coverage which is identical to similarly situated employees who are not on USERRA leave. This means that if the coverage for similarly situated employees and dependents is modified, coverage for the individual on USERRA leave will be modified.

What is the cost of continuing coverage under USERRA?
The cost of continuing your coverage will be:

1. For leaves of 30 days or less, the same as the contribution required from similarly situated employees;

2. For leaves of 31 days or more, up to 102% of the contribution required from similarly situated employees and your Employer.

Continuation applies to all coverage provided under this Plan, except for short and long-term disability, and life insurance, coverage.

When will coverage continued through USERRA terminate?

Continued coverage under this provision will terminate on the earlier of the following events:

1. The date you fail to apply for, or return to, work for your Employer following completion of your leave. You must notify your Employer of your intent to return to employment within:

    a. For leaves of 30 days or less, or if you are absent from employment for a period of any length for the purposes of an examination to determine your fitness to perform service in the uniformed service, by reporting to the Employer:

        i. Not later than the beginning of the first full regularly scheduled work period on the first full calendar day following the completion of your period of service and the expiration of eight hours after a period allowing for your safe transportation from the place of service to your residence; or

        ii. If reporting within such period is impossible or unreasonable through no fault of yours, then as soon as possible after the expiration of the eight-hour period referred to above.

    b. For leaves of 31 to 180 days, by submitting an application for reemployment with your Employer:

        i. Not later than 14 days after completing uniformed service; or

        ii. If submitting such application within that period is impossible or unreasonable through no fault of yours, then the next first full calendar day when submission of such application becomes possible.

    c. For leaves of more than 180 days, by submitting an application for reemployment with your Employer not later than 90 days after completing uniformed service.

    d. If you are hospitalized for, or convalescing from, an illness or injury incurred in, or aggravated during, the performance of service in the uniformed service, by reporting to, or submitting an application for reemployment with, your Employer (depending upon the length of your leave as indicated above), at the end of the period that is necessary for you to recover from such illness or injury. This period may not exceed two years, except if circumstances beyond your control make reporting to your Employer impossible or unreasonable, then the two-year period may be extended by the minimum time required to accommodate such circumstances.

Continued coverage provided under this provision will reduce the maximum period allowed for continuation provided under COBRA.

How will my coverage be reinstated on return from USERRA leave?

The law also requires, regardless of whether continuation of coverage was elected, that your coverage and your dependents' coverage be reinstated immediately upon your return to employment, so long as you comply with the requirements set forth above in "May I continue participation while I am absent under USERRA?" and, if your absence was more than 30 days, you have furnished any available documents requested by your Employer to establish that you are entitled to the protections offered by USERRA. Further, your separation from service or discharge may not be dishonorable or based upon bad conduct, on grounds less than honorable, absent without leave (AWOL), or ending in a conviction under court martial.

Upon reinstatement, an exclusion or waiting period may not be imposed if that exclusion or waiting period would not have been imposed had your coverage (or your dependents' coverage) not terminated as a result of your service in the uniformed service. However, this does not apply to coverage of any illness or injury determined by the Secretary of Veteran Affairs to have been incurred in, or aggravated during, performance of your service in the uniformed services.

NOTE: For complete information regarding your rights under USERRA, contact your Employer.

PLAN ADMINISTRATION

The Plan Administrator

The Plan is administered by the Plan Administrator. The Plan Administrator has retained the services of Gilsbar, L.L.C., as the Benefit Services Manager to provide certain claims processing and other ministerial services, which the Benefit Services Manager may further delegate to others. The Plan Administrator's relationship with Gilsbar, L.L.C. is governed by the Benefit Services Management Agreement. The Benefit Services Manager has no responsibility or obligation to Plan Participants, but only to the Plan and the Plan Administrator, as set forth in the Benefit Services Management Agreement.

The Plan has retained the services of FAIROS, as the Claims Delegate, to reprice submitted claims and perform certain claims review functions including providing recommendations to the Benefit Services Manager for the initial claim benefits determination. The Claims Delegate has the authority to handle certain appeals related to repricing in accordance with this Plan Document and Summary Plan Description. The Plan Administrator's relationship with the Claims Delegate is governed by a contractual agreement.

An individual or entity may be appointed by the Plan Sponsor to be Plan Administrator and serve at the convenience of the Plan Sponsor. If the Plan Administrator resigns, dies, is otherwise unable to perform, is dissolved, or is removed from the position, the Plan Sponsor will appoint a new Plan Administrator as soon as reasonably possible.

The Plan Administrator will 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 will 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 (including the determination of what services, supplies, care and treatments are Medically Necessary or Experimental and determinations of the Maximum Allowable Charge), to decide disputes which may arise relative to a covered person's rights, and to decide questions of Plan interpretation and those of fact relating to the Plan. The decisions of the Plan Administrator as to the facts related to any claim for benefits and the meaning and intent of any provision of the Plan, or its application to any claim, shall receive the maximum deference provided by law and will be final and binding on all interested parties. Benefits under this Plan will be paid only if the Plan Administrator decides, in its discretion, that the covered person is entitled to them.

The duties of the Plan Administrator include the following:

1. To administer the Plan in accordance with its terms;

2. To determine all questions of eligibility, status and coverage under the Plan;

3. To interpret the Plan, including the authority to construe possible ambiguities, inconsistencies, omissions and disputed terms;

4. To make factual findings;

5. To decide disputes which may arise relative to a covered person's rights;

6. To prescribe procedures for filing a claim for benefits, to review claim denials and appeals relating to them and to uphold or reverse such denials;

7. To keep and maintain the Plan documents and all other records pertaining to the Plan;

8. To appoint and supervise a benefit services manager to pay claims;

9. To perform all necessary reporting as required;

10. To establish and communicate procedures to determine whether MCSOs and NMSNs are QMCSOs;

11. To delegate to any person or entity such powers, duties and responsibilities as it deems appropriate; and

12. To perform each and every function necessary for or related to the Plan's administration.

Amendment and Termination

The Plan Sponsor expects to maintain this Plan indefinitely; however, the Plan Sponsor may, in its sole discretion, at any time, amend, suspend or terminate the Plan in whole or in part. This includes amending the benefits under the Plan.

Any such amendment, suspension or termination shall be enacted, if the Plan Sponsor is a corporation, by resolution of the Plan Sponsor's directors and officers, which shall be acted upon as provided in the Plan Sponsor's articles of incorporation or bylaws, as applicable, and in accordance with applicable federal and state law. Notice shall be provided as required. In the event that the Plan Sponsor is a different type of entity, then such amendment, suspension or termination shall be taken and enacted in accordance with applicable federal and state law and any applicable governing documents. In the event that the Plan Sponsor is a sole proprietorship, then such action shall be taken by the sole proprietor, in his or her own discretion.

If the Plan is terminated, the rights of covered persons are limited to expenses Incurred before termination. All amendments to this Plan shall become effective as of a date established by the Plan Sponsor.

Expenses

All claims, expenses, or charges for the administration and operation of the Plan will be paid by the Plan and the trust, if any, that funds the Plan, or in the absence of a trust, by the Employer, as the Plan Sponsor.

Notices

All payments or notices of any kind to an employee, Participant, beneficiary or Plan official may be mailed to the address for that person last appearing on the records of the Plan Administrator. When such a notice is mailed by first class mail, it is deemed to have been (a) duly delivered on the date post-marked, and (b) duly received three calendar days after being deposited, postage prepaid, in the United States Mail. When such a notice is delivered in person, it is deemed to have been received the same day as delivery. Each Participant must keep the Plan Administrator notified of his or her current address. If there is doubt about the accuracy of an address, the Plan may give notice, by registered mail to any such person's last address, that payments and other mail are being withheld pending receipt of a proper mailing address from that person.

Invalidity

In the event that any provision in this Plan is deemed to be invalid or unenforceable, no other provision of this Plan shall be affected.

Other Statements

This written document and any later amendments to it constitute the complete and only statement of the Plan and cannot be changed by any oral or other written statement regarding the Plan.

HIPAA PRIVACY

Commitment to Protecting Health Information

The Plan will comply with the Standards for Privacy of Individually Identifiable Health Information (i.e., the "Privacy Rule") set forth by the U.S. Department of Health and Human Services ("HHS") pursuant to the Health Insurance Portability and Accountability Act of 1996 ("HIPAA"). Such standards control the dissemination of "protected health information" ("PHI") of Participants. Privacy Standards will be implemented and enforced in the offices of the Employer and Plan Sponsor and any other entity that may assist in the operation of the Plan.

The Plan is required by law to take reasonable steps to ensure the privacy of the Participant's PHI, and inform him/her about:

1. The Plan's disclosures and uses of PHI;
2. The Participant's privacy rights with respect to his or her PHI;
3. The Plan's duties with respect to his or her PHI;
4. The Participant's right to file a complaint with the Plan and with the Secretary of HHS; and
5. The person or office to contact for further information about the Plan's privacy practices.

Within this provision capitalized terms may be used, but not otherwise defined. These terms shall have the same meaning as those terms set forth in 45 CFR Sections 160.103 and 164.501. Any HIPAA regulation modifications altering a defined HIPAA term or regulatory citation shall be deemed incorporated into this provision.

Disclosure of Summary Health Information to the Plan Sponsor

In accordance with HIPAA's Standards for Privacy of Individually Identifiable Health Information (the "Privacy Standards"), the Plan may disclose Summary Health Information to the Plan Sponsor, if the Plan Sponsor requests the Summary Health Information for the purpose of:

1. Obtaining premium bids from health plans for providing health insurance coverage under this Plan; or

2. Modifying, amending or terminating the Plan.

"Summary Health Information" may be individually identifiable health information and it summarizes the claims history, claims expenses or the type of claims experienced by individuals in the Plan, but it excludes all identifiers that must be removed for the information to be de-identified, except that it may contain geographic information to the extent that it is aggregated by five-digit zip code.

Disclosure of Protected Health Information ("PHI") to the Plan Sponsor for Plan Administration Purposes

In order that the Plan Sponsor may receive and use PHI for Plan Administration purposes, the Plan Sponsor agrees to:

- Not use or further disclose PHI other than as permitted or required by the Plan documents or as Required by Law (as defined in the Privacy Standards);
- Ensure that any agents to whom the Plan Sponsor provides PHI received from the Plan agree to the same restrictions and conditions that apply to the Plan Sponsor with respect to such PHI;
- Not use or disclose PHI for employment-related actions and decisions or in connection with any other benefit or group employee benefitplan of the Plan Sponsor, except pursuant to an authorization which meets the requirements of the Privacy Standards;
- Report to the Plan any PHI use or disclosure that is inconsistent with the uses or disclosures provided for of which the Plan Sponsor becomes aware;
- Make available PHI in accordance with section 164.524 of the Privacy Standards (45 CFR 164.524);
- Make available PHI for amendment and incorporate any amendments to PHI in accordance with section 164.526 of the Privacy Standards (45 CFR 164.526);
- Make available the information required to provide an accounting of disclosures in accordance with section 164.528 of the Privacy Standards (45 CFR 164.528);
- Make its internal practices, books and records relating to the use and disclosure of PHI received from the Plan available to the Secretary of the U.S. Department of Health and Human Services ("HHS"), or any other officer or employee of HHS to whom the authority involved has been delegated, for purposes of determining compliance by the Plan with part 164, subpart E, of the Privacy Standards (45 CFR 164.500 et seq);
- If feasible, return or destroy all PHI received from the Plan that the Plan Sponsor still maintains in any form and retain no copies of such PHI when no longer needed for the purpose for 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 PHI infeasible; and
- Ensure that adequate separation between the Plan and the Plan Sponsor, as required in section 164.504(f)(2)(iii) of the Privacy Standards (45 CFR 164.504(f)(2)(iii)), is established as follows:

- The following employees, or classes of employees, or other persons under control of the Plan Sponsor, shall be given access to the PHI to be disclosed:

  Appropriate personnel designated by the Plan Administrator

- The access to and use of PHI by the individuals described above shall be restricted to the Plan Administration functions that the Plan Sponsor performs for the Plan.

- In the event any of the individuals described in above do not comply with the provisions of the Plan documents relating to use and disclosure of PHI, the Plan Administrator shall impose reasonable sanctions as necessary, in its discretion, to ensure that no further non-compliance occurs. Such sanctions shall be imposed progressively (for example, an oral warning, a written warning, time off without pay and termination), if appropriate, and shall be imposed so that they are commensurate with the severity of the violation.

"Plan Administration" activities are limited to activities that would meet the definition of payment or health care operations, but do not include functions to modify, amend or terminate the Plan or solicit bids from prospective issuers. "Plan Administration" functions include quality assurance, claims processing, auditing, monitoring and management of carve-out plans, such as vision and dental. It does not include any employment-related functions or functions in connection with any other benefit or benefit plans.

The Plan shall disclose PHI to the Plan Sponsor only upon receipt of a certification by the Plan Sponsor that:

- The Plan documents have been amended to incorporate the above provisions; and

- The Plan Sponsor agrees to comply with such provisions.

Disclosure of Certain Enrollment Information to the Plan Sponsor
Pursuant to section 164.504(f)(1)(iii) of the Privacy Standards (45 CFR 164.504(f)(1)(iii)), the Plan may disclose to the Plan Sponsor information on whether an individual is participating in the Plan or is enrolled in or has disenrolled from a health insurance issuer or health maintenance organization offered by the Plan to the Plan Sponsor.

Disclosure of PHI to Obtain Stop-loss or Excess Loss Coverage
The Plan Sponsor hereby authorizes and directs the Plan, through the Plan Administrator or the Benefit Services Manager, to disclose PHI to stop-loss carriers, excess loss carriers or managing general underwriters ("MGUs") for underwriting and other purposes in order to obtain and maintain stop-loss or excess loss coverage related to benefit claims under the Plan. Such disclosures shall be made in accordance with the Privacy Standards.

Other Disclosures and Uses of PHI
With respect to all other uses and disclosures of PHI, the Plan shall comply with the Privacy Standards.

HIPAA SECURITY

Standards for Security of Individually Identifiable Health Information ("Security Rule")

The Security Rule imposes regulations for maintaining the integrity, confidentiality and availability of protected health information that it creates, receives, maintains, or maintains electronically that is kept in electronic format (ePHI) as required under the Health Insurance Portability and Accountability Act (HIPAA).

Definitions

- **Electronic Protected Health Information (ePHI)** – The term "Electronic Protected Health Information" has the meaning set forth in 45 C.F.R. § 160.103, as amended from time to time, and generally means protected health information that is transmitted or maintained in any electronic media.
- **Security Incident** – The term "Security Incident" has the meaning set forth in 45 C.F.R. § 164.304, as amended from time to time, and generally means the attempted or successful unauthorized access, use, disclosure, modification, or destruction of information or interference with system operations in an information system.

Plan Sponsor Obligations

Where Electronic Protected Health Information will be created, received, maintained, or transmitted to or by the Plan Sponsor on behalf of the Plan, the Plan Sponsor shall reasonably safeguard the Electronic Protected Health Information as follows:

- Plan Sponsor shall implement administrative, physical, and technical safeguards that reasonably and appropriately protect the confidentiality, integrity, and availability of the Electronic Protected Health Information that Plan Sponsor creates, receives, maintains, or transmits on behalf of the Plan;
- Plan Sponsor shall ensure that the adequate separation that is required by 45 C.F.R. § 164.504(f)(2)(iii) of the HIPAA Privacy Rule is supported by reasonable and appropriate security measures;
- Plan Sponsor shall ensure that any agent, including a subcontractor, to whom it provides Electronic Protected Health Information agrees to implement reasonable and appropriate security measures to protect such Information; and
- Plan Sponsor shall report to the Plan any Security Incident of which it becomes aware as described below:
  - Plan Sponsor shall report to the Plan within a reasonable time after Plan Sponsor becomes aware, any Security Incident that results in unauthorized access, use, disclosure, modification, or destruction of the Plan's Electronic Protected Health Information; and
  - Plan Sponsor shall report to the Plan any other Security Incident on an aggregate basis at renewal, or more frequently upon the Plan's request.

OTHER INFORMATION

Plan Name	University of the Incarnate Word Group Health Plan
SFP Number	S2855
State of Organization	University of the Incarnate Word is organized under the laws of the State of Texas.
Plan Sponsor	University of the Incarnate Word 4301 Broadway, CPO 320 San Antonio, TX 78209 (210) 829-6019
Tax Identification Number	74-1109661
Plan Administrator	University of the Incarnate Word 4301 Broadway, CPO 320 San Antonio, TX 78209 (210) 829-6019
Plan Affiliates/Subsidiaries	None
Benefit Services Manager	Gilsbar, L.L.C. P.O. Box 998 Covington, LA 70434 Telephone (985) 892-3520 or (800) 445-7227 Fax (985) 898-1500
Type of Plan and Administration	This Plan is a self-funded group medical cost indemnity plan; claims are processed by a claims payment company (the Benefit Services Manager), separate from the Plan Sponsor but under the direction of the Plan Administrator.
Plan Year Ends	The plan year begins on June 1 and ends on May 31.
Named Fiduciary	For purposes of determining the amount of, and entitlement to, benefits of the Plan, University of the Incarnate Word is the named fiduciary under the Plan, with the full power to interpret and apply the terms of the Plan.

Plan Cost	The Employer shares the cost of employee and dependent coverage under this Plan with the Covered Employees. The level of any employee contributions is set by the Plan Administrator. The Plan Administrator reserves the right to change the level of employee contributions.
Benefits	Plan benefits are provided by University of the Incarnate Word.
Agent for Service of Legal Process	Service of legal process may be made upon the Plan Administrator.
Plan is Not an Employment Contract	The Plan shall not be deemed to constitute a contract between the Employer and any employee or to be a consideration for, or an inducement, or condition of, the employment of any employee. Nothing in the Plan shall be deemed to give any employee the right to be retained in the service of the Employer or to interfere with the right of the Employer to discharge any employee at any time; provided, however, that the foregoing shall not be deemed to modify the provisions of any collective bargaining agreement which may be made by the Employer with the bargaining representatives of any employees.
Effective Date	This Plan was adopted by University of the Incarnate Word effective June 1 2018, and has been restated in this updated Plan Document and Summary Plan Description. The effective date of this amendment of the Plan is June 1, 2020.

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