Medical Plan Document and
Summary Plan Description (SPD)
For LAKEVIEW DENTAL CARE

Amended & Restated June 1st, 2023

For the Schedule of Benefits, see page 4

SPD Table of Contents

For assistance in a non-English language, please call844-302-7771.
Para obtener asistencia en Español, por favor llame al número arriba.

Introduction

Welcome to the LAKEVIEW DENTAL CARE Medical Plan.

This Plan Document and Summary Plan Description ("SPD") explains the operation of your health plan. Please call844-302-7771 if you have any questions.

Introduction
The Plan Sponsor has established the Plan, for the benefit of its Employees, to help offset the financial impact of an Injury or Sickness.

The Plan Document describes the terms for payment of covered medical and prescription charges.

Applicable Law
This Plan is subject to the Employee Retirement Income Security Act of 1974 ("ERISA"). To the extent not preempted by Federal law, the Plan shall be governed by the laws of the State where the Plan Sponsor maintains its principal place of business.

Type of Administration
The Plan is a self-funded group health plan. HealthEZ serves as a third-party claims administrator for the Plan.

Discretionary Authority
The Plan Administrator has the exclusive right to interpret the Plan and to decide all matters arising under the Plan, including the right to make determinations of fact, and construe and interpret possible ambiguities, inconsistencies, or omissions in the Plan and the SPD. The Plan Administrator also has full discretionary authority to interpret the Plan and to determine all questions relating to the Plan as they relate to eligibility to participate in the Plan. The Plan Administrator may delegate one or more of its responsibilities to one or more individuals, committees, or third-parties.

Fiduciary
The Plan Administrator is the named fiduciary of the Plan.

Legal Entity; Service of Process
The Plan is a legal entity. Legal process may be served on the Plan Administrator. You must exhaust your appeal rights (other than external review) before bringing legal action.

Plan Contributions & Funding
The Plan is self-funded by the general assets of the Plan Sponsor. The Plan Sponsor determines the level of Employee contributions.

Schedule of Benefits

Call844-302-7771 to verify eligibility for benefits before the charge is incurred.

Reimbursement from the Plan may be reduced or denied due to the provisions in the Plan, such as coordination of benefits, subrogation, or medical necessity.

DEDUCTIBLE

Before benefits can be paid in a Plan Year, a Plan Participant must pay the Deductible shown in the Schedule of Benefits.

OUT-OF-POCKET MAXIMUM

After the deductible is met, a Plan Participant will be required to continue to pay for a share of the Covered Expenses until the out-of-pocket maximum is met. Once the out-of-pocket maximum is reached, the Plan will pay for the entirety of the Covered Expenses for the remainder of the Plan Year.

COPAY AND COINSURANCE

Copay. A flat fee that is paid each time a service is provided.

Coinsurance. A portion of the cost of the service that the Plan Participant pays after the deductible is met.

Copayments and coinsurance accrue toward the out-of-pocket maximum, but not toward the deductible.

MAXIMUM ALLOWABLE CHARGE LIMITATION

The Plan has a fiduciary obligation to its participants to preserve Plan assets against charges that exceed the Maximum Allowable Charge. The Plan only pays benefits based on the Maximum Allowable Charge rather than billed charges. If a Provider charges more than the Maximum Allowable Charge (as determined by the Plan), the Plan Participant may be responsible for the amount in excess of the Maximum Allowable Charge, unless prohibited by applicable law. Any excess amount charged to the Plan Participant is not counted toward satisfaction of the Deductible, and it is not paid by the Plan even after satisfaction of the Deductible.

The Maximum Allowable Charge will not include charges for Unbundling, as defined by this Plan Document, which includes any items billed separately that are customarily included in a global billing procedure code in accordance with the American Medical Association's CPT® (Current Procedural Terminology) and/or the Healthcare Common Procedure Coding System (HCPCS) codes used by CMS.

ADVOCACY

It is the Plan's position that a Provider should not balance bill a Plan Participant for amounts in excess of the Maximum Allowable Charge. It is the Plan's position that these Excess Charges are clearly excessive and exorbitant.

PROVIDER NETWORK

Your Provider network name, phone number and website are displayed on of your ID card.

This Plan has entered into an agreement with Provider networks. In-network Providers have agreed to charge reduced fees to Plan Participants.

The Plan may pay for out-of-network services at the in-network benefit level if:

- A Plan Participant has no in-network Providers in the necessary specialty within the PPO service area; or
- A Plan Participant unavoidably receives services from an out-of-network Provider at an in-network facility.

Also, pursuant to the No Surprises Act, effective January 1, 2022, the Plan shall provide for out-of-network services at the in-network benefit level if:

- A Plan Participant receives emergency services from an out-of-network Provider or emergency facility;
- A Plan Participant receives non-emergency services from an out-of-network Provider at an in-network facility, unless the Provider furnishes notice to the Plan Participant, beneficiary, or authorized representative and receives consent from the individual in compliance with the No Surprises Act; or
- A Plan Participant receives air ambulance services furnished by an out-of-network Provider.

Additional information about this option, as well as a list of in-network Providers, will be made available to a Plan Participant upon request and without charge.

You have a free choice of any Provider (i.e. in-network or out-of-network) and you, together with your Provider, are 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.

Effective January 1, 2022, if a Provider is removed from the Plan's network, the Plan will notify Plan Participants who are receiving care from the Provider under a continuing care relationship that the Provider is no longer in the Plan's network and that the Participant has the right to elect to continue receiving transitional care from the Provider under the same terms and conditions that would have applied had the Provider remained in-network for up to a 90-day period from when the notice was furnished to the Participant.

SUPPLEMENTAL INFORMATION AND RECORDS REQUESTS

The Plan Administrator or its delegate may require additional information to make a benefit determination. The Plan Participant or Provider must send this information in the timeframe requested. Failure to send such requested information may result in denial of payment.

CLAIMS REVIEW

The Plan Administrator or its delegate may use its discretionary authority to utilize an independent bill review and/or claim audit program.

The Plan Administrator or its delegate has the discretionary authority to reduce any charge to a Usual and Customary or Reasonable amount. The Medicare reimbursement methodology is used in determining a Usual and Customary or Reasonable amount by the Plan.

Schedule of Benefits
HDHP 2

Non-Embedded Deductible Non-Embedded Out-of-Pocket Maximum	In Network	Out of Network
DEDUCTIBLE		
Individual Coverage	$2,000	$4,000
Family Coverage	$4,000	$8,000
OUT-OF-POCKET MAXIMUM		
Individual Coverage	$5,000	$10,000
Family Coverage	$10,000	$20,000
PLAN OPERATIONS		

- All deductible and out-of-pocket payments cross accumulate toward the in network and out of network deductible and out of pocket limits, as well as the individual and family limits.
- Both Medical and Pharmacy copayments, along with the services counted towards the deductible, will accrue toward the out-of-pocket maximum
- This plan is considered a High Deductible Health Plan and eligible for HSA.

For those who have elected family coverage:

- This health plan(s) has a non-embedded Deductible. This means that the family Deductible must be met before the Plan begins paying benefits that are subject to a Deductible.
- This health plan(s) has a non-embedded out-of-pocket maximum. This means that the family out-of-pocket maximum must be met before the Plan begins paying in full for all individuals.

Deductible Year	Grandfathered status	Coinsurance/Copay
Calendar	Not grandfathered	Indicates Plan Participant responsibility.

PREVENTIVE CARE SERVICES		
Well Child Care (up to age 18)	No Charge	50% Coinsurance
Adult Preventive Care	No Charge	50% Coinsurance
Routine Prenatal Care	No Charge	50% Coinsurance
Breast Feeding Equipment Limit to one pump per pregnancy	No Charge	

with a $350 limit for reimbursement unless otherwise precluded by applicable law.		
Routine Eye Exam One per 12 months	No Charge	50% Coinsurance
Any other preventive care services required by the Affordable Care Act.	No Charge	50% Coinsurance
TELEMEDICINE SERVICES PROVIDED THROUGH RECURO HEALTH		
Recuro	No Charge	
CLINIC AND INDEPENDENT LAB SERVICES		
Primary Care Office Visit	$30 Copay after Deductible	25% Coinsurance after Deductible
Specialist Office Visit	$75 Copay after Deductible	25% Coinsurance after Deductible
Walk In Clinic	$50 Copay after Deductible	25% Coinsurance after Deductible
Urgent Care Clinic	$75 Copay after Deductible	25% Coinsurance after Deductible
In Office Procedures	Primary: $30 Copay after Deductible Specialist: $75 Copay after Deductible	25% Coinsurance after Deductible
Labs, Pathology, Ultrasound and X-Ray	Primary: $30 Copay after Deductible Specialist: $75 Copay after Deductible	25% Coinsurance after Deductible
Allergy Shots, Testing, and Serum	Primary: $30 Copay after Deductible Specialist: $75 Copay after Deductible	25% Coinsurance after Deductible
Immunizations-Foreign Travel	0% Coinsurance after Deductible	25% Coinsurance after Deductible
Temporomandibular Joint Disorder (TMJ) No hardware coverage.	0% Coinsurance after Deductible	25% Coinsurance after Deductible
Infertility Care, services, supplies for the diagnosis and charges for surgical correction of physical abnormalities.	0% Coinsurance after Deductible	25% Coinsurance after Deductible
INJECTIONS AND INTRAVENOUS THERAPY		

Infusions and Injections	0% Coinsurance after Deductible	25% Coinsurance after Deductible
ADVANCED IMAGING		
Complex Imaging: MRI/CT/PET Scans	$300 Copay after Deductible	25% Coinsurance after Deductible
Nuclear Medicine, DEXA Scans, Diagnostic Mammogram	$300 Copay after Deductible	25% Coinsurance after Deductible
HOSPITAL AND SURGICAL SERVICES		
Inpatient Hospital Services	0% Coinsurance after Deductible	25% Coinsurance after Deductible
Outpatient Procedures – Facility and Physician Charges	0% Coinsurance after Deductible	25% Coinsurance after Deductible
Outpatient Hospital Labs & Pathology	$50 Copay after Deductible	25% Coinsurance after Deductible
Outpatient Hospital Ultrasound & X-Ray	$75 Copay after Deductible	25% Coinsurance after Deductible
Dialysis/ Hemodialysis Dialysis Treatment is the treatment of an acute renal failure or chronic irreversible renal insufficiency by removing waste products from the body. This includes hemodialysis and peritoneal dialysis. All benefits for dialysis treatment are paid at the Reasonable and Appropriate amount. This Plan does not utilize any network for this benefit.	0% Coinsurance after Deductible	
Organ Transplants Must be performed at a designated center of excellence for transplants.	0% Coinsurance after Deductible	Not Covered
EMERGENCY SERVICES		
Emergency Room Care	$300 Copay after Deductible	
Ground Ambulance	0% Coinsurance after Deductible	
Air Ambulance	0% Coinsurance after Deductible	
MENTAL HEALTH & SUBSTANCE ABUSE SERVICES		
Inpatient, Residential, Partial Hospitalization, or Intensive Outpatient	0% Coinsurance after Deductible	25% Coinsurance after Deductible
Office Visit	$75 Copay after Deductible	25% Coinsurance after Deductible
REHABILITATIVE/ HABILITATIVE OUTPATIENT THERAPY		

Occupational Therapy 30 visit limit per year.	$75 Copay after Deductible	25% Coinsurance after Deductible
Speech Therapy 30 visit limit per year.	$75 Copay after Deductible	25% Coinsurance after Deductible
Physical Therapy 30 visit limit per year.	$75 Copay after Deductible	25% Coinsurance after Deductible
Chiropractic Services 24 visit limit per year.	$75 Copay after Deductible	25% Coinsurance after Deductible
ANCILLARY SERVICES		
Skilled Nursing Facility 60 days per year maximum	0% Coinsurance after Deductible	25% Coinsurance after Deductible
Hospice	0% Coinsurance after Deductible	25% Coinsurance after Deductible
Private Duty Nursing Care Inpatient, only when ICU is not available.	0% Coinsurance after Deductible	25% Coinsurance after Deductible
Home Health Care	0% Coinsurance after Deductible	25% Coinsurance after Deductible
MEDICAL EQUIPMENT		
Medical Equipment	0% Coinsurance after Deductible	25% Coinsurance after Deductible
Prosthetics	0% Coinsurance after Deductible	25% Coinsurance after Deductible
Medically Necessary Wigs $1,000 Lifetime Maximum unless otherwise precluded by applicable law.	0% Coinsurance after Deductible	
PRESCRIPTION DRUG SERVICES		
	Retail (per 30-day supply)	**Mail Order (per 90-day Supply)**
Generic	$10 Copay after Deductible	$20 Copay after Deductible
Preferred Brand	$25 Copay after Deductible	$50 Copay after Deductible
Brand Non-Formulary	$75 Copay after Deductible	$150 Copay after Deductible
	Retail and Mail Order (per 30-day Supply)	**Retail and Mail Order (per 90-day Supply)**
Specialty Drugs	$150 Copay after Deductible	Not Available

Eligibility

Eligibility Requirements are determined by your Employer and set forth below. If you have any questions regarding eligibility, contact your Employer.

REQUIREMENTS	
Employee	30 hours per week or 130 hours per month
Waiting Period	Coverage Effective Date is the first day of the month following 90 days
Eligible Dependent	1. An Employee's spouse; 2. An Employee's Domestic Partner; 3. An Employee's Child who is less than 26 years of age, without regard to the child's student or marital status or whether the child is the Employee's financial dependent; and 4. An Employee's Child, regardless of age, who became Disabled prior to reaching 26 years of age and who has been continuously covered by the Plan since becoming Disabled. For purposes of this section, a Child is considered "disabled" if he or she meets the criteria used by the Social Security Administration to determine disability for purposes of the Supplemental Security Income program. The Plan reserves the right to require documentation to establish a Dependent relationship.
Coverage Termination	The date the Employee is terminated
Rehired Employees	If an Employee is rehired within 13 weeks of their termination, they are eligible no later than first of the month following that rehire.

Enrollment

An Employee must enroll for coverage with the Plan Sponsor within 31 days after the Employee becomes eligible. This enrollment cannot be changed or dropped without a qualifying event. During Open Enrollment, Employees will be able to elect, change, or discontinue coverage. The Plan Sponsor must forward the completed enrollment to HealthEZ in a timely manner.

Special Enrollment Rights

Federal law allows a Special Enrollment right if you had a qualifying event. This request for enrollment must be made within 31 days of the qualifying event unless a longer time is provided in this Plan Document or required by law. Coverage will be effective on the date of the qualifying event. An Employee or Eligible Dependent who is already enrolled in the Plan at the time of the Qualifying Event may also make changes to their enrollment at this time.

Qualifying events include:

- Loss of eligibility for health coverage:
    - Losing eligibility for existing health coverage, including job-based, individual, and student plans.
    - Losing eligibility for Medicaid or CHIP or becoming eligible for a state premium assistance subsidy under Medicaid or CHIP.
        - If an Employee has declined enrollment in the Plan for themselves or Dependents because of coverage under Medicaid or CHIP and loses that coverage or becomes eligible for a state premium assistance subsidy under Medicaid or CHIP, there is a right to enroll in this Plan. However, a request for enrollment must be made within 60 days after the Medicaid or CHIP coverage ends or after becoming eligible for a state premium subsidy under Medicaid or CHIP.

- Changes in household:
    - Acquisition of a new spouse due to marriage
    - Acquisition of a new Dependent through marriage, birth, adoption, or placement for adoption

Note: If other health plan coverage was lost because of failure to pay coverage premiums or required contributions, that Employee does not have Special Enrollment Rights based on such loss of coverage.

Termination of Coverage

Coverage will terminate on the earliest of these dates:

- The date the Plan is terminated or amended such that an individual loses coverage; or
- The date the Employee ceases to be eligible for participation in the Plan.

The Plan Sponsor also has the right to rescind any coverage for cause, including making a fraudulent claim or lying when obtaining coverage. In addition to being considered fraud on the Plan and an intentional misrepresentation, enrolling ineligible dependents or maintaining coverage for a person who no longer satisfies the dependent eligibility rules violates LAKEVIEW DENTAL CARE policy. If LAKEVIEW DENTAL CARE determines that an ineligible dependent has been enrolled, coverage may be canceled retroactively. LAKEVIEW DENTAL CARE reserves the right to recover any and all benefit payments made for services received by ineligible dependents and to terminate the Employee's employment.

Except in cases where you and/or your covered Dependents fail to pay any required contribution to the cost of coverage, the Plan will not retroactively terminate coverage under the Plan unless you and/or your covered Dependents (or a person seeking coverage on behalf of you and/or your covered Dependents) performs an act, practice or omission that constitutes fraud with respect to the Plan or unless the individual makes an intentional misrepresentation of material fact. In such cases, the Plan will provide at least 30 days advance written notice to you or your covered Dependent who is affected before coverage will be retroactively terminated. As provided above, coverage may be retroactively terminated in cases where the required Employee contributions have not been paid by the applicable deadline. In those cases, no advance written notice is required.

Coverage During Disability or Leave of Absence

A person may remain eligible for a limited time if disabled or during a leave of absence. Refer to your Employee handbook and/or policies for further information. If coverage continuance is granted, coverage will end when the Employer ends the continuance.

For continuation during FMLA leave, coverage ends at the end of the FMLA maximum coverage period. Refer to your Employee Handbook for further information. COBRA continuation coverage may be available after coverage ends.

Employees on Military Leave

Under the Uniformed Services Employment and Reemployment Rights Act (USERRA), if an Employee is absent from work because of service in the uniformed services, the Employee can continue health coverage for the Employee and the Employee's Dependents. If the Employee or the Employee's covered Dependents choose coverage under USERRA, then the Employee or the Dependents must pay monthly premiums for coverage.

During a military leave that is expected to be 30 days or less, the Employee's current employee coverage will continue without interruption, assuming the Employee pays the normal share of premiums for the coverage.

While on paid military service leave (for up to one year), the Employee may maintain the health benefits for which the Employee was enrolled before military service leave by paying the Employee's normal share of premiums for coverage.

For Employees who continue coverage while in military service, coverage will terminate at the earliest of these dates:

- The 24-month period beginning on the date absence begins; or
- The date the Employee fails to return to work as required.

A person who elects to continue health plan coverage may be required to pay up to 102% of the full contribution under the Plan, unless on active duty for 30 days or less.

A Waiting Period may not be imposed upon reemployment if one would not have been imposed had coverage not been terminated because of military service. However, an exclusion or Waiting Period may be imposed for coverage of any Illness or Injury determined by the Secretary of Veterans Affairs to have been incurred in, or aggravated during, the performance of active military service.

After your paid military service leave ends, the Employee may elect continuation coverage for up to 24 months under USERRA. In general, the Employee must meet the same requirements for electing USERRA coverage as are required under COBRA continuation coverage requirements. Coverage elected under these circumstances is concurrent, not cumulative. Dependents do not have any independent right to elect USERRA health plan continuation.

Covered Expenses

Covered Expenses are subject to the Usual and Customary Charge as determined by HealthEZ.

1. **Ambulance.** Professional land or air service, if medically necessary, to the nearest Hospital or Skilled Nursing Facility.

2. **Cardiac Rehabilitation.** Following a myocardial infarction, coronary occlusion, or coronary bypass surgery.

3. **Chemotherapy and Radiation Therapy.**

4. **Chiropractic services.** When performed by a licensed M.D., D.O. or D.C.

5. **Clinical Trials.** Routine patient costs for participation in an Approved Clinical Trial**.** Charges relating to the prevention, detection, or treatment of a life-threatening disease or condition, as defined under the PPACA, provided the clinical trial is approved by:

    - The Centers for Disease Control and Prevention of the U.S. Department of Health and Human Services;
    - The National Institute of Health;
    - The U.S. Food and Drug Administration;
    - The U.S. Department of Defense; or
    - The U.S. Department of Veterans Affairs.

6. **Contact Lenses.** The initial contact lenses required following cataract surgery.

7. **Contraceptives.** The charges for all FDA approved contraceptive methods are covered in accordance with Health Resources and Services Administration (HRSA) guidelines.

8. **Dental Services.** When recommended by a physician and Incurred during a dental procedure, facility and anesthesia charges are covered for a child under age 5; an individual who is severely disabled; or an individual who has a medical condition. Oral surgery for partially or completely unerupted impacted teeth; or tooth without the extraction of the entire tooth (this does not include root canal therapy); or the gums and tissues of the mouth when not performed in connection with the extraction or repair of teeth.

9. **Diabetic Supplies, Equipment and Devices**

10. **Home Health Care Services and Supplies.** When a Hospital or Skilled Nursing Facility would otherwise be required. The care must be prescribed by the attending Physician and be contained in a Home Health Care Plan. A Home Health Care Service visit is defined as a periodic visit by a nurse or therapist, or four hours of home health aide services.

11. **Dialysis Treatment.** The treatment of an acute renal failure or chronic irreversible renal insufficiency by removing waste products from the body. This includes hemodialysis and peritoneal dialysis. All benefits for dialysis treatment are paid at the Reasonable and Appropriate amount. This Plan does not utilize any network for this benefit.

12. **Hospice Care Services and Supplies.** When the patient is not expected to live more than six months, as certified by a Physician, and is placed under a Hospice Care Plan.

13. **Hospital Care.** After 23 observation hours, charges will be considered under inpatient confinement.

14. **Implantable Device.** An invoice must be included and represent the actual cost (net amount, exclusive of rebates and discounts) for the implantable device. The maximum allowable under the Plan is 135% of the documented invoice amount.

    In the event the implant invoice is not obtained by the Plan, the plan will have the discretionary authority to apply for a Reasonable payment, the PPO discount and/or audit negotiation in place of the calculation based on the actual billing.

15. **Infertility**. Diagnosis and surgical correction of physical abnormalities.

16. **Mental Disorders and Substance Abuse.** Treatment when billed by a Physician (M.D.), licensed consulting psychologists (Ph.D.), or licensed consulting Master of Social Work (M.S.W.). Other licensed mental health practitioners must be under the direction of and must bill the Plan through these professionals.

17. **Medical/Surgical Equipment Purchase or Rentals.** Rental costs cannot exceed the fair market value of the equipment.

18. **Occupational / Physical Therapy.** Rendered by a licensed therapist. Therapy must be rehabilitative and result from an Injury or Sickness other than a learning or Mental Disorder.

19. **Oral Procedures:**

    - Facility and Anesthesia charges are covered, when recommended by a physician, and when incurred during a dental procedure by: (i) a child under age 5; (ii) an individual who is severely disabled; or (iii) an individual who has a medical condition.
    - Oral surgery for partially or completely unerupted impacted teeth, such as impacted wisdom tooth removal; or tooth without the extraction of the entire tooth (this does not include root canal therapy); or the gums and tissues of the mouth, when not performed in connection with the extraction or repair of teeth.
    - Excision of tumors and cysts;
    - Surgery needed to correct injuries;
    - Excision of benign bony growths;
    - External incision and drainage of cellulitis;
    - Incision of sensory sinuses, salivary glands or ducts; or
    - Temporomandibular joint syndrome (TMJ).

20. **Organ transplant**. When performed at a **designated center of excellence for transplants**. Contact your network Provider for a list of designated centers of excellence for transplants.

21. **Obtaining donor organs or tissues.** When the donor has medical coverage, his or her plan will pay first. Donor charges include those for:

    - Evaluating the organ or tissue;
    - Removing the organ or tissue from the donor; and
    - Transportation of the organ or tissue from within the United States and Canada to the place where the transplant is to take place.

22. **Orthotic Appliances.** The initial purchase, fitting, and repair of non-foot orthotics when required for support of an injured or deformed body part.

23. **Pregnancy.** Routine Prenatal is covered as Preventive Care.

24. **Preventive and Wellness Care for Adults and Children**. In accordance with Federal Law, benefits are available for evidence-based items or services that have a rating of “A” or “B” in the current recommendations of the United States Preventive Services Task Force (USPSTF).

    Immunizations that have a recommendation from the Advisory Committee on Immunization Practices (ACIP) of the Centers for Disease Control and Prevention with respect to the individual involved.

    A list of Preventive and Wellness Services can be found at: https://www.uspreventiveservicestaskforce.org/uspstf/recommendation-topics/uspstf-and-b-recommendations

25. **Private Duty Nursing Care.** Rendered by a licensed nurse (R.N., L.P.N. or L.V.N.) when care is not Custodial in nature, or when the hospital has no Intensive Care Unit or is filled.

26. **Prosthetic Devices.** The purchase, fitting, and repair of devices which replace body parts.

27. **Reconstructive Surgery.** Non-cosmetic procedures, including mammoplasties.

28. **Skilled Nursing Facility.** Covered when:

    - The patient is confined as an inpatient in the facility;
    - The attending Physician certifies that confinement is needed; and
    - The attending Physician completes a treatment plan.

29. **Smoking Cessation.** To the extent required by law and when under the treatment of a Physician.

30. **Speech therapy**. Rendered by a licensed speech therapist and ordered by a Physician. Must follow a surgery, Injury, or Sickness, other than a learning or Mental Disorder.

31. **Surgeons Fees.**

    - If bilateral or multiple surgical procedures are performed, 50% of the Usual and Customary Charge will be allowed for each additional procedure performed through the same incision. Any unrelated procedure will be considered "incidental" and no benefits will be provided for such procedures. If two or more surgeons perform a procedure that is normally performed by one surgeon, benefits will not exceed the Usual and Customary Charge percentage allowed for that procedure; and

    - If an assistant surgeon is required, the assistant surgeon's covered charge will not exceed 20% of the surgeon's Usual and Customary Charge allowance.

32. **Sterilization.** To the extent required by the Patient Protection and Affordable Care Act (PPACA).

33. **Wigs.** Non-cosmetic, for medically certified conditions.

Plan Exclusions

The following are excluded from Covered Expenses.

Note: Please see Prescription Drug Coverage for exclusions related to Prescriptions Drugs.

1. **Abortions.** Except to save the life of the mother, when caused by rape or incest, or the fetus has been diagnosed with a lethal abnormality.

2. **Alcohol.** Ordered evaluation or treatment which occurred as a result of the Plan Participant's illegal use of alcohol. The arresting officer's determination of inebriation will be sufficient for this exclusion. This exclusion does not apply to the extent not permitted by Applicable Law or if the injury resulted from the victim of an act of domestic violence, or as a direct result of the Participant's mental or physical medical condition.

3. **Alternative Medicine/Therapies**. This includes acupuncture, acupressure, aromatherapy, biofeedback, kinetic therapy, hypnotherapy, homeopathic medicine; massage therapy, and neurofeedback, among others.

4. **Amniocentesis.** Services performed solely for the purpose of determining the gender or paternity of a fetus.

5. **Behavior Therapy Treatment.** Programs for the treatment of autism spectrum disorders unless explicitly required by Applicable Law.

6. **Blood Products.** Collection and/or storage of blood products to include stem cells or non-covered medical procedures. Salvage and storage of umbilical cord.

7. **Breast Implants.** Including replacement and removal of breast implants, except when required to be covered by the Women's Health and Cancer Rights Act.

8. **Cell and Gene Therapies.** Chimeric Antigen receptor (CAR) T-Cell Therapies and Gene Therapies.

9. **Communications and Accessibility Services.** Provider charges for interpretation, translation, accessibility or other special accommodations. Devices and computers to assist in communication and speech, including professional sign language or foreign language interpreter services.

10. **Complications of Non-Covered treatments.** Treatment required as a result of a complication from a non-covered service under the Plan.

11. **Cosmetic Surgery/Services.** Medical, surgical, and mental health services for or related to cosmetic surgery or procedures.

12. **Court or Police Ordered Services.** Examinations, reports, or appearances in connections with legal proceedings, including child custody, competency issues, parole and/or probation, and other court-ordered related issues.

13. **Custodial Care.** Non-medical assistance for activities of daily life, or maintenance.

14. **Oral Procedures**. The medical portion of the Plan covers only those oral procedures specifically stated in the section titled "Covered Medical Expenses."

15. **Diabetic Supplies, Equipment and Devices.** Non-covered services include the following:

- Over-the-counter supplies, medications, and equipment;
- Take home medications, supplies, and equipment after discharge from a Hospital, Nursing Home, Skilled Nursing Facility or other Inpatient or Outpatient facility.

16. **Educational evaluations or vocational testing.** Exams or other services for employment, insurance, licensure, judicial or administrative proceedings or research.

17. **Exercise.** Equipment, programs, clothing, or devices for treatment of any condition.

18. **Experimental or Investigational Treatment.**

19. **Eye care.** Eye Exercises, Orthoptic and Vision Therapy, Radial keratotomy, Lasik or other eye surgery to correct refractive disorders.

20. **Facility Charges.** Treatment provided at group homes, wilderness programs, boarding schools, halfway houses, assisted living centers, shelters, or foster homes.

21. **Foot care.** Unless related to diabetic care, treatment of weak, strained, flat, unstable or unbalanced feet, and treatment of corns, calluses or toenails. Shoes; shoe lifts; corrective shoes; foot orthotics; shoe inserts and arch supports.

22. **Foreign services.** Non-emergency related treatment outside of the U.S.

23. **Gender Reassignment – Cosmetic Procedures.** The following procedures that may be performed as a component of gender reassignment are considered cosmetic:

    - Rhinoplasty
    - Face lift
    - Lip enhancement
    - Facial bone reduction
    - Blepharoplasty
    - Liposuction
    - Reduction thyroid chondroplasty
    - Hair removal
    - Hair plugs or implants
    - Laryngoplasty
    - Skin resurfacing
    - Chin implant
    - Nose implant
    - Lip reduction
    - Any other procedure to enhance masculinization or feminization, beyond those considered Medically Necessary to achieve and support gender reassignment.

24. **Genetic Testing.** For a patient that is asymptomatic, unless otherwise precluded by applicable law

25. **Hair loss (cosmetic).** Treatment including wigs (non-medically necessary), hair transplants or any drug for hair growth.

26. **Hazardous Pursuit, Hobby or Activity.** Treatment that results from engaging in a hazardous pursuit of extreme sports or activity.

27. **Hearing Aids, Cochlear Implants, and Exams.** Services in connection with hearing aids, cochlear implants, or exams for their fitting or for hearing loss if not due to Illness or Injury.

28. **Home Maternity Services.** Deliveries at home including Doula and birth coach expenses.

29. **Hospital-based Infusion Therapy.** Intravenous-administered services provided in a Hospital-based setting. This Exclusion may be waived in cases of emergency, if it is medically necessary for the member to receive infusion therapy in a hospital-based setting or if treatment provided in a hospital-based setting is obtained at a lower cost to the Plan.

30. **Illegal Acts.** Charges for services rendered as a result of an Injury or Illness which was caused by one of the following:
    - the use of illegal narcotics or non-prescribed controlled substances (unless administered on the advice of a Physician); or
    - being illegally intoxicated (where the blood alcohol content meets the legal presumption of intoxication under the law of the state where the Accident took place), while operating a motorized vehicle; or
    - engaging in a riot or public disturbance, aggravated assault, illegal occupation, misdemeanor or felony; or
    - a Serious Illegal Act. A “Serious Illegal Act” is any act or series of acts for which a sentence to a term of imprisonment in excess of one year could be imposed (regardless of the individual’s own criminal history) if the act were prosecuted as a criminal offense in the state where the act took place.

31. **Impotence/Sexual Dysfunction.** Behavioral Treatment or medication regardless of the cause of the dysfunction.

32. **Infertility Treatment.** Infertility treatment which is not expressly included in the Schedule of Benefits.

33. **Maintenance Therapy.** Treatment after an individual has reached the maximum level of improvement.

34. **Malpractice**. Services required to treat injuries or illnesses including infections and complications that are contracted while under the care of a Provider that are not reasonably expected to occur. This includes but is not limited to: surgery on the wrong body part, foreign object left in the patient after surgery, electric shock, burn, or fall while confined in a facility.

35. **Medical Equipment.** Examples include, but are not limited to, the following:

    - Exercise equipment, air purifiers, central or unit air conditioners, water purifiers, allergenic pillows, mattresses or waterbeds, escalators or elevators, ramps, automobile modifications, safety bars, saunas, swimming pools, Jacuzzi or whirlpools, and hygienic equipment;
    - Equipment for a patient in an institution that is ordinarily provided by an institution, such as wheelchairs, hospital beds, and oxygen tents;
    - More than one device designed to provide essentially the same function;
    - Deluxe, electric, model upgrades, specialized, customized or other non-standard equipment;
    - Scooters and other power operated vehicles;
    - Warning devices, stethoscopes, blood pressure cuffs;
    - Repair, replacement or routine maintenance of equipment or parts due to misuse or abuse;
    - Over-the-counter braces and other devices, prophylactic braces; braces used primarily for sports activities;
    - Replacement of braces of the leg, arm, back, neck, or artificial arms or legs;
    - Communication devices (speech generating devices) and/or training to use such devices;
    - Bionic and hydraulic devices;
    - Oxygen when services are outside of the Service Area and non-emergent or urgent, or when used for convenience;
    - Personal comfort items such as compression stockings and Transcutaneous Electrical Nerve

Stimulation (TENS) units.

36. **Non-Compliance.** Additional or noneffective treatment that is the result of noncompliance or against medical advice from a Hospital, Mental Health or Substance Abuse Facility, to the extent permitted by Applicable Law.

37. **Non-Emergency Ambulance Services/ Hospital Admissions.** Non-emergency ambulance services and/or non-emergency hospital admissions unless pre-certified and/or expressly covered under the Schedule of Benefits.

38. **Nutrition.** Infant formulas or other internal supplementation.

39. **Nutritionists and dietitians**.

40. **Obesity.** Treatment for weight loss, dietary control, or Morbid Obesity except to the extent required by Applicable Law. Bariatric surgery, including but not limited to, gastric bypass, stapling and intestinal bypass, and lap band surgery, including reversals.

41. **Occupational Services.** Charges that arise from work for wage or profit, including self-employment.

42. **Over-the-Counter Medical Supplies and Medications.** Over-the-counter medical supplies and medications except to the extent required by Applicable Law.

43. **Physical and Psychiatric Exams.** Testing and/or other services in connection with obtaining or maintaining employment, school or camp attendance or insurance qualification, or any type of license or medical research.

44. **Private Duty Nursing.** Charges for outpatient private duty nursing care, treatment or services.

45. **Rehabilitation/Habilitative Services.** Maintenance and/or non-Acute therapies; or therapies where a significant and measurable improvement of a condition cannot be expected in a Reasonable and predictable period of time.

46. **Self-Inflicted Deliberate Injury.** Unless resulting from being the victim of an act of domestic violence or a medical condition (including both physical and mental health conditions).

47. **Surrogate Mother Pregnancies.** Surrogate mother pregnancies unless the surrogate mother is a Plan Participant, in which case the Plan will cover preventative care services as required by Applicable Law.

48. **Temporomandibular Joint Disorder**

    - Dental splints, dental prosthesis or any treatment on or to the teeth, gums, or jaws;
    - Treatment of pain or infection due to a dental cause, surgical correction of malocclusion, maxilla facial orthognathic and prognathic surgery, orthodontia treatment.

49. **Transportation, Travel or Accommodations.**

50. **War and Riots.** Expenses caused by or arising out of riots, insurrection, rebellion, armed invasion, or aggression.

Defined Terms

These terms have significant meaning and when used in this Plan Document will be capitalized.

1. **Adverse Benefit Determination.** A failure to provide or make payment (in whole or in part) for a benefit. This includes, but is not limited to: denials, reduction, termination, or rescission.

2. **Allowable Expenses.** The dollar amount considered payment in full by an insurance plan. The allowable charge is a discounted rate rather than the actual charge.

3. **Approved Clinical Trial**. means a phase I, II, III or IV trial that is Federally funded by specified Agencies (National Institutes of Health, CDCP, Agency for Health Care Research, Centers for Medicare and Medicaid Services ("CMS"), Dept. of Defense or Veterans Affairs, or a non-governmental entity identified by NIH guidelines) or is conducted under an Investigational new drug application reviewed by the FDA (if such application is required).

   The Patient Protection and Affordable Care Act requires that if a "qualified individual" is in an "Approved Clinical Trial," the Plan cannot deny coverage for related services ("routine patient costs").

   A "qualified individual" is someone who is eligible to participate in an "Approved Clinical Trial" and either the individual's doctor has concluded that participation is appropriate, or the Participant provides medical and scientific information establishing that their participation is appropriate.

   "Routine patient costs" include all items and services consistent with the coverage provided in the Plan that is typically covered for a qualified individual who is not enrolled in a clinical trial. Routine patient costs do not include 1) the Investigational item, device or service itself; 2) items and services that are provided solely to satisfy data collection and analysis needs and that are not used in the direct clinical management of the patient; and 3) a service that is clearly inconsistent with the widely accepted and established standards of care for a particular Diagnosis. Plans are not required to provide benefits for routine patient care services provided outside of the Plan's network area unless out-of-network benefits are otherwise provided under the Plan.

4. **Center of Excellence.** Medical care facilities that have met stringent criteria for quality care in the specialized procedures of organ transplantation. These centers have the best outcomes in performing transplant procedures and the best survival rates. The Plan Administrator or its delegate shall determine what network Centers of Excellence are to be used.

5. **Child.** Employee's own blood descendant of the first degree, a stepchild, lawfully adopted Child, or a Child placed with a covered Employee in anticipation of legal adoption, and/or a covered Employee's Child who is an alternate recipient under a "Qualified Medical Child Support Order" required by law.

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

7. **Claim**. A detailed invoice that you or your healthcare Provider sends to your health plan. This invoice shows the services you received**.**

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

9. **Covered Expense.** A service or treatment which is eligible for coverage in this Plan.

10. **Custodial Care.** Services that are rendered for assistance in daily living that can be provided safely and reasonably by individuals who are neither skilled nor licensed medical personnel.

11. **Dependent.** A non-Employee who is eligible for coverage under the Eligibility section of the Plan.

12. **Domestic Partner.** An unrelated and unmarried person who shares living quarters with an Employee and relies on the Employee for more than one half of his or her support for the plan year.

13. **Emergency.** A serious, unexpected, or dangerous situation requiring immediate medical attention.

14. **Employee.** A person who is employed by the Plan Sponsor and eligible for coverage.

15. **Effective Date**. The first day of coverage.

16. **ERISA**. The Employee Retirement Income Security Act of 1974, as amended.

17. **Errors.** Charges based on billing mistakes, improprieties, or illegitimate billing entries, including, but not limited to, up-coding, duplicate charges, charges for care, supplies, treatment, and/or services not actually rendered or performed, or charges otherwise determined to be invalid, impermissible, or improper based on any applicable law, regulation, rule, or professional standard. It is in the Plan Administrator's sole discretion to determine what constitutes an error under the terms of this Plan.

18. **Experimental and/or Investigational.** Services or treatments that are not United States Food and Drug Administration (FDA) approved. Services or treatments which are not widely used or accepted by most practitioners or lack credible evidence, and that are not the subject of, or related to, the conduct of an Approved Clinical Trial, as such term is defined herein; these services are not included under or as Medicare reimbursable procedures, and include services, supplies, care, procedures, treatments or courses of treatment.

19. **Family.** The covered Employee and the Dependents who are covered under the Plan.

20. **FMLA.** Family and Medical Leave Act of 1993, as amended.

21. **FMLA Leave** is a leave of absence, which the Employer is required to extend to an Employee under FMLA.

22. **Formulary.** A list of covered prescription medications compiled by the Pharmacy Benefit Manager.

23. **Generic Drug**. A Prescription Drug which has the equivalency of the Brand Name drug with the same use and metabolic disintegration.

24. **GINA**. 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.

25. **Health Savings Account (HSA).** An IRS-regulated, pre-tax account that may be established and controlled by the Employee. Both the Employee and Employer can contribute to the Health Savings Account (HSA) up to the annual IRS maximum. The Health Savings Account (HSA), when combined with an HSA-eligible health plan, can be used to fund the deductible as well as pay other IRS-qualified medical, dental, or vision expenses.

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

27. **Home Health Care Agency.** An organization whose main function is to provide Home Health Care Services and Supplies; The agency must be federally certified and licensed by the state in which it is operating.

28. **Home Health Care Plan**. A formal written plan made by the patient's attending Physician; which states the diagnosis and specifies the type and extent of Home Health Care required.

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

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

31. **Hospice Care Services and Supplies.** Those provided through a Hospice Agency and under a Hospice Care Plan and include inpatient care in a Hospice Unit or other licensed facility, and home care. See the Schedule of Benefits to determine whether this includes family counseling during the bereavement period.

32. **Hospital.** An institution which is engaged primarily in providing medical care is accredited as a Hospital by The Joint Commission on Accreditation of Healthcare Organizations or the American Osteopathic Association Healthcare Facilities Accreditation Program or is approved by Medicare as a Hospital. The definition of "Hospital" shall be expanded to include the following: A facility operating legally as a psychiatric Hospital or residential treatment facility for mental health and licensed as such by the state in which the facility operates.

33. **Illness.** A bodily disorder, disease, physical Sickness or Mental Disorder. Illness includes Pregnancy, childbirth, miscarriage or complications of Pregnancy.

34. **Incurred**. A Covered Expense is “Incurred” on the date the service is rendered, or the supply is obtained.

35. **Infertility.** Incapable of producing offspring.

36. **Injury.** A physical Injury to the body caused by unexpected or external means.

37. **Intensive Care Unit.** A department of a hospital of which patients who are dangerously ill are kept under constant observation.

38. **Legal Guardian.** A person recognized by a court of law as having the duty of taking care of the person and managing the property and rights of an individual.

39. **Maximum Allowable Charge.** means the benefit payable for a specific coverage item or benefit under the Plan. Maximum Allowable Charge(s) shall be calculated by the Plan Administrator taking into account and after having analyzed at least one of the following:

    1. The Reasonable and Appropriate amount.
    2. The allowable charge specified under the terms of the Plan.
    3. The actual billed charges for the covered services.

    The Plan has the discretionary authority to decide if a charge is Reasonable and Appropriate, as well as medically Necessary. 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.

    Reasonable and Appropriate fees shall be limited to Covered Expenses which are identified

as eligible for payment by the Plan Administrator in accordance with the terms of this Plan. "Reasonable and Appropriate" amounts may be determined and established by the Plan, at the Plan Administrator's discretion, using normative data such as, but not limited to, the fee(s) which the Provider most frequently charges the majority of patients for the service or supply, amounts the Provider most often 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), the prevailing range of fees charged in the same "area" by Providers of similar training and experience for the service or supply, rates negotiated with the Plan, and/or Medicare reimbursement rates.

Medicare rates plus 40% are generally considered to be Reasonable and Appropriate; however, the Plan Administrator may in its discretion, taking into consideration specific circumstances and negotiated terms, deem a greater amount to payable.

The term(s) "same geographic locale" and/or "area" shall be 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.

Furthermore, Reasonable and Appropriate shall be limited to those claims that, in the Plan Administrator's discretion, are services or supplies or fees for services or supplies that are necessary for the care and treatment of Illness or Injury not unreasonably caused by the treating Provider. Determination that fee(s) or services are therefore Reasonable and Appropriate 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 Reasonable and Appropriate, service(s) and/or fee(s) must be in compliance with generally accepted billing practices for unbundling or multiple procedures. Services, supplies, care and/or treatment that result from errors in medical care that are clearly identifiable, preventable, and serious in their consequence for patients, are not Reasonable and Appropriate. The Plan Administrator retains discretionary authority to determine whether service(s) and/or fee(s) are Reasonable and Appropriate based upon information presented to the Plan Administrator. A finding of Provider negligence and/or malpractice is not required for service(s) and/or fee(s) to be considered not Reasonable and Appropriate.

40. **Medical Care Necessity**, **Medically Necessary**, **Medical Necessity.** Health care services ordered by a licensed Physician exercising prudent clinical judgment provided to a Plan Participant for the purposes of evaluation, diagnosis or treatment of that Plan Participant's Sickness or Injury. Such services, to be considered Medically Necessary, must be clinically appropriate in terms of type, frequency, extent, site and duration for the diagnosis or treatment of the Plan Participant's Sickness or Injury. The Medically Necessary setting and level of service is that setting and level of service which, considering the Plan Participant's medical symptoms and conditions, cannot be provided in a less intensive medical setting. Such services, to be considered Medically Necessary must be no more costly than alternative interventions, including no intervention, and are at least as likely to produce equivalent therapeutic or diagnostic results as to the diagnosis or treatment of the Plan Participant's Sickness or Injury without adversely affecting the Plan Participant's medical condition. To be considered Medically Necessary, the services:

    (1) Must not be maintenance therapy or maintenance treatment;
    (2) Purpose must be to restore health;
    (3) Must not be primarily custodial in nature; and
    (4) Must not be a listed item or treatment not allowed for reimbursement by CMS (Medicare).

The Plan reserves the right to incorporate CMS (Medicare) guidelines in effect on the date of treatment as additional criteria for determination of Medical Necessity and/or an Allowable Expense.

For Hospital stays, this means that acute care as an Inpatient is necessary due to the kind of services the Plan Participant is receiving or the severity of the Plan Participant's condition and that safe and adequate care cannot be received as an outpatient or in a less intensified medical 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."

To be Medically Necessary, all these criteria must be met. Merely because a Physician or Dentist recommends, approves, or orders certain care does not mean that it is Medically Necessary. The determination of whether a service, supply, or treatment is or is not Medically Necessary may include findings of the FDA and other medical advisors. The Plan Administrator has the discretionary authority to decide whether care or treatment is Medically Necessary.

41. **Medical Equipment.** Equipment and supplies ordered by a healthcare Provider for everyday or extended use.

42. **Medicare**. The Health Insurance for the Aged and Disabled under Title XVIII of the Social Security Act, as amended.

43. **Mental Disorder.** A disease or condition is classified as a Mental Disorder in the current edition of International Classification of Diseases, published by the U.S. Department of Health and Human Services or is listed in the current edition of Diagnostic and Statistical Manual of Mental Disorders, published by the American Psychiatric Association.

44. **Morbid Obesity.** A diagnosed condition in which the body weight exceeds the medically recommended weight by either 100 pounds or is twice the medically recommended weight for a person of the same height, age, and mobility as the Plan Participant.

45. **No-Fault Coverage.** The basic reparations provision of a law providing for payments without determining fault in connection with automobile accidents.

46. **Open Enrollment**. The yearly period when employees can enroll in benefits.

47. **Outpatient Services.** Medical procedures or tests that can be done in a medical center without an overnight stay.

48. **Partial Hospitalization.** A structured program of outpatient psychiatric or substance abuse services. This treatment is provided during the day and does not require an overnight stay.

49. **Pharmacy.** An establishment where covered Prescription Drugs are filled and dispensed by a licensed pharmacist.

50. **Physician**. A Doctor of Medicine (M.D.), Osteopathy (D.O.), Podiatric Medicine (D.P.M.), Chiropractic (D.C.), Dental Surgery (D.D.S), or Optometry (O.D). Licensed Professional Counselor, Licensed Professional Physical Therapist, Master of Social Work (M.S.W.), Midwife, Licensed Professional Occupational Therapist, Psychiatrist, Psychologist (Ph.D.), or Licensed Professional Speech Language Pathologist. All physicians must be practicing within the scope of their license.

51. **Plan.** LAKEVIEW DENTAL CARE Medical Plan, which is a group health plan for eligible Employees.

52. **Plan Participant.** An Employee or Dependent who is covered under this Plan.

53. **Plan Sponsor.** LAKEVIEW DENTAL CARE

54. **Provider**. A health professional who provides health care services.

55. **Prenatal.** Existing or occurring before birth.

56. **Prescription Drug.** A pharmaceutical drug that legally requires a medical prescription to be dispensed.

57. **Preventive Care**. Routine healthcare that includes screenings, check-ups, and patient counseling to prevent illnesses, disease, or other health problems.

58. **Reasonable** and/or **Reasonableness.** In the Plan Administrator's discretion, services or supplies, or fees for services or supplies which are necessary for the care and treatment of illness or injury not caused by the treating Provider. Determination that fee(s) or services are reasonable will be made by the Plan Administrator or its delegate.

    This determination will consider the findings and assessments of the following entities: (a) The National Medical Associations, Societies, and organizations; and (b) the U.S. Food and Drug Administration. To be Reasonable, service(s) and/or fee(s) must be in compliance with generally accepted billing practices for unbundling or multiple procedures. Services, supplies, care and/or treatment that results from errors in medical care that are clearly identifiable, preventable, and serious in their consequence for patients, are not Reasonable. The Plan Administrator retains discretionary authority to determine whether service(s) and/or fee(s) are Reasonable based upon information presented to it or its delegate. A finding of Provider negligence and/or malpractice is not required for service(s) and/or fee(s) to be considered not Reasonable.

    Charge(s) and/or services are not considered to be Reasonable, and as such are not eligible for payment (exceed the Maximum Allowable Charge), when they result from Provider error(s) and/or facility-acquired conditions deemed "reasonably preventable" through the use of evidence-based guidelines, taking into consideration CMS guidelines.

    The Plan reserves for itself and parties acting on its behalf the right to review charges processed and/or paid by the Plan, to identify charge(s) and/or service(s) that are not Reasonable and therefore not eligible for payment by the Plan.

59. **Rehabilitative.** The process of helping a person who has suffered an Illness or Injury, restore lost skills and regain maximum self-sufficiency.

60. **Sickness.** A person's Illness, disease or Pregnancy (including complications).

61. **Skilled Nursing Facility.** A facility that fully meets all of these tests: (i) services are provided for compensation and under the full-time supervision of a Physician; (ii) provides 24-hour per day nursing services by licensed nurses, under the direction of a full-time registered nurse; (iii) maintains a complete medical record on each patient; (iv) has an effective utilization review plan; (v) has ability to store and dispense Prescription Drugs; and, (vi) is approved and licensed by Medicare. This term also applies to charges Incurred in a facility referring to itself as an extended care facility, convalescent nursing home, rehabilitation hospital, long-term acute care facility or any other similar nomenclature.

62. **Special Enrollment Period**. A time outside the yearly Open Enrollment Period when you can enroll in benefits. You qualify for a Special Enrollment Period if you've had certain life qualifying events.

63. **Special Enrollment Rights.** A right granted by federal law to enroll in the Plan during a Special Enrollment Period.

64. **Spouse.** An individual who is lawfully married to an Employee under the law of the state where the Employee resides.

65. **Substance Abuse.** Any use of alcohol, any drug (whether obtained legally or illegally), or other illegal substance, which produces a pattern of pathological use, causing impairment in social or occupational functioning, or which produces physiological dependency evidenced by physical tolerance or withdrawal. It is the excessive use of a substance, especially alcohol or a drug. The Diagnostic and Statistical Manual of Mental Disorders (DSM) definition of "Substance Use Disorder" is applied as a maladaptive pattern of substance use leading to clinically significant impairment or distress, as manifested by one (or more) of the following, occurring within a 12-month period:

    - Recurrent substance use resulting in a failure to fulfill major role obligations at work, school or home
    - Recurrent substance use in situations in which it is physically hazardous
    - Craving or a strong desire or urge to use a substance;
    - Continued substance use despite having persistent or recurrent social or interpersonal problems caused or exacerbated by the effects of the substance

66. **Substance Abuse Treatment Center.** A facility operating primarily for the treatment of Substance Abuse if it meets these tests: (i) maintains permanent and full-time facilities for bed care and full-time confinement of at least 15 resident patients; (ii) has a Physician in regular attendance; (iii) continuously provides 24-hour a day nursing service by a registered nurse (R.N.); (iv) has a full-time psychiatrist or psychologist on the staff; and (v) is primarily engaged in providing diagnostic and therapeutic services and facilities for treatment of Substance Abuse. This Institution must be: affiliated with a Hospital under a contractual agreement with an established system for patient referral; accredited as such a facility by The Joint Commission on Accreditation of Hospitals; or licensed, certified, or approved as an alcohol or Substance Abuse treatment program or center by a State agency having legal authority to do so.

67. **Temporomandibular Joint (TMJ) Syndrome**. Jaw joint disorders, including conditions of structures linking the jaw bone and skull and the complex of muscles, nerves and other tissues related to the Temporomandibular joint.

68. **Unbundling.** Charges for any items billed separately that are customarily included in a global billing procedure code in accordance with the American Medical Association's CPT® (Current Procedural Terminology) and/or the Healthcare Common Procedure Coding System (HCPCS) codes used by CMS.

69. **Usual and Customary (U&C).** Covered Expenses which are identified by the Plan Administrator or its delegate, taking into consideration the fee(s) which the Provider most frequently charges the majority of patients for the service or supply, the cost to the Provider for providing the services, the prevailing range of fees charged in the same "area" by Providers of similar training and experience for the service or supply, and the Medicare reimbursement rates.

    The term(s) "same geographic locale" and/or "area" shall be 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. To be Usual and Customary, fee(s) must be in compliance with generally accepted billing practices for unbundling or multiple procedures.

    The term "Usual" refers to the amount of a charge made for medical services, care, or supplies, to the extent that the charge does not exceed the common level of charges made by other medical professionals with similar credentials, or health care facilities, pharmacies, or equipment suppliers of similar standing, which are located in the same geographic locale in which the charge is Incurred.

The term “Customary” refers to the form and substance of a service, supply, or treatment provided in accordance with generally accepted standards of medical practice to one individual, which is appropriate for the care or treatment of a person of the same sex, comparable age and who receive such services or supplies within the same geographic locale.

The term “Usual and Customary” does not necessarily mean the actual charge made nor the specific service or supply furnished to a Plan Participant by a Provider of services or supplies, such as a physician, therapist, nurse, hospital, or pharmacist. The Plan Administrator or its delegate will determine what the Usual and Customary charge is, for any procedure, service, or supply, and whether a specific procedure, service or supply is Usual and Customary.

Usual and Customary charges may, at the Plan Administrator’s discretion, alternatively be determined and established by the Plan using normative data such as, Medicare cost to charge ratios, average wholesale price (AWP) for prescriptions and/or manufacturer’s retail pricing (MRP) for supplies and devices.

Care Management Services

Care Management Services Phone Number:**844-302-7771**

The Plan Participant or a family member must call to receive certification of certain Care Management Services.

UTILIZATION REVIEW

Utilization review is designed to help ensure that all Plan Participants receive necessary and appropriate health care while avoiding unnecessary expenses. The program consists of:

- Precertification of Medical Necessity for certain non-Emergency services before services are provided;
- Concurrent review of the listed services requested by the attending Physician; and
- Planning for discharge or cessation of medical treatment.

If a course of treatment or medical service is not certified, it means that the Plan may not pay in full for the charges. The patient is urged to find out why there is a discrepancy between what was requested and what was certified before incurring charges.

Precertification

The utilization review program is set in motion by a telephone call from the Plan Participant or Provider. Initiate the review at **least 48 hours before** services are scheduled by calling the precertification phone number on the ID card with the following information:

- The name of the patient and relationship to the Employee, Subscriber number, and address.
- The name and telephone number of the Physician.
- The name of the Medical Facility, proposed admission date, and proposed length of stay.
- The diagnosis and/or type of surgery or treatment.

Find a list of services that commonly require Precertification at www.LakeviewDentalCareBenefits.com. For a list of services specific to the Plan that require Precertification, please call 844-302-777.

If there is an **Emergency** admission to the Facility, the utilization review administrator must be contacted **within 48 hours** of the first business day after the admission.

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.

Failure to pre-certify required service may result in denial of or reduction in payment for services.

Boost Your Baby- Maternity Management

If included in your Plan, Moms-to-be are identified, assisted, and followed by a Mommy Mentor to support a healthy Pregnancy. Those determined to be high risk are placed with a nurse in Care Management. All moms in Boost Your Baby are followed monthly and through six months post-delivery.

Alternative Care Plans
When a medical service at a specific place of service is not deemed medically necessary, the Plan reserves the right to limit coverage for the service to the amount that would apply from the more cost-effective location. A care manager consults with the patient, the family, and the Physician to develop a plan of care. Once a plan has been implemented, the Plan will reimburse for expenses as stated in the treatment plan, even if these expenses normally would not be paid by the Plan.

Prescription Drug Coverage

Participating pharmacies have contracted with the Plan to charge Plan Participants reduced fees for covered Prescription Drugs. Contact your Pharmacy Benefit Manager ("PBM") for more information.

If a drug is purchased from a non-participating pharmacy or when the Plan Participant's ID card is not used, the total amount eligible for benefits will be the ingredient cost and the dispensing fee.

Prior Authorization

Certain prescription drugs require a Prior Authorization. This means a review of a medication prescribed will be done before the Plan will cover it. A prior authorization may be required for drugs listed or not listed on the PBM's formulary.

Generic Medications:

Generic Medications: At times, certain generic and OTC medications may be available at a lower cost outside of the pharmacy benefit. The plan will monitor claims and if identified, may reach out to you to help you obtain these products. If obtained through this process, the medication's cost may be completely covered by the plan.

Expenses Not Covered

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

1. **Appetite suppressants.** A charge for appetite suppressants, dietary supplements, or vitamin supplements, except for Prenatal vitamins requiring a prescription, or prescription vitamin supplements containing fluoride.

2. **Drugs used for cosmetic purposes.** Charges for drugs used for cosmetic purposes, such as anabolic steroids, Retin A, or medications for hair growth or removal.

3. **Experimental, Investigational, or non-FDA Approved.**

4. **Growth hormones.** Charges for drugs to enhance physical growth or athletic performance or appearance. Human Growth Hormone except for children or adolescents who have one of the following conditions:
    - Documented growth hormone deficiency causing slow growth;
    - Documented growth hormone deficiency causing infantile hypoglycemia;
    - SHOX
    - Short stature and growth due to Turner syndrome, Prader-Willi syndrome, chronic renal insufficiency prior to transplantation, central nervous system tumor treated with radiation;
    - Documented growth hormone deficiency due to a hypothalamic or pituitary condition.

5. **Impotence.** A charge for impotence medication.

6. **Injectable supplies.** A charge for hypodermic syringes and/or needles (other than for insulin).

7. **Inpatient medication.** A drug or medicine that is to be taken while Hospital confined. This includes being confined in any institution that has a facility for the dispensing of drugs and medicines on its premises. Instead, inpatient medication may be covered by the Plan's medical coverage.

8. **Medical exclusions.** A charge excluded under Medical Plan Exclusions.

9. **Copay Assistance.** A charge for Prescription Drugs which may be properly received without charge under local, state, or federal programs.

10. **Off-Label drugs.** A charge for FDA-approved drugs that are prescribed for non-FDA-approved uses.

11. **No prescription.** A drug or medicine that can legally be bought without a written prescription.

12. **Preventive Prescriptions**. The Patient Protection and Affordable Care Act (PPACA), as part of Health Care Reform, contains a provision that requires your health plan to provide certain preventive care services with no cost-sharing, i.e., not subject to Copays, coinsurance, or Deductibles. * These services include but are not limited to: routine physicals; pediatric wellness examination; selected preventive, diagnostic, and cancer screenings; and certain pediatric preventive services, including but not limited to, oral health assessment, sensory screening, and developmental and behavioral assessment. Brand medications with a generic equivalent will require the standard cost share/deductible

    - Contraceptive management: Includes preventive services for women as required by PPACA without cost share for prescribed FDA approved contraceptives, including oral contraceptives, transdermal patches, and vaginal rings. If a Generic Drug version is not available or would not be medically appropriate (as determined by your health care provider) a prescribed FDA-approved Brand Name contraceptive method will be paid by the Plan with no cost sharing. Brand medications with a generic equivalent will require the standard cost share/deductible

    - Smoking Cessation: Included with prescription without cost share for nicotine replacement therapy (i.e., gum, lozenge, transdermal patches, inhaler and nasal spray); sustained release Bupropion; Varenicline. Brand medications with a generic equivalent will require the standard cost share/deductible

    - Preventive Medications: Includes certain prescribed over-the-counter products without cost share as required by PPACA. Brand medications with a generic equivalent will require the standard cost share/deductible In addition, certain preventive medications may be available with deductible waived. For details, contact your pharmacy benefit manager at the number listed on your ID card.

13. **Refills.** Any refill that is requested more than one year after the prescription was written or any refill that is more than the number of refills ordered by the Physician.

14. **Specialty Drugs.** Specialty drugs with a gross cost of $5,000 per month are not covered by the plan. The Plan may permit for one (1) 30-day fill for each of these drugs during the Benefit Year. To speak with an advocate about programs for continued coverage outside of your Prescription Drug benefit, please contact Franklin Health at 484-588-4289.

Specialty Medications

Specialty medications are drugs that are used to treat complex conditions and illnesses, such as cancer, growth hormone deficiency, hemophilia, hepatitis C, immune deficiency, multiple sclerosis, and rheumatoid arthritis. These drugs usually require special handling, special administration, or intensive patient monitoring. Medications used to treat diabetes are not considered specialty medications. Whether they are administered by a healthcare professional, self-injected, or taken by mouth, specialty medications require an enhanced level of service.

Specialty pharmaceuticals are covered under your prescription drug and/or medical benefit program.

Your prescription drug program requires that Specialty Medications for multiple sclerosis and inflammatory conditions (Rheumatoid Arthritis, Crohn's, Psoriasis, Psoriatic Arthritis, etc.) be accessed through your prescription benefit effective 1/1/2022. At that time, you may no longer be covered for those specialty medications through your medical benefit. The list of medications subject to the program is available by calling the pharmacy telephone number on your ID card. If you are currently using specialty medications affected by the program and you do not obtain them through Welldyne, you may be required to transfer those. If you continue to purchase your medications from your doctor or another pharmacy, you may be responsible for their full cost. When you order a covered specialty medication through Welldyne, your out-of-pocket cost will be limited to the applicable co-payment.

In order to provide you with sufficient time to transfer your prescriptions from your medical coverage to your pharmacy benefit, through 1/1/2022, you may appeal through the appropriate appeals process for coverage for one additional prescription from your current provider. In addition, if you have an extenuating medical condition that prevents you from transitioning to the pharmacy benefit, you may be granted an override and continue on your medical benefit as long as there is a reviewed medical reason not to transition.

The list of medications subject to this specialty drug program may change, and you should check the list before you fill a prescription for a specialty medication.

How to Submit a Claim

In-network Providers will submit Claims to the Plan. When a Plan Participant has an out of network claim to submit for consideration, they must submit:

- Subscriber number
- Employee's name
- Patient's Name
- Name, address, tax ID, NPI, and telephone number of the Provider of care
- Type of services rendered, with diagnosis and procedure codes
- Date of service(s)
- Any receipt

Send information to HealthEZ:

Mail – PO Box 211186, Eagan, MN 55121
Email – claimsubmission@healthez.com

WHEN CLAIMS SHOULD BE FILED

Claims must be filed within 180 days of the date of service or they will be denied as untimely, unless tolled under the COVID-19 tolling rules. Benefits are applied based on the date of service.

If the Plan Participant is accessing the Cigna PPO network, the timely filing limit is 365 days of the date of service.

HealthEZ reserves the right to request more information from the Plan Participant or Provider.

TIMEFRAMES

The following timetable applies to post-service claims:	
Notification to Plan Participant of an adverse benefit determination	30 days
Extension due to matters beyond the control of the Plan	15 days
Extension due to insufficient information on the Claim	15 days
Response by the Plan Participant following notice of insufficient information	45 days
Review of Adverse Benefit Determination	60 days after benefit appeal
The following timetable applies to non-urgent pre-service claims:	
Notification to Plan Participant of a benefit determination	15 days
Notification to Plan Participant of failure to follow procedures	5 days
Extension due to matters beyond the control of the Plan	15 days
Extension due to insufficient information on the Claim	15 days
Response by the Plan Participant following notice of insufficient information	45 days
Review of Adverse Benefit Determination	30 days after benefit appeal
The following timetable applies to urgent care claims:	

Notification to Plan Participant of a benefit determination	72 hours from receipt of a complete claim. If initial claim was incomplete, 48 hours after the earlier of: (1) date claimant provides requested information, or (2) end of the 48-hour period for claimant to provide the information.
Notification to Plan Participant of failure to follow procedures	24 hours from receipt of a claim
Notice of incomplete claim	24 hours
Time for claimant to provide requested information	48 hours
Review of Adverse Benefit Determination	72 hours
Deadline to notify claimant of determination on request to extend treatment involving urgent care (concurrent care)	24 hours after receipt of claim if claim made at least 24 hours prior to expiration of treatment
The following timetable applies to concurrent care claims:	
Notification to claimant of benefit reduction	Sufficiently prior to scheduled termination of course of treatment to allow claimant to appeal
Notification to claimant of recission	30 days
Notification of determination on Appeal of Claims involving urgent care	24 hours (provided claimant files appeal more than 24 hours prior to scheduled termination of course of treatment
Notification of Adverse Benefit Determination on Appeal for non-urgent claims	As soon as feasible, but not more than 30 days
Notification of Adverse Benefit Determination on Appeal for recission claims	30 days
Notification to claimant of benefit reduction	Sufficiently prior to scheduled termination of course of treatment to allow claimant to appeal

Notice to the Plan Participant of Adverse Benefit Determinations

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

- A reference to the specific portion(s) of the Plan upon which a denial is based;
- Specific reason(s) for the Adverse Benefit Determination;
- A description of any additional material or information necessary for the claimant to perfect the claim and an explanation of why such material or information is necessary;
- A description of the Plan's review procedures and the time limits applicable to such procedures, including a statement of the claimant's right to bring a civil action under Section 502(a) of ERISA following an Adverse Benefit Determination on review;

- If an internal rule, guideline, protocol, or other similar criterion was relied upon in making the Adverse Benefit Determination, either the specific rule, guideline, protocol, or other similar criterion, or a statement that such a rule, guideline, protocol, or other similar criterion was relied upon in making the Adverse Benefit Determination and that a copy of such rule, guideline, protocol, or other criterion will be provided free of charge to the claimant upon request;
- If the Adverse Benefit Determination is based on a medical necessity or experimental treatment or similar exclusion or limit, either an explanation of the scientific or clinical judgment for the determination, applying the terms of the Plan to the claimant's medical circumstances, or a statement that such explanation will be provided free of charge upon request; and
- In the case of an Adverse Benefit Determination concerning a claim involving urgent care, a description of the expedited review process applicable to such claims.

Appeals

When a Plan Participant receives an Adverse Benefit Determination, the Plan Participant has 180 days following receipt of the notification in which to appeal the decision. A Plan Participant may submit written comments, documents, records, and other information relating to the Claim. If the Plan Participant 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.

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

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

Appeals should be submitted to:

HealthEZ
Attn: Appeals
7201 West 78th Street, Suite 100
Bloomington, MN 55439

The decision timeline begins at the time an appeal is filed without regard to whether all the necessary information accompanies the filing.

The review shall take into account all information submitted by the Plan Participant relating to the Claim. The review will not afford deference to the initial Adverse Benefit Determination and will be conducted by the named fiduciary of the Plan, or a delegate of the named fiduciary, who is neither the individual who made the adverse determination nor a subordinate of that individual.

If the determination is based, in whole or in part, 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 appropriate named fiduciary shall consult with a health care professional who has appropriate training and experience in the field of medicine involved in the medical judgement. The identification information for the medical or vocational experts whose advice was obtained on behalf of the Plan in connection with the claimant's Adverse Benefit Determination, without regard to whether the advice was relied upon in making the determination, will be provided. Also, the health care professional engaged for purposes of consultation will be an individual who is neither an individual who was consulted in connection with the Adverse Benefit Determination that is subject to the appeal, nor the subordinate of any such individual.

In the case of a Claim involving urgent care, there is an expedited review process pursuant to which: (a) a request for an expedited appeal of an Adverse Benefit Determination may be submitted orally or in writing by the claimant; and (b) all necessary information, including the Plan's benefit determination on review, shall be transmitted between the Plan and the claimant by telephone, fax, or other available similarly expeditious method.

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

- The specific reason(s) for the adverse determination;
- Reference to the specific Plan provisions on which the benefit determination is based;
- A statement that the claimant is entitled to receive, upon request and free of charge, reasonable access to, and copies of, all documents, records, and other information relevant to the claimant's claim for benefits;
- A statement describing any voluntary appeal procedures offered by the Plan and the claimant's right to obtain information about such procedures;
- A statement of the claimant's right to bring action under Section 502(a) of ERISA;
- If an internal rule, guideline, protocol, or other similar criterion was relied upon in making the Adverse Benefit Determination, either the specific rule, guideline, protocol, or other similar criterion; or a statement that such a rule, guideline, protocol, or other similar criterion was relied upon in making the Adverse Benefit Determination and that a copy of such rule, guideline, protocol, or other criterion will be provided free of charge to the claimant upon request;
- If the Adverse Benefit Determination is based on a medical necessity or experimental treatment or similar exclusion or limit, either an explanation of the scientific or clinical judgment for the determination, applying the terms of the Plan to the claimant's medical circumstances, or a statement that such explanation will be provided free of charge upon request; and
- The following statement: "You and your plan may have other voluntary alternative dispute resolution options, such as mediation. One way to find out what may be available is to contact your local U.S. Department of Labor Office and your State insurance regulatory agency."

External Review Process

If a claimant receives a final Adverse Benefit Determination, then the claimant may be eligible to request that the Claim be reviewed under the Plan's External Review Process. The Federal external review process applies only to:

- An Adverse Benefit Determination that involves medical judgment as determined by the external reviewer;
- Rescission; and
- Effective January 1, 2022, an Adverse Benefit Determination that involves the No Surprises Act surprise medical billing provisions.

Claims based on (a) legal or contractual disputes or (b) issues regarding your eligibility are not eligible for external review.

Standard external review

1. Request for external review. A Plan Participant must file a request for external review within 4 months after the receipt of an Adverse Benefit Determination. The Plan Participant can only file a request for external review after an Appeal determination has been issued.

2. Preliminary review. Within 5 business days following the receipt of the external review request, HealthEZ, as claims administrator, will complete a preliminary review to determine whether:

- The claimant is or was covered under the Plan at the time the service was provided or requested;
- The claimant is eligible for federal external review;
- The claimant has exhausted the Plan's Appeal process; and
- The claimant has provided all the information required to process an external review.

HealthEZ will issue a notification to the claimant within one business day of completion of the preliminary review. If the request is complete but not eligible for external review, such notification will include the reasons for its ineligibility and contact information for the Employee Benefits Security Administration. If the request is not complete, such notification will describe the information needed to make the request complete and the Plan will allow a claimant to amend the request for external review within the four-month filing period or within the 48-hour period following the receipt of the notification, whichever is later.

3. Referral to Independent Review Organization. Once the claimant's request is complete and determined to be eligible for external review, the Plan will assign an accredited IRO to conduct the external review and will provide the IRO with the internal file and other materials considered during the internal appeals process within 5 days of the date of assignment of the IRO. The IRO will timely notify the claimant in writing whether the request is eligible for external review, and this notice will include a statement that the claimant may submit in writing to the IRO, within 10 business days following the receipt of the notice, additional information for the IRO to consider when conducting the external review. The IRO will forward the information submitted by the claimant to the Plan within 1 business day of receipt.

   In addition to the documents and information provided, the IRO, to the extent the information or documents are available and the IRO considers them appropriate, will consider the following in reaching a decision:
   - The claimant's medical records;
   - The attending health care professional's recommendation;
   - Reports from appropriate health care professionals and other documents submitted by the Plan, claimant, or the claimant's treating Provider;
   - The terms of the claimant's plan to ensure that the IRO's decision is not contrary to the terms of the plan, unless the terms are inconsistent with applicable law;
   - Appropriate practice guidelines, which must include applicable evidence-based standards and may include any other practice guidelines developed by the Federal government, national or professional medical societies, boards, and associations;
   - Any applicable clinical review criteria developed and used by the plan, unless the criteria are inconsistent with the terms of the plan or coverage or with applicable law; and
   - The opinion of the IRO's clinical reviewer.

   The IRO will provide written notice of the final external review decision within 45 days after it receives the request for external review. The notice will contain a general description of the reason for the request for external review and a discussion of the principal reason or reasons for its decision, including the rationale for its decision and any evidence-based standards that were relied on in making its decision.

4. Reversal of Plan's decision. Upon receipt of a notice of a final external review decision reversing the Adverse Benefit Determination, the Plan will provide payment for the claim without delay, regardless of whether the Plan intends to seek judicial review.

Expedited External Review

A claimant may request an expedited external review when the Adverse Benefit Determination involves a medical condition for which the timeframe of a standard appeal would seriously jeopardize the health of the claimant. The IRO will provide notice of the final external review decision as quickly as your medical condition or circumstances require, but in no event more than 72 hours after the Independent Review Organization receives the request for an expedited external review.

Deemed Exhaustion of Internal Claims Procedures and De Minimis

A Plan Participant is normally required to exhaust the Plan's claim procedures (other than external review) before suing. However, a Plan Participant will not be required to exhaust the internal appeals process if the Plan fails to adhere to the claims procedures requirements. In such an instance, a Plan Participant may proceed immediately to the External Review Program or file a claim in court. However, if the violation is not likely to cause harm to the Plan Participant, the Plan demonstrates that it was for good cause or due to matters beyond its control, the violation occurred in the context of an ongoing, good faith exchange of information between the Plan and the Plan Participant, and the violation is not reflective of a pattern or practice of non-compliance, then the Plan Participant will be required to follow the appeals process.

If a Plan Participant believes the Plan has engaged in a violation of the claims procedures and would like to pursue an immediate review, the Plan Participant may request that the Plan provide a written explanation of the violation and explain why violation should not result in a "deemed exhaustion" of the claims procedures. The Plan will respond to this request within ten days. If the External Reviewer or a court rejects a requestor immediate review because the Plan has met the requirements for the "de minimis exception" described above, the Plan will provide the Plan Participant with notice of an opportunity to resubmit and pursue an internal appeal of the claim.

Deadline to Sue

A Plan Participant must commence any lawsuit under the Plan within 2 years after you knew or reasonably should have known of the facts behind your claim or, if earlier, within 6 months after the claims procedure is completed.

Venue

All litigation in any way related to the Plan (including but not limited to any and all claims brought under ERISA, such as claims for benefits and claims for breach of fiduciary duty) must be filed in the United States federal court siting in or otherwise having jurisdiction over where the Plan Sponsor maintains its principal place of business.

Recovery of Payments

Occasionally, benefits are paid in error. HealthEZ has the right to recover any erroneous payment directly from the entity or person who received it and/or from other payers and/or the Plan Participant on whose behalf the payment was made.

The Plan Administrator will have the sole discretion to choose who will repay an erroneous payment and whether such payment will be reimbursed in a lump sum. When an entity or person does not comply, the HealthEZ will have the authority to deny payment of any claims for benefits by the Plan Participant and to deny or reduce future benefits payable by the amount due.

Any payments made in accordance with the above provisions will be repaid to the Plan within 30 days of discovery or demand or incur prejudgment interest of 1.5% per month. If the Plan must bring an action against an entity to enforce the provisions of this Plan, then that entity or person will pay the Plan's attorneys' fees and costs, regardless of the action's outcome.

Payments to Providers and Assignment of Benefits

A Plan Participant's right to receive payment hereunder is personal to that Plan Participant and may not be assigned, alienated, sold, encumbered, or transferred, or be subject to anticipation, garnishment, attachment, execution, or levy of any kind, or otherwise be liable for the debts or obligations of a Plan Participant, without the express written consent of the Plan. Unless otherwise prohibited by Applicable Law, the Plan will not accept an assignment of benefits to a Provider or facility for any reason, including, but not limited to, an assignment of:

- The benefits due under the Plan.
- The right to receive payments due under the Plan.
- Any claim you make for damages resulting from an alleged violation of the terms of the Plan, including, but not limited to, any alleged breach of fiduciary duties under ERISA.

For this section, "assignment of benefits" is defined as an arrangement whereby a Plan Participant attempts to assign its right to seek and receive payment of eligible Plan benefits, less deductible, co-payments and coinsurance amount, to a Provider.

Any direct payments made by the Plan to a Provider do not confer upon the Provider status as a beneficiary or grant the Provider any rights under the Plan or Applicable Law, including ERISA, and shall not be construed to be an assignment of benefits to the Provider. Any attempt to create such rights will not be recognized by the Plan, except as required by Applicable Law.

Coordination of Benefits

Coordination of benefits sets out rules for the order of payment when two or more plans are paying.

Automobile Limitations. When medical payments are available under vehicle insurance, the Plan shall pay excess benefits only.

Benefit Plan Payment Order. When two or more plans provide benefits for the same allowable charge, benefit payment will follow these rules.

1. Plans that do not have a coordination provision will pay first.

2. Plans with a coordination provision will pay their benefits up to the Allowable Charge in this order:

    a. The benefits of the plan which covers the person directly ("Plan A") are determined before those of the plan which covers the person as a dependent ("Plan B").

    b. The benefits of a plan which covers a person as an Active Employee are determined before those of a benefit plan which covers that person as a laid-off or Retired Employee. If the other plan does not have this rule, and if, as a result, the plans do not agree on the order of benefits, this rule does not apply.

    c. The plan which covers a person as an Active Employee or a Dependent of an Employee is determined before those of a plan which covers the person as a COBRA beneficiary.

    d. When a child’s parents are married, these rules will apply:
        i. The plan of the parent whose birthday falls earlier in the calendar year is determined first.
        ii. If both parents have the same birthday, the plan which has covered the patient for the longer period is determined first.

    e. When a child's parents are divorced or legally separated, these rules will apply:
        i. When the parent with custody has not remarried, their plan will be considered first.
        ii. When the parent with custody has remarried, their plan will be considered first. The plan of the stepparent will be considered next. The plan of the parent without custody will be considered last.
        iii. A court decree state may overrule the above and state which parent is financially responsible for medical and dental benefits of the child.
        iv. For parents who were never married, the rules apply as set out above as long as paternity has been established.

    f. If there is still a conflict after these rules have been applied, the plan which has covered the patient for the longer time will be considered first. When there is a conflict in the coordination of benefit rules, this Plan will never pay more than 50% of allowable charges when paying secondary.

3. When the Plan Participant is covered by Medicare and Medicare is to be the primary payer, this Plan will base its payment upon benefits that would have been paid by Medicare under Parts A and B in compliance with the Medicare coordination of benefits rules.

4. If a Plan Participant is under a disability extension from a previous benefit plan, that benefit plan will pay first.

End-Stage Renal Disease. When an individual is covered under this Plan, this Plan will reimburse treatment for End-Stage Renal Disease (ESRD) as required by Applicable Law. For Plan Participant's enrolled in Medicare, the coverage for ESRD or any other dialysis will continue for the initial 30 months at a rate not to exceed 135% of the Medicare allowable rate.

Reimbursement and / or Subrogation

A. If a Plan Participant receives any benefits arising out of an Injury or Illness (herein, referred to collectively as "Injury") for which the Plan Participant has or may have any claim or right to recovery from any other coverages:
   - payments under this Plan shall be made on the condition that this Plan will be reimbursed in full out of the proceeds of such claim of right to recovery;
   - payment of benefits under this Plan shall be conditioned upon the understanding that accepting of these benefits under the Plan is confirmation that the Insured Member, Plan Participant and/or Parent/Guardian are in agreement with the Right of Recovery and Subrogation provision of the Plan and will comply with full reimbursement without any reduction.
   - payment of benefits may be revoked, and the Plan may seek refunds of payments or denied for failure to comply
   - If benefits are paid and a future recovery is received, the Plan reserves the right to offset any future payment by an amount equal to, but not exceeding the total recovery before any reductions for costs or fees.

B. The Plan Participant agrees:
   - to refrain from doing anything to prejudice the Plan's rights to reimbursement or subrogation, or the pursuit of claims directly or indirectly to recover reimbursement of benefits paid;
   - to cooperate fully and exclusively with the Plan and its appointed agents regarding subrogation rights, including executing and delivering all instruments and do whatever else is necessary to fully protect any and all subrogation or reimbursement rights;
   - that any such funds received will be held in constructive trust for the reimbursement of the Plan inasmuch as the Plan Participant is not the rightful recipient of such funds and should not be in possession of any funds until the Plan has been fully reimbursed;
   - to direct any attorneys or fiscal intermediaries to hold recovery of all funds related to the Injury in trust for the benefit of the Plan, and to direct that such parties deal exclusively with the cost recovery agent for the Plan;
   - to assign to the Plan and its designees all rights against such agents and attorneys to enforce the direction to hold the funds in trust; and
   - to reimburse the Plan in full before any amounts (including, but not limited to, attorney fees, expenses, or costs), are deducted from such funds.

   The Plan Participant shall be required to cooperate in the timely response to requested related information and executed documents as may be required in order to facilitate benefit payment related to a subrogation claim. Failure to return the required completed and signed subrogation acknowledgment form and other requested documents to the Claims Administrator within 30 days from the date that such form (s) is (are) first sent by the Claims Administrator to the Plan Participant shall result in a loss of coverage for all claims directly related to or arising out of the Injury or Illness. The preceding sentence shall also apply to the obligations of Plan Participant's counsel under Paragraph E. below. (Please see also Medical Benefit Exclusions under Subrogation.)

C. Recoveries subject to the Plan's reimbursement claims shall include, but not necessarily be limited to, funds or rights acquired by the Plan Participants:
   1. from any No-Fault and/or Personal Injury Protection ("PIP") auto insurance coverage, Uninsured

      /Underinsured insurance coverage, Med-Pay insurance coverage, other insurance policies or funds (this specifically includes, but is not limited to, the Plan Participant's own insurance coverages); and

2. any person, entity, corporation, plan, association, liability/Excess/Umbrella coverage(s) or other at fault party as a result of judgment, settlement, arbitration award, or any other arrangement; or
3. worker's compensation award, settlement, or agreement.

D. Without limiting the preceding paragraph C., this Plan will be subrogated to all claims, demands, actions and right of recovery against any person, corporation and/or other entity who has or may have caused, contributed to, or aggravated the Injury/Illness which the Plan Participant claims an entitlement to benefits under this Plan.

E. If the Plan Participant retains an attorney, the attorney, Plan Participant, Member or Parent/Guardian if injured is a Minor, expressly agrees and rejects application of the "made whole" and "common fund" doctrines and statutes, and any equitable or legal remedies or defenses that would preclude the 100% reimbursement of the Plan out of first dollars recovered from any source, regardless of whether the Plan Participant will recover any funds from the source after reimbursement of the Plan and regardless of whether the attorney will be compensated or reimbursed for any fees, costs or expenses. The Plan will pay no costs or attorneys' fees, nor reduce its claims for reimbursement.

F. The amount of the Plan's subrogation interest will be deducted first from any recovery by or on behalf of the Plan Participant without regard to whether the Plan Participant is made whole. This paragraph is intended as an express and complete repudiation of the "made whole" and "common fund" doctrine/statutes, or any equitable or legal remedy or defense to 100% reimbursement and should be interpreted consistent with this intention. If any party or insurance coverage or other source makes payment before this Plan pays, no benefits will be paid under this Plan to the extent of such payment.

G. If any action is taken by the Plan Participant, or his or her representatives to hinder, defeat or compromise the Plan's rights under this section, the Plan Participant agrees by receipt of benefits under this Plan, that the Plan may deduct from present or future claims for payment under this Plan, or any other plan or program of benefits (e.g., disability, sick pay or paid leave) until the Plan has recouped full reimbursement of all expenditures relating to the Injuries as set forth in this section.

Continuation Coverage Rights Under COBRA

COBRA continuation coverage is the temporary extension of group health plan coverage due to a Qualifying Event. The right to enroll in COBRA is triggered by the loss of coverage under the terms of the Plan. The coverage must be identical to the Plan coverage that the Qualified Beneficiary had immediately before the Qualifying Event.

FMLA qualified leaves do not constitute a Qualifying Event because coverage is not lost during such leave. However, if an Employee does not return to employment at the end of the FMLA leave, then that loss of coverage due to termination of employment or reduction in hours may be a Qualifying Event for COBRA.

What are the alternatives to COBRA? A Plan Participant has the right to request special enrollment in another group health plan for which they are otherwise eligible (such as a plan sponsored by their Spouse's employer) within 30 days after the coverage under this Plan ends. They will also have the same right at the end of COBRA coverage if they take COBRA for the maximum time available.

How long is the COBRA election period? The election period begins on the day the Plan Participant would lose coverage and ends 60 days after either that date, or the date the Plan Participant is provided notice of their right to elect COBRA, whichever is later.

The Plan Sponsor is responsible for notifying the COBRA Vendor within 30 days when the Qualifying Event is one of the following:

- End of employment or reduction of hours;
- Death of Employee; or
- Employer bankruptcy proceeding.

IMPORTANT: The Employee is responsible for notifying the Plan Administrator within 60 days of the Qualifying Event if it is one of the following:

- Divorce;
- Legal separation; or
- Dependent Child's losing eligibility for coverage.

QUALIFYING EVENT NOTICE PROCEDURES:

A Participant's notice of Qualifying Event must be ***in writing***. If mailed, the notice must be postmarked no later than the last day of the required notice period. The notice must state:

- The **name of the Plan** under which the Plan Participant lost coverage,
- The **name and address of the Employee** covered under the Plan,
- The **name(s) and address(es) of the Qualified Beneficiary(ies)**, and
- The **Qualifying Event** and the **date** it happened.

The Plan Administrator or its delegate reserves the right to request proof of the Qualifying Event.

Each Qualified Beneficiary has an independent right to elect COBRA within the deadline stated in the COBRA election notice. Covered Employees may elect COBRA for their spouse, and parents may elect COBRA on behalf of their children.

Can a waiver be revoked? If during the election period, a Qualified Beneficiary waives COBRA continuation coverage, the waiver can be revoked at any time before the end of the election period.

However, coverage need not be provided retroactively (that is, from the date of the loss of coverage until the waiver is revoked).

Is COBRA available if a Qualified Beneficiary has other coverage? Qualified beneficiaries who are entitled to elect COBRA may do so even if they are covered under another group health plan or are entitled to Medicare benefits. However, a Qualified Beneficiary's COBRA coverage will terminate automatically if, after electing COBRA, they become entitled to Medicare or become covered under other group health plan coverage.

When will COBRA be terminated? COBRA will end on the earliest of the following dates:

- The last day of the maximum coverage period;
- The first day for which Timely Payment is not made;
- The date upon which the Employer ceases to provide any group health plan;
- The date, after election, that the Qualified Beneficiary first enrolls in Medicare, or
- In the case of a Qualified Beneficiary in a disability extension period, the first day of the month more than 30 days after the final determination that the Plan Participant is no longer disabled.

What are the maximum coverage periods? The maximum coverage periods are based on the type of the Qualifying Event and the status of the Qualified Beneficiary:

1. If the Qualifying Event is a termination of employment or reduction of hours, the maximum coverage period is 18 months, or 29 months if there is a disability extension;

2. If an Employee is enrolled in Medicare before experiencing a termination of employment or reduction of hours, then the maximum coverage period for Qualified Beneficiaries other than the Employee ends on the later of:
    - 36 months after the date the Employee enrolled in the Medicare program; or
    - 18 months (29 months, if there is a disability extension) after the date of the Employee's termination of employment or reduction of hours;

3. In the case of any other Qualifying Event than that described above, the maximum coverage period is 36 months.

Under what circumstances can the maximum coverage period be expanded? If a Qualifying Event that gives rise to an 18-month or 29-month maximum coverage period is followed, within that 18-month or 29-month period, by a second Qualifying Event that gives rise to a 36-months maximum coverage period, the original period is expanded to 36 months, but only for individuals who are Qualified Beneficiaries at the time of and with respect to both Qualifying Events. In no circumstance can the COBRA maximum coverage period be expanded to more than 36 months.

How does a Qualified Beneficiary become entitled to a disability extension? A disability extension will be granted if a Qualified Beneficiary is determined by the Social Security Administration to have been disabled at any time during the first 60 days of COBRA coverage. To qualify for the disability extension, the Qualified Beneficiary must provide the COBRA vendor or Plan Sponsor with notice of the disability determination within 60 days of the determination.

Does the Plan require payment for COBRA continuation coverage? Qualified beneficiaries will pay 102% of the premium for the first 18 months and 150% of the premium if receiving a disability extension of COBRA.

What is timely payment for COBRA continuation coverage? COBRA premiums are due on the first of the month. However, you will be allowed a grace period of 30 days.

Notwithstanding the above paragraph, the Plan does not require payment earlier than 45 days after the election of COBRA.

For more information about your rights under ERISA, including COBRA, the Health Insurance Portability and Accountability Act (HIPAA), and other laws affecting group health plans, contact the nearest Regional or District Office of the U.S. Department of Labor's Employee Benefits Security Administration (EBSA). Addresses and phone numbers of Regional and District EBSA Offices are available through EBSA's website at www.dol.gov/ebsa.

KEEP YOUR PLAN ADMINISTRATOR INFORMED OF ADDRESS CHANGES
In order to protect your family's rights, please keep HealthEZ informed of any changes in the addresses of family members. You should also keep a copy, for your records, of any notices you send to HealthEZ.

Responsibilities of Plan Administrator

PLAN ADMINISTRATOR. LAKEVIEW DENTAL CARE is the Plan Administrator. The Plan Administrator has legal discretionary authority to interpret the Plan and to decide disputes which may arise. The decisions of the Plan Administrator or its delegate will be final and binding on all interested parties.

The Plan pays for all expenses for plan administration. Legal proceedings may be initiated against the Plan once the appeals process has been exhausted.

FUNDING THE PLAN AND PAYMENT OF BENEFITS

Funding is derived from the funds of the Plan Sponsor and contributions made by the covered Employees. HealthEZ facilitates benefit payments on behalf of the Plan.

CLERICAL ERROR. Any clerical error in making any changes in eligibility will not invalidate coverage or continue coverage validly terminated. In the case of clerical error, the Plan requires reimbursement for the overpayment.

AMENDING AND TERMINATING THE PLAN. If the Plan is terminated, the rights of the Plan Participants are limited to expenses Incurred before termination. The Plan Sponsor reserves the right, at any time and for any reason, to amend, suspend, or terminate the Plan.

SUMMARY OF MATERIAL MODIFICATION (SMM). A Summary of Material Modification reports changes in the Summary Plan Description.

The Plan Sponsor will notify all Plan Participants of any plan amendment considered a Summary of Material Modifications, no later than 210 days after the close of the Plan Year in which the changes became effective.

The Plan Sponsor will notify all Plan Participants of any plan amendment considered a material reduction, no later than 60 days after adoption.

If a Plan's Material Modifications are not reflected in the most recent Summary of Benefits and Coverage (SBC) then the Plan will provide written notice to Plan Participants at least 60 days before the effective date of the modification.

Certain Plan Participants Rights under ERISA

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

Receive Information About Your Plan and Benefits

Examine, without charge, at the Plan Administrator's office and at other specified locations, such as worksites and union halls, all documents governing the Plan, including insurance contracts and collective bargaining agreements, and a copy of the latest annual report (Form 5500 Series) filed by the Plan with the U.S. Department of Labor and available at the Public Disclosure Room of the Employee Benefits Security Administration.

Obtain, upon written request to the Plan Administrator, copies of documents governing the operation of the Plan, including collective bargaining agreements, and Plan copies of the latest annual report (Form 5500 Series) and updated summary plan description. The Plan Administrator may make a reasonable charge for the copies.

Receive a summary of the Plan's annual financial report. The Plan Administrator is required by law to furnish each participant with a copy of this summary annual report.

Prudent Actions by Plan Fiduciaries

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

Enforce Your Rights

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

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

Continue Group Health Plan Coverage

Continue health care coverage for yourself, spouse or dependents if there is a loss of coverage under the plan as a result of a qualifying event. You or your dependents may have to pay for such coverage.

Review this SPD and the documents governing the Plan on the rules governing your COBRA continuation coverage rights.

Assistance with Your Questions

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

Important Notices

WOMEN'S HEALTH AND CANCER RIGHTS ACT OF 1998 (WHCRA) NOTICE

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:

(i) All stages of reconstruction of the breast on which the mastectomy was performed;
(ii) Surgery and reconstruction of the other breast to produce a symmetrical appearance;
(iii) Prostheses; and
(iv) Treatment of physical complications of mastectomy, including lymphedemas.

These benefits are subject to the same deductibles and coinsurance as other procedures covered by the Plan.

GINA NOTICE

The Genetic Information Nondiscrimination Act of 2008 (Public Law No. 110-233), prohibits discrimination on the basis of Genetic Information. GINA expands on HIPAA in several ways:

- Group health plans and health insurers cannot base premiums on Genetic Information;
- Plans and insurers are prohibited from requesting or requiring an individual to undergo a genetic test; and
- Plans and insurers are prohibited from collecting Genetic Information (including family history) prior to or in connection with enrollment, or for underwriting purposes.

NOTICE OF RIGHTS UNDER THE MOTHERS & NEWBORNS HEALTH PROTECTION ACT

Under Federal law, group health plans offering group health insurance coverage 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, the plan may pay for a shorter stay if the attending Provider (*e.g.,* your physician, nurse midwife, or physician assistant), after consultation with the mother, discharges the mother or newborn earlier.

Also, under Federal law, plans may not set the level of benefits or out-of-pocket costs so that any later portion of the 48-hour (or 96-hour) stay is treated in a manner less favorable to the mother or newborn than any earlier portion of the stay.

In addition, a plan may not, under Federal law, require that a physician or other health care Provider obtain authorization for prescribing a length of stay of up to 48 hours (or 96 hours). However, to use certain Providers or facilities, or to reduce your out-of-pocket costs, you may be required to obtain precertification. For information on precertification, contact your Plan Administrator.

MENTAL HEALTH PARITY

The Mental Health Parity Act of 1996 (MHPA) and the Mental Health Parity and Addiction Equity Act of 2008 (MHPAEA), enforce parity between covered health care benefits and covered mental health and substance disorder benefits.

COMPLIANCE WITH HIPAA PRIVACY REQUIREMENTS

This Plan provides each Plan Participant with a separate Notice of Privacy Practices in compliance with the Health Insurance Portability and Accountability Act of 1996 (HIPAA) and the Health Information Technology for Economic and Clinical Health (HITECH) Act. This Notice describes how the Plan uses and discloses your personal health information. It also describes certain rights you have regarding this information. Additional copies of the Plan's Notice of Privacy Practices are available by contacting the HIPAA Compliance Officer(s).

HIPAA Compliance Officer(s): Alyssa Canale, 609-653-0980

MICHELLE'S LAW NOTICE

Under a Federal law known as "Michelle's Law," the Plan cannot terminate coverage for a dependent child whose enrollment in a plan requires student status at a postsecondary educational institution, if the student status is lost because of a medically necessary leave of absence. In this situation, the Plan will continue the dependent's coverage until the earlier of: (a) the date that is one year after the first day of the medically necessary leave of absence or (b) the date on which the dependent's coverage would otherwise end under the Plan's terms. The dependent must provide written certification from the dependent's treating physician to the Plan.

NOTICE REGARDING COVERAGE FOR OBSTETRIC OR GYNECOLOGICAL CARE

You do not need prior authorization from the Plan or from any other person (including a primary care Provider) in order to obtain access to obstetrical or gynecological care from a health care professional in your network who specializes in obstetrics or gynecology. The health care professional, however, may be required to comply with certain procedures, including obtaining prior authorization for certain services, following a pre-approved treatment plan, or procedures for making referrals.

NOTICE REGARDING DESIGNATION OF PRIMARY CARE PROVIDERS

The Plan generally allows the designation of a primary care Provider. You have the right to designate any primary care Provider who participates in your network and who is available to accept you and your family members.

QUALIFIED MEDICAL CHILD SUPPORT ORDERS (QMCSOs)

Please contact844-302-7771 to request of a copy of the written procedures used by HealthEZ to determine QMCSOs.

MEDICARE PART D PRESCRIPTION DRUG CREDITABLE COVERAGE

If you or a covered dependent are eligible for prescription drug coverage under the Plan and are also eligible for Medicare, the Medicare Prescription Drug, Improvement, and Modernization Act of 2003 requires the employer to provide you with an annual notice addressing whether the Plan's prescription drug coverage is creditable or non-creditable. You should receive the notice each year by October 15.

Creditable means that the Plan's prescription drug coverage is expected to pay out, on average, as much or more as the standard prescription drug benefit under Medicare Part D will pay. You do not need to enroll in coverage under Medicare Part D if your coverage under the Plan is creditable.

If your coverage under the Plan is non-creditable, you may pay higher Medicare Part D premiums if you have a break in creditable coverage of 63 days or more and then enroll in Medicare Part D prescription drug coverage.

Additional information about your prescription drug coverage under the Plan is available in the notice that you receive. The notice is intended to help you decide between Medicare Part D prescription drug coverage and employer-provided coverage, if available. You can request a copy of the notice by contacting the Plan Administrator.

NO SURPRISES ACT

The No Surprises Act of the 2021 Consolidated Appropriations Act prohibits "surprise billing" or "balance billing" for: (1) emergency care at an out-of-network Hospital; (2) post-stabilization services provided in a Hospital following an emergency visit at an out-of-network Hospital: (3) care received from an out-of-network Provider while at an in-network Hospital or certain other facilities; or (4) air ambulance services from an out-of-network Provider. The Plan must cover emergency services without requiring prior authorization and must cover emergency services even if the services are provided by Providers who are outside of the Plan's network. Any required cost sharing (co-pays, coinsurance, or deductibles) for emergency care received from an out-of-network Provider or facility must be the same as the cost sharing for emergency care received from a Provider or facility in the group health plan's network.

COVID-19 BENEFITS

Effective March 18, 2020, through the end of the national public health emergency, the Plan will cover 100% of the cost of:

- diagnostic testing for the detection of SARS-CoV-2 or the virus that causes COVID-19 (as long as such test is FDA-approved or otherwise required to be covered at no cost-sharing under Federal law), and the related Provider visit;
- health care items and services necessary for such testing (including the Provider visit) where such testing is ordered or administered; and
- items, services and the Provider visit where the participant is being evaluated for the need for such diagnostic testing and where such testing is ordered or administered or where the visit results in a COVID-19 diagnosis code.

Effective as of the date required by Federal law and through the date required by Federal law, the Plan will cover 100% of the cost for an item, service or immunization that (i) has an "A" or "B" rating from the United States Preventive Services Task Force and is intended to prevent or mitigate COVID-19, and (ii) an immunization that has in effect a recommendation from the Advisory Committee on Immunization Practices of the Centers for Disease Control and Prevention with respect to the individual involved.

Effective January 15, 2022, coverage also is provided for over-the-counter COVID-19 diagnostic tests authorized, cleared, or approved by the FDA. The Plan will cover up to eight over-the-counter COVID-19 tests per covered individual per month.

COVID-19 TOLLING RULES

In response to the proclamation declaring that COVID-19 constitutes a public health emergency, federal agencies issued rules extending various deadlines. Under the guidance, the Outbreak Period is disregarded when calculating (i) the Plan Administrator's deadline to notify you of the right to elect COBRA after a COBRA qualifying event; and (ii) an individual's deadline associated with the following:

- Requesting HIPAA special enrollment under the Plan
- Electing COBRA
- Making COBRA premium payments
- Notifying the Plan Administrator of a COBRA qualifying event
- Notifying the Plan Administrator of the Social Security Administration's determination of disability of you or another COBRA qualified beneficiary

- Filing a claim for benefits under the Plan
- Filing an appeal of an Adverse Benefit Determination under the Plan
- Filing a request for external review under the Plan
- Perfecting a request for external review upon a finding that the request was not complete

The Outbreak Period begins the date the individual or the Plan is first eligible for relief, but no earlier than March 1, 2020, and ends the earlier of: (a) one year from the date the individual or the Plan was eligible for relief or (b) 60 days after the announced end of the COVID-19 public health emergency. The Outbreak Period may not exceed one year.

For example, if a COBRA qualified beneficiary would have been required to make a COBRA election by March 1, 2021, then the deadline for making the election is delayed until the earlier of March 1, 2022, or 60 days after the end of the public health emergency.

General Plan Information & Establishment of the Plan

Name of Plan:	LAKEVIEW DENTAL CARE Medical Plan
Plan Sponsor:	LAKEVIEW DENTAL CARE 63 N Lakeview Dr. Suite 100, Gibbsboro, NJ 08026
Plan Administrator (Named Fiduciary):	LAKEVIEW DENTAL CARE 63 N Lakeview Dr. Suite 100, Gibbsboro, NJ 08026
Plan Sponsor EIN:	21-0548200
Source of Funding:	Self-Funded
Applicable Law:	ERISA
Plan Year:	June 1 – May 31
Plan Number:	501
Plan Status:	Non-Grandfathered
Plan Type:	Group health plan providing medical and prescription drug benefits
Third-Party Claims Administrator:	America's TPA, LLC d/b/a HealthEZ P.O. Box 211186 Eagan, Minnesota 55121
Type of Administrator:	Contract administration
Agent for Service of Process:	LAKEVIEW DENTAL CARE 63 N Lakeview Dr. Suite 100, Gibbsboro, NJ 08026

Adoption of the Plan Document
The Plan Sponsor, as the settlor of the Plan, hereby adopts this non-grandfathered 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, the Plan Sponsor has caused this Plan Document to be executed.

LAKEVIEW DENTAL CARE

By: Alyssa Canale

Name: Alyssa Canale

Title: Director of Operations

Date: 6/7/2023