Your Group Health Plan

White Earth Band of Chippewa Indians

Government PPO 1

Effective Date: October 1, 2018

BlueLink TPA is a product of QCC Insurance Company, an independent licensee of the Blue Cross and Blue Shield Association.
AHA MN.WhiteEarth.GOV.PPO1.Blue.Tribal.NONErisa.NG.M.Ehh.Ahh.10.2018v12.16cm.kcFinalFinal

Nondiscrimination Notice and Notice of Availability of Auxiliary Aids and Services

QCC Insurance Company ("QCC") complies with applicable Federal civil rights laws and does not discriminate on the basis of race, color, national origin, age, disability, or sex. QCC does not exclude people or treat them differently because of race, color, national origin, age, disability, or sex.
BlueLink TPA:

- provides free aids and services to people with disabilities to communicate effectively with us and written information in other formats, such as large print
- provides free language services to people whose primary language is not English and information written in other languages

If you need these services, contact our Civil Rights Coordinator.
If you believe that QCC has failed to provide these services or discriminated in another way on the basis of race, color, national origin, age, disability, or sex, you can file a grievance with our Civil Rights Coordinator. There are four ways to file a grievance directly through BlueLink TPA:

- by mail: BlueLink TPA,
  ATTN: Civil Rights Coordinator, 1900 Market Street, Philadelphia, PA 19103;
- by phone: 833-803-4457 (TTY 711),
- by fax: 215-761-0920, or
- by email: BLCivilRightsCoordinator@qccbluelink.com.

If you need help filing a grievance, our Civil Rights Coordinator is available to help you.

You can also file a civil rights complaint with the U.S. Department of Health and Human Services, Office for Civil Rights electronically through the Office for Civil Rights Complaint Portal, available at **https://ocrportal.hhs.gov/ocr/portal/lobby.jsf** or by mail or phone at: U.S. Department of Health and Human Services, 200 Independence Avenue SW, Room 509F, HHH Building, Washington, DC 20201, 800-368-1019, 800-537-7697 (TDD). Complaint forms are available at **http://www.hhs.gov/ocr/office/file/index.html**.

Language Access Services

ATTENTION: If you speak English, language assistance services, free of charge, are available to you. Call the number on your ID card (TTY: 711).

ATENCIÓN: si habla español, tiene a su disposición servicios gratuitos de asistencia lingüística. Llame al nûmero que aparece en su tarjeta de identificación (TTY: 711). (Spanish)

注意：如果您說中文，您可以免費獲得語言協助服務。請致電您 ID 卡上的電話號碼。(Chinese)

LO LUS TSEEMCEEB: Yog koj hais lus Hmoob, yeej muaj kev pab txhais lus pub dawb rau koj. Hu tus xovtooj rau ntawm koj daim npav ID. (Hmong)

CHÚ Ý: Nếu bạn nói tiếng Việt, có sẵn các dịch vụ hỗ trợ ngôn ngữ, miễn phí, cho bạn. Gọi số trên thẻ ID của bạn. (Vietnamese)

FIIRO GAAR AH: Hadii aad ku hadasho af-soomaali, waxaad heleysaa adeegyada kaalmada luuqada, oo bilaash ah. Lahadal lambarka ku qoran kaadha Aqoonsiga. (Somali)

သတိပြုရန်- သင် အင်္ဂလိပ်ဘာသာစကားကို ပြောဆိုလျှင် ဘာသာစကား အကူအညီ
ဝန်ဆောင်မှုများကို အခမဲ့ ရရှိနိုင်ပါသည်။ သင်၏ ID ကတ်ပေါ်ရှိ ဖုန်းနံပါတ်သို့ ခေါ်ဆိုပါ ။ (Burmese)

ВНИМАНИЕ! Если Вы говорите по-русски, Вы можете получить бесплатные услуги языковой поддержки. Позвоните по номеру телефона, указанному в Вашей идентификационной карте. (Russian)

انتباه: إذا كنت تتحدث اللغة العربية، فإن خدمات المساعدة اللغوية، متوفرة لك، مجاناً. اتصل على الرقم الموجود على بطاقة هويتك.(Arabic)

Xiyyeeffannaa: yoo affan Inglizii kandubbatuu, gargaarsa tajaajilaa afaan,, kafalitii mallee, sifii qobayyaa. Lakkobissa waraqaa eenyummaa kaardii kee irra. Bilibilli. (Oromo)

ATTENTION : si vous parlez français, sachez que vous pouvez bénéficier de services d'assistance linguistique gratuits. Appelez le numéro repris sur votre carte d'identité (French)

ACHTUNG: Wenn Sie Deutsch sprechen, stehen Ihnen kostenlose Sprachassistenz-Systeme zur Verfügung. Rufen Sie die Nummer auf Ihrer ID-Karte an. (German)

ትኩረት፡ አማርኛ የሚናገሩ ከሆነ፣ ያለምንም ክፍያ የቋንቋ እገዛ አገልግሎት ይሰጣቦል። በመታወቂያ ካርድዎ ላይ በሚገኘው ቁጥር ላይ ይደውሉ (Amharic)

주의: 한국어로 말하실 경우, 무료 언어 지원 서비스를 이용하실 수 있습니다. 귀하의 신분증에 있는 번호 로 전화하십시오. (Korean)

ເຊີນຊາບ: ຖ້າທ່ານເວົ້າພາສາລາວ, ບໍລິການຊ່ວຍເຫຼືອດ້ານພາສາໂດຍບໍ່ເສຍຄ່າ ພ້ອມໃຊ້ງານສຳລັບທ່ານ. ໂທຫາໝາຍເລກຢູ່ໃນບັດປະຈຳຕົວຂອງທ່ານ. (Laotian)

PAUNAWA: Kung nagsasalita ka ng Tagalog, makakakuha ka ng mga serbisyo ng tulong para sa wika nang walang bayad. Tawagan ang numero na nasa iyong ID card. (Tagalog)

BAA ÁKONÍNÍZIN: Bilagáana bizaad bee yáníłti'go , saad bee áká aná'álwo', t'áá jíík'e bee ná ahóót'i'. Kojį' hólne'. Bee néého'dílzinii nanitinígíí bikáá'. (Navajo)

សម្គាល់៖ ប្រសិនបើអ្នកនិយាយភាសាខ្មែរ សេវាកម្មជំនួយផ្នែកភាសាដែលគតគិតថ្លៃ អាចមានផ្តល់ជូនអ្នក។ សូមហៅទៅលេខនៅលើកាតសម្គាល់ខ្លួនរបស់អ្នក ។ (Khmer)

Wann du schwetzscht, kannscht du mitaus Koschte ebber gricke, ass dihr helft mit die englisch Schprooch. Ruf selli Nummer uff dei ID-Card uff. (Pennsylvania Dutch)

ATTENZIONE: Se parli Italiano, servizi di assistenza linguistica, gratuiti, sono a tua disposizione. Chiama il numero sulla tua scheda di identificazione. (Italian)

સાવધાન: જો તમે ગુજરાતી બોલતા હોય, તો ભાષા સહાય સેવાઓ, મફતમાં, તમારા માટે ઉપલબ્ધ છે. તમારા ID કાર્ડ પર નંબર પર કૉલ કરો. (Gujarati)

UWAGA: Jeżeli mówisz po polsku, możesz skorzystać z darmowych usług pomocy językowej. Zadzwoń na numer widoczny na Twoim identyfikatorze. (Polish)

ATANSYON: Si ou pale kreyòl, gen sèvis èd ak lang disponib pou ou gratis. Rele nimewo ki sou kat ID ou a. (Creole)

ATENÇÃO: Se falar português, tem disponíveis serviços gratuitos de assistência nesta língua. Ligue para o número no seu cartão ID. (Portuguese)

注：英語以外の言語をご利用の方には無料の言語アシスタントサービスがございます。ID カードに記載された番号にお電話ください。(Japanese)

توجه: اگر به زبان فارسی صحبت می‌کنید، خدمات کمکی زبانی به صورت رایگان برای شما مهیا است. با شماره مندرج بر روی کارت شناسایی‌تان تماس بگیرید. (Farsi)

Coverage of Health Care Services on the Basis of Gender

Federal law prohibits denying or limiting health services, that are ordinarily or exclusively available to individuals of one sex, to a transgender individual based on the fact that the individual's sex assigned at birth, gender identity, or gender otherwise recorded is different from the one to which such health services are ordinarily or exclusively available. Eligible, covered services must be medically necessary, and remain subject to any requirements outlined in the Claims Administrator's medical policy and/or federal law.

Annual Notifications

Women's Health and Cancer Rights Act

Under the federal Women's Health and Cancer Rights Act of 1998, you are entitled to the following services:

1. reconstruction of the breast on which the mastectomy was performed;
2. surgery and reconstruction of the other breast to produce a symmetrical appearance; and
3. prosthesis and treatment for physical complications during all stages of mastectomy, including swelling of the lymph glands (lymphedema).

Services are provided in a manner determined in consultation with the physician and patient. Coverage is provided on the same basis as any other illness.

Important Notice From the Plan Administrator About Your Prescription Drug Coverage and Medicare.

Please read this notice carefully and keep it where you can find it. This notice has information about your current prescription drug coverage with the Claims Administrator and about your options under Medicare's prescription drug coverage. If you are considering joining, you should compare your current coverage, including which drugs are covered at what cost, with the coverage and costs of the plans offering Medicare prescription drug coverage in your area. This information can help you decide whether or not you want to join a Medicare drug plan. Information about where you can get help to make decisions about your prescription drug coverage is at the end of this notice.

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

1. **Medicare prescription drug coverage became available in 2006 to everyone with Medicare. You can get this coverage if you join a Medicare Prescription Drug Plan or join a Medicare Advantage Plan (like an HMO or PPO) that offers prescription drug coverage. All Medicare prescription drug plans provide at least a standard level of coverage set by Medicare. Some plans may also offer more coverage for a higher monthly premium.**

2. **The Claims Administrator has determined that the prescription drug coverage offered through your employer is, on average for all plan participants, expected to pay out as much as standard Medicare prescription drug coverage pays and is therefore considered Creditable Coverage. Because your existing coverage is on average, at least as good as standard Medicare prescription drug coverage, you can keep this coverage and not pay a higher premium (a penalty) if you later decide to join a Medicare drug plan.**

When Can You Join A Medicare Drug Plan?

You can join a Medicare drug plan when you first become eligible for Medicare and each year from October 15th to December 7th.

However, if you lose creditable prescription drug coverage through no fault of your own, you will be eligible for a two (2) month Special Enrollment Period (SEP) to join a Medicare drug plan.

What Happens To Your Current Coverage If You Decide To Join A Medicare Drug Plan?

If you decide to join a Medicare drug plan, your current coverage will not be affected. You may keep your current coverage with the Claims Administrator and this Plan will coordinate with your Medicare drug plan.

If you do decide to join a Medicare drug plan and drop your current coverage, be aware that you and your dependents might not be able to get this coverage back.

When Will You Pay A Higher Premium (Penalty) To Join A Medicare Drug Plan?

You should also know that if you drop or lose your current coverage and do not join a Medicare drug plan within 63 continuous days after your current coverage ends, you may pay a higher premium (a penalty) to join a Medicare drug plan later.

If you go 63 continuous days or longer without creditable prescription drug coverage, your monthly premium may go up by at least 1 percent of the Medicare base beneficiary premium per month for every month that you did not have that coverage. For example, if you go 19 months without creditable coverage, your premium may consistently be at least 19 percent higher than the Medicare base beneficiary premium. You may have to pay this higher premium (a penalty) as long as you have Medicare prescription drug coverage. In addition, you may have to wait until the following October to join.

For More Information About This Notice Or Your Current Prescription Drug Coverage…

Contact Customer Service at the telephone number provided in the Customer Service section.

NOTE: You will receive this notice each year. You will also receive it before the next period you can join a Medicare drug plan and if this coverage through the Claims Administrator changes. You may request a copy of this notice anytime.

For More Information About Your Options Under Medicare Prescription Drug Coverage…

More detailed information about Medicare plans that offer prescription drug coverage is in the "Medicare & You" handbook. You will get a copy of the handbook in the mail every year from Medicare. You may also be contacted directly by Medicare drug plans.

For more information about Medicare prescription drug coverage:

- Visit **www.medicare.gov**
- Call your State Health Insurance Assistance Program (see the inside back cover of your copy of the "Medicare & You" handbook for their telephone number) for personalized help
- Call **1-800-MEDICARE (1-800-633-4227)**. TTY users should call **1-877-486-2048**

If you have limited income and resources, extra help paying for Medicare prescription drug coverage is available. For information about this extra help, visit Social Security on the web at **www.socialsecurity.gov**, or call them at **1-800-772-1213 (TTY 1-800-325-0778)**.

Remember: Keep this Creditable Coverage notice. If you decide to join one of the Medicare drug plans, you may be required to provide a copy of this notice when you join to show whether or not you have maintained creditable coverage, and therefore, whether you are required to pay a higher premium (a penalty).

CONTENTS

Introduction

This Summary Plan Description (SPD) contains a summary of the White Earth Band of Chippewa Indians/National Tribal Claim Center Preferred Provider Organization (PPO) Health Care Plan for benefits effective October 1, 2018.

Coverage under this Plan for eligible employees and dependents will begin as defined in the Eligibility section.

All coverage for dependents and all references to dependents in this Summary Plan Description are inapplicable for employee-only coverage.

This Plan, financed and administered by White Earth Band of Chippewa Indians/National Tribal Claim Center, is a self-insured medical plan within the meaning of 25 U.S.C. §1621e, 1623(b), 1603(12) and 1603(25). Employees, who are enrolled tribal members, should refer to the Coordination of Benefits section for more information about Tribal Health Program Status and Rights and Special Coordination Rules for Tribal Programs. The Plan provides non-taxable benefits for eligible non-member and member employees in accordance with Sections 105(b), 105(h), 106 and/or 139D of the Internal Revenue Code, as applicable. QCC Insurance Company, through its product BlueLink TPA is the Claims Administrator and provides administrative services only. The Claims Administrator does not assume any financial risk or obligation with respect to claims. Payment of benefits is subject to all terms and conditions of this SPD, including medical necessity.

Nothing in the SPD, including any references to state or federal laws and any references to legal action, shall be construed as a waiver of sovereign immunity, tribal court jurisdiction, the tribal court exhaustion doctrine, or any other exemption to which the Plan Sponsor or the Plan may otherwise be entitled to at law or in equity, including Section 3(32) of ERISA, as applicable.

This Plan is not subject to ERISA.

This Plan provides benefits for covered services you receive from eligible health care providers. You receive the highest level of coverage when you use In-Network Providers. In-Network Providers have a contract with the Claims Administrator specific to this Plan to provide you quality health services at favorable prices. These providers are also referred to as Participating Providers.

The Plan also provides benefits for covered services you receive from Out-of-Network Providers. In some cases, you receive a reduced level of coverage when you use these providers. Out-of-Network Providers are also referred to as Nonparticipating Providers. Nonparticipating Providers have not entered into a specific network contract with the Claims Administrator. You may pay a greater portion of your health care expenses when you use Nonparticipating Providers.

IMPORTANT! When receiving care, present your identification (ID) card to the provider who is rendering the services. If you have questions about your coverage, please contact the Claims Administrator at the address or telephone numbers listed on the following page.

Questions?	The Claims Administrator's customer experience staff is available to answer your questions about your coverage and direct your calls for prior authorization, preadmission notification, preadmission certification, and emergency admission notification. Customer experience staff will provide interpreter services to assist you if needed. This includes spoken language and hearing interpreters. Monday through Thursday: 8:00 am – 6:00 pm United States Central Time Friday: 9:00 am – 6:00 pm United States Central Time Hours are subject to change without prior notice.
Customer Experience Telephone Number	Claims Administrator: (833) 803-4457
QCC Insurance Company Member Portal	www.myqccbluelink.com
Claims Administrator's Mailing Address	Claims review requests, and written inquiries may be mailed to the address below: P.O. Box 21974 St. Paul, MN 55121
Pharmacy Telephone Number	Toll free 1-800-509-0545 This number is used to locate a participating pharmacy
Precertification:	
Medical/Surgical Services:	1-888-234-2393
Mental Health/Substance Abuse:	1-800-778-2119

SCHEDULE OF BENEFITS

This Schedule of Benefits lists benefits, maximums, and allowances that your Plan provides for each enrolled person. The coinsurance rates shown in this table are based on your Plan's allowance for each service. *Read the section on* ***The Preferred Provider Network*** *carefully* to see how you can save money by receiving your care from Preferred Providers.

Remember…Your Plan has Clinical Services requirements for all inpatient admissions. It may also require pre-certification for certain outpatient procedures. If you do not comply with these provisions, your Plan may reduce the benefits for those services or may not cover them at all. *Read the sections on* ***Clinical Services.***

BENEFIT	If the Covered Person uses a Preferred Provider or a BlueCard Provider, the Plan will pay:	If the Covered Person uses a Non-Preferred Provider, the Plan will pay:
Calendar Year Deductible		
• Individual	$500	$500
• Family Embedded	$1,500	$1,500
Out-Of-Pocket Maximum Expense You Could Pay In A Calendar Year (includes deductible, copayments, and coinsurance)		
• Individual	$4,500	$9,000
• Family Embedded	$6,500	$18,000
Coinsurance — This table shows the percentage of the Plan's allowance your Plan pays for different covered services. *All payments are based on your Plan's allowance* for the service performed. Your Plan begins to pay for eligible expenses, at the rate shown in the table, *after you meet your Calendar Year Deductible*.		
Coinsurance rates for various services *(based on the Plan's allowance)*		
HOSPITAL BENEFITS		
Inpatient Hospital Facility	80% after deductible	70% after deductible
Inpatient Hospital Physician	80% after deductible	70% after deductible
Outpatient Surgery Facility	80% after deductible	70% after deductible
Outpatient Surgery Physician	80% after deductible	70% after deductible
Inpatient Maternity *Includes delivery and inpatient services*	80% after deductible	70% after deductible
EMERGENCY SERVICES		
Emergency Accident Treatment Facility	80% after deductible	80% after preferred deductible
Urgent Care Facility	80% after deductible	70% after deductible
Ambulance	90% after deductible	80% after preferred deductible

BENEFIT	If the Covered Person uses a Preferred Provider or a BlueCard Provider, the Plan will pay:	If the Covered Person uses a Non-Preferred Provider, the Plan will pay:
OUTPATIENT SERVICES		
Physician Office Visits	80% after deductible	70% after deductible
Specialist Office Visits	80% after deductible	70% after deductible
Pre-Natal/Post-Natal Office Visits	100% deductible waived	70% after deductible
Chiropractic Office Visit *24 visits maximum per year for Routine or Maintenance Services*	80% after deductible	70% after deductible
Diagnostic Test (X-Ray, Blood Work)	80% after deductible	70% after deductible
Diagnostic Imaging *MRI/MRA, CT/CTA Scan, PET Scan*	80% after deductible	70% after deductible
Injectable Medications	80% after deductible	70% after deductible
THERAPY SERVICES		
Physical Therapy	80% after deductible	70% after deductible
Occupational Therapy	80% after deductible	70% after deductible
Speech Therapy	80% after deductible	70% after deductible
MISCELLANEOUS SERVICES AND SUPPLIES		
Durable Medical Equipment	80% after deductible	70% after deductible
Home Health Care	80% after deductible	70% after deductible
Hospice	80% after deductible	70% after deductible
Skilled Nursing Facility - *Benefit maximum of 120 days per calendar year*	80% after deductible	70% after deductible
ADULT PREVENTIVE CARE – Age and frequency limits may apply		
Adult Physical Examination	100% deductible waived	70% after deductible
Routine Gynecological Exams	100% deductible waived	100% deductible waived
PAP Test	100% deductible waived	100% deductible waived
Mammogram	100% deductible waived	100% deductible waived
CHILD PREVENTIVE CARE – Age and frequency limits may apply		
Well-Child Care Examination	100% deductible waived	100% deductible waived
Pediatric Immunizations	100% deductible waived	100% deductible waived

BENEFIT	If the Covered Person uses a Preferred Provider or a BlueCard Provider, the Plan will pay:	If the Covered Person uses a Non-Preferred Provider, the Plan will pay:
MENTAL HEALTH CARE AND SUBSTANCE ABUSE TREATMENT		
Inpatient Detox/Rehabilitation Facility	80% after deductible	70% after deductible
Inpatient Residential Treatment Facility	80% after deductible	Not Covered
Outpatient Facility	80% after deductible	70% after deductible
Outpatient Visit	80% after deductible	70% after deductible
VISION CARE		
Eye Exam	100% deductible waived	100% deductible waived
Frames/Lenses/Contact Lenses	Not Covered	Not Covered
Eyeglasses/Lenses after Cataract Surgery	80% after deductible	70% after deductible
PRESCRIPTION DRUGS		
Retail Pharmacy *30-day supply*		
Generic Drug **Preferred-Brand Drug** **Non-Preferred Drug**	$10 copayment $30 copayment $60 copayment	
Mail Order *90-day supply*		
Generic Drug **Preferred-Brand Drug** **Non-Preferred Drug**	$10 copayment $30 copayment $60 copayment	

ELIGIBILITY

EMPLOYMENT WAITING PERIOD

First of the month following 60 days of continuous full-time employment with the Company.

CLASS(ES) ELIGIBLE FOR COVERAGE

The following classes are eligible for coverage under the terms of the Plan:

ELIGIBLE EMPLOYEES

Full-time Employees who work 30 or more hours per week.

Employees who work in the United States or its Territories. Employees who work and reside in foreign countries are not eligible for coverage. Employees who are U.S. citizens or permanent residents of the U.S. working outside of the U.S. on a temporary basis are eligible.

ELIGIBLE DEPENDENTS

NOTE: If both you and your spouse are employees of the employer, you may be covered as either an employee or as a dependent, but not both. Your eligible dependent children may be covered under either parent's coverage, but not both.

SPOUSE

Spouse, meaning:

a. Legally married spouse; or

b. Domestic Partner of the unmarried employee. An adult whom the Plan Administrator determines:

   1) is in a committed and mutually exclusive relationship, jointly responsible for the domestic partner's welfare and financial obligations; and

   2) is at least 18 years of age and unmarried; and

   3) resides with the domestic partner in the same principal residence and intends to do so permanently; and

   4) is not a blood relative of the domestic partner; and

   5) is mentally competent.

DEPENDENT CHILDREN

1. Unmarried children of the domestic partner of the employee to age 26
2. Natural-born dependent children to age 26.
3. Legally adopted children and children placed with you for legal adoption to age 26. Date of placement means the assumption and retention by a person of a legal obligation for total or partial support of a child in anticipation of adoption of the child. The child's placement with a person terminates upon the termination of the legal obligation of total or partial support.
4. Stepchildren to age 26.
5. Dependent children for whom you or your spouse have been appointed legal guardian to age 26.
6. Foster children placed with you or your spouse by an authorized placement agency or by judgment decree, or other order of any court of competent jurisdiction.
7. Unmarried grandchildren to age 26 who live with you continuously from birth and are financially dependent upon you
8. Children of the employee who are required to be covered by reason of a Qualified Medical Child Support Order (QMCSO). The Plan has detailed procedures for determining whether an order qualifies as a QMCSO. You and your dependents can obtain, without charge, a copy of such procedures from the Plan Administrator.

DISABLED DEPENDENTS

Disabled dependent children who reach the limiting age while covered under this Plan if all of the following apply:

a. primarily dependent upon you;

b. are incapable of self-sustaining employment because of physical disability, developmental disability, mental illness, or mental disorders;

c. for whom application for extended coverage as a disabled dependent child is made within 31 days after reaching the age limit. After this initial proof, the Claims Administrator may request proof again two (2) years later, and each year thereafter; and

d. must have become disabled prior to reaching limiting age.

REHIRE CLAUSE:

If the employee is rehired within 120 days, the coverage that was in place at the time of separation will be reinstated effective on the first of the month following the date of rehire.

TRANSFER FROM A WHITE EARTH ENTITY TO ANOTHER WHITE EARTH ENTITY:

- Providing that a 60-day eligibility waiting period is met, coverage will transfer effective on the first calendar day following separation
- Having not yet reached a 60-day eligibility waiting period, coverage will be effective the first of the month following 60-days of combined employment at both White Earth Entities

TERMINATION OF COVERAGE

TRANSFER FROM A WHITE EARTH ENTITY TO ANOTHER WHITE EARTH ENTITY
Coverage will end on the date the employee separates from employment

DEFINITION, WHITE EARTH ENTITY

- White Earth Reservation Business Committee
- Shooting Star Casino
- White Earth Tribal & Community College
- White Earth Housing Authority
- Pine Point Schools

EFFECTIVE DATE OF COVERAGE

Coverage for you or your eligible dependents who were eligible on the effective date of the Plan will take effect on that date.

Adding New Employees

1. If the Plan Administrator receives your application within 31 days after you become eligible, coverage for you and your eligible dependents starts upon completion of the waiting period.

2. If the Plan Administrator receives your application more than 30 days after you become eligible, coverage for you and your eligible dependents starts the first of the month following the day the Plan Administrator receives the application.

Adding New Dependents

This section outlines the time period for application and the date coverage starts.

Adding spouse and/or stepchildren

1. If the Plan Administrator receives the application within 31 days of the date of marriage, coverage for your spouse and/or stepchildren starts on the date of marriage.

2. If the Plan Administrator receives the application more than 30 days after the date of marriage, coverage for your spouse and/or stepchildren starts the first of the month following the day the Plan Administrator receives the application.

Adding newborns, children placed for adoption or foster care, and court ordered dependents

The Plan Administrator requests that you submit written application to add your newborn child or newborn grandchild within 31 days of the date of birth. Coverage for your newborn child or newborn grandchild starts on the date of birth.

The Plan Administrator requests that you submit written application to add your adopted or foster child within 31 days of the date of placement. Coverage for your adopted or foster child starts on the date of placement.

If coverage is sought pursuant to a child support order or other order to provide coverage, coverage may be effective as of the date of the court order.

Adding disabled children or disabled dependents

A disabled dependent may be added to the Plan if the disabled dependent is otherwise eligible under the Plan. Coverage starts the first of the month following the day the Plan Administrator receives the application. A disabled dependent will not be denied coverage.

Special Enrollment Periods

Special enrollment periods are periods when an eligible employee or dependent may enroll in the Plan under certain circumstances **after they were first eligible for coverage**. In order to enroll, the eligible employee or dependent **must notify the Plan Administrator within 31 days** of the triggering event. If you have a new eligible dependent as a result of birth, adoption or placement for adoption, or foster care or court order you must request enrollment within 31 days after the birth, adoption or placement for adoption, or foster care or court order. Coverage will be made effective in accordance with applicable regulatory requirements. The eligible circumstances are:

Special Enrollment Triggering Events

Loss of Minimum Essential Coverage (does not include loss due to failure to pay premiums or rescission):

- loss of eligibility for employer sponsored coverage;
- plan no longer offers benefits;
- termination of employer contributions
- termination of employment or reduction in hours;
- legal separation or divorce;
- loss of dependent child status;
- death of employee;
- move outside HMO or ACO service area;
- exceeding the plan's lifetime maximum;
- employer bankruptcy;
- COBRA exhaustion; or
- employee becomes entitled to Medicare.

Minimum Essential Coverage includes coverage under specified government sponsored plans (including Medicare and Medicaid), employer-sponsored coverage, individual market policies, grandfathered coverage, and other coverage recognized by the secretary of the U.S. Department of Health and Human Services.

Additional Special Enrollment Triggering Events

- Gaining or becoming a dependent due to marriage.
- Gaining a dependent due to birth, adoption, placement for adoption, or

placement for foster care.

- An individual loses or gains eligibility for Medical Assistance (Medicaid) or Children's Health Insurance Program (CHIP).
- Child support order or other Court order to provide coverage

THE PREFERRED PROVIDER NETWORK

Your PPO Network Plan is a program, which allows you to maximize your health care benefits by utilizing the PPO Network, which is comprised of Providers that have a contractual arrangement with QCC Insurance Company and BlueCard PPO providers. These Providers are called "Preferred Providers." You may think of them as "in-network" providers. Preferred Providers are doctors, hospitals and other health care professionals and institutions that are part of the PPO Network, which is designed to provide access to care through a selected managed network of providers. Services by Preferred Providers are delivered through a selected, managed network of providers designed to provide quality care. The PPO Network includes hospitals, primary care physicians and specialists, and a wide range of ancillary providers, including suppliers of Durable Medical Equipment, Hospice and Home Health agencies, Skilled Nursing Facilities, free standing dialysis facilities and Ambulatory Surgical Centers.

When you receive health care through a Provider that is a member of the PPO Network, you incur lower out-of-pocket expenses and there are no claim forms to fill out. Benefits are also provided if you choose to receive health care through a Provider that is not a Preferred Provider. However, the level of benefits will be reduced, and you will be responsible for a greater share of out-of-pocket expenses, and the amount of your expenses could be substantial. You may have to reach a deductible before receiving benefits, and you may be required to file a claim form.

To locate a BlueCard PPO network provider go to www.myQCCbluelink.com or call 1-800-810-BLUE (2583). QCC Insurance Company covers only care that is Medically Necessary. Medically Necessary care is care that is needed for your particular condition and that you receive at the most appropriate level of service. Examples of different levels of service are Hospital Inpatient care, treatment in short procedure units and care in a hospital outpatient department.

Some of the services you receive through this Plan must be precertified before you receive them, to determine whether they are Medically Necessary. Failure to precertify services to be provided by a Non-Preferred Provider, when required, may result in a reduction of benefits. Precertification of services is a vital program feature that reviews the Medical Necessity of certain procedures/admissions. In certain cases, Precertification helps determine whether a different treatment may be available that is equally effective. Precertification also helps determine the most appropriate setting for certain services. Innovations in health care enable doctors to provide services, once provided exclusively in an inpatient setting, in many different settings – such as an outpatient department of a hospital or a doctor's office.

If the request for Precertification is denied, you will be notified in writing that the admission/service will not be paid because it is considered to not be medically necessary. If you decide to continue treatment or care that has not been approved, you will be asked to do the following:

1. Acknowledge this in writing.
2. Request to have services provided.
3. State your willingness to assume financial liability.

When you seek treatment from a Non-Preferred Provider or a BlueCard Provider, you are responsible for initiating the Precertification process. You or your provider should call the Precertification number listed on the back of your Identification Card, and give your name, facility's name, diagnosis, and procedure or reason for admission. Failure to precertify required services will result in a reduction of benefits payable to you.

For more Information regarding precertification please see the ***Clinical Services*** section of this SPD.

REGARDING USE OF NON-PREFERRED PROVIDERS

While the PPO has an extensive network, it may not contain every Provider that you elect to see. To receive the maximum benefits available under this program, you must obtain Covered Services from Preferred Providers that participate in the PPO Network or is a Blue Card PPO Provider.

In addition, your PPO program allows you to obtain Covered Services from Non-Preferred Providers. If you use a Non-Preferred Provider you will be reimbursed for Covered Services but will incur significantly higher out-of-pocket expenses including Deductibles and Coinsurance. The Non-Preferred Provider may charge you for the balance of the Provider's bill. This is true whether you use a Non-Preferred Provider by choice, for level of expertise, for convenience, for location, because of the nature of the services or based on the recommendation of a Provider. For payment of Covered Services provided by a Non-Preferred Provider, please refer to the definition of Covered Expense.

For specific terms regarding Non-Preferred Providers, please refer to the following sections: ***Definitions***, including but not limited to the definition of Covered Expense and Non-Preferred Provider, and the Payment of Providers subsection under ***General Provisions***.

BLUECARD PPO PROGRAM

Out-of-Area Services

Overview

QCC Insurance Company has a variety of relationships with other Blue Cross and/or Blue Shield Licensees. Generally, these relationships are called "Inter-Plan Arrangements." These Inter-Plan Arrangements work based on rules and procedures issued by the Blue Cross Blue Shield Association ("Association"), an association of independent Blue Cross and Blue Shield plans. Whenever you access healthcare services outside of the geographic area QCC Insurance Company serves, the claims for these services may be processed through one of these Inter-Plan Arrangements. The Inter-Plan Arrangements are described below.

When you receive care outside of QCC Insurance Company's service area, you will receive it from one of two kinds of providers. Most providers ("participating providers") contract with the local Blue Cross and/or Blue Shield Licensee in that other geographic area ("Host Blue"). Some providers ("nonparticipating providers") don't contract with the Host Blue. QCC Insurance Company explains below how it pays both kinds of providers.

Inter-Plan Arrangements Eligibility - Claim Types

All claim types are eligible to be processed through Inter-Plan Arrangements, as described above, except for all Dental Care Benefits except when paid as medical claims/benefits, and those Prescription Drug Benefits or Vision Care Benefits that may be administered by a third party contracted by QCC Insurance Company to provide the specific service or services.

BlueCard® Program

Under the BlueCard® Program, when you receive Covered Services within the geographic area served by a Host Blue, QCC Insurance Company will remain responsible for doing what we agreed to in the contract. However, the Host Blue is responsible for contracting with and generally handling all interactions with its participating providers.

When you receive Covered Services outside QCC Insurance Company's service area and the claim is processed through the BlueCard Program, the amount you pay for Covered Services is calculated based on the lower of:

- The billed charges for Covered Services; or
- The negotiated price that the Host Blue makes available to QCC Insurance Company.

Often this "negotiated price" will be a simple discount that reflects an actual price that the Host Blue pays to your healthcare provider.

Sometimes, it is an estimated price that takes into account special arrangements with the Member's healthcare provider or provider group that may include types of settlements, incentive payments and/or other credits or charges. Occasionally, it may be an average price, based on a discount that results in expected average savings for similar types of healthcare providers after taking into account the same types of transactions as with an estimated price. Estimated pricing and average pricing also take into account adjustments to correct for over- or underestimation of past pricing of claims, as noted above. However, such adjustments will not affect the price QCC Insurance Company has used for your claim because they will not be applied after a claim has already been paid.

Special Cases: Value-Based Programs

BlueCard® Program

If you receive Covered Services under a Value-Based Program inside a Host Blue's service area, you will not be responsible for paying any of the Provider Incentives, risk-sharing, and/or Care Coordinator Fees that are a part of such an arrangement, except when a Host Blue passes these fees to QCC Insurance Company through average pricing or fee schedule adjustments.

Value-Based Programs: Negotiated (non-BlueCard Program) Arrangements

If QCC Insurance Company has entered into a Negotiated Arrangement with a Host Blue to provide Value-Based Programs to the Group on the Member's behalf, QCC Insurance Company will follow the same procedures for Value-Based Programs administration and Care Coordinator Fees as noted above for the BlueCard Program.

Nonparticipating Providers Outside QCC Insurance Company's Service Area

Please refer to the Covered Expense definition in the Defined Terms section of the SPD for a description of QCC Insurance Company's reimbursement for Nonparticipating/Non-Preferred Providers.

Blue Cross Blue Shield Global Core

If you are outside the United States, the Commonwealth of Puerto Rico, and the U.S. Virgin Islands (hereinafter "BlueCard service area"), you may be able to take advantage of the Blue Cross Blue Shield Global Core when accessing Covered Services. The Blue Cross Blue Shield Global Core is unlike the BlueCard Program available in the BlueCard service area in certain ways. For instance, although the Blue Cross Blue Shield Global Core assists you with accessing a network of inpatient, outpatient and professional providers, the network is not served by a Host Blue.

As such, when you receive care from providers outside the BlueCard service area, you will typically have to pay the providers and submit the claims themselves to obtain reimbursement for these services.

If you need medical assistance services (including locating a doctor or hospital) outside the BlueCard service area, the Member should call the Blue Cross Blue Shield Global Core Service Center at 1.800.810.BLUE (2583) (TTY: 711) or call collect at 1.804.673.1177 (TTY: 711), 24 hours a day, seven days a week. An assistance coordinator, working with a medical professional, can arrange a physician appointment or hospitalization, if necessary.

- **Inpatient Services**

  In most cases, if you contact the service center for assistance, hospitals will not require you to pay for covered inpatient services, except for your deductibles, coinsurance, etc. In such cases, the hospital will submit your claims to the service center to begin claims processing. However, if you paid in full at the time of service, you must submit a claim to receive reimbursement for Covered Services. **You must contact QCC Insurance Company to obtain precertification for non-emergency inpatient services.**

- **Outpatient Services**

  Physicians, urgent care centers and other outpatient providers located outside the BlueCard service area will typically require you to pay in full at the time of service. You must submit a claim to obtain reimbursement for Covered Services.

PAYMENT OF COVERED MEDICAL CHARGES

1. The Calendar Year Deductible is as shown in the ***Schedule of Benefits***. A Covered Person must Incur covered medical charges of at least this amount within a calendar year before any benefits are payable during that year, unless otherwise stated in the ***Schedule of Benefits***.

   A Covered Person must satisfy the individual deductible amount only once during a calendar year. However, after the Covered Persons in a family unit have satisfied the family deductible amount during a calendar year, benefits will be payable for covered medical charges incurred for all Covered Persons in a family unit for the remainder of that calendar year. Please refer to the ***Schedule of Benefits*** for individual and family deductible information.

2. When a Covered Person is confined in a Hospital, Rehabilitation Facility, or Skilled Nursing Facility, benefits payable will be determined by the condition primarily being treated. Determination will be made by QCC Insurance Company based on the Covered Person's medical history and will be conclusive.

3. In counting the number of days of medical care furnished to a Covered Person while confined in a Hospital, Rehabilitation Facility, or Skilled Nursing Facility, either the day of admission or the day of discharge will be counted, but not both.

4. No benefits will be payable under the Plan for charges Incurred after the Hospital's regular discharge hour, provided the Covered Person has been advised by his attending Doctor prior to such discharge that further confinement is not required.

5. Pregnancy benefits will be provided under the same conditions and limitations as any other Illness.

   This Plan does not restrict benefits for any hospital length of stay in connection with childbirth, for the mother or newborn child, to less than the following:

   a. 48 hours following a normal vaginal delivery; or
   b. 96 hours following a caesarean section.

   This Plan does not require that a Provider obtain authorization from the Plan for prescribing a length of stay that does not exceed these periods.

COVERED MEDICAL CHARGES

Subject to "Exceptions and Exclusions" which follows, covered medical charges include the charges described below that are Medically Necessary and Incurred while covered under the Plan. (A charge is deemed Incurred as of the date of the service, treatment, or purchase giving rise to the charge.)

FACILITY SERVICES

1. Room and Board

   a. Semiprivate Room — Includes special diets and general nursing care.

   b. Private Room — In a Facility having primarily private accommodations, the Covered Person is entitled to either the Facility's most common semiprivate room charge, if any, or an allowance agreed upon by QCC Insurance Company and the Facility. The difference between the Plan's allowance and the Facility's charge is the Covered Person's responsibility.

      Private Room accommodations will be covered in full if Medically Necessary.

   c. Special care accommodations — Special care accommodations include intensive care, cardiac care, and burn treatment or such other special care accommodations approved by QCC Insurance Company.

2. Ancillary Services — Includes those services and Supplies that are regularly provided and billed by a Facility, such as:

   a. use of operating, delivery, and treatment rooms and equipment;

   b. administration of blood and blood processing including blood and blood plasma to the extent that it is not donated or otherwise replaced;

   c. oxygen and other gases and their administration;

   d. prescribed drugs and medications that are dispensed for use in the Facility;

   e. anesthesia and the administration of anesthetics when performed by an employee of the Facility;

   f. medical and surgical dressings, Supplies, casts, and splints; and

   g. diagnostic services.

   When counting the number of days of care furnished to an Inpatient, either the day of admission or the day of discharge will be counted, but not both.

Charges Incurred after a Facility's regular discharge hour are not covered provided the Covered Person has been advised by his attending Professional Provider prior to such discharge that further confinement is not required.

MEDICAL CARE

Medical care and Facility services rendered to an Inpatient by the Doctor in charge of the case for a condition not related to Surgery or pregnancy, except as specifically provided. Such care includes Inpatient intensive medical care rendered to a Covered Person whose condition requires a Professional Provider's constant attendance and treatment for a prolonged period.

1. Concurrent Care

   Medical care rendered to an Inpatient by a Professional Provider who is not in charge of the case, but whose particular skills are required for the treatment of complicated conditions. This does not include observation or reassurance of the Covered Person, standby services, routine preoperative physical examinations, or medical care routinely performed in the preoperative or postoperative or prenatal or postnatal periods, or medical visits required by a Facility's rules and regulations.

2. Consultation Services

   Consultation services rendered to an Inpatient by a Professional Provider at the request of the attending Professional Provider. Consultation services do not include staff consultations that are required by a Facility's rules and regulations.

   Benefits are provided for one consultation per consultant during each period of confinement.

REHABILITATION HOSPITAL CONFINEMENTS

Facility services and medical care rendered to an Inpatient in a Rehabilitation Hospital.

No benefits are provided for services in a Rehabilitation Facility:

1. once the Covered Person reaches the maximum level of recovery possible for his or her particular condition and no longer requires definitive treatment; or

2. when the services are primarily provided to maintain the Covered Person's level of functioning; or to assist the Covered Person with the activities of daily living; or to provide an institutional environment for the convenience of the Covered Person.

SKILLED NURSING FACILITY CONFINEMENTS

Facility services and medical care rendered to an Inpatient in a Skilled Nursing Facility as described in the ***Schedule of Benefits***.

Benefits for medical care in a Skilled Nursing Facility are provided for up to two visits during the first week of confinement and one visit a week for each consecutive week of confinement thereafter.

No benefits are provided for services in a Skilled Nursing Facility:

1. once the Covered Person reaches the maximum level of recovery possible for his or her particular condition and no longer requires definitive treatment;

2. when the services are primarily provided to maintain the Covered Person's level of functioning; or to assist the Covered Person with the activities of daily living; or to provide an institutional environment for the convenience of the Covered Person.

SURGICAL SERVICES

Surgery for the treatment of Illness or Accidental Injury.

Covered Surgery includes sterilization procedures regardless of their Medical Necessity.

If more than one surgical procedure is performed by the same Professional Provider during the same operative session, benefits will be provided for the highest paying procedure plus an allowance of 50% of eligible charges for the additional procedure(s), plus any additional payment beyond the 50% that is deemed appropriate due to the nature or circumstances of the procedure. No additional allowance will be provided for those surgical procedures determined by QCC Insurance Company to be incidental to or an integral part of another surgical procedure performed during the same operative session.

1. Preoperative and Postoperative Medical Care

   The payment allowance for Surgery includes related preoperative and postoperative care rendered by the surgeon within the timeframe based on the surgical procedure.

2. Maternity Delivery

   The payment for maternity delivery includes prenatal and postpartum care normally provided by a Doctor for the care and management of pregnancy.

3. Surgical Assistance

   Services rendered by an assistant surgeon who actively assists the operating surgeons in the performance of Surgery.

   The condition of the Covered Person or the type of Surgery must require the active assistance of an assistant surgeon. Surgical assistance is not covered when performed by a Professional Provider who himself performs and bills for another surgical procedure during the same operative session.

4. Anesthesia

   Anesthesia and the administration of anesthetics in connection with the performance of covered medical services when rendered by or under the direct supervision of a Professional Provider other than the surgeon, assistant surgeon, or attending Professional Provider.

5. Second Surgical Opinion Consultation

   Consultation services rendered by a surgeon or specialist to determine the Medical Necessity of an Elective Surgery. Such services must be performed and billed by a surgeon or specialist who is not in association with the one who initially recommended the Surgery.

   Benefits are provided for one additional consultation, as a third opinion, in cases where the second opinion disagrees with the first recommendation. In such instances, benefits will be provided for a maximum of two consultations, but limited to one consultation per consultant.

6. Transplant Services

   If a human organ or tissue transplant is provided from a donor to a human transplant recipient:

   a. When both the donor and recipient are covered by the Plan, each is entitled to the benefits of the Plan.

   b. When only the recipient is covered by the Plan, both the donor and recipient are entitled to the benefits of the Plan. The donor benefits are limited to only those not provided or available to the donor from any other source. This includes, but is not limited to, other insurance coverage or any government program. Benefits provided to the donor will be charged against the recipient's coverage under the Plan.

   c. When only the donor is covered by the Plan, the donor is entitled to the benefits of the Plan. The donor benefits are limited to only those not provided or available to the donor from any other source. This includes, but is not limited to, other insurance coverage or any government program available to the recipient. No benefits are provided under the Plan to the non-Covered Person transplant recipient.

   d. If any organ or tissue is sold rather than donated to the Covered Person recipient, no benefits will be payable for the purchase price of such organ or tissue. However, other costs related to evaluation and procurement are covered up to the Covered Person recipient's Plan limit.

PREADMISSION TESTING

Diagnostic tests and studies performed on an Outpatient basis prior to Elective Surgery. Benefits are provided for preadmission testing if:

1. the Covered Person was scheduled for Surgery prior to the testing;
2. the Surgery is not delayed beyond the 14 day period immediately following the testing; and
3. the Surgery to which the testing is related is covered by the Plan.

EMERGENCY ACCIDENT TREATMENT

Ancillary services and medical services by a Professional Provider rendered on an Outpatient basis in connection with the initial treatment of an Emergency Accident, as defined.

Benefits are provided for emergency treatment that commences within 72 hours following the accident.

EMERGENCY MEDICAL TREATMENT

Ancillary services and medical services by a Professional Provider rendered on an Outpatient basis in connection with the initial treatment of a condition with acute symptoms of sufficient severity that the absence of immediate medical attention could:

1. permanently place the Covered Person's health in jeopardy;
2. cause other serious medical consequences;
3. cause serious impairment to bodily functions; or
4. cause serious and permanent dysfunction of any bodily organ or part.

Benefits are provided for emergency treatment that commences within 72 hours following the onset of the medical emergency.

Should any dispute arise as to whether an emergency condition existed, the determination by QCC Insurance Company will be final.

HOME VISITS, OFFICE VISITS, AND OTHER OUTPATIENT VISITS

Medical visits and consultation services for the examination, diagnosis, and treatment of a condition not related to Surgery, or pregnancy, except as specifically provided.

1. Well-child care and immunizations

Well-child care including routine physical examinations and immunizations. Benefits are provided for these services as prescribed by the American Pediatric Association. Immunizations as recommended by the Department of Health.

Well Child Care and Immunizations are described in the ***Schedule of Benefits***.

2. Routine physical examinations

   Examinations including a complete medical history.

   Benefits are provided for these services as prescribed by the American Medical Association. Services provided under a Vision Care program are not covered.

   Routine Physical Examinations are described in the ***Schedule of Benefits***.

3. Preventive care services

   100% coverage for certain designated preventive care services. There will be no cost sharing (copayments, coinsurance, deductibles) for the following preventive care services if provided by a Participating Provider:

   a. Evidence-based items/services with a rating of "A" or "B" in the current recommendations of the U.S. Preventative Services Task Force.
   b. Immunizations recommended by the Advisory Committee on Immunization Practices of the Centers for Disease Control and Prevention.
   c. Evidence-informed preventive care and screenings provided for in the comprehensive guidelines supported by the Health Resources and Services Administration (HRSA) for infants, children, and adolescents.
   d. With respect to women, additional preventive care and screenings provided for in guidelines supported by HRSA.

   You can find online links to these lists of services at www.Healthcare.gov. Click the *Learn About Prevention* tab.

   Be aware that you may be required to pay some costs of the office visit if the preventive service is not the primary purpose of the visit, or if your doctor bills you for the preventive services separately from the office visit.

AUTISM SPECTRUM DISORDERS (ASD)

Benefits are provided for the diagnostic assessment and treatment of Autism Spectrum Disorders (ASD) for Covered Persons less than twenty-one (21) years of age.

Diagnostic assessment is defined as Medically Necessary assessments, evaluations or tests performed by a licensed physician, licensed physician assistant, licensed psychologist or certified registered nurse practitioner, or Autism Service Provider to diagnose whether an individual has an Autism Spectrum Disorder. Results of the diagnostic assessment shall be valid for a period of not less than twelve (12) months,

unless a licensed physician or licensed psychologist determines an earlier assessment is necessary.

Treatment of Autism Spectrum Disorders shall be identified in an ASD Treatment Plan and shall include any Medically Necessary Pharmacy Care, Psychiatric Care, Psychological Care, Rehabilitative Care and Therapeutic Care that is: (i) prescribed, ordered or provided by a licensed physician, licensed physician assistant, licensed psychologist, licensed clinical social worker or certified registered nurse practitioner, (ii) provided by an Autism Service Provider, including a Behavior Specialist, or (iii) provided by a person, entity or group that works under the direction of an autism service provider. An ASD Treatment Plan shall be developed by a licensed physician or licensed psychologist pursuant to a comprehensive evaluation or reevaluation performed in a manner consistent with the most recent clinical report or recommendations of the American Academy of Pediatrics. Depending on the service that is being requested, members, or a health care provider on their behalf, may be required to submit a treatment plan to QCC Insurance Company prior to receiving treatment. This plan may need to be reviewed and approved QCC Insurance Company every six months.

Treatment of Autism Spectrum Disorders will include any of the following Medically Necessary services that are listed in an ASD Treatment Plan developed by a licensed physician or licensed psychologist:

1. Applied Behavioral Analysis – The design, implementation and evaluation of environmental modifications, using behavioral stimuli and consequences, to produce socially significant improvement in human behavior or to prevent loss of attained skill or function, including the use of direct observation, measurement and functional analysis of the relations between environment and behavior.
2. Pharmacy Care – Medications prescribed by a licensed physician, licensed physician assistant or certified registered nurse practitioner and any assessment, evaluation or test prescribed or ordered by a licensed physician, licensed physician assistant or certified registered nurse practitioner to determine the need or effectiveness of such medications. The ASD medications may be purchased at a pharmacy, subject to the cost-sharing arrangement applicable to the prescription drug coverage. Benefits for ASD medications are subject to the ASD annual benefit maximum.
3. Psychiatric Care – Direct or consultative services provided by a physician who specializes in psychiatry.
4. Psychological Care – Direct or consultative services provided by a psychologist.
5. Rehabilitative Care – Professional services and treatment programs, including applied behavioral analysis, provided by an Autism Service Provider to produce socially significant improvements in human behavior or to prevent loss of attained skill or function.
6. Therapeutic Care – Services provided by speech language pathologists, occupational therapists or physical therapists.

UPON FULL OR PARTIAL DENIAL OF COVERAGE FOR ANY AUTISM SPECTRUM DISORDERS BENEFITS, A COVERED PERSON SHALL BE ENTITLED TO FILE AN APPEAL. THE APPEAL PROCESS WILL: 1) PROVIDE INTERNAL REVIEW FOLLOWED BY INDEPENDENT EXTERNAL REVIEW; AND, 2) HAVE LEVELS, EXPEDITED AND STANDARD APPEAL TIME FRAMES, AND OTHER TERMS ESTABLISHED BY THE CARRIER CONSISTENT WITH APPLICABLE PENNSYLVANIA AND FEDERAL LAW. APPEAL FILING PROCEDURES WILL BE DESCRIBED IN NOTICES DENYING ANY AUTISM SPECTRUM DISORDERS BENEFITS.)

DIAGNOSTIC SERVICES

The following procedures when ordered by a Professional Provider to determine a definite condition because of specific symptoms:

1. diagnostic X-ray consisting of radiology, ultrasound, and other diagnostic X-ray procedures.
2. diagnostic laboratory and pathology tests;
3. diagnostic medical procedures consisting of EKG, EEG, and other diagnostic medical procedures; and
4. allergy testing consisting of percutaneous, intracutaneous, and patch tests.

THERAPY SERVICES

The following Therapy Services:

1. Radiation Therapy, including the cost of radioactive materials;
2. Chemotherapy by intravenous, intra-arterial, or intracavity injection infusion or perfusion, subcutaneous and intramuscular routes. Oral chemotherapy, including its administration, is also covered. The cost if listed as approved or indicated for the diagnosis under treatment by one or more of the following: FDA, NCCN, NIH, NCI. Notwithstanding experimental and investigational use of chemotherapy agents is not covered. All chemotherapy is subject to medical necessity review as antineoplastic agents is covered, provided they are administered as described in this paragraph;
3. Dialysis Treatment;
4. Physical Therapy;
5. Cardiac Rehabilitation;
6. Any other therapy services QCC Insurance Company determines necessary to treat Accidental Injury or Illness.

HOME HEALTH CARE SERVICES

The following services, as described in the ***Schedule of Benefits***, when provided to an essentially homebound Covered Person by a Home Health Care Agency:

1. Skilled Nursing Care; and
2. Therapy Services;
3. Medical Social Work;
4. Nutritional Services
5. Health services furnished by a home health aide;
6. Medical appliances;
7. Medical equipment;
8. Special meals;
9. Diagnostic or therapeutic services, including surgical services furnished;
    a. In an outpatient department of a Hospital;
    b. In a Physician's office; or
    c. At any other licensed health care facility.

Benefits are also provided for certain other medical services when furnished along with a primary service. Such other services include prescription drugs, diagnostic services, Supplies, and other Medically Necessary services.

No benefits are provided for services in connection with:

1. Custodial Care, food, housing, homemaker services, home delivered meals, and supplementary dietary assistance;
2. services provided by a member of the Covered Person's Immediate Family;
3. patient transportation, including Ambulance services;
4. visiting teachers, friendly visitors, vocational guidance and other counselors, and services related to diversional occupational therapy or social services;
5. services provided to Covered Persons who are not essentially home bound for medical reasons; or
6. visits solely for the purpose of assessing the Covered Person's condition and determining whether or not the Covered Person requires and qualifies for home health care services.

HOSPICE SERVICES

Hospice benefits, as described in the ***Schedule of Benefits***, are provided when the Covered Person's attending Doctor certifies that the Covered Person has a terminal Illness with a medical prognosis of six months or less to live.

Hospice benefits are provided for the following services when rendered by a Hospice or under arrangements made by a Hospice in accordance with a Hospice care program and approved by QCC Insurance Company.

1. Medical care by a Doctor affiliated with the Hospice care program;
2. Nursing care by an R.N., or L.P.N., or home health aide;
3. Medical social services;
4. Therapy services except for dialysis treatments;
5. Dietary services;
6. Laboratory services;
7. Prescribed drugs and medicines;
8. Family counseling services;
9. Ambulance services when Medically Necessary to transport the Covered Person to and from the nearest Inpatient Hospice Facility;
10. The following medical services, Supplies, and equipment:
    a. oxygen, including the rental of oxygen equipment;
    b. artificial limbs or other prosthetic devices, but not including replacement;
    c. rental of Durable Medical Equipment;
11. Inpatient Hospice care when needed to control pain and other symptoms associated with the terminal Illness, but only if the Covered Person's attending Doctor certifies that it is Medically Necessary for the care to be provided on an Inpatient basis rather than in a home setting or on an Outpatient basis;
12. Inpatient respite care in a Hospice, which may be subject to a benefit maximum.

Special Exclusions and Limitations

1. The Hospice care program must deliver Hospice care in accordance with a treatment plan approved by and periodically reviewed by QCC Insurance Company.
2. No Hospice care benefits will be provided for:

a. Medical care rendered by the Covered Person's private Doctor;

b. Volunteers who do not regularly charge for services;

c. Homemaker services;

d. Food or home delivered meals;

e. Legal or financial services or counseling;

f. Curative treatment or services;

AMBULANCE SERVICES

Ambulance service by an authorized agency or a Facility providing local transportation of a sick or injured Covered Person:

1. from the site of injury or medical emergency to the nearest Facility; or

2. from the first Facility to the nearest Facility that can provide services Medically Necessary for the treatment of the Covered Person's condition, but only if the services necessary to treat the condition are not available at the first Facility.

Benefits are provided for air Ambulance transportation only if QCC Insurance Company determines that the Covered Person's condition, and the type of service required for the treatment of the Covered Person's condition, and the type of Facility required to treat the Covered Person's condition justify the use of air Ambulance instead of another means of transport.

DURABLE MEDICAL EQUIPMENT AND PROSTHETIC APPLIANCES

1. Durable Medical Equipment

   The rental or purchase of Durable Medical Equipment when prescribed by a Doctor and required for therapeutic use.

   a. Rental — Benefits are provided for rental fees up to an amount that equals, but does not exceed, the purchase price of the equipment.

   b. Purchase — Benefits may be provided for the purchase of Durable Medical Equipment at the option of the Plan.

   If a Claim is filed for equipment containing features of an aesthetic nature or features of a medical nature that are not required by the Covered Person's condition or if there exists a reasonable or feasible and medically appropriate alternative piece of equipment that is less costly than the equipment furnished, the benefit provided is based on the charge for the equipment that meets the Covered Person's medical needs **Payment for the purchase or rental of Durable Medical Equipment may require preauthorization. Preauthorization may be obtained by calling QCC Insurance**

Company' Clinical Services Department at the number listed on your identification (ID) card.

2. Prosthetic Appliances

   The first purchase and fitting of artificial limbs, eyes, and other prosthetic appliances that replace all or part of an absent or inoperative or malfunctioning body organ but only if required for the replacement of natural parts of the body lost or becoming inoperative while covered by the Plan (excluding dental appliances).

3. Replacement and Modification

   Benefits are provided for the replacement or modification of Durable Medical Equipment, orthotics, and prosthetic appliances when Medically Necessary due to a change in the Covered Person's physical condition. Benefits for the replacement of such items are provided to the extent that the cost of the purchase is less expensive than the modification. In no event will the Plan pay for contact lenses other than the initial pair of contact lenses following cataract surgery.

4. Diabetic Education

5. Orthotics

   Benefits are provided if orthotics are an integral part of a leg brace and the cost is included in the orthotist's charges, including the initial purchase, fitting and repair of orthotic appliance that are required for support for an injured or deformed part of the body as a result of a disabling congenital condition or an injury or illness.

6. Cranial prosthesis (wigs) are covered only in relation to baldness as a result of burns, chemotherapy, radiation therapy, or surgery.

DENTAL SERVICES

1. Dental treatment performed within six months following Accidental Injury to sound natural teeth, but only if such injury occurs while covered by the Plan. Accidental Injury does not include injuries that result from biting or chewing.

2. Oral Surgery performed for the removal of impacted teeth partially or totally covered by bone.

ROUTINE NEWBORN CARE

Professional visits to examine the newborn while an Inpatient in a Hospital or Birthing Center. Facility charges for ordinary nursery care of the newborn as well as routine newborn circumcisions are also covered.

MENTAL ILLNESS BENEFITS

Treatment of Mental Illness is eligible anywhere when performed by a Professional Provider as follows:

1. Psychiatric Visits
2. Electro-Convulsive Therapy
3. Individual Psychotherapy
4. Group Psychotherapy
5. Psychological Testing
6. Family Counseling

   Counseling with family members to assist in the Covered Person's diagnosis and treatment.

Facility Services for Mental Illness

1. Inpatient Facility Services

   Facility services provided for Inpatient treatment of Mental Illness by a Facility.

2. Partial Hospitalization

   Treatment of Mental Illness in a planned therapeutic program when such services are rendered during the day only or during the night only.

3. Outpatient Mental Illness Services

   Facility services and supplies provided to an Outpatient by a Facility.

SUBSTANCE ABUSE BENEFITS

1. Inpatient Detoxification Services

   Benefits are payable for a detoxification program provided either in a Hospital or in a licensed Substance Abuse Treatment Facility.

   a. Room and board
   b. Doctors, psychologist, nurse, certified addictions counselor, and trained staff services
   c. Diagnostic X-ray
   d. Psychiatric, psychological, and medical laboratory testing
   e. Drugs, medicine, equipment, and Supplies

2. Inpatient Rehabilitation Services

   Benefits are payable for Inpatient services provided in a licensed Substance Abuse Treatment Facility provided the Covered Person: (a) has been certified by a Doctor or psychologist as a person who suffers from Substance Abuse or dependency; and (b) is referred for treatment by such Doctor or psychologist.

   a. Room and board
   b. Doctors, psychologist, nurse, certified addictions counselor, and trained staff services
   c. Rehabilitation therapy and counseling
   d. Family counseling and intervention
   e. Psychiatric, psychological, and medical laboratory testing
   f. Drugs, medicine, equipment, and Supplies

3. Outpatient Rehabilitation Services

   Benefits are payable for Outpatient services provided in a licensed Substance Abuse Treatment Facility provided the Covered Person: (a) has been certified by a Doctor or psychologist as a person who suffers from Substance Abuse or dependency; and (b) is referred for treatment by such Doctor or psychologist.

   a. Doctors, psychologist, nurse, certified addictions counselor, and trained staff services;
   b. rehabilitation therapy and counseling;
   c. family counseling and intervention;
   d. psychiatric, psychological, and medical laboratory testing; and
   e. drugs, medicine, equipment, and Supplies.

ROUTINE PATIENT COSTS ASSOCIATED WITH QUALIFYING CLINICAL TRIALS

Benefits are provided for Routine Patient Costs Associated With Participation in a Qualifying Clinical Trial (see ***Definitions*** section). To ensure coverage and appropriate claims processing, the Plan must be notified in advance of the Covered Person's participation in a Qualifying Clinical Trial. Benefits are payable if the Qualifying Clinical Trial is conducted by a Preferred Professional Provider, and conducted in a Preferred Facility Provider. If there is no comparable Qualifying Clinical Trial being performed by a Preferred Professional Provider, and in a Preferred Facility Provider, then the Plan will consider the services by a Non-Preferred Provider, participating in the clinical trial, as covered if the clinical trial is deemed a Qualifying Clinical Trial (see ***Definitions*** section) by the Plan.

CHILD IMMUNIZATION COVERAGE

Coverage will be provided for those child immunizations, including the immunizing agents, which, as determined by the Department of Health, conform with standards of the Advisory Committee on Immunization Practices of the Center of Disease Control, U.S. Department of Health and Human Services. Benefits will be exempt from deductibles or dollar limits.

ANNUAL GYNECOLOGICAL EXAMINATION AND ROUTINE PAP SMEARS

- Annual gynecological examination, including a pelvic examination and clinical breast examination; and
- Routine pap smears in accordance with the recommendations of the American College of Obstetricians and Gynecologists.

These gynecological examination/pap smear benefits are exempt from any deductible or dollar limit provisions in the contract.

COLORECTAL CANCER SCREENING COVERAGE

Coverage for colorectal cancer screening may be subject to annual deductibles, coinsurance, and copayment requirements applicable to your group health plan.

Symptomatic individuals;

Colonoscopy
Sigmoidoscopy
Colorectal Screening Tests (any combination thereof a determined by the treating Physician)

Non-symptomatic individuals covered at age 50 and over;

Annual Fecal Occult Blood Test
Sigmoidoscopy – a screening barium enema test once every five years
Colonoscopy once every 10 years
Colon Cancer test at least once every 5 years

Non-symptomatic coverage for individuals at high or increased risk of colorectal cancer under age 50;

Colonoscopy
Any combination of colorectal cancer screening tests.

CLINICAL SERVICES

Except in an emergency, before receiving a service requiring precertification, either you or your provider, MUST CALL the number listed on your identification (ID) card to fulfill the precertification requirements

The precertification process reviews the Medical Appropriateness/Medical Necessity of the requested services only. Precertification is not a guarantee of eligibility for the coverage or payment of a Claim. Coverage and payment are dependent upon, among other things, the Covered Person being eligible, i.e., actively enrolled in the health benefits plan when the services occur. Coverage and payment are also subject to limitations, exclusions, and other specific terms of the health benefits plan that apply to the coverage request.

A. UTILIZATION REVIEW PROCESS

A basic condition of the Plan's benefit plan coverage is that in order for a health care service to be covered or payable, the service must be Medically Appropriate/Medically Necessary. Medically Appropriate/Medically Necessary care is care that is needed for your particular condition and that you receive at the most appropriate level of service. Examples of different levels of service are Hospital Inpatient care, treatment in Short Procedure Units and care in a Hospital Outpatient Department. To assist QCC Insurance Company' delegate in making coverage determinations for requested health care services, QCC Insurance Company uses established medical policies and medical guidelines based on clinically credible evidence to determine the Medical Appropriateness/Medical Necessity of the requested services. The appropriateness of the requested setting in which the services are to be performed is part of this assessment. The process of determining the Medical Appropriateness/Medical Necessity of requested health care services for coverage determinations based on the benefits available under a Covered Person's benefit plan is called utilization review.

It is not practical to verify Medical Appropriateness/Medical Necessity on all procedures on all occasions; therefore, certain procedures may be determined by QCC Insurance Company to be Medically Appropriate/Medically Necessary and automatically approved based on the accepted Medical Appropriateness/Medical Necessity of the procedure itself, the diagnosis reported, or an agreement with the performing Provider. An example of such automatically approved services is an established list of services received in an emergency room which has been approved by QCC Insurance Company' delegate based on the procedure meeting emergency criteria and the severity of diagnosis reported (e.g. rule out myocardial infarction, or major trauma). Other requested services, such as certain elective Inpatient or Outpatient procedures may be reviewed on a procedure specific or setting basis.

Utilization review generally includes several components which are based on when the review is performed. When the review is required before a service is performed, it is called a precertification review. Reviews occurring during a Hospital stay are called a concurrent review, and those reviews occurring after services have been performed are called either retrospective or post-service reviews. QCC Insurance Company's delegate follows applicable state and federally required standards for the timeframes in which such reviews are to be performed.

Generally, where a requested service is not automatically approved and must undergo Medical Appropriateness/Medical Necessity review, nurses perform the initial case review using medical policies, established guidelines and evidence-based clinical criteria and protocols; however, only a medical director employed by QCC Insurance Company or its delegate may deny coverage for a procedure based on Medical Appropriateness/Medical Necessity. The evidence-based clinical protocols evaluate the Medical Appropriateness/Medical Necessity of specific procedures and the majority are computer-based. Information provided in support of the request is entered into the computer-based system and evaluated against the clinical protocols. Nurses apply applicable guidelines and evidence-based clinical criteria and protocols, taking into consideration the Covered Person's condition and applying sound professional judgment. When the clinical criteria are not met, the given service request is referred to a medical director for further review for approval or denial. Independent medical consultants may also be engaged to provide clinical review of specific cases or for specific conditions. Should a procedure be denied for coverage based on lack of Medical Appropriateness/Medical Necessity, a letter is sent to the requesting Provider and the Covered Person in accordance with applicable law.

QCC Insurance Company utilization review program encourages peer dialogue regarding coverage decisions based on Medical Appropriateness/Medical Necessity by providing physicians with direct access to QCC Insurance Company or its delegate's medical directors to discuss coverage of a case. Medical directors and nurses receive salaries. Contracted external physicians and other professional consultants are compensated on a per case reviewed basis, regardless of the coverage determination. Neither QCC Insurance Company nor its delegates specifically reward or provide financial incentives to individuals performing utilization review services for issuing denials of coverage. There are no financial incentives for such individuals which would encourage utilization review decisions that result in underutilization.

B. CLINICAL CRITERIA, GUIDELINES AND RESOURCES

The following guidelines, clinical criteria and other resources are used to help make Medically Appropriate/Medically Necessary coverage decisions.

Clinical Decision Support Criteria — Clinical Decision Support Criteria is an externally validated and computer-based system used to assist QCC Insurance Company or its delegate in determining Medical Appropriateness/Medical Necessity. This evidence-based, Clinical Decision Support Criteria is nationally recognized and validated. Using a model based on evaluating intensity of service and severity of Illness, these criteria assist clinical staff in evaluating the Medical Appropriateness/Medical Necessity of services based on a Covered Person's specific clinical needs. Clinical Decision Support Criteria helps promote consistency in plan determinations for similar medical issues and requests, and reduces practice variation among QCC Insurance Company or its delegate's clinical staff to minimize subjective decision-making.

Clinical Decision Support Criteria may be applied for Covered Services including but not limited to the following: some elective Surgeries - settings for Inpatient and Outpatient procedures (e.g., hysterectomy and sinus surgery), Inpatient hospitalizations, Inpatient and Outpatient rehabilitation, diagnostic procedures, Home Health Care, Durable Medical Equipment, and Skilled Nursing Facility.

Medical Policies — QCC Insurance Company and its delegates maintain an internally developed set of policies, which document the coverage and conditions for certain medical/surgical procedures and ancillary services.

Covered Services for which Medical Polices are applied include, but are not limited to: Ambulance, Infusion, Speech Therapy, Occupational Therapy, Durable Medical Equipment, and review of potential cosmetic procedures.

Internally Developed Guidelines — A set of guidelines developed with input by clinical experts based on accepted practice guidelines within the specific fields and reflecting medical policies for coverage.

C. DELEGATION OF UTILIZATION REVIEW ACTIVITIES AND CRITERIA

QCC Insurance Company has agreements with state licensed utilization review entities, where required, and a NCQA (National Committee for Quality Assurance) accredited utilization management program. QCC Insurance Company has delegated certain utilization review activities, including precertification review, concurrent review, and case management, to entities with an expertise in medical management of certain conditions and services (such as, mental illness/substance abuse), or certain membership populations (such as, neonates/premature infants), or after-hours precertification services. In such instances, a formal delegation and oversight process is established in accordance with applicable law and nationally-recognized accreditation standards. In such cases, the delegate's utilization review criteria are generally used, with QCC Insurance Company' approval.

D. PRECERTIFICATION REVIEW

When required, Precertification review evaluates the Medical Necessity, including the appropriateness of the setting, of proposed services for coverage under the Covered Persons benefit plan. Examples of these services include planned or elective Inpatient admissions and selected Outpatient procedures. For Covered Persons located in the PPO Network service area, Precertification review may be initiated by the Provider or the Covered Person depending on whether the Provider is a PPO Network Provider. For Covered Person's located outside QCC Insurance Company PPO Network who are accessing BlueCard PPO Providers, the Covered Person is responsible for initiating or requesting the Provider to initiate the Precertification review. Where Precertification review is required, QCC Insurance Company's coverage of the proposed procedure is contingent upon the review being completed and receipt of the approval certification. Coverage penalties will be applied where Precertification review is required for a procedure but is not obtained.

1. INPATIENT PRE-ADMISSION REVIEW

Inpatient Admissions

In accordance with the criteria and procedures described above, Inpatient admissions, other than an emergency admission, must be precertified in accordance with the standards of QCC Insurance Company as to the Medical Appropriateness/Medical Necessity of the admission. The precertification requirements for emergency admissions are set forth in the "Emergency Admission Review" subsection immediately following below. The Covered Person is responsible to have the admission (other than for an Emergency or maternity admission) certified in advance as an approved admission.

a. To obtain Precertification, the Covered Person is responsible to contact or have the admitting Physician or other Facility Provider contact QCC Insurance Company prior to admission to the Hospital, Skilled Nursing Facility, or other Facility Provider. QCC Insurance Company will notify the Covered Person, admitting Physician and the Facility Provider of the determination. The Covered Person is eligible for Inpatient benefits at the Preferred or Non-Preferred level shown in the ***Schedule of Benefits*** if, and only if, prior approval of such benefits has been certified in accordance with the provisions of this SPD.

b. If such prior approval for a Medically Appropriate/Medically Necessary Inpatient admission has not been certified as required, there will be a penalty for non-compliance and benefits for Covered Services will be reduced 20%, per hospitalization to the Covered Person. Such penalty, and any difference in what is covered by the Plan and the Covered Person's obligation to the Provider, will be the sole responsibility of, and payable by, the Covered Person.

c. If a Covered Person elects to be admitted to the Facility Provider after review and notification that the reason for admission is not approved for an Inpatient level of care, Inpatient benefits will not be provided and the Covered Person will be financially liable for non-covered Inpatient charges.

d. If Precertification is denied, the Covered Person, the Physician or the Facility Provider may appeal the determination and submit information in support of the claim for Inpatient benefits. A final determination concerning eligibility for Inpatient benefits will be made and the Covered Person, Physician, or Facility Provider will be so notified.

2. EMERGENCY ADMISSION REVIEW

Emergency Admissions

1. Covered Persons are responsible for notifying QCC Insurance Company of an emergency admission within two (2) business days of the admission, or as soon as reasonably possible, as determined by QCC Insurance Company.

2. Failure to initiate Emergency admission review will result in a penalty for non-compliance and benefits for Covered Services will be reduced 20% per hospitalization to the Covered Person. Such penalty will be the sole responsibility of, and payable by, the Covered Person.

3. If the Covered Person elects to remain hospitalized after QCC Insurance Company and the attending Doctor have determined that an Inpatient level of care is not Medically Appropriate/Medically Necessary, the Covered Person will be financially liable for non-covered Inpatient charges from the date of notification.

3. CONCURRENT AND RETROSPECTIVE/POST-SERVICE REVIEW, PRENOTIFICATION AND DISCHARGE PLANNING

Concurrent review may be performed while services are being performed. If concurrent review is performed during an Inpatient stay, the expected and current length of stay is evaluated to determine if continued hospitalization is Medically Appropriate/Medically Necessary. When performed, the review assesses the level of care provided to the Covered Person and coordinates discharge planning. Concurrent review continues until the patient is discharged. Not all Inpatient stays are reviewed concurrently. Concurrent review may not be performed where an Inpatient Facility is paid based on a per case or diagnosis-related basis, or where an agreement with a Facility does not require such review.

Retrospective/post-service review occurs after services have been provided. This may be for a variety of reasons, including when QCC Insurance Company has not been notified of a Covered Person's admission until after discharge, or where

medical charts are unavailable at the time of a concurrent review. Certain services are only reviewed on a retrospective/post-service basis.

In addition to these standard utilization reviews, QCC Insurance Company may determine coverage of certain procedures and other benefits available to Covered Persons through prenotification as required by the Covered Person's benefit plan and discharge planning.

Prenotification is advance notification to QCC Insurance Company of an Inpatient admission or Outpatient service where no Medical Appropriateness/Medical Necessity review is required, such as maternity admissions/deliveries. Pre-notification is primarily used to identify Covered Persons for concurrent review needs, to ascertain discharge planning needs proactively, and to identify Covered Persons who may benefit from case management programs.

Discharge planning is performed during an Inpatient admission and is used to identify and coordinate a Covered Person's needs and benefit coverage following the Inpatient stay, such as covered home care, ambulance transport, acute rehabilitation, or Skilled Nursing Facility placement. Discharge planning involves QCC Insurance Company authorization of covered post-Hospital services along with identifying and referring Covered Persons for disease management or case management services.

E. TRANSPLANT SERVICES

QCC Insurance Company requests pre-certification of transplant services as soon as the need for an organ or tissue transplant is known. For a complete list of services requiring Precertification please call the number or visit the website for Clinical Services listed on your identification (ID) card. This list may be subject to change.

F. MATERNITY SERVICES

QCC Insurance Company requests maternity care notification as soon as the pregnancy is confirmed by a Doctor.

Precertification requirements apply when:

1. a Covered Person is admitted for any condition or procedure other than delivery of the baby;

2. the type of delivery anticipated or place of service changes before admission for delivery;

3. the Covered Person's medical condition requires a stay longer than 48 hours after a vaginal delivery or 96 hours after an approved cesarean section. QCC Insurance Company must precertify additional Inpatient days;

4. the baby is required to stay after the mother is discharged. QCC Insurance Company must precertify additional Inpatient days.

A Covered Person is encouraged to call QCC Insurance Company if medical problems develop during the pregnancy.

G. OTHER PRECERTIFICATION REQUIREMENTS

Precertification is required by QCC Insurance Company in advance for services such as Home Health Care, Hospice Care, certain surgical and diagnostic procedures, Inpatient and Partial Hospitalization services for Substance Abuse, Mental Illness and Serious Mental Illness. For a complete list of Precertification requirements please call the number or visit the website for Clinical Services listed on your identification (ID) card. This list may be subject to change. When a Covered Person plans to receive any of these listed procedures, QCC Insurance Company will review the Medical Appropriateness/Medical Necessity for the procedure or treatment in accordance with the criteria and procedures described above and grant prior approval of benefits accordingly.

Surgical, diagnostic and other procedures that are performed during an emergency, as determined by QCC Insurance Company, do not require precertification. However, QCC Insurance Company should be notified within two (2) business days of emergency services for such procedures, or as soon as reasonably possible, as determined by QCC Insurance Company. A complete list of Precertification requirements is available by calling the number or visiting the website for Clinical Services listed on your identification (ID) card. This list may be subject to change.

The Covered Person is responsible to have the Provider performing the service contact QCC Insurance Company to initiate precertification. QCC Insurance Company will notify the Covered Person, the Doctor and the Facility, if applicable, of the determination.

If such prior approval is not obtained and the Covered Person undergoes the Surgical Procedure, diagnostic or other procedure, or treatment then benefits will be provided for Medically Appropriate/Medically Necessary treatment, but there will be a penalty for non-compliance. Benefits for Covered Services will be reduced 20% per service to the Covered Person. Such penalty, and any difference in what is covered by QCC Insurance Company and the Covered Person's obligation to the Provider, may be the sole responsibility of, and payable by, the Covered Person. For a complete list of services requiring Pre-certification please call the number for Clinical Services listed on your identification (ID) card or visit the website listed on your identification (ID) card. This list may be subject to change.

For a complete list of services requiring Precertification please call the number or visit the website for Clinical Services lsted on your identification (ID) card. This list may be subject to change.

H. SERVICES REQUIRING PRECERTIFICATION

For a complete list of services requiring Precertification please call the number or visit the website for Clinical Services listed on your identification (ID) card. This list may be subject to change.

I. CASE MANAGEMENT

Case management serves individuals who have been diagnosed with a complex, catastrophic, or chronic Illness or injury. The objectives of case management are to facilitate access by the patient to ensure the efficient use of appropriate health care resources, link Covered Persons with appropriate health care or support services, assist Providers in coordinating prescribed services, monitor the quality of services delivered, and improve outcomes of Covered Persons. Case management supports Covered Persons and Providers by locating, coordinating, and/or evaluating services for a Covered Person who has been diagnosed with a complex, catastrophic or chronic Illness and/or injury across various levels and sites of care.

QCC Insurance Company will provide case management services for those identified Covered Persons that would benefit from:

- Support during the continuum of care;
- Improved self-management skills;
- Improved transition and coordination among multiple Providers and/or levels of care;
- Assistance to maximize the effective use of health plan benefits;
- Reduction of acute exacerbation of a chronic Illness; and,
- Reduction of preventable complications.

Covered Persons may be identified for case management through the precertification process or through claims review. External referrals are also accepted from Covered Persons' Providers or family members. Covered Persons referred to case management are screened and accessed prior to acceptance into the program. Only those Covered Persons likely to benefit from case management are accepted into case management.

A case manager will consult with the patient, the patient's authorized representative, the caregiver and the attending Doctor in order to develop a plan of care for approval by the patient's attending Doctor and the patient. This plan of care may include some or all of the following:

- personal support to the patient;
- contacting the care giver to offer assistance and support;
- monitoring Inpatient care;
- identifying available resources for appropriate care;
- determining alternative care options; and

- assisting in obtaining any necessary equipment and services.

The case manager will coordinate and implement the case management program by providing guidance and information on available resources and suggesting the most appropriate treatment plan. The attending Doctor, the patient and the patient's caregiver must all agree to the alternate treatment plan. Once agreement has been reached, QCC Insurance Company may reimburse necessary expenses in the treatment plan, even if some expenses normally would not be paid by the benefit plan.

Case management is a voluntary service. Covered Persons must provide their consent for enrollment into case management. There is no reduction in benefits if the patient and the patient's family choose not to participate.

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

EXCEPTIONS AND EXCLUSIONS

Except as specifically provided in this SPD, no benefits will be provided for services, supplies or charges:

1. Which are not Medically Necessary as determined by the Plan for the diagnosis or treatment of illness or injury;

2. Which are Experimental/Investigational, except, as approved by the Plan, Routine Costs Associated with a Qualifying Clinical Trial that meets the definition of a Qualifying Clinical Trial under the Plan;

3. Which were Incurred prior to the Covered Person's effective date of coverage;

4. Which are in excess of the Covered Expense, as defined herein;

5. Which were or are Incurred after the date of termination of the Covered Person's coverage;

6. For any loss sustained or expenses Incurred during military service while on active duty as a member of the armed forces of any nation; or as a result of enemy action or act of war, whether declared or undeclared;

7. For which a Covered Person would have no legal obligation to pay, or another party has primary responsibility;

8. Received from a dental or medical department maintained by or on behalf of an employer, a mutual benefit association, labor union, trust, or similar person or group;

9. Paid or payable by Medicare when Medicare is primary. For purposes of this plan, a service, supply or charge is "payable under Medicare" when the Covered Person is eligible to enroll for Medicare benefits, regardless of whether the Covered Person actually enrolls for, pays applicable premium for, maintains, claims or receives Medicare benefits;

10. For any occupational illness or bodily injury which occurs in the course of employment if benefits or compensation are available, in whole or in part, under the provisions of the Worker's Compensation Law or any similar Occupational Disease Law or Act. This exclusion applies whether or not the Covered Person claims the benefits or compensation;

11. To the extent a Covered Person is legally entitled to receive when provided by the Veteran's Administration or by the Department of Defense in a government facility reasonably accessible by the Covered Person;

12. For injuries resulting from the maintenance or use of a motor vehicle if such treatment or service is paid under a plan or policy of motor vehicle insurance,

including a certified self-insured plan, or payable in any manner under the state's Motor Vehicle Financial Responsibility Law or similar law;

13. Which are not billed and performed by a Provider as defined under this coverage as a "Professional Provider", "Facility Provider" or "Ancillary Provider" except as otherwise indicated under the subsections entitled: (a) Therapy Services" (that identifies covered therapy services as provided by licensed therapists) and (b) "Ambulance Services" in the ***Covered Medical Charges*** section;

14. Rendered by a member of the Covered Person's Immediate Family;

15. Performed by a Professional Provider enrolled in an education or training program when such services are related to the education or training program and are provided through a Hospital or university;

16. For ambulance services except as specifically provided under this Plan;

17. For services and operations for cosmetic purposes which are done to improve the appearance of any portion of the body, and from which no improvement in physiologic function can be expected. However, benefits are payable to correct a condition resulting from an accident. Benefits are also payable to correct functional impairment which results from a covered disease, injury or congenital birth defect. This exclusion does not apply to mastectomy related charges as provided for in this SPD;

18. For telephone consultations, charges for failure to keep a scheduled visit, or charges for completion of a claim form;

19. For alternative therapies/complementary medicine, including but not limited to, music therapy, dance therapy, equestrian/hippotherapy, homeopathy, primal therapy, rolfing, psychodrama, vitamin or other dietary supplements and therapy, aromatherapy, massage therapy, therapeutic touch, recreational, wilderness, educational and sleep therapies;

20. For marriage counseling;

21. For Custodial Care, domiciliary care or rest cures;

22. For equipment costs related to services performed on high cost technological equipment as defined by the Plan, such as, but not limited to, computer tomography (CT) scanners, magnetic resonance imagers (MRI) and linear accelerators, unless the acquisition of such equipment by a Professional Provider was approved through the precertification process and/or by the Plan;

23. For dental services related to the care, filling, removal or replacement of teeth (including dental implants to replace teeth or to treat congenital anodontia, ectodermal dysplasia or dentinogenesis imperfecta), and the treatment of injuries

to or diseases of the teeth, gums or structures directly supporting or attached to the teeth, except as otherwise specifically stated in this SPD/certificate. Services not covered include, but are not limited to, apicoectomy (dental root resection), prophylaxis of any kind, root canal treatments, soft tissue impactions, alveolectomy, bone grafts or other procedures provided to augment an atrophic mandible or maxilla in preparation of the mouth for dentures or dental implants; and treatment of periodontal disease unless otherwise indicated;

24. For dental implants for any reason;

25. For dentures, unless for the initial treatment of an Accidental Injury/trauma;

26. For orthodontic treatment, except for appliances used for palatal expansion to treat congenital cleft palate;

27. For injury as a result of chewing or biting (neither is considered an Accidental Injury);

28. For palliative or cosmetic foot care including treatment of bunions (except for capsular or bone surgery), toenails (except surgery for ingrown nails), the treatment of subluxations of the foot, care of corns, calluses, fallen arches, pes planus (flat feet), weak feet, chronic foot strain, and other routine podiatry care, unless associated with the Medically Necessary treatment of peripheral vascular disease and/or peripheral neuropathic disease, including but not limited to diabetes;

29. For supportive devices for the foot (orthotics), such as, but not limited to, foot inserts, arch supports, heel pads and heel cups, and orthopedic/corrective shoes. This exclusion does not apply to orthotics and podiatric appliances required for the prevention of complications associated with diabetes;

30. For any treatment leading to or in connection with transsexual Surgery except for sickness or injury resulting from such Surgery;

31. For treatment of sexual dysfunction not related to organic disease except for sexual dysfunction resulting from an injury;

32. For treatment of obesity, except for surgical treatment of obesity when the Plan (a) determines the surgery is Medically Necessary; and (b) the surgery is limited to one surgical procedure per lifetime regardless of whether such procedure was covered by the Plan or another Plan. Any new or different obesity surgery, revisions, repeat, or reversal of any previous surgery are not covered. The exclusion of coverage for a repeat, reversal or revision of a previous obesity surgery does not apply when the procedure results in technical failure or when the procedure is required to treat complications, which if left untreated, would result in endangering the health of the Covered Person;

33. For correction of myopia or hyperopia by means of corneal microsurgery, such as keratomileusis, keratophakia, and radial keratotomy and all related services;

34. For diagnostic screening examinations, except for mammograms and preventive care as provided in the ***Covered Medical Charges*** section;

35. For routine physical examinations for non-preventive purposes, such as pre-marital examinations, physicals for college, camp or travel, and examinations for insurance, licensing and employment;

36. For travel, whether or not it has been recommended by a Professional Provider or if it is required to receive treatment at an out of area Provider;

37. For immunizations required for employment purposes, or for travel;

38. For care in a nursing home, home for the aged, convalescent home, school, camp, institution for intellectually disabled children, Custodial Care in a Skilled Nursing Facility;

39. For counseling or consultation with a Covered Person's relatives, or Hospital charges for a Covered Person's relatives or guests, except as may be specifically provided;

40. For home blood pressure machines, except for Covered Persons: (a) with pregnancy-induced hypertension, (b) with hypertension complicated by pregnancy, or (c) with end-stage renal disease receiving home dialysis;

41. As described in the "Durable Medical Equipment" section in the ***Covered Medical Charges*** section for personal hygiene, comfort and convenience items (such as total electric beds, massage devices, ramps. saunas, and alarms) ; equipment and devices of a primarily nonmedical nature (like exercise equipment, raised toilet seats, bathtub lifts, elevators, stair glides, strollers, power wheelchairs with a seat elevator, rails for the bathtub or toilet, transfer benches, bed boards, over the bed tables, safety enclosures for a hospital bed, feeding chairs, car beds, and car seats); equipment inappropriate for home use (typically called institutional equipment); equipment containing features of a medical nature that are not required by the Covered Person's condition (like heating pads, cold pads, electric or fixed patient lifts, ; equipment for environmental control (like air conditions, air purifiers, and dehumidifiers),non-reusable supplies; equipment which cannot reasonably be expected to serve a therapeutic purpose; duplicate equipment, whether or not rented or purchased as a convenience; devices and equipment used for environmental control; and customized wheelchairs;

42. For medical supplies such as but not limited to thermometers, ovulation kits, early pregnancy or home pregnancy testing kits;

43. For prescription drugs, except as may be provided in the ***Prescription Drug Coverage*** section of this SPD. This exclusion does not apply to insulin, insulin analogs and pharmacological agents for controlling blood sugar levels as provided for the treatment of diabetes;

44. For over-the-counter drugs and any other medications that may be dispensed without a doctor's prescription, except for medications administered during an Inpatient admission;

45. For amino acid supplements, non-elementals formulas, appetite suppressants or nutritional supplements. This exclusion includes basic milk, soy, or casein hydrolyzed formulas (e.g., Nutramigen, Alimentun, Pregestimil) for the treatment of lactose intolerance, milk protein intolerance, milk allergy or protein allergy;

46. For any care that extends beyond traditional medical management for pervasive development disorders, attention deficit disorder, learning disabilities, behavioral problems, intellectually disabled or autism spectrum disorders; or treatment or care to effect environmental or social change;

47. For maintenance of chronic conditions;

48. For charges Incurred for expenses in excess of Benefit limits as specified in the ***Schedule of Benefits***;

49. For any therapy service provided for: the ongoing Outpatient treatment of chronic medical conditions that are not subject to significant functional improvement; additional therapy beyond this Plan's limits, if any, shown on the ***Schedule of Benefits***; work hardening; evaluations not associated with therapy; or therapy for back pain in pregnancy without specific medical conditions;

50. For cognitive rehabilitative therapy, except when provided integral to other supportive therapies, such as, but not limited to physical, occupational and speech therapies in a multidisciplinary, goal-oriented and integrated treatment program designed to improve management and independence following neurological damage to the central nervous system caused by illness or trauma (e.g. stroke, acute brain insult, encephalopathy);

51. For self-injectable Prescription Drugs, regardless of whether the drugs are provided or administered by a Provider. Drugs are considered self-injectable Prescription Drugs even when initial medical supervision and/or instruction is required prior to patient self-administration. This exclusion does not apply to self-injectable Prescription Drugs that are: (a) mandated to be covered by law, such as insulin or any drugs required for the treatment of diabetes, unless these drugs are covered by Prescription Drug coverage under the Plan or free-standing Prescription Drug Contract issued to the Group by the Plan; or (b) required for treatment of an emergency condition that requires a self-injectable drug;

52. For assisted fertilization techniques such as, but not limited to, in-vitro fertilization, gamete intra-fallopian transfer (GIFT) and zygote intra-fallopian transfer (ZIFT);

53. For any Surgery performed for the reversal of a sterilization procedure;

54. For diagnosis and treatment of autism spectrum disorders that is provided through a school as part of an individualized education program;

55. For diagnosis and treatment of autism spectrum disorders that is not included in the autism spectrum disorders treatment plan for autism spectrum disorders;

56. For eyeglasses, lenses or contact lenses and the vision examination for prescribing or fitting eyeglasses or contact lenses unless otherwise indicated;

57. Care, treatment or supplies furnished by a program or agency funded by any government. This exclusion does not apply when otherwise prohibited by law or pursuant to coverage authorized by a reimbursement agreement under 25 U.S.C. Section 1621e(f);

58. Care and treatment for which there would not have been a charge if no coverage had been in force;

59. Charges incurred for which the Plan has no legal obligation to pay, and unless waived by the Plan Sponsor, charges incurred for which the Covered Person would have no legal obligation to pay, had the Covered Person applied to another program or alternative resource. This provision shall be construed as an exclusionary clause in accordance with Section 2-3.8(I) of the Contract Health Service Manual and 25 U.S.C. Section 1621e and 1623. This exclusion shall not prohibit reimbursement agreements entered into in accordance with 25 U.S.C. Section 1621e(f);

60. Subject to its right to make provisional payments under the Special Coordination Rules for Tribal Programs, the Plan hereby excludes all care that is covered by an Individual Policy as referred to in the Special Coordination Rules for Tribal Programs set forth below;

61. Subject to its right to waive or limit this provision, the Plan hereby excludes all care or services eligible for reimbursement through the Catastrophic Health Emergency Fund ("CHEF"), 25 U.S.C. Section 1621a. This provisions shall be construed as an exclusionary clause in accordance with Section 2-3.8(I) of the Contract Health Service Manual and 25 U.S.C. Section 1621e and 1623.

62. Subject to its right to waive or limit this provision, the Plan hereby excludes all care or services eligible for coverage by a Contract Health Service ("CHS") program, also referred to as a Purchased or Referred Care ("PRC") program (referred to herein as "CHS" or "PRC") operated by, through or in connection with the federal Indian Health Service or by an Indian tribe, tribal organization or tribal consortium of tribes or tribal organizations pursuant to a self-determination contract of self-governance compact under P.L. 93-638, as amended (or other applicable federal law governing tribal health care and Indian Health Service programs). This provision shall be construed as an exclusionary clause in accordance with Section 2-3.8(I) of the

Contract Health Service Manual and 25 U.S.C. Section 1621e and 1623. The Plan Sponsor reserves the right to waive this exclusion in full or in part for designated care pursuant to express reimbursement agreements between the Plan Sponsor and a contracting facility. The Plan Sponsor also reserves the right to pay CHS eligible care as a member-based benefit herein. In no event will the Plan be required to pay more than MLR for care that would be paid at MLR if paid directly through CHS;

63. Subject to its right to waive or limit this provision, the Plan hereby excludes all direct service care or services covered by or provided through a federal Indian Health Service program or a tribal health program operating under the ISDEAA, except for programs, services or facilities for which the Plan Sponsor has elected to provide reimbursements in accordance with 25 U.S.C. Section 1621e(f). This provision shall be construed as an exclusionary clause in accordance with Section 2-3.8(I) of the Contract Health Service Manual and 25 U.S.C. Sections 1621e and 1623;

64. Subject to its right to coordinate benefits, the Plan hereby excludes coverage for which the Plan is the payer of last resort under 25 U.S.C. Section 1623(b).

The Plan reserves the right to waive certain exclusions based on the specific terms or conditions of an individual case management plan, or as required to comply with a reimbursement agreement entered into under 25 U.S.C. Section 1621e(f).

For any other service or treatment except as provided under this Plan.

COORDINATION OF BENEFITS

APPLICABILITY

1. This Coordination of Benefits ("COB") provision applies to This Plan when an Employee or the Employee's covered Dependent has health care coverage under more than one Plan. "Plan" and "This Plan" are defined below.

2. If this COB provision applies, the Order Of Benefit Determination Rules should be looked at first. Those rules determine whether the benefits of This Plan are determined before or after those of another Plan. The benefits of This Plan:

   a. shall not be reduced when, under the Order of Benefit Determination Rules, This Plan determines its benefits before another Plan; but

   b. may be reduced when, under the Order of Benefit Determination Rules, another Plan determines its benefits first. The above reduction is described in "Effect on the Benefits of This Plan."

DEFINITIONS

1. "Plan" is any of these which provides benefits or services for, or because of, medical or dental care or treatment:

   a. Group insurance or group-type coverage, whether insured or uninsured. This includes prepayment, group practice, or individual practice coverage. It does not include school accident-type coverage, group or group-type hospital indemnity benefits of $100 per day or less.

   b. Coverage under a governmental plan or required or provided by law. This does not include a state plan under Medicaid. It also does not include any plan when, by law, its benefits are excess to those of any private insurance program or other non-governmental program.

   Each contract or other arrangement for coverage under (a) or (b) is a separate Plan. Also, if an arrangement has two parts and COB rules apply only to one of the two, each of the parts is a separate Plan.

2. **"This Plan"** is the part of the group contract that provides benefits for health care expenses.

3. **"Primary Plan/Secondary Plan."** The Order Of Benefit Determination Rules state whether This Plan is a Primary Plan or Secondary Plan as to another Plan covering the person.

   When This Plan is a Primary Plan, its benefits are determined before those of the other Plan and without considering the other Plan's benefits.

When This Plan is a Secondary Plan, its benefits are determined after those of the other Plan and may be reduced because of the other Plan's benefits.

When there are more than two Plans covering the person, This Plan may be a Primary Plan as to one or more other Plans, and may be a Secondary Plan as to a different Plan or Plans.

4. **"Allowable Expense"** means a necessary, reasonable, and customary item of expense for health care, when the item of expense is covered at least in part by one or more Plans covering the person for whom the claim is made.

   The difference between the cost of a private hospital room and the cost of a semiprivate hospital room is not considered an Allowable Expense under the above definition unless the patient's stay in a private hospital room is medically necessary either in terms of generally accepted medical practice, or as specifically defined in the Plan.

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

5. **"Claim Determination Period"** means a calendar year. However, it does not include any part of a year during which a person has no coverage under This Plan, or any part of a year before the date this COB provision or a similar provision takes effect.

ORDER OF BENEFIT DETERMINATION RULES

1. **General.** When there is a basis for a claim under This Plan and another Plan, This Plan is a Secondary Plan which has its benefits determined after those of the other Plan, unless:

   a. the other Plan has rules coordinating its benefits with those of This Plan; and

   b. both those rules and This Plan's rules, in subparagraph 2 below, require that This Plan's benefits be determined before those of the other Plan.

2. **Rules.** This Plan determines its order of benefits using the first of the following rules which applies:

   a. **Non-dependent/Dependent.** The benefits of the Plan which covers the person as other than a dependent are determined before those of the Plan which covers the person as a dependent.

   b. **Dependent Child/Parents Not Separated or Divorced.** Except as stated in subparagraph 2 (c) below, when This Plan and another Plan cover the same child as a dependent of different persons, called "parents":

(1) the benefits of the Plan of the parent whose birthday falls earlier in a year are determined before those of the Plan of the parent whose birthday falls later in the year; but

(2) if both parents have the same birthday, the benefits of the Plan that covered the parent longer are determined before those of the Plan that covered the other parent for a shorter period.

However, if the other Plan does not have the rule described in (1) immediately above, but instead has a rule based upon the gender of the parent, and if, as a result, the Plans do not agree on the order of benefits, the rule in the other Plan will determine the order of benefits.

c. **Dependent Child/Parents Separated or Divorced**. If two or more Plans cover a person as a dependent child of divorced or separated parents, benefits for the child are determined in this order:

(1) first, the Plan of the parent with custody of the child;

(2) then, the Plan of the spouse of the parent with custody of the child; and

(3) finally, the Plan of the parent not having custody of the child.

However, if the specific terms of a court decree state that one of the parents is responsible for the health care expenses of the child, and the entity obligated to pay or provide the benefits of the Plan of that parent has actual knowledge of those terms, the benefits of that Plan are determined first. This paragraph does not apply with respect to any Claim Determination Period or plan year during which any benefits are actually paid or provided before the entity has that actual knowledge.

d. **Active/Inactive Employee.** The benefits of a Plan that covers a person as an employee who is neither laid off nor retired (or as that employee's dependent) are determined before those of a Plan that covers that person as a laid off or retired employee (or as that employee's dependent). 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 is ignored.

e. **Longer/Shorter Length of Coverage.** If none of the above rules determines the order of benefits, the benefits of the Plan that covered an employee longer are determined before those of the Plan that covered that person for the shorter time.

EFFECT ON THE BENEFITS OF THIS PLAN

1. **When this Section Applies.** This section applies when, in accordance with "Order of Benefit Determination Rules," This Plan is a Secondary Plan as to one or more other

Plans. In that event the benefits of This Plan may be reduced under this section. Such other Plan or Plans are referred to as "the other Plans" in 2 immediately below.

2. **Reduction in This Plan's Benefits.** The benefits of This Plan will be reduced when the sum of:

   a. the benefits that would be payable for the Allowable Expenses under This Plan in the absence of this COB provision; and

   b. the benefits that would be payable for the Allowable Expenses under the other Plans, in the absence of provisions with a purpose like that of this COB provision, whether or not claim is made exceeds those Allowable Expenses in a Claim Determination Period. In that case, the benefits of This Plan will be reduced so that they and the benefits payable under the other Plans do not total more than those Allowable Expenses.

      When the benefits of This Plan are reduced as described above, each benefit is reduced in proportion. It is then charged against any applicable benefit limit of This Plan.

RIGHT TO RECEIVE AND RELEASE NEEDED INFORMATION

QCC Insurance Company has the right to release or obtain benefit information in order to implement this provision.

FACILITY OF PAYMENT

If payments should have been made under this Plan but were made under any other Plan(s), QCC Insurance Company may make payments to such other Plan(s) to satisfy the intent of the provision. Benefits under this Plan will then be deemed paid. The Plan will no longer be liable for such payments.

RIGHT OF RECOVERY

QCC Insurance Company has the right to recover any excess payments made to satisfy the intent of this provision.

SPECIAL COORDINATION RULES FOR TRIBAL PROGRAMS (APPLICABLE ONLY TO PARTICIPANTS WHO ARE ELIGIBLE FOR TRIBAL HEALTH PROGRAM BENEFITS DUE TO THEIR STATUS AS AN ENROLLED TRIBAL MEMBER)

This Section shall take into account coverage through Indian Health Service, tribal direct care, PRC Programs and other programs, as applicable. Notwithstanding anything in the SPD to the contrary, programs purporting to limit or prohibit coordination (like Medicaid and Medicare) may not limit coordination with the Plan in violation of 25 U.S.C. Sections 1621e(f) or 1623(b).

The following coordination rules apply to all Plan benefits eligible for MLR, CHEF, Sponsorship and payer of last resort rights including, without limitation, those arising under the Indian Health Care Improvement Act, the Indian Self-Determination and Education Assistance Act, 42 CFR 136.30, 42 CFR 136.201-136.204, and 25 U.S.C. Sections 1621a, 1621e, 1623 and 1642:

a. PRC and IHS as Primary Payers/MLR: PRC and IHS programs shall pay primary or to the exclusion of the Plan, and the Plan reserves the right to exclude all MLR Eligible Care, except as follows:

   1) Permitted Reimbursements (Direct Service). The Plan will reimburse direct services care to any IHS Program or tribal health program to the extent that the Plan Sponsor has agreed to such reimbursement in accordance with 25 U.S.C. 1621e(f).

   2) Permitted Reimbursements (Purchased Referred Care). The Plan reserves the right to make direct payments to a provider otherwise entitled to reimbursement through a PRC Program, or to make reimbursements or funding available to any PRC Program for charges paid through that program that are otherwise covered herein. The foregoing reimbursements or payments are permitted only to the extent agreed to by the Plan Sponsor in accordance with 25 U.S.C. 1621e(f).

   3) CHEF Coverage. In no event will coverage under the Plan, including without limitation under (1) or (2) above, obligate the Plan to pay for care that is eligible for reimbursement under CHEF; provided that the Plan may pay such claims on a provisional basis pending a final determination as to whether the charges qualify for reimbursement through CHEF. Once CHEF eligibility is determined: (1) the applicable PRC Program shall reimburse any provisional payments as a Plan overpayment, (2) the Plan may reverse the payment (with PRC paying the provider direct), or (3) the Plan Sponsor and PRC Program may agree that the Plan should continue to pay such claims on a provisional basis on behalf of the PRC Program for claims efficiency and continuity of care. Upon rejection of a CHEF claim by IHS, the Plan may invoke its exclusionary clause and reverse any provisional Plan payments for direct payment through PRC.

   4) MLR Eligible Care. In no event will coverage under (1) through (3) above require the Plan to provide in excess of what would be paid through a PRC Program for such care or services. Any reimbursements or payments for MLR Eligible Care are made on a provisional basis and expressly contingent upon the provider accepting MLR from the Plan as payment in full.

   5) Supplemental Funding Arrangement. All reimbursements or payments under (1) through (4) above represent payments for and on behalf of the applicable IHS, Tribal health program, or PRC eligible care as a means to

provide supplemental funding as part of the Sponsor's coordinated tribal health program.

6) Provisional Payments. The Plan may pay any claim otherwise covered by the express terms of the Plan on a provisional basis pending a final determination under the Plan coordination of benefits rules and procedures. In the event that it is confirmed that IHS or PRC should have been primary under this coordination of benefits provision after a provisional payment has been made by the Plan, the Plan shall be entitled to reimbursement.

7) Reservation of Rights. Nothing in this section requires the Plan Sponsor to adopt policies authorizing reimbursement or payment of IHS or PRC eligible care.

b. Individual Policy Rules: In the event that a service or charge would be paid for through or by an Individual Policy in the absence of benefits hereunder, the following special coordination of benefits rules shall apply:

1) The Plan shall pay secondary to available Individual Policy coverage in accordance with 25 U.S.C. Section 1623(b), which provides that health programs operated by Indian tribes and tribal organizations shall be the payer of last resort for services notwithstanding any Federal, State or local law to the contrary.

2) An Individual Policy that is required to pay primary to IHS or PRC Program benefits shall pay primary to any benefits available hereunder to the extent that benefits herein are entitled to secondary status behind IHS or PRC, including, without limitation, any benefits subject to an exclusionary clause as referred to in 25 U.S.C. Section 1621e(f) or CHS Manual Section 2-3.8(I).

3) Regardless of (1) or (2) above, an Individual Policy that does not contain a coordination of benefits provision shall pay primary to any benefits available hereunder.

c. Medicare / Medicaid – Special Federal and State Program Rules:

1) Medicare, Medicaid and other federal or State programs shall pay primary to this Plan for any care or services (1) as required by 25 U.S.C. Sections 1621e(f) and 1623(b), and (2) that such State and Federal programs would otherwise pay primary to IHS or PRC. Medicare shall also pay primary to any member-based benefits. See 42 U.S.C. Section 1395y(b)(v); 42 CFR 411.20; and 26 U.S.C. Section 5000(b)(1)(v).

2) The benefits provided hereunder shall not be treated as an alternate resource for purposes of eligibility under Indian Health Service, Contract Health Service or Purchased / Referred Care.

d. Other Programs or Policies: The Plan Sponsor reserves the right to assert secondary payer status to any other program, plan or policy to the extent provided in 25 U.S.C. Section 1623(b).

e. Exclusionary and MLR Provisions: This special coordination of benefits provision shall be construed to permit the Plan Sponsor to enter into arrangements for the payment of designated IHS or PRC benefits for (1) a provider that agrees to accept MLR as payment in full, and (2) which are not covered under an Individual Policy.

f. Other Rules:

1) Payments hereunder processed by or through the third party Claims Administrator (whether In-Network or Out-of-Network) are paid in its capacity as a contract fiscal intermediary of the tribal health program (including direct and PRC services where applicable). All payments for member care are made from the Tribe's assets on behalf of the tribe and its health program(s) as a means of providing supplemental funding for care in addition to care or services otherwise available to members through IHS, direct service care, or PRC.

2) The Plan Sponsor or Plan is entitled to a refund of any overpayments and may offset any future payments to recoup any such overpayments. In the event that payments are provided hereunder as a result of another plan, program or policy failing to pay in accordance with the coordination of benefit provision set forth herein, the payment shall be deemed a contingent, provisional or conditional payment and the Plan Sponsor or Plan shall be entitled to bring a legal action through reimbursement or subrogation to recoup all such overpayments plus fees and costs.

3) All payments hereunder through reimbursement or otherwise, including conditional or provisional payments made as a result of another plan, program or policy's failure to comply with the coordination of benefits rules shall apply against the Plan's specific or aggregate stop loss reinsurance limits, as applicable, unless or until recovered. Nothing herein or in any other plan or SPD document or communication shall be construed as a waiver of sovereign immunity. Acceptance of benefits or payments shall constitute an assignment of the above reimbursement and subrogation rights to the Plan Sponsor or Plan, as well as consent by the recipient to tribal court jurisdiction and to the laws of the Tribe except as may be waived by express action of the Plan Sponsor.

4) Nothing herein shall be construed to create any private right of action against the Plan Sponsor, the Plan Sponsor's health program, or the Plan Sponsor's PRC or IHS program or any employee thereof.

The Plan may pay any claim on a provisional basis pending a final determination under the Plan coordination of benefit rules.

TERMINATION OF COVERAGE

EMPLOYEE

Coverage for an Employee will end on the earliest of:

1. the date the Plan terminates;
2. the end of the month in which coverage terminates under the Plan for the class of Employees to which the Employee belongs;
3. the end of the month in which the Employee transfers to an ineligible class of Employees;
4. the end of the period covered by the last contribution made by the Employee for coverage under the Plan;
5. the end of the month in which the Employee's employment is terminated;
6. the date the Employee becomes involved in a labor dispute, strike, or work stoppage. Coverage will be reinstated only upon the return of such Employee to the Plan.

DEPENDENTS

Coverage for a Dependent will end on the earliest of:

1. the date an Employee's coverage terminates under the Plan;
2. the end of the month in which the Dependent no longer satisfies the eligibility requirements for coverage as a Dependent under the Plan;
3. the end of the period covered by the last contribution made by the Employee for Dependent coverage.

CONTINUATION OF COVERAGE DURING CERTAIN LEAVES OF ABSENCE

In certain instances, the Company may allow you to continue your coverage while you are on an approved leave of absence. Please refer to the Company's leave of absence policies outlined in a separate document.

CONSOLIDATED OMNIBUS BUDGET RECONCILIATION ACT (COBRA)

COBRA affects employers who have employed 20 or more Employees on more than 50% of the typical business days during the previous calendar year. The employer is responsible for notifying each qualified beneficiary of their rights under COBRA.

Individuals entitled to COBRA continuation coverage are called qualified beneficiaries. Individuals who may be qualified beneficiaries are the spouse and dependent children

of a covered employee and, in certain cases, the covered employee. In order to be a qualified beneficiary an individual must generally be covered under a group health plan on the day before the event that causes a loss of coverage (such as a termination of employment, or a divorce from or death of the covered employee). A child who is born to the covered employee, or who is placed for adoption with the covered employee, during a period of COBRA continuation coverage is also a qualified beneficiary.

Each qualified beneficiary, as defined under the Consolidated Omnibus Budget Reconciliation Act of 1985, whose coverage would end under the Contract as a result of a qualifying event (listed below) will have an opportunity to elect continuation coverage under the Contract as required by law.

The employer retains full responsibility for notifying Employees of the rights of continuation coverage and for administering the exercise of continuation rights, as required by COBRA.

Each Employee has a right to continue coverage if:

1. employment with the employer ends for a reason other than gross misconduct;
2. work hours are reduced.

Each Dependent has a right to continue coverage if:

1. the Employee's employment with the employer ends for a reason other than gross misconduct;
2. the Employee's work hours are reduced;
3. the Employee dies;
4. in the case of the Employee's spouse, such spouse ceases to be an eligible Dependent as a result of divorce or legal separation;
5. the Employee is entitled to Medicare benefits, or
6. in the case of a Dependent child, such child ceases to be an eligible Dependent according to the terms of the Contract.

If any of the qualifying events occur, each qualified beneficiary, as reported to QCC Insurance Company by the employer, will receive a form from the employer to decide whether or not to elect COBRA continuation. Each qualified beneficiary will then have 45 days to pay the premium due. Premiums are payable from the date of the qualifying event.

In the case of the Employee's termination of employment or reduction in work hours, the coverage may be continued for up to 18 months, or 29 months if the individual is disabled either at the time of his qualifying event or during the first 60 days of COBRA

coverage and has received notification of disability eligibility from the Social Security Administration and notifies the employer within 60 days after receiving such notification.

If the individual entitled to the disability extension has non-disabled family members who are entitled to COBRA continuation coverage, those non-disabled family members are also entitled to the 29 month disabilities extension. With respect to all other events, coverage may be continued for up to 36 months.

However, coverage will cease earlier if one of the following events occurs:

1. the employer ceases to provide group health coverage to any Employee; or
2. the qualified beneficiary fails to make timely payments of any premium required; or
3. the qualified beneficiary is covered under another group health plan; or
4. the qualified beneficiary is entitled to benefits under Title XVIII of the Social Security Act (Medicare); or
5. the spouse remarries and becomes covered under another group health insurance plan.

QCC Insurance Company will have no obligation to ensure that any termination instructions received by it from the employer comply with the requirement of COBRA.

Instead of enrolling in COBRA continuation coverage, there may be other coverage options for you and your family through the Health Insurance Marketplace, Medicaid, or other group health plan coverage options (such as a spouse's plan) through what is called a "special enrollment period." Some of these options may cost less than COBRA continuation coverage. You can learn more about many of these options at www.healthcare.gov.

Uniformed Services Employment and Reemployment Rights Act (USERRA)

If you are called to active duty in the uniformed services, you may elect to continue coverage for you and your eligible dependents under USERRA. This continuation right runs concurrently with your continuation right under COBRA and allows you to extend an 18-month continuation period to 24 months. You and your eligible dependents qualify for this extension if you are called into active or reserve duty, whether voluntary or involuntary, in the Armed Forces, the Army National Guard, the Air National Guard, full-time National Guard duty (under a federal, not a state, call-up), the commissioned corps of the Public Health Services and any other category of persons designated by the President of the United States.

THIRD PARTY RECOVERY PROVISION

To the extent payment for the Illness or injury is made, or may be made in the future, by or for the party or parties legally responsible (as a settlement, judgment or in any other way), charges arising from that Illness or injury are not considered to be eligible charges under the terms of the Plan. If, however, payment by or for the party or parties legally responsible has not yet been made and the Covered Person(s) involved (or if incapable, that person's legal representative) agrees in writing to pay back promptly the benefits paid as a result of the Illness or injury to the extent of any future payments made by or for the party or parties legally responsible for the Illness or injury, the Plan will consider charges arising from that Illness or injury as eligible charges and benefits will be paid under the terms of the Plan. The agreement is to apply whether or not: (a) liability for the payments is admitted by the party or parties legally responsible; and (b) such payments are itemized.

When a Covered Person incurs medical expenses which are payable under Workers' Compensation, any statute, any uninsured or underinsured motorist program, any no fault or school insurance program, any other insurance policy or any other plan of benefits, or if medical expenses that arise through an act or omission of another person are paid by a third party, whether through legal action, settlement or for any other reason, the Covered Person shall reimburse the Plan for the cost of any and all medical expenses out of any funds or monies that he recovers from any third party, whether by coverage under another program, statute, insurance policy, lawsuit, settlement, judgment or otherwise.

Because the Plan is entitled to reimbursement for any payment which a Covered Person may receive from a third party if the Plan has paid medical benefits for expenses that arose from the same circumstances that were the basis for the payment received from the third party, the Plan shall be fully subrogated to any and all rights, recovery or causes of actions or claims that a Covered Person may have against any third party. The Plan is granted a specific and first right of reimbursement from any payment, amount and/or recovery from a third party. This right to reimbursement comes first regardless of the manner in which the recovery is structured or worded, and/or even if the Covered Person has not been paid fully or reimbursed for all of his/her damages or expenses. Therefore, the Plan's share of the recovery shall not be reduced because the Covered Person has not received the full damages or expenses claimed unless the Plan agrees in writing to such reduction.

Each Covered Person hereby consents and agrees that a constructive trust, lien and/or an equitable lien by agreement in favor of the Plan exists with regard to any payment, amount and/or recovery from a third party; and in accordance with that constructive trust, lien and/or equitable lien by agreement, each Covered Person agrees to cooperate with the Plan in reimbursing it for the Plan's costs and expenses.

To that end, once a Covered Person has any reason to believe that he may be entitled to recovery from any third party, he must notify the Plan. And, at that time, the Covered Person (and his attorney, if applicable) must sign a subrogation/reimbursement agreement that acknowledges the Plan's subrogation rights and its right to be reimbursed for expenses arising from circumstances that entitle the Covered Person to any payment, amount and/or recovery from a third party.

If a Covered Person fails or refuses to execute the required subrogation/reimbursement agreement, the Plan may deny payment of any benefits to the Covered Person and/or any of his dependents until the agreement is signed. Alternatively, if a Covered Person fails or refuses to execute the required subrogation/reimbursement agreement and the Plan nevertheless pays benefits to or on behalf of the Covered Person, the Covered Person's acceptance of such benefits shall constitute his or her agreement to the Plan's right to subrogation or reimbursement from any recovery by the Covered Person from any third party that is based on the circumstances from which the expenses or benefits paid by the Plan arose, and the Covered Person's agreement to a constructive trust, lien and/or an equitable lien by agreement in favor of the Plan on any payment, amount or recovery that the Covered Person recovers from any third party.

The Plan also may enforce its subrogation or reimbursement rights by requiring the Covered Person to assert a claim to any of the foregoing coverage to which he or she may be entitled. The Plan will not pay attorneys' fees or costs associated with the Covered Person's claim or lawsuit without express written authorization from the Plan Sponsor.

Each Covered Person consents and agrees that he/she shall not assign his/her rights to any payment, amount or recovery against a third party to any other party, including his/her attorneys without the Plan's consent. As such, the Plan's reimbursement will not be reduced by attorneys' fees and expenses without express written authorization from the Plan.

The Plan's right to subrogation or reimbursement will not be affected or reduced by the "make whole" doctrine, the "fund" doctrine, the "common fund" doctrine, comparative/contributory negligence, "collateral source" rule, "attorneys fund" doctrine, regulatory diligence or any other equitable defense that may affect the Plan's right to subrogation or reimbursement.

If the Plan shall become aware that a Covered Person has received a third party payment amount and/or recovery and not reported such amount, the Plan, in its sole discretion, may suspend all further payments related to the Covered Person and/or his or her dependents until the reimbursable portion is returned to the Plan or offset against amounts that would otherwise be paid to the Covered Person.

WHEN YOU HAVE A CLAIM

FROM A DOCTOR OR FACILITY

If you are treated for a covered Accidental Injury or Illness at a Facility or a participating doctor's office, present your identification card. QCC Insurance Company will pay the provider directly for covered expenses.

If you are required to pay the Facility or the Doctor, be sure to get a receipted, itemized bill. Besides the itemized charges it should show:

- your name and address
- patient's name and age
- doctor's or hospital's name and address
- Provider or Facility identification number
- date of admission or treatment

ADVERSE DETERMINATIONS

An adverse determination is a denial, reduction, or termination of, or a failure to provide or make a payment (in whole or in part*) for a benefit, including any such denial, reduction, termination, or failure to provide or make a payment that is based on: a determination that a benefit is not a covered benefit; the source-of-injury exclusion, network exclusion, or other limitation on otherwise covered benefits; or a determination that a benefit is experimental, investigational, or not medically necessary or appropriate. This can include both pre-service claims as well as post-service claims. The scope of adverse benefit determination eligible for internal claims and appeals includes a rescission of coverage (whether or not the rescission has an adverse effect on any particular benefit at the time).

*Including a denial of part of the claim due to the terms of a plan or health insurance coverage regarding copayments, deductibles, or other cost-sharing requirements.

COMPLAINT PROCESS

QCC Insurance Company has a process for a Covered Person to express complaints. To register a complaint, the Covered Person should call the Customer Service Department at the telephone number on their identification card or write to QCC Insurance Company at the address listed below.

c/o Processing Center
P.O. Box 21974
Eagan, MN 55121

Most Covered Persons' concerns are resolved informally at this level. However, if QCC Insurance Company is unable to immediately resolve the complaint, it will be investigated, and the Covered Person will receive a response within thirty (30) days.

APPEAL PROCESS

Filing an Appeal

QCC Insurance Company maintains procedures for the resolution of appeals. Appeals may be filed within 180 days of the receipt of a decision from QCC Insurance Company stating an adverse benefit determination. An appeal occurs when the Covered Person or another authorized representative requests a change of a previous decision made by QCC Insurance Company by following the procedures described here. In order to authorize someone else to be your representative for the appeal, you must complete a valid authorization form.

Contact QCC Insurance Company at the address listed above or access your online services at the address on your identification card to obtain a form to authorize an appeal by a provider or other representative or for questions regarding the requirements for an authorized representative.

The Covered Person or other authorized person on behalf of the Covered Person, may request an appeal by calling or writing to QCC Insurance Company, as stated in the letter notifying the Covered Person of the decision.

Types of Appeals

The following are the two types of appeals and the issues they address.

- **Medical Necessity Appeal** — An appeal by or on behalf of a Covered Person that focuses on issues of Medical Appropriateness/Medical Necessity and requests QCC Insurance Company to change its decision to deny or limit the provision of a Covered Service. Medical Necessity appeals include appeals of adverse benefit determinations based on failure to meet established medical guidelines and peer review of medical appropriateness. It may also include the exclusions for Experimental/Investigational services or cosmetic services. Internal and External Appeals apply.*
- **Administrative Appeal** — An appeal by or on behalf of a Covered Person that focuses on unresolved disputes or objections regarding QCC Insurance Company' decision that concerns coverage terms such as exclusions and non-covered benefits, exhausted benefits, and claims payment issues. Although an administrative appeal may present issues related to Medical Appropriateness/Medical Necessity, these are not the primary issues that affect the outcome of the appeal. Internal Appeals apply.*

* **First Step — Internal Appeal** — An appeal filed with your health plan/plan administrator for evaluation and determination.

* **Second Step — External Appeal** — An appeal filed with your health plan/plan administrator for evaluation and determination by an independent review organization (IRO).

Timeframe Classifications

The timeframes described below for completing a review of each appeal depend on whether the appeal is classified as standard appeal or an expedited appeal for urgent care.

- Standard appeal timeframes apply to both pre-service appeals and post-service appeals that concern claims for non-urgent care.

  Standard pre-service appeal — An appeal for benefits that, under the terms of the Plan, must be pre-certified or pre-approved (either in whole or in part) *before* medical care is obtained in order for coverage to be available.

  Standard post-service appeal — An appeal for benefits that is not a pre-service appeal. (Post-service appeals concerning claims for services that the Covered Person has already obtained do not qualify for review as expedited/urgent appeals.)

  Urgent-care/Expedited appeal timeframes may apply to pre-service or on-going requests for urgent care.

- **Expedited appeal for urgent care** — An appeal that provides faster review, according to the procedures described below, on a pre-service issue. QCC Insurance Company will conduct an urgent-care/expedited appeal on a pre-service issue when it determines, based on applicable guidelines, that delay in decision-making would seriously jeopardize the Covered Person's life, health or ability to regain maximum function or would subject the Covered Person to severe pain that cannot be adequately managed while awaiting a standard appeal decision.

Information for the Appeal Review including Matched Specialist's Report

The Covered Person or other authorized person on behalf of the Covered Person, may submit to QCC Insurance Company additional information pertaining to your case. You may specify the remedy or action being sought. Upon request at any time during the appeal process, QCC Insurance Company will provide you or your authorized representative, free of charge, access to, and copies of, all relevant documents and records, including any additional information received and reviewed by the decision maker(s) on the appeal.

Input from a matched specialist is obtained for certain Medical Necessity Appeals. A matched specialist is a licensed physician or psychologist in the same or similar specialty as typically manages the care under review. The matched specialist cannot be the

person who made the initial adverse benefit determination nor can they be a subordinate of the person who made that determination.

Appeal Decision makers

QCC Insurance Company has representatives that have been designated to act as decision maker(s) on the appeal. The decision maker(s) did not make the initial adverse benefit determination at issue in the appeal. Each decision maker will review all relevant information for the appeal, whether from the Covered Person or his authorized representative, or obtained from other sources during the investigation of the appeal issues. If the additional information meets plan guidelines the appeal may be overturned by the decision maker(s). To avoid conflict of interest and for compliance with regulatory and accreditation requirements, QCC Insurance Company also utilizes peer medical reviewers including contracted external review organizations for matched-specialty (peer) reviews, and for review of administrative and medical necessity external appeal review requests. Matched specialty /peer reviewers were not involved in the initial review process and are not subordinates of the person who made the initial determination.

Full and Fair Review

If the reviewer upholds the original decision, QCC Insurance Company will provide the Covered Person with the rational and new or additional evidence considered or relied upon in connection with the appeal. This is to give the Covered Person a reasonable opportunity to respond prior to the final determination.

Changes in Appeal Processes

Please note that the Appeal processes described here may change due to changes that QCC Insurance Company makes to comply with applicable state and federal laws and regulations and/or accreditation standards or to improve the appeal processes.

External Review of Adverse Determination/Appeals

You are entitled to the external review process described below for all appeals of adverse determination (denials) concerning:

- Rescission of coverage;
- Medical judgment (including, based on the plans requirements, medical necessity, appropriateness, health care setting, level of care, effectiveness of a covered benefit; or its determination that a treatment is experimental or investigational), as determined by the external reviewer.

Standard External Review Procedures

External appeals may be filed up to four (4) months after receipt of the notice from QCC Insurance Company of an adverse determination (denial) or final adverse determination (denial) for appeals involving the above stated issues.

You or your authorized representative can file an external appeal by calling the number listed on your ID card.

The Covered Person may be responsible for a nominal fee for the administrative duties performed in order to process the appeal for the external review.

Preliminary Review

Within five (5) business days following the date of receipt of the external review request, we will complete a preliminary review of the request to determine eligibility for the external review. Within one (1) business day after completion of this preliminary review, we will issue a written notification informing you if it is eligible for external review and if not, the reason why not and additional contact information. If your request is incomplete, we will inform you of the additional information needed to make the request for external review complete. If your request is eligible for external review you may submit, within ten (10) business days following the date of receipt of the notice, additional information that the Independent Review Organization (IRO) will consider when conducting the external review.

Referral to Independent Review Organization (IRO)

Eligible external review requests will be referred to a contracted, accredited independent review organization.

Final external review decisions are made by the external review organization within 45 days and will be forwarded in writing to the claimant and the Plan (Plan Administrator). The external decision is binding on QCC Insurance Company.

If you have any questions or concerns during the external review process or if you want to initiate an urgent care claim review, you (or your authorized representative) can call the toll-free number on your identification (ID) card.

Expedited External Review Process

If you (the claimant) have a medical condition where the timeframe for completion of a standard external review would seriously jeopardize your (claimant's) life or health or would jeopardize the ability to regain maximum function or if the matter concerns an admission, availability of care, continued stay, or health care item or service for which you received emergency services but have not been discharged from a facility then you or your authorized representative (including your healthcare provider with knowledge of your condition) may request an expedited external review.

You may make a written or oral request for the expedited (urgent) external review.

- Urgent care reviews may be initiated by calling the toll-free number on your identification (ID) card.

Preliminary Review

Immediately upon receipt, we (or the Plan) will determine whether the request meets the eligible review requirements for an expedited (urgent) external review and will notify you of the eligibility for expedited (urgent) review or standard external review.

Referral to Independent Review Organization (IRO)

Upon the determination that a request is eligible for expedited (urgent) external review following the preliminary review we (or the Plan) will assign an independent review organization and provide them all necessary documents and information considered in making the adverse determination or final adverse benefit determination.

If during the external review process, we (or the Plan) reconsiders and decides to provide coverage, we (or the Plan) will provide oral notice followed by written notice within 48 hours.

Notice of the Final External Review Decision

- The IRO/external examiner provides notice of the final external review decision.
- The decision is completed as expeditiously as the claimant's medical condition or circumstances require, but in no event more than 72 hours after the IRO receives the request for the expedited external review.
- If the notice is not in writing, the assigned IRO must provide written confirmation of the decision to you (the claimant) and the Plan. within 48 hours after the date of providing that notice,

The external decision is binding on QCC Insurance Company.

If the Adverse Determination (denial) is Reversed

Upon our receipt of the notice of the external review decision, we immediately will authorize to provide the coverage or payment for the claim as required by federal rule set under the Patient Protection and Affordable Care Act.

NOTICE: Please see the subsection entitled "NOTICE OF CLAIMS" found under the *General Provisions* section of this booklet.

GENERAL PROVISIONS

REGARDING TREATMENT WHICH IS NOT MEDICALLY NECESSARY

QCC Insurance Company only covers treatment which it determines Medically Necessary. A Preferred Provider accepts QCC Insurance Company decision and contractually is not permitted to bill the Covered Person for treatment which QCC Insurance Company determines is not Medically Necessary unless the Preferred Provider specifically advises the Covered Person in writing, and the Covered Person agrees in writing that such services are not covered by QCC Insurance Company, and that the Covered Person will be financially responsible for such services. A Non-Preferred Provider, however, is not obligated to accept QCC Insurance Company determination and the Covered Person may not be reimbursed for treatment which QCC Insurance Company determines is not Medically Necessary. The Covered Person is responsible for these charges when treatment is received by a Non-Preferred Provider. You can avoid these charges simply by choosing a Preferred Provider for your care. The term "Medically Necessary" is defined in the ***Definitions*** section.

LIMITATION OF LIABILITY

QCC Insurance Company will not be liable for any injury(ies) or damage(s) resulting from acts or omissions of any person, institution or other Provider furnishing services or supplies to the Covered Person.

No legal action may be taken to recover benefits provided by the Plan until 30 days after QCC Insurance Company has received a properly completed claim. In no event may such action be taken later than one year after services or Supplies were performed or provided.

NOTICE OF CLAIMS

Payments of benefits will not be made under the Plan unless proper notice is furnished to QCC Insurance Company that covered expenses have been provided to a Covered Person. **Written notice must be given within 60 days after expenses are Incurred for covered expenses.**

Failure to give notice to QCC Insurance Company within the specified time will not reduce any benefit if it is shown that the notice was given as soon as reasonably possible, but **in no event will QCC Insurance Company be required to accept notice more than one year after covered expenses are Incurred.**

PAYMENT OF BENEFITS

QCC Insurance Company is authorized by the Plan to make payment directly to Facilities and Preferred Providers furnishing Covered Services for which benefits are provided under the Plan. However, QCC Insurance Company reserves the right to make

the payments directly to the Covered Person. The right of the Covered Person to receive payment is not otherwise assignable unless required by State law.

If any benefit remains unpaid at the death of the Employee, payment will be made to the Employee's estate. If no estate is probated or expected to be probated, QCC Insurance Company will have the right to make payment to a third party who has paid covered expenses for the Employee, upon receipt of proper documentation of such payment. QCC Insurance Company will incur no liability due to such payment made pursuant to this provision.

A request for payment of benefits will be deemed to authorize QCC Insurance Company to institute an investigation and to have access to all pertinent data, including all records of a Hospital and/or Doctor pertaining to the Covered Person.

COVERED PERSON/PROVIDER RELATIONSHIP

1. The choice of a Provider or choice of treatment by a Provider is solely that of the Covered Person.

2. The Plan does not furnish Covered Services but only makes payment for Covered Services received by a Covered Person. The Plan is not liable for any act or omission of any Provider. The Plan has no responsibility for a Provider's rendering of, failure or refusal to render Covered Services to a Covered Person.

PAYMENT OF PROVIDERS

1. PREFERRED PROVIDER REIMBURSEMENT

Reimbursement of health care providers who participate in the Preferred Provider Network is intended to encourage the provision of quality, cost-effective care. Set forth below is a general description of the reimbursement programs, by type of Network health care provider.

Please note that these reimbursement programs may change from time to time, and the arrangements with particular Providers may be modified as new contracts are negotiated. If you have any questions about how your health care provider is compensated, please speak with your healthcare provider directly or contact Customer Service.

PHYSICIANS

Network physicians, including primary care physicians (PCPs) and specialists, are paid on a fee-for-service basis, meaning that payment is made according to the Network fee schedule for the specific medical services that the Physician performs.

INSTITUTIONAL PROVIDERS

Hospitals

For most Inpatient medical and surgical services, Hospitals are paid per diem rates, which are specific amounts paid for each day a Covered Person is in the Hospital. These rates usually vary according to the intensity of the Covered Services provided. Some Hospitals are also paid case rates, which are set dollar amounts paid for a complete Hospital stay related to a specific procedure or diagnosis, e.g., transplants. For most Outpatient and Emergency Services and procedures, most Hospitals are paid specific rates based on the type of Covered Service performed. For a few Covered Services, Hospitals are paid based on a percentage of billed charges. Most Hospitals are paid through a combination of the above payment mechanisms for various services.

QCC Insurance Company is implementing a quality incentive program with a few of the Hospitals in the Network. This program will provide increased reimbursement to these Hospitals based on them meeting specific quality criteria, including "Patient Safety Measures". Such patient safety measures are consistent with recommendations by the President's Advisory Commission on Consumer Protection and Quality in the Health Care Industry and are designed to help reduce medical and medication errors. Other criteria are directed at improved patient outcomes, higher nursing staff ratios, and electronic submissions. This is a new incentive program that is expected to evolve over time.

Skilled Nursing Facilities, Rehabilitation Hospitals, and other care facilities

Most Skilled Nursing Facilities and other special care facilities are paid per diem rates, which are specific amounts paid for each day a Covered Person is in the Facility. These amounts may vary according to the intensity of the Covered Services provided.

Ambulatory Surgical Centers ("ASCs")

Most ASCs are paid specific rates based on the type of Covered Service performed. For a few services, some ASCs are paid based on a percentage of billed charges.

Physician Group Practices, Physician Associations and Integrated Delivery Systems

Certain physician group practices, independent physician associations ("IPAs") and integrated hospital/physician organizations called Integrated Delivery Systems ("IDS") employ or contract with individual physicians to provide medical services. These groups are paid as described in the Physicians reimbursement subsection outlined above. These groups may pay their affiliated physicians a salary and/or provide incentives based on production, quality, service, or other performance standards.

Ancillary Service Providers, certain Facility Providers and Mental Health/Substance Abuse Providers

Ancillary service providers, such as Durable Medical Equipment providers, laboratory providers, Home Health Care agencies, and Mental Health and Substance Abuse providers are paid on the basis of fee-for-service payments according to the Network fee schedule for the specific Covered Services performed. In some cases, such as for mental health and substance abuse benefits, one vendor arranges for all such services through a contracted set of Providers. QCC Insurance Company reimburses the contracted Providers of these vendors on a fee-for-service basis. An affiliate of QCC Insurance Company has less than a three percent ownership interest in this mental health/substance abuse vendor.

Hospitalists

QCC Insurance Company currently does not have a hospitalist program in place but is considering implementing such a program in the future. However, QCC Insurance Company continues to maintain interest in encouraging Hospitals to contract with Physicians who specialize in providing emergency room consultation and inpatient management services.

2. PAYMENT METHODS

The Covered Person or the Provider may submit bills directly to QCC Insurance Company and, to the extent that benefits are payable within the terms and conditions of this SPD, reimbursement will be furnished as detailed below. The Covered Person's benefits for Covered Services are based on the rate of reimbursement as set forth under "Covered Expense" in the ***Definitions*** section of this SPD.

FACILITY PROVIDERS

Preferred Facility Providers

Preferred Facility Providers are members of the PPO Network and have a contractual arrangement with QCC Insurance Company for the provision of services to Covered Persons. Benefits will be provided as specified in the ***Schedule of Benefits*** for Covered Services which have been performed by a Preferred Facility Provider. QCC Insurance Company will compensate the Preferred Facility Providers in accordance with the contracts entered into between such Providers and QCC Insurance Company. BlueCard PPO Providers will be compensated by the Blue Cross and Blue Shield Plans with which they contract. No payment will be made directly to the Covered Person for Covered Services rendered by any Preferred Facility Provider.

Non-Preferred Facility Providers

Non-Preferred Facility Providers include facilities that are not part of the PPO Network.

When a Covered Person seeks care from a Non-Preferred Facility Provider, benefits will be provided to the Covered Person at the Non-Preferred cost sharing level

specified in the ***Schedule of Benefits***. The reimbursement rate is specified under "Covered Expense" in the ***Definitions*** section of this SPD.

Once Covered Services are rendered by a Facility Provider, the Plan will not honor a Covered Person's request not to pay for claims submitted by the Facility Provider. The Covered Person will have no liability to any person because of its rejection of the request.

PROFESSIONAL PROVIDERS

Preferred Professional Providers

QCC Insurance Company is authorized by the Covered Person to make payment directly to the Preferred Professional Providers furnishing Covered Services for which benefits are provided under this coverage. Preferred Professional Providers have agreed to accept the rate of reimbursement determined by a contract as payment in full for Covered Services. BlueCard PPO Providers will be compensated by the Blue Cross and Blue Shield Plans with which they contract. Preferred Professional Providers will make no additional charge to Covered Persons for Covered Services except in the case of certain Copayments, Coinsurance or other cost sharing features as specified under this program. The Covered Person is responsible, within 60 days of the date in which QCC Insurance Company finalizes such services, to pay, or make arrangements to pay, such amounts to the Preferred Professional Provider.

Benefit amounts, as specified in the ***Schedule of Benefits*** of this coverage, refer to Covered Services rendered by a Professional Provider which are regularly included in such Provider's charges and are billed by and payable to such Provider. Any dispute between the Preferred Professional Provider and a Covered Person with respect to balance billing shall be submitted to QCC Insurance Company for determination. The decision of QCC Insurance Company shall be final.

Once Covered Services are rendered by a Professional Provider, QCC Insurance Company will not honor a Covered Person's request not to pay for claims submitted by the Professional Provider. QCC Insurance Company will have no liability to any person because of its rejection of the request.

Emergency Care by Non-Preferred Providers

If QCC Insurance Company determines that Covered Services provided by a Non-Preferred Provider were for Emergency Care, the Covered Person will be subject to the Preferred cost-sharing levels. For such Covered Services, payment will be made to the Provider. For payment of Covered Services provided by a Non-Preferred Provider, please refer to the definition of Covered Expense in the ***Definitions*** section of this SPD. Inpatient admissions for Emergency Care must be certified within two business days of admission, or as soon as reasonably possible, as determined by QCC Insurance Company.

A Non-Preferred Provider who provided Emergency Care can bill you directly for their services, for either the Provider's charges or amounts in excess of QCC Insurance Company payment for the Emergency Care, i.e., "balance billing." In such situations, you will need to contact QCC Insurance Company at the Customer Service telephone number listed on the back of your I.D. card. Upon such notification, QCC Insurance Company will resolve the balance-billing.

Non-Preferred Hospital-Based Provider

When you receive Covered Services from a Non-Preferred Hospital-Based Provider while you are an Inpatient at a Preferred Hospital or other Preferred Facility Provider and are being treated by a Preferred Professional Provider, you will receive the Preferred cost-sharing level of benefits for the Covered Services provided by the Non-Preferred Hospital-Based Provider. For such Covered Services, payment will be made to the Provider. For payment of Covered Services provided by a Non-Preferred Professional Provider, please refer to the definition of Covered Expense in the ***Definitions*** section of this SPD.

A Non-Preferred Hospital–Based Provider can bill you directly for their services, for either the Provider's charges or amounts in excess of QCC Insurance Company payment to the Non-Preferred Hospital-Based Providers, i.e., "balance billing." In such situations, you will need to contact QCC Insurance Company at the Customer Service telephone number listed on the back of your I.D. card. Upon such notification, QCC Insurance Company will resolve the balance billing.

Note that when you elect to see a Non-Preferred Hospital-Based Provider for follow-up care or any other service where you have the ability to select a Preferred Provider, the Covered Services will be covered at a Non-Preferred benefit level. Except for Emergency Treatment, if a Non-Preferred Provider admits you to a Hospital or other Facility Provider, Covered Services provided by a Non-Preferred Hospital-Based Provider will be reimbursed at the Non-Preferred benefit level. For such Covered Services, payment will be made to the Provider. The Covered Person will be responsible to reimburse the Provider for the difference between QCC Insurance Company payment and the Provider's charge.

For payment of Covered Services provided by a Non-Preferred Professional Provider, please refer to the definition of Covered Expense in the ***Definitions*** section of this SPD.

Inpatient Hospital Consultations by a Non-Preferred Professional Provider

When you receive Covered Services for an Inpatient hospital consultation from a Non-Preferred Professional Provider while you are Inpatient at a Preferred Facility Provider, and the Covered Services are referred by a Preferred Professional Provider, you will receive the Preferred cost-sharing level of benefits for the Inpatient hospital consultation.

For such Covered Services, payment will be made to the Provider. For payment of Covered Services provided by a Non-Preferred Professional Provider, please refer to the definition of Covered Expense in the ***Definitions*** section of this SPD.

A Non-Preferred Professional Provider can bill you directly for their services, for either the Provider's charges or amounts in excess of QCC Insurance Company payment to the Non-Preferred Professional Providers, i.e., "balance billing." In such situations, you will need to contact QCC Insurance Company at the Customer Service telephone number listed on the back of your I.D. card. Upon such notification, QCC Insurance Company will resolve the balance billing.

Note that when you elect to see a Non-Preferred Professional Provider for follow-up care or any other service when you have the ability to select a Preferred Provider, the Covered Services will be covered at a Non-Preferred benefit level. Except for Emergency Care, if a Non-Preferred Professional Provider admits you to a Hospital or other Facility Provider, services provided by Non-Preferred Professional Provider will be reimbursed at the Non-Preferred benefit level. For such Covered Services, payment will be made to the Provider. The Covered Person will be responsible to reimburse the Provider for the difference between QCC Insurance Company' payment and the Provider's charge. For payment of Covered Services provided by a Non-Preferred Professional Provider, please refer to the definition of Covered Expense in the ***Definitions*** section of this SPD.

Non-Preferred Professional Provider

Except as set forth above, when a Covered Person seeks care from a Non-Preferred Professional Provider, benefits will be provided to the Covered Person at the Non-Preferred cost sharing level specified in the ***Schedule of Benefits***. For payment of Covered Services provided by a Non-Preferred Professional Provider, please refer to the definition of Covered Expense in the ***Definitions*** section of this SPD. When a Covered Person seeks care and receives Covered Services from a Non-Preferred Professional Provider, the Covered Person will be responsible to reimburse the Non-Preferred Professional Provider for the difference between QCC Insurance Company payment and the Non-Preferred Professional Provider's charge.

ANCILLARY PROVIDERS

Preferred Ancillary Providers

Preferred Ancillary Providers include members of the PPO Network that have a contractual relationship with QCC Insurance Company for the provision of services or supplies to Covered Persons. Benefits will be provided as specified in the ***Schedule of Benefits*** for the provision of services or supplies provided to Covered Persons by Preferred Ancillary Providers. QCC Insurance Company will compensate Preferred Ancillary Providers in the PPO Network in accordance with the contracts entered into between such Providers and QCC Insurance Company.

Non-Preferred Ancillary Providers

Non-Preferred Ancillary Providers are not members of the PPO Network. Benefits will be provided to the Covered Person at the Non-Preferred cost sharing level. The Covered Person will be penalized by the application of higher cost sharing. For payment of Covered Services provided by a Non-Preferred Ancillary Provider, please refer to the definition of Covered Expense in the ***Definitions*** section of this SPD. When a Covered Person seeks care and receives Covered Services from a Non-Preferred Ancillary Provider, the Covered Person will be responsible to reimburse the Non-Preferred Ancillary Provider for the difference between QCC Insurance Company payment and the Non-Preferred Ancillary Provider's charge.

ASSIGNMENT OF BENEFITS TO PROVIDERS

The right of a Covered Person to receive benefit payments under this coverage is personal to the Covered Person and is not assignable in whole or in part to any person, Hospital, or other entity nor may benefits of this coverage be transferred, either before or after Covered Services are rendered. However, a Covered Person can assign benefit payments to the custodial parent of a Dependent covered under the coverage, as required by law.

RIGHT TO RECOVER EXCESS PAYMENTS

QCC Insurance Company reserves the right to recover claim payments made in excess of the benefits payable for Covered Services under the Plan. QCC Insurance Company may request that the payee, either a Covered Person or Provider, return the excess payment to QCC Insurance Company.

TRANSFER OF COVERAGE

An Employee may enroll in the Plan's coverage during the annual Open Enrollment Period established by the Company.

If written application is made during the annual Open Enrollment Period, coverage under the Plan will be effective on the first of the month following the month of the established Open Enrollment Period.

Notwithstanding anything in this provision to the contrary, the Employee and/or Dependent must satisfy all other eligibility requirements under the Plan prior to or simultaneously with the date that such Employee's coverage under the Plan is effective.

PLAN ADMINISTRATION

Plan Administrator

The general administration of the Plan and the duty to carry out its provisions is vested in the Employer. The board of directors will perform such duties on behalf of the Employer, provided it may delegate such duty or any portion thereof to a named person, including employees and agents of the Employer, and may from time to time revoke such authority and delegate it to another person. Any delegation of responsibility must be in writing and accepted by the designated person. Notwithstanding any designation or delegation of final authority with respect to claims, the Plan Administrator generally has final authority to administer the Plan.

Powers and Duties of the Plan Administrator

The Plan Administrator will have the authority to control and manage the operation and administration of the Plan. This will include all rights and powers necessary or convenient to carry out its functions as Plan Administrator. Without limiting that general authority, the Plan Administrator will have the express authority to:

1. construe and interpret the provisions of the Plan and decide all questions of eligibility.
2. prescribe forms, procedures, policies, and rules to be followed by you and other persons claiming benefits under the Plan;
3. prepare and distribute information to you explaining the Plan;
4. receive from you and any other parties the necessary information for the proper administration of eligibility requirements under the Plan;
5. receive, review, and maintain reports of the financial condition and receipts and disbursements of the Plan; and
6. to retain such actuaries, accountants, consultants, third party administration service providers, legal counsel, or other specialists, as it may deem appropriate or necessary for the effective administration of the Plan.

Actions of the Plan Administrator

The Plan Administrator may adopt such rules as it deems necessary, desirable, or appropriate. All determinations, interpretations, rules, and decisions of the Plan Administrator shall be made in its sole discretion and shall be conclusive and binding upon all persons having or claiming to have any interest or right under the Plan, except with respect to claim determinations where final authority has been delegated to the Claims Administrator. All rules and decisions of the Plan Administrator will be

uniformly and consistently applied so that all individuals who are similarly situated will receive substantially the same treatment.

The Plan Administrator or the Employer may contract with one (1) or more service agents, including the Claims Administrator, to assist in the handling of claims under the Plan and/or to provide advice and assistance in the general administration of the Plan. Such service agent(s) may also be given the authority to make payments of benefits under the Plan on behalf of and subject to the authority of the Plan Administrator. Such service agent(s) may also be given the authority to determine claims in accordance with procedures, policies, interpretations, rules, or practices made, adopted, or approved by the Plan Administrator.

Nondiscrimination

The Plan shall not discriminate in favor of "highly compensated employees" as defined in Section 105(h) of the Internal Revenue Code, as to eligibility to participate or as to benefits.

Termination or Changes to the Plan

No agent can legally change the Plan or waive any of its terms.

The Employer reserves the power at any time and from time to time (and retroactively if necessary or appropriate to meet the requirements of the Internal Revenue Code) to terminate, modify or amend, in whole or in part, any or all provisions of the Plan. Any amendment to this Plan may be effected by a written resolution adopted by the Employer. The Plan Administrator will communicate any adopted changes to the employees.

Funding

This Plan is a self-insured medical plan funded by contributions from the employer and/or employees. Funds for benefit payments are provided by the employer according to the terms of its agreement with the Claims Administrator. Your contributions toward the cost of coverage under the Plan will be determined by the employer each year. The Claims Administrator provides administrative services only and does not assume any financial risk or obligation with respect to providing benefits. The Claims Administrator's payment of claims is contingent upon the Plan Administrator continuing to provide sufficient funds for benefits.

Controlling Law

Except as they may be subject to federal law, any questions, claims, disputes, or litigation concerning or arising from the Plan will be governed by the laws of the State of Minnesota.

Privacy of Protected Health Information

Protected Health Information (PHI) is individually identifiable information created or received by a health care provider or a health care plan. This information is related to your past, present, or future health or the payment for such health care. PHI includes demographic information that either identifies you or provides a reasonable basis to believe that it could be used to identify you.

Restrictions on the Use and Disclosure of Protected Health Information

The employer may not use or disclose PHI for employment-related actions or decisions. The employer may only use or further disclose PHI as permitted or required by law and will report any use or disclosure of PHI that is inconsistent with the allowed uses and disclosures.

Separation Between the Employer and the Plan

The employees, classes of employees or other workforce members below will have access to PHI only to perform the plan administration functions that the employer provides for the plan. The following may be given access to PHI:

3. Benefit Administrator, Benefit Assistant, Claims Supervisor, Customer Service Representative, Claims Examiner

This list includes every employee or class of employees or other workforce members under the control of the employer who may receive PHI relating to the ordinary course of business.

The employees, classes of employees or other workforce members identified above will be subject to disciplinary action and sanctions for any use or disclosure of PHI that is in violation of these provisions. The employer will promptly report such instances to the Plan and will cooperate to correct the problem. The employer will impose appropriate disciplinary actions on each employee or workforce member and will reduce any harmful effects of the violation.

TRIBAL HEALTH PROGRAM STATUS AND RIGHTS (APPLICABLE ONLY TO PARTICIPANTS WHO ARE ELIGIBLE FOR TRIBAL HEALTH PROGRAM BENEFITS DUE TO THEIR STATUS AS AN ENROLLED TRIBAL MEMBER)

(a) Self-Insurance/Tribal Health Program: All program benefits are "self-insured", which means benefits are paid from general assets rather than through a policy or policies of insurance. Plan benefits are intended to qualify as self-insured tribal health program benefits under 25 U.S.C. Sections 1623(b), 1621e(f), 1603(12) and 1603(25). The Plan Sponsor also reserves the right to receive federal funding for benefits provided herein in accordance with 25 U.S.C. Section 1642.

(b) Payer of Last Resort/Coordination with Indian Health Service (IHS) and Other Coverage: This program is entitled to payer of last resort rights under 25 U.S.C. Section 1623(b). Coverage under this program shall be coordinated as one component of an integrated tribal health program consisting of care provided through the Plan Sponsor using one or more mechanisms including self-insurance, direct care, sponsorship, and PRC services. The Claims Administrator shall serve as a fiscal intermediary or applicable ordering official when necessary to coordinate coverage though or on behalf of each component and applicable PRC services. This program shall not be treated as an alternate resource for purposes of PRC and CHEF. Benefits provided hereunder are intended in part to serve as supplemental funding for benefits otherwise available to IHS Beneficiaries through other federal, tribal and third party programs or payers. This program shall not pay in front of available federal, tribal and other third party programs or payers except to the extent agreed to under 25 U.S.C. Section 1621e(f).

(c) Medicare-Like Rate Discounts/CHEF: This Plan is entitled to Medicare-Like Rates ("MLR") pricing under Section 506 of the Medicare Modernization Act of 2003 and the final regulations issued thereunder at 42 CFR 136.30-136.32 and 42 CFR 489.29. Per 42 CFR 136.30(b), MLR shall apply "to all levels of care furnished by a Medicare-participating hospital, whether provided inpatient, outpatient, skilled nursing facility care, as other services of a department, subunit, distinct part, or other component of a hospital (including services furnished directly by the hospital or under arrangements) that is … authorized by a Tribe or tribal organization carrying out a CHS [now referred to as PRC] program of the IHS under the Indian Self-Determination and Education Assistance Act [the "ISDEAA"]." The Plan Sponsor reserves the right to authorize MLR eligible care through its PRC program and to coordinate payment through the Claims Administrator herein, to assert Professional Services and Non-Hospital-Based Discounts to the extent permitted under 42 CFR 136.201-136.204, and to coordinate benefits and PRC services to maximize CHEF reimbursements under 25 U.S.C. Section 1621a.

(d) Member-Based Benefits: The Plan Sponsor reserves the right to treat this program as a member-based tribal health program to the fullest extent permitted at law including, without limitation, 25 U.S.C. Sections 1621e, 1623, and 1642. If this option is exercised, in the event that an enrolled tribal member qualifies for both employment-based and member-based benefits, the benefits paid hereunder shall be presumed to be paid as member-based benefits to the extent necessary to preserve member rights provided at law. This provision shall be construed to ensure that the Plan Sponsor's establishment of self-insurance or employment-based benefits will not waive any member-based rights and preferences available at law.

DEFINITIONS

ACCIDENTAL INJURY — A sudden, unforeseen, and identifiable event causing injury to a Covered Person, which is the direct result of the event and which occurs while coverage under the Plan for the Covered Person is in force.

ADMINISTRATIVE SERVICES AGREEMENT — The agreement between the Plan Sponsor and QCC Insurance Company, under which QCC Insurance Company provides administrative services to the Plan Sponsor in connection with the Plan.

AMBULANCE — A specially designed and medically equipped vehicle used solely for the transportation of the sick and/or injured.

AMBULATORY SURGICAL CENTER — A Facility that: (1) has permanent facilities and equipment for the primary purpose of performing Surgery on an Outpatient basis; and (2) provides such treatment by or under the supervision of an organized staff of Doctors; and (3) provides nursing services whenever the patient is in the Facility; and (4) does not provide Inpatient accommodations; and (5) is approved by the Joint Commission on Accreditation of Healthcare Organizations, or by the American Osteopathic Hospital Association, or by Medicare, or by QCC Insurance Company; and (6) is not, other than incidentally, a Facility used as an office or clinic for the private practice of a Professional Provider.

AMENDMENT — A supplement made a part of the Plan, which alters the benefits or terms of the Plan.

ANCILLARY PROVIDER — An individual or entity that provides services, supplies or equipment (such as, but not limited to, home infusion therapy services, Durable Medical Equipment and ambulance services), for which benefits are provided under the Plan.

ANESTHESIA — The administration of regional or local anesthetic or the administration of a drug or other anesthetic agent by injection or inhalation, the purpose and effect of which is to obtain muscular relaxation, loss of sensation, or loss of consciousness.

BIRTHING CENTER — A Facility that: (1) is primarily organized and staffed to provide maternity care by a Nurse Midwife; and (2) is licensed as a Birthing Center under the laws of the state where it is located; or (3) is approved by QCC Insurance Company.

BLUECARD PPO PROGRAM — A program that allows a Covered Person travelling or living outside of their plan's area to receive coverage for services at an in-network benefit level if the Covered Person receives services from Blue Cross Blue Shield providers that participate in the BlueCard PPO Program.

BLUECARD PPO PROVIDER — A Provider that participates in the BlueCard PPO Program as a Preferred Provider.

CALENDAR YEAR DEDUCTIBLE — The amount of eligible expenses the Covered Person is required to pay each calendar year before the Plan begins to pay benefits.

CERTIFIED REGISTERED NURSE — A Professional Provider who: (1) is a certified registered nurse anesthetist, certified registered nurse practitioner, certified enterostomal therapy nurse, certified community health nurse, certified psychiatric mental health nurse, or certified clinical nurse specialist; and (2) is certified by the State Board of Nursing or a national nursing organization recognized by the State Board of Nursing.

CHEF — The Catastrophic Health Emergency Fund in 25 U.S.C. Section 1621a.

CHSDA — The contract health service delivery area, as applicable.

CLAIM — A request for payment of benefits for services rendered or Supplies received, which is presented to QCC Insurance Company for payment. Such request must be submitted to QCC Insurance Company with all statements, questionnaires, certifications, instruments, documents, and affidavits requested by QCC Insurance Company that are necessary to properly process the request for benefits. Claim forms will be provided by QCC Insurance Company.

COINSURANCE — The specified percentage of Covered Expense the Covered Person is required to pay.

COMPANY — White Earth Band of Chippewa Indians.

CONTRACT HEALTH SERVICE OR "CHS" — See Purchased Referred Care/PRC.

COVERED EXPENSE — Refers to the basis on which a Covered Person's Deductibles, Coinsurance, benefit Maximums and benefits are calculated.

A. For Covered Services provided by a Facility Provider, "Covered Expense" means the following:

   i. For Covered Services provided by a Preferred Facility or BlueCard PPO Provider, "Covered Expense" for Outpatient services means the amount payable to the Provider under the contractual arrangement in effect with QCC Insurance Company or the BlueCard PPO Provider.

   ii. For Covered Services provided by a Preferred Facility or BlueCard PPO Provider, "Covered Expense" for Inpatient services means the amount payable to the Provider under the contractual arrangement in effect with QCC Insurance Company or the BlueCard PPO Provider.

   iii. For Covered Services provided by a Non-Preferred Facility Provider, "Covered Expense" for Outpatient services means the lesser of 1.75 times the Medicare Allowable Payment for Facilities or the Facility Provider's charges for the Covered Services. For Covered Services not recognized or reimbursed by the Medicare traditional program, the amount is determined by reimbursing forty percent (40%)

of the Facility Provider's charges for Covered Services.

iv. For Covered Services provided by a Non-Preferred Facility Provider, "Covered Expense" for Inpatient services means the lesser of 1.75 times the Medicare Allowable Payment for Facilities or the Facility Provider's charges for the Covered Services. For Covered Services not recognized or reimbursed by the Medicare traditional program, the amount is determined by reimbursing forty percent (40%) of the Facility Provider's charges for Covered Services.

B. For Covered Services provided by a Professional Provider, "Covered Expense" means the following:

i. For Covered Services by a Preferred Professional Provider or BlueCard PPO Provider, "Covered Expense" means the rate of reimbursement for Covered Services that the Professional Provider has agreed to accept as set forth by contract with QCC Insurance Company, or the BlueCard PPO Provider.

ii. For a Non-Preferred Professional Provider, "Covered Expense" means the lesser of 1.75 times the Medicare Professional Allowable Payment or the Provider's charges for the Covered Services. For Covered Services not recognized or reimbursed by the Medicare traditional program, the amount will be denied.

C. For Covered Services provided by an Ancillary Provider, "Covered Expense" means the following:

i. For Covered Services provided by a Preferred Ancillary Provider or BlueCard PPO Provider, "Covered Expense" means the amount payable to the Provider under the contractual arrangement in effect with QCC Insurance Company or BlueCard PPO Provider.

ii. For Covered Services provided by a Non-Preferred Ancillary Provider, "Covered Expense" means the lesser of 1.75 times the Medicare Ancillary Allowable Payment or the Provider's charges for the Covered Services. For Covered Services not recognized or reimbursed by the Medicare traditional program, the amount will be denied.

D. Nothing in this section shall be construed to mean that QCC Insurance Company would provide coverage for services other than Covered Services.

COVERED PERSON — The Employee and/or his Dependent, if any, covered under the Plan.

COVERED SERVICE — A service, Supply, equipment, device, or drug specified in the Plan for which benefits will be provided when billed for by a Professional Provider, Facility, or Supplier.

CUSTODIAL CARE — Care that is provided primarily to assist the patient in meeting his activities of daily living. Such care is not provided primarily for its restorative or therapeutic value in the treatment of an Illness, injury, disease, or condition.

DEPENDENT — The Employee's: (1) spouse under a legally valid existing marriage; or (2) natural born or legally adopted child (including a child for whom adoption proceedings have been initiated), including a stepchild; or (3) unmarried child age 26 or older who is unable to earn his own living due to a physical or Mental Illness or handicap (subject to Eligibility — Continuation of Eligibility).

Dependent spouses may not be on active military service.

DOCTOR — A practitioner, other than a Covered Person, who is acting within the scope of his license as a Doctor of medicine; osteopathy; podiatry; dentistry; optometry; chiropractic; licensed speech pathologist; licensed audiologist; licensed teacher of the hearing impaired; or any other practitioner that the Plan must by law recognize as a Doctor legally entitled to render treatment.

DURABLE MEDICAL EQUIPMENT — Charges for: (1) non-disposable equipment that is primarily medical in nature, such as wheelchairs and hospital beds; and (2) orthotics or medical devices that are applied to or around the body for care or treatment of an injury or Illness; and (3) assorted medical items necessary for the treatment of respiratory diseases, such as oxygen tanks, oxygen contents, and oxygen masks.

EMERGENCY ACCIDENT TREATMENT — Provider expenses charged for the initial treatment of an Accidental Injury. Such treatment must begin within 72 hours of the injury that is being treated and excludes Ambulance services.

EMERGENCY MEDICAL TREATMENT — Provider expenses charged for the initial treatment of a condition with acute symptoms that is life threatening or that could cause serious damage to a bodily function. Such treatment must begin within 72 hours of the onset of the condition that is being treated and excludes Ambulance services.

EMPLOYEE — A person employed by the Company.

EMPLOYMENT WAITING PERIOD — The period, beginning with the date of employment, that an Employee must serve continuously before he is eligible to receive benefits under the Plan.

EXPERIMENTAL/INVESTIGATIONAL SERVICES AND SUPPLIES — A drug, biological product, device, medical treatment or procedure which meets any of the following criteria:

- Is the subject of ongoing Phase I or Phase II Clinical Trials;
- Is the research, experimental, study or investigational arm of on-going Phase III Clinical Trials or is otherwise under a systematic, intensive investigation to

determine its maximum tolerated dose, its toxicity, its safety, its efficacy or its efficacy as compared with a standard means of treatment or diagnosis;

- Is not of proven benefit for the particular diagnosis or treatment of the Covered Person's particular condition;
- Is not generally recognized by the medical community, as clearly demonstrated by Reliable Evidence, as effective and appropriate for the particular diagnosis or treatment of the Covered Person's particular condition; or
- Is generally recognized by either Reliable Evidence or the medical community that additional study on its safety and efficacy for the particular diagnosis or treatment of the Covered Person's particular condition, is recommended.

A drug will not be considered Experimental/Investigative if it has received final approval by the U.S. Food and Drug Administration (FDA) to market for the particular diagnosis or condition. Any other approval granted as an interim step in the FDA regulatory process, e.g., an Investigational New Drug Exemption (as defined by the FDA), is not sufficient. Once FDA approval has been granted for a particular diagnosis or condition, use of the drug for another diagnosis or condition shall require that one or more of the following established reference compendia:

- The American Hospital Formulary Service Drug Information; or
- The United States Pharmacopoeia Drug Information

recognize the usage as appropriate medical treatment. In any event, any drug which the FDA has determined to be contraindicated for the specific treatment for which the drug has been prescribed will be considered Experimental/Investigational.

In addition to the above criteria that pertains strictly to the use of a drug, biological product or device, any drug, biological product, device, medical treatment or procedure is not considered Experimental/Investigational if it meets all of the criteria listed below in paragraphs A - E:

A. Reliable Evidence exists that the biological product, device, medical treatment or procedure has a definite positive effect on health outcomes.

B. Reliable Evidence exists that over time the biological product, device, medical treatment or procedure leads to improvement in health outcomes; i.e., the beneficial effects outweigh any harmful effects.

C. Reliable Evidence clearly demonstrates that the biological product, device, medical treatment or procedure is at least as effective in improving health outcomes as established technology, or is usable in appropriate clinical contexts in which established technology is not employable.

D. Reliable Evidence clearly demonstrates that improvement in health outcomes, as defined above in paragraph C, is possible in standard conditions of medical practice, outside clinical investigative settings.

E. Reliable Evidence shows that the prevailing opinion among experts regarding the biological product, device, medical treatment or procedure is that studies or clinical trials have determined its maximum tolerated dose, its toxicity, its safety, its efficacy or its efficacy as compared with a standard means of treatment for a particular diagnosis.

FACILITY — An institution or entity licensed, where required, to provide care. Such Facilities include:

- Alcoholism Treatment Facility
- Ambulatory Surgical Center
- Birthing Center
- Freestanding Dialysis Facility
- Freestanding Outpatient Facility
- Home Health Care Agency
- Hospital
- Psychiatric Hospital
- Rehabilitation Facility
- Skilled Nursing Facility
- Substance Abuse Treatment Facility

FAMILY UNIT — An Employee and his covered Dependents.

FULL-TIME EMPLOYEE — An Employee of the Company who works at least [30] hours per week for the Company for compensation in the form of salary, wages, or commission. In the case of a proprietorship or partnership, the individual proprietor or each of the partners whose principal occupation is the conduct of the Company's business, and whose duties for the Company normally require at least [30] hours per week, shall be deemed a Full-time Employee.

No member of the Board of Directors shall be deemed a Full-time Employee unless such person is otherwise eligible as a bona fide Employee of the Company.

HOME HEALTH AGENCY — An agency, association, or part of a Hospital that: (1) provides Skilled Nursing Care in the patient's home for the treatment of a physical Illness or injury that requires medical supervision and treatment; and (2) provides such care by or under the supervision of a Registered Nurse acting under the direction of a Doctor; and (3) is approved by the Joint Commission on Accreditation of Healthcare Organizations or Medicare.

HOSPICE — A Facility that: (1) is primarily engaged in providing palliative care to terminally ill individuals; and (2) is licensed and operated according to the laws of the state in which it is located and approved by QCC Insurance Company.

HOSPITAL — A short-term, acute care Facility that: (1) is a duly licensed institution; and (2) is primarily engaged in providing Inpatient diagnostic and medical services for the care or treatment of sick and injured persons; and (3) provides such care by or under

the supervision of an organized staff of Doctors; and (4) has organized departments of medicine; and (5) provides continuous 24-hour nursing service by or under the supervision of Registered Nurses; and (6) is approved by the Joint Commission on Accreditation of Healthcare Organizations, or by the American Osteopathic Hospital Association, or by QCC Insurance Company. A Hospital is not, other than incidentally, a:

- Nursing Home
- Place for Rest
- Place for the Aged
- Place for the Provision of Hospice care
- Place for the Provision of Rehabilitation Care
- Place for the Treatment of Alcoholism or other Drug Abuse
- Place for the Treatment of Mental Illness
- Skilled Nursing Facility
- Spa or Sanitarium

HOSPITAL-BASED PROVIDER - A physician who provides Medically Necessary services in a Hospital or Preferred Facility Provider supplemental to the primary care being provided in the Hospital or Preferred Facility Provider, for which the Covered Person has limited or no control of the selection of such physician. Hospital-based providers include physicians in the specialties of radiology, anesthesiology and pathology and/or other specialties as determined by QCC Insurance Company. When these physicians provide services other than in the Hospital or Preferred Facility, they are not considered Hospital-Based Providers.

IHS BENEFICIARY — An individual who may also be eligible for Indian Health Service, tribal direct care, and/or Purchased Referred Care benefits.

IHS BENEFITS — Includes any direct care services or contract health services (now referred to as "Purchased Referred Care") available through the Indian Health Service or through a tribal health clinic or program operated under the ISDEAA, as amended.

ILLNESS — A condition marked by pronounced deviation from the normal, healthy state.

IMMEDIATE FAMILY — The Covered Person's spouse, parent, child, brother, sister, mother-in-law, father-in-law, sister-in-law, brother-in-law, daughter-in-law, or son-in-law.

INCURRED — A charge is deemed Incurred as of the date of the service or purchase giving rise to the charge.

INDIAN HEALTH SERVICE OR "IHS" PROGRAM — A program that provides direct services to Indian and other eligible individuals including care or services pursuant to the Indian Health Care Improvement Act and 42 CFR Part 136, Subpart B, regardless of whether the IHS program is operated directly by the federal Indian Health Service or through an Indian tribe, tribal organization or tribal consortium of tribes or tribal organizations

pursuant to a self-determination contract or self-governance compact under the ISDEAA, as amended.

INPATIENT — A person who is treated as a registered overnight bed patient in a Facility.

ISDEAA — The Indian Self-Determination and Education Assistance Act, as amended.

INPATIENT — A person who is treated as a registered overnight bed patient in a Facility.

LICENSED PRACTICAL OR VOCATIONAL NURSE (L.P.N. OR L.V.N.) — A nurse who has graduated from a formal practical or vocational nursing education program and is licensed by the appropriate state authority.

MAINTENANCE CARE — Care provided to maintain the patient's current level of functioning or to prevent deterioration. Such care is not primarily provided for its therapeutic value in the treatment of an Illness, disease, injury, or condition and does not require participation or administration by professional medical personnel.

MEDICALLY APPROPRIATE/MEDICALLY NECESSARY (or MEDICAL APPROPRIATENESS/MEDICAL NECESSITY) — An intervention will be covered if it is (a) a Covered Service, (b) not specifically excluded, and (c) Medically Appropriate/Medically Necessary. An intervention is Medically Appropriate/Medically Necessary if, as ordered by the treating Professional Provider and determined by QCC Insurance Company's medical director or physician designee, it meets all of the following criteria:

A. It is a "Health Intervention". A Health Intervention is an item or service delivered or undertaken primarily to treat (i.e., prevent, diagnose, detect, treat or palliate) a "medical condition" or to maintain or restore functional ability. A medical condition is one of the following: disease; Illness; injury; genetic or congenital defect; pregnancy; biological or psychological condition that lies outside the range of normal, age-appropriate human variation.

A Health Intervention is defined not only by the intervention itself, but also by the medical condition and patient indications for which it is being applied.

B. It is the most appropriate Supply or level of service, considering the potential benefit and harm to the Subscriber.

C. It is known to be "effective" in improving "health outcomes". Effective means that the intervention can reasonably be expected to produce the intended results and to have expected benefits that outweigh potential harmful effects. Health outcomes are outcomes that affect health status. The effectiveness of an intervention is based upon being a "new" or "existing" intervention.

i. New interventions: Effectiveness is determined by Scientific Evidence. An intervention is considered new if it is not yet in widespread use for (a) the medical condition, and (b) the patient indications being considered.

"Scientific Evidence" consists primarily of controlled clinical trials that either directly or indirectly demonstrate the effect of the intervention on health outcomes. If controlled clinical trials are not available, observational studies that demonstrate a causal relationship between the intervention and health outcomes can be used.

Partially controlled observational studies and uncontrolled clinical series may be suggestive. These do not by themselves demonstrate a causal relationship unless the magnitude of the effect observed exceeds anything that could be explained either by (a) the natural history of the medical condition, or (b) potential experimental biases.

New interventions for which clinical trials have not been conducted because of epidemiological reasons (i.e., rare or new diseases or orphan populations) shall be evaluated on the basis of professional standards of care or expert opinion.

ii. **Existing interventions**: Effectiveness is determined first by Scientific Evidence, then by professional standards, then by expert opinion. For existing interventions, Scientific Evidence should be considered first and, to the greatest extent possible, be the basis for a determination of Medical Necessity. If no Scientific Evidence is available, professional standards of care should be considered. If professional standards of care do not exist, are outdated, or contradictory, decisions about existing interventions should be based on expert opinion. Giving priority to Scientific Evidence does not mean that coverage of existing interventions should be denied in the absence of conclusive Scientific Evidence. Existing interventions can meet the contractual definition of Medical Necessity in the absence of Scientific Evidence if: (a) there is a strong conviction of effectiveness and benefit expressed through up-to-date and consistent professional standards of care, or, (b) in the absence of such standards, convincing expert opinion.

D. **It is cost-effective for this condition compared to alternative interventions, including no intervention.** "Cost effective" does not necessarily mean lowest price. An intervention is considered cost effective if the benefit and harm relative to costs represent an economically, efficient use of resources for patients with this condition. In the application of this criterion to an individual case, the characteristics of the individual patient shall be determinative.

An intervention may be medically indicated yet not be a Covered Service or meet this Medically Appropriate/Medically Necessary definition.

MEDICARE ALLOWABLE PAYMENT FOR FACILITIES — The payment amount, as determined by the Medicare program, for the Covered Service for a Facility Provider.

MEDICARE ANCILLARY ALLOWABLE PAYMENT — The payment amount, as determined by the Medicare program, for the Covered Service for an Ancillary Provider.

MEDICARE PARTS A AND B — "Hospital Insurance Benefits for the Aged and Disabled" under Title XVIII, Part A and/or Part B respectively, of the Social Security Act, as amended from time to time.

MEDICARE PROFESSIONAL ALLOWABLE PAYMENT — The payment amount, as determined by the Medicare program, for the Covered Service based on the Medicare Par Physician Fee Schedule.

MENTAL ILLNESS — An emotional or mental disorder characterized by an abnormal functioning of the mind or emotions and in which psychological, intellectual, emotional, or behavioral disturbances are the dominating feature.

Mental or nervous disorders that have a demonstrable organic origin will not be considered Mental Illness.

MLR ELIGIBLE CARE — Any care for which a provider must accept MLR as payment in full under 42 CFR 136.30 and Professional Services and Non-Hospital-Based Discounting, as applicable.

NON-PREFERRED ANCILLARY PROVIDER — An Ancillary Provider that is not a member of the PPO Network or is not a BlueCard PPO Provider.

NON-PREFERRED FACILITY PROVIDER — A Facility Provider that is not a member of the PPO Network or is not a BlueCard PPO Provider.

NON-PREFERRED PROFESSIONAL PROVIDER — A Professional Provider who is not a member of the PPO Network or is not a BlueCard PPO Provider.

NON-PREFERRED PROVIDER — A Facility Provider, Professional Provider or Ancillary Provider that is not a member of the PPO Network or is not a BlueCard PPO Provider.

NURSE MIDWIFE — A Professional Provider who: (a) is certified to practice as a Nurse Midwife; and (b) is licensed by the appropriate state authority as a Registered Nurse; and (c) has completed a program for the preparation of Nurse Midwife that is approved by the state in which the person is practicing.

OPEN ENROLLMENT PERIOD — The 31 day period immediately prior to the anniversary date of the Plan.

ORGANIC DISEASE — Includes any health condition in which there is an observable and measurable disease process (biomarker), e.g. inflammation or tissue damage. Non organic diseases or functional disorders, demonstrate no disease process which is visible or which can be established through standard diagnostic testing.

OUTPATIENT — A person who receives services or Supplies while not an Inpatient.

PLAN — White Earth Band of Chippewa Indians Employee Benefit Plan.

PLAN SPONSOR — White Earth Band of Chippewa Indians.

PREFERRED ANCILLARY PROVIDER — An Ancillary Provider that is a member of the PPO Network or is a BlueCard PPO Provider and has agreed to a rate of reimbursement determined by contract for the provision of "in-network" Covered Services and/or supplies to Covered Persons.

PREFERRED FACILITY PROVIDER — A Facility Provider that is a member of the PPO Network or is a BlueCard PPO Provider and has agreed to a rate of reimbursement determined by contract for the provision of "in-network" Covered Services to Covered Persons.

PREFERRED PROFESSIONAL PROVIDER — A Professional Provider who is a member of the PPO Network or is a BlueCard PPO Provider and has agreed to a rate of reimbursement determined by contract for "in-network" Covered Services rendered to a Covered Person.

PREFERRED PROVIDER — A Facility Provider, Professional Provider or Ancillary Provider that is a member of the PPO Network or is a BlueCard PPO Provider, authorized to perform specific "in-network" Covered Services at the Preferred level of benefits.

PREFERRED PROVIDER ORGANIZATION (PPO) NETWORK — The network of Providers with whom QCC Insurance Company has contractual arrangements and BlueCard PPO Providers.

PRIOR AUTHORIZATION — Written approval by QCC Insurance Company for medical or surgical treatment given prior to such treatment that outlines the Plan's liability for such treatment. Such approval will be given only after QCC Insurance Company: (1) reviews the case; and (2) receives the Covered Person's medical history and an explanation of the condition and treatment to be given (including any Surgical Procedures to be performed) written by his Doctor, and any supporting documentation.

PRIVATE ROOM — Accommodations in a room designed as such by the Hospital, Rehabilitation Facility, or Skilled Nursing Facility and containing not more than one bed.

PROFESSIONAL PROVIDER — A licensed person or practitioner performing services within the scope of such licensure. The Professional Providers include:

- Certified Registered Nurse
- Chiropractor
- Dentist
- Doctor
- Independent Clinical Laboratory
- Licensed Practical Nurse (LPN)
- Licensed Vocational Nurse (LVN)
- Nurse Midwife
- Optometrist
- Physical Therapist
- Podiatrist
- Psychologist

PROVIDER — A Facility, Professional or Ancillary Provider, licensed where required.

PSYCHIATRIC HOSPITAL — A Facility that: (1) is primarily engaged in providing Inpatient diagnostic, medical, and psychiatric services for the care or treatment of Mental Illness; and (2) provides such services by or under the supervision of an organized staff of

Doctors; and (3) provides continuous 24-hour nursing services by or under the supervision of Registered Nurses; and (4) is approved by the Joint Commission on Accreditation of Healthcare Organizations, or by the American Osteopathic Hospital Association, or by QCC Insurance Company.

PURCHASED REFERRED CARE OR "PRC" — The terms Purchased Referred Care or PRC are used interchangeably with "Contract Health Services" or "CHS" as used herein.

PURCHASED REFERRED CARE OR "PRC" PROGRAM — A contract health service program (also referred to as "CHS", "Purchased Referred Care" or "PRC") under 42 CFR Part 136, Subpart C, regardless of whether the PRC program is operated directly by the federal IHS, a tribe or tribal organization, including a PRC program operated by an Indian tribe, tribal organization or tribal consortium of tribes or tribal organizations pursuant to a self-determination contract of self-governance compact under the ISDEAA, as amended.

QUALIFYING CLINICAL TRIAL — The systematic, intensive investigation or evaluation of a drug, biological product, device, medical treatment, therapy or procedure that meets all of the following criteria:

A. investigates a service that falls within a benefit category of the Plan;

B. is not specifically excluded from coverage;

C. has a therapeutic effect upon enrolled patients with diagnosed disease;

D. is intended to clarify or establish health outcomes of interventions already in common clinical use as defined by the available Reliable Evidence;

E. does not duplicate existing studies;

F. is designed to collect and disseminate Reliable Evidence and answer specific research questions being asked in the trial;

G. is designed and conducted according to appropriate standards of scientific integrity;

H. complies with Federal regulations relating to the protection of human subjects;

I. has a principal purpose to discern whether the service improves health outcomes on enrolled patients with diagnosed disease;

J. is: (1) funded by, or supported by centers or cooperative groups that are funded by: the National Institutes of Health (NIH), Centers for Disease Control and Prevention (CDC), Agency for Healthcare Research and Quality (AHRQ), Centers for Medicare and Medicaid Services (CMS), or a research arm of the Department of Defense (DOD) or Department of Veterans Affairs (VA); or(2) conducted under an investigational new drug application (IND) reviewed by the FDA, or an Investigational New Drug Exemption as defined by the FDA;

K. is conducted by a Network Provider. If there is no comparable FDA Approved Clinical Trial being conducted by a Network Provider, the Plan will consider covering an FDA Approved Clinical Trial being conducted by a Non-network Provider.

In the absence of meeting the criteria listed in (a) - (j) above, the Clinical Trial must be approved by the Plan as a Qualifying Clinical Trial.

REGIONAL NETWORK DISCOUNT — The percentage reduction from Facility charges for Covered Services that QCC Insurance Company passes on to its customers as a share of the savings BlueLink TPA is expected to realize from its negotiated Hospital contracts. The balance of any savings not passed on to its customers is for the sole benefit of QCC Insurance Company. The amount of the discount may be changed prospectively from time to time.

REGISTERED NURSE (R.N.) — A nurse who has graduated from a formal program of nursing education (diploma school, associate degree program, or baccalaureate program) and is licensed by the appropriate state authority.

REHABILITATION FACILITY — An institution or part of an institution that: (1) specializes in providing restorative and therapeutic services on an Inpatient and Outpatient basis for the treatment of a physical Illness or injury, Mental Illness, drug addiction and alcoholism; and (2) provides such services by or under the supervision of a staff of Doctors; and (3) provides continuous 24-hour nursing service by or under the supervision of Registered Nurses; and (4) is approved by the Joint Commission on Accreditation of Healthcare Organizations or Medicare.

RELIABLE EVIDENCE — Only published reports and articles in the authoritative medical and scientific literature; the written protocol or protocols used by the treating facility or the protocol(s) of another facility studying substantially the same drug, biological product, device, medical treatment or procedure; or the written informed consent used by the treating facility or by another facility studying substantially the same drug, biological product, device, medical treatment or procedure.

ROUTINE COSTS ASSOCIATED WITH A QUALIFYING CLINICAL TRIAL — Routine Costs include: (a) Covered Services under this Contract that would typically be provided absent a Qualifying Clinical Trial; (b) services and supplies required solely for the provision of the Experimental/ Investigational drug, biological product, device, medical treatment or procedure; (c) the clinically appropriate monitoring of the effects of the drug, biological product, device, medical treatment or procedure required for the prevention of complications; and (d) the services and supplies required for the diagnosis or treatment of complications.

Routine Costs do not include the Experimental/Investigational drug, biological product, device, medical treatment or procedure itself, the services and supplies provided solely to satisfy data collection and analysis needs and that are not used in the direct clinical

management of the patient; and services and supplies customarily provided by the research sponsors free of charge for any enrollee in the Qualifying Clinical Trial.

SCHEDULE OF BENEFITS — The Schedule of Benefits, which describes benefits, maximums, and allowances of the coverage provided under the Plan for each Covered Person.

SECOND SURGICAL OPINION/CONSULTATION — A written evaluation by another surgeon/specialist, who is not associated in practice with the first surgeon, as to the Medical Necessity of the surgery recommended by the first surgeon.

SEMIPRIVATE ROOM — Accommodations in a room designated as such by the Hospital, Rehabilitation Facility, or Skilled Nursing Facility and containing no less than two nor more than four beds.

SKILLED NURSING CARE — All covered medical expenses charged for services that are primarily restorative and therapeutic in treatment of a physical Illness or injury that requires medical supervision of a Registered Nurse acting under the direction of a Doctor.

SKILLED NURSING FACILITY — An institution or part of an institution that: (1) specializes in providing Skilled Nursing Care on an Inpatient basis for the treatment of a physical Illness or injury that requires extended medical supervision and treatment; and (2) provides such care by or under the supervision of a staff of Doctors; and (3) provides continuous 24-hour nursing service by or under the supervision of Registered Nurses; and (4) is approved by the Joint Commission on Accreditation of Healthcare Organizations or Medicare.

SUBSTANCE ABUSE — Any use of alcohol or other drug that produces a pattern of pathological use causing impairment in social or occupational functions or that produces physiological dependency evidenced by physical tolerance or withdrawal.

SUBSTANCE ABUSE TREATMENT FACILITY — A Facility that: (1) is primarily engaged in providing detoxification and/or rehabilitation services for alcoholism and/or other drug abuse and (2) is approved by the Joint Commission on Accreditation of Healthcare Organizations, appropriate government agency, or by QCC Insurance Company.

SUPPLIES — Charges made by a Hospital or Doctor for nonprescription, nondurable, disposable medical and surgical items that are necessary for the care or treatment of an Illness or Accidental Injury.

SURGERY/SURGICAL PROCEDURE — Treatment of an Illness, injury, or deformity by manual and operative methods.

A. **Cosmetic Surgery** — A Surgical Procedure for the correction of superficial areas of the body to enhance appearance or to change contour. Such surgeries are performed without the expectation of restoring function to the body area.

B. **Elective Surgery** — A Surgical Procedure that is of a non-emergency nature and not required to be immediately carried out.

C. **Reconstructive Surgery** — A Surgical Procedure for the correction, restoration, or improvement of bodily functions, or the relief of pain.

THERAPY SERVICES — The following services and Supplies when prescribed by a Doctor for the treatment of an Illness or injury to promote the recovery of the Covered Person:

A. **Radiation Therapy** — Treatment of disease by X-ray, gamma ray, accelerated particles, mesons, neutrons, radium, or radioactive isotopes.

B. **Chemotherapy** — Treatment of malignant disease by chemical or biological antineoplastic agents.

C. **Dialysis Treatment** — Treatment of acute renal failure or chronic irreversible renal insufficiency for removal of waste materials from the body. This includes hemodialysis or peritoneal dialysis.

D. **Physical Therapy** — Treatment by physical means, hydrotherapy, heat, or similar modalities, physical agents, biomechanical and neurophysiological principles, and devices to relieve pain and restore maximum function following disease, injury, or loss of body part.

E. **Respiratory Therapy** — Introduction of dry or moist gases into the lungs for treatment purposes.

F. **Occupational Therapy** — Treatment of a disabled person by means of constructive activities designed and adapted to promote the restoration of the person's ability to satisfactorily accomplish the ordinary tasks of daily living and those required by the person's particular occupational role.

G. **Speech Therapy** — Treatment to restore speech lost or impaired through Illness or injury, or to correct an impairment due to a congenital defect for which corrective Surgery has been performed.

TRIBE — White Earth Band of Chippewa Indians.

SPECIAL RULES FOR TRIBAL HEALTH PROGRAMS

Section Tribal Provisions

In the event a conflict exists between this Section and the remainder of the Plan Document, this Section controls. For purposes of this Section, "Tribe" shall refer to the Indian tribal government that sponsors or has jurisdiction over the sponsor of the Plan.

1. Nature of the Plan

(a) Self-Insurance / Tax Status: The Plan is self-insured, and provides non-taxable benefits for eligible individuals in accordance with Internal Revenue Code Sections 105(b), 105(h), 106, 139E and/or 139D, as applicable.

(b) Governing Law and Sovereign Immunity: Unless otherwise indicated on the Plan Options Form or through duly adopted resolutions or laws of the Tribe's governing body, this Plan shall be construed in accordance with the laws of the Tribe, and jurisdiction over any claims or disputes related to or arising out of the Plan shall be heard within the exclusive jurisdiction of the Tribal courts or other decision making body approved by the Tribe for such matters. Nothing herein, including any references to state or federal laws and any references to legal action, shall be construed as a waiver of sovereign immunity, tribal court jurisdiction, the tribal court exhaustion doctrine, or any other exemption to which the Tribe, the Plan Sponsor or the Plan may otherwise be entitled to at law or in equity, including Section 3(32) of ERISA, as applicable. A waiver of this section must be made in accordance with Tribal law, must be in writing, and must be express and unequivocal in its intent and scope. Any such waiver shall be construed narrowly.

The receipt of benefits (whether direct, through assignment or otherwise) shall operate as consent to the foregoing.

(c) Incorporation of Applicable Law / Changes: The Plan shall be construed to comply with all applicable federal and tribal laws and regulations, and shall be deemed amended to incorporate any applicable law or regulatory changes hereafter.

2. ERISA Provisions (Governmental, Commercial, and Member-based Plans

(a) Governmental Plans: ERISA does not apply to Governmental Plans. If this Plan is intended to be construed as a Governmental Plan (as indicated on the Plan Options Form), all references to ERISA and any other legal provisions that do not apply to a Governmental Plan are hereby deleted.

Any decision to retain or adopt features, policies or procedures that are modeled after ERISA or other laws which do not apply to a Governmental Plan (including those identified on the Plan Options Form)

shall be treated as a voluntary design decision and not as a waiver of legal exemptions or as consent to enforcement actions or regulatory authority not applicable to a Governmental Plan.

(b) "Commercial" Plans: ERISA applies to Commercial Plans. If this Plan is intended to be construed as a Commercial Plan (as indicated on the Plan Options Form), all references to ERISA remain in force with respect to the Plan or any such participation groups therein that are subject to the Commercial Plan rules.

(c) Member-based Plans: ERISA does not apply to member-based plans that are not based on employment. If this Plan is intended to be construed as a member-based plan (as indicated on the Plan Options Form), all references to ERISA and any other legal provisions that do not apply to a member-based plan are hereby deleted. Any decision to retain or adopt features, policies or procedures that are modeled after ERISA or other laws which do not apply to a member-based plan (including those identified on the Plan Options Form) shall be treated as a voluntary design decision and not as a waiver of legal exemptions or as consent to enforcement actions or regulatory authority not applicable to a member-based plan. If member-based plan status is indicated, a member who is also employed will not lose member status solely because of said employment (so long as eligibility is based on membership and not employment).

(d) Rule of Construction / Split Plans: The Plan Sponsor shall determine whether each covered employee is a government sector or commercial-based employee in accordance with ERISA Section 3(32). As of the writing of this document, there is no guidance from the Department of Labor on what tribal plans will qualify as "government" plans or "commercial" plans under ERISA Section 3(32). The IRS has issued Notice 2006-89 and 2007-67. In the event that any participation groups are deemed ineligible for governmental plan or member-based treatment based on the sponsor's election or as may otherwise be required under law, the Plan Sponsor reserves the right to assert treatment of the Plan as two or more separate plans solely for purposes of retaining commercial, government and/or member-based participation groups.

(d) Non-Duplication: Notwithstanding anything herein to the contrary, participation in the government, commercial and member-based classifications, if applicable, is aggregated for purposes of applying Deductible, Coinsurance and limitation provisions to avoid any duplication of benefits or cost-sharing features. If this provision is invoked participation will be coordinated to avoid any loss or duplication of benefits.

3. Special Rules Applicable to Tribal Health Programs

(a) Tribal Health Program: Plan benefits are intended to qualify as self-insured tribal health program benefits under 25 U.S.C. Sections 1623(b), 1621e(f), 1603(12) and 1603(25) to the fullest extent possible. The Plan Sponsor also reserves the right to receive federal funding for benefits provided herein in accordance with 25 U.S.C. Section 1642, if applicable.

(b) Payer of Last Resort / IHS Coordination / Non-Alternate Resource Designation: This program is entitled to payer of last resort rights under 25 U.S.C. Section 1623(b). Coverage under this program shall be coordinated as one component of an integrated tribal health program consisting of care provided through the Plan Sponsor using one or more mechanisms including self-insurance, direct care,

sponsorship, and PRC services. The Claims Administrator shall serve as a fiscal intermediary or applicable ordering official when necessary to coordinate coverage though or on behalf of each component and applicable PRC services. This program shall not be treated as an alternate resource for purposes of PRC and CHEF. Benefits provided hereunder are intended in part to serve as supplemental funding for benefits otherwise available to IHS Beneficiaries through other federal, tribal and third party programs or payers. This program shall not pay in front of available federal, tribal and other third party programs or payers except to the extent agreed to under 25 U.S.C. Section 1621e(f).

(c) Medicare-Like Rate Discounts / CHEF: Eligible claims paid through this Plan are intended to qualify for Medicare-Like Rates ("MLR") pricing under Section 506 of the Medicare Modernization Act of 2003 and the final regulations issued thereunder at 42 CFR 136.30-136.32 and 42 CFR 489.29. Per 42 CFR 136.30(b), MLR shall apply "to all levels of care furnished by a Medicare-participating hospital, whether provided inpatient, outpatient, skilled nursing facility care, as other services of a department, subunit, distinct part, or other component of a hospital (including services furnished directly by the hospital or under arrangements) that is … authorized by a Tribe or tribal organization carrying out a CHS [now referred to as PRC] program of the IHS under the Indian Self-Determination and Education Assistance Act [the "ISDEAA"]." The Plan Sponsor reserves the right to authorize MLR eligible care through its PRC program and to coordinate payment through the Claims Administrator herein, to assert Professional Services and Non-Hospital-Based Discounts to the extent permitted under 42 CFR 136.201-136.204, and to coordinate benefits and PRC services to maximize CHEF reimbursements under 25 U.S.C. Section 1621a.

(d) Member-Based Benefits: The Plan Sponsor reserves the right to treat this program, or any qualifying portion thereof, as a member-based tribal health program to the fullest extent permitted at law including, without limitation, 25 U.S.C. Sections 1621e, 1623, and 1642. If this option is exercised, in the event that an enrolled tribal member qualifies for both employment-based and member-based benefits, the benefits paid hereunder shall be presumed to be paid as member-based benefits to the extent necessary to preserve member rights provided at law. This provision shall be construed to ensure that the Plan Sponsor's establishment of self-insurance or employment-based benefits will not waive any member-based rights and preferences available at law.

Note: Medicare participating providers may be required to accept MLR as payment in full for certain care provided under the Plan regardless of whether the provider is an In-Network, Out-of-Network, or Out-of-Area Provider. Nothing in this Section or the Plan Document shall be construed to permit balance billing by a provider for treatment qualifying for and paid at MLR.

4. Additional Tribal Plan Exclusions

The following special tribal plan exclusions shall apply in addition to the medical plan exclusions set forth in other sections or articles of the Plan:

(a) CHEF Eligible Care or Services. Subject to its right to waive or limit this provision, the Plan hereby excludes all care or services eligible for reimbursement through the Catastrophic Health

Emergency Fund ("CHEF"), 25 U.S.C. Section 1621a. This provision shall be construed as an exclusionary clause in accordance with Section 2-3.8(I) of the Contract Health Service Manual and 25 U.S.C. Section 1621e and 1623.

(b) Contract Health Service Coverage ("CHS" or "PRC"). Subject to its right to waive or limit this provision, the Plan hereby excludes all care or services eligible for coverage by a Contract Health Service ("CHS") program, also referred to as a Purchased or Referred Care ("PRC") program (referred to herein as "CHS" or "PRC") operated by, through or in connection with the federal Indian Health Service or by an Indian tribe, tribal organization or tribal consortium of tribes or tribal organizations pursuant to a self-determination contract of self-governance compact under P.L. 93-638, as amended (or other applicable federal law governing tribal health care and Indian Health Service programs). This provision shall be construed as an exclusionary clause in accordance with Section 2-3.8(I) of the Contract Health Service Manual and 25 U.S.C. Section 1621e and 1623. The Plan Sponsor reserves the right to waive this exclusion in full or in part for designated care pursuant to express reimbursement agreements between the Plan Sponsor and a contracting facility. The Plan Sponsor also reserves the right to pay CHS eligible care as a member-based benefit herein. In no event will the Plan be required to pay more than MLR for care that would be paid at MLR if paid directly through CHS.

(c) Indian Health Service Coverage (Direct Services). Subject to its right to waive or limit this provision, the Plan hereby excludes all direct service care or services covered by or provided through a federal Indian Health Service program or a tribal health program operating under the ISDEAA, except for programs, services or facilities for which the Plan Sponsor has elected to provide reimbursements in accordance with 25 U.S.C. Section 1621e(f). This provision shall be construed as an exclusionary clause in accordance with Section 2-3.8(I) of the Contract Health Service Manual and 25 U.S.C. Sections 1621e and 1623.

(e) Individual Policy Coverage. Subject to its right to make provisional payments under the Coordination of Benefits, the Plan hereby excludes all care that is covered by an Individual Policy as referred to in the Special Coordination Rules for Tribal Programs set forth below.

(f) No Charge / No Obligation to Pay. Subject to its right to waive or limit this provision, the Plan hereby excludes care and treatment for which there would not have been a charge if no coverage under this Plan had been in force; charges for which the Plan has no legal obligation to pay; and/ or charges incurred for which the Covered Person would have no legal obligation to pay had the Covered Person applied to another program or alternative resource.

This provision shall be construed as an exclusionary clause in accordance with Section 2-3.8(I) of the Contract Health Service Manual and 25 U.S.C. Section 1621e and 1623. This exclusion shall not prohibit reimbursement agreements as permitted under 25 U.S.C. Section 1621e(f).

(h) Payer of Last Resort. Subject to its right to coordinate benefits, the Plan hereby excludes coverage for which the Plan is the payer of last resort under 25 U.S.C. Section 1623(b).

The Plan reserves the right to waive certain exclusions based on the specific terms or conditions of an individual case management plan, as permitted under the coordination of benefits provisions set forth in

this Section, or as required to comply with a reimbursement agreement entered into under 25 U.S.C. Section 1621e(f).

5. Special Coordination Rules for Tribal Plans / Medicare-Like Rates

The following coordination rules apply to all Plan benefits eligible for MLR, CHEF, Sponsorship and payer of last resort rights including, without limitation, those arising under the Indian Health Care Improvement Act, the Indian Self-Determination and

Education Assistance Act, 42 CFR 136.30, 42 CFR 136.201-136.204, and 25 U.S.C. Sections 1621a, 1621e, 1623 and 1642:

(a) PRC and IHS as Primary Payers / MLR: PRC and IHS programs shall pay primary or to the exclusion of the Plan, and the Plan reserves the right to exclude all MLR Eligible Care, except as follows:

1. Permitted Reimbursements (Direct Service). The Plan will reimburse direct services care to any IHS Program or tribal health program only to the extent that the Plan Sponsor has agreed to such reimbursement in accordance with 25 U.S.C. 1621e(f). Such agreement may be indicated on the Plan Options Form and/or by duly adopted resolution or other documentation in accordance with applicable laws of the Tribe.

2. Permitted Reimbursements (Purchased Referred Care). The Plan reserves the right to make direct payments to a provider otherwise entitled to reimbursement through a PRC Program, or to make reimbursements or funding available to any PRC Program for charges paid through that program that are otherwise covered herein. The foregoing reimbursements or payments are permitted only to the extent agreed to by the Plan Sponsor in accordance with 25 U.S.C. 1621e(f). Such agreement may be indicated on the Plan Options Form and/or by duly adopted resolution or other documentation in accordance with applicable laws of the Tribe.

3. CHEF Coverage. If CHEF coordination is indicated on the Plan Options Form or by duly adopted resolutions of the Tribe's governing body, provisional coverage under the Plan, including without limitation payments under (1) or (2) above, shall not obligate the Plan to pay for care that is eligible for reimbursement under CHEF.

When CHEF coordination is elected, all payments made by the Plan are provisional pending a final determination as to whether the charges qualify for reimbursement through CHEF. Once CHEF eligibility is determined: (1) the applicable PRC Program shall reimburse any provisional payments as a Plan overpayment, (2) the Plan may reverse the payment (with PRC paying the provider direct), or (3) the Plan Sponsor and PRC Program may agree that the Plan should continue to pay such claims on a provisional basis on behalf of the PRC Program for claims efficiency and continuity of care. Upon rejection of a CHEF claim by IHS, the Plan may invoke its exclusionary clause and reverse any provisional Plan payments for direct payment through PRC.

4. MLR Eligible Care. In no event will coverage under (1) through (3) above require the Plan to provide in excess of what would be paid through a PRC Program for such care or services. Any reimbursements or payments for MLR Eligible Care are made on a provisional basis and expressly contingent upon the provider accepting MLR from the Plan as payment in full.

5. Supplemental Funding Arrangement. All reimbursements or payments under (1) through (4) above represent payments for and on behalf of the applicable IHS, Tribal health program, or PRC eligible care as a means to provide supplemental funding as part of the Sponsor's coordinated tribal health program. To this extent, the Plan is intended to serve as part of its PRC program.

6. Provisional Payments. The Plan may pay any claim otherwise covered by the express terms of the Plan on a provisional basis pending a final determination under the Plan coordination of benefits rules and procedures. In the event that it is confirmed that IHS or PRC should have been primary under this coordination of benefits provision after a provisional payment has been made by the Plan, the Plan shall be entitled to reimbursement.

7. Reservation of Rights. Nothing in this section requires the Plan Sponsor to adopt policies authorizing reimbursement or payment of IHS or PRC eligible care.

(b) Individual Policy Rules: In the event that a service or charge would be paid for through or by an Individual Policy in the absence of benefits hereunder, the following special coordination of benefits rules shall apply:

1. The Plan shall pay secondary to available Individual Policy coverage in accordance with 25 U.S.C. Section 1623(b), which provides that health programs operated by Indian tribes and tribal organizations shall be the payer of last resort for services notwithstanding any Federal, State or local law to the contrary.

2. An Individual Policy that is required to pay primary to IHS or PRC Program benefits shall pay primary to any benefits available hereunder to the extent that benefits herein

are entitled to secondary status behind IHS or PRC, including, without limitation, any benefits subject to an exclusionary clause as referred to in 25 U.S.C. Section 1621e(f) or CHS Manual Section 2-3.8(I).

3. Regardless of (1) or (2) above, an Individual Policy that does not contain a coordination of benefits provision shall pay primary to any benefits available hereunder.

(c) Medicare / Medicaid – Special Federal and State Program Rules:

1. Medicare, Medicaid and other federal or State programs shall pay primary to this Plan for any care or services (1) as required by 25 U.S.C. Sections 1621e(f) and 1623(b), and (2) that such State and Federal programs would otherwise pay primary to IHS or PRC. Medicare shall also pay primary to any member-based benefits. *See* 42 U.S.C. Section 1395y(b)(v); 42 CFR 411.20; and 26 U.S.C. Section 5000(b)(1)(v).

2. The benefits provided hereunder shall not be treated as an alternate resource for purposes of eligibility under Indian Health Service, Contract Health Service or Purchased / Referred Care.

3. Notwithstanding anything in the remainder of the Plan Document to the contrary, programs purporting to limit or prohibit coordination (like Medicaid and Medicare) may not limit coordination with the Plan in violation of 25 U.S.C. Sections 1621e(f) or 1623(b).

(d) Other Programs or Policies:

The Plan Sponsor reserves the right to assert secondary payer status to any other program, plan or policy to the extent provided in 25 U.S.C. Section 1623(b).

(e) Exclusionary and MLR Provisions:

This special coordination of benefits provision shall be construed to permit the Plan Sponsor to enter into arrangements for the payment of designated IHS or PRC benefits for (1) a provider that agrees to accept MLR as payment in full, and (2) which are not covered under an Individual Policy.

Other Rules:

1. Payments hereunder processed by or through the third party Claims Administrator (whether In-Network or Out-of-Network) are paid in its capacity as a contract fiscal intermediary and/or designated ordering official of the tribal health program (including direct and PRC services where applicable). All payments for member care are made from tribal assets on behalf of the tribe and its health program(s) as a means of providing supplemental funding for care in addition to care or services otherwise available to members through IHS, direct service care, or PRC.

2. The sponsor or Plan is entitled to a refund of any overpayments and may offset any future payments to recoup any such overpayments. In the event that payments are provided hereunder as a result of another plan, program or policy failing to pay in accordance with the coordination of benefit provision set forth herein, the payment shall be deemed a contingent, provisional or conditional payment and the Plan sponsor or Plan shall be entitled to bring a legal action through reimbursement or subrogation to recoup all such overpayments plus fees and costs.

3. All payments hereunder through reimbursement or otherwise, including conditional or provisional payments made as a result of another plan, program or policy's failure to comply with the coordination of benefits rules shall apply against the Plan's specific or aggregate stop loss reinsurance limits, as applicable. Future reimbursement to the Plan shall be credited to the stop loss carrier in accordance with agreements between the sponsor and the carrier. Nothing herein or in any other plan or SPD document or communication shall be construed as a waiver of sovereign immunity. Acceptance of benefits or payments shall constitute an assignment of the above reimbursement and subrogation rights to the Plan sponsor or Plan, as well as consent by the recipient to the jurisdiction and governing law provisions set forth herein.

4. Nothing herein shall be construed to create any private right of action against the Plan sponsor, the Plan, or the Plan sponsor's PRC or IHS program or any employee thereof.

5. No assignment related to MLR pricing shall create any enforceable right against the Plan, the Plan Sponsor, the Tribe, or any other party unless the assignment is accepted in writing by the party who the assignment purports to bind. No assignment shall be valid to the extent it purports to convey rights in excess of those set forth in this Plan.

The Plan may pay any claim on a provisional basis pending a final determination under the Plan coordination of benefit rules. The Plan reserves the right to exclude any care for which a provider declines to accept MLR as payment in full or for which is eligible for CHEF.

6. Additional Definitions

The following additional definitions are hereby added to the Plan:

CHEF – Refers to the Catastrophic Health Emergency Fund in 25 U.S.C. Section 1621a.

CHSDA – Means the contract health service delivery area, as applicable.

Contract Health Service or "CHS" – See Purchased Referred Care / PRC.

Commercial Plan - A plan that which is established and maintained by an Indian tribal government (as defined in section 7701(a)(40) of title 26), a subdivision of an Indian tribal government (determined in accordance with section 7871(d) of title 26), or an agency or instrumentality of either, but does not qualify as a governmental plan under ERISA Section 3(32).

Governmental Plan - A "governmental plan" for purposes of ERISA includes a plan which is established and maintained by an Indian tribal government (as defined in section 7701(a)(40) of title 26), a subdivision of an Indian tribal government (determined in accordance with section 7871(d) of title 26), or an agency or instrumentality of either, and all of the participants of which are employees of such entity substantially all of whose services as such an employee are in the performance of essential governmental functions but not in the performance of commercial activities (whether or not an essential government function).

IHS Beneficiary – An individual who may also be eligible for Indian Health Service, tribal direct care, and/or Purchased Referred Care benefits.

IHS Benefits – Includes any direct care services or contract health services (now referred to as "Purchased Referred Care") available through the Indian Health Service or through a tribal health clinic or program operated under the ISDEAA, as amended.

Indian Health Service or "IHS" Program – A program that provides direct services to Indian and other eligible individuals including care or services pursuant to the Indian Health Care Improvement Act and 42 CFR Part 136, Subpart B, regardless of whether the IHS program is operated directly by the federal Indian Health Service or through an Indian tribe, tribal organization or tribal consortium of tribes or tribal organizations pursuant to a self-determination contract or self-governance compact under the ISDEAA, as amended.

Individual Policy – Shall include any policy of insurance (including a health maintenance organization) or a policy offered through a Patient Protection and Affordable Care Act marketplace/exchange for which the Plan asserts secondary status herein.

ISDEAA – The Indian Self-Determination and Education Assistance Act, as amended.

Medicare-Like Rates or "MLR" – Shall include the amount a provider is required to accept as payment in full under Section 506 of the Medicare Modernization Act of 2003 and the final regulations issued thereunder at 42 CFR 136.30-136.32 and 42 CFR 489.29. This Plan shall be construed as part of a tribal health program consisting of self-insurance, direct service care, and PRC. These benefits are authorized in part by a tribe or tribal organization carrying out a CHS program of the IHS under the ISDEAA, as amended. In the event the Plan covers MLR Eligible Care, the Plan shall pay no more than MLR. Any payment made by the Plan for MLR Eligible Care in accordance with the foregoing is made under a reservation of rights for a full refund if the provider refuses to accept payment at MLR as payment in full. MLR for purposes of this Plan shall also include, where applicable, Professional Services and Non-Hospital-Based Discounting to the extent permitted under 42 CFR 136.201-136.204.

MLR Eligible Care – Shall mean any care for which a provider must accept MLR as payment in full under 42 CFR 136.30 and Professional Services and Non-Hospital-Based Discounting, as applicable.

Professional Services and Non-Hospital-Based Discounting – Discounts asserted under 42 CFR 136, Subpart I, Limitation on Charges for Indian Care Professional Services and Non-Hospital-Based Care, Subsection 136.201-136.204.

Purchased Referred Care or "PRC" – The terms Purchased Referred Care or PRC are used interchangeably with "Contract Health Services" or "CHS" as used herein.

Purchased Referred Care or "PRC" Program – A contract health service program (also referred to as "CHS", "Purchased Referred Care" or "PRC") under 42 CFR Part 136, Subpart C, regardless of whether the PRC program is operated directly by the federal IHS, a tribe or tribal organization, including a PRC program operated by an Indian tribe, tribal organization or tribal consortium of tribes or tribal organizations pursuant to a self-determination contract of self-governance compact under the ISDEAA, as amended.

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