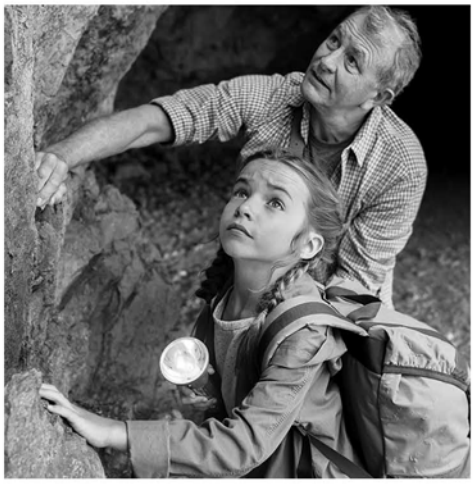
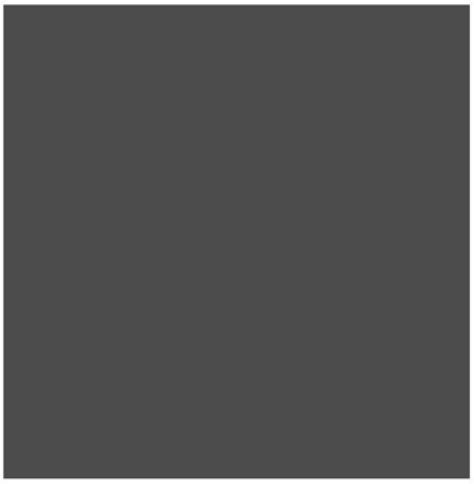
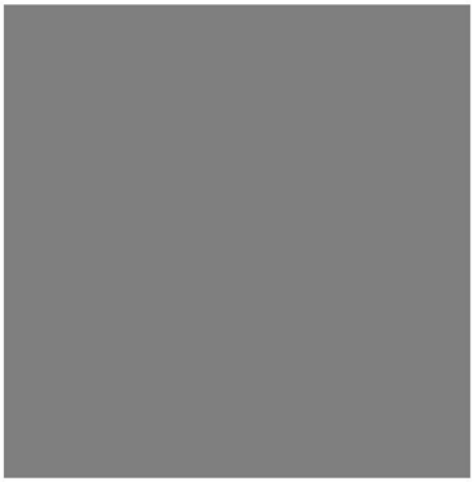
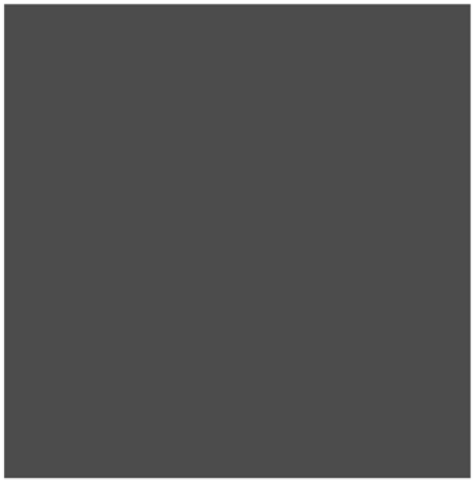
Administered by:

BlueCross BlueShield of Texas






Your Health Care Benefits Program

Managed Health Care
Pharmacy Benefits

Blue Cross and Blue Shield of Texas, a Division of Health Care Service Corporation, a Mutual Legal Reserve Company, an Independent Licensee of the Blue Cross and Blue Shield Association

Michaels Stores, Inc.

Account #363242
Group #363243 - Enhanced Plan

July 1, 2023

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SCHEDULE OF COVERAGE

Plan Provisions	In-Network Benefits	Out-of-Network Benefits
Deductibles		
• Plan Year Deductible *Applies to all Eligible Expenses*	$750 – per individual $1,500 – per family	$1,500 – per individual $3,000 – per family
Co-Share Stop-Loss Amounts *Includes Plan Year Deductible and Copayment Amounts*	$4,000 – per individual $8,000 – per family	$8,000 – per individual $16,000 – per family
Copayment Amounts Required		
• Physician office visit/consultation for Primary Care Providers	$25 Physician office visit	Does Not Apply
• Physician office visit/consultation for Specialty Care Providers	$40 Physician office visit	Does Not Apply
• Outpatient Hospital Emergency Room/Treatment Room visit	$250 outpatient Hospital Emergency Room/Treatment Room visit	$250 outpatient Hospital Emergency Room/Treatment Room visit
• Retail Health Clinic	$25 Retail Health Clinic visit	Does Not Apply
• Virtual Visit - Medical	$25 Virtual Visit	Does Not Apply
• Virtual Visit - Behavioral Health	$25 Virtual Visit	Does Not Apply
Inpatient Hospital Expenses		
All usual Hospital services and supplies, including semiprivate room, intensive care, and coronary care units.	80% of Allowable Amount after Plan Year Deductible No penalty for failure to obtain Prior Authorization for services	60% of Allowable Amount after Plan Year Deductible $400 penalty for failure to obtain Prior Authorization for services
Medical-Surgical Expenses		
• Office visit/consultation (Primary Care Providers)	100% of Allowable Amount after $25 Copayment Amount	60% of Allowable Amount after Plan Year Deductible
• Office visit/consultation (Specialty Care Providers)	100% of Allowable Amount after $40 Copayment Amount	60% of Allowable Amount after Plan Year Deductible
• Radiation Therapy and Chemotherapy in the office setting • Allergy Injections (without office visit) • Physician surgical services in the office setting	100% of Allowable Amount after $25/$40 Copayment Amount	60% of Allowable Amount after Plan Year Deductible
• Inpatient visits and Certain Diagnostic Procedures • Home Infusion Therapy • Physician surgical services in all other setting • Lab & X-ray (including Independent Lab & X-ray) • Early Detection Tests for Cardiovascular Disease (Limited to one test every five years)	80% of Allowable Amount after Plan Year Deductible	60% of Allowable Amount after Plan Year Deductible

SCHEDULE OF COVERAGE

Plan Provisions	In-Network Benefits	Out-of-Network Benefits
Medical-Surgical Expenses (Cont'd)		
• Diabetic Management (training/nutritional)	100% of Allowable Amount	100% of Allowable Amount
Extended Care Expenses		
Certain services will require Prior Authorization		
• Skilled Nursing Facility	80% of Allowable Amount after Plan Year Deductible	60% of Allowable Amount after Plan Year Deductible
	60 days maximum per Plan Year	
• Home Health Care	80% of Allowable Amount after Plan Year Deductible	60% of Allowable Amount after Plan Year Deductible
	60 visits maximum per Plan Year	
• Hospice Care	80% of Allowable Amount after Plan Year Deductible	60% of Allowable Amount after Plan Year Deductible
	Unlimited	
Mental Health Care/Serious Mental Illness/Treatment of Substance Use Disorder (SUD)		
Certain services will require Prior Authorization		
Inpatient Services		
• Hospital Services (facility)	80% of Allowable Amount after Plan Year Deductible	60% of Allowable Amount after Plan Year Deductible
• Behavioral Health Practitioner Services	80% of Allowable Amount after Plan Year Deductible	60% of Allowable Amount after Plan Year Deductible
Outpatient Services		
• Behavioral Health Practitioner Expenses (office setting)	100% of Allowable Amount after $25 Copayment Amount	60% of Allowable Amount after Plan Year Deductible
• Other Outpatient Services	80% of Allowable Amount after Plan Year Deductible	60% of Allowable Amount after Plan Year Deductible
Emergency Care		
Accidental Injury & Emergency Care (including Accidental Injury, Emergency and non-emergency Care for Behavioral Health Services)		
• Facility Charges	80% of Allowable Amount after Plan Year Deductible and $250 outpatient Hospital emergency room Copayment Amount (waived if admitted)	
• Lab & X-ray without emergency room or treatment room	80% of Allowable Amount after Plan Year Deductible	
• Physician Charges	80% of Allowable Amount after Plan Year Deductible	

SCHEDULE OF COVERAGE

Plan Provisions	In-Network Benefits	Out-of-Network Benefits
Emergency Care (Cont'd)		
Non-Emergency Care		
• Facility Charges	80% of Allowable Amount after $250 outpatient Hospital emergency room Copayment Amount (waived if admitted)	60% of Allowable Amount after Plan Year Deductible and $250 outpatient Hospital emergency room Copayment Amount (waived if admitted)
• Physician Charges	80% of Allowable Amount after Plan Year Deductible	60% of Allowable Amount after Plan Year Deductible
Urgent Care Services		
• Urgent Care Center visit including lab & x-ray services (excluding Certain Diagnostic Procedures)	80% of Allowable Amount after Plan Year Deductible	60% of Allowable Amount after Plan Year Deductible
Ambulance Services	80% of Allowable Amount after Plan Year Deductible	
Retail Health Clinic	100% of Allowable Amount after $25 Copayment Amount	60% of Allowable Amount after Plan Year Deductible
Virtual Visit		
• Medical	100% of Allowable Amount after $25 Virtual Visit Copayment Amount	Not Covered
• Behavioral Health	100% of Allowable Amount after $25 Virtual Visit Copayment Amount	Not Covered
Preventive Care Services • Evidence-based items or services that have in effect a rating of "A" or "B" in the current recommendations of the United States Preventive Services Task Force ("USPSTF") • Immunizations recommended by the Advisory Committee on Immunization Practices of the Centers for Disease Control and Prevention ("CDC") with respect to the individual involved • 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 • With respect to women, such additional preventive care and screenings, not described in the first bullet above, as provided for in comprehensive guidelines supported by the HRSA	100% of Allowable Amount	60% of Allowable Amount after Plan Year Deductible

SCHEDULE OF COVERAGE

Plan Provisions	In-Network Benefits	Out-of-Network Benefits
Preventive Care Services (Cont'd)		
• Routine physical examinations, well baby care, immunizations and routine lab	100% of Allowable Amount	60% of Allowable Amount after Plan Year Deductible
• Routine X-Rays, Routine EKG, Routine Diagnostic Medical Procedures (Independent Lab & X-Ray Provider)		
• Colonoscopy Professional (physician charges)		
• Colonoscopy facility charges		
• Healthy diet counseling and obesity screening/counseling		
• Immunizations Birth up to age 6	100% of Allowable Amount	100% of Allowable Amount
Other Routine Services		
• Routine X-Rays, Routine EKG, Routine Diagnostic Medical Procedures, routine digital rectal exam, routine prostate test	100% of Allowable Amount	60% of Allowable Amount after Plan Year Deductible
• Annual Hearing Examination (limited to one visit every two Plan Years)		
• Annual Vision Examination (limited to one visit per Plan Year)		
Speech and Hearing Services, excluding hearing aids*		
• Office visit	100% of Allowable Amount after $25/$40 Copayment Amount	60% of Allowable Amount after Plan Year Deductible
• All other services	80% of Allowable Amount after Plan Year Deductible	60% of Allowable Amount after Plan Year Deductible
* Benefits for Autism Spectrum Disorder will not apply towards and are not subject to any speech services visits maximum.		
Chiropractic Services		
• Office visit/Office services	100% of Allowable Amount after $40 Copayment Amount	60% of Allowable Amount after Plan Year Deductible
• All other services in the outpatient setting	80% of Allowable Amount after Plan Year Deductible	60% of Allowable Amount after Plan Year Deductible
	Limited to $2,500 Annual maximum combined with Acupuncture	
Physical Medicine Services		
• Office visit/Office services	100% of Allowable Amount after $40 Copayment Amount	60% of Allowable Amount after Plan Year Deductible
• All other services in the outpatient setting	80% of Allowable Amount after Plan Year Deductible	60% of Allowable Amount after Plan Year Deductible

SCHEDULE OF COVERAGE

Plan Provisions	In-Network Benefits	Out-of-Network Benefits
Acupuncture	80% of Allowable Amount after Plan Year Deductible	60% of Allowable Amount after Plan Year Deductible
	Limited to $2,500 Annual maximum combined with Chiropractic Services	
In-Vitro Fertilization Services	80% of Allowable Amount after Plan Year Deductible	60% of Allowable Amount after Plan Year Deductible
	Limited to one cycle lifetime maximum	
Organ Transplant	80% of Allowable Amount after Plan Year Deductible	Not Covered
Durable Medical Equipment	80% of Allowable Amount after Plan Year Deductible	60% of Allowable Amount after Plan Year Deductible
	Limited to one durable medical equipment for same/similar purpose (excludes repairs for misuse/abuse)	

SCHEDULE OF COVERAGE

Plan Provisions Blue Distinction	Blue Distinction+ Designated Center	Blue Distinction Designated Center	In-Network Benefits	Out-of-Network Benefits
Bariatric Surgery	80% of Allowable Amount after Plan Year Deductible	80% of Allowable Amount after Plan Year Deductible	Not Covered	Not Covered
	Limited to $20,000 lifetime maximum			
Transplants	80% of Allowable Amount after Plan Year Deductible	80% of Allowable Amount after Plan Year Deductible	Not Covered	Not Covered
Fertility Care - Professional Services Only				
Office visit	80% of Allowable Amount after Plan Year Deductible	80% of Allowable Amount after Plan Year Deductible	80% of Allowable Amount after Plan Year Deductible	60% of Allowable Amount after Plan Year Deductible
Outpatient	80% of Allowable Amount after Plan Year Deductible	80% of Allowable Amount after Plan Year Deductible	80% of Allowable Amount after Plan Year Deductible	60% of Allowable Amount after Plan Year Deductible

SCHEDULE OF COVERAGE

PHARMACY BENEFITS

Plan Provisions	Participating Pharmacy	Non-Participating Pharmacy
Retail Pharmacy 30 day supply with 1 Copayment/Co-Share Amount per 30-day supply at a Participating Pharmacy	$10 Copayment Amount – Generic Drug $35 Copayment Amount* – Preferred Brand Name Drug 50% of Allowable Amount ($100 minimum/$250 maximum)* – Non-Preferred Brand Name Drug	Not Covered
Extended Retail Prescription Drug Supply (if allowed by the Prescription Order) - one Copayment/Co-Share Amount per 90-day supply, up to a 90-day supply	$20 Copayment Amount – Generic Drug $70 Copayment Amount* – Preferred Brand Name Drug 50% of Allowable Amount ($100 minimum/$250 maximum)* – Non-Preferred Brand Name Drug	Not Covered
Specialty Pharmacy Program **Specialty Drugs - limited to a 30-day supply at a Specialty Pharmacy Provider**	**Specialty Pharmacy Provider** $10 Copayment Amount – Generic Specialty Drug $35 Copayment Amount* – Preferred Brand Name Specialty Drug 50% of Allowable Amount up to $350 maximum* - Non-Preferred Brand Name Specialty Drug	Not Covered
Mail Service Prescription	**Mail-Order Pharmacy**	
Mail-Order Program One Copayment/Co-Share Amount per 90 day supply up to a 90-day supply only	$20 Copayment Amount – Generic Drugs $70 Copayment Amount* – Preferred Brand Name Drugs 50% of Allowable Amount ($100 minimum/$250 maximum)* – Non-Preferred Brand Name Drugs	Not Covered
Plan Provisions	**Participating Pharmacy**	**Non-Participating Pharmacy**
Select Vaccinations Obtained through Participating Pharmacies**	Select Participating Pharmacy - 100% of Allowable Amount Any other Participating Pharmacy - Not Covered	Not Covered
Fertility Drugs Lifetime Maximum	Limited to 4 fills (one cycle)	

SCHEDULE OF COVERAGE

Plan Provisions	Participating Pharmacy	Non-Participating Pharmacy
Prior Authorization Provision	Applies	
Step Therapy Provision	Applies	
Limitations on Quantities Dispensed	Applies	
Diabetes Supplies are available under the Pharmacy Benefits portion of your Plan. All provisions of this portion of the Plan will apply including any Copayment Amounts, Co-Share Amounts, and any pricing differences.		
Contraceptive drugs and devices obtained from a that are identified on the BCBSTX website under Contraceptive - Pharmacy information (referenced in the medical portion of the Plan as part of ***Benefits for Preventive Care Services****)* will not be subject to Deductibles, Copayment Amounts and Co-Share Amounts. Additional contraceptive drugs are covered under the Pharmacy portion of the Plan and are subject to the applicable Copayment Amounts, Co-Share Amounts, and any pricing differences. Additional contraceptive devices are covered under the Pharmacy portion of the Plan and are subject to the applicable Copayment Amounts, Co-Share Amounts, and any pricing differences.		
Tobacco cessation drugs (including both prescription and over-the-counter drugs) prescribed by a Health Care Practitioner are covered at no cost share and will not be subject to Deductibles, Copayment Amounts and Co-Share Amounts for two 90-day treatment regimens per benefit period as required by the United States Preventive Services Task Force as referenced in the Preventive Care subsection of the **PHARMACY BENEFITS** portion of the Plan.		

* If you receive a Preferred Brand Name Drug or a Non-Preferred Brand Name Drug when a Generic Drug is available, you may incur additional costs. Refer to the Pharmacy Benefits portion of this Benefit Booklet for details.

** Select Participating Pharmacies that have contracted with BCBSTX to provide this service may have age, scheduling, or other requirements that will apply, so you are encouraged to contact them in advance. Childhood immunizations subject to state regulations are not available under this pharmacy benefit. Refer to your BCBSTX medical coverage for benefits available for childhood immunizations. A Select is a Pharmacy that has specifically contracted with BCBSTX to administer vaccinations to Participants. Not all Participating Pharmacies are Select Participating Pharmacies.

NOTE: In the ***How Member Payment is Determined*** subsection of the **PHARMACY BENEFITS** section, an explanation of how the prescription drug products are separated into tiers is shown.

SCHEDULE OF COVERAGE

Dependent Eligibility

Dependent Child Age Limit to age 26.

Dependent children are eligible for Maternity Care benefits.

Preexisting Conditions

Preexisting conditions are covered immediately.

INTRODUCTION

This Plan is offered by your Employer as one of the benefits of your employment. The benefits provided are intended to assist you with many of your health care expenses for Medically Necessary services and supplies. Coverage under this Plan is provided regardless of your race, color, national origin, disability, age, sex, gender identity or sexual orientation. There are provisions throughout this Benefit Booklet that affect your health care coverage. It is important that you read the Benefit Booklet carefully so you will be aware of the benefits and requirements of this Plan.

The defined terms in this Benefit Booklet are capitalized and shown in the appropriate provision in the Benefit Booklet or in the **DEFINITIONS** section of the Benefit Booklet. Whenever these terms are used, the meaning is consistent with the definition given. Terms in italics may be section headings describing provisions or they may be defined terms.

The terms "you" and "your" as used in this Benefit Booklet refer to the Employee.

Managed Health Care - In-Network Benefits

To receive In-Network Benefits as indicated on your Schedule of Coverage, **you must** choose Providers within the Network for all care **(other than for emergencies**). The Network has been established by BCBSTX and consists of Physicians, Specialty Care Providers, Hospitals, and other health care facilities to serve Participants throughout the Network Plan Service Area. Refer to your Provider directory or visit the BCBSTX website at www.bcbstx.com/michaels to make your selections. The listing may change occasionally, so make sure the Providers you select are still Network Providers. An updated directory will be available at least annually. You may access our website, www.bcbstx.com/michaels, for the most current listing to assist you in locating a Provider.

If you choose a Network Provider, the Provider will bill the Claim Administrator - not you - for services provided.

The Provider has agreed to accept as payment in full the least of...

- The billed charges, or
- The Allowable Amount as determined by the Claim Administrator, or
- Other contractually determined payment amounts.

You are responsible for paying any Deductibles, Copayment Amounts, and Co-Share Amounts. You may be required to pay for limited or non-covered services. No claim forms are required.

Managed Health Care - Out-of-Network Benefits

If you choose Out-of-Network Providers, only Out-of-Network Benefits will be available. If you go to a Provider outside the Network, benefits will be paid at the Out-of-Network Benefits level. If you choose a health care Provider outside the Network, you may have to submit claims for the services provided.

You will be responsible for paying

- Billed charges above the Allowable Amount as determined by the Claim Administrator,
- Co-Share Amounts and Deductibles,
- Limited or non-covered services, and
- Failure to obtain Prior Authorization penalty.

Pharmacy Benefits

Benefits are provided for those Covered Drugs as explained in the **PHARMACY BENEFITS** section and shown on your Schedule of Coverage in this Benefit Booklet. The amount of your payment under the Plan depends on whether:

- the Prescription Order is filled at a Participating Pharmacy or through the mail-order program; or
- the Prescription Order is filled by a provider contracting with BCBSTX; or
- a Generic Drug is dispensed; or
- a Preferred or Non-Preferred Brand Name Drug is dispensed; or
- a Specialty Drug is dispensed.

Important Contact Information

Resource	Contact Information	Accessible Hours
Customer Service Helpline	**1-877-269-1180**	**24 hours a day 7 days a week**
Website	**www.bcbstx.com/michaels**	**24 hours a day 7 days a week**
Medical Prior Authorization Helpline	**1-800-441-9188**	**Monday – Friday 6:00 a.m. – 6:00 p.m.**
Mental Health/Substance Use Disorder Prior Authorization Helpline	**1-800-528-7264**	**24 hours a day 7 days a week**

Customer Service Helpline

Customer Service Representatives can:

- Identify your Plan Service Area
- Give you information about Network and *ParPlan* and other Providers contracting with BCBSTX
- Distribute claim forms
- Answer your questions on claims
- Assist you in identifying a Network Provider (but will not recommend specific Network Providers)
- Provide information on the features of the Plan
- Record comments about Providers
- Assist you with questions regarding the **PHARMACY BENEFITS**

Benefits Value Advisor (BVA)

The Benefit Value Advisor (BVA) program has been established to assist Participants in maximizing their benefits under the Plan. Benefit Value Advisors are specially-trained customer service representatives who assist Participants by comparing cost and providing information on Participating Providers for certain types of health care services. A BVA helps Participants navigate their benefits.

In addition to calling the Benefit Value Advisors, Participants may have other call requirements. A call to BVA does not satisfy any other call requirements Participants may have.

BCBSTX Website

Visit the BCBSTX website at www.bcbstx.com/michaels for information about BCBSTX, access to forms referenced in this Benefit Booklet, and much more.

Mental Health/Substance Use Disorder Prior Authorization Helpline

To satisfy Prior Authorization requirements for Participants seeking treatment for Behavioral Health Services, Mental Health Care, Serious Mental Illness, and Substance Use Disorder, you, your Behavioral Health Practitioner, or a family member may call the Mental Health/Substance Use Disorder Prior Authorization Helpline at any time, day or night.

Medical Prior Authorization Helpline

To satisfy all medical Prior Authorization requirements for inpatient Hospital Admissions, Extended Care Expenses, or Home Infusion Therapy, call the Medical Prior Authorization Helpline.

WHO GETS BENEFITS

Eligibility Requirements for Coverage

The Eligibility Date is the date a person becomes eligible to be covered under the Plan. A person becomes eligible to be covered when the person becomes an Employee or a Dependent and is in a class eligible to be covered under the Plan. The Eligibility Date is:

1. The date the Employee, including any Dependents to be covered, completes the Waiting Period, if any, for coverage;

2. Described in the ***Dependent Enrollment Period*** subsection for a new Dependent of an Employee already having coverage under the Plan.

No eligibility rules or variations in rates will be imposed based on your health status, medical condition, claims experience, receipt of health care, medical history, genetic information, evidence of insurability, disability, or any other health status related factor. Coverage under this Plan is provided regardless of your race, color, national origin, disability, age, sex, gender identity or sexual orientation. Variations in the administration, processes or benefits of this Plan that are based on clinically indicated reasonable medical management practices, or are part of permitted wellness incentives, disincentives and/or other programs do not constitute discrimination.

Employee Eligibility

Any person eligible under this Plan and covered by the Employer's previous Health Benefit Plan on the date prior to the Plan Effective Date, including any person who has continued group coverage under applicable federal or state law, is eligible on the Plan Effective Date. Otherwise, you are eligible for coverage under the Plan when you satisfy the definition of an Employee and you reside or work in the Plan Service Area.

Dependent Eligibility

If you apply for coverage, you may include your Dependents. Eligible Dependents are:

1. Your spouse or your Domestic Partner;
2. A child under the limiting age shown in your Schedule of Coverage;
3. A child of your child who is your Dependent for federal income tax purposes at the time application for coverage of the child is made and with whom you have legal custody;
4. Any other child included as an eligible Dependent under the Plan.

A detailed description of Dependent is in the **DEFINITIONS** section of this Benefit Booklet. An Employee must be covered first in order to cover their eligible Dependents. No Dependent shall be covered hereunder prior to the Employee's Effective Date.

Effective Dates of Coverage

In order for an Employee's coverage to take effect, the Employee must submit electronic enrollment for coverage for himself and any Dependents. The Effective Date is the date the coverage for a Participant actually begins. The Effective Date under the Plan is shown on your Identification Card. It may be different from the Eligibility Date.

Timely Applications

It is important that your electronic application for coverage under the Plan is received timely by the Claim Administrator through the Plan Administrator.

If you apply for coverage and make the required contributions for yourself or for yourself and your eligible Dependents and if you:

1. Are eligible on the Plan Effective Date and the electronic application is received by the Claim Administrator through the Plan Administrator prior to or within 30 days following such date, your coverage will become effective on the Plan Effective Date;

2. Enroll for coverage for yourself or for yourself and your Dependents during an Open Enrollment Period, coverage shall become effective on the Plan Anniversary Date; or

3. Become eligible after the Plan Effective Date and if the electronic application is received by the Claim Administrator through the Plan Administrator within the first 30 days following your Eligibility Date, the coverage will become effective in accordance with eligibility information provided by your Employer.

Effective Dates - Delay of Benefits Provided

Coverage becomes effective for you and/or your Dependents on the Plan Effective Date upon completion of an electronic application for coverage. If you or your eligible Dependent(s) are confined in a Hospital or Facility Other Provider on the Plan Effective Date, your coverage is effective on the Plan Effective Date. However, if this Plan is replacing a discontinued Health Benefit Plan or self-funded Health Benefit Plan, benefits for any Employee or Dependent may be delayed until the expiration of any applicable extension of benefits provided by the previous Health Benefit Plan or self-funded Health Benefit Plan.

Effective Dates - Late Enrollee

If your electronic application is not received within 30 days from the Eligibility Date, you will be considered a Late Enrollee. You will become eligible to apply for coverage during your Employer's next Open Enrollment Period. Your coverage will become effective on the Plan Anniversary Date.

Loss of Other Health Insurance Coverage

An Employee who is eligible, but not enrolled for coverage under the terms of the Plan (and/or a Dependent, if the Dependent is eligible, but not enrolled for coverage under such terms) shall become eligible to apply for coverage if each of the following conditions is met:

1. The Employee or Dependent was covered under a Health Benefit Plan, self-funded Health Benefit Plan, or had other health insurance coverage at the time this coverage was previously offered; and
2. Coverage was declined under this Plan, on the basis of coverage under another Health Benefit Plan or self-funded Health Benefit Plan; and
3. There is a loss of coverage under such prior Health Benefit Plan or self-funded Health Benefit Plan as a result of:
    a. Exhaustion of continuation under Title X of the Consolidated Omnibus Budget Reconciliation Act (COBRA) of 1985, as amended; or
    b. Cessation of Dependent status (such as divorce or attaining the maximum age to be eligible as a dependent child under the Plan), termination of employment, a reduction in the number of hours of employment, or employer contributions toward such coverage were terminated; or
    c. Termination of the other plan's coverage, a situation in which an individual incurs a claim that would meet or exceed a lifetime limit on all benefits, a situation in which the other plan no longer offers any benefits to the class of similarly situated individuals that include you or your Dependent, or, in the case of coverage offered through an HMO, you or your Dependent no longer reside, live, or work in the service area of that HMO and no other benefit option is available; and
4. You request to enroll no later than 30 days after the date coverage ends under the prior Health Benefit Plan or self-funded Health Benefit Plan or, in the event of the attainment of a lifetime limit on all benefits, the request to enroll is made not later than 30 days after a claim is denied due to the attainment of a lifetime limit on all benefits. Coverage will become effective the first day of the Plan Month following receipt of the electronic application by the Claim Administrator through the Plan Administrator.

If all conditions described above are not met, you will be considered a Late Enrollee.

Loss of Governmental Coverage

An individual who is eligible to enroll and who has lost coverage under Medicaid (Title XIX of the Social Security Act), other than coverage consisting solely of benefits under Section 1928 of that Act (42 U.S.C. Section 1396s) or under the Children's Health Insurance Program (CHIP), Chapter 62, Health and Safety Code, is not a Late Enrollee provided appropriate electronic enrollment application/change forms and applicable contributions are received by the Claim Administrator within sixty (60) days after the date on which such individual loses coverage. Coverage will be effective the day after prior coverage terminated.

Health Insurance Premium Payment (HIPP) Reimbursement Program

An individual who is eligible to enroll and who is a recipient of medical assistance under the Medicaid Program or enrolled in CHIP, and who is a participant in the HIPP Reimbursement Program may enroll with no enrollment period restrictions. If the individual is not eligible unless a family member is enrolled, both the individual and family member may enroll. The Effective Date of Coverage is on the first day of the month after the Claim Administrator receives (i) written notice from the Texas Health and Human Services Commission, or (ii) electronic enrollment forms, from you, provided such forms and applicable contributions are received by the Claim Administrator within sixty (60) days after the date the individual becomes eligible for participation in the HIPP Reimbursement Program.

Dependent Enrollment Period

1. ***Special Enrollment Period for Newborn Children***
   Coverage of a newborn child will be automatic for the first 30 days following the birth of your newborn child. For coverage to continue beyond this time, you must notify the Claim Administrator through the Plan Administrator within 30 days of birth and pay any required contributions within that 30-day period or a period consistent with the next billing cycle. Coverage will become effective on the date of birth. If the Claim Administrator is notified through the Plan Administrator after that 30-day period, the newborn child's coverage will become effective on the Plan Anniversary Date following the Employer's next Open Enrollment Period.

2. ***Special Enrollment Period for Adopted Children or Children Involved in a Suit for Adoption***
   Coverage of an adopted child or child involved in a suit for adoption will be automatic for the first 30 days following the adoption or date on which a suit for adoption is sought. For coverage to continue beyond this time, the Claim Administrator through the Plan Administrator must receive all necessary forms and the required contributions within the 30-day period or a period consistent with the next billing cycle. Coverage will become effective on the date of adoption or date on which a suit for adoption is sought. If you notify the Claim Administrator through the Plan Administrator after that 30-day period, the child's coverage will become effective on the Plan Anniversary Date following the Employer's next Open Enrollment Period.

3. ***Court Ordered Dependent Children***
   If a court has ordered an Employee to provide coverage for a child, coverage will be automatic for the first 30 days after the date your Employer receives notification of the court order. To continue coverage beyond the 30 days, the Claim Administrator through the Plan Administrator must receive all necessary forms and the required contributions within the 30-day period. If you notify the Claim Administrator through the Plan Administrator after that 30-day period, the Dependent child's coverage will become effective on the Plan Anniversary Date following your Employer's next Open Enrollment Period.

4. ***Other Dependents***
   Electronic application must be received within 30 days of the date that a spouse or Domestic Partner or child first qualifies as a Dependent. If the electronic application is received within 30 days, coverage will become effective on the date the child or spouse or Domestic Partner first becomes an eligible Dependent. If application is not made within the initial 30 days, then your Dependent's coverage will become effective on the Plan Anniversary Date following your Employer's next Open Enrollment Period.

   If you ask that your Dependent be provided health care coverage after having canceled their coverage while your Dependent was still entitled to coverage, your Dependent's coverage will become effective in accordance with the provisions of the Plan.

In no event will your Dependent's coverage become effective prior to your Effective Date.

Other Employee Enrollment Period

1. As a special enrollment period event, if you acquire a Dependent through birth, adoption, or through suit for adoption, and you previously declined coverage for reasons other than under ***Loss of Other Health Insurance Coverage***, as described above, you may apply for coverage for yourself, your spouse or Domestic Partner, and a newborn child, adopted child, or child involved in a suit for adoption. If the electronic application is received within 30 days of the birth, adoption, or suit for adoption, coverage for the child, you, or your spouse or Domestic Partner will become effective on the date of the birth, adoption, or date suit for adoption is sought.

If you marry or enter into a Domestic Partnership and you previously declined coverage for reasons other than under ***Loss of Other Health Insurance Coverage*** as described above, you may apply for coverage for yourself and your spouse or Domestic Partner. If the electronic application is received within 30 days of the marriage or establishment of a Domestic Partnership, coverage for you and your spouse or Domestic Partner will become effective on the first day of the month following receipt of the electronic application by the Claim Administrator through the Plan Administrator.

2. If you are required to provide coverage for a child as described in ***Court Ordered Dependent Children*** above, and you previously declined coverage for reasons other than under ***Loss of Other Health Insurance Coverage***, you may apply for coverage for yourself. If the electronic application is received within 30 days of the date your Employer receives notification of the court order, coverage for you will become effective on the date your Employer receives notification of the court order.

Changes In Your Family

You should promptly notify the Claim Administrator through the Plan Administrator in the event of a birth or follow the instructions below when events, such as but not limited to, the following take place:

- If you are adding a Dependent due to marriage or establishment of a Domestic Partnership, adoption, or a child being involved in a suit for which an adoption of the child is sought, or your Employer receives a court order to provide health coverage for a Participant's child or your spouse, you must submit an electronic *Enrollment Application/Change Form* and the coverage of the Dependent will become effective as described in ***Dependent Enrollment Period***.
- When you divorce or terminate a Domestic Partnership or your child reaches the age indicated on your Schedule of Coverage as "Dependent Child Age Limit," or a Participant in your family dies, coverage under the Plan terminates in accordance with the **Termination of Coverage** provisions selected by your Employer. **Notify your Employer promptly if any of these events occur. Benefits for expenses incurred after termination are not available.** If your Dependent's coverage is terminated, refund of contributions will not be made for any period before the date of notification. If benefits are paid prior to notification to the Claim Administrator by the Plan Administrator, refunds will be requested.
  Please refer to the **Continuation of Group Coverage - Federal** subsection in this Benefit Booklet for additional information.

HOW THE PLAN WORKS

Allowable Amount

The Allowable Amount is the maximum amount of benefits the Claim Administrator will pay for Eligible Expenses you incur under the Plan. The Claim Administrator has established an Allowable Amount for Medically Necessary services, supplies, and procedures provided by Providers that have contracted with the Claim Administrator or any other Blue Cross and/or Blue Shield Plan, and Providers that have not contracted with the Claim Administrator or any other Blue Cross and/or Blue Shield Plan. When you choose to receive services, supplies, or care from a Provider that does not contract with the Claim Administrator, you will be responsible for any difference between the Claim Administrator's Allowable Amount and the amount charged by the non-contracting Provider. You will also be responsible for charges for services, supplies, and procedures limited or not covered under the Plan, any applicable Deductibles, Co-Share Amounts, and Copayment Amounts.

Review the definition of Allowable Amount in the **DEFINITIONS** section of this Benefit Booklet to understand the guidelines used by the Claim Administrator.

Case Management

Under certain circumstances, the Plan allows the Claim Administrator the flexibility to offer benefits for expenses which are not otherwise Eligible Expenses. The Claim Administrator, at its sole discretion, may offer such benefits if:

- The Participant, their family, and the Physician agree;
- Benefits are cost effective; and
- The Claim Administrator anticipates future expenditures for Eligible Expenses which may be reduced by such benefits.

Any decision by the Claim Administrator to provide such benefits shall be made on a case-by-case basis. The case coordinator for the Claim Administrator will initiate case management in appropriate situations.

Freedom of Choice

Each time you need medical care, you can choose to:		
See a Network Provider	***See an Out-of-Network Provider***	
	ParPlan Provider (refer to ParPlan, below, for more information)	***Out-of-Network Provider (not a contracting Provider)***
• You receive the higher level of benefits (In-Network Benefits) • You are not required to file claim forms • You are not balance billed; Network Providers will not bill for costs exceeding the Claim Administrator's Allowable Amount for covered services • Your Provider will obtain Prior Authorization for necessary services	• You receive the lower level of benefits (Out-of-Network Benefits) • You are not required to file claim forms in most cases; *ParPlan* Providers will usually file claims for you • You are not balance billed; *ParPlan* Providers will not bill for costs exceeding the Claim Administrator's Allowable Amount for covered services • In most cases, *ParPlan* Providers will obtain Prior Authorization for necessary services	• You receive Out-of-Network Benefits (the lower level of benefits) • You are required to file your own claim forms • You may be billed for charges exceeding the Claim Administrator's Allowable Amount for covered services • You must obtain Prior Authorization for necessary services

Identification Card

The Identification Card tells Providers that you are entitled to benefits under your Employer's Health Benefit Plan. The card offers a convenient way of providing important information specific to your coverage including, but not limited to, the following:

- ***Your Subscriber identification number***. This unique identification number is preceded by a three character alpha prefix that identifies Blue Cross and Blue Shield of Texas as your Claim Administrator.
- ***Your group number***. This is the number assigned to identify your Employer's Health Benefit Plan with the Claim Administrator.
- ***Any Copayment Amounts that may apply to your coverage.***
- ***Important telephone numbers***.

Always remember to carry your Identification Card with you and present it to your Providers or Participating Pharmacies when receiving health care services or supplies.

Please remember that any time a change in your family takes place it may be necessary for a new Identification Card to be issued to you (refer to the **WHO GETS BENEFITS** section for instructions when changes are made). Upon receipt of the change in information, the Claim Administrator will provide a new Identification Card.

Unauthorized, Fraudulent, Improper, or Abusive Use of Identification Cards

1. The unauthorized, fraudulent, improper, or abusive use of Identification Cards issued to you and your covered Dependents will include, but not be limited to, the following actions, when intentional:

    a. Use of the Identification Card prior to your Effective Date;
    b. Use of the Identification Card after your date of termination of coverage under the Plan;
    c. Obtaining prescription drugs or other benefits for persons not covered under the Plan;
    d. Obtaining prescription drugs or other benefits that are not covered under the Plan;
    e. Obtaining Covered Drugs for resale or for use by any person other than the person for whom the Prescription Order is written, even though the person is otherwise covered under the Plan;
    f. Obtaining Covered Drugs without a Prescription Order or through the use of a forged or altered Prescription Order;
    g. Obtaining quantities of prescription drugs in excess of Medically Necessary or prudent standards of use or in circumvention of the quantity limitations of the Plan;
    h. Obtaining prescription drugs using Prescription Orders for the same drugs from multiple Providers;
    i. Obtaining prescription drugs from multiple Pharmacies through use of the same Prescription Order.

2. The fraudulent or intentionally unauthorized, abusive, or other improper use of Identification Cards by any Participant can result in, but is not limited to, the following sanctions being applied to all Participants covered under your coverage:

    a. Denial of benefits;
    b. Cancellation of coverage under the Plan for **all** Participants under your coverage;
    c. Recoupment from you or any of your covered Dependents of any benefit payments made;
    d. Pre-approval of drug purchases and medical services for all Participants receiving benefits under your coverage;
    e. Notice to proper authorities of potential violations of law or professional ethics.

Medical Necessity

All services and supplies for which benefits are available under the Plan must be Medically Necessary as determined by the Claim Administrator. Charges for services and supplies which the Claim Administrator determines are not Medically Necessary will not be eligible for benefit consideration and may not be used to satisfy Deductibles or to apply to the Co-Share Stop-Loss Amount.

ParPlan

When you consult a Physician or Professional Other Provider who does not participate in the Network, you should inquire if they participate in the Claim Administrator's *ParPlan*…a simple direct-payment arrangement. If the Physician or Professional Other Provider participates in the *ParPlan,* they agree to:

- File all claims for you,
- Accept the Claim Administrator's Allowable Amount determination as payment for Medically Necessary services, and
- Not bill you for services over the Allowable Amount determination.

You will receive Out-of-Network Benefits and be responsible for:

- Any Deductibles,
- Co-Share Amounts, and
- Services that are limited or not covered under the Plan.

NOTE: If you have a question regarding a Physician's or Professional Other Provider's participation in the *ParPlan*, please contact the Claim Administrator's Customer Service Helpline.

Preexisting Conditions Provision

Benefits for Eligible Expenses incurred for treatment of a preexisting condition will be available immediately with no preexisting condition Waiting Period.

Specialty Care Providers

A wide range of Specialty Care Providers is included in the Network. When you need a specialist's care, In-Network Benefits will be available, but only if you use a Network Provider.

There may be occasions however, when you need the services of an Out-of-Network Provider. This could occur if you have a complex medical problem that cannot be taken care of by a Network Provider.

- If the services you require are not available from Network Providers, In-Network Benefits will be provided when you use Out-of-Network Providers.
- If you elect to see an Out-of-Network Provider and if the services could have been provided by a Network Provider, only Out-of-Network Benefits will be available.

Use of Non-Contracting Providers

When you choose to receive services, supplies, or care from a Provider that does not contract with BCBSTX (a non-contracting Provider), you receive Out-of-Network Benefits (the lower level of benefits). Benefits for covered services will be reimbursed based on the BCBSTX non-contracting Allowable Amount, which in most cases is less than the Allowable Amount applicable for BCBSTX contracted Providers. Please see the definition of non-contracting Allowable Amount in the **DEFINITIONS** section of this Benefit Booklet. **The non-contracted Provider is not required to accept the BCBSTX non-contracting Allowable Amount as payment in full and may balance bill you for the difference between the BCBSTX non-contracting Allowable Amount and the non-contracting Provider's billed charges. You will be responsible for this balance bill amount, which may be considerable. You will also be responsible for charges for services, supplies, and procedures limited or not covered under the Plan, any applicable Deductibles, Co-Share Amounts, and Copayment Amounts**.

UTILIZATION MANAGEMENT

Utilization Management

Utilization management may be referred to as Medical Necessity reviews, utilization review (UR) or medical management reviews. A Medical Necessity review for a procedure/service, inpatient admission, and length of stay is based on BCBSTX medical policy and/or level of care review criteria. Medical Necessity reviews may occur prior to services rendered, during the course of care, or after care has been completed for a Post-Service Medical Necessity Review. Some services may require a Prior Authorization before the start of services, while other services will be subject to a Post-Service Medical Necessity Review. If requested, services normally subject to a Post- Service Medical Necessity Review may be reviewed for Medical Necessity prior to the service through a Recommended Clinical Review.

Refer to the definition of Medical Necessity or Medically Necessary in the **DEFINITIONS** section of this Benefit Booklet for additional information regarding any limitations and/or special conditions pertaining to your benefits.

Prior Authorization Requirements

Prior Authorization establishes in advance the Medical Necessity or Experimental/Investigational nature of certain care and services covered under this Plan. It ensures that the care and services described below for which you have obtained Prior Authorization will not be denied on the basis of Medical Necessity or Experimental/Investigational. However, Prior Authorization does not guarantee payment of benefits.

Coverage is always subject to other requirements of the Plan, such as limitations and exclusions, payment of contributions, and eligibility at the time care and services are provided.

The following types of services require Prior Authorization:

- All inpatient Hospital Admissions,
- Extended Care Expenses,
- Home Health,
- Home Infusion Therapy,
- Home Hospice,
- Non-emergency Air Ambulance: Fixed Wing;
  Please refer to Fixed-Wing Air Ambulance definition in the **DEFINITIONS** section of this Benefit Booklet.

For specific details about the Prior Authorization requirement for the above referenced outpatient procedures/services, please call Customer Service at the number on the back of your Identification Card. BCBSTX reserves the right to no longer require Prior Authorization during the Plan Year. Updates to the list of services requiring Prior Authorization may be confirmed by calling Customer Service.

- All inpatient treatment of Mental Health Care/Serious Mental Illness including partial hospitalization programs and treatment received at Residential Treatment Centers,
- All inpatient treatment of Substance Use Disorder (SUD) including partial hospitalization programs and treatment received at Residential Treatment Centers, and
- If you transfer to another facility or to or from a specialty unit within the facility.
- The following outpatient treatment of Mental Health Care, Serious Mental Illness and Substance Use Disorder (SUD):
  - Psychological Testing or Neuropsychological Testing in some cases (BCBSTX will notify your Provider if Prior Authorization is required for these testing services),
  - Applied Behavioral Analysis (Please see coverage details as described in the Benefits for Autism Spectrum Disorder in the **COVERED MEDICAL SERVICES** section of this Benefit Booklet),
  - Electroconvulsive therapy,
  - Intensive Outpatient Program, and
  - Repetitive Transcranial Magnetic Stimulation.

In-Network Benefits will be available if you use a Network Provider or Network Specialty Care Provider. In-Network Providers will obtain Prior Authorization of services for you, when required.

If you elect to use Out-of-Network Providers for services and supplies available In-Network, Out-of-Network Benefits will be paid.

However, if care is not available from Network Providers as determined by the Claim Administrator, and the Claim Administrator acknowledges your visit to an Out-of-Network Provider **prior to the visit**, In-Network Benefits will be paid; otherwise, Out-of-Network Benefits will be paid and the claim will have to be resubmitted for review and adjusted, if appropriate.

Your Network Provider is required to obtain Prior Authorization for inpatient Hospital admissions. You are responsible for satisfying all other Prior Authorization requirements. This means that you must ensure that you, an authorized representative, your Physician, Behavioral Health Practitioner or Provider of services must comply with the guidelines below. Failure to obtain Prior Authorization of services will require additional steps and/or benefit reductions as described in the subsection entitled *Failure to Obtain Prior Authorization*.

Prior Authorization for Inpatient Hospital Admissions
In the case of an elective inpatient Hospital Admission, the call for Prior Authorization should be made at least two working days before you are admitted unless it would delay Emergency Care. In an emergency, Prior Authorization should take place within two working days after admission, or as soon thereafter as reasonably possible.

Your Network Provider is required to obtain Prior Authorization for any inpatient admissions. If Prior Authorization is not obtained, the Network Provider will be sanctioned based on BCBSTX's contractual agreement with the Provider, and you will be held harmless for the Provider sanction.

If the Physician or Provider of services is not a Network Provider then you, your Physician, the participating Provider of services, or an authorized representative should obtain Prior Authorization by the Plan by calling one of the toll-free numbers shown on the back of your Identification Card. The call should be made between 6:00 a.m. and 6:00 p.m., Central Time, on business days and 9:00 a.m. and 12:00 p.m., Central Time on Saturdays, Sundays and legal holidays. Calls made after these hours will be recorded and returned no later than 24 hours after the call is received. We will follow-up with your Provider's office. After working hours or on weekends, please call the **Medical Prior Authorization Helpline** toll-free number listed on the back of your Identification Card. Your call will be recorded and returned the next working day. A benefits management nurse will follow up with your Provider's office. All timelines for Prior Authorization requirements are provided in keeping with applicable state and federal regulations.

In-Network Benefits will be available if you use a Network Provider or Network Specialty Care Provider. If you elect to use Out-of-Network Providers for services and supplies available In-Network, Out-of-Network Benefits will be paid. In-Network and Out-of-Network Providers may obtain Prior Authorization of services for you, when required, but it is your responsibility to ensure Prior Authorization requirements are satisfied.

However, if care is not available from Network Providers as determined by BCBSTX, and BCBSTX authorizes your visit to an Out-of-Network Provider to be covered at the In-Network Benefit level **prior to the visit**, In-Network Benefits will be paid; otherwise, Out-of-Network Benefits will be paid.

When Prior Authorization of an inpatient Hospital Admission is obtained, a length-of-stay is assigned. If you require a longer stay, your Provider may seek an extension for the additional days. Benefits will not be available for room and board charges for medically unnecessary days. For more information regarding lengths of stay, refer to the **Length of Stay/Service Review** subsection of this Benefit Booklet.

Prior Authorization not Required for Maternity Care and Treatment of Breast Cancer Unless Extension of Minimum Length of Stay Requested
Your Plan is required to provide a minimum length-of-stay in a Hospital facility for the following:

- Maternity Care
  - 48 hours following an uncomplicated vaginal delivery
  - 96 hours following an uncomplicated delivery by caesarean section

- Treatment of Breast Cancer
  - 48 hours following a mastectomy
  - 24 hours following a lymph node dissection

You or your Provider will not be required to obtain Prior Authorization from BCBSTX for a length of stay less than 48 hours (or 96 hours) for Maternity Care or less than 48 hours (or 24 hours) for Treatment of Breast Cancer. If you require a longer stay, you or your Provider must seek an extension for the additional days by obtaining Prior Authorization from BCBSTX.

Prior Authorization for Extended Care Expenses and Home Infusion Therapy
Prior Authorization for Extended Care Expenses and Home Infusion Therapy may be obtained by having the agency or facility providing the services contact the Claim Administrator to request Prior Authorization. The request should be made:

- Prior to initiating Extended Care Expenses or Home Infusion Therapy;
- When an extension of the service is required; and
- When the treatment plan is altered.

The Claim Administrator will review the information submitted prior to the start of Extended Care Expenses or Home Infusion Therapy and will send a letter to you and the agency or facility confirming Prior Authorization or denying benefits. If Extended Care Expenses or Home Infusion Therapy is to take place in less than one week, the agency or facility should call the Claim Administrator's **Medical Prior Authorization Helpline** telephone number indicated in this Benefit Booklet or shown on your Identification Card.

If the Claim Administrator has given notification that benefits for the treatment plan requested will be denied based on information submitted, claims will be denied.

Prior Authorization for Mental Health Care, Serious Mental Illness, and Treatment of Substance Use Disorder
In order to receive maximum benefits, you must obtain Prior Authorization from the Plan for all inpatient treatment for Mental Health Care, Serious Mental Illness, and Substance Use Disorder. Prior Authorization is also required for certain outpatient services. Outpatient services requiring Prior Authorization include psychological testing, neuropsychological testing, repetitive transcranial magnetic stimulation, Intensive Outpatient Programs, applied behavior analysis, and outpatient electroconvulsive therapy. Prior Authorization is not required for therapy visits to a Physician, Behavioral Health Practitioner and/or Professional Other Provider.

To satisfy Prior Authorization requirements, you, an authorized representative, or your Behavioral Health Practitioner must call the **Mental Health/Substance Use Disorder Prior Authorization Helpline** toll-free number indicated in this Benefit Booklet or shown on your Identification Card. The **Mental Health/Substance Use Disorder Prior Authorization Helpline** is available 24 hours a day, 7 days a week. All timelines for Prior Authorization requirements are provided in keeping with applicable state and federal regulations.

In-Network Benefits will be available if you use a Network Provider or Network Specialty Care Provider. If you elect to use Out-of-Network Providers for services and supplies available In-Network, Out-of-Network Benefits will be paid. In-Network and Out-of-Network Providers may obtain Prior Authorization of services for you, when required, but it is your responsibility to ensure Prior Authorization requirements are satisfied.

However, if care is not available from Network Providers as determined by BCBSTX, and BCBSTX authorizes your visit to an Out-of-Network Provider to be covered at the In-Network Benefit level **prior to the visit**, In-Network Benefits will be paid; otherwise, Out-of-Network Benefits will be paid.

When you obtain Prior Authorization for a treatment or service, a length of stay or length of service is assigned. If you require a longer stay or length of service, your Behavioral Health Practitioner may seek an extension for the additional days or visits. Benefits will not be available for medically unnecessary treatments or services.

Length of Stay/Service Review

Length of stay/service review is not a guarantee of benefits. Actual availability of benefits is subject to eligibility and the other terms, conditions, limitations and exclusions under this Plan.

Upon completion of the preadmission or emergency admission review, BCBSTX will send you a letter confirming that you or your representative called BCBSTX. A letter authorizing a length of service or length of stay will be sent to you, your Physician, Provider of services, and/or the Hospital or facility.

An extension of the length of stay/service will be based solely on whether continued Inpatient care or other health care services are Medically Necessary. If the extension is determined not to be Medically Necessary, the coverage for the length of stay/service will not be extended, except as otherwise described in the **CLAIM FILING AND APPEALS PROCEDURES** section of this Benefit Booklet.

A length of stay/service review, also known as a concurrent Medical Necessity review, is when you, your Provider, or other authorized representative may submit a request to BCBSTX for continued services. If you, your Provider or authorized representative requests to extend care beyond the approved time limit and it is a request involving Urgent Care or an ongoing course of treatment, BCBSTX will make a determination on the request as soon as possible (taking into account medical exigencies) but no later than 72 hours after it receives the initial request, or within 48 hours after it receives the missing information (if the initial request is incomplete).

Recommended Clinical Review Option

There are services that do not require a Prior Authorization that may be subject to a Post-Service Medical Necessity Review before the claim is paid. There is an option for your Provider to request a Recommended Clinical Review to determine if the service meets approved medical policy and/or level of care review criteria before services are provided to you. Once a decision has been made on the services reviewed as part of the Recommended Clinical Review process, the same services will not be reviewed for Medical Necessity after they have been performed.

To determine if a Recommended Clinical Review is available for a specific service, visit our website at www.bcbstx.com/find-care/where-you-go-matters/utilization-management.com for the Recommended Clinical Review list, which is updated when new services are added or when services are removed. You can also call BCBSTX Customer Service at the number on the back of your Identification Card. This website also includes information on which services *require* Prior Authorization before services are performed.

In the event a Recommended Clinical Review determines the proposed services are not Medically Necessary, you have the right to file an appeal as described in the CLAIM FILING AND APPEALS PROCEDURES section. All appeal and review requirements related to Medical Necessity determinations, including independent review, apply to services where your Provider requests a Recommended Clinical Review.

Recommended Clinical Review is not a guarantee of benefits. Actual availability of benefits is subject to eligibility and the other terms, conditions, limitations and exclusions of the Plan. Please coordinate with your Provider to submit a written request for a Recommended Clinical Review.

General Provisions Applicable to All Recommended Clinical Reviews

1. **No Guarantee of Payment**

   A Recommended Clinical Review is not a guarantee of benefits or payment of benefits by BCBSTX. Actual availability of benefits is subject to eligibility and the other terms, conditions, limitations, and exclusions of this Plan. Even if the service has been approved in a Recommended Clinical Review, coverage or payment can be affected for a variety of reasons. For example, you may have become ineligible as of the date of service or the member's benefits may have changed as of the date of service.

2. **Request for Additional Information**

   The Recommended Clinical Review process may require additional documentation from your Provider or pharmacist. In addition to the written request for a Recommended Clinical Review, the Provider or pharmacist may be required to include pertinent documentation explaining the proposed services, the functional aspects of the treatment, the projected outcome, treatment plan and any other supporting documentation, study models, prescription, itemized repair and replacement cost statements, photographs, x-rays, etc., as may be requested by BCBSTX to make a determination of coverage pursuant to the terms and conditions of this Plan.

Post-Service Medical Necessity Review

A Post-Service Medical Necessity Review, sometimes referred to as a retrospective review or post-service claims request, is the process of determining coverage after treatment has been provided and is based on Medical Necessity

guidelines. A Post-Service Medical Necessity Review confirms your eligibility, availability of benefits at the time of service, and reviews necessary clinical documentation to ensure the service was Medically Necessary. Providers should submit appropriate documentation at the time of a Post-Service Medical Necessity Review request. A Post-Service Medical Necessity Review may be performed when a Prior Authorization or Recommended Clinical Review was not obtained prior to services being rendered.

General Provisions Applicable to All Post-Service Medical Necessity Reviews

1. **No Guarantee of Payment**

   A Post-Service Medical Necessity Review is not a guarantee of benefits. Actual availability of benefits is subject to eligibility and the other terms, conditions, limitations, and exclusions of this Plan. Post-Service Medical Necessity Review does not guarantee payment of benefits by BCBSTX, for instance you may become ineligible as of the date of service or your benefits may have changed as of the date of service.

2. **Request for Additional Information**

   The Post-Service Medical Necessity Review process may require additional documentation from your Provider or pharmacist. In addition to the written request for Post-Service Medical Necessity Review, the Provider or pharmacist may be required to include pertinent documentation explaining the services rendered, the functional aspects of the treatment, the projected outcome, treatment plan and any other supporting documentation, study models, prescription, itemized repair and replacement cost statements, photographs, x-rays, etc., as may be requested by BCBSTX to make a determination of coverage pursuant to the terms and conditions of this Plan.

Failure to Obtain Prior Authorization

If Prior Authorization for inpatient Hospital Admissions, Extended Care Expense, Home Infusion Therapy, all inpatient and the above specified outpatient treatment of Mental Health Care, treatment of Serious Mental Illness, and treatment of Substance Use Disorder is not obtained:

- BCBSTX will review the Medical Necessity of your treatment or service prior to the final benefit determination.
- If BCBSTX determines the treatment or service is not Medically Necessary or is Experimental/Investigational, benefits will be reduced or denied.
- You may be responsible for a penalty in connection with the following Covered Services, if indicated on your Schedule of Coverage:
  - Inpatient Hospital Admission
  - Inpatient treatment of Mental Health Care, treatment of Serious Mental Illness, and treatment of Substance Use Disorder

Network Providers are responsible for satisfying the Prior Authorization requirements for any inpatient admissions. If Prior Authorization is not obtained, the Network Provider will be sanctioned based on the BCBSTX contractual agreement with the Provider and no penalty charges will be deducted.

The penalty charge will be deducted from any benefit payment which may be due for Covered Services.

If Prior Authorization of an inpatient Hospital Admission, Extended Care Expense, Home Infusion Therapy, any treatment of Mental Health Care, treatment of Serious Mental Illness, and treatment of Substance Use Disorder or extension for any treatment or service described above is not obtained and it is determined that the treatment, service, or extension was not Medically Necessary or was Experimental/Investigational, benefits will be reduced or denied.

Prior Authorization Renewal Process

Renewal of an existing Prior Authorization issued by BCBSTX can be requested by a Physician or health care Provider up to 60 days prior to the expiration of the existing Prior Authorization.

CLAIM FILING AND APPEALS PROCEDURES

Claim Filing Procedures

Filing of Claims Required

Claim Forms

When the Claim Administrator receives notice of claim, it will furnish to you, or to your Employer for delivery to you, the Hospital, or your Physician or Professional Other Provider, the claim forms that are usually furnished by it for filing Proof of Loss.

The Claim Administrator for the Plan must receive claims prepared and submitted in the proper manner and form, in the time required, and with the information requested before it can consider any claim for payment of benefits.

Who Files Claims

Providers that contract with the Claim Administrator and some other health care Providers (such as *ParPlan* Providers) will submit your claims directly to the Claim Administrator for services provided to you or any of your covered Dependents. At the time services are provided, inquire if they will file claim forms for you. To assist Providers in filing your claims, you should carry your Identification Card with you.

Contracting Providers

When you receive treatment or care from a Provider or Covered Drugs dispensed from a Pharmacy that contracts with the Claim Administrator, you will generally not be required to file claim forms. The Provider will usually submit the claims directly to the Claim Administrator for you.

Non-Contracting Providers

When you receive treatment or care from a health care Provider that does not contract with the Claim Administrator, you may be required to file your own claim forms. Some Providers, however, will do this for you. If the Provider does not submit claims for you, refer to the subsection entitled ***Participant-Filed Claims*** below for instruction on how to file your own claim forms.

Mail-Order Program

When you receive Covered Drugs dispensed through the mail-order program, you must complete and submit the mail service prescription drug claim form to the address on the claim form. Additional information may be obtained from your Employer, from the Claim Administrator, from the BCBSTX website at www.bcbstx.com/michaels, or by calling the Customer Service Helpline.

Participant-Filed Claims - *Medical Claims*

If your Provider does not submit your claims, you will need to submit them to the Claim Administrator using a Subscriber-filed claim form provided by the Plan. Your Employer should have a supply of claim forms or you can obtain copies from the BCBSTX website at www.bcbstx.com/michaels, or by calling Customer Service at the toll-free number on your Identification Card. Follow the instructions on the reverse side of the form to complete the claim. Remember to file each Participant's expenses separately because any Copayment Amounts, Deductibles, maximum benefits, and other provisions are applied to each Participant separately. Include itemized bills from the health care Providers, labs, etc., printed on their letterhead and showing the services performed, dates of service, charges, and name of the Participant involved.

VISIT THE BCBSTX WEBSITE FOR SUBSCRIBER CLAIM FORMS AND OTHER USEFUL INFORMATION
www.bcbstx.com/michaels

Where to Mail Completed Claim Forms

Medical Claims

Blue Cross and Blue Shield of Texas
Claims Division
P. O. Box 660044
Dallas, TX 75266-0044

Who Receives Payment

Benefit payments will be made directly to contracting Providers when they bill the Claim Administrator. Written agreements between the Claim Administrator and some Providers may require payment directly to them.

Any benefits payable to you, if unpaid at your death, will be paid to your surviving spouse, as beneficiary. If there is no surviving spouse, then the benefits will be paid to your estate.

Except as provided in the subsection **Assignment and Payment of Benefits,** rights and benefits under the Plan are not assignable, either before or after services and supplies are provided.

Benefit Payments to a Managing Conservator

Benefits for services provided to your minor Dependent child may be paid to a third party if:

- the third party is named in a court order as managing or possessory conservator of the child; and
- the Claim Administrator has not already paid any portion of the claim.

In order for benefits to be payable to a managing or possessory conservator of a child, the managing or possessory conservator must submit to the Claim Administrator, with the claim form, proof of payment of the expenses and a certified copy of the court order naming that person the managing or possessory conservator.

The Claim Administrator for the Health Benefit Plan may deduct from its benefit payment any amounts it is owed by the recipient of the payment. Payment to you or your Provider, or deduction by the Plan from benefit payments of amounts owed to it, will be considered in satisfaction of its obligations to you under the Plan.

An *Explanation of Benefits* summary is sent to you so you will know what has been paid.

When to Submit Claims

All claims for benefits under the Health Benefit Plan must be properly submitted to the Claim Administrator within twelve (12) months of the date you receive the services or supplies. Claims submitted and received by the Claim Administrator after that date will not be considered for payment of benefits except in the absence of legal capacity.

Receipt of Claims by the Claim Administrator

A claim will be considered received by the Claim Administrator for processing upon actual delivery to the Administrative Office of the Claim Administrator in the proper manner and form and with all of the information required. If the claim is not complete, it may be denied or the Claim Administrator may contact either you or the Provider for the additional information.

After processing the claim, the Claim Administrator will notify the Participant by way of an *Explanation of Benefits* summary.

Review of Claim Determinations

Claim Determinations

When the Claim Administrator receives a properly submitted claim, it has authority and discretion under the Plan to interpret and determine benefits in accordance with the Health Benefit Plan provisions. The Claim Administrator will receive and review claims for benefits and will accurately process claims consistent with administrative practices and procedures established in writing between the Claim Administrator and the Plan Administrator.

You have the right to seek and obtain a full and fair review of your claim in accordance with the benefits and procedures detailed in your Health Benefit Plan.

Timing of Required Notices and Extensions for Initial Determinations

Separate schedules apply to the timing of required notices and extensions, depending on the type of Claim. There are four types of Claims as described below.

1. **Urgent Care Clinical Claim** is any Pre-Service Claim that requires Prior Authorization, as described in this Benefit Booklet, for benefits for medical care or Treatment with respect to which the application of regular time

periods for making health Claim decisions could seriously jeopardize the life or health of the claimant or the ability of the claimant to regain maximum function or, in the opinion of a Physician with knowledge of the claimant's medical condition, would subject the claimant to severe pain that cannot be adequately managed without the care or Treatment.

2. **Pre-Service Claim** is any non-urgent request for benefits with respect to which the terms of the benefit plan condition receipt of the benefit on approval of the benefit in advance of obtaining medical care.

3. **Concurrent Care Claim** is a claim for a health benefit which the Claim Administrator, after having previously approved an ongoing course of treatment provided over a period of time or a specific number of treatments, subsequently reduces or terminates coverage for the treatments (other than by Plan amendment or termination) or a request to extend the course of the treatment beyond what was previously approved that is an Urgent Care Clinical Claim.

4. **Post-Service Claim** is any other claim for a benefit for a service that has been provided to you. Your Claim must be in a form acceptable to the Claim Administrator. Your Claim must include full details of the service received, including your name, age, sex, identification number, the name and address of the Provider, an itemized statement of the service rendered or furnished, the date of service, the diagnosis, the Claim charge, and any other information which the Claim Administrator may request in connection with services rendered to you.

The following table summarizes the applicable deadlines and extension periods for each type of claim:

	Urgent Care Claims	**Pre-Service Claims**	**Post-Service Claims**	**Concurrent Care Claims**
What is the general deadline for initial determination?	No later than 72 hours from receipt of the claim	15 calendar days from receipt of the claim	30 calendar days from receipt of the claim	Must be provided sufficiently in advance to give you an opportunity to appeal and obtain a decision before the previously approved treatment is reduced or terminated. A request to extend an approved course of treatment that is an Urgent Care Clinical Claim will receive a response within 24 hours, if the request is made at least 24 hours prior to the expiration of the previously approved period or number of treatments. **Note:** If such request for extension is not made at least 24 hours prior to the expiration of the previously approved period of time or number of treatments, then the claim will be handled as an Urgent Care Clinical Claim. If a request to extend a course of treatment is not an Urgent Care Clinical Claim, the request may be treated as a new Pre-Service or Post-Service claim depending on the circumstances.
Are there any extensions?	No, but see below for extensions based on insufficient information	Yes. One 15 calendar day extension is allowed if the Claim Administrator determines it is necessary due to matters beyond its control and informs you of the extension within the initial 15 calendar day timeframe.	Yes. One 15 calendar day extension is allowed if the Claim Administrator determines it is necessary due to matters beyond its control and informs you of the extension within the initial 30 calendar day timeframe.	No

	Urgent Care Claims	Pre-Service Claims	Post-Service Claims	Concurrent Care Claims
What if additional information is needed?	You must be notified of the need for additional information to decide the claim within 24 hours of receipt of the claim. You must be given at least 48 hours to respond.	If an extension is necessary because you failed to provide information necessary to decide the claim, notice of extension must specify the information needed. You must be given at least 45 calendar days to respond. The running of time for the initial claims determination is suspended until the end of the prescribed response period or until the information is received, whichever is earlier.	If an extension is necessary because you failed to provide information necessary to decide the claim, notice of extension must specify the information needed. You must be given at least 45 calendar days to respond. The running of time for the initial claims determination is suspended until the end of the prescribed response period or until the information is received, whichever is earlier.	Not applicable
What is the deadline if additional information is needed?	You must be notified of the decision no later than 48 hours after the earlier of: 1) the Claim Administrator's receipt of the requested information; or 2) the end of the prescribed response period.	If there is an extension, you must be notified of the decision no later than 15 calendar days after the Claim Administrator receives a response to the request for information or 15 calendar days after the end of the deadline for you to provide the information, whichever is earlier.	If there is an extension, you must be notified of the decision no later than 15 calendar days after the Claim Administrator receives a response to the request for information or 15 calendar days after the end of the deadline for you to provide the information, whichever is earlier.	

NOTE: Improperly Filed Claims. For Pre-Service Claims which name a specific claimant, medical condition, and service or supply for which approval is requested and which are submitted to a representative of the Claim Administrator responsible for handling benefit matters, but which otherwise fail to follow the procedures for filing Pre-Service Claims, you will be notified on the failure within 5 days (within 24 hours in the case of an Urgent Care Claim) and of the proper procedures to be followed. The notice may be oral, but you may also request a written notice.

If a Claim Is Denied or Not Paid in Full

On occasion, the Claim Administrator may deny all or part of your claim. There are a number of reasons why this may happen. We suggest that you first read the *Explanation of Benefits* summary prepared by the Claim Administrator; then review this Benefit Booklet to see whether you understand the reason for the determination. If you have additional information that you believe could change the decision, send it to the Claim Administrator and request a review of the decision as described in **Claim Appeal Procedures** below.

If the claim is denied in whole or in part, you will receive a written notice from the Claim Administrator with the following information, if applicable:

- The reasons for the determination;
- A reference to the Health Benefit Plan provisions on which the determination is based;
- A description of additional information which may be necessary to perfect the claim and an explanation of why such material is necessary;

- Information sufficient to identify the claim including the date of service, health care provider, claim amount (if applicable), denial codes with their meanings and the standards used. Upon request, diagnosis/treatment codes with their meanings and the standards used are also available;
- An explanation of the internal review/appeals and external review processes available to you (and how to initiate an internal review or external review) and applicable time limits, information on any voluntary appeal procedures offered by the Plan, and a statement of your right, if any, to bring a civil action under Section 502(a) of ERISA following a final denial on internal review and the timeframe within which such action must be filed;
- In certain situations, a statement in non-English language(s) that written notice of claim denials and certain other benefit information may be available (upon request) in such non-English language(s);
- In certain situations, a statement in non-English language(s) that indicates how to access the language services provided by the Claim Administrator;
- The right to request, free of charge, reasonable access to and copies of all documents, records and other information relevant to the claim for benefits;
- Any internal rule, guideline, protocol or other similar criterion relied on in the determination, or a statement that a copy of such rule, guideline, protocol or other similar criterion will be provided free of charge upon request;
- An explanation of the scientific or clinical judgment relied on in the determination as applied to claimant's medical circumstances, if the denial was based on medical necessity, experimental treatment or similar exclusion, or a statement that such explanation will be provided free of charge upon request;
- In the case of a denial of an Urgent Care Clinical Claim, a description of the expedited internal and external review procedures applicable to such claims. An Urgent Care Clinical Claim decision may be provided orally, so long as a written notice is furnished to the claimant within three days of oral notification;
- Contact information for any applicable office of health insurance consumer assistance or ombudsman.

Claim Review/Appeal Procedures

Claim Appeal Procedures - Definitions

An "**Adverse Benefit Determination**" means a denial, reduction, or termination of, or a failure to provide or make payment (in whole or in part) for, a benefit, including any such denial, reduction, termination, or failure to provide in response to a claim, Pre-Service Claim or Urgent Care Clinical Claims, or make payment for, a benefit resulting from the application of any utilization review, as well as a failure to cover an item or service for which benefits are otherwise provided because it is determined to be experimental or investigational or not medically necessary or appropriate. If an ongoing course of treatment had been approved by the Claim Administrator and the Claim Administrator reduces or terminates such treatment (other than by amendment or termination of the Employer's benefit plan) before the end of the approved treatment period, that is also an Adverse Benefit Determination.

A "**Final Internal Adverse Benefit Determination**" means an Adverse Benefit Determination that has been upheld by the Claim Administrator at the completion of the internal review/appeal process of an Adverse Benefit Determination with respect to which the internal review/appeal process has been deemed exhausted.

Note: Expedited Internal Review of Urgent Care Claims

If your claim is an Urgent Care Claim, you have the right to an expedited review. You also have the right to request an expedited external review of your Urgent Care Claim at the same time you request expedited internal review.

How to Request a Drug List Exception

Please refer to the **PHARMACY BENEFITS** section for information on requesting a Drug List Exception.

How to Appeal an Adverse Benefit Determinations

You have the right to seek and obtain a full and fair internal review of your claim and an Adverse Benefit Determination in accordance with the benefits and procedures detailed below and in your Plan.

An appeal of an Adverse Benefit Determination may be filed by you or a person authorized to act on your behalf. In Urgent Care Clinical Claim situations, a health care provider may appeal on your behalf. With the exception of Urgent Care Clinical Claim situations, your designation of a representative must be in writing as it is necessary to protect against disclosure of information about you except to your authorized representative. To obtain an Authorized Representative Form, you or your representative may call the Claim Administrator at the number on the back of your Identification Card.

If you believe the Claim Administrator incorrectly denied all or part of your benefits, you may have your claim reviewed. The Claim Administrator will review its decision in accordance with the following procedure:

- Within 180 days after you receive notice of a denial or partial denial of your claim, you must call or write to the Claim Administrator's Administrative Office. The Claim Administrator will need to know the reasons why you do not agree with the denial or partial denial. Send your appeal request to:

  Claim Review Section
  Blue Cross and Blue Shield of Texas
  P. O. Box 660044
  Dallas, Texas 75266-0044

- The Claim Administrator will honor telephone requests for information. However, such inquiries will not constitute a request for review.
- In support of your claim review, you have the option of presenting evidence and testimony to the Claim Administrator. You and your authorized representative may ask to review your file and any relevant documents and may submit written issues, comments and additional medical information during the internal review process.

  The Claim Administrator will provide you or your authorized representative with any new or additional evidence or rationale and any other information and documents used in the internal review of your claim without regard to whether such information was considered in the initial determination. No deference will be given to the initial Adverse Benefit Determination. Such new or additional evidence or rationale will be provided to you or your authorized representative sufficiently in advance of the date a Final Internal Adverse Benefit Determination on the appeal is made in order to give you a chance to respond before the final determination is made. If the information is received so late that it would be impossible to provide it to you in time for you to have a reasonable opportunity to respond, the time periods below for providing notice of Final Internal Adverse Benefit Determination will be tolled until such time as you have had a reasonable opportunity to respond. After you respond, or have had a reasonable opportunity to respond but failed to do so, the Claim Administrator will notify you of the benefit determination in a reasonably prompt time taking into account the medical exigencies.

  The appeal determination will be made by the Claim Administrator or, if required by a Physician associated or contracted with the Claim Administrator and/or by external advisors, who were not involved in making the initial denial of your claim and the individuals who made the Adverse Benefit Determination will not conduct the appeal. Before you or your authorized representative may bring any action to recover benefits you must exhaust the appeal process and must raise all issues with respect to a claim and must file an appeal or appeals and the appeals must be finally decided by the Claim Administrator.
- If you have any questions about the claims procedures or the review procedure, write to the Claim Administrator's Administrative Office or call the toll-free Customer Service Helpline number shown in this Benefit Booklet or on your Identification Card.

If you don't appeal on time, you lose your right to later object to the decision on the claim.

Timing of Appeal Determinations - Note: Your Plan provides for one level of internal review

	Urgent Care Claim	**Pre-Service Claim**	**Post-Service Claim**
Deadline by which a claimant will be notified of an appeals decision	As soon as possible taking into account the medical exigencies, but no more than 72 hours after receipt of the request for review. **Note:** The request may be submitted in writing or orally.	Not later than 30 days after receipt of the request for review. (Not later than 15 days for each level if your Plan offers two levels of Internal review.)	Not later than 60 days after receipt of the request for review. (Not later than 30 days for each level if your Plan offers two levels of internal review).

Notice of Appeal Determination

The Claim Administrator will notify the party filing the appeal, you, and, if a clinical appeal, any health care provider who recommended the services involved in the appeal, by a written notice of the determination.

The written notice to you or your authorized representative will include:

1. A reason for the determination;
2. A reference to the benefit Plan provisions on which the determination is based, and the contractual, administrative or protocol for the determination;
3. Information sufficient to identify the claim including the date of service, health care provider, claim amount (if applicable), denial codes with their meanings and the standards used. Diagnosis/treatment codes with their meanings and the standards used are also available upon request;
4. An explanation of the external review processes (and how to initiate an external review) and a statement of your right, if any, to bring a civil action under Section 502(a) of ERISA following a final denial on internal review and the timeframe within which such action must be filed;
5. In certain situations, a statement in non-English language(s) that written notice of claim denials and certain other benefit information may be available (upon request) in such non-English language(s);
6. In certain situations, a statement in non-English language(s) that indicates how to access the language services provided by the Claim Administrator;
7. The right to request, free of charge, reasonable access to and copies of all documents, records and other information relevant to the claim for benefits;
8. Any internal rule, guideline, protocol or other similar criterion relied on in the determination, or a statement that a copy of such rule, guideline, protocol or other similar criterion will be provided free of charge on request;
9. An explanation of the scientific or clinical judgment relied on in the determination, or a statement that such explanation will be provided free of charge upon request;
10. A description of the standard that was used in denying the claim and a discussion of the decision;
11. Contact information for any applicable office of health insurance consumer assistance or ombudsman.

If the Claim Administrator's decision is to continue to deny or partially deny your claim or you do not receive timely decision and your claim meets the External Review Criteria below, you have the right to request an external review of your claim by an independent third party, who will review the denial and issue a final decision. Your external review rights are described in the **Standard External Review** subsection below.

If You Need Assistance

If you have any questions about the claims procedures or the review procedure, write or call the Claim Administrator Headquarters at 1-877-269-1180. The Claim Administrator Customer Service Helpline is accessible from 8:00 A.M. to 8:00 P.M., Monday through Friday.

Claim Review Section
Blue Cross and Blue Shield of Texas
P. O. Box 660044
Dallas, Texas 75266-0044

If you need assistance with the internal claims and appeals or the external review processes that are described below, you may call the number on the back of your Identification Card for contact information. In addition, for questions about your appeal rights or for assistance, you can contact the Employee Benefits Security Administration at 1- 866-444-EBSA (3272).

External Review Criteria

External Review is available for Adverse Benefit Determinations and Final Adverse Benefit Determinations that involve rescission and determinations that involve medical judgment including, but not limited to, those based on requirements for medical necessity, appropriateness, health care setting, level of care, or effectiveness or a covered benefit; determinations that a treatment is experimental or investigational; determinations whether you are entitled to a reasonable alternative standard for a reward under a wellness program; or a determination of compliance with the nonquantitative treatment limitation provisions of the Mental Health Parity and Addiction Equity Act.

Standard External Review

You or your authorized representative (as described above) may make a request for a standard external review or expedited external review of an Adverse Benefit Determination or Final Internal Adverse Benefit Determination by an Independent Review Organization (IRO).

1. **Request for external review.** Within four months after the date of receipt of a notice of an Adverse Benefit Determination or Final Internal Adverse Benefit Determination from the Claim Administrator, you or your authorized representative must file your request for standard external review.
2. **Preliminary review.** Within five business days following the date of receipt of the external review request, the Claim Administrator must complete a preliminary review of the request to determine whether:
   a. You are, or were, covered under the plan at the time the health care item or service was requested or, in the case of a retrospective review, was covered under the plan at the time the health care item or service was provided;

   b. The Adverse Benefit Determination or the Final Adverse Internal Benefit Determination does not relate to your failure to meet the requirements for eligibility under the terms of the plan (e.g., worker classification or similar determination);

   c. You have exhausted the Claim Administrator's internal appeal process unless you are not required to exhaust the internal appeals process under the interim final regulations. Please read the **Exhaustion** subsection below for additional information and exhaustion of the internal appeal process; and

   d. You or your authorized representative have provided all the information and forms required to process an external review.

   You will be notified within one business day after we complete the preliminary review if your request is eligible or if further information or documents are needed. You will have the remainder of the four month external review request period (or 48 hours following receipt of the notice), whichever is later, to perfect the request for external review. If your claim is not eligible for external review, we will outline the reasons it is ineligible in the notice, and provide contact information for the Department of Labor's Employee Benefits Security Administration (toll-free number 1-866-444-EBSA (3272)).

3. **Referral to Independent Review Organization (IRO).** When an eligible request for external review is completed within the time period allowed, the Claim Administrator will assign the matter to an IRO. The IRO assigned will be accredited by URAC or by similar nationally-recognized accrediting organization. Moreover, the Claim Administrator will ensure that the IRO is unbiased and independent. Accordingly, the Claim Administrator must contract with at least three IROs for assignments under the plan and rotate claims assignments among them (or incorporate other independent, unbiased methods for selection of IROs, such as random selection). In addition, the IRO may not be eligible for any financial incentives based on the likelihood that the IRO will support the denial of benefits. The IRO must provide the following:
   a. Utilization of legal experts where appropriate to make coverage determinations under the plan.

   b. Timely notification to you or your authorized representative, in writing, of the request's eligibility and acceptance for external review. This notice will include a statement that you may submit in writing to the assigned IRO within 10 business days following the date of receipt of the notice additional information that the IRO must consider when conducting the external review. The IRO is not required to, but may, accept and consider additional information submitted after 10 business days.

   c. Within five business days after the date of assignment of the IRO, the Claim Administrator must provide to the assigned IRO the documents and any information considered in making the Adverse Benefit Determination or Final Internal Adverse Benefit Determination. Failure by the Claim Administrator to timely provide the documents and information must not delay the conduct of the external review. If the Claim Administrator fails to timely provide the documents and information, the assigned IRO may terminate the external review and make a decision to reverse the Adverse Benefit Determination or Final Internal Adverse Benefit Determination. Within one business day after making the decision, the IRO must notify the Claim Administrator and you or your authorized representative.

d. Upon receipt of any information submitted by you or your authorized representative, the assigned IRO must within one business day forward the information to the Claim Administrator. Upon receipt of any such information, the Claim Administrator may reconsider the Adverse Benefit Determination or Final Internal Adverse Benefit Determination that is the subject of the external review. Reconsideration by the Claim Administrator must not delay the external review. The external review may be terminated as a result of the reconsideration only if the Claim Administrator decides, upon completion of its reconsideration, to reverse the Adverse Benefit Determination or Final Internal Adverse Benefit Determination and provide coverage or payment. Within one business day after making such a decision, the Claim Administrator must provide written notice of its decision to you and the assigned IRO. The assigned IRO must terminate the external review upon receipt of the notice from the Claim Administrator.

e. Review all of the information and documents timely received. In reaching a decision, the assigned IRO will review the claim de novo and not be bound by any decisions or conclusions reached during the Claim Administrator's internal claims and appeals process. In addition to the documents and information provided, the assigned IRO, to the extent the information or documents are available and the IRO considers them appropriate, will consider the following in reaching a decision:

(1) Your medical records;

(2) The attending health care professional's recommendation;

(3) Reports from appropriate health care professionals and other documents submitted by the Claim Administrator, you, or your treating provider;

(4) The terms of your plan to ensure that the IRO's decision is not contrary to the terms of the plan, unless the terms are inconsistent with applicable law;

(5) Appropriate practice guidelines, which must include applicable evidence-based standards and may include any other practice guidelines developed by the Federal government, national or professional medical societies, boards, and associations;

(6) Any applicable clinical review criteria developed and used by the Claim Administrator, unless the criteria are inconsistent with the terms of the plan or with applicable law; and

(7) The opinion of the IRO's clinical reviewer or reviewers after considering information described in this notice to the extent the information or documents are available and the clinical reviewer or reviewers consider appropriate.

f. Written notice of the final external review decision must be provided within 45 days after the IRO receives the request for the external review. The IRO must deliver the notice of final external review decision to the Claim Administrator and you or your authorized representative.

g. The notice of final external review decision will contain:

(1) A general description of the reason for the request for external review, including information sufficient to identify the claim (including the date or dates of service, the health care provider, the claim amount (if applicable), the diagnosis code and its corresponding meaning, the treatment code and its corresponding meaning, and the reason for the previous denial);

(2) The date the IRO received the assignment to conduct the external review and the date of the IRO decision;

(3) References to the evidence or documentation, including the specific coverage provisions and evidence-based standards, considered in reaching its decision;

(4) A discussion of the principal reason or reasons for its decision, including the rationale for its decision and any evidence-based standards that were relied on in making its decision;

(5) A statement that the determination is binding except to the extent that other remedies may be available under State or Federal law to either the Claim Administrator or you or your authorized representative;

(6) A statement that judicial review may be available to you or your authorized representative; and

(7) Current contact information, including phone number, for any applicable office of health insurance consumer assistance or ombudsman established under PHS Act section 2793.

h. After a final external review decision, the IRO must maintain records of all claims and notices associated with the external review process for six years. An IRO must make such records available for examination by the Claim Administrator, State or Federal oversight agency upon request, except where such disclosure would violate State or Federal privacy laws, and you or your authorized representative.

4. **Reversal of plan's decision.** Upon receipt of a notice of a final external review decision reversing the Adverse Benefit Determination or Final Internal Adverse Benefit Determination, the Claim Administrator must immediately provide coverage or payment (including immediately authorizing or immediately paying benefits) for the claim.

Expedited External Review

1. **Request for expedited external review.** You may request for an expedited external review with the Claim Administrator at the time you receive:

   a. An Adverse Benefit Determination, if the Adverse Benefit Determination involved a medical condition of yours for which the timeframe for completion of an expedited internal appeal under the interim final regulations would seriously jeopardize your life or health or would jeopardize your ability to regain maximum function and you have filed a request for an expedited internal appeal; or

   b. A Final Internal Adverse Benefit Determination, if the determination involved a medical condition of yours for which the timeframe for completion of a standard external review would seriously jeopardize your life or health or would jeopardize your ability to regain maximum function, or if the Final Internal Adverse Benefit Determination concerns an admission, availability of care, continued stay, or health care item or service for which you received emergency services, but have not been discharged from a facility.

2. **Preliminary review**. Immediately upon receipt of the request for expedited external review, the Claim Administrator must determine whether the request meets the reviewability requirements set forth in the **Standard External Review** subsection above. The Claim Administrator must immediately send you a notice of its eligibility determination that meets the requirements set forth in **Standard External Review** subsection above.

3. **Referral to Independent Review Organization (IRO).** Upon a determination that a request is eligible for external review following the preliminary review, the Claim Administrator will assign an IRO pursuant to the requirements set forth in the **Standard External Review** subsection above. The Claim Administrator must provide or transmit all necessary documents and information considered in making the Adverse Benefit Determination or Final Internal Adverse Benefit Determination to the assigned IRO electronically or by telephone or facsimile or any other available expeditious method. The assigned IRO, to the extent the information or documents are available and the IRO considers them appropriate, must consider the information or documents described above under the procedures for standard review. In reaching a decision, the assigned IRO must review the claim de novo and is not bound by any decisions or conclusions reached during the Claim Administrator's internal claims and appeals process.

4. **Notice of final external review decision.** The assigned IRO will provide notice of the final external review decision, in accordance with the requirements set forth in the **Standard External Review** subsection above, as expeditiously as your medical condition or circumstances require, but in no event more than 72 hours after the IRO receives the request for an expedited external review. If the notice is not in writing, within 48 hours after the date of providing verbal notice, the assigned IRO must provide written confirmation of the decision to the Claim Administrator and you or your authorized representative.

Exhaustion

For standard internal review, you have the right to request external review once the internal review process has been completed and you have received the Final Internal Adverse Benefit Determination. For expedited internal review, you may request external review simultaneously with the request for expedited internal review. The IRO will determine whether or not your request is appropriate for expedited external review or if the expedited internal review process must be completed before external review may be requested.

You will be deemed to have exhausted the internal review process and may request external review if the Claim Administrator waives the internal review process or the Claim Administrator has failed to comply with the internal claims and appeals process other than a de minimis failure. In the event you have been deemed to exhaust the internal review process due to the failure by the Claim Administrator to comply with the internal claims and appeals process other than a de minimis failure, you also have the right to pursue any available remedies under 502(a) of ERISA or under State law.

The internal review process will not be deemed exhausted based on *de minimis* violations that do not cause, and are not likely to cause, prejudice or harm to you so long as the Claim Administrator demonstrates that the violation was for good cause or due to matters beyond the control of the Claim Administrator and that the violation occurred in the context of an ongoing, good faith exchange of information between you and the Claim Administrator.

External review may not be requested for an Adverse Benefit Determination involving a claim for benefits for a health care service that you have already received until the internal review process has been exhausted.

Except as described above, you must exhaust the mandatory levels of appeal before you request external review or seek other legal recourse.

Interpretation of Employer's Plan Provisions

The Plan Administrator has given the Claim Administrator the final authority to establish or construe the terms and conditions of the Health Benefit Plan and the discretion to interpret and determine benefits in accordance with the Health Benefit Plan's provisions.

The Plan Administrator has all powers and authority necessary or appropriate to control and manage the operation and administration of the Health Benefit Plan, including but not limited to, a person's eligibility to be covered under the Health Benefit Plan.

All powers to be exercised by the Claim Administrator or the Plan Administrator shall be exercised in a non-discriminatory manner and shall be applied uniformly to assure similar treatment to persons in similar circumstances.

ELIGIBLE EXPENSES, PAYMENT OBLIGATIONS, AND BENEFITS

Eligible Expenses

The Plan provides coverage for the following categories of Eligible Expenses:

- Inpatient Hospital Expenses
- Medical-Surgical Expenses
- Extended Care Expenses
- Special Provisions Expenses
- Pharmacy Expenses

Wherever Schedule of Coverage is mentioned, please refer to your Schedule(s) in this Benefit Booklet. Your benefits are calculated on a Plan Year benefit period basis unless otherwise stated. At the end of a Plan Year, a new benefit period starts for each Participant.

Copayment Amounts

Some of the care and treatment you receive under the Plan will require that a Copayment Amount be paid at the time you receive the services. Refer to your Schedule of Coverage under "Copayment Amounts Required" for your specific Plan information.

A Copayment Amount as indicated on your Schedule of Coverage will be required for each Physician office visit charge you incur when services are received by a family practitioner, a general practitioner, an obstetrician/gynecologist, a pediatrician, an internist or a Professional Other Provider and defined in the **DEFINITIONS** section of this Benefit Booklet. A Copayment Amount is required for the initial office visit for Maternity Care, but will not be required for subsequent visits.

A different Copayment Amount as indicated on your Schedule of Coverage will be required for each Physician office visit charge you incur when services are received by a Specialty Care Provider as classified by the American Board of Medical Specialties as a Specialty Care Provider.

In-Network ***Preventive Care Services*** are not subject to this Copayment Amount provision.

The following services are not payable under this Copayment Amount provision but instead are considered Medical-Surgical Expense, subject to the Deductible, if applicable, and Co-Share Amounts shown on your Schedule of Coverage:

- any services provided during the office visit or at the time of consultation (i.e., lab and x-ray services);
- physical therapy billed separately from an office visit;
- occupational modalities in conjunction with physical therapy;
- therapeutic injections;
- any services requiring Prior Authorization;
- Certain Diagnostic Procedures;
- services provided by an Independent Lab, Imaging Center, radiologist, pathologist, and anesthesiologist;
- outpatient treatment therapies or services such as radiation therapy, chemotherapy, and renal dialysis.

A Copayment Amount will be required for facility charges for each Hospital outpatient emergency room visit. If admitted to the Hospital as a direct result of the emergency condition or accident, the Copayment Amount will be waived.

A Copayment Amount, if shown on your Schedule of Coverage, will be required for each visit to a Retail Health Clinic.

A Copayment Amount, if shown on your Schedule of Coverage, will be required for each Virtual Visit.

Deductibles

The benefits of the Plan will be available after satisfaction of the applicable Deductibles as shown on your Schedule of Coverage. The Deductibles are explained as follows:

Plan Year Deductible: The individual Deductible amount shown under "Deductibles" on your Schedule of Coverage must be satisfied by each Participant under your coverage each Plan Year.

The following are exceptions to the Deductibles described above: In-

Network ***Preventive Care Services*** are not subject to Deductibles.

If you have several covered Dependents, all charges used to apply toward an "individual" Deductible amount will be applied toward the "family" Deductible amount shown on your Schedule of Coverage. When that family Deductible amount is reached, no further individual Deductibles will have to be satisfied for the remainder of that Plan Year. No Participant will contribute more than the individual Deductible amount to the "family" Deductible amount.

Eligible Expenses applied toward satisfying the "individual" and "family" In-Network Deductible will only apply to the In-Network Deductible. Eligible Expenses applied toward satisfying the "individual" and "family" Out-of-Network Deductible will only apply to the Out-of-Network Deductible.

Co-Share Stop-Loss Amount

Most of your Eligible Expense payment obligations including Copayment Amounts and Deductibles are considered Co-Share Amounts and are applied to the Co-Share Stop-Loss Amount maximum.

Your Co-Share Stop-Loss Amount will **not** include:

- Services, supplies, or charges limited or excluded by the Plan;
- Expenses not covered because a benefit maximum has been reached;
- Any Eligible Expenses paid by the Primary Plan when the Plan is the Secondary Plan for purposes of coordination of benefits;
- Penalties applied for failure to obtain Prior Authorization;
- Any pricing differences between the cost of brand name drugs and their generic equivalents that you pay under pharmacy benefits.

Individual Co-Share Stop-Loss Amount

When the Co-Share Amount for the In-Network or Out-of-Network Benefits level for a Participant in a Plan Year equals the "individual" "Co-Share Stop-Loss Amount" shown on your Schedule of Coverage for that level, the benefit percentages automatically increase to 100% for purposes of determining the benefits available for additional Eligible Expenses incurred by that Participant for the remainder of that Plan Year for that level.

Family Co-Share Stop-Loss Amount

When the Co-Share Amount for the In-Network or Out-of-Network Benefits level for all Participants under your coverage in a Plan Year equals the "family" "Co-Share Stop-Loss Amount" shown on your Schedule of Coverage for that level, the benefit percentages automatically increase to 100% for purposes of determining the benefits available for additional Eligible Expenses incurred by all family Participants for the remainder of that Plan Year for that level. No Participant will be required to contribute more than the individual Co-Share Stop-Loss Amount to the family "Co-Share Stop-Loss Amount."

The following are exceptions to the Co-Share Stop-Loss Amounts described above:

There are separate Co-Share Stop-Loss Amounts for In-Network Benefits and Out-of-Network Benefits.

Eligible Expenses applied toward satisfying the "individual" and "family" In-Network Co-Share Stop-Loss Amount maximum will only apply to the In-Network Co-Share Stop-Loss Amount maximum. Eligible Expenses applied toward satisfying the "individual" and "family" Out-of-Network Co-Share Stop-Loss Amount maximum will only apply to the Out-of-Network Co-Share Stop-Loss Amount maximum.

Changes In Benefits

Changes to covered benefits will apply to all services provided to each Participant under the Plan. Benefits for Eligible Expenses incurred during an admission in a Hospital or Facility Other Provider that begins before the change will be those benefits in effect on the day of admission.

COVERED MEDICAL SERVICES

Inpatient Hospital Expenses

The Plan provides coverage for Inpatient Hospital Expenses for you and your eligible Dependents. Each inpatient Hospital Admission requires Prior Authorization. Refer to the **UTILIZATION MANAGEMENT** section of this Benefit Booklet for additional information.

The benefit percentage of your total eligible Inpatient Hospital Expense, in excess of any Deductible, shown under "Inpatient Hospital Expenses" on your Schedule of Coverage is the Plan's obligation. The remaining unpaid Inpatient Hospital Expense, in excess of any Deductible, is your obligation to pay. This excess amount will be applied to the Co-Share Amounts.

Services and supplies provided by an Out-of-Network Provider will receive In-Network Benefits when those services and supplies are not available from a Network Provider provided the Claim Administrator acknowledges your visit to an Out-of-Network Provider **prior** to the visit. Otherwise, Out-of-Network Benefits will be paid and the claim will have to be resubmitted for review and adjustment, if appropriate.

Refer to your Schedule of Coverage for information regarding Deductibles, Co-Share percentages, and penalties for failure to obtain Prior Authorization that may apply to your coverage.

Medical-Surgical Expenses

The Plan provides coverage for Medical-Surgical Expense for you and your covered Dependents. Some services require Prior Authorization. Refer to the **UTILIZATION MANAGEMENT** section of this Benefit Booklet for more information.

Copayment Amounts must be paid to your Network Physician or other Network Providers at the time you receive services.

The benefit percentages of your total eligible Medical-Surgical Expense shown under "Medical-Surgical Expenses" on your Schedule of Coverage in excess of your Copayment Amounts, Co-Share Amounts, and any applicable Deductibles shown are the Plan's obligation. The remaining unpaid Medical-Surgical Expense in excess of the Copayment Amounts, Co-Share Amounts, and any Deductibles is your obligation to pay.

Medical-Surgical Expense shall include:

1. Services of Physicians and Professional Other Providers.

2. Consultation services of a Physician and Professional Other Provider.

3. Services of a certified registered nurse-anesthetist (CRNA).

4. Diagnostic x-ray and laboratory procedures.

5. Radiation therapy.

6. Rental of durable medical equipment required for therapeutic use unless purchase of such equipment is required by the Plan. The term "durable medical equipment (DME)" shall not include:

   a. Equipment primarily designed for alleviation of pain or provision of patient comfort; or
   b. Home air fluidized bed therapy.

   Examples of non-covered equipment include, but are not limited to, air conditioners, air purifiers, humidifiers, physical fitness equipment, and whirlpool bath equipment.

7. For Emergency Care, professional local ground ambulance transportation or air ambulance transportation to the nearest Hospital appropriately equipped and staffed for treatment of the Participant's condition. Non-emergency ground ambulance transportation from one acute care Hospital to another acute care Hospital for diagnostic or therapeutic services (e.g., MRI, CT scans, acute interventional cardiology, intensive care unit services, etc.) may be considered Medically Necessary when specific criteria are met. The non-emergency ground ambulance transportation to or from a Hospital or medical facility, outside of the acute care Hospital setting, may be considered Medically Necessary when the Participant's condition is such that trained ambulance attendants are required to monitor the Participant's clinical status (e.g., vital signs and oxygenation), or provide treatment such as oxygen, intravenous fluids or medications, in order to safely transport the Participant, or the Participant is confined to bed and cannot be safely transported by any other means. Non-emergency ground ambulance transportation services provided primarily for the convenience of the Participant, the Participant's family/caregivers or Physician, or the transferring facility are considered not Medically Necessary.

   Non-emergency air ambulance transportation means transportation from a Hospital emergency department, health care facility, or Inpatient setting to an equivalent or higher level of acuity facility may be considered Medically Necessary when the Participant requires acute Inpatient care and services are not available at the originating facility and commercial air transport or safe discharge cannot occur. Non-emergency air ambulance transportation services provided primarily for the convenience of the Participant, the Participant's family/caregivers or Physician, or the transferring facility are considered not Medically Necessary.

8. Anesthetics and its administration, when performed by someone other than the operating Physician or Professional Other Provider.

9. Oxygen and its administration provided the oxygen is actually used.

10. Blood, including cost of blood, blood plasma, and blood plasma expanders, which is not replaced by or for the Participant.

11. Prosthetic Appliances, including replacements necessitated by growth to maturity of the Participant.

12. Orthopedic braces (i.e., an orthopedic appliance used to support, align, or hold bodily parts in a correct position) and crutches, including rigid back, leg or neck braces, casts for treatment of any part of the legs, arms, shoulders, hips or back; special surgical and back corsets, Physician-prescribed, directed, or applied dressings, bandages, trusses, and splints which are custom designed for the purpose of assisting the function of a joint.

13. Home Infusion Therapy.

14. Services or supplies used by the Participant during an outpatient visit to a Hospital, a Therapeutic Center, or a Substance Use Disorder Treatment Center, or scheduled services in the outpatient treatment room of a Hospital.

15. Certain Diagnostic Procedures.

16. Outpatient Contraceptive Services. NOTE: Prescription contraceptive medications are covered under the **PHARMACY BENEFITS** portion of your Plan.

17. Telehealth Services and Telemedicine Medical Services.

18. Foot care in connection with an illness, disease, or condition, such as but not limited to peripheral neuropathy, chronic venous insufficiency, and diabetes.

19. Drugs that have not been approved by the FDA for self-administration when injected, ingested or applied in a Physician's or Professional Other Provider's office.

20. Elective Abortions.

21. Elective Sterilizations.

22. Acupuncture.

Extended Care Expenses

The Plan also provides benefits for Extended Care Expenses for you and your covered Dependents. Certain Extended Care Expenses require Prior Authorization. Refer to the **UTILIZATION MANAGEMENT** section of this Benefit Booklet for more information.

The Plan's benefit obligation as shown on your Schedule of Coverage will be:

1. At the benefit percentage under "Extended Care Expenses," and
2. Up to the number of days or visits shown for each category of Extended Care Expenses on your Schedule of Coverage.

All payments made by the Plan, whether under the In-Network or Out-of-Network Benefit level, will apply toward the benefit maximums under both levels of benefits.

The benefit maximums will also include any benefits provided to a Participant for Extended Care Expenses under a Health Benefit Plan held by the Employer with the Claim Administrator immediately prior to the Participant's Effective Date of coverage under the Plan.

Any unpaid Extended Care Expenses in excess of the benefit maximums shown on your Schedule of Coverage will not be applied to any Co-Share Stop-Loss Amount.

Any charges incurred as Home Health Care or home Hospice Care for drugs (including antibiotic therapy) and laboratory services will not be Extended Care Expenses but will be considered Medical-Surgical Expenses.

Services and supplies for Extended Care Expenses:

1. For Skilled Nursing Facility:
   a. All usual nursing care by a Registered Nurse (R.N.), Advanced Practice Nurse (A.P.N.), or by a Licensed Vocational Nurse (L.V.N.);
   b. Room and board and all routine services, supplies, and equipment provided by the Skilled Nursing Facility;
   c. Physical, occupational, speech, and respiratory therapy services by licensed therapists.
2. For Home Health Care:
   a. Part-time or intermittent nursing care by a Registered Nurse (R.N.), Advanced Practice Nurse (A.P.N.), or by a Licensed Vocational Nurse (L.V.N.);
   b. Part-time or intermittent home health aide services which consist primarily of caring for the patient;
   c. Physical, occupational, speech, and respiratory therapy services by licensed therapists;
   d. Supplies and equipment routinely provided by the Home Health Agency.

   Benefits will **not** be provided for Home Health Care for the following:

   - Food or home delivered meals;
   - Social case work or homemaker services;
   - Services provided primarily for Custodial Care;
   - Transportation services;
   - Home Infusion Therapy;
   - Durable medical equipment.

3. For Hospice Care:

   Home Hospice Care:

   a. Part-time or intermittent nursing care by a Registered Nurse (R.N.), Advanced Practice Nurse (A.P.N.), or by a Licensed Vocational Nurse (L.V.N.);
   b. Part-time or intermittent home health aide services which consist primarily of caring for the patient;
   c. Physical, speech, and respiratory therapy services by licensed therapists;
   d. Homemaker and counseling services routinely provided by the Hospice agency, including bereavement counseling.

Facility Hospice Care:

a. All usual nursing care by a Registered Nurse (R.N.), Advanced Practice Nurse (A.P.N.), or by a Licensed Vocational Nurse (L.V.N.);
b. Room and board and all routine services, supplies, and equipment provided by the Hospice facility;
c. Physical, speech, and respiratory therapy services by licensed therapists.

Special Provisions Expenses

The benefits available under this **Special Provisions Expenses** subsection are generally determined on the same basis as other Inpatient Hospital Expenses, Medical-Surgical Expenses, and Extended Care Expenses, except to the extent described in each item. Benefits for Medically Necessary expenses will be determined as indicated on your Schedule(s) of Coverage. Remember that certain services require Prior Authorization and that any Copayment Amounts, Co-Share Amounts, and Deductibles shown on your Schedule(s) of Coverage will also apply. Refer to the **UTILIZATION MANAGEMENT** section of this Benefit Booklet for more information.

Benefits for Treatment of Complications of Pregnancy

Benefits for Eligible Expenses incurred for treatment of Complications of Pregnancy will be determined on the same basis as treatment for any other sickness. Dependent children will be eligible for treatment of Complications of Pregnancy.

Benefits for Maternity Care

Benefits for Eligible Expenses incurred for Maternity Care will be determined on the same basis as for any other treatment of sickness. A Copayment Amount will be required for the initial office visit for Maternity Care, but will not be required for subsequent visits. Dependent children will be eligible for Maternity Care benefits.

Services and supplies incurred by a Participant for delivery of a child shall be considered Maternity Care and are subject to all provisions of the Plan.

The Plan provides coverage for inpatient care for the mother and newborn child in a health care facility for a minimum of:

- 48 hours following an uncomplicated vaginal delivery; and
- 96 hours following an uncomplicated delivery by caesarean section.

If the mother or newborn is discharged before the minimum hours of coverage, the Plan provides coverage for *Postdelivery Care* for the mother and newborn. The *Postdelivery Care* may be provided at the mother's home, a health care Provider's office, or a health care facility.

Postdelivery Care means postpartum health care services provided in accordance with accepted maternal and neonatal physical assessments. The term includes:

- parent education,
- assistance and training in breast-feeding and bottle feeding, and
- the performance of any necessary and appropriate clinical tests.

Charges for well-baby nursery care, including the initial examination, of a newborn child during the mother's Hospital Admission for the delivery will be considered Inpatient Hospital Expense of the child and will be subject to the benefit provisions as described under **Inpatient Hospital Expenses**. Benefits will also be subject to any Deductible amounts shown on your Schedule of Coverage.

Benefits for In Vitro Fertilization Services

Benefits for Medical-Surgical Expenses incurred for in vitro fertilization services will be the same as for Maternity Care provided **all** of the following requirements are met:

1. The patient for the in vitro fertilization procedure is a covered Participant under this Plan;

2. The fertilization or attempt at fertilization is made only with the sperm of the Participant's spouse;

3. The Participant and her spouse have a history of infertility of at least five continuous years duration or the infertility is associated with one or more of the following conditions:

   - Endometriosis;
   - Exposure in utero diethylstilbestrol (DES);
   - Blockage or surgical removal of one or both fallopian tubes; or
   - Oligospermia;

4. The Participant has been unable to obtain a successful pregnancy through any less costly applicable infertility treatment which is covered under the Plan; and

5. The in vitro fertilization procedures are performed in a facility licensed and approved to provide in vitro fertilization services under the appropriate state authority, if any.

   No benefits for in vitro fertilization services are available if:

   - Any condition contained in items (1) through (5) indicated above, is not complied with;
   - The services or supplies are for Inpatient Hospital Expense.

Maximum of one cycle per lifetime allowed.

Benefits for Emergency Care and Treatment of Accidental Injury

The Plan provides coverage for Emergency Care medical emergencies wherever they occur. Examples of medical emergencies are unusual or excessive bleeding, broken bones, acute abdominal or chest pain, unconsciousness, convulsions, difficult breathing, suspected heart attack, sudden persistent pain, severe or multiple injuries or burns, and poisonings. Services provided in an emergency room, freestanding emergency room, or other comparable facility that are not Emergency Care may be excluded from Emergency Care coverage, although these services may be covered under another benefit, if applicable. If you disagree with the Claim Administrator's determination in processing your benefits as non-emergency care instead of Emergency Care, you may call the Claim Administrator at the number on the back of your Identification Card. Please review the *Review of Claim Determinations* provision of this Benefit Booklet for specific information on your right to seek and obtain a full and fair review of your claim.

Emergency Care does not require Prior Authorization. However, if reasonably possible, contact your Network Physician or Behavioral Health Practitioner before going to the Hospital emergency room/treatment room. They can help you determine if you need Emergency Care or treatment of an Accidental Injury and recommend that care. If not reasonably possible, go to the nearest emergency facility, whether or not the facility is in the Network.

Whether you require hospitalization or not, you should notify your Network Physician or Behavioral Health Practitioner within 48 hours, or as soon as reasonably possible, of any emergency medical treatment so they can recommend the continuation of any necessary medical services.

Benefits for Eligible Expenses for Accidental Injury or Emergency Care, including Accidental Injury or Emergency Care for Behavioral Health Services, will be determined as shown on your Schedule of Coverage. Copayment Amounts will be required for facility charges for each outpatient Hospital emergency room/treatment room visit as indicated on your Schedule of Coverage. If admitted for the emergency condition immediately following the visit, the Copayment Amount will be waived and Prior Authorization of the inpatient Hospital Admission will be required.

All treatment received following the onset of an accidental injury or emergency care will be eligible for In-Network Benefits. For a non-emergency, In-Network Benefits will be available only if you use Network Providers. For a non-emergency, if you can safely be transferred to the care of a Network Provider but are treated by an Out-of-Network Provider, only Out-of-Network Benefits will be available.

Benefits for Urgent Care

Benefits for Eligible Expenses for Urgent Care will be determined as shown on your Schedule of Coverage. A Copayment Amount, in the amount indicated on your Schedule of Coverage, will be required for each Urgent Care visit. Urgent Care means the delivery of medical care in a facility dedicated to the delivery of scheduled or unscheduled, walk-in care outside of a Hospital emergency room/treatment room or physician's office. The necessary medical care is for a condition that is not life-threatening.

Benefits for Retail Health Clinics

Benefits for Eligible Expenses for Retail Health Clinics will be determined as shown on your Schedule of Coverage. Retail Clinics provide diagnosis and treatment of uncomplicated minor conditions in situations that can be handled without a traditional primary care office visit, Urgent Care visit or Emergency Care visit.

Benefits for Virtual Visits

Benefits for Eligible Expenses for Virtual Visits will be determined as shown on your Schedule of Coverage. BCBSTX provides you with access to Virtual Providers that can provide diagnosis and treatment of non- emergency medical and behavioral health conditions in situations that can be handled without a traditional primary care office visit, behavioral health office visit, Urgent Care visit or Emergency Care visit. Covered Services may be provided via consultation with a licensed medical professional through interactive audio via telephone or interactive audio-video via online portal or mobile application. For information on accessing this service, you may access the website at www.bcbstx.com/michaels or contact customer service at the toll-free number on the back of your Identification Card.

Note: not all medical or behavioral health conditions can be appropriately treated through Virtual Visits. The Virtual Provider will identify any condition for which treatment by an in-person Provider is necessary.

Benefits for Early Detection Tests for Cardiovascular Disease

Benefits are available for one of the following noninvasive screening tests for atherosclerosis and abnormal artery structure and function every five years when performed by a laboratory that is certified by a recognized national organization:

1. Computed tomography (CT) scanning measuring coronary artery calcifications; or
2. Ultrasonography measuring carotid intima-media thickness and plaque.

Tests are available to each covered individual who is (1) a male older than 45 years of age and younger than 76 years of age, or (2) a female older than 55 years of age and younger than 76 years of age. The individual must be a diabetic or have a risk of developing coronary heart disease, based on a score derived using the Framingham Heart Study coronary prediction algorithm that is intermediate or higher.

Benefits are limited as indicated on your Schedule of Coverage.

Benefits for Speech and Hearing Services

Benefits as shown on your Schedule of Coverage are available for the services of a Physician or Professional Other Provider to restore loss of or correct an impaired speech or hearing function. Coverage also includes habilitation and rehabilitation services.

Benefits for Autism Spectrum Disorder will not apply towards and are not subject to any speech services visits maximum indicated on your Schedule of Coverage.

Benefits for Certain Therapies for Children with Developmental Delays

Medical-Surgical Expense benefits are available to a covered Dependent child for the necessary rehabilitative and habilitative therapies in accordance with an Individualized Family Service Plan.

Such therapies include:

- occupational therapy evaluations and services;
- physical therapy evaluations and services;
- speech therapy evaluations and services; and
- dietary or nutritional evaluations.

The *Individualized Family Service Plan* must be submitted to the Claim Administrator prior to the commencement of services and when the Individualized Family Service Plan is altered.

Once the child reaches the age of three, when services under the *Individualized Family Service Plan* are completed, Eligible Expenses, as otherwise covered under this Plan, will be available. All contractual provisions of this Plan will apply, including but not limited to, defined terms, limitations and exclusions, and benefit maximums.

Developmental Delay means a significant variation in normal development as measured by appropriate diagnostic instruments and procedures, in one or more of the following areas:

- Cognitive development;
- Physical development;
- Communication development;
- Social or emotional development; or
- Adaptive development.

Individualized Family Service Plan means an initial and ongoing treatment plan.

Benefits for Treatment of Autism Spectrum Disorder

Generally recognized services prescribed in relation to Autism Spectrum Disorder by the Participant's Physician or Behavioral Health Practitioner in a treatment plan recommended by that Physician or Behavioral Health Practitioner are available for a covered Participant.

Individuals providing treatment prescribed under that plan must be:

1. a Health Care Practitioner:
   - who is licensed, certified, or registered by an appropriate agency of the state of Texas;
   - whose professional credential is recognized and accepted by an appropriate agency of the United States; or
   - who is certified as a provider under the TRICARE military health system: or

2. an individual acting under the supervision of a Health Care Practitioner described in 1 above.

For purposes of this section, generally recognized services may include services such as:

- evaluation and assessment services;
- screening at 18 and 24 months;
- applied behavior analysis;
- behavior training and behavior management;
- speech therapy;
- occupational therapy;
- physical therapy; or
- medications or nutritional supplements used to address symptoms of Autism Spectrum Disorder.

Benefits for Autism Spectrum Disorder will not apply towards any maximum indicated on your Schedule of Coverage. Please review the *Benefits for Physical Medicine Services* and *Benefits for Speech and Hearing Services* provisions of this Benefit Booklet for more specific information about how visit maximums for Physical Medicine Services and speech services apply to benefits for Autism Spectrum Disorder.

Prior Authorization will assess whether services meet coverage requirements. Review the **UTILIZATION MANAGEMENT** section in this Benefit Booklet for more specific information about Prior Authorization.

Please see the definition of "Qualified ABA Provider" in the **DEFINITIONS** section of this Benefit Booklet for more information.

Benefits for Screening Tests for Hearing Impairment

Benefits are available for Eligible Expenses incurred by a covered Dependent child:

- For a screening test for hearing loss from birth through the date the child is 30 days old; and
- Necessary diagnostic follow-up care related to the screening tests from birth through the date the child is 24 months.

Deductibles indicated on your Schedule of Coverage will not apply to this provision.

Benefits for Cosmetic, Reconstructive, or Plastic Surgery

The following Eligible Expenses described below for Cosmetic, Reconstructive, or Plastic Surgery will be the same as for treatment of any other sickness as shown on your Schedule of Coverage:

- Treatment provided for the correction of defects incurred in an Accidental Injury sustained by the Participant; or
- Treatment provided for reconstructive surgery following cancer surgery; or
- Surgery performed on a newborn child for the treatment or correction of a congenital defect; or
- Surgery performed on a covered Dependent child (other than a newborn child) under the age of 19 for the treatment or correction of a congenital defect other than conditions of the breast; or
- Reconstruction of the breast on which mastectomy has been performed; surgery and reconstruction of the other breast to achieve a symmetrical appearance; and prostheses and treatment of physical complications, including lymphedemas, at all stages of the mastectomy; or
- Reconstructive surgery performed on a covered Dependent child due to craniofacial abnormalities to improve the function of, or attempt to create a normal appearance of an abnormal structure caused by congenital defects, developmental deformities, trauma, tumors, infections, or disease.

Benefits for Dental Services

Benefits for Eligible Expenses incurred by a Participant will be provided on the same basis as for treatment of any other sickness as shown on your Schedule of Coverage only for the following:

- Covered Oral Surgery;
- Services provided to a newborn child which are necessary for treatment or correction of a congenital defect; or
- The correction of damage caused solely by Accidental Injury, and such injury resulting from domestic violence or a medical condition, to healthy, un-restored natural teeth and supporting tissues. An injury sustained as a result of biting or chewing shall not be considered an Accidental Injury.

Any other dental services, except as excluded in the **MEDICAL LIMITATIONS AND EXCLUSIONS** section of this Benefit Booklet, for which a Participant incurs Inpatient Hospital Expenses for a Medically Necessary inpatient Hospital Admission, will be determined as described in **Benefits for Inpatient Hospital Expenses**.

Benefits for Organ and Tissue Transplants

1. Subject to the conditions described below, benefits for covered services and supplies provided to a Participant by a Hospital, Physician, or Other Provider related to an organ or tissue transplant will be determined as follows, but only if all the following conditions are met:
   a. The transplant procedure is not Experimental/Investigational in nature; and
   b. Donated human organs or tissue or an FDA-approved artificial device are used; and
   c. The recipient is a Participant under the Plan; and

d. The transplant procedure obtains Prior Authorization as required under the Plan; and
e. The Participant meets all of the criteria established by the Claim Administrator in pertinent written medical policies; and
f. The Participant meets all of the protocols established by the Hospital in which the transplant is performed.

Covered services and supplies "related to" an organ or tissue transplant include, but are not limited to, x-rays, laboratory testing, chemotherapy, radiation therapy, prescription drugs, procurement of organs or tissues from a living or deceased donor, and complications arising from such transplant.

2. Benefits are available and will be determined on the same basis as any other sickness when the transplant procedure is considered Medically Necessary and meets all of the conditions cited above.

   Benefits will be available for:

   a. A recipient who is covered under this Plan; and
   b. A donor who is a Participant under this Plan.

3. Covered services and supplies include services and supplies provided for the:

   a. Evaluation of organs or tissues including, but not limited to, the determination of tissue matches; and
   b. Donor search and acceptability testing of potential live donors; and
   c. Removal of organs or tissues from living or deceased donors; and
   d. Transportation and short-term storage of donated organs or tissues; and
   e. Living and/or travel expenses of the recipient or a live donor.
   f. Transplant travel benefit is limited to $10,000 per occurrence. Recipient must reside more than 50 miles from the transplant facility.

4. No benefits are available for a Participant for the following services or supplies:

   a. Expenses related to maintenance of life of a donor for purposes of organ or tissue donation;

   b. Purchase of the organ or tissue; or
   c. Organs or tissue (xenograft) obtained from another species.

5. Prior Authorization is required for any organ or tissue transplant. Review the **UTILIZATION MANAGEMENT** section in this Benefit Booklet for more specific information about Prior Authorization.

   a. Such specific Prior Authorization is required even if the patient is already a patient in a Hospital under another Prior Authorization.
   b. At the time of Prior Authorization, the Claim Administrator will assign a length-of-stay for the admission. Upon request, the length-of-stay may be extended if the Claim Administrator determines that an extension is Medically Necessary.

6. No benefits are available for any organ or tissue transplant procedure (or the services performed in preparation for, or in conjunction with, such a procedure) which the Claim Administrator considers to be Experimental/Investigational.

Benefits for Treatment of Acquired Brain Injury

Benefits for Eligible Expenses incurred for Medically Necessary treatment of an Acquired Brain Injury will be determined on the same basis as treatment for any other physical condition. Eligible Expenses include the following *services* as a result of and related to an Acquired Brain Injury:

- Cognitive communication therapy - *Services* designed to address modalities of comprehension and expression, including understanding, reading, writing, and verbal expression of information;
- Cognitive rehabilitation therapy - *Services* designed to address therapeutic cognitive activities, based on an assessment and understanding of the individual's brain-behavioral deficits;
- Community reintegration services - *Services* that facilitate the continuum of care as an affected individual transitions into the community, including outpatient day treatment or other post-acute care treatment;
- Neurobehavioral testing - An evaluation of the history of neurological and psychiatric difficulty, current symptoms, current mental status, and pre-morbid history, including the identification of problematic behavior and the relationship between behavior and the variables that control behavior. This may include interviews

of the individual, family, or others;

- Neurobehavioral treatment - Interventions that focus on behavior and the variables that control behavior;
- Neurocognitive rehabilitation - *Services* designed to assist cognitively impaired individuals to compensate for deficits in cognitive functioning by rebuilding cognitive skills and/or developing compensatory strategies and techniques;
- Neurocognitive therapy - *Services* designed to address neurological deficits in informational processing and to facilitate the development of higher level cognitive abilities;
- Neurofeedback therapy - *Services* that utilizes operant conditioning learning procedure based on electroencephalography (EEG) parameters, and which are designed to result in improved mental performance and behavior, and stabilized mood;
- Neurophysiological testing - An evaluation of the functions of the nervous system;
- Neurophysiological treatment - Interventions that focus on the functions of the nervous system;
- Neuropsychological testing - The administering of a comprehensive battery of tests to evaluate neurocognitive, behavioral, and emotional strengths and weaknesses and their relationship to normal and abnormal central nervous system functioning;
- Neuropsychological treatment - Interventions designed to improve or minimize deficits in behavioral and cognitive processes;
- Post-acute transition services - *Services* that facilitate the continuum of care beyond the initial neurological insult through rehabilitation and community reintegration, including outpatient day treatment or other post-acute care treatment. This shall include coverage for reasonable expenses related to periodic reevaluation of the care of an individual covered under this Plan who:
    1. has incurred an Acquired Brain Injury;
    2. has been unresponsive to treatment; and
    3. becomes responsive to treatment at a later date.
- Psychophysiological testing - An evaluation of the interrelationships between the nervous system and other bodily organs and behavior;
- Psychophysiological treatment - Interventions designed to alleviate or decrease abnormal physiological responses of the nervous system due to behavioral or emotional factors;
- Remediation - The process(es) of restoring or improving a specific function.

Service means the work of testing, treatment, and providing therapies to an individual with an Acquired Brain Injury.

Therapy means the scheduled remedial treatment provided through direct interaction with the individual to improve a pathological condition resulting from an Acquired Brain Injury.

Treatment for an Acquired Brain Injury may be provided at a Hospital, an acute or post-acute rehabilitation hospital, an assisted living facility or any other facility at which appropriate services or therapies may be provided.

Benefits for Acquired Brain Injury will not be subject to any visit limit indicated on your Schedule of Coverage.

Benefits for Treatment of Diabetes

Benefits are available and will be determined on the same basis as any other sickness for those Medically Necessary items for *Diabetes Equipment* and *Diabetes Supplies* (for which a Physician or Professional Other Provider has written an order) and *Diabetic Management Services/Diabetes Self-Management Training*. Such items, when obtained for a *Qualified Participant,* shall include but not be limited to the following:

1. *Diabetes Equipment*
    a. Blood glucose monitors (including noninvasive glucose monitors and monitors for the blind);
    b. Insulin pumps (both external and implantable) and associated appurtenances, which include:
        - Insulin infusion devices,
        - Batteries,
        - Skin preparation items,
        - Adhesive supplies,

- Infusion sets,
- Insulin cartridges,
- Durable and disposable devices to assist in the injection of insulin, and
- Other required disposable supplies; and

c. Podiatric appliances, including up to two pairs of therapeutic footwear per Plan Year, for the prevention of complications associated with diabetes.

2. *Diabetes Supplies*

   a. Test strips specified for use with a corresponding blood glucose monitor,
   b. Visual reading and urine test strips and tablets for glucose, ketones, and protein,
   c. Lancets and lancet devices,
   d. Insulin and insulin analog preparations,
   e. Injection aids, including devices used to assist with insulin injection and needleless systems,
   f. Biohazard disposable containers,
   g. Insulin syringes,
   h. Prescriptive and non-prescriptive oral agents for controlling blood sugar levels, and
   i. Glucagon emergency kits.

   NOTE: *All Diabetes Supplies listed in item 2. above will be covered under the* **PHARMACY BENEFITS** *portion of your plan.*

3. Repairs and necessary maintenance of insulin pumps not otherwise provided for under the manufacturer's warranty or purchase agreement, rental fees for pumps during the repair and necessary maintenance of insulin pumps, neither of which shall exceed the purchase price of a similar replacement pump.

4. As new or improved treatment and monitoring equipment or supplies become available and are approved by the U. S. Food and Drug Administration (FDA), such equipment or supplies may be covered if determined to be Medically Necessary and appropriate by the treating Physician or Professional Other Provider who issues the written order for the supplies or equipment.

5. Medical-Surgical Expense provided for the nutritional, educational, and psychosocial treatment of the *Qualified Participant*. Such *Diabetic Management Services/Diabetes Self-Management Training* for which a Physician or Professional Other Provider has written an order to the Participant or caretaker of the Participant is limited to the following when rendered by or under the direction of a Physician.

   Initial and follow-up instruction concerning:

   a. The physical cause and process of diabetes;
   b. Nutrition, exercise, medications, monitoring of laboratory values and the interaction of these in the effective self-management of diabetes;
   c. Prevention and treatment of special health problems for the diabetic patient;
   d. Adjustment to lifestyle modifications; and
   e. Family involvement in the care and treatment of the diabetic patient. The family will be included in certain sessions of instruction for the patient.

Diabetes Self-Management Training for the *Qualified Participant* will include the development of an individualized management plan that is created for and in collaboration with the *Qualified Participant* (and/or their family) to understand the care and management of diabetes, including nutritional counseling and proper use of *Diabetes Equipment* and *Diabetes Supplies*.

A *Qualified Participant* means an individual eligible for coverage under this Plan who has been diagnosed with (a) insulin dependent or non-insulin dependent diabetes, (b) elevated blood glucose levels induced by pregnancy, or (c) another medical condition associated with elevated blood glucose levels.

Benefits for Physical Medicine Services

Benefits for Medical-Surgical Expenses incurred for Physical Medicine Services are available and will be determined on the same basis as treatment for any other sickness shown on your Schedule of Coverage.

Benefits for Chiropractic Services

Benefits for Medical-Surgical Expenses incurred for Chiropractic Services are available as shown on your Schedule of Coverage.

However, Chiropractic Services benefits for all visits during which physical treatment is rendered, whether under the In-Network or Out-of-Network Benefits level, will not be provided for more than the maximum number of visits (outpatient facility and office combined) shown on your Schedule of Coverage. Any visits during which no physical treatment is rendered will not count toward the visit maximum.

Benefits for Routine Patient Costs for Participants in Approved Clinical Trials

Benefits for Eligible Expenses for Routine Patient Care Costs are provided in connection with a phase I, phase II, phase III, or phase IV clinical trial if the clinical trial is conducted in relation to the prevention, detection, or treatment of cancer or other Life-Threatening Disease or Condition and recognized under state and/or federal law.

Benefits for Certain Tests for Detection of Prostate Cancer

Benefits are available as shown on the Schedule of Coverage for an annual medically recognized diagnostic physical examination for the detection of prostate cancer and a prostate-specific antigen test used for the detection of prostate cancer for each male under the Plan who is at least:

- 50 years of age and asymptomatic; or
- 40 years of age with a family history of prostate cancer or another prostate cancer risk factor.

Benefits for Preventive Care Services

Preventive Care Services will be provided for the following covered services:

a. evidence-based items or services that have in effect a rating of "A" or "B" in the current recommendations of the United States Preventive Services Task Force ("USPSTF");

b. immunizations recommended by the Advisory Committee on Immunization Practices of the Centers for Disease Control and Prevention ("CDC") with respect to the individual involved;

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; and

d. with respect to women, such additional preventive care and screenings, not described in item a. above, as provided for in comprehensive guidelines supported by the HRSA.

For purposes of this benefit, the current recommendations of the USPSTF regarding breast cancer screening and mammography and prevention will be considered the most current (other than those issued in or around November 2009).

The Preventive Care Services listed in items a. through d. above may change as USPSTF, CDC and HRSA guidelines are modified and will be implemented by BCBSTX in the quantities and at the times required by applicable law or regulatory guidance. For more information, you may access the website at www.bcbstx.com/michaels or contact customer service at the toll-free number on your Identification Card.

Examples of covered services included are routine annual physicals; immunizations; well-child care; breastfeeding support, services and supplies; cancer screening mammograms; bone density test; screening for colorectal cancer; smoking cessation counseling services and intervention (including a screening for tobacco use, counseling and FDA-approved tobacco cessation medications); healthy diet counseling; and obesity screening/counseling.

NOTE: Tobacco cessation medications are covered under the **PHARMACY BENEFITS** portion of your Plan, when prescribed by a Health Care Practitioner.

Examples of covered immunizations included are Diphtheria, Haemophilus influenzae type b, Hepatitis B, Measles, Mumps, Pertussis, Polio, Rubella, Tetanus, Varicella and any other immunization that is required by law for a child. Allergy injections are not considered immunizations under this benefit provision.

Examples of covered services for women with reproductive capacity are female sterilization procedures and Outpatient Contraceptive Services; FDA-approved over-the-counter female contraceptives with a written prescription by a Health Care Practitioner; and specified FDA-approved contraception methods with a written prescription by a Health Care Practitioner provided in this section or in **PHARMACY BENEFITS** if applicable from the following categories: progestin-only contraceptives, combination contraceptives, emergency contraceptives, extended cycle/continuous oral contraceptives, cervical caps, diaphragms, implantable contraceptives, intra-uterine devices, injectables, transdermal contraceptives, vaginal contraceptive devices, spermicide, and female condoms. To determine if a specific contraceptive drug or device is included in this benefit, refer to the Women's Preventive Health Services - Contraceptive Information page located on the website at www.bcbstx.com/michaels or contact Customer Service at the toll-free number on your Identification Card. The list may change as FDA guidelines are modified.

Benefits are not available under this benefit provision for contraceptive drugs and devices not listed on the Women's Preventive Health Services - Contraceptive Information page. You may, however, have coverage under other sections of this Benefit Booklet, subject to any applicable Co-Share Amounts, Deductibles, Copayment Amounts and/or benefit maximums.

Preventive Care Services provided by an In-Network Provider and/or a Participating Pharmacy for the items a. through d. above and/or the Women's Preventive Health Services - Contraceptive Information List will not be subject to Co-Share Amounts, Deductibles, Copayment Amounts and/or dollar maximums.

Preventive Care Services provided by an Out-of-Network Provider for the items a. through d. above and/or the Women's Preventive Health Services - Contraceptive Information List will be subject to Co-Share Amounts, Deductibles, Copayment Amounts and/or applicable dollar maximums. Deductibles are not applicable to immunizations covered under ***Benefits for Childhood Immunizations*** provision.

Covered services not included in items a. through d. above and/or the Women's Preventive Health Services - Contraceptive Information List will be subject to Co-Share Amounts, Deductibles, Copayment Amounts and/or applicable dollar maximums.

Benefits for Breastfeeding Support, Services and Supplies

Benefits will be provided for breastfeeding counseling and support services when rendered by a Provider, during pregnancy and/or in the post-partum period. Benefits include the purchase of manual or electric breast pumps, accessories and supplies. Benefits for electric breast pumps are limited to one per Plan Year. Limited benefits are also included for the rental only of Hospital grade breast pumps. You may be required to pay the full amount and submit a claim form to BCBSTX with a written prescription and the itemized receipt for the manual, electric or Hospital grade breast pump, accessories and supplies. Visit the BCBSTX website at www.bcbstx.com/michaels to obtain a claim form.

If you use an Out-of-Network Provider, the benefits may be subject to any applicable Deductible, Co-Share, Copayment and/or benefit maximum.

Contact Customer Service at the toll-free number on the back of your Identification Card for additional information.

Benefits for Mammography Screening

Benefits are available for a screening by low-dose mammography for the presence of occult breast cancer for a Participant, as shown in ***Preventive Care Services*** on your Schedule of Coverage, except that benefits will not be available for more than one routine mammography screening each Plan Year. Low-dose mammography includes digital mammography or breast tomosynthesis.

Benefits for Detection and Prevention of Osteoporosis

If a Participant is a *Qualified Individual*, benefits are available for medically accepted bone mass measurement for the detection of low bone mass and to determine a Participant's risk of osteoporosis and fractures associated with osteoporosis, as shown in ***Preventive Care Services*** on your Schedule of Coverage.

Qualified Individual means:

1. A postmenopausal woman not receiving estrogen replacement therapy;

2. An individual with:

   - vertebral abnormalities,
   - primary hyperparathyroidism, or
   - a history of bone fractures; or

3. An individual who is:

   - receiving long-term glucocorticoid therapy, or
   - being monitored to assess the response to or efficacy of an approved osteoporosis drug therapy.

Benefits for Tests for Detection of Colorectal Cancer

Benefits are available for a diagnostic, medically recognized screening examination for the detection of colorectal cancer, for Participants who are 45 years of age or older and who are at normal risk for developing colon cancer, include:

- A fecal occult blood test performed annually and a flexible sigmoidoscopy performed every five years; or
- A colonoscopy performed every ten years.

Benefits will be provided for Physician Services, as shown in ***Preventive Care Services*** on your Schedule of Coverage.

Benefits for Certain Tests for Detection of Human Papillomavirus and Cervical Cancer

Benefits are available for certain tests for detection of Human Papillomavirus and Cervical Cancer for each woman enrolled in the Plan who is 18 years of age or older, for an annual medically recognized diagnostic examination for the early detection of cervical cancer, as shown in ***Preventive Care Services*** on your Schedule of Coverage. Coverage includes, at a minimum, a conventional Pap smear screening or a screening using liquid-based cytology methods as approved by the United States Food and Drug Administration alone or in combination with a test approved by the United States Food and Drug Administration for the detection of the human papillomavirus.

Benefits for Childhood Immunizations

Benefits for Medical-Surgical Expenses incurred by a Dependent child for childhood immunizations will be determined at 100% of the Allowable Amount. Deductibles, Copayment Amounts, and Co-Share Amounts will not be applicable, as shown in ***Preventive Care Services*** on your Schedule of Coverage.

Benefits are available for:

- Diphtheria,
- Haemophilus influenzae type b,
- Hepatitis B,
- Measles,
- Mumps,
- Pertussis,
- Polio,
- Rubella,
- Tetanus,
- Varicella, and
- Any other immunization that is required by law for the child.

Injections for allergies are not considered immunizations under this benefit provision.

Benefits for Morbid Obesity

Benefits for Eligible Expenses incurred by a Participant for the Medically Necessary treatment of Morbid Obesity will be provided at Blue Distinction and Blue Distinction Plus Designated Center only. Benefits are available for healthy diet counseling and obesity screening/counseling as shown in ***Preventive Care Services*** on your Schedule of Coverage.

Benefits for Non-ACA Preventive Drug Program

In addition, to the preventive care services listed above, your benefits include coverage for certain outpatient prescription drugs that are covered under the Non-ACA Preventive Drug Program, when prescribed by a Health Care Practitioner.

Benefits for outpatient prescription drugs covered under the Non-ACA Preventive Drug Program will not be subject to Co-Share, Deductibles and/or Copayment when obtained from a Participating Pharmacy when prescribed for preventive purposes.

The Non-ACA Preventive Drug Program includes outpatient prescription drugs in the following drug categories (This list of drug categories is not all inclusive and may be subject to change. Please call the Customer Service Helpline telephone number shown in this Benefit Booklet or on your Identification Card to confirm the categories that apply.):

- Anti-coagulants/anti-platelets
- Anti-anginal
- Anti-arrhythmics
- Anti-psychotics
- Bowel prep
- Breast cancer primary prevention
- Breast cancer secondary prevention
- Contraceptives
- Depression - selective serotonin reuptake inhibitors (SSRIs)
- Diabetes medication - insulin only
- Diabetes medication - oral only
- Estrogens
- Gastrointestinal Ulcer
- Fluoride supplements
- Heparin/LMWH
- High blood pressure (Antihypertensives)
- High cholesterol Orals
- HIV/AIDS
- Immunosuppressants - prevention of transplant rejection
- Osteoporosis
- Prenatal vitamins
- Respiratory (Asthma/COPD)
- Tobacco cessation (Smoking Cessation)

These drugs could also at times be prescribed for treatment purposes. If your Health Care Practitioner has prescribed a listed drug for treatment purposes (and not preventive purposes) then it will be subject to any applicable Deductible, Co-Share Amount, and Copayment Amount.

NOTE: For more information on drugs covered under your outpatient prescription drug benefit refer to the **PHARMACY BENEFITS** portion of your Plan.

Benefits for Other Routine Services

Benefits for other routine services are available for the following as indicated on your Schedule of Coverage:

- routine x-rays, routine EKG, routine diagnostic medical procedures;
- annual hearing examinations, except for benefits as provided under ***Benefits for Screening Tests for Hearing Impairment***; and
- annual vision examinations.

Behavioral Health Services

Benefits for Mental Health Care, Treatment of Serious Mental Illness and Treatment of Substance Use Disorder

Benefits for Eligible Expenses incurred for Mental Health Care, treatment of Serious Mental Illness and treatment of Substance Use Disorder will be the same as for treatment of any other sickness. Refer to the **UTILIZATION MANAGEMENT** section to determine what services require Prior Authorization.

Any Eligible Expenses incurred for the services of a Psychiatric Day Treatment Facility, a Crisis Stabilization Unit or Facility, a Residential Treatment Center, or a Residential Treatment Center for Children and Adolescents for Medically Necessary Mental Health Care or treatment of Serious Mental Illness in lieu of inpatient Hospital services will, for the purpose of this benefit, be considered **Inpatient Hospital Expenses**.

Inpatient treatment of Substance Use Disorder must be provided in a Substance Use Disorder Treatment Center or Hospital. Benefits for the medical management of acute life-threatening intoxication (toxicity) in a Hospital will be available on the same basis as for sickness generally as described under **Inpatient Hospital Expense**.

Mental Health Care provided as part of the Medically Necessary treatment of Substance Use Disorder will be considered for benefit purposes to be treatment of Substance Use Disorder until completion of Substance Use Disorder treatments. (Mental Health Care treatment after completion of Substance Use Disorder treatments will be considered Mental Health Care.)

Benefits for Eligible Expenses incurred for family and marriage counseling are covered under this Plan.

Blue Distinction® and Blue Distinction Specialty Care Program

Blue Distinction® ("Blue Distinction") is a national designation awarded by Blue Cross and Blue Shield Plans to health care Providers. The Blue Distinction Specialty Care program includes two levels of designation: Blue Distinction Centers (BDC) and Blue Distinction Centers+ (BDC+). The Blue Distinction Specialty Care program focuses on BDC and BDC+ providers that excel in providing safe, effective treatment for specialty care needs.

Blue Distinction Centers

The Blue Distinction designation uses nationally consistent criteria to designate high-performing providers based on objective, evidence-based selection criteria. The Blue Distinction Specialty Care program's purpose is to assist you in finding BDC and BDC+ providers that have met overall quality measures for patient safety and outcomes, fewer medical complications, lower readmission rates, and higher survival rates in the administration of specialty care.

Blue Distinction Centers provide care in the following specialty care areas:

- Cardiac Care
- Cellular Immunotherapy (CAR-T)
- Fertility Care*
- Substance Use Treatment and Recovery
- Gene Therapy
- Spine Surgery

- Bariatric Surgery
- Knee and Hip Replacement Surgery
- Maternity Care
- Transplants

* BDC and BDC+ Fertility Care programs are currently supported by plans with Fertility Care programs at the professional level.

BDC and BDC+ Benefit Differential

Your plan offers lower out-of-pocket costs when you receive treatment at a BDC and/or BDC+ Provider for certain services related to Fertility Care services. You may choose to receive treatment at a Non-BDC and/or Non-BDC+ provider; however, your out-of-pocket costs will be higher. Please refer to your Schedule of Coverage section to review the payment levels for procedures performed at a BDC or BDC+ designated Provider, and procedures performed at other facilities. Blue Distinction benefit levels apply to Blue Distinction facility benefits only, except for Fertility, which offers Professional Provider services.

Mandatory Blue Distinction Centers and Blue Distinction Centers+ Specialty Care Product

The Mandatory BDC and BDC+ Specialty Care product requires you to obtain Transplants, Bariatric services at a Blue Distinction Center and/or Blue Distinction Center+ in order to obtain maximum benefits. If you choose to utilize a Non-Blue Distinction Center and/or Non-Blue Distinction Center+ you will be responsible for 100% of costs associated with any specialty care received at such facility.

For additional information regarding Blue Distinction Centers for specialty care, please contact a Customer Service Representative at the toll-free telephone number shown on your Identification Card or visit the following website: www.bcbs.com/why-bcbs/blue-distinction.

MEDICAL LIMITATIONS AND EXCLUSIONS

The benefits as described in this Benefit Booklet are not available for:

1. Any services or supplies which are not Medically Necessary and essential to the diagnosis or direct care and treatment of a sickness, injury, condition, disease, or bodily malfunction.

2. Any Experimental/Investigational services and supplies.

3. Any portion of a charge for a service or supply that is in excess of the Allowable Amount as determined by the Claim Administrator.

4. Any services or supplies provided in connection with an occupational sickness or an injury sustained in the scope of and in the course of any employment whether or not benefits are, or could upon proper claim be, provided under the Workers' Compensation law.

5. Any services or supplies for which benefits are, or could upon proper claim be, provided under any present or future laws enacted by the Legislature of any state, or by the Congress of the United States, or any laws, regulations or established procedures of any county or municipality, provided, however, that this exclusion shall not be applicable to any coverage held by the Participant for hospitalization and/or medical-surgical expenses which is written as a part of or in conjunction with any automobile casualty insurance policy.

6. Any services or supplies for which a Participant is not required to make payment or for which a Participant would have no legal obligation to pay in the absence of this or any similar coverage, except services or supplies for treatment of mental illness or mental retardation provided by a tax supported institution of the State of Texas.

7. Any services or supplies provided by a person who is related to the Participant by blood or marriage.

8. Any services or supplies provided for injuries sustained:

   - as a result of war, declared or undeclared, or any act of war; or
   - while on active or reserve duty in the armed forces of any country or international authority.

9. Any charges:

   - resulting from the failure to keep a scheduled visit with a Physician or Professional Other Provider; or
   - for completion of any insurance forms; or
   - for acquisition of medical records.

10. Room and board charges incurred during a Hospital Admission for diagnostic or evaluation procedures unless the tests could not have been performed on an outpatient basis without adversely affecting the Participant's physical condition or the quality of medical care provided.

11. Any services or supplies provided before the patient is covered as a Participant hereunder or any services or supplies provided after the termination of the Participant's coverage.

12. Any services or supplies provided for Dietary and Nutritional Services, except as may be provided under the Plan for:

    - ***Preventive Care Services*** as shown on your Schedule of Coverage; or
    - an inpatient nutritional assessment program provided in and by a Hospital and approved by the Claim Administrator; or
    - ***Benefits for Autism Spectrum Disorder*** as described in **Special Provisions Expenses**; or
    - ***Benefits for Treatment of Diabetes*** as described in **Special Provisions Expenses**; or
    - ***Benefits for Certain Therapies for Children with Developmental Delays*** as described in **Special Provisions Expenses**.

13. Any services or supplies provided for Custodial Care.

14. Any non-surgical, dental, therapeutic (dental restorations, orthodontics, or physical therapy) or non-diagnostic services or supplies (oral appliances, oral splints, oral orthotics, devices, or prosthetics) provided for the treatment of the temporomandibular joint (including the jaw and craniomandibular joint) and all adjacent or related muscles.

15. Any items of Medical-Surgical Expenses incurred for dental care and treatments, dental surgery, or dental appliances, except as provided for in the ***Benefits for Dental Services*** provision in the **Special Provisions Expenses** portion of this Benefit Booklet.

16. Any services or supplies provided for Cosmetic, Reconstructive, or Plastic Surgery, except as provided for in the ***Benefits for Cosmetic, Reconstructive, or Plastic Surgery*** provision in the **Special Provisions Expenses** portion of this Benefit Booklet.

17. Any services or supplies provided for:

    - treatment of myopia and other errors of refraction, including refractive surgery; or
    - orthoptics or visual training; or
    - eyeglasses or contact lenses, provided that intraocular lenses shall be specific exceptions to this exclusion; or
    - examinations for the prescription or fitting of eyeglasses or contact lenses; or
    - restoration of loss or correction to an impaired speech or hearing function, including hearing aids, except as may be provided under the ***Benefits for Speech and Hearing Services*** and ***Benefits for Autism Spectrum Disorder*** provisions in the **Special Provisions Expenses** portion of this Benefit Booklet.

18. Any occupational therapy services which do not consist of traditional physical therapy modalities and which are not part of an active multi-disciplinary physical rehabilitation program designed to restore lost or impaired body function, except as may be provided under the ***Benefits for Physical Medicine Services and Benefits for Autism Spectrum Disorder*** provision in the **Special Provisions Expenses** portion of this Benefit Booklet.

19. Travel or ambulance services because it is more convenient for the patient than other modes of transportation whether or not recommended by a Physician or Professional Other Provider.

20. Any services or supplies provided primarily for:

    - Environmental Sensitivity;
    - Clinical Ecology or any similar treatment not recognized as safe and effective by the American Academy of Allergists and Immunologists; or
    - inpatient allergy testing or treatment.

21. Any services or supplies provided as, or in conjunction with, chelation therapy, except for treatment of acute metal poisoning.

22. Any services or supplies provided for, in preparation for, or in conjunction with:

    - sterilization reversal (male or female);
    - sexual dysfunctions; and
    - promotion of fertility through extra-coital reproductive technologies including, but not limited to, artificial insemination, intrauterine insemination, super ovulation uterine capacitation enhancement, direct intra-peritoneal insemination, trans-uterine tubal insemination, gamete intra-fallopian transfer, pronuclear oocyte stage transfer, zygote intra-fallopian transfer, and tubal embryo transfer.

23. Any services or supplies in connection with routine foot care, including the removal of warts, corns, or calluses, or the cutting and trimming of toenails in the absence of severe systemic disease.

24. Any services or supplies in connection with foot care for flat feet, fallen arches, and chronic foot strain.

25. Any prescription antiseptic or fluoride mouthwashes, mouth rinses, or topical oral solutions or preparations.

26. With the exception of prescription and over-the-counter medications for tobacco cessation and tobacco cessation counseling covered in this Plan, supplies for smoking cessation programs and the treatment of nicotine addiction are excluded.

27. Any services or supplies provided for the following treatment modalities:
    - intersegmental traction;
    - surface EMGs;
    - spinal manipulation under anesthesia; and
    - muscle testing through computerized kinesiology machines such as Isostation, Digital Myograph and Dynatron.

28. Any services or supplies furnished by a Contracting Facility for which such facility had not been specifically approved to furnish under a written contract or agreement with the Claim Administrator will be paid at the Out-of-Network benefit level.

29. Any items that include, but are not limited to, an orthodontic or other dental appliance; splints or bandages provided by a Physician in a non-Hospital setting or purchased "over-the-counter" for support of strains and sprains; orthopedic shoes which are a separable part of a covered brace, specially ordered, custom-made or built-up shoes, cast shoes, shoe inserts designed to support the arch or affect changes in the foot or foot alignment, arch supports, elastic stockings and garter belts.

    NOTE: This exclusion does not apply to podiatric appliances when provided as Diabetic Equipment.

30. Any benefits in excess of any specified dollar, day/visit, or Plan Year maximums.

31. Any services and supplies provided to a Participant incurred outside the United States if the Participant traveled to the location for the purposes of receiving medical services, supplies, or drugs.

32. Donor expenses for a Participant in connection with an organ and tissue transplant if the recipient is not covered under this Plan.

33. Replacement Prosthetic Appliances when it is necessitated by misuse or loss by the Participant.

34. Private duty nursing services.

35. Any Covered Drugs for which benefits are available under the Pharmacy Benefits portion of the Plan.

36. Any outpatient prescription or nonprescription drugs.

37. Any non-prescription contraceptive medications or devices for male use.

38. Self-administered drugs dispensed or administered by a Physician in their office.

39. Any services or supplies provided for reduction mammoplasty.

40. Any services or supplies provided for reduction of obesity or weight, including surgical procedures, even if the Participant has other health conditions which might be helped by a reduction of obesity or weight, except for healthy diet counseling and obesity screening/counseling as may be provided under ***Benefits for Preventive Care Services***.

41. Biofeedback (except for an Acquired Brain Injury diagnosis) or other behavior modification services.

42. Any services or supplies from more than one Provider on the same day(s) to the extent benefits were duplicated.

43. Behavioral health services provided at behavioral modification facilities, boot camps, emotional group academies, military schools, therapeutic boarding schools, wilderness programs, halfway houses and group homes, except for Covered Services provided by appropriate Providers as described in this Benefit Booklet.

44. Any of the following applied behavior analysis (ABA) services;

    - services with a primary diagnosis that is not Autism Spectrum Disorder;
    - services that are facilitated by a Provider that is not properly credentialed. Please see the definition of Qualified ABA Provider in the **DEFINITIONS** section of this Benefit Booklet;
    - activities primarily of an educational nature;
    - respite, shadow, or companion services; or
    - any other services not provided by an appropriately licensed Provider in accordance with nationally accepted treatment standards.

45. Any services or supplies not specifically defined as Eligible Expenses in this Plan.

46. Any related services to a non-covered service. Related services are:

    - services in preparation for the non-covered service;
    - services in connection with providing the non-covered service;
    - hospitalization required to perform the non-covered service; or
    - services that are usually provided following the non-covered service, such as follow up care or therapy after surgery.

DEFINITIONS

The definitions used in this Benefit Booklet apply to all coverage unless otherwise indicated.

Accidental Injury means accidental bodily injury resulting, directly and independently of all other causes, in initial necessary care provided by a Physician or Professional Other Provider.

Acquired Brain Injury means a neurological insult to the brain, which is not hereditary, congenital, or degenerative. The injury to the brain has occurred after birth and results in a change in neuronal activity, which results in an impairment of physical functioning, sensory processing, cognition, or psychosocial behavior.

Allowable Amount means the maximum amount determined by the Claim Administrator (BCBSTX) to be eligible for consideration of payment for a particular service, supply, or procedure.

- ***For Hospitals and Facility Other Providers, Physicians, and Professional Other Providers contracting with the Claim Administrator in Texas or any other Blue Cross and Blue Shield Plan*** - The Allowable Amount is based on the terms of the Provider contract and the payment methodology in effect on the date of service. The payment methodology used may include diagnosis-related groups (DRG), fee schedule, package pricing, global pricing, per diems, case-rates, discounts, or other payment methodologies.
- ***For Hospitals and Facility Other Providers, Physicians, Professional Other Providers, and any other provider not contracting with the Claim Administrator in Texas*** - The Allowable Amount will be the lesser of: (i) the Provider's billed charges, or; (ii) the BCBSTX non-contracting Allowable Amount. Except as otherwise provided in this section, the non-contracting Allowable Amount is developed from base Medicare Participating reimbursements adjusted by a predetermined factor established by the Claim Administrator. Such factor shall be not less than 75% and will exclude any Medicare adjustment(s) which is/are based on information on the claim.

  Notwithstanding the preceding sentence, the non-contracting Allowable Amount for Home Health Care is developed from base Medicare national per visit amounts for low utilization payment adjustment, or LUPA, episodes by Home Health discipline type adjusted for duration and adjusted by a predetermined factor established by the Claim Administrator. Such factor shall be not less than 75% and shall be updated on a periodic basis.

  When a Medicare reimbursement rate is not available or is unable to be determined based on the information submitted on the claim, the Allowable Amount for non-contracting Providers will represent an average contract rate in aggregate for Network Providers adjusted by a predetermined factor established by the Claim Administrator. Such factor shall be not less than 75% and shall be updated not less than every two years.

  The Claim Administrator will utilize the same claim processing rules and/or edits that it utilizes in processing Network Provider claims for processing claims submitted by non-contracted Providers which may also alter the Allowable Amount for a particular service. In the event the Claim Administrator does not have any claim edits or rules, the Claim Administrator may utilize the Medicare claim rules or edits that are used by Medicare in processing the claims. The Allowable Amount will not include any additional payments that may be permitted under the Medicare laws or regulations which are not directly attributable to a specific claim, including, but not limited to, disproportionate share and graduate medical education payments.

  Any change to the Medicare reimbursement amount will be implemented by the Claim Administrator within ninety (90) days after the effective date that such change is implemented by the Centers for Medicaid and Medicare Services, or its successor.

  The non-contracting Allowable Amount does not equate to the Provider's billed charges and Participants receiving services from a non-contracted Provider will be responsible for the difference between the non-contracting Allowable Amount and the non-contracted Provider's billed charge, and this difference may be considerable. To find out the BCBSTX non-contracting Allowable Amount for a particular service, Participants may call customer service at the number on the back of your BCBSTX Identification Card.
- ***For multiple surgeries*** - The Allowable Amount for all surgical procedures performed on the same patient on the same day will be the amount for the single procedure with the highest Allowable Amount plus a determined percentage of the Allowable Amount for each of the other covered procedures performed.

- ***For procedures, services, or supplies provided to Medicare recipients*** - The Allowable Amount will not exceed Medicare's limiting charge.
- ***For Covered Drugs as applied to Participating Pharmacies -*** The Allowable Amount for Participating Pharmacies and the mail-order program will be based on the provisions of the contract between the Claim Administrator and the Participating Pharmacy or Pharmacy for the mail-order program in effect on the date of service.

Autism Spectrum Disorder (ASD) means a *neurobiological disorder* that includes autism, Asperger's syndrome, or pervasive development disorder--not otherwise specified. A *neurobiological disorder* means an illness of the nervous system caused by genetic, metabolic, or other biological factors.

Average Wholesale Price means any one of the recognized published averages of the prices charged by wholesalers in the United States for the drug products they sell to a Pharmacy.

Behavioral Health Practitioner means a Physician or Professional Other Provider who renders services for Mental Health Care, Serious Mental Illness or Substance Use Disorder, only as listed in this Benefit Booklet.

Blue Distinction Centers (BDC) means a health care Provider, Hospital or medical facility recognized for their expertise in delivering specialty care. Please see the subsection entitled **Blue Distinction Centers** for more information.

Blue Distinction Centers+ (BDC+) means a health care Provider, Hospital or medical facility recognized for their expertise and efficiency in delivering specialty care. Please see the subsection entitled Blue Distinction Centers for more information.

Blue Distinction Centers (BDC) and Blue Distinction Centers+ (BDC+) Benefit Differential Product means your employer has chosen to provide a lower out-of-pocket cost when you utilize a BDC or BDC+ designated provider for certain specialty care procedures and treatment.

Calendar Year means the period commencing on January 1 and ending on the next succeeding December 31, inclusive.

Care Coordination means organized, information-driven patient care activities intended to facilitate the appropriate responses to Covered Person's healthcare needs across the continuum of care.

Care Coordinator Fee means a fixed amount paid by a Blue Cross and/or Blue Shield Plan to providers periodically for Care Coordination under a Value-Based Program.

Certain Diagnostic Procedures means:

- Bone Scan
- Cardiac Stress Test
- CT Scan (with or without contrast)
- MRI (Magnetic Resonance Imaging)
- Myelogram
- PET Scan (Positron Emission Tomography)

Chiropractic Services means any of the following services, supplies or treatment provided by or under the direction of a Doctor of Chiropractic acting within the scope of their license: general office services, general services provided in an outpatient facility setting, x-rays, supplies, and physical treatment. Physical treatment includes functional occupational therapy, physical/mechano therapy, muscle manipulation therapy and hydrotherapy.

Claim Administrator means Blue Cross and Blue Shield of Texas, a Division of Health Care Service Corporation. The Claim Administrator assumed only the authority and discretion as given by the employer to interpret the Plan provisions and benefit determinations.

Clinical Ecology means the inpatient or outpatient diagnosis or treatment of allergic symptoms by:

1. Cytotoxicity testing (testing the result of food or inhalant by whether or not it reduces or kills white blood cells);
2. Urine auto injection (injecting one's own urine into the tissue of the body);
3. Skin irritation by Rinkel method;
4. Subcutaneous provocative and neutralization testing (injecting the patient with allergen); or
5. Sublingual provocative testing (droplets of allergenic extracts are placed in mouth).

Complications of Pregnancy means:

1. Conditions (when the pregnancy is not terminated) whose diagnoses are distinct from pregnancy but are adversely affected by pregnancy or are caused by pregnancy, such as acute nephritis, nephrosis, cardiac decompensation, missed abortion, and similar medical and surgical conditions of comparable severity, but *shall not include* false labor, occasional spotting, Physician-prescribed rest during the period of pregnancy, morning sickness, hyperemesis gravidarum, pre-eclampsia, and similar conditions associated with the management of a difficult pregnancy not constituting a nosologically distinct complication of pregnancy, and

2. Non-elective cesarean section, termination of ectopic pregnancy, and spontaneous termination of pregnancy occurring during a period of gestation in which a viable birth is not possible.

Contracting Facility means a Hospital, a Facility Other Provider, or any other facility or institution with which the Claim Administrator has executed a written contract for the provision of care, services, or supplies furnished within the scope of its license for benefits available under the Plan. A Contracting Facility shall also include a Hospital or Facility Other Provider located outside the State of Texas, and with which any other Blue Cross Plan has executed such a written contract; provided, however, any such facility that fails to satisfy each and every requirement contained in the definition of such institution or facility as provided in the Plan shall be deemed a Non-Contracting Facility regardless of the existence of a written contract with another Blue Cross Plan.

Copayment Amount means the payment, as expressed in dollars, that must be made by or on behalf of a Participant for certain services at the time they are provided.

Co-Share Amount means the dollar amount of Eligible Expenses including Deductible(s) and Copayment Amounts incurred by a Participant during a Plan Year that exceeds benefits provided under the Plan. Refer to **Co-Share Stop-Loss Amount** in **ELIGIBLE EXPENSES, PAYMENT OBLIGATIONS, AND BENEFITS** of the Benefit Booklet for additional information.

Cosmetic, Reconstructive, or Plastic Surgery means surgery that:

1. Can be expected or is intended to improve the physical appearance of a Participant; or
2. Is performed for psychological purposes; or
3. Restores form but does not correct or materially restore a bodily function.

Covered Oral Surgery means maxillofacial surgical procedures limited to:

1. Excision of non-dental related neoplasms, including benign tumors and cysts and all malignant and premalignant lesions and growths;
2. Surgical and diagnostic treatment of conditions affecting the temporomandibular joint (including the jaw and the craniomandibular joint) as a result of an accident, a trauma, a congenital defect, a developmental defect, or a pathology;
3. Incision and drainage of facial abscess; and
4. Surgical procedures involving salivary glands and ducts and non-dental related procedures of the accessory sinuses.

Crisis Stabilization Unit or Facility means an institution which is appropriately licensed and accredited as a Crisis Stabilization Unit or Facility for the provision of Mental Health Care and Serious Mental Illness services to persons who are demonstrating an acute demonstrable psychiatric crisis of moderate to severe proportions.

Custodial Care means any service primarily for personal comfort for convenience that provides general maintenance, preventive, and/or protective care without any clinical likelihood of improvement of your condition. Custodial Care Services also means those services which do not require the technical skills, professional training and clinical assessment ability of medical and/or nursing personnel in order to be safely and effectively performed. These services can be safely provided by trained or capable non-professional personnel, are to assist with routine medical needs (e.g. simple care and dressings, administration of routine medications, etc.) and are to assist with activities of daily living (e.g. bathing, eating, dressing, etc.).

Deductible means the dollar amount of Eligible Expenses that must be incurred by a Participant before benefits under the Plan will be available.

Dependent means your spouse as defined by applicable law, or your Domestic Partner (you may be required to submit a certified copy of a marriage certificate or an affidavit of Domestic Partnership at the time of enrollment), or any *child* covered under the Plan who is under the Dependent child limiting age shown on your Schedule of Coverage.

Child means:

a. Your natural child; or

b. Your legally adopted child, including a child for whom the Participant is a party in a suit in which the adoption of the child is sought; or

c. Your stepchild; or

d. An eligible foster child; or

e. A child of your Domestic Partner; or

f. A child of your child who is your Dependent for federal income tax purposes at the time application for coverage of the child is made and with whom you have legal custody; or

g. A child not listed above:

   (1) whose primary residence is your household; and
   (2) to whom you are legal guardian or related by blood or marriage; and
   (3) who is dependent upon you for more than one-half of their support as defined by the Internal Revenue Code of the United States.

For purposes of this Plan, the term *Dependent* will also include those individuals who no longer meet the definition of a Dependent, but are beneficiaries under the Consolidated Omnibus Budget Reconciliation Act (COBRA).

Dietary and Nutritional Services means the education, counseling, or training of a Participant (including printed material) regarding:

1. Diet;
2. Regulation or management of diet; or
3. The assessment or management of nutrition.

Domestic Partner means a person with whom you have entered into a Domestic Partnership in accordance with the guidelines established by the Plan in its affidavit or certification of Domestic Partnership. For purposes of this Plan, Domestic Partners are eligible beneficiaries for continuation under the Consolidated Omnibus Budget Reconciliation Act of 1985 (COBRA). For specific criteria or necessary forms required to establish eligibility for benefit coverage under this Plan, contact your Employer or Human Resources Department.

Domestic Partnership means, for purposes of this Plan, a committed relationship of mutual caring and support between two people who are jointly responsible for each other's common welfare and share financial obligations and who have executed an affidavit or certification of Domestic Partnership form provided by the Plan.

Durable Medical Equipment Provider means a Provider that provides therapeutic supplies and rehabilitative equipment and is accredited by the Joint Commission on Accreditation of Healthcare Organizations.

Effective Date means the date the coverage for a Participant actually begins. It may be different from the Eligibility Date.

Eligibility Date means the date the Participant satisfies the definition of either "Employee" or "Dependent" and is in a class eligible for coverage under the Plan as described in the **WHO GETS BENEFITS** section of this Benefit Booklet.

Eligible Expenses mean Inpatient Hospital Expenses, Medical-Surgical Expenses, Extended Care Expenses, **Special Provisions Expenses**, and Pharmacy Expenses as described in this Benefit Booklet.

Emergency Care means health care services provided in a Hospital emergency facility (emergency room) or comparable facility to evaluate and stabilize medical conditions of a recent onset and severity, including but not limited to severe pain, that would lead a prudent layperson, possessing an average knowledge of medicine and health, to believe that the person's condition, sickness, or injury is of such a nature that failure to get immediate care could result in:

1. placing the patient's health in serious jeopardy;
2. serious impairment of bodily functions;
3. serious dysfunction of any bodily organ or part;
4. serious disfigurement; or
5. in the case of a pregnant woman, serious jeopardy to the health of the fetus.

Employee means a person who:

1. Regularly provides personal services at the Employee's usual and customary place of employment with the Employer; and
2. Works a specified number of hours per week or month as required by the Employer; and
3. Is recorded as an Employee on the payroll records of the Employer; and
4. Is compensated for services by salary or wages. If applicable to this group, proprietors, partners, corporate officers and directors need not be compensated for services by salary or wages.

For purposes of this plan, the term *Employee* will also include those individuals who are no longer an Employee of the Employer, but who are participants covered under the Consolidated Omnibus Budget Reconciliation Act (COBRA).

Employer means the person, firm, or institution named on this Benefit Booklet.

Environmental Sensitivity means the inpatient or outpatient treatment of allergic symptoms by:

1. Controlled environment; or
2. Sanitizing the surroundings, removal of toxic materials; or
3. Use of special non-organic, non-repetitive diet techniques.

Experimental/Investigational means the use of any treatment, procedure, facility, equipment, drug, device, or supply not accepted as *standard medical treatment* of the condition being treated and any of such items requiring Federal or other governmental agency approval not granted at the time services were provided.

Approval by a Federal agency means that the treatment, procedure, facility, equipment, drug, device, or supply has been approved for the condition being treated and, in the case of a drug, in the dosage used on the patient. Approval by a federal agency will be taken into consideration by BCBSTX in assessing Experimental/Investigational status but will not be determinative.

As used herein, *medical treatment* includes medical, surgical, or dental treatment.

Standard medical treatment means the services or supplies that are in general use in the medical community in the United States, and:

- have been demonstrated in peer reviewed literature to have scientifically established medical value for curing or alleviating the condition being treated;
- are appropriate for the Hospital or Facility Other Provider in which they were performed; and
- the Physician or Professional Other Provider has had the appropriate training and experience to provide the treatment or procedure.

The Claim Administrator for the Plan shall determine whether any treatment, procedure, facility, equipment, drug, device, or supply is Experimental/Investigational, and will consider factors such as the guidelines and practices of Medicare, Medicaid, or other government-financed programs and approval by a federal agency in making its determination.

Although a Physician or Professional Other Provider may have prescribed treatment, and the services or supplies may have been provided as the treatment of last resort, the Claim Administrator still may determine such services or supplies to be Experimental/Investigational within this definition. Treatment provided as part of a clinical trial or a research study is Experimental/Investigational.

Extended Care Expenses means the Allowable Amount of charges incurred for those Medically Necessary services and supplies provided by a Skilled Nursing Facility, a Home Health Agency, or a Hospice as described in the **Extended Care Expenses** portion of this Benefit Booklet.

Fixed-Wing Air Ambulance means a specially equipped airplane used for ambulance transport.

Group Health Plan (GHP) as applied to this Benefit Booklet means a self-funded employee welfare benefit plan. For additional information, refer to the definition of Plan Administrator.

Health Benefit Plan means a group, blanket, or franchise insurance policy, a certificate issued under a group policy, a group hospital service contract, or a group subscriber contract or evidence of coverage issued by a Health Maintenance Organization that provides benefits for health care services. The term does not include:

1. Accident only or disability income insurance, or a combination of accident-only and disability income insurance;
2. Credit-only insurance;
3. Disability insurance coverage;
4. Coverage for a specified disease or illness;
5. Medicare services under a federal contract;
6. Medicare supplement and Medicare Select policies regulated in accordance with federal law;
7. Long-term care coverage or benefits, home health care coverage or benefits, nursing home care coverage or benefits, community-based care coverage or benefits, or any combination of those coverages or benefits;
8. Coverage that provides limited-scope dental or vision benefits;
9. Coverage provided by a single service health maintenance organization;
10. Coverage issued as a supplement to liability insurance;
11. Workers' compensation or similar insurance;
12. Automobile medical payment insurance coverage;
13. Jointly managed trusts authorized under 29 U.S.C. Section 141, et seq., that;
    - contain a plan of benefits for employees;
    - is negotiated in a collective bargaining agreement governing wages, hours, and working conditions of the employees; and
    - is authorized under 29 U.S.C. Section 157;
14. Hospital indemnity or other fixed indemnity insurance;
15. Reinsurance contracts issued on a stop-loss, quota-share, or similar basis;

16. Short-term major medical contracts;
17. Liability insurance, including general liability insurance and automobile liability insurance;
18. Other coverage that is:
    - similar to the coverage described by this subdivision under which benefits for medical care are secondary or incidental to other insurance benefits; and
    - specified in federal regulations;
19. Coverage for onsite medical clinics; or
20. Coverage that provides other limited benefits specified by federal regulations.

Health Care Practitioner means an Advanced Practice Nurse, Doctor of Medicine, Doctor of Dentistry, Physician Assistant, Doctor of Osteopathy, Doctor of Podiatry, or other licensed person with prescription authority.

HIPAA means the Health Insurance Portability and Accountability Act of 1996.

Home Health Agency means a business that provides Home Health Care and is licensed, approved, or certified by the appropriate agency of the state in which it is located or is certified by Medicare as a supplier of Home Health Care.

Home Health Care means the health care services for which benefits are provided under the Plan when such services are provided during a visit by a Home Health Agency to patients confined at home due to a sickness or injury requiring skilled health services on an intermittent, part-time basis.

Home Infusion Therapy means the administration of fluids, nutrition, or medication (including all additives and chemotherapy) by intravenous or gastrointestinal (enteral) infusion or by intravenous injection in the home setting. Home Infusion Therapy shall include:

1. Drugs and IV solutions;
2. Pharmacy compounding and dispensing services;
3. All equipment and ancillary supplies necessitated by the defined therapy;
4. Delivery services;
5. Patient and family education; and
6. Nursing services.

Over-the-counter products which do not require a Physician's or Professional Other Provider's prescription, including but not limited to standard nutritional formulations used for enteral nutrition therapy, are not included within this definition.

Home Infusion Therapy Provider means an entity that is duly licensed by the appropriate state agency to provide Home Infusion Therapy.

Hospice means a facility or agency primarily engaged in providing skilled nursing services and other therapeutic services for terminally ill patients and which is:

1. Licensed in accordance with state law (where the state law provides for such licensing); or
2. Certified by Medicare as a supplier of Hospice Care.

Hospice Care means services for which benefits are provided under the Plan when provided by a Hospice to patients confined at home or in a Hospice facility due to a terminal sickness or terminal injury requiring skilled health care services.

Hospital means a short-term acute care facility which:

1. Is duly licensed as a Hospital by the state in which it is located and meets the standards established for such licensing, and is either accredited by the Joint Commission on Accreditation of Healthcare Organizations or is certified as a Hospital provider under Medicare;

2. Is primarily engaged in providing inpatient diagnostic and therapeutic services for the diagnosis, treatment, and care of injured and sick persons by or under the supervision of Physicians or Behavioral Health Practitioners for compensation from its patients;

3. Has organized departments of medicine and major surgery, either on its premises or in facilities available to the Hospital on a contractual prearranged basis, and maintains clinical records on all patients;

4. Provides 24-hour nursing services by or under the supervision of a Registered Nurse; and

5. Has in effect a Hospital Utilization Review Plan.

Hospital Admission means the period between the time of a Participant's entry into a Hospital or a Substance Use Disorder Treatment Center as a *Bed patient* and the time of discontinuance of bed-patient care or discharge by the admitting Physician, Behavioral Health Practitioner or Professional Other Provider, whichever first occurs. The day of entry, but not the day of discharge or departure, shall be considered in determining the length of a Hospital Admission.

Bed patient means confinement in a bed accommodation of a Substance Use Disorder Treatment Center on a 24-hour basis or in a bed accommodation located in a portion of a Hospital which is designed, staffed, and operated to provide acute, short-term Hospital care on a 24-hour basis; the term does not include confinement in a portion of the Hospital (other than a Substance Use Disorder Treatment Center) designed, staffed, and operated to provide long-term institutional care on a residential basis.

Identification Card means the card issued to the Employee by the Claim Administrator of the Plan indicating pertinent information applicable to their coverage.

Imaging Center means a Provider that can furnish technical or total services with respect to diagnostic imaging services and is licensed through the *Department of State Health Services Certificate of Equipment Registration and/or Department of State Health Services Radioactive Materials License*.

Independent Laboratory means a Medicare certified laboratory that provides technical and professional anatomical and/or clinical laboratory services.

In-Network Benefits means the benefits available under the Plan for services and supplies that are provided by a Network Provider or an Out-of-Network Provider when acknowledged by the Claim Administrator.

Inpatient Hospital Expense means the Allowable Amount incurred for the Medically Necessary items of service or supply listed below for the care of a Participant, provided that such items are:

1. Furnished at the direction or prescription of a Physician, Behavioral Health Practitioner or Professional Other Provider; and

2. Provided by a Hospital or a Substance Use Disorder Treatment Center; and

3. Furnished to and used by the Participant during an inpatient Hospital Admission.

An expense shall be deemed to have been incurred on the date of provision of the service for which the charge is made.

Inpatient Hospital Expense shall include:

1. Room accommodation charges. If the Participant is in a private room, the amount of the room charge in excess of the Hospital's average semiprivate room charge *is not* an Eligible Expense.

2. All other usual Hospital services, including drugs and medications, which are Medically Necessary and consistent with the condition of the Participant. Personal items *are not* an Eligible Expense.

Medically Necessary Mental Health Care or treatment of Serious Mental Illness in a Psychiatric Day Treatment Facility, a Crisis Stabilization Unit or Facility, Residential Treatment Center, or a Residential Treatment Center for Children and Adolescents, in lieu of hospitalization, shall be Inpatient Hospital Expense.

Intensive Outpatient Program means a freestanding or Hospital-based program that provides services for at least three hours per day, two or more days per week, to treat mental illness, drug addiction, substance abuse or alcoholism, or specializes in the treatment or co-occurring mental illness with drug addiction, substance abuse or alcoholism. These programs offer integrated and aligned assessment, treatment and discharge planning services for treatment of severe or complex co-occurring conditions which make it unlikely that the Participants will benefit from programs that focus solely on mental illness conditions.

Late Enrollee means any Employee or Dependent eligible for enrollment who requests enrollment in an Employer's Health Benefit Plan (1) after the expiration of the initial enrollment period established under the terms of the first plan for which that Participant was eligible through the Employer, (2) after the expiration of an Open Enrollment Period, or (3) after the expiration of a special enrollment period.

An Employee or a Dependent is *not* a Late Enrollee if:

1. The individual:
    a. Was covered under another Health Benefit Plan or self-funded Health Benefit Plan at the time the individual was eligible to enroll; and
    b. Declines at the time of initial eligibility, stating that coverage under another Health Benefit Plan or self-funded Health Benefit Plan was the reason for declining enrollment; and
    c. Has lost coverage under another Health Benefit Plan or self-funded Health Benefit Plan as a result of:
        (1) termination of employment;
        (2) reduction in the number of hours of employment;
        (3) termination of the other plan's coverage;
        (4) termination of contributions toward the premium made by the Employer;
        (5) COBRA coverage has been exhausted;
        (6) cessation of Dependent status;
        (7) the Plan no longer offers any benefits to the class of similarly situated individuals that include the individual; or
        (8) in the case of coverage offered through an HMO, the individual no longer resides, lives, or works in the service area of the HMO and no other benefit option is available; and
    d. Requests enrollment not later than the 30th day after the date on which coverage under the other Health Benefit Plan or self-funded Health Benefit Plan terminates or in the event of the attainment of a lifetime limit on all benefits, the individual must request to enroll not later than 30 days after a claim is denied due to the attainment of a lifetime limit on all benefits.
2. The request for enrollment is made by the individual within the 60th day after the date on which coverage under Medicaid or CHIP terminates.
3. The individual is employed by an Employer who offers multiple Health Benefit Plans and the individual elects a different Health Benefit Plan during an Open Enrollment Period.
4. A court has ordered coverage to be provided for a spouse under a covered Employee's plan and the request for enrollment is made not later than the 30th day after the date on which the court order is issued.
5. A court has ordered coverage to be provided for a child under a covered Employee's plan and the request for enrollment is made not later than the 30th day after the date on which the Employer receives notice of the court order.
6. A Dependent child is not a Late Enrollee if the child:
    a. Was covered under Medicaid or the Children's Health Insurance Program (CHIP) at the time the child was eligible to enroll;
    b. The employee declined coverage for the child, stating that coverage under Medicaid or CHIP was the reason for declining coverage;
    c. The child has lost coverage under Medicaid or CHIP; and
    d. The request for enrollment is made within the 60th day after the date on which coverage under Medicaid or CHIP terminates.

Life Threatening Disease or Condition means, for the purposes of a clinical trial, any disease or condition from which the likelihood of death is probable unless the course of the disease or condition is interrupted.

Marriage and Family Therapy means the provision of professional therapy services to individuals, families, or married couples, singly or in groups, and involves the professional application of family systems theories and techniques in the delivery of therapy services to those persons. The term includes the evaluation and remediation of cognitive, affective, behavioral, or relational dysfunction within the context of marriage or family systems.

Maternity Care means care and services provided for treatment of the condition of pregnancy, other than Complications of Pregnancy.

Medical Social Services means those social services relating to the treatment of a Participant's medical condition. Such services include, but are not limited to assessment of the:

1. Social and emotional factors related to the Participant's sickness, need for care, response to treatment, and adjustment to care; and

2. Relationship of the Participant's medical and nursing requirements to the home situation, financial resources, and available community resources.

Medical-Surgical Expenses means the Allowable Amount for those charges incurred for the Medically Necessary items of service or supply listed below for the care of a Participant, provided such items are:

1. Furnished by or at the direction or prescription of a Physician, Behavioral Health Practitioner or Professional Other Provider; and
2. Not included as an item of Inpatient Hospital Expense or Extended Care Expense in the Plan.

A service or supply is furnished at the direction of a Physician, Behavioral Health Practitioner or Professional Other Provider if the listed service or supply is:

1. Provided by a person employed by the directing Physician, Behavioral Health Practitioner or Professional Other Provider; and
2. Provided at the usual place of business of the directing Physician, Behavioral Health Practitioner or Professional Other Provider; and
3. Billed to the patient by the directing Physician, Behavioral Health Practitioner or Professional Other Provider.

An expense shall have been incurred on the date of provision of the service for which the charge is made.

Medically Necessary or **Medical Necessity** means those services or supplies covered under the Plan which are:

1. Essential to, consistent with, and provided for the diagnosis or the direct care and treatment of the condition, sickness, disease, injury, or bodily malfunction; and
2. Provided in accordance with and are consistent with generally accepted standards of medical practice in the United States; and
3. Not primarily for the convenience of the Participant, their Physician, Behavioral Health Practitioner, the Hospital, or the Other Provider; and
4. The most economical supplies or levels of service that are appropriate for the safe and effective treatment of the Participant. When applied to hospitalization, this further means that the Participant requires acute care as a bed patient due to the nature of the services provided or the Participant's condition, and the Participant cannot receive safe or adequate care as an outpatient. BCBSTX does not determine course of treatment or whether particular health care services are received. The decision regarding the course of treatment and receipt of particular health care services is a matter entirely between the Participant, their Physician, Behavioral Health Practitioner, the Hospital, or the Other Provider.

The medical staff of the Claim Administrator shall determine whether a service or supply is Medically Necessary under the Plan and will consider the views of the state and national medical communities, the guidelines and practices of Medicare, Medicaid, or other government-financed programs, and peer reviewed literature. Although a Physician, Behavioral Health Practitioner or Professional Other Provider may have prescribed treatment, such treatment may not be Medically Necessary within this definition.

Mental Health Care means any one or more of the following:

1. The diagnosis or treatment of a mental disease, disorder, or condition listed in the *Diagnostic and Statistical Manual of Mental Disorders of the American Psychiatric Association*, as revised, or any other diagnostic coding system as used by the Claim Administrator, whether or not the cause of the disease, disorder, or condition is physical, chemical, or mental in nature or origin;

2. The diagnosis or treatment of any symptom, condition, disease, or disorder by a Physician, Behavioral Health Practitioner or Professional Other Provider (or by any person working under the direction or supervision of a Physician, Behavioral Health Practitioner or Professional Other Provider) when the Eligible Expense is:

    a. Individual, group, family, or conjoint psychotherapy,
    b. Counseling,
    c. Psychoanalysis,
    d. Psychological testing and assessment,
    e. The administration or monitoring of psychotropic drugs, or
    f. Hospital visits or consultations in a facility listed in subsection 5, below;

3. Electroconvulsive treatment;

4. Psychotropic drugs;

5. Any of the services listed in subsections 1 through 4, above, performed in or by a Hospital, Facility Other Provider, or other licensed facility or unit providing such care.

Morbid Obesity means a Body Mass Index (BMI) of greater than or equal to 40 kg/meter^2 or a BMI greater than or equal to 35 kg/meters^2 with at least two of the following co-morbid conditions which have not responded to a maximum medical management and which are generally expected to be reversed or improved by bariatric treatment:

- Hypertension
- Dyslipidemia
- Type 2 diabetes
- Coronary heart disease
- Sleep Apnea

Negotiated National Account Arrangement means an agreement negotiated between one or more Blue Cross and/or Blue Shield Plans for any national account that is not delivered through the BlueCard Program.

Network means identified Physicians, Behavioral Health Practitioner, Professional Other Providers, Hospitals, and other facilities that have entered into agreements with BCBSTX (and in some instances with other participating Blue Cross and/or Blue Shield Plans) for participation in a managed care arrangement.

Network Provider means a Hospital, Physician, Behavioral Health Practitioner, or Other Provider who has entered into an agreement with BCBSTX (and in some instances with other participating Blue Cross and/or Blue Shield Plans) to participate as a managed care Provider.

Neuropsychological Testing means the administering of a comprehensive battery of tests to evaluate neurocognitive, behavioral, and emotional strengths and weaknesses and their relationship to normal and abnormal central nervous system functioning.

Non-Contracting Facility means a Hospital, a Facility Other Provider, or any other facility or institution which has not executed a written contract with BCBSTX for the provision of care, services, or supplies for which benefits are provided by the Plan. Any Hospital, Facility Other Provider, facility, or institution with a written contract with BCBSTX which has expired or has been canceled is a Non-Contracting Facility.

Open Enrollment Period means the 14-day period during which Employees and Dependents may enroll for coverage for the next Plan Anniversary Date.

Other Provider means a person or entity, other than a Hospital or Physician, that is licensed where required to furnish to a Participant an item of service or supply described herein as Eligible Expenses. Other Provider shall include:

1. **Facility Other Provider** - an institution or entity, only as listed:
   a. Substance Use Disorder Treatment Center
   b. Crisis Stabilization Unit or Facility
   c. Durable Medical Equipment Provider
   d. Home Health Agency
   e. Home Infusion Therapy Provider
   f. Hospice
   g. Imaging Center
   h. Independent Laboratory
   i. Prosthetics/Orthotics Provider
   j. Psychiatric Day Treatment Facility
   k. Renal Dialysis Center
   l. Residential Treatment Center for Children and Adolescents
   m. Skilled Nursing Facility
   n. Therapeutic Center

2. **Professional Other Provider** - a person or practitioner, when acting within the scope of their license and who is appropriately certified, only as listed:
   a. Advanced Practice Nurse
   b. Doctor of Chiropractic
   c. Doctor of Dentistry
   d. Doctor of Optometry
   e. Doctor of Podiatry
   f. Doctor in Psychology
   g. Licensed Acupuncturist
   h. Licensed Audiologist
   i. Licensed Substance Use Disorder Counselor
   j. Licensed Dietitian
   k. Licensed Hearing Instrument Fitter and Dispenser
   l. Licensed Marriage and Family Therapist
   m. Licensed Clinical Social Worker
   n. Licensed Occupational Therapist
   o. Licensed Physical Therapist
   p. Licensed Professional Counselor
   q. Licensed Speech-Language Pathologist
   r. Licensed Surgical Assistant
   s. Nurse First Assistant
   t. Physician Assistant
   u. Psychological Associates who work under the supervision of a Doctor in Psychology

In states where there is a licensure requirement, other Providers must be licensed by the appropriate state administrative agency.

Out-of-Network Benefits means the benefits available under the Plan for services and supplies that are provided by an Out-of-Network Provider.

Out-of-Network Provider means a Hospital, Physician, Behavioral Health Practitioner, or Other Provider who has not entered into an agreement with BCBSTX (or other participating Blue Cross and/or Blue Shield Plan) as a managed care Provider.

Outpatient Contraceptive Services means a consultation, examination, procedure, or medical service that is provided on an outpatient basis and that is related to the use of a drug or device intended to prevent pregnancy.

Participant means an Employee or Dependent whose coverage has become effective under this Plan.

Physical Medicine Services means those modalities, procedures, tests, and measurements listed in the *Physicians' Current Procedural Terminology Manual* (Procedure Codes 97010-97799), whether the service or supply is provided by a Physician or Professional Other Provider, and includes, but is not limited to, physical therapy, occupational therapy, hot or cold packs, whirlpool, diathermy, electrical stimulation, massage, ultrasound, manipulation, muscle or strength testing, and orthotics or prosthetic training.

Physician means a person, when acting within the scope of their license, who is a Doctor of Medicine or Doctor of Osteopathy.

Plan means a program of health and welfare benefits established for the benefit of its Participants whether the plan is subject to the rules and regulations of the Employee's Retirement and Income Security Act (ERISA) or, for government and/or church plans, where compliance is voluntary.

Plan Administrator means a named administrator of the Group Health Plan (GHP) having fiduciary responsibility for its operation. BCBSTX is not the Plan Administrator.

Plan Anniversary Date means the day, month, and year of the 12-month period following the Plan Effective Date and corresponding date in each year thereafter for as long as this Benefit Booklet is in force.

Plan Effective Date means the date on which coverage for the Employer's Plan begins with the Claim Administrator.

Plan Month means each succeeding calendar month period, beginning on the Plan Effective Date.

Plan Service Area means the geographical area(s) or areas in which a Network of Providers is offered and available and is used to determine eligibility for **Managed Health Care Plan** benefits.

Plan Year means the period commencing on the Contract Date/Contract Anniversary and ending on the day before the next Contract Anniversary date. Please contact your Employer for Plan Year information.

Post-Service Medical Necessity Review means the process of determining coverage after treatment has already occurred and is based on Medical Necessity guidelines. Can also be referred to as a retrospective review or post-service claims request.

Primary Care Copayment Amount means the payment, as expressed in dollars, that must be made by or on behalf of a Participant for each office visit charge you incur when services are rendered by a family practitioner, an obstetrician/gynecologist, a pediatrician, Behavioral Health Practitioner, an internist, and a Physician Assistant or Advanced Practice Nurse who works under the supervision of one of these listed Physicians.

Primary Care Provider means a Physician or Professional Other Provider who has entered into an agreement with Claim Administrator (and in some instances with other participating Blue Cross and/or Blue Shield Plans) to participate as a managed care Provider of a family practitioner, obstetrician/gynecologist, pediatrician, Behavioral Health Practitioner, an internist or a Physician Assistant or Advanced Practice Nurse who works under the supervision of one of these.

Prior Authorization means the process that determines in advance the Medical Necessity or Experimental/Investigational nature of certain care and services under this Plan.

Proof of Loss means written evidence of a claim including:

1. The form on which the claim is made;
2. Bills and statements reflecting services and items furnished to a Participant and amounts charged for those services and items that are covered by the claim; and
3. Correct diagnosis code(s) and procedure code(s) for the services and items.

Prosthetic Appliances means artificial devices including limbs or eyes, braces or similar prosthetic or orthopedic devices, which replace all or part of an absent body organ (including contiguous tissue) or replace all or part of the function of a permanently inoperative or malfunctioning body organ (excluding dental appliances and the replacement of cataract lenses). For purposes of this definition, a wig or hairpiece is not considered a Prosthetic Appliance.

Prosthetics/Orthotics Provider means a certified prosthetist that supplies both standard and customized prostheses and orthotic supplies.

Provider means a Hospital, Physician, Behavioral Health Practitioner, Other Provider, or any other person, company, or institution furnishing to a Participant an item of service or supply listed as Eligible Expenses.

Provider Incentive means an additional amount of compensation paid to a healthcare provider by a Blue Cross and/or Blue Shield Plan, based on the provider's compliance with agreed-upon procedural and/or outcome measures for a particular population of covered persons.

Psychiatric Day Treatment Facility means an institution which is appropriately licensed and is accredited by the Joint Commission on Accreditation of Healthcare Organizations as a Psychiatric Day Treatment Facility for the provision of Mental Health Care and Serious Mental Illness services to Participants for periods of time not to exceed eight hours in any 24-hour period. Any treatment in a Psychiatric Day Treatment Facility must be certified in writing by the attending Physician or Behavioral Health Practitioner to be in lieu of hospitalization.

Qualified ABA Provider means a Provider operating within the scope of their license or certification that has met the following requirements:

For the treatment supervisor/case manager/facilitator:

1. Health Care Practitioner, independently licensed clinician, who is licensed, certified, or registered by an appropriate agency in the state where services are being provided; or
2. Health Care Practitioner whose professional credential is recognized and accepted by an appropriate agency of the United States, (i.e. Board-Certified Behavior Analyst (BCBA) or Board-Certified Behavior Analyst - Doctoral (BCBS-D); or
3. Health Care Practitioner who is certified as a provider under the TRICARE military health system.

For the para-professional/line therapist:

1. Two years of college educated staff person with a Board Certified Assistant Behavior Analyst (BCaBA) for the para-professional/therapist, or
2. A staff person with a Registered Behavior Tech (RBT) certification for the direct line therapist effective as of January 1, 2019.

Recommended Clinical Review means an optional voluntary review of a Provider's recommended medical procedure, treatment or test, that does not require Prior Authorization, to make sure it meets approved Blue Cross and Blue Shield medical policy guidelines and Medical Necessity requirements.

Renal Dialysis Center means a facility which is Medicare certified as an end-stage renal disease facility providing staff assisted dialysis and training for home and self-dialysis.

Research Institution means an institution or Provider (person or entity) conducting a phase I, phase II, phase III, or phase IV clinical trial.

Residential Treatment Center means a facility setting (including a Residential Treatment Center for Children and Adolescents) offering a defined course of therapeutic intervention and special programming in a controlled environment which also offers a degree of security, supervision, structure and is licensed by the appropriate state and local authority to provide such service. It does not include half-way houses, wilderness programs, supervised living, group homes, boarding houses or other facilities that provide primarily a supportive environment and address long-term social needs, even if counseling is provided in such facilities. Patients are medically monitored with 24 hour medical availability and 24 hour onsite nursing service for Mental Health Care and/or for treatment of Substance Use Disorder. BCBSTX requires that any facility providing Mental Health Care and/or a Substance Use Disorder Treatment Center must be licensed in the state where it is located, or accredited by a national organization that is recognized by BCBSTX as set forth in its current credentialing policy, and otherwise meets all other credentialing requirements set forth in such policy.

Residential Treatment Center for Children and Adolescents means a child-care institution which is appropriately licensed and accredited by the Joint Commission on Accreditation of Healthcare Organizations or the American Association of Psychiatric Services for Children as a residential treatment center for the provisions of Mental Health Care and Serious Mental Illness services for emotionally disturbed children and adolescents.

Retail Health Clinic means a Provider that provides treatment of uncomplicated minor illnesses. Retail Health Clinics are typically located in retail stores and are typically staffed by Advanced Practice Nurses or Physician Assistants.

Routine Patient Care Costs means the costs of any Medically Necessary health care service for which benefits are provided under the Plan, without regard to whether the Participant is participating in a clinical trial.

Routine Patient Care Costs do not include:

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

Serious Mental Illness means the following psychiatric illnesses defined by the *American Psychiatric Association in the Diagnostic and Statistical Manual (DSM):*

1. Bipolar disorders (hypomanic, manic, depressive, and mixed);
2. Depression in childhood and adolescence;
3. Major depressive disorders (single episode or recurrent);
4. Obsessive-compulsive disorders;
5. Paranoid and other psychotic disorders;
6. Schizo-affective disorders (bipolar or depressive); and
7. Schizophrenia.

Skilled Nursing Facility means a facility primarily engaged in providing skilled nursing services and other therapeutic services and which is:

1. Licensed in accordance with state law (where the state law provides for licensing of such facility); or
2. Medicare or Medicaid eligible as a supplier of skilled inpatient nursing care.

Specialty Care Provider means a Physician or Professional Other Provider who has entered into an agreement with Claim Administrator (and in some instances with other participating Blue Cross and/or Blue Shield Plans) to participate as a managed care Provider of specialty services with the exception of a family practitioner, obstetrician/gynecologist, pediatrician, Behavioral Health Practitioner, an internist or a Physician Assistant or Advanced Practice Nurse who works under the supervision of one of these.

Specialty Copayment Amount means the payment, as expressed in dollars, that must be made by or on behalf of a Participant for each office visit charge you incur when services are rendered by a Specialty Care Provider.

Substance Use Disorder means the abuse of or psychological or physical dependence on or addiction to alcohol or a controlled substance.

Substance Use Disorder Treatment Center means a facility which provides a program for the treatment of Substance Use Disorder pursuant to a written treatment plan approved and monitored by a Behavioral Health Practitioner and which facility is also:

1. Affiliated with a Hospital under a contractual agreement with an established system for patient referral; or
2. Accredited as such a facility by the Joint Commission on Accreditation of Healthcare Organizations; or
3. Licensed as a Substance Use Disorder treatment program by the Texas Commission on Alcohol and Drug Abuse; or
4. Licensed, certified, or approved as a Substance Use Disorder treatment program or center by any other state agency having legal authority to so license, certify, or approve.

Telehealth Service means a health service, other than a Telemedicine Medical Service, delivered by a health professional licensed, certified, or otherwise entitled to practice in Texas and acting within the scope of the health care professional's license, certification, or entitlement to a patient at a different physical location than the health professional using telecommunications or information technology.

Telemedicine Medical Service means a health care service delivered by a Physician licensed in Texas, or a health professional acting under the delegation and supervision of a Physician licensed in Texas state, and acting within the scope of the Physician's or health professional's license to a patient at a different physical location than the Physician or health professional using telecommunications or information technology.

Therapeutic Center means an institution which is appropriately licensed, certified, or approved by the state in which it is located and which is:

1. An ambulatory (day) surgery facility;
2. A freestanding radiation therapy center; or
3. A freestanding birthing center.

Value-Based Program means an outcome-based payment arrangement and/or a coordinated care model facilitated with one or more local providers that is evaluated against cost and quality metrics/factors and is reflected in provider payment.

Virtual Provider means a licensed Provider that has entered into a contractual agreement with BCBSTX to provide diagnosis and treatment of injuries and illnesses through either (i) interactive audio communication (via telephone or other similar technology), or (ii) interactive audio/video examination and communication (via online portal, mobile application or similar technology).

Virtual Visits means services provided for the treatment of non-emergency medical and behavioral health conditions as described in ***Benefits for Virtual Visits*** provision.

Waiting Period means a period established by an Employer that must pass before an individual who is a potential enrollee in a Health Benefit Plan is eligible to be covered for benefits.

PHARMACY BENEFITS

Covered Drugs

Benefits are available under the Plan for Medically Necessary Covered Drugs prescribed to treat a Participant for a chronic, disabling, or life-threatening illness if the drug:

1. Has been approved by the United States Food and Drug Administration (FDA) for at least one indication; and
2. Is recognized by the following for treatment of the indication for which the drug is prescribed
   a. a prescription drug reference compendium, approved by the appropriate state agency, or
   b. substantially accepted peer-reviewed medical literature.

As new drugs are approved by the FDA, such drugs, unless the intended use is specifically excluded under the Plan, are eligible for benefits if included on the applicable Drug List.

Injectable Drugs

Injectable drugs approved by the FDA for self-administration are covered under the Plan. Benefits will not be provided under **PHARMACY BENEFITS** for any self-administered drugs dispensed or administered by a Physician. You are responsible for any Deductibles, Copayment Amounts, Co-Share Amounts, and pricing differences that may apply to the Covered Drug dispensed.

Diabetes Supplies for Treatment of Diabetes

Benefits are available for Medically Necessary items of Diabetes Supplies for which a Physician or authorized Health Care Practitioner has written an order. Such Diabetes Supplies, when obtained for a Qualified Participant (for more information regarding Qualified Participant, refer to the ***Benefits for Treatment of Diabetes*** subsection of the medical portion of this Benefit Booklet), shall include but not be limited to the following:

- Test strips specified for use with a corresponding blood glucose monitor
- Lancets and lancet devices
- Visual reading strips and urine testing strips and tablets which test for glucose, ketones, and protein
- Insulin and insulin analog preparations
- Injection aids, including devices used to assist with insulin injection and needleless systems
- Insulin syringes
- Biohazard disposable containers
- Prescriptive and non-prescriptive oral agents for controlling blood sugar levels, and
- Glucagon emergency kits

A separate Copayment/Co-Share Amount will apply to each fill of a prescription purchased on the same day for insulin and insulin syringes.

Preventive Care

Drugs (including both prescription and over-the-counter drugs) prescribed by a Health Care Practitioner which have in effect a rating of "A" or "B" in the current recommendations of the United States Preventive Services Task Force ("USPSTF") (to be implemented in the quantities and within the time period allowed under applicable law) or as required by state law will be covered and will not be subject to any Copayment Amount, Co-Share Amount, Deductible or dollar maximum when obtained from a Participating Pharmacy.

Select Vaccinations Obtained through Participating Pharmacies

Benefits for select vaccinations, as shown on your Schedule of Coverage, are available through certain Participating Pharmacies that have contracted with BCBSTX to provide this service. To locate one of these contracting Participating Pharmacies in the Pharmacy Vaccine Network in your area, and to determine which vaccinations are covered under this benefit, you may access our website at www.bcbstx.com/michaels or call our Customer Service Helpline number shown in this booklet or on your Identification Card. At the time you receive services, present your BCBSTX Identification Card to the pharmacist. This will identify you as a Participant in the BCBSTX health care plan provided by your employer. The pharmacist will inform you of the appropriate Copayment/Co-Share Amount, if any.

Please note that each Pharmacy that provides this service may have age, scheduling, or other requirements that will apply, so you are encouraged to contact them in advance.

Childhood immunizations subject to state regulations are not available under these Pharmacy Benefits. Refer to your BCBSTX medical coverage for benefits available for childhood immunizations.

Formulas for the Treatment of Phenylketonuria or Other Heritable Diseases

Benefits are available for dietary formulas necessary for the treatment of phenylketonuria or other heritable diseases to the same extent as any other Covered Drug available only on the orders of a Health Care Practitioner.

Specialty Drugs

Benefits are available for Specialty Drugs. Specialty Drugs are generally prescribed to treat a chronic complex medical condition. They often require careful adherence to treatment plans and have special handling and storage requirements. You must obtain these drugs from the Specialty Pharmacy Program (see ***Specialty Pharmacy Program*** below). In order to receive the highest level of benefits, use a Specialty Pharmacy Provider to obtain Specialty Drugs.

Proton Pump Inhibitors

Benefits are available for Generic, Preferred Brand and Non-Preferred Brand Name Drug proton pump inhibitors.

Retin A or Pharmacologically Similar Topical Drugs

Retin A or pharmacologically similar topical drugs are covered.

Selecting a Pharmacy

Participating Pharmacy

When you go to a Participating Pharmacy:

- present your Identification Card to the pharmacist along with your Prescription Order,
- provide the pharmacist with the birth date and relationship of the patient,
- sign the insurance claim log,
- pay the appropriate Copayment/Co-Share Amount for each Prescription Order filled or refilled and the pricing difference when it applies to the Covered Drug you receive.

Participating Pharmacies have agreed to accept as payment in full the least of:

- the billed charges, or
- the Allowable Amount as determined by the Claim Administrator, or
- other contractually determined payment amounts.

You may be required to pay for limited or non-covered services. No claim forms are required.

If you are unsure whether a Pharmacy is a Participating Pharmacy, you may access our website at www.bcbstx.com/michaels or contact the Customer Service Helpline telephone number shown in this Benefit Booklet or on your Identification Card.

Non-Participating Pharmacy

If you have a Prescription Order filled at a non-Participating Pharmacy, you must pay the Pharmacy the full amount of its bill. Benefits are not available for Covered Drugs, services or supplies received from a Non-Participating Pharmacy.

Extended Prescription Drug Supply Program

Your coverage includes benefits for up to a 90-day supply of covered maintenance type drugs and diabetic supplies purchased from a Participating Pharmacy contracted with Us to take part in the extended retail prescription drug supply program (which will include retail or mail-order pharmacies). Each prescription or refill is subject to the Copayment Amount, Co-Share Amount and any Deductible shown in your Schedule of Coverage and any applicable pricing differences.

Benefits will not be provided for more than a 90-day supply of drugs or diabetic supplies purchased from a Participating Pharmacy not participating in the extended prescription drug supply program.

Mail-Order and 90 DayMyWay Program

The mail-order program provides delivery of Covered Drugs directly to your home address. If you and your covered Dependents elect to use the mail-order service, refer to your Schedule of Coverage for applicable payment levels.

In order to receive benefits for Maintenance Drugs, you must obtain a 90 day supply for these medications through the mail-order program or through one of the extended supply pharmacies. For a listing of Maintenance Drugs, you may access the website at www.bcbstx.com/michaels or contact Customer Service at the toll-free number on your Identification Card. Benefits are available for the original Prescription Order plus one refill at a retail Pharmacy for Maintenance Drugs. For the third fill of the medication, benefits are only available for Maintenance Drugs through the mail-order program or through one of the extended supply pharmacies. Benefits are not available if you continue to fill your Prescription Order for Maintenance Drugs at a non-extended supply retail Pharmacy.

Some drugs may not be available through the mail-order program. If you have any questions about this mail-order program, need assistance in determining the amount of your payment, or need to obtain the mail-order prescription form, you may access the website at www.bcbstx.com/michaels or contact Customer Service at the toll-free number on your Identification Card. Mail the completed form, your Prescription Order(s) and payment to the address indicated on the form.

If you send an incorrect payment amount for the Covered Drug dispensed, you will: (a) receive a credit if the payment is too much; or (b) be billed for the appropriate amount if it is not enough.

Specialty Pharmacy Program

This program provides delivery of medications from the Specialty Pharmacy Provider directly to your Health Care Practitioner, administration location or to the home of the Participant.

Due to special storage requirements and high cost, Specialty Drugs are not covered unless obtained through the Specialty Pharmacy Program. However, the first fill of your Specialty Drug Prescription Order may be obtained through a retail Pharmacy to allow you time to become established under the Specialty Pharmacy Program.

In order to receive the highest level of benefits, use a Specialty Pharmacy Provider to obtain Specialty Drugs.

The Specialty Pharmacy Program delivery service offers:

- Coordination of coverage between you, your Health Care Practitioner and BCBSTX,
- Educational materials about the patient's particular condition and information about managing potential medication side effects,
- Syringes, sharps containers, alcohol swabs and other supplies with every shipment for FDA approved self-injectable medications, and
- Access to a pharmacist for urgent medication issues 24 hours a day, 7 days a week, 365 days each year.

If you and your covered Dependents use the Specialty Pharmacy Program, you should contact Customer Service at the toll-free number shown in this Benefit Booklet or on your Identification Card for information about how to submit your Prescription Orders. You will also be given information on how to make payment for your share of the cost (see **Your Cost** below).

A list identifying these Specialty Drugs is available by accessing the website at www.bcbstx.com/michaels or by contacting Customer Service at the toll-free number on your Identification Card. Your cost will be the appropriate Copayment/Co-Share Amount indicated on the Schedule of Coverage and any applicable pricing differences. You will also be responsible for any Deductible amounts that may apply to your coverage.

Your Cost

Copayment/Co-Share Amounts

Copayment/Co-Share Amounts for a Participating Pharmacy, the mail-order program or a Provider that supplies Preferred Specialty Drugs are shown on your Schedule of Coverage. The amount you pay depends on the Covered Drug dispensed. If the Covered Drug dispensed is a:

1. Generic Drug - You pay the Generic Drug Copayment Amount

2. Preferred Brand Name Drug - You pay the Preferred Brand Name Drug Copayment Amount

3. Non-Preferred Brand Name Drug - You pay the Non-Preferred Brand Name Drug Copayment/Co-Share Amount

4. Generic Specialty Drug - You pay the Generic Specialty Drug Copayment Amount

5. Preferred Brand Name Specialty Drug - You pay the Preferred Brand Name Specialty Drug Copayment Amount

6. Non-Preferred Brand Name Specialty Drug - You pay the Non-Preferred Brand Name Specialty Drug Copayment/Co-Share Amount

If the Allowable Amount of the Covered Drug is less than the Copayment/Co-Share Amount, the Participant will pay the lower cost.

How Brand Name Drug Pricing Difference Applies

When your authorized Health Care Practitioner has marked the Prescription Order "Brand Necessary" or "Brand Medically Necessary," the pharmacist may *only* dispense the Brand Name Drug and you pay the applicable Copayment Amount and/or Co-Share Amount after your Deductible (if Deductible applies to the Plan) based on the current tier of Brand Name Drug.

If the authorized Health Care Practitioner has not stipulated a dispensing directive prohibiting substitution of a generic equivalent, you may still choose to buy the Brand Name Drug instead of the Generic Drug.

If the Brand Name Drug is dispensed, your payment amount will be the sum of:

(a) applicable Copayment Amount and/or Co-Share Amount after your Deductible (if Deductible applies to the Plan) based on the current tier of Brand Name Drug, **plus**

(b) the difference between the Allowable Amount of the Generic Drug and the Allowable Amount of the Preferred Brand Name Drug.

Exceptions to this provision may be allowed for certain preventive medications (including prescription contraceptive medications) if your Health Care Practitioner submits a request to BCBSTX indicating that the Generic Drug would be medically inappropriate, along with supporting documentation. If BCBSTX grants the exception request, any difference between the Allowable Amount for the Brand Name Drug and the Generic Drug will be waived.

Member Pay the Difference

If you obtain a Brand Name Drug when a Generic Drug is available, you will pay the applicable Copayment Amount and/or Co-Share Amount after your Deductible (if Deductible applies to the Plan) based on the current tier of Brand Name Drug **plus** the difference between the Allowable Amount of the Non-Preferred Brand Name Drug and the Allowable Amount of the Generic Drug. The difference between the Allowable Amount of the Non-Preferred Brand Name Drug and the Allowable Amount of the Generic Drug will not apply to the Deductible (if Deductible applies to the Plan) and Out-of-Pocket Maximum and will continue to be applicable after the Out-of-Pocket Maximum is met.

Exceptions to this provision may be allowed for certain preventive medications (including prescription contraceptive medications) if your Health Care Practitioner submits a request to BCBSTX indicating that the Generic Drug would be medically inappropriate, along with supporting documentation. If BCBSTX grants the exception request, any difference between the Allowable Amount for the Non-Preferred Brand Name Drug and the Generic Drug will be waived.

Drug Coupons, Rebates or Other Discounts

If a covered prescription drug was paid for using a drug manufacturer's coupon card, the coupon or copay card amount will not apply to your Plan Deductible or Out-of-Pocket Maximum.

How Member Payment is Determined

Prescription drug products are separated into tiers. Generally, each drug is placed into one of six drug tiers:

- **Tier 1** includes mostly Generic Drugs and may contain some Brand Name Drugs.
- **Tier 2** includes mostly Preferred Brand Name Drugs and may contain some Generic Drugs.
- **Tier 3** includes mostly Non-Preferred Brand Name Drugs and may contain some Generic Drugs.
- **Tier 4** includes mostly Generic Specialty Drugs and may contain some Brand Name Specialty Drugs.
- **Tier 5** includes mostly Preferred Brand Name Specialty Drugs and may contain some Generic Specialty Drugs.
- **Tier 6** includes mostly Non-Preferred Brand Name Specialty Drugs and may contain some Generic Specialty Drugs.

Any Deductible, Copayment Amount or Co-Share Amount for Covered Drugs on each drug tier is shown on your Schedule of Coverage. You can also contact customer service at the toll-free number on your Identification Card.

About Your Benefits

Drug List

The Drug List is developed using monographs written by the American Medical Association, Academy of Managed Care Pharmacies, and other Pharmacy and medical related organizations, describing clinical outcomes, drug efficacy, and side effect profiles.

BCBSTX will routinely review the Drug List and periodically adjust it to modify the status of existing or new drugs. Changes to this list will occur as frequently as quarterly. The Drug List and any modifications will be made available to Participants. Participants may access our website at www.bcbstx.com/michaels or call the Customer Service Helpline at the telephone number shown in this Benefit Booklet or on your Identification Card to determine if a particular drug is on the Drug List. Drugs that do not appear on the Balanced Drug List will not be covered under the Plan.

Drug List Exception Requests

You, or your Health Care Practitioner, can ask for a Drug List exception if your drug is not on the Drug List. To request this exception, you, or your Health Care Practitioner, can call the number on the back of your Identification Card to ask for a review. If you have a health condition that may jeopardize your life, health, or keep you from regaining function, or your current drug therapy uses a non-covered drug, you, or your Health Care Practitioner, may be able to ask for an expedited review process. BCBSTX will let you, and your Health Care Practitioner, know the coverage decision within the lesser of 48 business hours or 72 calendar hours after they receive your request for an expedited review. If the coverage request is denied, BCBSTX will let you and your Health Care Practitioner know why it was denied and offer you a covered alternative drug (if applicable). If your exception is denied, you may appeal the decision according to the appeals process you will receive with the denial determination. Call the number on the back of your Identification Card if you have any questions.

Day Supply

Benefits for Covered Drugs obtained from a Participating Pharmacy, or through the mail-order program or through Providers that supply Preferred Specialty Drugs are provided up to the maximum day supply limit as indicated on your Schedule of Coverage. The Copayment/Co-Share Amount applicable for the designated day supply of dispensed drugs are also indicated on your Schedule of Coverage. The Claim Administrator has the right to determine the day supply. Payment for benefits covered under this Plan may be denied if drugs are dispensed or delivered in a manner intended to change, or having the effect of changing or circumventing, the stated maximum day supply limitation.

If you are leaving the country or need an extended supply of medication, call Customer Service at least two weeks before you intend to leave. (Extended supplies or vacation override are not available through the mail-order Pharmacy but may be approved through the retail Pharmacy only. In some cases, you may be asked to provide proof of continued enrollment eligibility under the Plan.)

Dispensing Quantity Versus Time Limits

Dispensing limits are based upon FDA dosing recommendations and nationally recognized guidelines. Coverage limits are placed on medications in certain drug categories. Limits may include: quantity of covered medication per prescription, quantity of covered medication in a given time period, or coverage only for Participants within a certain age range. Quantities of some drugs are restricted regardless of the quantity ordered by the Health Care Practitioner. To determine if a specific drug is subject to this limitation, you may access the website at www.bcbstx.com/michaels or contact Customer Service at the toll-free number on your Identification Card.

If your Health Care Practitioner prescribes a greater quantity of medication than what the dispensing limit allows, you can still get the medication. However, you will be responsible for the full cost of the prescription beyond what your coverage allows.

If you require a Prescription Order in excess of the dispensing limit established by BCBSTX, ask your Health Care Practitioner to submit a request for clinical review on your behalf. The Health Care Practitioner can obtain an override request form by accessing our website at www.bcbstx.com/michaels. Any pertinent medical information along with the completed form should be faxed to Clinical Pharmacy Programs at the fax number indicated on the form. The request will be approved or denied after evaluation of the submitted clinical information. BCBSTX has the right to determine dispensing limits. Payment for benefits covered by under this Plan may be denied if drugs are dispensed or delivered in a manner intended to change, or having the effect of changing or circumventing, the stated maximum quantity limitation.

Step Therapy

Coverage for certain designated prescription drugs or drug classes may be subject to a step therapy program. Step therapy programs favor the use of clinically acceptable alternative medications before requested agent may be covered.

When you submit a Prescription Order to a Participating Pharmacy or through the mail service prescription drug program or through Providers that supply Preferred Specialty Drugs for one of these designated medications, the Pharmacist will be alerted if the online review of your prescription claims history indicates an acceptable alternative medication that has not been previously tried. A list of step therapy medications are available to you and your Health Care Practitioner on our website at www.bcbstx.com/michaels.

If it is Medically Necessary, coverage can be obtained for the prescription drugs subject to the Step Therapy Program without trying an alternative medication first. In this case, your Health Care Practitioner must contact BCBSTX to obtain an exception for coverage of such drug. If authorization is granted, the Participant and the Health Care Practitioner will be notified and the medication will then be covered at the applicable Copayment Amount or Co-Share Amount.

Prior Authorizations

Coverage for certain designated prescription drugs is subject to Prior Authorization criteria. This means that in order to ensure that a drug is safe, effective, and part of a specific treatment plan, certain medications may require Prior Authorization and the evaluation of additional clinical information before dispensing. A list of the medications which require Prior Authorization is available to you and your Health Care Practitioner on our website at www.bcbstx.com/michaels or contact customer service at the toll-free number on your Identification Card.

When you submit a Prescription Order to a Participating Pharmacy or through the mail service prescription drug program or through Providers that supply Preferred Specialty Drugs for one of these designated medications, the Pharmacist will be alerted online if your Prescription Order is on the list of medication which requires Prior Authorization before it can be filled. If this occurs, your Health Care Practitioner will be required to submit an authorization form. This form may also be submitted by your Health Care Practitioner in advance of the request to the Pharmacy. The Health Care Practitioner can obtain the authorization form by accessing our website at www.bcbstx.com/michaels. The requested medication may be approved or denied for coverage under the Plan based upon its accordance with established clinical criteria.

RxRunway Transition Fill Program

This program gives you 90 days to amend current prescriptions should there be a change in your benefits that impacts coverage to your current medications due to a change in drug list or utilization requirements.

The 90-day window begins when the benefit change takes effect, during which you may obtain a 1-time refill of each of your current medicines if those medications are not on the new drug list and/or require a Prior Authorization/Step Therapy. You will receive a letter after the transition fill, reminding you to contact your prescriber and discuss moving to a covered medication or submitting a Prior Authorization/Step Therapy request.

This program does not apply to specialty medications or to standard non-covered benefits, such as medications not approved by the FDA or some medications administered by your health care provider.

If you have any questions about this program, you may access the website at www.bcbstx.com/michaels or contact Customer Service at the toll-free number on your Identification Card.

Controlled Substances Limitations

If it is determined that a Participant may be receiving quantities of controlled substance medications not supported by FDA approved dosages or recognized safety or treatment guidelines, any coverage for additional drugs may be subject to review to assess whether Medically Necessary or appropriate and restrictions may include but not be limited to a certain Provider and/or Pharmacy of the Participant's choice and/or quantities and/or days' supply for the prescribing and dispensing of the controlled substance medication. If the Participant does not choose such Provider and/or Pharmacy within a reasonable time, BCBSTX will make the choice. Additional Copayment Amounts, Co-Share Amounts and any Deductible may apply.

Right of Appeal

In the event that a requested Prescription Order is still denied on the basis of Prior Authorization criteria, step therapy criteria, or quantity versus time dispensing limits with or without your authorized Health Care Practitioner having submitted clinical documentation, you have the right to appeal as indicated under the **Review of Claim Determinations** subsection of this Benefit Booklet.

Limitations and Exclusions

Pharmacy benefits are not available for:

1. Drugs which do not by law require a Prescription Order, except as indicated under ***Preventive Care*** in **PHARMACY BENEFITS**, from a Provider or authorized Health Care Practitioner (**except** insulin, insulin analogs, insulin pens, and prescriptive and non-prescriptive oral agents for controlling blood sugar levels, and select vaccinations administered through certain Participating Pharmacies as shown on your Schedule of Coverage); and Legend Drugs or covered devices for which no valid Prescription Order is obtained.

2. Drugs which are not included on the Drug List including new to market FDA approved drugs which have not been reviewed by the Plan for inclusion on the Drug List.

3. Pharmaceutical aids such as excipients found in the USP-NF (United States Pharmacopeia-National Formulary), including, but not limited to preservatives, solvents, ointment bases and flavoring coloring diluting emulsifying and suspending agents.

4. Devices or durable medical equipment of any type (even though such devices may require a Prescription Order) such as, but not limited to therapeutic devices, including support garments and other non-medicinal substances, artificial appliances, or similar devices (provided that disposable hypodermic needles and syringes for self-administered injections and those devices listed as Diabetes Supplies shall be specific exceptions to this exclusion). NOTE: Coverage for the rental or purchase of a manual, electric, or Hospital grade breast pump and female contraceptive devices is provided as indicated under the medical portion of this Plan.

5. Administration or injection of any drugs.

6. Vitamins (**except** those vitamins which by law require a Prescription Order and for which there is **no** non-prescription alternative or as indicated under ***Preventive Care*** in **PHARMACY BENEFITS**).

7. Drugs injected, ingested or applied in a Physician's or authorized Health Care Practitioner's office or during confinement while a patient is in a Hospital, or other acute care institution or facility, including take-home drugs; and drugs dispensed by a nursing home or custodial or chronic care institution or facility.

8. Covered Drugs, devices, or other Pharmacy services or supplies provided or available in connection with an occupational sickness or an injury sustained in the scope of and in the course of employment whether or not benefits are, or could upon proper claim be, provided under the Workers' Compensation law.

9. Covered Drugs, devices, or other Pharmacy services or supplies for which benefits are, or could upon proper claim be, provided under any present or future laws enacted by the Legislature of any state, or by the Congress of the United States, or the laws, regulations or established procedures of any county or municipality, or any prescription drug which may be properly obtained without charge under local, state, or federal programs, unless such exclusion is expressly prohibited by law; provided, however, that the exclusions of this section shall not be applicable to any coverage held by the Participant for prescription drug expenses which is written as a part of or in conjunction with any automobile casualty insurance policy.

10. Any special services provided by the Pharmacy, including but not limited to, counseling and delivery. Select Vaccinations administered through Participating Pharmacies are an exception to this exclusion.

11. Covered Drugs for which the Pharmacy's usual and customary charge to the general public is less than or equal to the Participant's cost share determined under this Plan.

12. Non-prescription contraceptive materials, (**except** prescription contraceptive drugs which are Legend Drugs. Contraceptive drugs provided by a Participating Pharmacy will not be subject to Co-Share Amounts, Deductibles, Copayment Amounts and/or dollar maximums as shown in ***Benefits for Preventive Care Services***.)

13. Any non-prescription contraceptive medications or devices for male use.

14. Any prescription antiseptic or fluoride mouthwashes, mouth rinses, or topical oral solutions or preparations, except as required by the Affordable Care Act.

15. Drugs required by law to be labeled: “Caution - Limited by Federal Law to Investigational Use,” or experimental drugs, even though a charge is made for the drugs.

16. Drugs dispensed in quantities in excess of the day supply amounts stipulated in your Schedule of Coverage, certain Covered Drugs exceeding the clinically appropriate predetermined quantity, or refills of any prescriptions in excess of the number of refills specified by the Physician or authorized Health Care Practitioner or by law, or any drugs or medicines dispensed more than one year following the Prescription Order date.

17. Legend Drugs which are not approved by the U.S. Food and Drug Administration (FDA) for a particular use or purpose or when used for a purpose other than the purpose for which the FDA approval is given, except as required by law or regulation.

18. Fluids, solutions, nutrients, or medications (including all additives and chemotherapy) used or intended to be used by intravenous or gastrointestinal (enteral) infusion or by intravenous, intramuscular (in the muscle), unless approved by the FDA for self-administration, intrathecal (in the spine), or intraarticular (in the joint) injection in the home setting. NOTE: This exclusion does not apply to dietary formula necessary for the treatment of phenylketonuria (PKU) or other heritable diseases.

19. Any drugs or supplies provided for reduction of obesity or weight, even if the Participant has other health conditions which might be helped by a reduction of obesity or weight.

20. Drugs, that the use or intended use of which would be illegal, unethical, imprudent, abusive, not Medically Necessary, or otherwise improper.

21. Drugs obtained by unauthorized, fraudulent, abusive, or improper use of the Identification Card.

22. Drugs used or intended to be used in the treatment of a condition, sickness, disease, injury, or bodily malfunction which is not covered under your Employer's group health care plan, or for which benefits have been exhausted.

23. Rogaine, minoxidil, or any other drugs, medications, solutions, or preparations used or intended for use in the treatment of hair loss, hair thinning, or any related condition, whether to facilitate or promote hair growth, to replace lost hair, or otherwise.

24. Compounded drugs that do not meet the definition of Compound Medications in this portion of your Benefit Booklet.

25. Cosmetic drugs used primarily to enhance appearance, including, but not limited to, correction of skin wrinkles and skin aging.

26. Prescription Orders for which there is an over-the-counter product available with the same active ingredient(s) in the same strength, unless otherwise determined by the Plan. NOTE: This exclusion does not apply to Omeprazole 20mg.

27. Athletic performance enhancement drugs.

28. Bulk powders.

29. Surgical supplies.

30. Ostomy products.

31. Diagnostic agents. This exclusion does not apply to diabetic test strips.

32. Drugs used for general anesthesia.

33. Allergy serum and allergy testing materials.

34. Injectable drugs, except self-administered Specialty Drugs or those approved by the FDA for self-administration including growth hormones.

35. Self-administered drugs dispensed or administered by a Physician in their office.

36. Prescription Orders which do not meet the required Step Therapy criteria.

37. Prescription Orders which do not meet the required Prior Authorization criteria.

38. Some drugs have equivalents/therapeutic alternatives. In some cases, BCBSTX may limit benefits to only certain therapeutic equivalents/therapeutic alternatives. If you do not choose the therapeutic equivalents/therapeutic alternatives that are covered under your Plan, the drug purchased will not be covered under any benefit level.

39. Specialty Drugs, unless obtained through the ***Specialty Pharmacy Program***.

40. Specialty Drugs obtained from a retail Pharmacy in excess of the first fill as described in ***Specialty Pharmacy Program.***

41. Replacement of drugs or other items that have been lost, stolen, destroyed or misplaced.

42. Shipping, handling or delivery charges.

43. Institutional packs and drugs that are repackaged by anyone other than the original manufacturer.

44. Prescription Orders written by a member of your immediate family, or a self-prescribed Prescription Order.

45. Drugs in a drug class where there is an over the counter alternative available, unless otherwise determined by the Group Health Plan.

46. Depo-Provera (IM injectable).

47. Drugs determined to have inferior efficacy or significant safety issues.

48. Drugs that are not considered Medically Necessary or treatment recommendations that are not supported by evidence-based guidelines or clinical practice guidelines.

Definitions

(In addition to the applicable terms provided in the **DEFINITIONS** *section of the Benefit Booklet, the following terms will apply specifically to this* **PHARMACY BENEFITS** *section*.)

Allowable Amount means the maximum amount determined by the Claim Administrator to be eligible for consideration of payment for a particular Covered Drug. As applied to Participating Pharmacies, the mail-order program and Providers that supply Preferred Specialty Drugs, the Allowable Amount is based on the provisions of the contract between BCBSTX and the Participating Pharmacy or Pharmacy for the mail-order program or the Provider that supplies Preferred Specialty Drugs in effect on the date of service.

Brand Name Drug means a drug or product manufactured by a single manufacturer as defined by a nationally recognized provider of drug product database information. There may be some cases where two manufacturers will produce the same product under one license, known as a co-licensed product, which would also be considered as a Brand Name Drug. There may also be situations where a drug's classification changes from generic to brand name due to a change in the market resulting in the generic being a single source, or the drug product database information changing, which would also result in a corresponding change in Copayment/Co-Share Amount obligations from generic to brand name.

Compound Medications mean those drugs that have been measured and mixed with U.S. Food and Drug Administration (FDA) approved pharmaceutical ingredients by a pharmacist to produce a unique formulation because commercial products either do not exist or do not exist in the correct dosage, size, or form. The drugs used must meet the following requirements:

1. The drugs in the compounded product are Food and Drug Administration (FDA) approved;
2. The approved product has an assigned National Drug Code (NDC); and
3. The primary active ingredient is a Covered Drug under the Plan.

Controlled Substance means an abusable volatile chemical as defined in the Texas Health and Safety Code, or a substance designated as a Controlled Substance in the Texas Health and Safety Code.

Copayment/Co-Share Amount means the dollar amount paid by the Participant for each Prescription Order filled or refilled through a Participating Pharmacy.

Covered Drugs means any Legend Drug (including insulin, insulin analogs, insulin pens, and prescriptive and non-prescriptive oral agents for controlling blood sugar levels, with disposable syringes and needles needed for self-administration):

1. Which is Medically Necessary and is ordered by an authorized Health Care Practitioner naming a Participant as the recipient;
2. Which is included on the applicable Drug List;
3. For which a written or verbal Prescription Order is provided by an authorized Health Care Practitioner;
4. For which a separate charge is customarily made;
5. Which is not consumed at the time and place that the Prescription Order is written;
6. For which the U.S. Food and Drug Administration (FDA) has given approval for at least one indication; and
7. Which is dispensed by a Pharmacy and is received by the Participant while covered under the Plan, **except when** received from a Provider's office, or during confinement while a patient in a Hospital or other acute care institution or facility (refer to **Limitations and Exclusions**).

Drug List means a list of drugs that may be covered under the **PHARMACY BENEFITS** portion of the Plan. This list is available by accessing the website at www.bcbstx.com/michaels. You may also contact Customer Service at the toll-free number on your Identification Card for more information. Changes to this list will occur as frequently as quarterly. The Drug List and any modifications will be made available to Participants.

Generic Drug means a drug that has the same active ingredient as a Brand Name Drug and is allowed to be produced after the Brand Name Drug's patent has expired. In determining the brand or generic classification for Covered Drugs, BCBSTX utilizes the generic/brand status assigned by a nationally recognized provider of drug product database information. You should know that not all drugs identified as a "generic" by the drug product database, manufacturer, Pharmacy, or your Health Care Practitioner will adjudicate as generic by BCBSTX. Generic Drugs are shown on the Drug List which is available by accessing the BCBSTX website at www.bcbstx.com/michaels. You may also contact the Customer Service Helpline number shown on your Identification Card for more information.

Generic Specialty Drug means a Specialty Drug which appears on the Balanced Drug List as a Generic Specialty Drug. The Balanced Drug List is available by accessing the website at www.bcbstx.com/michaels**.**

Health Care Practitioner means an Advanced Practice Nurse, Doctor of Medicine, Doctor of Dentistry, Physician Assistant, Doctor of Osteopathy, Doctor of Podiatry, or other licensed person with prescription authority.

Legend Drugs mean drugs, biologicals, or compounded prescriptions which are required by law to have a label stating "Caution - Federal Law Prohibits Dispensing Without a Prescription," and which are approved by the U.S. Food and Drug Administration (FDA) for a particular use or purpose.

Maintenance Drugs mean drugs prescribed for chronic conditions and are taken on a regular basis to treat conditions such as high cholesterol, high blood pressure, or asthma.

National Drug Code (NDC) means a national classification system for the identification of drugs.

Non-Preferred Brand Name Drug means a Brand Name Drug which appears on the Balanced Drug List as a Non-Preferred Brand Name Drug. This Balanced Drug List is available by accessing the website at www.bcbstx.com/michaels.

Non-Preferred Brand Name Specialty Drug means a Brand Name Specialty Drug which appears on the Balanced Drug List as a Non-Preferred Brand Name Specialty Drug. This Balanced Drug List is available by accessing the website at www.bcbstx.com/michaels.

Participant means an Employee or Dependent whose coverage has become effective under this Plan.

Participating Pharmacy means an independent retail Pharmacy, chain of retail Pharmacies, mail-order Pharmacy or specialty drug Pharmacy which has entered into an agreement to provide pharmaceutical services to Participants under the Plan. A retail Participating Pharmacy may or may not be a **Select Participating Pharmacy** as that term is used in the ***Select Vaccinations Obtained through Participating Pharmacies*** subsection above.

Pharmacy means a state and federally licensed establishment that is physically separate and apart from any Provider's office, and where Legend Drugs and devices are dispensed under Prescription Orders to the general public by a pharmacist licensed to dispense such drugs and devices under the laws of the state in which the pharmacist practices.

Pharmacy Vaccine Network means the network of select Participating Pharmacies which have a written agreement with BCBSTX to provide certain vaccinations to Participants under this Plan.

Preferred Brand Name Drug means a Brand Name Drug which appears on the Balanced Drug List as Preferred Brand Name Drug. The Balanced Drug List is available by accessing the website at www.bcbstx.com/michaels.

Preferred Brand Name Specialty Drug means a Brand Name Specialty Drug which appears on the Balanced Drug List as Preferred Brand Name Specialty Drug. The Balanced Drug List is available by accessing the website at www.bcbstx.com/michaels.

Prescription Order means a written or verbal order from an authorized Health Care Practitioner to a pharmacist for a drug or device to be dispensed. Orders written by an authorized Health Care Practitioner located outside the United States to be dispensed in the United States are not covered under the Plan.

Select Participating Pharmacy means a Pharmacy that has specifically contracted with BCBSTX to administer vaccinations to Participants. Not all Participating Pharmacies are Select Participating Pharmacies.

Specialty Drug means specialty medication that are used to treat complex medical conditions and are typically given by injection, but may be topical or taken by mouth. They also often require careful adherence to treatment plans, may have special handling or storage requirements, and may not be stocked by retail pharmacies.

To determine which drugs are Specialty Drugs, you may contact the Customer Service Helpline number shown on your Identification Card.

Specialty Pharmacy Provider means a Participating Pharmacy which has entered into a written agreement with BCBSTX to provide Specialty Drugs to Participants under the Plan.

GENERAL PROVISIONS

Agent

The Employer is not the agent of the Claim Administrator.

Amendments

The Plan may be amended or changed at any time by agreement between the Employer and the Claim Administrator.

The Claim Administrator's Ownership Interests

The Claim Administrator or its subsidiaries or affiliates may have ownership interests in certain Providers who provide covered services to Participants, and/or vendors or other third parties who provide covered services related to the benefits and requirements of this Plan or provide services to certain Providers.

Assignment and Payment of Benefits

Rights and benefits under the Plan shall not be assignable, either before or after services and supplies are provided.

In the absence of a written agreement with a Provider, the Claim Administrator reserves the right to make benefit payments to the Provider or the Employee, as the Claim Administrator elects. Payment to either party discharges the Plan's responsibility to the Employee or Dependents for benefits available under the Plan.

Claims Liability

BCBSTX, in its role as Claim Administrator, provides administrative claims payment services only and does not assume any financial risk or obligation with respect to claims.

Disclosure Authorization

If you file a claim for benefits, it will be necessary that you authorize any health care Provider, insurance carrier, or other entity to furnish the Claim Administrator all information and records or copies of records relating to the diagnosis, treatment, or care of any individual included under your coverage. If you file claims for benefits, you and your Dependents will be considered to have waived all requirements forbidding the disclosure of this information and records.

Identity Theft Protection

As a Participant, BCBSTX makes available at no additional cost to you identity theft protection services, including credit monitoring, fraud detection, credit/identity repair and insurance to help protect your information. These identity theft protection services are currently provided by BCBSTX's designated outside vendor and acceptance or declination of these services is optional to the Participant. Participants who wish to accept such identity theft protection services will need to individually enroll in the program online at www.bcbstx.com/michaels or by calling the Customer Service Helpline. Services may automatically end when the person is no longer an eligible Participant. Services may change or be discontinued at any time with reasonable notice. BCBSTX does not guarantee that a particular vendor or service will be available at any given time.

Medicare

Special rules apply when you are covered by this Plan and by Medicare. Generally, this Plan is a Primary Plan if you are an active Employee, and Medicare is a Primary Plan if you are a retired Employee.

Participant/Provider Relationship

The choice of a health care Provider should be made solely by you or your Dependents. The Claim Administrator does not furnish services or supplies but only makes payment for Eligible Expenses incurred by Participants. The Claim Administrator is not liable for any act or omission by any health care Provider. The Claim Administrator does not have any responsibility for a health care Provider's failure or refusal to provide services or supplies to you or your Dependents. Care and treatment received are subject to the rules and regulations of the health care Provider selected and are available only for sickness or injury treatment acceptable to the health care Provider.

The Claim Administrator, Network Providers, and/or other contracting Providers are independent contractors with respect to each other. The Claim Administrator in no way controls, influences, or participates in the health care treatment decisions entered into by said Providers. The Claim Administrator does not furnish medical, surgical, hospitalization, or similar services or supplies, or practice medicine or treat patients. The Providers, their employees, their agents, their ostensible agents, and/or their representatives do not act on behalf of BCBSTX nor are they employees of BCBSTX.

Overpayment

If your Group Health Plan or the Claim Administrator pays benefits for Eligible Expenses incurred by you or your Dependents and it is found that the payment was more than it should have been, or it was made in error ("Overpayment"), your Group Health Plan or the Claim Administrator has the right to obtain a refund of the Overpayment amount from: (i) the person to, or for whom, such benefits were paid, or (ii) any insurance company or plan, or (iii) any other persons, entities, or organizations, including, but not limited to Network Providers or Out-of-Network Providers.

If no refund is received, your Group Health Plan and/or Blue Cross and Blue Shield (in its capacity as insurer or administrator) has the right to deduct any refund for any Overpayment due up to an amount equal to the Overpayment, from:

1. Any future benefit payment made to any person or entity under this Benefit Booklet, whether for the same or a different Participant; or
2. Any future benefit payment made to any person or entity under another Blue Cross and Blue Shield administered ASO benefit program and/or Blue Cross and Blue Shield administered insured benefit program or policy, if the future benefit payment owed is to a Network Provider; or
3. Any future benefit payment made to any person or entity under another Blue Cross and Blue Shield insured group benefit plan or individual policy, if the future benefit payment owed is to a Network Provider; or
4. Any future benefit payment, or other payment, made to any person or entity; or
5. Any future payment owed to one or more Network Providers.

Further, the Claim Administrator has the right to reduce your Group Health Plan's payment to a Network Provider by the amount necessary to recover another Blue Cross and Blue Shield's plan or policy Overpayment to the same Network Provider and to remit the recovered amount to the other Blue Cross and Blue Shield plan or policy.

Rescission

Rescission is the cancellation or discontinuance of coverage that has retroactive effect. Your coverage may not be rescinded unless you or a person seeking coverage on your behalf performs an act, practice or omission that constitutes fraud, or makes an intentional misrepresentation of material fact. A cancellation or discontinuance of coverage that has only prospective effect is not a rescission. A retroactive cancellation or discontinuance of coverage based on a failure to timely pay required premiums or contributions toward the cost of coverage (including COBRA premiums) is not a rescission. You will be given 30 days advance notice of rescission. A rescission is considered an Adverse Benefit Determination for which you may seek internal review and external review.

Subrogation

If the Plan pays or provides benefits for you or your Dependents, the Plan is subrogated to all rights of recovery which you or your Dependent have in contract, tort, or otherwise against any person, organization, or insurer for the amount of benefits the Plan has paid or provided. That means the Plan may use your rights to recover money through judgment, settlement, or otherwise from any person, organization, or insurer.

For the purposes of this provision, *subrogation* means the substitution of one person or entity (the Plan) in the place of another (you or your Dependent) with reference to a lawful claim, demand or right, so that the person who is substituted succeeds to the rights of the other in relation to the debt or claim, and its rights or remedies.

Right of Reimbursement

In jurisdictions where subrogation rights are not recognized, or where subrogation rights are precluded by factual circumstances, the Plan will have a right of reimbursement.

If you or your Dependent recover money from any person, organization, or insurer for an injury or condition for which the Plan paid benefits, you or your Dependent agree to reimburse the Plan from the recovered money for the amount of benefits paid or provided by the Plan. That means you or your Dependent will pay to the Plan the amount of money recovered by you through judgment, settlement or otherwise from the third party or their insurer, as well as from any person, organization or insurer, up to the amount of benefits paid or provided by the Plan.

Right to Recovery by Subrogation or Reimbursement

You or your Dependent agree to promptly furnish to the Plan all information which you have concerning your rights of recovery from any person, organization, or insurer and to fully assist and cooperate with the Plan in protecting and obtaining its reimbursement and subrogation rights. You, your Dependent or your attorney will notify the Plan before settling any claim or suit so as to enable us to enforce our rights by participating in the settlement of the claim or suit. You or your Dependent further agree not to allow the reimbursement and subrogation rights of the Plan to be limited or harmed by any acts or failure to act on your part.

Coordination of Benefits

The availability of benefits specified in This Plan is subject to Coordination of Benefits (COB) as described below. This COB provision applies to This Plan when a Participant has health care coverage under more than one Plan.

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 shall not be reduced when This Plan determines its benefits before another Plan; but may be reduced when another Plan determines its benefits first.

Coordination of Benefits – Definitions

1. **Plan** means any group insurance or group-type coverage, whether insured or uninsured. This includes:

   a. group or blanket insurance;
   b. franchise insurance that terminates upon cessation of employment;
   c. group hospital or medical service plans and other group prepayment coverage;
   d. any coverage under labor-management trustee arrangements, union welfare arrangements, or employer organization arrangements; or
   e. governmental plans, or coverage required or provided by law.

   Plan does *not* include:
   a. any coverage held by the Participant for hospitalization and/or medical-surgical expenses which is written as a part of or in conjunction with any automobile casualty insurance policy;
   b. a policy of health insurance that is individually underwritten and individually issued;
   c. school accident type coverage; or
   d. a state plan under Medicaid (Title XIX, Grants to States for Medical Assistance Programs, of the United States Social Security Act, as amended).

   Each contract or other arrangement for coverage 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** means the part of this Benefit Booklet 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 covering the Participant. A *Primary Plan* is a Plan whose benefits are determined before those of the other Plan and without considering the other Plan's benefit. A *Secondary Plan* is a Plan whose benefits are determined after those of a Primary Plan and may be reduced because of the other Plan's benefits.

   When there are more than two Plans covering the Participant, 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 Participant for whom claim is made.

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

6. **We** or **Us** means Blue Cross and Blue Shield of Texas.

Order of Benefit Determination Rules

1. **General Information**

   a. 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 require that This Plan's benefits be determined before those of the other Plan.

   b. If this Benefit Booklet contains any dental or vision benefits, the benefits provided by the health portion of This Plan will be the Secondary 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 Participant as an Employee, member or subscriber are determined before those of the Plan which covers the Participant as a Dependent. However, if the Participant is also a Medicare beneficiary, and as a result of the rule established by Title XVIII of the Social Security Act and implementing regulations, Medicare is:

      (1) secondary to the Plan covering the Participant as a Dependent and

      (2) primary to the Plan covering the Participant as other than a Dependent (e.g., a retired Employee), then the benefits of the Plan covering the Participant as a Dependent are determined before those of the Plan covering that Participant other than a Dependent.

   b. ***Dependent Child/Parents Not Separated or Divorced.*** Except as stated in Paragraph c below, when This Plan and another Plan cover the same child as a Dependent of different parents:

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

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

      However, if the other Plan does not have the rule described in this Paragraph b, but instead has a rule based on 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 Participant 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, if applicable;
      (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 expense 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. The Plan of the other parent shall be the Secondary Plan. This paragraph does not apply with respect to any Plan Year during which any benefits are actually paid or provided before the entity has that actual knowledge.

d. ***Joint Custody.*** If the specific terms of a court decree state that the parents shall share joint custody, without stating that one of the parents is responsible for the health care expenses of the child, the Plans covering the child shall follow the order of benefit determination rules outlined in Paragraph b.

e. ***Active/Inactive Employee.*** The benefits of a Plan which covers a Participant as an Employee who is neither laid off nor retired are determined before those of a Plan which covers that Participant as a laid off or retired Employee. The same would hold true if a Participant is a Dependent of a person covered as a retired Employee and an Employee. If the other Plan does not have this rule, and if, as a result, the Plans do not agree on the order of benefits, this Paragraph e does not apply.

f. ***Continuation Coverage.*** If a Participant whose coverage is provided under a right of continuation pursuant to federal or state law is also covered under another Plan, the following shall be the order of benefit determination:

(1) First, the benefits of a Plan covering the Participant as an Employee, member or subscriber (or as that Participant's Dependent);

(2) Second, the benefits under the continuation coverage.

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 Paragraph f does not apply.

g. ***Longer/Shorter Length of Coverage.*** If none of the above rules determine the order of benefits, the benefits of the Plan which covered an Employee, member or subscriber longer are determined before those of the Plan which covered that Participant for the shorter period of time.

Effect on the Benefits of This Plan

1. **When This Section Applies**
   This section applies when This Plan is the Secondary Plan in accordance with the order of benefits determination outlined above. In that event, the benefits of This Plan may be reduced under this section.

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 Expense under This Plan in the absence of this COB provision; and

   b. The benefits that would be payable for the Allowable Expense 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 previously 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

We assume no obligation to discover the existence of another Plan, or the benefits available under the other Plan, if discovered. We have the right to decide what information we need to apply these COB rules. We may get needed information from or release information to any other organization or person without telling, or getting the consent of, any person. Each person claiming benefits under This Plan must give us any information concerning the existence of other Plans, the benefits thereof, and any other information needed to pay the claim.

Facility of Payment

A payment made under another Plan may include an amount that should have been paid under This Plan. If it does, We may pay that amount to the organization that made that payment. That amount will then be treated as though it were a benefit paid under This Plan. We will not have to pay that amount again.

Right to Recovery

If the amount of the payments We make is more than We should have paid under this COB provision, We may recover the excess from one or more of:

1. the persons We have paid or for whom We have paid; or
2. insurance companies; or
3. Hospitals, Physicians, or Other Providers; or
4. any other person or organization.

Termination of Coverage

Termination of Individual Coverage

Coverage under the Plan for you and/or your Dependents will automatically terminate when:

1. Your contribution for coverage under the Plan is not received timely by the Plan Administrator; or
2. You no longer satisfy the definition of an Employee as defined in this Benefit Booklet, including termination of employment; or
3. The Plan is terminated or the Plan is amended, at the direction of the Plan Administrator, to terminate the coverage of the class of Employees to which you belong; or
4. A Dependent ceases to be a Dependent as defined in the Plan.

However, when any of these events occur, you and/or your Dependents may be eligible for continued coverage. See **Continuation of Group Coverage - Federal** in the **GENERAL PROVISIONS** section of this Benefit Booklet.

The Claim Administrator may refuse to renew the coverage of an eligible Employee or Dependent for fraud or intentional misrepresentation of a material fact by that individual.

Coverage for a child of any age who is medically certified as *Disabled* and dependent on the parent will not terminate upon reaching the limiting age shown in your Schedule of Coverage if the child continues to be both:

1. *Disabled*, and
2. Dependent upon you for more than one-half of their support as defined by the Internal Revenue Code of the United States.

Disabled means any medically determinable physical or mental condition that prevents the child from engaging in self-sustaining employment. The child must be covered under the Plan and the disability must begin before the child attains the limiting age. You must submit satisfactory proof of the disability and dependency through your Plan Administrator to the Claim Administrator within 30 days following the child's attainment of the limiting age. As a condition to the continued coverage of a child as a *Disabled* Dependent beyond the limiting age, the Claim Administrator may require periodic certification of the child's physical or mental condition but not more frequently than annually after the two-year period following the child's attainment of the limiting age.

Termination of the Group

The coverage of all Participants will terminate if the group is terminated in accordance with the terms of the Plan.

Continuation of Group Coverage - Federal

COBRA Continuation - Federal

Under the provisions of the Consolidated Omnibus Budget Reconciliation Act of 1985 (COBRA), Participants may have the right to continue coverage after the date coverage ends. Participants will not be eligible for COBRA continuation if the Employer is exempt from the provisions of COBRA.

Please check with your Employer or Human Resources Department to determine if Domestic Partners are eligible for COBRA-like benefits in your Plan. For specific criteria or necessary forms required to establish eligibility for benefit coverage under this Plan, contact your Employer or Human Resources Department.

Minimum Size of Group

The Group must have normally employed more than twenty (20) employees on a typical business day during the preceding Plan Year. This refers to the number of full-time and part-time employees employed, not the number of employees covered by a Health Benefit Plan.

Loss of Coverage

If coverage terminates as the result of termination (other than for gross misconduct) or reduction of employment hours, then the Participant may elect to continue coverage for eighteen (18) months from the date coverage would otherwise cease.

A covered Dependent may elect to continue coverage for thirty-six (36) months from the date coverage would otherwise cease if coverage terminates as the result of:

1. divorce from the covered Employee,

2. death of the covered Employee,

3. the covered Employee becomes eligible for Medicare, or

4. a covered Dependent child no longer meets the Dependent eligibility requirements.

COBRA continuation under the Plan ends at the earliest of the following events:

1. The last day of the eighteen (18) month period for events which have a maximum continuation period of eighteen (18) months.

2. The last day of the thirty-six (36) month period for events which have a maximum continuation period of thirty-six (36) months.

3. The first day for which timely payment of contribution is not made to the Plan with respect to the qualified beneficiary.

4. The Group Health Plan is canceled.

5. The date, after the date of the election, upon which the qualified beneficiary first becomes covered under any other group health plan.

6. The date, after the date of the election, upon which the qualified beneficiary first becomes entitled to Medicare benefits.

Extension of Coverage Period

The eighteen (18) month coverage period may be extended if an event which could otherwise qualify a Participant for the thirty-six (36) month coverage period occurs during the eighteen (18) month period, but in no event may coverage be longer than thirty-six (36) months from the initial qualifying event.

If a Participant is determined to be disabled as defined under the Social Security Act and the Participant notifies the Employer before the end of the initial eighteen (18) month period, coverage may be extended up to an additional eleven (11) months for a total of twenty-nine (29) months. This provision is limited to Participants who are disabled at any time during the first sixty (60) days of COBRA continuation and only if the qualifying event is termination of employment (other than for gross misconduct) or reduction of employment hours.

Notice of COBRA Continuation Rights

The Employer is responsible for providing the necessary notification to Participants as required by the Consolidated Omnibus Budget Reconciliation Act of 1985 and the Tax Reform Act of 1986.

For additional information regarding your rights under COBRA continuation, refer to the Continuation Coverage Rights Notice in the **NOTICES** section of this Benefit Booklet.

Information Concerning Employee Retirement Income Security Act of 1974 (ERISA)

If the Health Benefit Plan is part of an "employee welfare benefits plan" and "welfare plan" as those terms are defined in ERISA:

1. The Plan Administrator will furnish summary plan descriptions, annual reports, and summary annual reports to you and other plan participants and to the government as required by ERISA and its regulations.

2. The Claim Administrator will furnish the Plan Administrator with this Benefit Booklet as a description of benefits available under this Health Benefit Plan. Upon written request by the Plan Administrator, the Claim Administrator will send any information which the Claim Administrator has that will aid the Plan Administrator in making its annual reports.

3. Claims for benefits must be made in writing on a timely basis in accordance with the provisions of this Health Benefit Plan. Claim filing and claim review health procedures are found in the **CLAIM FILING AND APPEALS PROCEDURES** section of this Benefit Booklet.

4. BCBSTX, as the Claim Administrator, is not the ERISA "Plan Administrator" for benefits or activities pertaining to the Health Benefit Plan.

5. This Benefit Booklet is not a Summary Plan Description.

6. The Plan Administrator has given the Claim Administrator the authority and discretion to interpret the Health Benefit Plan provisions and to make benefit determinations. The Plan Administrator has full and complete authority and discretion to make decisions regarding the Health Benefit Plan's provisions and determining questions of eligibility. Any decisions made by the Plan Administrator shall be final and conclusive.

Value Based Design Programs

BCBSTX has the right to offer medical management programs, quality improvement programs, and health behavior wellness, incentive, maintenance, or improvement programs that allow for a reward, a contribution, a differential in premiums, a differential in medical, prescription drug or equipment Copayment Amounts, Co-Share Amounts, Deductibles or costs, or a combination of these incentives or disincentives for participation in any such program offered or administered by BCBSTX or an entity chosen by BCBSTX to administer such program. In addition, discount or incentive programs for various health or wellness-related, insurance-related or other items and services may be available from time to time. Such programs may be discontinued without notice.

Individuals in wellness programs who are unable to participate in these incentives or disincentives due to an adverse health factor shall not be penalized based upon an adverse health status and, unless otherwise permitted by law, BCBSTX will allow a reasonable alternative to any individual for whom it is unreasonably difficult, due to a medical condition, to satisfy otherwise applicable wellness program standards.

Contact BCBSTX for additional information regarding any value based programs offered by BCBSTX.

AMENDMENTS

BENEFIT BOOKLET
NO SURPRISES ACT AMENDMENT

Amendment Effective Date: This Amendment is effective on the Employer's Contract Anniversary Date or for the Plan Year of Your Employer's Group Health Plan occurring on or after January 1, 2022.

The terms of this Amendment supersede the terms of the Benefit Booklet to which this Amendment is attached and becomes a part of the Benefit Booklet. Unless otherwise required by Federal or Texas law, in the event of a conflict between the terms on this Amendment and the terms of the Benefit Booklet, the terms on this Amendment apply. However, definitions set forth in this Amendment are for purposes of this Amendment only. Additionally, for purposes of this Amendment, references to You and Your mean any member, including Participant and Dependents.

The Benefit Booklet is hereby amended as indicated below:

I. Continuity of Care

If You are under the care of a Participating Provider as defined in the Benefit Booklet who stops participating in the Plan's network (for reasons other than failure to meet applicable quality standards, including medical incompetence or professional behavior, or fraud), You may be able to continue coverage for that Provider's covered services at the In-Network Benefit level if one of the following conditions is met:

1. You are undergoing a course of treatment for a serious and complex condition,
2. You are undergoing institutional or inpatient care,
3. You are scheduled to undergo nonelective surgery from the Provider (including receipt of postoperative care from such Provider with respect to such surgery),
4. You are pregnant or undergoing a course of treatment for Your pregnancy, or
5. You are determined to be terminally ill.

A serious and complex condition is one that (1) for an acute illness, is serious enough to require specialized medical treatment to avoid the reasonable possibility of death or permanent harm (for example, if You are currently receiving chemotherapy, radiation therapy, or post-operative visits for a serious acute disease or condition), and (2) for a chronic illness or condition, is (i) life-threatening, degenerative, disabling or potentially disabling, or congenital, and (ii) requires specialized medical care over a prolonged period of time.

Continuity coverage described in this provision shall continue until the treatment is complete but will not extend for more than 90 days beyond the date the Plan notifies You of the Provider's termination, or any longer period provided by state law. If You are in the second or third trimester of pregnancy when the Provider's termination takes effect, continuity of coverage may be extended through delivery of the child, immediate postpartum care, and the follow-up check-up within the first six (6) weeks of delivery. You have the right to appeal any decision made for a request for benefits under this provision, as explained in the Benefit Booklet.

II. Federal No Surprises Act

1. Definitions

The definitions below apply only to Section IV. Federal No Surprises Act, of this Amendment. To the extent the same terms are defined in both the Benefit Booklet and this Amendment, those terms will apply only to their use in the Benefit Booklet or this Amendment, respectively.

“Air Ambulance Services” means, for purposes of this Amendment only, medical transport by helicopter or airplane for patients.

“Emergency Medical Condition” means, for purposes of this Amendment only, a medical condition manifesting itself by acute symptoms of sufficient severity (including severe pain) such that a prudent layperson, who possesses an average knowledge of health and medicine, could reasonably expect the absence of immediate medical attention to result in a condition: (i) placing the health of the individual, or with respect to a pregnant woman her unborn

child in serious jeopardy; (ii) constituting a serious impairment to bodily functions; or (iii) constituting a serious dysfunction of any bodily organ or part.

"Emergency Services" means, for purposes of this Amendment only,

- a medical screening examination performed in the emergency department of a Hospital or an Independent Freestanding Emergency Department;
- further medical examination or treatment You receive at a Hospital, regardless of the department of the Hospital, or an Independent Freestanding Emergency Department to evaluate and treat an Emergency Medical Condition until Your condition is stabilized; and
- covered services You receive from a Non-Participating Provider during the same visit after Your Emergency Medical Condition has stabilized unless:
    1. Your Non-Participating Provider determines You can travel by non-medical or non-emergency transport;
    2. Your Non-Participating Provider has provided You with a notice to consent form for balance billing of services; and
    3. You have provided informed consent.

"Non-Participating Provider" means, for purposes of this Amendment only, with respect to a covered item or service, a Physician or other health care provider who does not have a contractual relationship with BCBSTX for furnishing such item or service under the Plan to which this Amendment is attached.

"Non-Participating Emergency Facility" means, for purposes of this Amendment only, with respect to a covered item or service, an emergency department of a Hospital or an Independent Freestanding Emergency Department that does not have a contractual relationship with BCBSTX for furnishing such item or service under the Plan to which this Amendment is attached.

"Participating Provider" means, for purposes of this Amendment only, with respect to a covered service, a Physician or other health care Provider who has a contractual relationship with BCBSTX setting a rate (above which the Provider cannot bill the member) for furnishing such item or service under the Plan to which this Amendment is attached regardless whether the Provider is considered a preferred or in-network Provider for purposes of In-Network or Out-of-Network Benefits under the subject Plan.

"Participating Facility" means, for purposes of this Amendment only, with respect to covered service, a Hospital or ambulatory surgical center that has a contractual relationship with BCBSTX setting a rate (above which the Provider cannot bill the member) for furnishing such item or service under the Plan to which this Amendment is attached. Whether the Provider is considered a preferred or in-network Provider for purposes of In-Network or Out-of-Network Benefits under the subject Plan.

"Qualifying Payment Amount" means, for purposes of this Amendment only, a median of contracted rates calculated pursuant to federal or state law, regulation and/or guidance.

"Recognized Amount" means, for purposes of this Amendment only, an amount determined pursuant a state law that provides a method for determining the total amount payable for the item or service (if applicable); or, if there is no state law that provides a method for determining the total amount payable for the item or service, the lesser of the Qualifying Payment Amount or billed charges.

2. Federal No Surprises Act Surprise Billing Protections

a. The federal No Surprises Act contains various protections relating to surprise medical bills on services performed by Non-Participating Providers and Non-Participating Emergency Facilities. The items and services included in these protections ("Included Services") are listed below.
    - Emergency Services obtained from a Non-Participating Provider or Non-Participating Emergency Facility.

- Covered non-Emergency Services performed by a Non-Participating Provider at a Participating Facility (unless You give written consent and give up balance billing protections).
- Air Ambulance Services received from a Non-Participating Provider, if the services would be covered if received from a Participating Provider.

b. **Claim Payments**

For Included Services, the Plan will send an initial payment or notice of denial of payment directly to the Provider.

c. **Cost-Sharing**

For non-Emergency Services performed by Non-Participating Providers at a Participating Facility, and for Emergency Services provided by a Non-Participating Provider or Non-Participating Emergency Facility, the Recognized Amount is used to calculate Your cost-share requirements, including Deductibles, Copayment Amounts, and Co-Share Amount.

For Air Ambulance Services received from a Non-Participating Provider, if the services would be covered if received from a Participating Provider, the amount used to calculate Your cost-share requirements, including Deductibles, Copayment Amounts, and Co-Share Amount, will be the lesser of the Qualifying Payment Amount or billed charges.

For Included Services, these cost-share requirements will be counted toward Your in-network Deductible and/or Out-of-Pocket Maximum, if any.

3. Prohibition of Balance Billing

You are protected from balance billing on Included Services as set forth below.

If You receive Emergency Services from a Non-Participating Provider or non-Participating Emergency Facility, the most the Non-Participating Provider or non-Participating Emergency Facility may bill You is Your in-network cost-share. You cannot be balance billed for these Emergency Services unless You give written consent and give up Your protections not to be balanced billed for services You receive after You are in a stable condition.

When You receive Covered Non-Emergency Services from a Non-Participating Provider at a Participating Facility, the most those Non-Participating Providers may bill You is Your Plan's in-network cost-share requirements. When You receive emergency medicine, anesthesia, pathology, radiology, laboratory, neonatology, assistant surgeon, hospitalist, or intensivist services at a Participating Facility, Non-Participating Providers can't balance bill You and may not ask You to give up Your protections not to be balance billed. If You get other services at Participating Facilities, Non-Participating Providers can't balance bill You unless You give written consent and give up Your protections.

If Your Plan includes Air Ambulance Services as a covered service, and such services are provided by a Non-Participating Provider, the most the Non-Participating Provider may bill You is Your in-network cost-share. You cannot be balance billed for these Air Ambulance Services.

NOTE: The revisions to Your Plan made by this Amendment are based upon the No Surprises Act, a federal law enacted in 2020 and effective for plan years beginning on or after January 1, 2022. To the extent federal regulations are adopted or additional guidance is issued by federal regulatory agencies that alter the terms of this Amendment, the regulations and any additional guidance will control over conflicting language in this Amendment.

NOTICES

NOTICE

Other Blue Cross and Blue Shield Plans Separate Financial Arrangements with Providers

Out-of-Area Services

Blue Cross and Blue Shield of Texas (BCBSTX) has a variety of relationships with other Blue Cross and/or Blue Shield Licensees referred to generally as "Inter-Plan Programs." Whenever you obtain healthcare services outside of BCBSTX service area, the claims for these services may be processed through one of these Inter-Plan Programs, which includes the BlueCard Program, and may include negotiated National Account arrangements available between BCBSTX and other Blue Cross and Blue Shield Licensees.

Typically, when accessing care outside our service area, you will obtain care from healthcare Providers that have a contractual agreement (i.e., are "participating Providers") with the local Blue Cross and/or Blue Shield Licensee in that other geographic area ("Host Blue"). In some instances, you may obtain care from non-participating healthcare Providers. Our payment practices in both instances are described below.

A. BlueCard® Program

Under the BlueCard® Program, when you access covered healthcare services within the geographic area served by a Host Blue, we will remain responsible for fulfilling our contractual obligations. However, the Host Blue is responsible for contracting with and generally handling all interactions with its participating healthcare Providers.

For inpatient facility services received in a Hospital, the Host Blue's participating Provider is required to obtain Prior Authorization. If Prior Authorization is not obtained, the participating Provider will be sanctioned based on the Host Blue's contractual agreement with the Provider, and the Participant will be held harmless for the Provider sanction.

Whenever you access covered healthcare services outside BCBSTX's service area and the claim is processed through the BlueCard Program, the amount you pay for covered healthcare services is calculated based on the lower of:

- The billed covered charges for your covered services; or
- The negotiated price that the Host Blue makes available to us.

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 your 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, going forward, also take into account adjustments to correct for over- or underestimation of modifications of past pricing for the types of transaction modifications noted above. However, such adjustments will not affect the price we use for your claim because they will not be applied retroactively to claims already paid.

Federal law or the laws in a small number of states may require the Host Blue to add a surcharge to your calculation. If federal law or any state laws mandate other liability calculation methods, including a surcharge, we would then calculate your liability for any covered healthcare services according to applicable law.

B. Negotiated (non-BlueCard Program) National Account Arrangements

As an alternative to the BlueCard Program, your claims for covered healthcare services may be processed through a negotiated National Account arrangement with a Host Blue.

The amount you pay for covered healthcare services under this arrangement will be calculated based on the lower of either billed covered charges or negotiated price (Refer to the description of negotiated price under Section A., BlueCard Program) made available to us by the Host Blue.

C. Non-Participating Healthcare Providers Outside BCBSTX Service Area

1. In General

   When Covered Services are provided outside of the Plan's service area by non-participating healthcare Providers, the amount(s) you pay for such services will be calculated using the methodology described in the Benefit Booklet for non-participating healthcare Providers located inside our service area. You may be responsible for the difference between the amount that the non-participating healthcare Provider bills and the payment the Plan will make for the Covered Services as set forth in this paragraph. Federal or state law, as applicable, will govern payments for out-of-network emergency services.

2. Exceptions

   In some exception cases, the Plan may, but is not required to, in its sole and absolute discretion negotiate a payment with such non-participating healthcare Provider on an exception basis. If a negotiated payment is not available, then the Plan may make a payment based on the lesser of:

   a. the amount calculated using the methodology described in the Benefit Booklet for non-participating healthcare Providers located inside your service area (and described in Section C(a)(1) above); or
   b. The following:

      1. for professional Providers, an amount equal to the greater of the minimum amount required in the methodology described in the Benefit Booklet for non-participating healthcare Providers located inside your service area; or an amount based on publicly available Provider reimbursement data for the same or similar professional services, adjusted for geographical differences where applicable, or

      2. for Hospital or facility Providers, an amount equal to the greater of the minimum amount required in the methodology described in the Benefit Booklet for non-participating healthcare Providers located inside your service area; or an amount based on publicly available data reflecting the approximate costs that Hospitals or facilities have incurred historically to provide the same or similar service, adjusted for geographical differences where applicable, plus a margin factor for the Hospital or facility.

In these situations, you may be liable for the difference between the amount that the non-participating healthcare Provider bills and the payment Blue Cross and Blue Shield of Texas will make for the Covered Services as set forth in this paragraph.

D. 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 bear any portion of the Provider Incentives, risk-sharing, and/or Care Coordinator Fees of such arrangement, except when a Host Blue passes these fees to Blue Cross and Blue Shield of Texas through average pricing or fee schedule incentive adjustments.

Under the Agreement, Employer has with Blue Cross and Blue Shield of Texas, Blue Cross and Blue Shield of Texas and Employer will not impose cost sharing for Care Coordinator Fees.

E. Blue Cross Blue Shield Global Core Program

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 Program when accessing Covered Services. The Blue Cross Blue Shield Global Core Program is unlike the BlueCard Program available in the BlueCard service area in certain ways. For instance, although the Blue Cross Blue Shield Global Core Program 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 yourself to obtain reimbursement for these services.

If you need medical assistance services (including locating a doctor or hospital) outside the BlueCard service area, you should call the service center at 1.800.810.BLUE (2583) or call collect at 1.804.673.1177, 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 cost-share amounts/Deductibles, Co-Share Amounts, 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 the Plan to obtain Prior Authorization for non-emergency inpatient services.**

- **Outpatient Services**

Outpatient Services are available for Emergency Care. 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.

- **Submitting a Blue Cross Blue Shield Global Core Claim**

When you pay for Covered Services outside the BlueCard service area, you must submit a claim to obtain reimbursement. For institutional and professional claims, you should complete a Blue Cross Blue Shield Global Core International claim form and send the claim form with the Provider's itemized bill(s) to the service center (the address is on the form) to initiate claims processing. Following the instructions on the claim form will help ensure timely processing of your claim. The claim form is available from the Plan, the service center or online at www.bcbsglobalcore.com. If you need assistance with your claim submission, you should call the service center at 1.800.810.BLUE (2583) or call collect at 1.804.673.1177, 24 hours a day, seven days a week.

NOTICE

The Women's Health and Cancer Rights Act of 1998 requires this notice. This Act is effective for plan year anniversaries on or after October 21, 1998. This benefit may already be included as part of your coverage.

In the case of a covered person receiving benefits under their plan in connection with a mastectomy and who elects breast reconstruction, coverage will be provided in a manner determined in consultation with the attending physician and the patient for:

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. Prostheses and treatment of physical complications at all stages of the mastectomy, including lymphedemas.

Deductibles, Co-Share and copayment amounts will be the same as those applied to other similarly covered medical services, such as surgery and prostheses.

NOTICE

ALTHOUGH HEALTH CARE SERVICES MAY BE OR HAVE BEEN PROVIDED TO YOU AT A HEALTH CARE FACILITY THAT IS A MEMBER OF THE PROVIDER NETWORK USED BY YOUR HEALTH BENEFIT PLAN, OTHER PROFESSIONAL SERVICES MAY BE OR HAVE BEEN PROVIDED AT OR THROUGH THE FACILITY BY PHYSICIANS AND OTHER HEALTH CARE PRACTITIONERS WHO ARE NOT MEMBERS OF THAT NETWORK. YOU MAY BE RESPONSIBLE FOR PAYMENT OF ALL OR PART OF THE FEES FOR THOSE PROFESSIONAL SERVICES THAT ARE NOT PAID OR COVERED BY YOUR HEALTH BENEFIT PLAN.

NOTICE

CONTINUATION COVERAGE RIGHTS UNDER COBRA

NOTE: Certain employers may not be affected by CONTINUATION OF COVERAGE AFTER TERMINATION (COBRA). See your employer or Group Administrator should you have any questions about COBRA.

INTRODUCTION

You are receiving this notice because you have recently become covered under your employer's group health plan (the Plan). This notice contains important information about your right to COBRA continuation coverage, which is a temporary extension of coverage under the Plan. **This notice generally explains COBRA continuation coverage, when it may become available to you and your family, and what you need to do to protect the right to receive it**.

The right to COBRA continuation coverage was created by a federal law, the Consolidated Omnibus Budget Reconciliation Act of 1985 (COBRA). COBRA continuation coverage may be available to you when you would otherwise lose your group health coverage. It can also become available to other members of your family who are covered under the Plan when they would otherwise lose their group health coverage.

For additional information about your rights and obligations under the Plan and under federal law, you should review the Plan's Summary Plan Description or contact the Plan Administrator.

WHAT IS COBRA CONTINUATION COVERAGE?

COBRA continuation coverage is a continuation of Plan coverage when coverage would otherwise end because of a life event known as a "qualifying event." Specific qualifying events are listed later in this notice. After a qualifying event, COBRA continuation coverage must be offered to each person who is a "qualified beneficiary." You, your spouse, and your dependent children could become qualified beneficiaries if coverage under the Plan is lost because of the qualifying event. Under the Plan, qualified beneficiaries who elect COBRA continuation coverage must pay for COBRA continuation coverage.

If you are an employee, you will become a qualified beneficiary if you lose your coverage under the Plan because either one of the following qualifying events happens:

- Your hours of employment are reduced; or
- Your employment ends for any reason other than your gross misconduct.

If you are the spouse of an employee, you will become a qualified beneficiary if you lose your coverage under the Plan because any of the following qualifying events happens:

- Your spouse dies;
- Your spouse's hours of employment are reduced;
- Your spouse's employment ends for any reason other than their gross misconduct;
- Your spouse becomes enrolled in Medicare benefits (under Part A, Part B, or both); or
- You become divorced or legally separated from your spouse.

Your dependent children will become qualified beneficiaries if they will lose coverage under the Plan because any of the following qualifying events happens:

- The parent-employee dies;
- The parent-employee's hours of employment are reduced;
- The parent-employee's employment ends for any reason other than their gross misconduct;
- The parent-employee becomes enrolled in Medicare (Part A, Part B, or both);
- The parents become divorced or legally separated; or
- The child stops being eligible for coverage under the Plan as a "dependent child."

If the Plan provides health care coverage to retired employees, the following applies: Sometimes, filing a proceeding in bankruptcy under title 11 of the United States Code can be a qualifying event. If a proceeding in bankruptcy is filed with respect to your employer, and that bankruptcy results in the loss of coverage of any retired employee covered under the Plan, the retired employee will become a qualified beneficiary with respect to the bankruptcy. The retired employee's spouse, surviving spouse, and dependent children will also become qualified beneficiaries if bankruptcy results in the loss of their coverage under the Plan.

WHEN IS COBRA COVERAGE AVAILABLE?

The Plan will offer COBRA continuation coverage to qualified beneficiaries only after the Plan Administrator has been notified that a qualifying event has occurred. When the qualifying event is the end of employment or reduction of hours of employment, death of the employee, in the event of retired employee health coverage, commencement of a proceeding in bankruptcy with respect to the employer, or the employee's becoming entitled to Medicare benefits (under Part A, Part B, or both), the employer must notify the Plan Administrator of the qualifying event.

YOU MUST GIVE NOTICE OF SOME QUALIFYING EVENTS

For the other qualifying events (divorce or legal separation of the employee and spouse or a dependent child's losing eligibility for coverage as a dependent child), you must notify the Plan Administrator within 60 days after the qualifying event occurs. Contact your employer and/or COBRA Administrator for procedures for this notice, including a description of any required information or documentation.

HOW IS COBRA COVERAGE PROVIDED?

Once the Plan Administrator receives notice that a qualifying event has occurred, COBRA continuation coverage will be offered to each of the qualified beneficiaries. Each qualified beneficiary will have an independent right to elect COBRA continuation coverage. Covered employees may elect COBRA continuation coverage on behalf of their spouses, and parents may elect COBRA continuation coverage on behalf of their children.

COBRA continuation coverage is a temporary continuation of coverage. When the qualifying event is the death of the employee, the employee's becoming entitled to Medicare benefits (under Part A, Part B, or both), your divorce or legal separation, or a dependent child's losing eligibility as a dependent child, COBRA continuation coverage lasts for up to 36 months.

When the qualifying event is the end of employment or reduction of the employee's hours of employment, and the employee became entitled to Medicare benefits less than 18 months before the qualifying event, COBRA continuation coverage for qualified beneficiaries other than the employee lasts until 36 months after the date of Medicare entitlement. For example, if a covered employee becomes entitled to Medicare 8 months before the date on which his employment terminates, COBRA continuation coverage for his spouse and children can last up to 36 months after the date of Medicare entitlement, which is equal to 28 months after the date of the qualifying event (36 months minus 8 months). Otherwise, when the qualifying event is the end of employment or reduction of the employee's hours of employment, COBRA continuation coverage generally lasts for only up to a total of 18 months. There are two ways in which this 18-month period of COBRA continuation coverage can be extended.

DISABILITY EXTENSION OF 18-MONTH PERIOD OF CONTINUATION COVERAGE

If you or anyone in your family covered under the Plan is determined by the Social Security Administration to be disabled and you notify the Plan Administrator in a timely fashion, you and your entire family may be entitled to receive up to an additional 11 months of COBRA continuation coverage, for a total maximum of 29 months. The disability would have to have started at some time before the 60th day of COBRA continuation coverage and must last at least until the end of the 18–month period of continuation coverage. Contact your employer and/or the COBRA Administrator for procedures for this notice, including a description of any required information or documentation.

SECOND QUALIFYING EVENT EXTENSION OF 18-MONTH PERIOD OF CONTINUATION COVERAGE

If your family experiences another qualifying event while receiving 18 months of COBRA continuation coverage, the spouse and dependent children in your family can get up to 18 additional months of COBRA continuation coverage, for a maximum of 36 months if notice of the second qualifying event is properly given to the Plan. This extension may be available to the spouse and dependent children receiving continuation coverage if the employee or former employee dies, becomes entitled to Medicare benefits (under Part A, Part B, or both), or gets divorced or legally separated or if the dependent child stops being eligible under the Plan as a dependent child, but only if the event would have caused the spouse or dependent child to lose coverage under the Plan had the first qualifying event not occurred.

IF YOU HAVE QUESTIONS

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

KEEP YOUR PLAN INFORMED OF ADDRESS CHANGES

In order to protect your family's rights, you should keep the Plan Administrator informed of any changes in the addresses of family members. You should also keep a copy, for your records, of any notices you send to the Plan Administrator.

PLAN CONTACT INFORMATION

Contact your employer for the name, address and telephone number of the party responsible for administering your COBRA continuation coverage.

Information Provided by your Employer

MICHAELS STORES INC. EMPLOYEE BENEFIT PLAN

As Amended and Restated Effective Generally July 1, 2023

MICHAELS STORES INC. EMPLOYEE BENEFIT PLAN
As Amended and Restated Effective Generally July 1, 2023

W I T N E S S E T H

WHEREAS, Michaels Stores, Inc. ("**Michaels**") previously established certain health, accident, life, disability, and other welfare benefit plans for the benefit of its eligible employees, the terms of which were set forth in two separate documents (i) the Michaels Stores Inc. Employee Benefit Plan, Plan Number 501 (the "**Employee Benefit Plan**"), which provided medical, dental, vision, life, disability and accidental death and dismemberment benefits, and (ii) the Michaels Stores, Inc. Flexible Benefits Plan (the "**Flexible Benefits Plan**"), which provided flexible spending account benefits and included a cafeteria plan, which benefits were incorporated into the Employee Benefit Plan.

WHEREAS, Michaels consolidated its health and welfare and cafeteria plan benefits into a single plan document, effective July 1, 2022, by retaining the Employee Benefits Plan as the surviving plan (the "**Plan**"), Plan Number 501, and updated the Plan to comply with applicable changes in the law and implement other administrative or design changes adopted by Michaels for 2022.

WHEREAS, by this instrument, Michaels desires to amend and restate the Plan effective July 1, 2023, to modify the election period for making mid-year changes in benefit elections, to reflect the end of the Covid-19 national emergency effective May 11, 2023, and to change the Plan Year for the Flexible Spending Account Programs and Health Savings Account to a calendar year, effective January 1, 2024.

NOW, THEREFORE, Michaels hereby amends and restates the Plan, generally effective July 1, 2023, except as otherwise stated herein.

EXECUTED this 11th day of March 2023.

MICHAELS STORES, INC.

By: _____

Printed Name: Lisa A. Cummings Title: Vice President, Total Rewards

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ARTICLE I ESTABLISHMENT AND PURPOSE

1.1 Establishment and Purpose

Michaels has adopted and established the Plan for the purpose of providing the benefits under and coordinating the administration of the Component Programs, which provide certain health, accident, life, disability, and other welfare benefits for Employees.

1.2 Intention to be Welfare Benefit Plan

Michaels intends the Plan to be an employee welfare benefit plan under section 3(1) of ERISA and its regulations, to the extent the benefits provided by each Component Program so permit. If any benefit provided under a Component Program is determined not to be a benefit eligible to constitute an employee welfare benefit plan under section 3(1) of ERISA, such a determination will not prevent the remainder of the Plan from qualifying as an employee welfare benefit plan within the meaning of such section. However, neither the Dependent Care Flexible Spending Account Program, the Cafeteria Plan and any Health Savings Account established by an HSA Eligible Participant will be considered an employee welfare benefit plan within the meaning of section 3(1) of ERISA and the regulations (unless such a determination is required by such regulations or by other Department of Labor guidance).

1.3 Intention to be Cafeteria Plan

Michaels intends the Plan to provide Employees a choice between taxable compensation (cash) and benefits with respect to the Cafeteria Component Programs. Michaels intends the Plan to qualify as a "cafeteria plan" under section 125 of the Code as to the Cafeteria Component Programs. In no event will the Plan be administered or construed to constitute a plan of deferred compensation. Cafeteria Plan provisions hereunder are intended to be severable. If the Plan is determined to be discriminatory within the meaning of section 125 of the Code, then only the Cafeteria Component Programs will be affected thereby.

End of Article I

ARTICLE II DEFINITIONS AND CONSTRUCTION

2.1 Definitions

The following capitalized terms have the respective meanings set forth below, unless the context clearly indicates otherwise:

(a) **Accidental Death and Dismemberment Plan**: The Component Program, if any, providing accidental death and dismemberment benefits to Covered Persons.

(b) **Administrative Agreement**: The agreement entered into with each individual or entity providing administrative services with respect to one or more Component Programs.

(c) **Administrative Committee**: The committee appointed by the Plan Administrator to act on its behalf. For purposes of Article VIII, the term "Administrative Committee" will also include any Administrative Provider or Insurer that processes benefit claims under the Plan.

(d) **Administrative Provider**: Any individual or entity operating under an Administrative Agreement to provide administrative services with respect to any benefits offered under one or more of the Component Programs.

(e) **Adverse Benefit Determination**: Any denial, reduction, or termination of or failure to provide or make payment (in whole or in part) for a Plan benefit, including any denial, reduction, termination, rescission, or failure to provide or make payment that is based on a determination of a Claimant's eligibility to participate in the Plan, and including with respect to health benefits a denial, reduction, termination, or failure to provide or make payment resulting from the application of any utilization review, as well as the failure to cover an item or service for which benefits are otherwise provided because it is determined to be experimental, investigational, unproven or not medically necessary or appropriate. Further, and with respect to health benefits, any reduction or termination of an ongoing course of treatment prior to its scheduled expiration will be treated as an Adverse Benefit Determination regarding a Concurrent Care Claim. Further, any invalidation of a claim for failure to furnish written proof of loss or to comply with the claim submission procedure will be treated as an Adverse Benefit Determination.

(f) **Affiliate**: Michaels and any other entity which is:

(i) A member of a controlled group of corporations (under section 414(b) of the Code) which includes Michaels;

(ii) A group of trades or businesses under common control (under section 414(c) of the Code) with Michaels including the rules under Treasury Regulation section 1.414(c)-5 regarding tax-exempt employers;

(iii) An affiliated service group (as defined in section 414(m) of the Code) of which Michaels is a member; or

(iv) Any other entity required to be aggregated with Michaels pursuant to section 414(o) of the Code;

provided, however, that for purposes of items (i) and (ii) above, 51% will be substituted for 80%.

(g) **Approved HSA Vendor**: An HSA vendor that has been approved by Michaels to market HSA products to its Employees and to receive Employer HSA contributions, if any, and Employee pre-tax HSA contributions made through the Cafeteria Program. Notwithstanding the foregoing, an HSA Eligible Participant may transfer, at any time, his HSA account balance to an HSA vendor that is not an Approved HSA Vendor (but any future employee health savings account contributions made by or on behalf of such HSA Eligible Participant to a health savings account maintained by a vendor that is not an Approved HSA Vendor must be made on after-tax basis and not pre-tax through the Cafeteria Component Program).

(h) **Board or Board of Directors**: The Board of Directors of Michaels.

(i) **Business Associate**: A person or entity, such as an Administrative Provider, COBRA vendor, or utilization review organization, that:

(i) Performs or assists in the performance of a function or activity involving the use or disclosure of individually identifiable health information or any other function or activity regulated by subchapter C of Title 45 of the Code of Federal Regulations on behalf of the Health Care Components of the Plan; or

(ii) Provides legal, actuarial, accounting, consulting, data aggregation, management, administrative, accreditation or financial services to or for the Health Care Components of the Plan, where the provision of such services involves the disclosure of individually identifiable health information from the Health Care Components of the Plan or another Business Associate of the Health Care Components of the Plan to the person.

Generally, the term "Business Associate" will not include an individual who is an Employee of (A) the Plan, or (B) Michaels or an Affiliate if such individual is performing services in connection with Michaels role as the Plan sponsor or at the direction of the Plan Administrator, unless such individual is performing services as an independent contractor outside the scope of his regular employment duties.

(j) **Cafeteria Component Program**: Each Component Program in which Participants pay for benefits on a pre-tax or after-tax basis pursuant to section 125 of the Code. Specifically, the Cafeteria Component Programs are to the extent applicable: (i) the Medical Plan; (ii) the Dental Plan; (iii) the Vision Plan; (iv) the Health Flexible Spending Account Program; (v) the Dependent Care Flexible Spending Account Program; (vi) the Life and Accidental Death and Dismemberment Plan, (vii) the Critical Illness Plan and (viii) any Health Savings Accounts established by HSA Eligible Participants. As required by COBRA, FMLA, USERRA, or other applicable law, Participants may also pay for benefits under the Cafeteria Component Programs or premiums for accident and health

plans of Employer (provided that the premiums for such accidental or health plan would normally be excludible from income under section 106 of the Code) on an after-tax basis as provided in the Plan. In addition, Participants may pay for benefits under the Long-Term Disability Plan, Short-Term Disability Plan, Life and Accidental Death and Dismemberment Plan on a pre-tax or after-tax basis as provided under this Plan and to the extent such Component Programs are fully insured, such payments may be made outside of the Cafeteria Component Program.

(k) **Cafeteria Plan**: The Component Program providing Participants with a choice between cash or participation in one or more Cafeteria Component Programs on a pre-tax or an after-tax basis under section 125 of the Code.

(l) **Change in Status**: Includes any of the following to the extent provided by a Component Program Document:

(i) Events that change an Employee's legal marital status, including marriage, death of Spouse, divorce, legal separation, or legal annulment;

(ii) Events that change an Employee's number of Children, including birth, adoption, placement for adoption, or death of a Child;

(iii) A termination or commencement of employment or a change in employment status of the Employee, Spouse, or Child;

(iv) A reduction or increase in hours of employment by the Employee, Spouse, or Child, including a switch between part-time and full-time status, a strike or lockout, or a commencement or return from an unpaid leave of absence;

(v) An event that causes a Dependent to satisfy or cease to satisfy the requirements for coverage due to attainment of age, student status, or any similar circumstance as may be provided in the applicable Component Program;

(vi) A change in the place of residence or work of the Employee, Spouse, or Child;

(vii) An event such as the loss of or eligibility for health coverage or addition of a Dependent, which gives rise to the special enrollment rights provided in section 9801(f) of the Code;

(viii) An election change made by the Spouse, former Spouse, or Child under another employer-sponsored plan, including an annual enrollment election or a permissible change in status election under such plan that results in a gain or loss of coverage under such plan;

(ix) With respect to an election to revoke coverage in the Medical Plan only, a reasonably expected reduction in hours of the Employee below 30 hours per week on average, regardless of whether such reduction would result in a loss of coverage in the Medical Plan, provided, that the Employee expresses his intent to enroll himself and his Dependents who lose

coverage in the Medical Plan, in health coverage under the health insurance market place exchange with such coverage becoming effective no later than the first day of the second month following the month that includes the date that coverage in the Medical Plan is revoked;

(x) With respect to an election to revoke coverage in the Medical Plan only, an annual or special enrollment period under the health insurance marketplace exchange where the Employee reasonably expresses his intent to enroll himself and his Dependents who lose coverage in the Medical Plan in health coverage under the health insurance market place exchange with such coverage becoming effective no later than the day immediately following the day that coverage in the Medical Plan is revoked; or

(xi) The occurrence of such other events that the Plan Administrator determines will permit a change or revocation of an election during a Plan Year under regulations and rulings of the Internal Revenue Service.

(m) **Child or Children**: The child (or children) of an Employee who is (or are) eligible to participate in a Component Program.

(n) **Claimant**: A Participant, Spouse, Dependent, or beneficiary or an authorized representative of such individual who has filed or desires to file a claim for a Plan benefit.

(o) **COBRA**: The Consolidated Omnibus Budget Reconciliation Act of 1985, as amended, and any regulations or rulings issued thereunder.

(p) **COBRA Beneficiary**: Each (i) qualified beneficiary within the meaning of Section 5.3 who has elected continuation of coverage pursuant to Article V and thereby is covered under the Plan, (ii) qualified beneficiary who has elected continuation of coverage pursuant to the COBRA provisions set forth in a Component Program Document or (iii) other individual covered under the Plan pursuant to Section 5.9(a).

(q) **Code**: The Internal Revenue Code of 1986 and the regulations and rulings thereunder, as amended. References to a Code section will be deemed to be to that section as it now exists and to any successor provision.

(r) **Compensation**: Unless otherwise specifically provided in a Component Program, the total of all wages, salaries, fees, and other amounts that are paid in cash by the Employer to or for the benefit of a Participant for services performed for the Employer, which are required to be reported on the Participant's federal income tax withholding statement (Form W-2).

(s) **Component Program**: A benefit program selected by Michaels that is listed in Appendix A to the Plan. The types and/or terms of the Component Programs and Appendix A may be amended from time to time without the need for a formal amendment to the Plan.

(t) **Component Program Document**: The written documents (*i.e.,* insurance policies, HMO contracts, and summary plan descriptions, pamphlets and brochures) setting forth the terms of the applicable Component Program, the provisions of which are incorporated herein by this reference.

(u) **Concurrent Care Claim**: Any request to extend an ongoing course of a health benefit treatment beyond the period of time or number of treatments that has previously been approved under the Plan.

(v) **Condition**: Any sickness, injury, or other mental or physical malady that may give rise to the payment of benefits under the Plan.

(w) **Contact Person**: The individual or entity appointed to serve as the HIPAA privacy contact person for purposes of inquiries and complaints.

(x) **Covered Dependent**: Each Dependent who is covered under the Plan pursuant to Section 3.5.

(y) **Covered Person**: Each Participant, Covered Dependent, and COBRA Beneficiary. For purposes of Articles XV and XVI regarding HIPAA, "Covered Person" means an Employee, Spouse, or Dependent who is enrolled in one or more of the Health Care Components.

(z) **Critical Illness Plan**: The Component Program, if any, providing critical illness benefits to Covered Persons.

(aa) **Dental Plan**: The Component Program, if any, providing group dental benefits to Covered Persons.

(bb) **Dependent**: Each (i) Spouse of a Participant, (ii) Domestic Partner of a Participant, (iii) Child of a Participant (including a Stepchild or Child placed for adoption), and (iv) other dependent of a Participant within the meaning of section 152 of the Code who is eligible for coverage under a Component Program. However, the definition of dependent is modified to conform with the underlying section for the Component Programs. For instance, for purposes of the Dependent Care Flexible Spending Account Program, whether a person is a dependent under section 152 of the Code will be determined without regard to sections 152(b)(1) and (b)(2) of the Code, which contain certain exceptions to the definition of dependent, and without regard to section 152(d)(1)(B) of the Code, which contains a gross income limitation for a qualifying relative. Additionally, a Dependent under the Medical Plan and the Health Flexible Spending Account Program will include a “child” as described in section 152(f)(1) of the Code under the age of 26 but will not include a Domestic Partner who is not the tax dependent of the Participant. The definition of Dependent applicable to the Component Programs will be specified in the Component Program. Such Component Program Documents may be updated from time to time without the need for a formal amendment to the Plan.

(cc) **Dependent Care Flexible Spending Account Program**: The Component Program, if any, providing flexible spending accounts for reimbursement of dependent-care expenses, pursuant to sections 125 and 129 of the Code;

provided, however, that accounts under such program will be maintained for recordkeeping purposes only, and will not be held in a separate fund or segregated from the other assets of the Plan or Michaels, as applicable.

(dd) **Domestic Partner**. A same or opposite sex domestic partner of a Participant who meets all of the following criteria and is covered by the terms of a Component Program:

(i) Must be at least eighteen (18) years of age;

(ii) Must have a close personal relationship with the Employee and are responsible for each other's welfare;

(iii) Must be the covered Employee's only domestic partner and intend to remain so indefinitely;

(iv) Must have shared the same legal residence in an exclusive relationship with the Employee for at least twelve (12) months;

(v) Must not be related by blood, or affinity in a way that would disqualify either individual from marriage under the laws of the state in which they reside;

(vi) Must not be married or in a domestic partnership with any other individual;

(vii) Must be legally competent to enter into a legal contract; and

(viii) Must share sufficient financial and legal obligations.

The Plan Administrator may promulgate a procedure and certification for a Participant to certify that a person is the Participant's Domestic Partner as defined above. When such certification is provided to the Plan Administrator pursuant to such procedure, the Plan Administrator shall be entitled to rely on such certification, and shall have no duty to investigate or independently determine the validity of any such purported or claimed partnership. Notwithstanding any other provision of the Plan, for the purposes of COBRA, ERISA, the Code or HIPAA, a Domestic Partner under this Plan shall not be considered a Spouse for the purposes of federal law as applicable to this Plan.

(ee) **Effective Date**: July 1, 2023, except as otherwise stated herein or required by law.

(ff) **Electronic Media**: For purposes of the HIPAA Security Standards, the:

(i) Electronic storage media including memory devices in computers (hard drives) and any removable/transportable digital memory medium, such as magnetic tape or disk, optical disk, digital memory card, or USB flash drive; or

(ii) Transmission media used to exchange information already in electronic storage media. Transmission media include, for example, the internet (wide-open), extranet (using internet technology to link a business with

information accessible only to collaborating parties), leased lines, dial-up lines, private networks, and the physical movement of removable/transportable electronic storage media. Certain transmissions, including of paper, via facsimile, and of voice via telephone, are not considered to be transmissions via Electronic Media, because the information being exchanged did not exist in electronic form before the transmission.

(gg) **Electronic Protected Health Information or ePHI**: PHI that is created, received, maintained, or transmitted in Electronic Media by or on behalf of the Plan.

(hh) **Employee**: Each individual employed or formerly employed by the Employer who is eligible for coverage under a Component Program. Except as provided in the preceding sentence, an "Employee" generally will not include any individual:

(i) Who is a leased employee within the meaning of section 414(n) of the Code or is determined by the Employer to be an independent contractor (even if such leased employee or independent contractor is subsequently determined by the Internal Revenue Service, the Department of Labor, a court of competent jurisdiction, or the Employer to be a common law employee of the Employer);

(ii) Whose terms and conditions of employment are governed by a collective bargaining agreement unless the agreement provides for his coverage under the Plan; or

(iii) Who is a nonresident alien with no United States source income.

For purposes of the Medical Plan, only Full-Time Employees as determined pursuant to Appendix C will be eligible to participate.

Each Component Program may vary the definition of an Employee or eligible Employee and in such an event the Component Program's definition will control.

An individual's status as an Employee for purposes of eligibility under the Plan will be determined by the Employer, and that determination will be conclusive and binding on all persons.

(ii) **Employee Assistance Program**: The Component Program, if any, providing employee assistance benefits to Covered Persons.

(jj) **Employer**: Michaels and each Participating Employer.

(kk) **ERISA**: The Employee Retirement Income Security Act of 1974 and the regulations and thereunder, as amended. References to an ERISA section will be deemed to be to that section as it now exists and to any successor provision.

(ll) **Flexible Spending Account Programs**: The Dependent Care Flexible Spending Account Program and the Health Flexible Spending Account Program.

(mm) **FMLA**: The Family and Medical Leave Act of 1993, as it may be amended, and any regulations or rulings issued thereunder.

(nn) **FMLA Coverage**: Coverage under a Health Care Component pursuant to Section 13.1.

(oo) **FMLA Leave**: A leave of absence taken pursuant to the FMLA as described in Section 13.1.

(pp) **GINA**: The Genetic Information Nondiscrimination Act of 2008, as it may be amended from time to time, and any regulations or rulings issued thereunder.

(qq) **HCR**: The Patient Protection and Affordable Care Act and the Health Care Act of 2010 and Education Reconciliation Act of 2010, and any regulations or rulings issued thereunder.

(rr) **Health Care Components**: The designated health care components of the Plan, which consist of the following group health plans within the meaning of section 5000(b)(1) of the Code or section 607(1) of ERISA, to the extent applicable: (i) the Medical Plan, (ii) the Dental Plan, (iii) the Vision Plan, (iv) the Health Flexible Spending Account Program, (v) the Employee Assistance Program, (vi) the Critical Illness Program and (vii) any other component that is offered under the Plan that provides "health care" within the meaning of HIPAA. In addition, if provided in a designation by the Plan Administrator or in the terms of an Employer's plan, other group health plans or plans that provide health care within the meaning of HIPAA sponsored by Michaels or an Affiliate will be a Health Care Component of the Plan for purposes of Articles XV and XVI regarding HIPAA.

(ss) **Health Flexible Spending Account Program**: The Component Program, if any, providing flexible spending accounts for reimbursement of medical expenses, pursuant to sections 125 and 105(b) of the Code; provided, however, that accounts under such program will be maintained for recordkeeping purposes only, and will not be held in a separate fund or segregated from the other assets of the Plan, as applicable.

(tt) **Health Care Professional**: A physician or other health care professional licensed, accredited, or certified to perform specified health services consistent with state law.

(uu) **Health Savings Account or HSA**: A "health savings account" within the meaning of section 223(d) of the Code that is established or maintained by an HSA Eligible Participant and provided by an Approved HSA Vendor. The Health Savings Account belongs to an HSA Eligible Participant and is not a component under the Plan. Rather, the Plan just provides a vehicle under which contributions may be made to the HSA.

(vv) **HSA Eligible Participant**: A Participant in a Health Care Component Program that is a "high deductible health plan" within the meaning of Code section 223(c)(2) and who is an "eligible individual" within the meaning of Code section 223(c)(1).

(ww) **HIPAA**: The Health Insurance Portability and Accountability Act of 1996, as amended, and any regulations or rulings issued thereunder. The privacy requirements of HIPAA with respect to the Plan are set forth in Article XV. The security requirements of HIPAA are set forth in Article XVI.

(xx) **HIPAA Special Enrollment Event**: The acquisition of a Spouse or Dependent or loss of other coverage by a Spouse, Domestic Partner or Dependent which gives rise to special enrollment rights under section 9801(f) of the Code and the regulations thereunder, as provided in Section 4.4(b). Such special enrollment rights will include, without limitation, those rights that apply (i) in the event of a Participant's acquisition of a new Dependent or the loss of group health plan or health insurance coverage by an eligible Employee, Spouse, Domestic Partner or Child and (ii) in the event that (A) such eligible Employee's or Dependent(s)' coverage under Medicaid or a state Michaels health insurance program is terminated as a result of loss of eligibility or (B) such eligible Employee or Dependent(s) becomes eligible for a premium assistance subsidy under Medicaid or a state Michaels health insurance program.

(yy) **HITECH**: The Health Information Technology for Economic and Clinical Health Act of 2009, as amended, and any regulations or rulings issued thereunder.

(zz) **HMO**: Any health maintenance organization or similar organization or network of individuals or organizations that has contracted to provide medical, mental, and/or other health-related benefits to Participants and Covered Dependents.

(aaa) **Independent Fiduciary**: The person or entity retained by the Plan Administrator to perform the review of an Adverse Benefit Determination, who must be an individual other than (i) the individual who made the Adverse Benefit Determination that is the subject of the review, and (ii) the subordinate of such individual.

(bbb) **Information System**: For purposes of the HIPAA Security Standards, an interconnected set of information resources under the same direct management control that shares common functionality. A system normally includes hardware, software, information, data, applications, communications, and people.

(ccc) **Insurer**: Any insurance company or vendor that Michaels has contracted to provide benefits under a Component Program.

(ddd) **Life Plan**: The Component Program, if any, providing life benefits to Covered Persons.

(eee) **Long-Term Disability Plan**: The Component Program, if any, providing long- term disability benefits to Covered Persons.

(fff) **Medical Plan**: The Component Program, if any, providing group medical benefits, including wellness benefits, to Covered Persons.

(ggg) **Medicare**: The medical care benefits program provided under title XVIII of the Social Security Act of 1965, as amended, and any regulations or rulings issued thereunder.

(hhh) **Mental Health Act**: The Paul Wellstone and Pete Domenici Mental Health Parity and Addiction Equity Act of 2008, as it may be amended from time to time, and any regulations or rulings issued thereunder.

(iii) **Michaels**: Michaels Stores, Inc.

(jjj) **Michelle's Law**: Public Law 110-381, as it may be amended from time to time, and any regulations or rulings issued thereunder.

(kkk) **Non-Health Care Components**: The non-health care components of the Plan, which consist of (i) the Long-Term Disability Plan, (ii) the Short-Term Disability Plan; (iii) the Dependent Care Flexible Spending Account Program, (iv) the Life and Accidental Death and Dismemberment Plan, and (v) any other Component Program that is offered under the Plan that does not provide "health care" within the meaning of HIPAA.

(lll) **Participant**: Each Employee who is a participant in the Plan pursuant to Article III.

(mmm) **Participating Employer**: Any Affiliate of Michaels that has adopted the Plan as listed in Appendix B, which appendix may be updated from time to time without a formal amendment to the Plan. An Affiliate's communication of the Plan, commencement of contributions or payment of benefits on behalf of its Eligible Employees will evidence its adoption of the Plan as a Participating Employer. Each participating Affiliate will be deemed to have appointed Michaels, the Board, the Plan Administrator, and the Administrative Committee as its agents under the Plan, and to have authorized such persons to exercise all authority and powers conferred on them under the Plan, on its behalf.

(nnn) **PHI**: Protected health information (*i.e.*, individually identifiable health information that is protected pursuant to HIPAA and the Regulations).

(ooo) **Plan**: The Michaels Stores Inc. Employee Benefit Plan.

(ppp) **Plan Administrator**: The administrator of the Plan, as set forth in Section 10.1. (qqq)

Plan Year: The twelve (12) consecutive-month period beginning on July 1 of a
year and ending on June 30 of the following year; provided, however, that effective January 1, 2024, the Flexible Spending Account Programs and Health Savings Account will have a January 1 to December 31 Plan Year, following a short Plan Year beginning July 1, 2023 and ending December 31, 2023. Further, Michaels will have the right to adopt alternate Plan Year interpretations for bona fide business purposes, and such Plan Year alterations will be communicated to Participants in compliance with any applicable law.

(rrr) **Post-Service Claim**: Any claim for a Plan health benefit that is not a Pre-Service Claim.

(sss) **PPO**: Any preferred provider organization or other similar organization or arrangement with which the Employer has contracted to provide medical and/or

other health-related benefits—including dental, vision, mental health, or pharmacy benefits—for Participants and Covered Dependents.

(ttt) **Pre-Service Claim**: Any claim for a Plan health benefit the terms of which condition receipt thereof, in whole or in part, on approval of the benefit in advance of obtaining medical care.

(uuu) **Primary Plan**: Except as otherwise provided in a Component Program Document, with respect to a Condition, if a Covered Person is:

(i) Covered under a plan (other than Medicare) of an employer other than the Employer that provides a benefit of the same type as the benefit provided under the Plan and which does not have a coordination of benefits provision, the Primary Plan is the other plan.

(ii) Covered under a plan (other than Medicare) of an employer other than the Employer that provides a benefit of the same type as the benefit provided under the Plan and which has a coordination of benefits provision, in accordance with the following:

(A) For a Condition incurred by a Participant (other than a Participant who is covered under the other plan as an eligible retiree and has been so covered for longer than his period of coverage under the Plan), the Primary Plan is the Plan;

(B) For a Condition incurred by (1) a Covered Dependent or (2) a Participant who is covered under the other plan as an eligible retiree and who has been so covered for a period of time longer than the period of coverage under the Plan, if the Covered Dependent or the Participant is an active participant (either as an employee, former employee, retiree, director, or former director) in the plan of an employer other than the Employer, the Primary Plan is the other plan;

(C) For a Condition incurred by a Covered Dependent who is covered through COBRA under a plan other than the Plan, the Primary Plan is the Plan;

(D) For a Condition incurred by a Covered Dependent who is a Child (other than a Child who is the Stepchild of either the Employee or his Spouse) and who is a covered dependent under a plan of the employer of the spouse, the Primary Plan is the plan covering the parent of the Child whose birthday falls earlier in the calendar year, except that, if the birthdays of both parents of the Child fall on the same day, the plan of the parent who has been an active participant in the plan for the longer period of time is the Primary Plan;

(E) For a Condition incurred by a Covered Dependent who is a Child and is the Stepchild of either the Employee or his Spouse, and who is a covered dependent under a plan of an employer other than the Employer, and whose natural parents were never married or whose

natural or adoptive parents are divorced or legally separated, (1) the Primary Plan is the plan of the parent who by divorce decree, separation agreement, other legal document, or state law is designated primarily responsible for the medical, dental, and other health care expenses of the Child or (2) in the absence of designation by divorce decree, separation agreement, other legal document, or state law a) the Primary Plan is the plan of the parent who has the primary right to possession of the Child, or b) in the absence of a plan described in Clause a), the Primary Plan is the plan of the spouse of the parent described in Clause a), if any, or c) in the absence of a plan described in Clause b), the Primary Plan is the plan of the parent who does not have the primary right to possession of the Child;

(F) For a Condition incurred by a COBRA Beneficiary who is an active participant (either as an employee, former employee, retiree, director, or former director) in a plan other than the Plan, the Primary Plan is the other plan; and

(G) For a Condition incurred by a COBRA Beneficiary who is covered as a dependent under a plan other than the Plan, the Primary Plan is the other plan.

(iii) For a Covered Person who is eligible for Medicare, in accordance with the following:

(A) In all cases except those described in (B) below, the Primary Plan is Medicare; and

(B) In the case of a Condition incurred by a Covered Person for whom Medicare—based on rules of the Social Security Act of 1965, as amended—is required to be the Secondary Plan, the Primary Plan is the Plan.

(vvv) **Privacy Officer**: The individual or entity appointed to serve as the Plan's HIPAA privacy officer.

(www) **Privacy Rules**: The privacy rules promulgated under HIPAA.

(xxx) **QMCSO**: A medical child support order which satisfies the requirements of section 609 of ERISA.

(yyy) **Regulations**: The regulations promulgated pursuant to HIPAA with respect to the privacy and security of PHI as set forth in 45 C.F.R. Parts 160 and 164 as in effect or as amended from time to time. A reference to a section of the Regulations will include such section as it may be subsequently amended or renumbered from time to time. Further, certain capitalized terms used in this Article or in Articles XV and XVI that are not defined herein will have the meaning ascribed to such terms under the Regulations.

(zzz) **Secondary Plan**: With respect to a Condition, if a Covered Person covered under the Plan also (i) is covered under a plan (other than Medicare) of an employer other than the Employer and that other plan provides a benefit of the same type as the applicable benefit provided under the Plan or (ii) is eligible for Medicare, the Secondary Plan is the Plan, other plan, or Medicare that is not the Primary Plan.

(aaaa) **Security Incident**: The attempted or successful unauthorized access, use, disclosure, modification, or destruction of information or interference with system operations in an Information System.

(bbbb) **Security or Security Measures**: All Administrative, Physical, and Technical Safeguards (as defined in the Regulations) in an Information System.

(cccc) **Security Officer**: The individual or entity appointed to serve as the Plan's HIPAA Security Officer.

(dddd) **Security Standards**: The security standards set forth in sections 164.306 (regarding general security standards), 164.308 (regarding Administrative Safeguards), 164.310 (regarding Physical Safeguards), 164.312 (regarding Technical Safeguards), 164.314 (regarding organizational requirements), and
164.316 (regarding policies and procedures and documentation requirements) of the Regulations, individually or collectively, as the context requires. Security Standards will also include any new security standards included in amendments to HIPAA or the Regulations.

(eeee) **SHI**: Summary health information (*i.e.*, information that summarizes the claims history, claims expense, or type of claims experienced by Covered Persons under the Health Care Components of the Plan as such term is described in section 164.504 of the Regulations).

(ffff) **Spouse**: An Employee's legal spouse, including a same sex spouse, except that such term will not include unless otherwise provided in a Component Program Document (i) a spouse who is a Participant, or (ii) a common law spouse unless all documentation of the common law marriage required by the Plan Administrator has been received by the Plan Administrator.

(gggg) **Short-Term Disability Plan**: The Component Program, if any, providing short- term disability benefits to Covered Persons.

(hhhh) **Stepchild**: A Child who (i) meets the eligibility requirements of any Component Program, (ii) is the natural or adoptive child of a Participant's Spouse, and (iii) is not the natural or adoptive child of such Participant.

(iv) **Third Party**: Any individual who or entity which is or may be liable to a Covered Person for a Condition or for payment of damages or expenses related to a Condition. This term includes first-party automobile insurance coverage such as personal-injury-protection/medical coverage and uninsured/underinsured motorist coverage of the Covered Person.

(jjjj) **Uniformed Person**: A Participant or Employee who is eligible for protection under USERRA.

(kkkk) **Urgent Care Claim**: Any Plan health benefit claim for medical care or treatment with respect to which the application of the time periods otherwise applicable to such claim (i) could seriously jeopardize, as determined either by a physician with knowledge of the Claimant's medical condition or by the Administrative Committee (applying the judgment of a prudent layperson who possesses an average knowledge of health and medicine), the Claimant's life, health, or ability to regain maximum function, or (ii) would subject the Claimant, in the opinion of a physician with knowledge of the Claimant's medical condition, to severe pain that cannot be adequately managed without the care or treatment that is the subject of the claim.

(llll) **USERRA**: The Uniformed Services Employment and Reemployment Rights Act of 1994, as amended, and any regulations or rulings issued thereunder.

(mmmm) **USERRA Coverage**: Coverage pursuant to Section 14.1.

(nnnn)
USERRA Leave: A leave of absence taken pursuant to USERRA as described in Section 14.1.

(oooo) **Vision Plan**: The Component Program, if any, providing group vision benefits to Covered Persons.

(pppp) **Workforce**: Employees and agents of Michaels who perform work for the Plan under the direct control of the Plan.

2.2 Number and Gender

Where appropriate herein, the singular includes the plural, and vice versa; and the masculine gender includes the feminine gender, and vice versa.

2.3 Miscellaneous Construction

The headings of Articles and Sections are solely for convenience. If there is any conflict between such headings and the text of the Plan, the text of the Plan will control. All references to the capitalized terms "Sections," "Articles," "Paragraphs," "Clauses" and the like are to this document unless otherwise indicated. The terms "herein" and "hereof," as well as other similar compounds of "here" when appearing in the Plan, refer to the entire document and not to any particular part, unless the context clearly indicates otherwise. The terms "includes" and "including" appearing herein mean "includes but is not limited to" and "including but not limited to," respectively.

2.4 Reference to Plan Includes Component Programs

Any reference to the Plan includes each Component Program unless otherwise indicated.

2.5 Incorporation of Component Programs

The Component Programs and the Component Program Documents in their entirety are incorporated herein by reference and made a part of the Plan.

2.6 Inconsistent Provisions in Component Program Documents

If, and only if, any provision in a Component Program Document conflicts with, contradicts, or renders ambiguous any provision in this document, the provision in this document will control unless otherwise specifically provided.

2.7 Effect Upon Other Plans

Except to the extent provided herein, nothing in the Plan will be construed to affect the provisions of any other plan maintained by the Employer, including a plan intended to comply with the qualification provisions of sections 401(a) and 501(a) of the Code.

2.8 Jurisdiction

Except to the extent ERISA or any other federal law applies to the Plan and preempts state law, the Plan will be construed, enforced, and administered according to the laws of the State of Texas.

2.9 Severability

If any provision of the Plan, a Component Program or any Insurance Contract is held illegal, invalid, or unenforceable for any reason, that holding will not affect the remaining provisions of the Plan. Instead, the Plan, the Component Program, or Insurance Contract will be construed and enforced as if the illegal, invalid, or unenforceable provision had not been included herein.

End of Article II

ARTICLE III PARTICIPATION

3.1 Commencement of Participation

Each Employee will become a Participant in the Plan coincident with the date the Employee becomes enrolled in and covered under one or more of the Component Programs, but only for those Component Programs in which such Employee is enrolled. By becoming a Participant in a Component Program under the Plan, an Employee will for all purposes be deemed conclusively to have assented to the terms and conditions of this Plan and each applicable Component Program.

3.2 Enrollment in Component Programs

Rules of eligibility, enrollment, coverage, and termination of coverage vary for each Component Program and are set forth in the respective Component Program Documents. Enrollment and coverage in a Component Program will be subject to any required premium payment applicable to such coverage and to all other terms and conditions set forth in the applicable Component Program Document. Under each Component Program, different benefits may be provided with respect to different eligible Employee categories or portions of such eligible Employee categories, and neither the Plan nor Michaels will be under any obligation to provide comparable benefits, in the aggregate or on a benefit-by- benefit basis, with respect to such separate eligible Employee categories or portions of such eligible Employee categories. Nothing in the Plan will be construed or applied to indicate that each Component Program is applicable to each eligible Employee category hereunder, or to all persons assigned to each eligible Employee category.

Notwithstanding any other provision of this Section 3.2 or the terms and conditions of an applicable Component Program Document, an eligible Employee must complete any applicable enrollment forms and processes and provide all necessary information (*e.g.*, Social Security Numbers) required for participation in, and coverage under, a Component Program. Enrollment in a Component Program will not be effective unless and until all required forms and information have been timely provided, and may be suspended in the event that the eligible Employee fails to provide necessary information or forms with respect to his coverage or that of an eligible Dependent, until such information or forms have been provided to the Plan Administrator.

3.3 Amending or Changing Coverage; Re-enrollment

Participants may amend or change coverage under a Component Program, or, where applicable, re-enroll in a Component Program, only when and as permitted herein or by the applicable Component Program and within applicable rules and regulations.

3.4 Termination of Participation

Except as otherwise specifically provided by the Plan, a Participant will cease to participate in the Plan when any one of the following occurs:

(a) The date the Participant is no longer enrolled in and covered under at least one Component Program;

(b) The later of the last day of the month in which the Participant fails to qualify as an Employee or the date the Participant loses coverage under all Component Programs (in accordance with the terms set forth in the Component Program Documents or in the summary plan descriptions for the Component Programs) as a result of his failure to qualify as an Employee whichever is later subject to Article V; or

(c) The effective date of termination of the Plan.

If a Participant ceases to participate in the Plan, he will be entitled to resume participating in accordance with Section 3.1.

3.5 Dependent Coverage.

(a) **Commencement of Participation**. Each Dependent will become a Covered Dependent under the Plan coincident with the date the Dependent becomes enrolled in and covered under at least one Component Program.

(b) **Enrollment in Component Programs**. Rules of eligibility, enrollment, coverage, and termination of coverage for Dependents in a Component Program vary for each Component Program and are set forth in the respective Component Program Documents.

(c) **Termination of Participation**. Plan coverage for a Participant's Covered Dependent will terminate when any one of the following occurs.

(i) The date the Dependent is no longer enrolled in and covered by at least one of the Component Programs.

(ii) The date the Covered Dependent ceases to qualify as a Dependent.

(iii) The date the Participant ceases to be enrolled in and covered under at least one Component Program covering the Covered Dependent, or

(iv) The effective date of termination of the Plan.

If coverage for a Covered Dependent terminates, he will be entitled to resume coverage in accordance with Paragraph (a) above.

(d) **QMCSOs**. Notwithstanding Paragraphs (a), (b), and (c) above, each Health Care Component will comply with a QMCSO within the meaning of section 609 of ERISA, but only to the extent required by and under the conditions specified in section 609 of ERISA. The Plan Administrator will establish such rules and procedures regarding such orders, as is required by ERISA.

3.6 Participation While on Leave.

(a) **FMLA and USERRA Leave**. During an FMLA Leave or USERRA Leave, to the extent provided by a Component Program Document, the Employer will continue to pay the cost of any non-contributory coverage, or core coverage, provided to the Participant under the Plan. In addition, to the extent required by FMLA or

USERRA, a Participant may elect to continue coverage under a Health Care Component during his leave. A Participant who elects such continuation is responsible for paying his share of the contributions for that coverage during the leave, and the Employer is obligated to pay its share during the leave. Further, to the extent permitted by the Component Program, a Participant may elect to continue all or a portion of his coverage under the other contributory Component Programs (*i.e.*, those which are not Health Care Components) during FMLA Leave or USERRA Leave. Except as otherwise provided in a Component Program Document, a Participant who desires to continue such other coverage must agree to pay his share of the contributions required for such other coverage during the leave, under one of the options described in this Section 3.6, and the Employer is obligated to pay its share during the leave.

Except as may be otherwise provided under the Employer's nondiscriminatory FMLA policies and procedures or a Component Program Document, or as may be required by applicable law, the payment options available to a Participant during FMLA Leave or USERRA Leave are:

(i) **Paid Leave**. If the FMLA Leave or USERRA Leave is a paid leave (including a paid leave by reason of the use of paid time off or extended illness benefits) and the Participant elects to continue his coverage, the Participant's contributions will continue to be paid by the method used prior to the leave.

(ii) **Unpaid Leave**. If the FMLA Leave or USERRA Leave is an unpaid leave and the Participant elects to continue his coverage, the Participant may elect to pay his contributions under any of the following options.

(A) **Pre-pay Option**. The Participant may elect to pay his contributions prior to going on the leave. Contributions under the pre-pay option may be made on either a pre-tax or after-tax basis, as elected by the Participant (and as permitted by law).

(B) **Pay-as-you-Go Option**. The Participant may elect to pay his contributions during the leave either on the same schedule as payments would be made if the Participant were not on leave, or alternatively, on the schedule applicable to COBRA premiums or any other schedule the Employer may establish consistent with applicable laws and regulations. Contributions under the pay-as-you-go option will be made on an after-tax basis.

(C) **Catch-Up Option**. The Participant may elect with the consent of the Employer, which consent will be granted on a non-discriminatory basis, to continue his benefits during the period of leave and, upon his return from the leave, to reduce his future Compensation in an amount sufficient to pay the contributions incurred during such leave. Payments under this catch-up option may be made with either pre-tax or after-tax dollars, as elected by the Participant.

With respect to Cafeteria Component Programs only, if the FMLA Leave or USERRA Leave will span two different Plan Years, the Participant may not elect the pre-pay option on a pre-tax basis for that portion of the FMLA Leave or USERRA Leave that occurs during the next Plan Year, but, instead, must elect either to pre-pay on an after-tax basis or another payment option (*i.e.*, the pay-as- you-go option or catch-up option) for the period of FMLA Leave or USERRA Leave during the next Plan Year. The Employer will be entitled to collect premiums that a Participant fails to pay in accordance with the terms of the payment option selected by such Participant to the fullest extent permitted by law.

If a Participant elects not to continue his coverage under the Health Flexible Spending Account Program during an FMLA Leave, then upon his return from that leave, the Participant will be given the option to either (i) resume coverage at the original level and make up the unpaid contributions or (ii) resume coverage at a reduced level in which case the Participant's coverage amount under the Health Flexible Spending Account Program will be adjusted to reflect the period of his FMLA Leave during which he did not make contributions and his contribution will resume at the original level.

Any continued coverage provided by the Employer pursuant to this Section 3.6 in the case of an FMLA Leave will be in addition to any COBRA continuation coverage the Participant and his covered Spouse and Dependents are entitled to under section 4980B of the Code, section 609 of ERISA, and Article V of this Plan. The Participant and his covered Spouse and Dependents will be provided with notice of their COBRA rights, if any, at the end of the FMLA Leave regardless of whether they elect to continue coverage pursuant to this Section during such FMLA Leave. Except as provided otherwise under the terms of a Component Program document, any continued coverage provided by the Employer pursuant to this Section 3.6 during a USERRA Leave will be treated as, and count against, satisfaction of the COBRA continuation period applicable to the Participant and his covered Spouse and Dependents under section 4980B of the Code, section 609 of ERISA, and Article V of this Plan. If the Participant does not elect to continue coverage pursuant to this Section 3.6, or elects to continue such coverage during such leave but ceases to pay his portion of the cost of such coverage during such leave, such Participant will be provided with notice of his COBRA rights if any.

(b) **Non-FMLA and Non-USERRA Unpaid Leave**. A Participant's coverage under the Plan will continue during an approved unpaid leave of absence or layoff (that is not an FMLA Leave or USERRA Leave) to the extent provided in the Component Programs. A Participant may elect to continue coverage under a Health Care Component during such leave or layoff if allowed by the Component Program. A Participant who elects such continuation during a leave or layoff is responsible for paying his share of the contributions for the coverage during such leave or layoff, and the Employer is obligated to pay its share during the leave or layoff (unless provided otherwise in the applicable Component Program Document). Further, to the extent permitted by the Non-Health Care Components, a Participant may elect to continue all or a portion of his contributory coverage under such other programs during the leave or layoff. A Participant who desires to continue such other coverage must agree to pay his share of the required contributions for the coverage during the leave under the

Pay-as-you-Go Option or the Catch-up Option described in Paragraph (a), unless specified otherwise in the Component Program Document.

If a Component Program does not allow a Participant's coverage to continue during an unpaid leave of absence or layoff (which does not qualify as FMLA Leave or USERRA Leave), coverage will be suspended during such unpaid leave of absence or layoff; provided, however, that the Participant and his Covered Dependents (who are qualified beneficiaries within the meaning of Section 5.3) may elect, pursuant to COBRA, to continue coverage under a Health Care Component that is a group health plan within the meaning of section 5000(b)(1) of the Code or section 607(1) of ERISA (*i.e.*, the Medical Plan component, the Dental Plan component, the Vision Plan component, the Employee Assistance Plan component, and the Health Flexible Spending Account Program component).

A Participant who takes a paid leave of absence will not be eligible to revoke his coverage elections pursuant to this Paragraph (b); but, instead, such coverage and the associated contribution elections will remain in effect for the duration of such leave.

Unless otherwise provided in a Component Program Document, any continued coverage provided by the Employer pursuant to this Paragraph (b) will be treated as, and count against, satisfaction of the COBRA continuation period applicable to the Participant and his covered Spouse and Dependents under section 4980B of the Code, section 609 of ERISA and Article V of this Plan. If the Participant does not elect to continue coverage pursuant to this Paragraph (b), or elects to continue such coverage during such leave but ceases to pay his portion of the cost of such coverage during such leave, the Participant will be provided with notice of his COBRA rights if any, at that time.

3.7 Enrollment Without Regard to Medicaid or Medicare Eligibility

Except as may otherwise be required with respect to a HIPAA Special Enrollment Event, each Health Care Component will enroll an individual in the Plan without regard to the fact the individual is eligible for or is provided (a) medical assistance under a state plan for medical assistance approved pursuant to title XIX of the Social Security Act, or (b) benefits under Part A or B of Medicare, to the extent such Health Care Component is required to comply with such laws.

3.8 Special Requirements for Health Care Components

To the extent applicable, each Health Care Component that is a group health plan within the meaning of section 9832 of the Code (*e.g.*, the Medical Plan component, the Dental Plan component, and the Vision Plan component, unless such Component Programs are providing only excepted benefits including limited scope dental and vision benefits) will operate in compliance with the applicable requirements of subtitle K, chapter 100 of the Code (*i.e.*, the special enrollment and portability requirements of section 9801 of the Code, the health status nondiscrimination requirements of section 9802 of the Code, the guaranteed renewability requirements of section 9803 of the Code, the newborns and mothers protection provisions in section 9811 of the Code, and the mental health and substance use disorder parity provisions of section 9812 of the Code, the coverage of dependent students on medically necessary leaves of absence of section 9813 of the

Code, and the applicable mandates of HCR, as amended, of section 9815 of the Code), which provisions are hereby incorporated herein by reference. Compliance with the requirements of subtitle K, chapter 100 of the Code will include, without limitation, compliance with the special enrollment rules that apply (a) in the event of a Participant's acquisition of a new Dependent or the loss of group health plan or health insurance coverage by an eligible Employee, Spouse, or Child and (b) in the event that (i) such eligible Employee's or Dependent(s)' coverage under Medicaid or a state Michaels health insurance program is terminated as a result of loss of eligibility and (ii) such eligible Employee or Dependent(s) becomes eligible for a premium assistance subsidy under Medicaid or a state Michaels health insurance program, provided that such eligible Employee requests such enrollment within 60 days after eligibility for such premium assistance subsidy is determined.

Each Health Care Component that is a group health plan within the meaning of section 733 of ERISA (*e.g.*, the Medical Plan component, the Dental Plan component, and the Vision Plan component, unless such Component Programs are only providing excepted benefits including limited scope dental and vision benefits) will also operate in compliance with section 713 of ERISA, regarding mandated coverage of post-mastectomy reconstructive surgery, to the extent applicable.

Each Health Care Component that is a "group health plan" within the meaning of the following laws (unless such Health Care Component is providing only excepted benefits including limited scope dental and vision benefits) will comply with the requirements of such laws, to the extent that they are applicable to the Plan: GINA, Michelle's Law, and the Mental Health Act.

Each Health Care Component that is a "group health plan" within the meaning of HCR (unless such Health Care Component is providing only excepted benefits including limited scope dental and vision benefits) will comply with the requirements of HCR as a grandfathered or non-grandfathered plan, as such terms are defined by HCR, to the extent that such requirements are applicable to the Plan.

Michaels or the Plan Administrator may make exceptions to the coverage provisions of a Health Care Component when it deems necessary and any such exception will not constitute binding precedent with respect to any other coverage situation.

3.9 Correction of Coverage or Enrollment Error

If the Plan Administrator determines in its discretion that an error has occurred with respect to enrollment or coverage under the Plan, the Plan Administrator may correct any such error in any manner it deems appropriate; provided, however, that, to the extent any such correction is not a permissible mid-year election change in accordance with Section 4.4 and under section 125 of the Code and results in a cost increase or decrease to the affected Participant, such Participant will not be permitted to make a corresponding change to the amount of his pre-tax contributions elected for the Plan Year, and any increase in cost to such Participant resulting from such correction must be paid by the Participant on an after-tax basis outside the Plan.

End of Article III

ARTICLE IV CAFETERIA PLAN PROVISIONS

4.1 Election of Cash or Qualified Benefits

(a) **Nature of Election**. A Participant may elect either to (i) receive his Compensation for any Plan Year in cash, or (ii) participate in one or more of the Cafeteria Component Programs in which he is eligible to participate and have his Compensation reduced on a pre-tax or an after-tax basis, with the amount of such reduction applied by the Employer toward his share of the cost of benefit coverage elected by the Participant under the Cafeteria Component Programs. (Notwithstanding the foregoing, a Participant's share of the cost of benefit coverage under a Health Care Component for a Participant's Stepchild who does not qualify as the Participant's dependent within the meaning of section 152 of the Code (determined without regard to sections 152(b)(1), (b)(2), and (d)(1)(B) of the Code) will be paid on an after-tax basis, and the Employer's share of the cost of such benefit coverage will be imputed as income subject to federal income tax.) In addition, a qualified beneficiary who elects continuation coverage under COBRA pursuant to Article V will pay the premiums for such coverage pursuant to the provisions of this Article IV on either a pre-tax or after-tax basis, as applicable and as permitted by section 125 of the Code. However, in no event will a Participant be allowed to elect a benefit that is offered under a Cafeteria Component Program if such benefit is not a "qualified benefit" within the meaning of section 125(f) of the Code, and any such election will be null and void.

(b) **Election Procedure**. A Participant's election to participate in a Cafeteria Component Program must be made according to the rules and procedures the Plan Administrator establishes. Such rules and procedures may include (but are not limited to) any or all of the following:

(i) Compensation reduction contributions from the last month of a Plan Year can be used to pay accident or health premiums for the first month of the immediately following Plan Year, if done on a uniform and consistent basis with respect to all Participants;

(ii) Evergreen elections (*i.e.*, benefit elections that automatically renew each Plan Year, to the extent that an eligible Employee does not make a new election during the applicable open enrollment period for such Plan Year) may be permitted for each of the Cafeteria Component Programs, including the Health Flexible Spending Account Program and the Dependent Care Flexible Spending Account Program; and

(iii) New elections and revocations or changes in elections are permitted to be made electronically, to the extent that such electronic elections comply with all applicable laws.

The Participant's Compensation will be reduced in accordance with such election, and an amount equal to the reduction will be contributed by the Employer to cover the Participant's share of the cost of such benefit coverage under the Cafeteria Component Program.

(c) **Maximum Election Amount**. The maximum amount of an election made pursuant to this Article IV will be the sum of the maximum permissible pre-tax and after-tax elections available under each Cafeteria Component Program. If a Cafeteria Component Program does not state a maximum election amount, the maximum election amount under such Cafeteria Component Program will be the total cost of the most expensive coverage offered under such Cafeteria Component Program at the time such election is made (pursuant to Section 4.2 below).

4.2 Annual Election Procedure

(a) **Open Enrollment**. Prior to the commencement of each Plan Year, the Plan Administrator will allow each Participant and each other Employee who will become a Participant as of the first day of the Plan Year to elect to reduce his Compensation on a pre-tax or after-tax basis, as appropriate, equal to such Participant's (or other Employee's) share of the cost of benefit coverage elected by such Participant (or other Employee) under the applicable Cafeteria Component Program (subject to any minimums or maximums set forth in such program which are hereby incorporated herein by this reference) in the manner described in Section 4.1. Such election will become effective as of the first day of the Plan Year and remain in effect for the entire Plan Year, except as provided below. Subject to a Participant's (or other Employee's) ability to revoke his election, as provided in Section 4.4, any Compensation reduction election will, where appropriate, be adjusted automatically in the event of a change in any such cost. For this purpose, any change in cost due to participation in any wellness program sponsored by the Employer will be deemed a cost change that is subject to this automatic contribution adjustment provision. Each election must be made in accordance with the rules and procedures established by the Plan Administrator and must be completed and submitted to the Plan Administrator on or before such date as the Plan Administrator will specify, but not later than the first day of the Plan Year.

(b) **Mid-Year Election For New or Newly Eligible Employees**. The Plan Administrator will allow an eligible Employee (whether a new Employee or a newly eligible current Employee) first becoming eligible for a Cafeteria Component Program, the opportunity to make the election described in Section 4.1 during the 30-day period following the date the Employee becomes eligible.

(c) **Failure to Elect**. Except as otherwise provided in a Cafeteria Component Program, a newly eligible Employee (whether a new Employee or a newly eligible current Employee described in Paragraph (b)) who fails to make his election in a timely manner will be deemed to have elected to receive his full Compensation for the Plan Year in cash and will not be enrolled in any of the Cafeteria Component Programs under the Plan.

If an Employee does not indicate his choice of pre-tax or after-tax treatment of his required contributions to the eligible Cafeteria Component Programs hereunder, the Employee will be deemed to have made a pre-tax election.

(d) **Carryover of Prior Election**. A Participant who had an election for a Cafeteria Component Program, other than the Flexible Spending Account Programs, in

effect for the current Plan Year and who fails to make a timely election for the subsequent Plan Year will, at the election of the Plan Administrator and communicated as part of open enrollment, be deemed (i) to have made the same benefit election for the subsequent Plan Year as was in effect for the current Plan Year, and/or (ii) to have elected spousal coverage for those Component Programs that provide such coverage, and (iii) to have agreed to a reduction in his Compensation for the subsequent Plan Year equal to the Participant's share of the cost of the benefits deemed elected for such Plan Year. In certain circumstances in which a significant change has been made to one or more Component Programs, the Participant may be required to affirmatively reenroll instead of having his prior election carry over.

(e) **Optional Retroactive Enrollments**. If a Cafeteria Component Program permits immediate entry into that Cafeteria Component Program for new hires, then the Employer may elect to apply a 30-day retroactive enrollment period with respect to such new hires. This retroactive enrollment period is not available to Employees who are not new hires or to Employees who terminate employment and are rehired within 30 days of termination or return to employment following an unpaid leave of absence of less than 30 days. The Employer may permit elections for retroactive enrollment to relate back to an otherwise eligible Employee's date of hire. However, Compensation reductions to pay for such an election must be from Compensation not yet currently available on the date of the election.

4.3 Election Changes by Plan Administrator

(a) **Changes Necessary to Comply With the Law**. Either prior to or during any Plan Year the Plan Administrator may, as to all or any class of Participants and under rules uniformly applicable to similarly situated Participants, change any election then in effect as to future reductions in Compensation, including a modification of elections by (a) "highly compensated participants," as such term is defined in section 125 of the Code, (b) "key employees," as such term is defined in section 416 of the Code, (c) "highly compensated individuals," as such term is defined in section 105(h) of the Code, or (d) highly compensated employees or principal shareholders or owners as defined in section 129 of the Code with or without the consent of such Employees, if the Plan Administrator, in its discretion, determines that such reduction is necessary or advisable in order to satisfy the nondiscrimination requirements under provisions of the Code, including section 125 thereof, or to maintain the nontaxable status of benefits payable under the Cafeteria Component Programs.

(b) **Administrative Action Necessary to Correct a Mistake**. If the Plan Administrator should discover that a mistake has been made with regard to the administration of any provision of the Plan (such as determining whether or when an individual is eligible to participate in the Plan or executing annual or special elections made by a Participant), the Plan Administrator may take such administrative action as it deems necessary or appropriate to remedy the mistake in question, including but not limited to allowing participation in the Plan, providing for catch-up contributions, or modifying enrollment elections. Any such administrative action will conform to the requirements of section 125 of the Code and the regulations issued thereunder.

4.4 Election Revocation and Changes by Participants During the Plan Year

(a) **General Rule**. Except as otherwise provided in this Section 4.4 and subject to the terms of the applicable Component Program Document, a Participant may not revoke or change his election during a Plan Year. Similarly, an eligible Employee who has elected not to participate in the Plan for a Plan Year may not change his election during such Plan Year (except as provided in this Section 4.4 and the terms of the applicable Component Program Document).

(b) **HIPAA Special Enrollment Event**. An eligible Employee, Participant or COBRA Beneficiary may change an election for the Medical Plan, Dental Plan or Vision Plan coverage (but not Health Flexible Spending Account Program and Dependent Care Flexible Spending Account coverage) during a Plan Year and make a new election that corresponds with a HIPAA Special Enrollment Event.

An election change due to a HIPAA Special Enrollment Event must be made within the 30-day period following the later of the date of the event or the date coverage is lost, or the 60-day period following the date of a HIPAA Special Enrollment Event described in Section 2.1(xx)(ii)(A) or (B) and proper documentation of such event must be provided to the Administrative Committee during such30-day or 60-day period. The summary plan description for the applicable Component Program will set forth the rules regarding election changes on account of a HIPAA Special Enrollment Event including the effective date of coverage. A Participant or COBRA Beneficiary may also change the type of coverage elected (*e.g.*, Choice Basic option vs. Consumer Choice option) on account of a HIPAA Special Enrollment Event as provided in the applicable regulations.

(c) **Changes in Status**. To the extent provided in the Component Program Documents and subject to such limitations as the Plan Administrator may adopt by rule or regulation, a Participant may revoke or modify his election for the balance of the Plan Year only if such revocation or modification is on account of and consistent with a Change in Status. If such revocation or modification is on account of and consistent with a Change in Status, the Participant may make a new election for the remaining portion of the Plan Year; provided, however, that the new election must be on account of and consistent with the Change in Status. A Participant desiring to revoke or modify an election and, if applicable, to file a new election will so advise the Plan Administrator on the form and within the 30-day period following the Change in Status Event. However, (i) a Change in Status on account of a HIPAA Special Enrollment Event need not satisfy the above consistency requirements and as permitted by HIPAA a Participant who incurs a special enrollment event may elect to change health care coverage options as provided in applicable regulations (ii) with respect to a Component Program that provides life insurance benefits, an election to increase or decrease coverage is deemed to correspond with such Change in Status; and (iii) if a Participant has a deficit balance under the Dependent Care Flexible Spending Account Program or Health Flexible Spending Account Program, such Participant may not revoke or reduce his election under that program on account of a Change in Status occurring during such Plan Year unless and until the deficit has been eliminated.

(d) **Cost or Coverage Changes**. To the extent provided in the Component Program Documents or by the Plan Administrator, a Participant may file a written election with the Plan Administrator to revoke or modify (subject to the conditions below) any prior election and/or to make a new election with respect to the remaining portion of a Plan Year as to each separate Component Program (other than the Health Flexible Spending Account Program) may allow on account of (i) a significant increase or decrease in the cost of coverage, (ii) an improvement or addition of a coverage option or (iii) a significant curtailment in the coverage provided under a Component Program. Any such election change must be made within 30 days following the date of the change in cost or coverage.

(i) **Cost Changes**. If the cost of a Participant's portion of coverage under a Component Program increases or decreases during the Plan Year, such Participant's Compensation reductions will automatically be increased or decreased on a prospective basis, as applicable; provided, however, that if the increase or decrease is significant, the Participant may elect to revoke his election as described in the next sentence. If the cost of a Component Program, significantly increases or decreases during a period of coverage, a Participant may prospectively increase payments, decrease payments or revoke his election and, in lieu thereof, elect to receive on a prospective basis coverage under another Component Program option providing similar coverage. If no other Component Program option exists that provides similar coverage, the Participant may be permitted to revoke coverage altogether on account of a significant increase or decrease in the cost of coverage. The determination of whether a cost increase or decrease is "significant" will be made by the Plan Administrator. Notwithstanding the foregoing, this Paragraph will only apply to the Dependent Care Flexible Spending Account Program if the change in cost is imposed by a provider who is not a relative of the Participant.

(ii) **Coverage Changes**. If the coverage under a Component Program is significantly curtailed or a new Component Program or coverage option is added during the Plan Year, a Participant may file a written election with the Plan Administrator to make the following election changes.

(A) **Significant curtailment without loss of coverage**. If a Participant has a significant curtailment of coverage during the Plan Year that is not a loss of coverage, such as a significant increase in the deductible, the co-pay or the out-of-pocket cost sharing limit under an accident or health plan, any Participant who is participating in the Plan and receiving that coverage may revoke his election for that coverage and make a new election on a prospective basis under a Component Program option providing similar coverage. The determination of whether a significant curtailment has occurred will be made by the Plan Administrator. However, coverage under the Medical Plan will be significantly curtailed only if there is an overall reduction in coverage provided to Participants generally. Accordingly, in most cases, the loss of one particular physician in a network does not constitute a significant curtailment.

(B) **Significant curtailment with loss of coverage**. If a Participant has a significant curtailment of coverage during the Plan Year that is a loss of coverage, the Participant may revoke his election and on a prospective basis elect to either receive new coverage under another Component Program coverage option providing similar coverage or to drop coverage if no similar Component Program coverage option is available. For this purpose, a loss of coverage means a complete loss of coverage under a Component Program or coverage option (including the elimination of a Component Program coverage option, an HMO ceasing to be available where the individual resides, or the individual losing all coverage under the option by reason of an overall lifetime or annual maximum). In addition, the following events will also constitute a loss of coverage: a) a substantial decrease in the medical care providers available under a coverage option under the Medical Plan; b) a reduction in the benefits for a specific type of medical condition or treatment with respect to a Participant (or enrolled Spouse or Child) currently in that course of treatment; or c) any other similar fundamental loss of coverage.

(iii) **Addition or improvement of benefit package option**. If the Plan adds a new Component Program coverage option or Component Program, or if coverage under an existing Component Program or coverage option is significantly improved during a period of coverage, an eligible Employee (whether or not he has previously made an election under the Plan or has previously elected the Component Program option) may revoke his election under the Plan and elect the newly added or improved Component Program option. For example, if a new HMO option is added as a Medical Plan coverage option during the Plan Year, the Plan may allow eligible Employees to elect that option or any existing Medical Plan option provided through the Plan. Conversely, if the eligible Employee had previously made an election under the Plan, then the Employee may only elect to revoke his coverage and elect the same type of coverage (*i.e.*, single or family coverage) under the Medical Plan option. For example, if prior to the beginning of the Plan Year, an Employee elects Employee plus one coverage under an indemnity plan coverage option provided under the Medical Plan and during the year Michaels adds an HMO option that provides Employee-only or family coverage, the Employee may elect to revoke his election for indemnity coverage and elect family coverage under the HMO option on a prospective basis. The Employee could not, however, elect Employee-only coverage under the HMO option because that election would not be consistent with the addition of the HMO option since prior to such date the Employee had Employee plus one coverage.

(e) **FMLA or USERRA Leave**. To the extent provided in a Component Program, a Participant may revoke his election for the balance of the Plan Year upon his taking FMLA Leave or USERRA Leave. In addition, a Participant upon his taking of or returning from, or during his, FMLA Leave or USERRA Leave may modify or revoke his election in accordance with the HIPAA Special Enrollment Event Rules in Paragraph (b), the Change in Status rules in Paragraph (c), or the cost or coverage change rules in Paragraph (d) above.

(f) **Medicare or Medicaid Entitlement**. In addition to any special enrollment rights that may apply to a Participant or his Dependent under section 9801 of the Code, a Participant may file a written election with the Plan Administrator to revoke or modify any prior election and/or to make a new election with respect to the remaining portion of a Plan Year as to each separate Component Program may allow on account of entitlement to Medicare or Medicaid (other than coverage solely for pediatric vaccines). Likewise, a Participant may file a written election with the Plan Administrator to revoke or modify any prior election and/or to make a new election with respect to the remaining portion of a Plan Year as each separate Component Program may allow on account of the loss of entitlement to Medicare or Medicaid. Any such election must be made during the 30-day period following the date of the Medicare or Medicaid entitlement.

(g) **Judgment, Decree or Order**. If a judgment, decree or order resulting from divorce, legal separation, annulment, or a change in legal custody (including a QMCSO) requires accident or health coverage of an Employee's Dependent Child, the Employee may change his election to (i) add coverage for the eligible Employee and/or the Dependent Child under a Health Care Component if the order requires or (ii) cancel coverage under a Health Care Component for the Dependent Child if the order requires the Spouse, former Spouse or someone else to provide coverage for the Child; provided, however, that the Employee will not be permitted to revoke coverage for the Child unless he provides proof of such alternate coverage.

(h) **Effective Date of Revocation or Change**. The Plan Administrator will review a Participant's request to revoke or modify his election and will determine whether the Participant has met the requirements of Paragraphs (b), (c), (d), (e), (f), or (g) above. Except with respect to events described in Paragraph (g) or as the Plan Administrator may otherwise provide by rule or regulation, and as permitted by law, the Plan Administrator will approve a Participant's request to revoke or modify his election only if the request is received in the form prescribed by the Plan Administrator no later than 30 days after the occurrence of the reason therefor and proper proof substantiating the reason for the election change is provided. Except as required by law, in no event will any revocation or modification be effective earlier than the first day of the first pay period after the request is completed, executed and submitted to the Plan Administrator. For events described in Paragraph (g), any revocation or change will be made in accordance with section 609 of ERISA and the regulations thereunder and the QMCSO policies and procedures adopted by the Plan Administrator. For the Dependent Care Flexible Spending Account Program, a Participant who elects to stop making contributions pursuant to this Section 4.4 may continue to seek reimbursement for Employment-Related Dependent Care Expense incurred at any time during the entire Plan Year, subject to the Participant's available Dependent Care Flexible Spending Account balance.

(i) **Health Savings Account Contributions**. Notwithstanding any provision of this section 4.4 or the Plan to the contrary, the following special rules apply to an HSA Eligible Participant:

(i) Subject to the limitations of section 223 of the Code, each HSA Eligible Participant may, at any time during the Plan Year, prospectively change his

election with regard to Employee contributions to such HSA (and only such contributions), and such election change will be effective as of the first day of the first administratively practicable pay period coincident with or next following the date such request for an election change is completed and filed with the Daily Administrator.

(ii) Subject to the limitations of section 223 of the Code, any Participant who ceases to be an HSA Eligible Participant may, at any time during the Plan Year, prospectively revoke his existing election with regard to his HSA contributions (and only such contributions), and any such revocation will be effective on the first day of the first administratively practicable pay period coincident with or next following the date the revocation request is completed and filed with the Daily Administrator

(j) **Component Programs Control**. A Participant will not be permitted to revoke an existing election and/or file a new election to the extent such revocation or filing conflicts with the terms of the applicable Component Program.

4.5 Termination and Reinstatement of Election

(a) **Automatic Termination of Election**. A Participant's election with respect to a Cafeteria Component Program will automatically terminate on the date on which the Participant ceases to be a Participant in that program; however, coverage or benefits under that program may continue if and to the extent provided therein.

(b) **Reinstatement of Former Participant**. Except as otherwise provided in a Component Program Document, in the event that an Employee's participation under a Cafeteria Component Program ceases on account of the Employee's termination of employment or failure to pay required premiums for such program during an unpaid leave of absence (other than an FMLA or USERRA leave of absence), and the Employee becomes eligible to participate again either through reemployment or return from leave,

(i) The Employee's prior elections will be reinstated if the time period from the date of termination is 30 days or less unless Employee is eligible to make an election change under Section 4.4; or

(ii) The Employee may make a new election as described in Section 4.2(b) if the time period from the date of termination is greater than 30 days.

4.6 Maintenance of and Adjustments to Flexible Spending Accounts

(a) **Establishment of Flexible Spending Accounts**. The Plan Administrator will maintain separate accounts for each Participant who elects to participate in either (or both) of the Flexible Spending Account Programs in accordance with Section 4.1. Likewise, the Plan Administrator will establish a separate account for each COBRA Beneficiary who continues COBRA coverage under the Health Flexible Spending Account Program as provided pursuant to Section 5.10. Each such separate account will be credited and charged only with those credits and charges attributable to such account as specified herein and in the Flexible Spending Account Programs. A credit or debit balance in any one such account

may not be used to credit or debit any other such account, and each such account will be administered separately. No interest will be credited to or accrue on any balance in such accounts.

(b) **Credits**. Each month or part thereof during which a Participant has an account pursuant to Paragraph (a), such account will reflect: (i) any credit thereto as of the close of the prior month, plus (ii) the amount credited thereto during such month in accordance with the Flexible Spending Account Programs.

(c) **Debits**. Each month, the value of any benefits paid to or on behalf of a Participant, Spouse, or Dependent under a Flexible Spending Account Program will be charged against such Participant's account for that program, and will reduce his balance in that account.

(d) **Forfeiture**. Any credit balance remaining in such an account as of the end of a Plan Year will be forfeited and applied in accordance with the provisions of the applicable Flexible Spending Account Program.

(e) **Substantiation**. All claims will be substantiated in accordance with the section 125 of the Code and the regulations thereunder prior to payment or reimbursement of expenses for "qualified benefits."

4.7 Nondiscrimination Requirements

Each Cafeteria Component Program will comply with the nondiscrimination requirements set forth in section 125 of the Code and the accompanying regulations.

4.8 Limitation of Article

This Article IV applies only to the Cafeteria Component Programs.

End of Article IV

ARTICLE V COBRA

5.1 Continuation of Coverage

(a) **General Rule**. Each "qualified beneficiary" who would "lose coverage" under a Health Care Component that is a group health plan within the meaning of section 5000(b)(1) of the Code or section 607(1) of ERISA (*i.e.*, the Medical Plan component, the Dental Plan component, the Vision Plan component, the Employee Assistance Program component, and the Health Flexible Spending Account Program component) as a result of a "qualifying event" will be entitled to elect, within the "election period," continuation of coverage under that Health Care Component subject to the provisions of this Article V, unless a Component Program Document contains its own COBRA procedures that comply with applicable law. However, if the Component Program Document's COBRA procedures do not address or are ambiguous with respect to a particular issue, and this Article V would address that issue or ambiguity, then this Article V will apply and control to the extent necessary to resolve the issue or ambiguity. The foregoing terms in quotations are defined below.

(b) **Coverage**. In Paragraph (a), "coverage" means coverage that—as of the time coverage is being provided—is identical to the coverage provided under the Health Care Component to similarly situated beneficiaries under the Health Care Component who have not had a qualifying event. If coverage under the Health Care Component is modified for any group of similarly situated beneficiaries, coverage under this Article V will likewise be modified for all individuals who are similarly situated qualified beneficiaries under that Health Care Component. Further, if there is a choice among coverage options available to Participants in the Health Care Component, this choice will be offered to each qualified beneficiary as required by the rules regarding open enrollment, Changes in Status and HIPAA Special Enrollment Events. Continuation of coverage will not be conditioned upon—nor discriminate on the basis of or lack of—evidence of insurability or medical underwriting.

5.2 Event and Loss of Coverage

(a) **Qualifying Event**. In this Article, the term "qualifying event" means, with respect to a Participant, any of the following events that—if not for the continuation of coverage required under Section 5.1—would cause a qualified beneficiary to "lose coverage" under a Health Care Component:

(i) Death of the Participant;

(ii) Termination of the Participant's employment (other than for the Participant's gross misconduct) or reduction in hours of service of the Participant's employment;

(iii) Divorce or legal separation of the Participant from his or her Spouse;

(iv) Entitlement by the Participant to Medicare benefits; or

(v) A Child ceasing to qualify as such under the terms of the Plan.

(b) **Loss of Coverage**. In this Article V, to "lose coverage" means to cease to be covered under the same terms and conditions as in effect immediately prior to the qualifying event. If coverage is reduced or eliminated in anticipation of an event, the reduction or elimination is disregarded in determining whether the event causes a loss of coverage. Moreover, a loss of coverage need not occur immediately after the event, so long as the loss of coverage will occur prior to the end of the coverage period described in Section 5.7. For purposes of an FMLA Leave, the loss of coverage and the qualifying event occur on the last day of the FMLA Leave, even if the Participant did not maintain coverage under the Health Care Component during the FMLA Leave; provided, however, that if coverage extends beyond the end of the FMLA Leave, then the qualifying event occurs at the time of the actual loss of coverage.

5.3 Qualified Beneficiaries

(a) **General Rule**. In this Article V, the term "qualified beneficiary" means any individual who (A) was a Participant or a Covered Dependent (including a former Spouse) of a Participant under a Health Care Component on the day before the qualifying event, except as described in Paragraph (b) below, or (B) is a Child born to or placed for adoption with the Participant during the period of the Participant's continuation of coverage under this Article V.

(b) **Exclusions**. The term "qualified beneficiary" will not include (i) a Participant whose status as an Employee is attributable to a period in which he was a nonresident alien and received from the Employer no earned income (within the meaning of section 911(d)(2) of the Code) constituting income from sources within the United States (within the meaning of section 861(a)(3) of the Code), or (ii) a Covered Dependent of a Participant described in (i) above.

5.4 Notice Requirements

(a) **Initial Notice of COBRA Rights**. The Plan Administrator will provide, at the time of commencement of coverage under a Health Care Component, written notice to each Participant and his Covered Dependents, if any, of the rights provided under this Article V. Such notice will be provided not later than the earlier of (i) 90 days after coverage under the Plan begins, or (ii) the first date on which the Plan Administrator is required to provide the Participant or Covered Dependent with notice of the right to elect to continue coverage under the Plan on account of the occurrence of a qualifying event. Further, in any case where the Plan Administrator is required to provide notice of the right to elect continuation coverage as described in (ii), the furnishing of the notice of the right to elect continuation coverage under Section 5.4(d) will be deemed to satisfy the requirements of this Section 5.4(a).

(b) **Employer Notice of Qualifying Event**. The Employer will notify the Plan Administrator of a qualifying event as described in Section 5.2(a)(i), (ii) or (iv) (respectively, the Participant's death, termination of employment or reduction in hours, or entitlement to Medicare) within 30 days of the later of (i) the date of the

qualifying event or (ii) the date coverage under the Plan is lost as a result of the qualifying event.

(c) **Participant or Qualified Beneficiary Notice**. Each Participant or qualified beneficiary must notify the Plan Administrator in writing of the occurrence of any qualifying event that is a divorce, legal separation, or loss of Dependent status, as described in Section 5.2(a)(iii) or (v), or the occurrence of a second qualifying event that would increase the duration of continuation coverage from 18 or 29 months to 36 months within 60 days of the later of (i) the date of the qualifying event, (ii) the date the qualified beneficiary would lose coverage because of the qualifying event, or (iii) the date the qualified beneficiary is informed through the distribution of a summary plan description or general notice of the responsibility to provide such notice to the Plan Administrator and the Plan's procedures for doing so. If this notice of qualifying event is not so provided, the qualified beneficiary will lose his right to elect such continuation of coverage. For purposes of the foregoing, if more than one qualified beneficiary would lose coverage on account of the divorce or legal separation of a Participant or the occurrence of a second qualifying event, a timely written notice of the divorce or legal separation or second qualifying event that is provided by the Participant or by any one of such qualified beneficiaries will be sufficient to preserve the election rights of the Participant and all such beneficiaries.

Each qualified beneficiary, who is determined under Title II or XVI of the Social Security Act to have been disabled (1) at the time of the qualifying event described in Section 5.2(a)(ii), or (2) within 60 days of such qualifying event (or, in the case of a newborn or recently adopted Child of the Participant, within 60 days of the date of birth or placement for adoption), is responsible for notifying the Plan Administrator in writing of the determination before the end of the initial 18 month continuation period and within the date that is 60 days after the latest of a) the date of such disability determination, b) the date of the qualifying event, c) the date the qualified beneficiary would lose coverage because of the qualifying event, or d) the date the qualified beneficiary is informed through the distribution of a summary plan description or a general notice of the responsibility to provide such notice to the Plan Administrator and the Plan's procedures for doing so. The qualified beneficiary is also responsible for notifying the Plan Administrator in writing of a final determination that the qualified beneficiary is no longer disabled under such titles within 30 days after the later of the date of such determination or the date that the qualified beneficiary is informed through the distribution of a summary plan description or a general notice of the responsibility to provide such notice to the Plan Administrator and the Plan's procedures for doing so.

(d) **Plan Administrator Notice of Rights to Elect Continuation Coverage**. Upon receipt of the notice by the Employer described in Section 5.4(b) (regarding a qualifying event which is, respectively, the Participant's death, termination of employment or reduction in hours, or entitlement to Medicare), or upon receipt of the notice from the Participant or qualified beneficiary described in Section 5.4(c) (regarding an initial qualifying event which is, respectively, divorce or legal separation, or loss of Dependent status or a second qualifying event), the Plan Administrator will notify any qualified beneficiary of the right to elect COBRA continuation coverage with respect to such qualifying event. This notice will be given to the qualified beneficiary within 14 days of the date on which the Plan

Administrator is notified under Section 5.4(b) or (c), whichever is applicable, and will contain the information required by Labor Regulation section 2590.606- 4(b)(4). Any such notice to an individual who is a qualified beneficiary as the Spouse of the Participant will be treated as notice to all other qualified beneficiaries who are minors residing with that Spouse at the time the notice is given.

(e) **Plan Administrator Notice of Unavailability of COBRA**. If the Plan Administrator receives notice from a Participant or qualified beneficiary of a qualifying event pursuant to Section 5.4(c) above and determines that such Participant or qualified beneficiary is not entitled to continuation coverage under COBRA, the Plan Administrator will notify the Participant or qualified beneficiary that COBRA continuation coverage is not available and the reasons why. Such notice of the unavailability of COBRA continuation coverage will be provided within 14 days after the Plan Administrator receives notice of the qualifying event pursuant to Section 5.4(c) above.

5.5 Election Requirements

(a) **Election Period**. The term "election period" means the period that begins on the date coverage terminates under the Health Care Component due to a qualifying event and ends 60 days after the later of (i) the date on which coverage terminates under the Health Care Component due to the qualifying event or (ii) the date the qualified beneficiary is sent the notice required under Section 5.4(d). An election of continuation coverage will be deemed made when sent by the qualified beneficiary. An election of continuation coverage made during the election period is retroactive to the date of the qualifying event. If a qualified beneficiary waives his right to elect continuation coverage, the waiver may be revoked by the qualified beneficiary at any time during the election period; provided, however, that if a qualified beneficiary revokes his waiver, continuation coverage will not be provided for any period prior to the waiver.

(b) **Nature of Election**. Each qualified beneficiary (including a Child who is born to, adopted or placed for adoption with a Participant receiving continuation coverage under this Article V) will be offered the opportunity to make an independent election of continuation coverage under this Article V. However, except as otherwise specified in an election, any election of continuation coverage that is made by a qualified beneficiary who is the Participant or a Spouse of the Participant and that does not specify whether the election is for self-only coverage will be deemed to include an election of continuation on behalf of any other qualified beneficiary who would lose coverage under the Health Care Component due to the qualifying event. If there is a choice among types of coverage under the Health Care Component, each qualified beneficiary is entitled to make a separate selection among the types of coverage.

5.6 Cost of Coverage

(a) **Responsible Party**. Subject to Section 5.6(d), a qualified beneficiary who elects continuation coverage under this Article V will be solely responsible for paying the full cost of such continued coverage. Payment is considered made when it is sent to the proper party. Except as provided in Section 5.6(d), the Employer

will not be obligated to contribute to the cost of continuation coverage. Payment of any initial premium by or on behalf of a qualified beneficiary will not be required until 45 days after the date continuation coverage is elected and will cover the cost of coverage for the period from the date of the qualifying event.

(b) **Amount**. The cost of continuation coverage will be determined by the Plan Administrator and will not exceed 102 percent of the cost of the Health Care Component for the same period of coverage for other similarly-situated individuals who have not experienced a qualifying event; provided, however, that if an 18-month period of coverage is extended to 29 months for the disabled qualified beneficiary pursuant to Section 5.7(a)(i)(B), any reference in this Paragraph (b) to 102 percent is deemed a reference to 150 percent for each month after 18 months with respect to the disabled qualified beneficiary and any other related qualified beneficiaries extending their coverage. Note, however, that if the disabled qualified beneficiary does not elect continuation beyond 18 months, then the cost for any other related qualified beneficiaries who do elect coverage beyond 18 months remains 102 percent and may not be increased to 150 percent. At the election of the payor, the cost of continuation coverage may be paid in monthly installments. If timely payment of such cost is made in an amount not significantly less than the amount required, then the amount paid will be deemed to satisfy the amount required, unless the qualified beneficiary is notified of the amount of the deficiency and is given a reasonable time not less than 30 days after the date of the notice in which to pay the deficiency.

(c) **Source of Payment**. Premiums for continuation coverage will be paid with after-tax dollars pursuant to the Cafeteria Plan provisions of this Plan, except to the extent permitted by applicable law and the Plan's administrative procedures.

(d) **Medical Premium Benefit**. In the event that an Employee incurs an involuntary termination of employment, without cause, that resulted directly from the Employer's reduction in force, program of layoffs, the closing of a plant or the discontinuance of operations, or other similar conditions, as determined by the Employer, or was by mutual agreement between the Employee and the Employer, the Employee will be entitled to a Medical Premium Benefit described in this Section 5.6(d); provided that, he timely elects COBRA continuation coverage under the Medical Plan component in which he participated in at the time of his termination of employment pursuant to this Article V. Under the Medical Premium Benefit the Employer will continue to pay its portion of the cost of the Employee's Medical Plan coverage in effect at the time of the Employee's termination of employment and the Employee will be allowed to pay the employee portion of such cost for the first three months of COBRA continuation coverage. After the end of this three month period, the Employee and his eligible Dependents may continue such COBRA continuation coverage for the remainder of the COBRA continuation period by paying the full COBRA rate described in Section 5.6(b). An Eligible Employee will be advised of his eligibility for the Medical Premium Benefit at the time of his termination of employment.

5.7 Period of Coverage

(a) **General Rule**. Except as provided in Section 5.10 with respect to the Health Flexible Spending Account Program, continuation coverage will extend for the period beginning on the date of the qualifying event and ending:

(i) For a qualifying event that is a termination of employment or reduction in hours that causes loss of coverage as described in Section 5.2(a)(ii), 18 months after the qualifying event, unless:

(A) a qualifying event occurs during the 18-month period, in which case coverage will end 36 months after the qualifying event described in Section 5.2(a)(ii), with respect to all qualified beneficiaries except the eligible Employee, or

(B) the qualified beneficiary is determined under Title II or Title XVI of the Social Security Act to have been disabled either at the time of a qualifying event described in Section 5.2(a)(ii) or at any time during the first 60 days of continuation coverage, in which case reference to 18 months in this Subparagraph (i) is deemed a reference to 29 months with respect to all related qualified beneficiaries, but only if the disabled qualified beneficiary (or any related qualified beneficiary) has provided notice of the determination as required by Section 5.4(c) before the end of the first 18 (not 29) months of continuation coverage and within 60 days of the Social Security disability determination; and

(ii) For a qualifying event not described in Section 5.2(a)(ii) (regarding termination or reduction in hours), 36 months after the qualifying event.

(b) **Special Rule for Medicare Entitlement**. For an event described in Section 5.2(a)(iv) (without regard to whether the event is a qualifying event), the period of coverage for qualified beneficiaries other than the Participant will not terminate before the end of the 36-month period beginning when the Participant becomes entitled to Medicare benefits. In addition, in the case of a qualifying event that is the termination or reduction in hours of the Employee, the Employee's subsequent entitlement to Medicare will not constitute a second qualifying event unless becoming covered by Medicare would have caused the Employee to lose active employee coverage under the Plan.

5.8 Termination of Coverage

(a) **Date of Termination**. Continuation coverage for a qualified beneficiary will terminate prior to the period of coverage described in Section 5.7 when any one of the following occurs:

(i) The Employer—and all entities that are members of a group that is described in section 414(b), (c), (m), or (o) of the Code and that includes the Employer—cease to provide any group health plan within the meaning of section 5000(b)(1) of the Code or section 607(1) of ERISA;

(ii) Coverage ceases under the Health Care Component due to a failure to pay any premium required under the Health Care Component within the latest of (A) 30 days after the date due, (B) the last date a Participant is permitted to make any required contribution under the terms of that program, or (C) if applicable, the last date the Employer is permitted to pay for coverage of similarly-situated Participants under the terms of a contract between the Employer and any Insurer, HMO, PPO, or other entity that provides group-health benefits on behalf of the Employer;

(iii) The qualified beneficiary first becomes covered under any other group health plan within the meaning of section 5000(b)(1) of the Code or section 607(1) of ERISA of an employer other than the Employer, provided that such coverage does not begin on or before the date on which continuation coverage is elected;

(iv) For a qualified beneficiary who is entitled to 29 months of continuation coverage on account of disability and for all related qualified beneficiaries, the earlier of (A) the first day of the month that begins more than 30 days after the date of the final determination under Title II or XVI of the Social Security Act that the disabled qualified beneficiary is no longer disabled, or (B) the end of the original 18-month continuation period specified in Section 5.7(a)(i); or

(v) The qualified beneficiary first becomes entitled to and enrolled in Medicare, provided the qualified beneficiary does not first become entitled to and enrolled in Medicare on or before the date continuation coverage is elected.

(b) **Notification of Termination**. The Plan Administrator will notify a COBRA Beneficiary that continuation coverage of the COBRA Beneficiary or any person enrolled pursuant to Section 5.9(a) has terminated under the provisions of either Section 5.7 or this Section 5.8, and of the effective date of such termination. The notice must also advise the COBRA Beneficiary of any rights to other group health coverage that are available upon the termination of coverage pursuant to this Article V. The notice will be provided as soon as administratively feasible after the date of termination.

5.9 Rights and Obligations of COBRA Beneficiary

(a) **Enrollment of Dependents**. Each qualified beneficiary who becomes a COBRA Beneficiary will be entitled to enroll each family member who would qualify as his Spouse or Child, subject to the same terms and conditions for enrollment of Dependents set forth in the applicable Health Care Component generally; provided, however, that persons enrolled pursuant to this Paragraph (a) are not themselves eligible to become qualified beneficiaries within the meaning of Section 5.3.

(b) **Other Rights**. Except as otherwise specifically provided in the Plan, each individual who becomes a COBRA Beneficiary pursuant to this Article V will have the same rights and obligations as those provided to Participants and Covered Dependents under the terms of the Plan, including those regarding enrollment,

amendment, termination or change of coverage, coordination of benefits, subrogation, claims procedure and review, and provision of information.

5.10 Applicability of Article

This Article V will apply only to a Participant, or Covered Dependent who, or to a Health Care Component that is a group health plan within the meaning of section 5000(b)(1) of the Code or section 607(1) of ERISA (*e.g.*, the Medical Plan component, the Dental Plan component, the Vision Plan component, and the Employee Assistance Program component, and the Health Flexible Spending Account Program component) which, is subject to or entitled to the continuation of coverage provisions of COBRA pursuant to section 4980B of the Code or sections 601 through 608 of ERISA. Moreover, this Article V will only apply to the Health Flexible Spending Account Program for the balance of the Plan Year in which the qualifying event occurred, and even then only to the extent the maximum benefit available to the Participant at the time of the qualifying event for the remainder of the Plan Year is not more than the maximum amount the Health Flexible Spending Account Program could require as payment to maintain coverage for the remainder of the Plan Year. Finally, this Article V will only apply with respect to a Health Care Component subject to COBRA that does not contain its own COBRA procedures or to the extent that the COBRA procedures contained within such Health Care Component fail to address or ambiguously address a particular issue.

5.11 Statutory Conflict

This Article V will be administered in the manner required by COBRA and the regulations issued thereunder. In the event that there is a discrepancy between the provisions of this Article V and COBRA or the regulations issued thereunder, such discrepancy will be resolved to give full effect to the provisions of COBRA and/or such regulations.

End of Article V

ARTICLE VI COORDINATION OF BENEFITS

6.1 Coordination With Other Plans

(a) **Other Plan Coverage**. If a Participant or Covered Dependent is covered under a plan (other than Medicare) of an employer other than the Employer, that provides a benefit of the same type as the applicable benefit provided under the Plan, a claim for a benefit under the Plan will be paid on behalf of the Participant or Covered Dependent as follows:

(i) If the Plan is the Primary Plan, a benefit will be paid by the Plan without regard to any amount paid or payable under any other plan.

(ii) If the Plan is the Secondary Plan, the amount paid by the Plan will be any excess of (A) the amount the Plan would be required to pay if it were the Primary Plan over (B) the amount paid or payable by the Primary Plan.

(b) **Reduction of Plan Benefits**. If the Plan is the Secondary Plan and a payment of a benefit payable under more than one provision of the Plan to a Participant or Covered Dependent is thereby reduced by the amount paid or payable from the Primary Plan, then each benefit payable under each such provision will be reduced by that portion of the total reduction which each such benefit bears to the total benefit payable under the Plan.

6.2 Coordination With Medicare

If a Participant or Covered Dependent is eligible for Medicare, a claim for benefits under the Plan will be paid on behalf of the Participant or Covered Dependent as follows:

(a) If the Plan is the Primary Plan, a benefit will be paid without regard to any amount paid or payable under the terms of Medicare.

(b) If the Plan is the Secondary Plan, the amount paid by the Plan will be any excess of (i) the amount the Plan would be required to pay if it were the Primary Plan over (ii) the amount paid or payable under the terms of Medicare, provided, however, that no payment will be made under the Plan to the extent such amount would exceed the maximum amount that may be billed to the Plan by the provider pursuant to Medicare.

(c) In determining the amount paid or payable under the terms of Medicare for purposes of this Section 6.2, the Plan will consider all Medicare benefits paid or payable to the Participant or Covered Dependent or to the provider directly for the same Condition.

6.3 Limitation on Coordination of Benefits

A Participant or Covered Dependent will not recover more under this Article VI than 100 percent of the expense incurred as a result of a Condition.

6.4 Right to Receive and Release Information

For the purpose of administering this Article VI, the Plan Administrator may—without consent of or notice to any Covered Person or other person—release to or obtain from any other individual or entity any information the Plan Administrator deems appropriate. Any Covered Person or other person or entity claiming benefits or reimbursement under the Plan will furnish the Plan Administrator with whatever information the Plan Administrator requests to implement this Article VI.

6.5 Corrective Payment

If another plan, person or entity paid a benefit that should have been paid by the Plan in accordance with this Article VI, the Plan Administrator will have the right to pay to any such plan, person, or entity an amount the Plan Administrator determines in its discretion to be necessary to comply with the provisions of this Article VI. Amounts paid pursuant to the preceding sentence will be deemed to be benefits paid under the Plan for all purposes, and the Plan Administrator will be fully discharged from liability under the Plan.

6.6 Right of Recovery

If the Plan pays a benefit that should have been paid by another plan, person, or entity in accordance with this Article VI, the Plan Administrator will have the right to recover the payment from such plan, person, or entity in any manner the Plan Administrator deems appropriate.

6.7 Effect of Medicaid or Medicare Eligibility

The amount of any benefit under a Health Care Component will be determined and paid without regard to the fact the Participant or Covered Dependent involved is eligible for or is provided (a) medical assistance under a state plan for medical assistance approved under Title XIX of the Social Security Act, or (b) benefits under Part A or B of Medicare.

6.8 Coordination with Component Program Document

If a Component Program Document contains coordination of benefits provisions, those provisions will control over this Article VI with respect to that Component Program. However, if the provisions in the Component Program Document do not address or are ambiguous with respect to a particular issue, and this Article VI would address that issue or ambiguity, then this Article will apply and will control to the extent necessary to resolve the issue or ambiguity.

End of Article VI

ARTICLE VII SUBROGATION

7.1 Plan's Right of Subrogation

Subject to the provisions of this Article VII (and except as provided otherwise under a superseding provision of a Component Program Document applicable pursuant to Section 7.7 below), if a Participant or Covered Dependent is entitled to a benefit under the Plan for a Condition caused or possibly caused by a Third Party or for which a Third Party may be liable, as a condition to receiving this benefit the Plan Administrator may require the Participant or Covered Dependent to sign an agreement to reimburse the Plan in full and first priority from the amounts recovered from such Third Party (as set forth in Section 7.2 below), and the Plan will be subrogated to all rights, however arising, of the Participant or Covered Dependent against the Third Party. The right of subrogation set forth herein will not limit any additional rights of subrogation the Plan may have under the applicable laws of any State to seek repayment of the benefit from the Third Party.

7.2 Amounts Recoverable

The Plan is subrogated to any right of a Participant or Covered Dependent to recover any and all benefits, which have been paid or are payable—or which are likely (in the opinion of the Plan Administrator) to become payable under the Plan—and which are related to any Condition for which a Third Party is or may be liable, without regard to whether the payment is characterized as recovery for pain and suffering, mental anguish, punitive damages, or any other basis of recovery other than for medical or other welfare benefits provided by the Plan and regardless of whether the liability of the Third Party is reduced to a recovery as a result of legal proceedings, arbitration, compromise settlement or otherwise.

The Plan's subrogation rights under this Article VII will be a first priority claim against all Third Parties and the amount to which the Plan is entitled pursuant to its rights under this Article VII will be paid to the Plan before any amounts are paid to the Participant or Covered Dependent, or in the event such amount to which the Plan is entitled is not paid immediately to the Plan, such amount will be segregated and held in constructive trust for the Plan. In addition, the Plan may recover from the amounts recovered from such Third Parties its reasonable costs and attorneys' fees.

The amount to which the Plan is subrogated, or the amount to which the Plan is entitled to reimbursement, will not be limited or reduced because the Third Party is liable only in part, the Third Party's resources or insurance is limited, the Participant has not been fully compensated (*i.e.*, made whole), or to share in a pro rata allocation of a Participant's fees and costs (including attorney fees) incurred in pursuit of a claim (*e.g.*, "common fund doctrine"), or because of any other reason.

7.3 Limitation on Plan's Recovery

The Plan's right of subrogation will not exceed either (a) the sum of the amount of benefits paid, payable, or likely (in the opinion of the Plan Administrator) to become payable under the Plan, plus the Plan's reasonable costs and attorneys' fees, or (b) the total amount of the recovery from Third Parties.

7.4 Enforcement

To enforce any provision of this Article VII, the Plan Administrator may:

(a) Bring an action in the name of the Plan, Participant or Covered Dependent against a Third Party or the Third Party's liability carrier or in the case of uninsured or underinsured motorist coverage, the Participant's or Covered Dependent's automobile insurance carrier;

(b) Join in any action by a Participant or Covered Dependent against a Third Party or the Third Party's liability carrier or in the case of uninsured or underinsured motorist coverage, the Participant's or Covered Dependent's automobile insurance carrier;

(c) Offset future benefits by amounts which a Participant or Covered Dependent has obtained (or could have obtained with reasonable diligence) from a Third Party or the Third Party's liability carrier or in the case of uninsured or underinsured motorist coverage, the Participant's or Covered Dependent's automobile insurance carrier;

(d) Bring an action to set aside any settlement agreement entered into without the consent of the Plan Administrator;

(e) Bring an action against a Participant or Covered Dependent for an equitable lien or constructive trust against amounts recovered by a Third Party;

(f) Without consent of or notice to any Participant or Covered Dependent, to the extent permitted by law, release to or obtain from any other individual or entity any information which the Plan Administrator deems necessary or advisable for the enforcement of the Plan's subrogation rights under this Article VII; or take any other action it deems appropriate.

7.5 Obligations of Participants

In addition to the other obligations set forth in this Article VII, the following obligations apply to Participants and Covered Dependents:

(a) The Participant or Covered Dependent will execute and deliver to the Plan Administrator any reimbursement agreement, assignment, and other documents the Plan Administrator requests for enforcing the Plan's rights under this Article VII, will provide to the Plan Administrator any information regarding recovery sought or received from any Third Party (including the amount and source of such recovery), will not take any action which might prejudice the Plan's rights under this Article VII, and will not release any Third Party (even if the release purports to be a partial release or a release for the excess liability over Plan benefits) without the Plan Administrator's advance written consent. The Plan's rights will not be affected by a release of any Third Party entered into without such consent.

(b) If a Participant or Covered Dependent initiates a liability claim against any Third Party or the Third Party's liability carrier, or if recovery is sought against the

Participant's or Covered Dependent's automobile insurance carrier under the uninsured or underinsured endorsement, the amounts described in Section 7.2 must be included in the claim.

(c) If a Participant or Covered Dependent receives money from or on behalf of any Third Party, the Participant or Covered Dependent will hold such money in trust for the Plan, to the extent of the Plan's rights under this Article VII. Failure to do so will constitute a breach of the Participant's or Covered Dependent's fiduciary duty under the Plan.

(d) Each Participant or Covered Dependent who incurs any Condition will inform the Plan Administrator whenever it appears a Third Party is or may be liable to the Participant or Covered Dependent as a result of that Condition. Each Participant or Covered Dependent will inform any Third Party, attorney, and insurance carrier, as well as any other individual or entity connected with a Condition or involved in the collection of any amount connected with a Condition, of the Plan's right of subrogation.

(e) Failure of the Participant or Covered Dependent to comply in all respects with this Article VII may, in the Plan Administrator's discretion, cause a denial of benefits for a Condition or a termination of coverage for the Participant or Covered Dependent under the applicable Component Program.

7.6 Waiver

The Plan Administrator may waive or modify any of the provisions of this Article VII whenever it deems appropriate under the facts and circumstances of a particular case.

7.7 Coordination with Component Program Document

If a Component Program Document contains subrogation provisions, those provisions will control over this Article VII with respect to that Component Program to the extent those provisions are in compliance with the law, including any applicable case law, and are drafted to provide for maximum allowable recovery by the Component Program. However, if the provisions in the Component Program Document do not address or are ambiguous with respect to a particular issue, and this Article VII would address that issue or ambiguity, then this Article VII will apply and will control to the extent necessary to resolve the issue or ambiguity.

End of Article VII

ARTICLE VIII CLAIMS PROCEDURE

8.1 Claims For Benefits

Claims for benefits or reimbursement under the Plan will be submitted and processed in accordance with this Article VIII, unless a Component Program Document contains its own claims procedures that are in compliance with applicable law, in which case the Component Program Document's claims procedures will apply with respect to that Component Program. However, if the Component Program Document's claims procedures do not address or are ambiguous with respect to a particular issue, and this Article VIII would address that issue or ambiguity, then this Article VIII will apply and will control to the extent necessary to resolve the issue or ambiguity. Different procedures apply to claims for health benefits ("**Health Claims**"), claims for disability benefits ("**Disability Claims**"), and eligibility claims or claims for non-health and non-disability claims ("**Other Claims**") (collectively referred to as "**Benefit Claims**"), which are outlined in this Article VIII.

8.2 Filing Benefit Claims

Except to the extent provided otherwise in a Component Program Document, a Claimant must file with the Administrative Committee (or Administrative Provider or Insurer, as applicable) a written claim, as applicable, for benefits under the Plan with written proof of loss no later than the end of the next Plan Year following the Plan Year in which the related expense was incurred on the form provided by, or in any other manner approved by, the Administrative Committee (or Administrative Provider or Insurer, as applicable). For purposes of applying the time periods for benefit determination pursuant to Sections 8.5 (Health Claims), 8.6 (Disability Claims) or 8.7 (Other Claims) below, filing a claim with the Administrative Committee (or Administrative Provider or Insurer, as applicable) will be treated as filing a claim with the Plan Administrator. In connection with the submission of a claim, the Claimant may examine the Plan and any other relevant documents relating to the claim and may submit written comments relating to such claim to the Administrative Committee (or Administrative Provider or Insurer, as applicable) coincident with the filing of the benefit claim form. Failure of a Claimant to furnish written proof of loss or to comply with the claim submission procedure will invalidate such claim unless the Administrative Committee (or Administrative Provider or Insurer, as applicable) in its discretion determines that it was not reasonably possible to provide such proof or comply with such procedure; provided that, if a Claimant's communication regarding a Pre-Service Claim is received by the Administrative Committee Administrative Provider or Insurer, as applicable) and names the Claimant, his specific medical condition or symptom, and the specific treatment, service, or product for which approval is requested but otherwise fails to follow the claims submission procedure, the Administrative Committee (or Administrative Provider or Insurer, as applicable) will notify the Claimant of the failure and the proper procedures to be followed to file a claim for benefits. Such notification will be provided as soon as possible, but not later than five days (24 hours in the case of an Urgent Care Claim) following the failure and may be oral unless the Claimant requests written notification.

8.3 Processing of Benefit Claims

Upon receipt of fully completed benefit claim forms from a Claimant, the Administrative Committee (or Administrative Provider or Insurer, as applicable) will determine if the Claimant's right to the requested benefit, payable at the time or times and in the form requested, is clear and, if so, will process such benefit claim without resort to the Plan Administrator (or Independent Fiduciary, as applicable).

If the claim is a Health Claim and the Administrative Committee (or Administrative Provider or Insurer, as applicable) or the Claimant's physician determines that a claim is a Pre- Service Urgent Care Claim other than a Concurrent Care Claim, the Administrative Committee (or Administrative Provider or Insurer, as applicable) will affirmatively notify the Claimant of the Plan's coverage decision as soon as possible taking into account his medical condition, and not later than 72 hours after receipt of the Benefit Claim in the case of an Urgent Care Claim other than a Concurrent Care Claim, unless sufficient information has not been provided for the Administrative Committee (or Administrative Provider or Insurer, as applicable) to determine whether and to what extent benefits are covered. In the case of a Concurrent Care Claim involving Urgent Care, the Administrative Committee (or Administrative Provider or Insurer, as applicable) will affirmatively notify the Claimant of the Plan's coverage decision within 24 hours, if the claim is submitted at least 24 hours before the scheduled date of treatment. Otherwise, the Concurrent Care Claim involving Urgent Care will be treated the same as a Pre-Service Urgent Care Claim. For all other Pre-Service Claims, the Administrative Committee (or Administrative Provider or Insurer, as applicable) will affirmatively notify the Claimant not less than 15 days after receipt of the Benefit Claim.

If the Administrative Committee (or Administrative Provider or Insurer, as applicable) determines that the Claimant's right to the requested benefit, payable at the time or times and in the form requested, is not clear, it may refer the Benefit Claim to the Plan Administrator (or Independent Fiduciary, as applicable) for review and determination, which referral will include:

(a) All materials submitted to the Administrative Committee (or Administrative Provider or Insurer, as applicable) by the Claimant in connection with the claim;

(b) A written description of why the Administrative Committee (or Administrative Provider or Insurer, as applicable) was of the view that the Claimant's right to the benefit, payable at the time or times and in the form requested, was not clear;

(c) A description of all Plan and Component Program provisions pertaining to the Benefit Claim;

(d) Where appropriate, a summary as to whether such Plan provisions have in the past been consistently applied with respect to other similarly situated Claimants; and

(e) Such other information as may be helpful or relevant to the Plan Administrator (or Independent Fiduciary, as applicable) in its consideration of the claim.

If the Claimant's claim is referred to the Plan Administrator (or Independent Fiduciary, as applicable), the Claimant may examine any relevant document relating to his claim and

may submit written comments or other information to the Plan Administrator (or Independent Fiduciary, as applicable) to supplement his benefit claim. Within the time period described in Sections 8.5 (Health Claims) , 8.6 (Disability Claims), or 8.7 (Other Claims), whichever is applicable to a claim, the Plan Administrator (or Independent Fiduciary, as applicable) will consider the referral regarding the claim of the Claimant and make a decision as to whether it is to be approved, modified, or denied. If the claim is approved, the Plan Administrator (or Independent Fiduciary, as applicable) will direct the Administrative Committee (or Administrative Provider or Insurer, as applicable) to process the approved claim as soon as administratively practicable and within the time periods specified in the first paragraph of this Section 8.3.

The Plan will ensure that all claims and appeals for health and disability benefits are adjudicated in a manner designed to ensure the independence and impartiality of the persons involved in making the decision by ensuring that decisions regarding hiring, compensation, termination, promotion, or other similar matters with respect to any individual, such as a medical or vocational expert, must not be based upon the likelihood that the individual will support the denial of benefits.

8.4 Notice of Adverse Determination on Initial Claim

In any case of an Adverse Benefit Determination of a claim for a Plan benefit, the Plan Administrator (or Independent Fiduciary, as applicable) will furnish written notice to the affected Claimant within the notification periods described in Sections 8.5 (Health Claims),
8.6 (Disability Claims), or 8.7 (Other Claims), whichever is applicable to such claim below. Any notice that denies a Benefit Claim of a Claimant in whole or in part will, in a manner calculated to be understood by the Claimant:

(a) Include information sufficient to identify the claim involved including for health claims under Component Programs subject to HCR, the date or dates of service, the health care provider and the claim amount (if applicable);

(b) State the specific reason or reasons for the Adverse Benefit Determination, including the opportunity to request the diagnostic and treatment codes and their meanings;

(c) Provide specific reference to pertinent Plan provisions on which the Adverse Benefit Determination is based;

(d) In the case of a Disability Claim, discuss the decision and include an explanation of the basis for disagreeing with or not following (i) the views presented by the Claimant to the Plan of health care professionals treating the Claimant and the vocational professionals who evaluated the Claimant, (ii) the views of medical or vocational experts whose advice was obtained on behalf of the Plan in connection with the Claimant's adverse benefit determination, without regard to whether the advice was relied on in making the benefit determination, and (iii) a disability determination regarding the Claimant presented by the Claimant to the Plan made by the Social Security Administration;

(e) In the case of a Disability Claim either the internal rule, guideline, protocol, or other similar criterion relied upon in making the Adverse Benefit Determination,

or, alternatively, state that such rules, guidelines, protocols, standards or other similar criteria do not exist;

(f) In the case of a Health Claim, if an internal rule, guideline, protocol, or other similar criterion was relied upon in making the Adverse Benefit Determination, either provide such criterion or state that such criterion was relied upon and that a copy of the criterion will be provided free of charge to the Claimant upon request;

(g) In the case of a Health or Disability Claim and if the Adverse Benefit Determination is based on a medical necessity, experimental treatment, or similar exclusion or limit, explain the scientific or clinical judgment for the determination, applying the terms of the Plan to the Claimant's medical circumstances;

(h) If applicable, describe any additional material or information necessary for the Claimant to perfect the claim and explain why such material or information is necessary;

(i) Describe the Plan's review procedures, including with respect to a Health Claim subject to HCR outside review procedures, and time limits applicable to such procedures, including a statement of the Claimant's right to bring a civil action under section 502(a) of ERISA or request an outside review following an Adverse Benefit Determination on appeal;

(j) Disclose the availability of – and contact information for – any applicable office of health insurance consumer assistance or ombudsman established under HCR to assist individuals with the internal and outside review procedures;

(k) If an Urgent Care Claim is involved, provide a description of the expedited review process available for Urgent Care Claims and outside review process for Urgent Care Claims (see Sections 8.12 and 8.15); and

(l) In the case of a Health or Disability Claim, include a statement that the Claimant is entitled to receive, upon request and free of charge, reasonable access to, and copies of, all documents, records, and other information relevant to the Claimant’s claim for benefits.

8.5 Timing of Notice of Initial Adverse Benefit Determination for Health Claims

The Plan Administrator (or Independent Fiduciary, as applicable) will provide a Claimant with notice of an Adverse Benefit Determination regarding a Health Claim that is not a Disability Claim within the following time periods:

(a) In the case of a Pre-Service Urgent Care Claim other than a Concurrent Care Claim, as soon as possible, taking into account the Claimant’s medical condition, but not later than 72 hours after the claim is received by the Plan Administrator (or Independent Fiduciary, as applicable) unless sufficient information has not been received from the Claimant to determine whether and to what extent benefits are covered. If there is not sufficient information for the Plan to decide whether the claim is covered, the Claimant will be notified, either directly or through the Claimant’s treating physician, of the information necessary to complete the claim as soon as possible, but within 24 hours after such claim is

received by the Plan Administrator (or Independent Fiduciary, as applicable) and will be given a reasonable additional amount of time, at least 48 hours, to provide the specified information, and notice of the Plan Administrator's (or Independent Fiduciary's, as applicable) benefit determination will be provided to the Claimant within 48 hours after the earlier of (i) the Plan Administrator's (or Independent Fiduciary's, as applicable) receipt of the specified information or (ii) the end of the period afforded the Claimant to provide the specified information. In addition, such notification may be provided orally (provided that written or electronic notification is provided within three days following such oral notification).

(b) In the case of a properly submitted Urgent Care Claim that is a Concurrent Care Claim, if such claim is made at least 24 hours prior to the scheduled expiration of treatment, notice of the disposition of the claim will be furnished to the Claimant as soon as possible, taking into account the Claimant's medical condition, but not later than 24 hours before the scheduled date of treatment. If such claim is not made at least 24 hours prior to the scheduled expiration of treatment, the claim will be governed by Paragraph (a) above.

(c) In the case of a decision to reduce or terminate a previously approved ongoing course of health benefit treatment that was to be provided over a period of time or a number of treatments, the Plan Administrator (or Independent Fiduciary, as applicable) will notify the Claimant of the Adverse Benefit Determination at a time sufficiently in advance of the reduction or termination to allow the Claimant to appeal and obtain a determination on review of such Adverse Benefit Determination before the benefit is reduced or terminated.

(d) In the case of a Pre-Service Claim not described in Paragraphs (a) through (c) above, the Plan Administrator (or Independent Fiduciary, as applicable) will notify the Claimant of the Adverse Benefit Determination within a reasonable period of time appropriate to the medical circumstances but not later than 15 days after receipt of the claim by the Plan (which period may be extended one time for up to an additional 15 days provided that the Plan Administrator (or Independent Fiduciary, as applicable) both determines that such extension is necessary due to matters beyond the control of the Plan Administrator (or Independent Fiduciary, as applicable) and notifies the Claimant prior to the expiration of the initial 15-day period of the circumstances requiring the extension of time and the date by which the Plan Administrator (or Independent Fiduciary, as applicable) expects to render a decision).

(e) In the case of a Post-Service Claim not described in Paragraphs (a) through (c) above, the Plan Administrator (or Independent Fiduciary, as applicable) will notify the Claimant of the Adverse Benefit Determination within a reasonable period of time but not later than 30 days after receipt of the claim (which period may be extended one time for up to 15 days provided that the Plan Administrator (or Independent Fiduciary, as applicable) both determines that such extension is necessary due to matters beyond the control of the Plan Administrator (or Independent Fiduciary, as applicable) and notifies the Claimant prior to the expiration of the initial 30-day period of the circumstances requiring the extension of time and the date by which the Plan Administrator (or Independent Fiduciary, as applicable) expects to render a decision).

The period of time within which an Adverse Benefit Determination will be made, as described above, will begin at the time a claim is received in accordance with the reasonable procedures of the Plan, without regard to whether all the information necessary to make a benefit determination accompanies the filing. In the case of claims described in Paragraphs (d) or (e) above, in the event an extension of the period of time for an Adverse Benefit Determination is required because additional information is necessary to decide the claim (including examination by a physician selected by the Plan Administrator (or Independent Fiduciary, as applicable) or the performance of an autopsy), the notice of extension will specifically describe the required information, the Claimant will be afforded at least 45 days from receipt of the notice to provide such specified information, and the period for making the Adverse Benefit Determination will be tolled from the date on which the notification of the extension is sent to the Claimant until the date on which the Claimant responds to the request for additional information.

8.6 Time of Notice of Adverse Benefit Determination for Disability Claims

The Plan Administrator (or Independent Fiduciary, as applicable) will notify the Claimant of the Adverse Benefit Determination regarding a Disability Claim in a culturally and linguistically appropriate manner by providing oral language services (such as a telephone customer assistance hotline) that includes answering questions in any "applicable non- English language," as defined below, and providing assistance with filing claims and appeals in any applicable non-English language, providing, upon request, a notice in any applicable non-English language and including in the English version of all notices, a statement prominently displayed in any applicable non-English language clearly indicating how to access the language services provided by the Plan. For this purpose, a non- English language is an applicable non-English language if ten percent or more of the population residing in the county to which a notice is sent is literate only in the same non-English language, as determined in guidance issued by the Secretary of the Department of Labor.

Such notice will be provided within a reasonable period of time but not later than 45 days after receipt of the claim. This period may be extended by the Plan Administrator (or Independent Fiduciary, as applicable) for up to 30 days, provided that the Plan Administrator (or Independent Fiduciary, as applicable) both determines that such extension is necessary due to matters beyond the control of the Plan Administrator (or Independent Fiduciary, as applicable) and notifies the Claimant, prior to expiration of the initial 45-day period, of the circumstances requiring the extension of time and the date by which the Plan Administrator (or Independent Fiduciary, as applicable) expects to render a decision. If, prior to the end of the first 30-day extension period, the Plan Administrator (or Independent Fiduciary, as applicable) determines that, due to matters beyond the control of the Plan Administrator (or Independent Fiduciary, as applicable), a decision cannot be rendered within that extension period, the period for making the determination may be extended for up to an additional 30 days, provided that the Plan Administrator (or Independent Fiduciary, as applicable) notifies the Claimant prior to the expiration of the first 30-day extension period of the circumstances requiring the extension and the date as of which the Plan Administrator (or Independent Fiduciary, as applicable) expects to render a decision. Any extension notice provided to a Claimant will specifically explain the standards on which entitlement to the benefit at issue is based, the unresolved issues that prevent a decision on the claim, and the additional information needed to resolve those issues, and the Claimant will be afforded at least 45 days in which to provide the specified information. In the event of such an extension, the period for making the Adverse

Benefit Determination will be tolled from the date on which the notification of extension is sent to the Claimant until the date on which the Claimant responds to the request for additional information. The period of time within which an Adverse Benefit Determination will be made, as described above, will begin at the time a claim is filed in accordance with the reasonable procedures of the Plan, without regard to whether all the information necessary to make a benefit determination accompanies the filing.

8.7 Timing of Notice of Adverse Benefit Determination for Other Claims

In any case of an Adverse Benefit Determination of an eligibility claim or a claim for a Plan benefit that is not a Health or a Disability Claim, the Plan Administrator (or Independent Fiduciary, as applicable) will furnish written notice to the affected Claimant within a reasonable period of time but not later than 90 days after receipt of such claim for Plan benefits (or within 180 days if special circumstances necessitate an extension of the 90- day period and the Claimant is informed of such extension in writing within the 90-day period and is provided with an extension notice consisting of an explanation of the special circumstances requiring the extension of time and the date by which the benefit determination will be rendered). The period of time within which an Adverse Benefit Determination will be made, as described in this Section 8.7, will begin at the time a claim is filed in accordance with the reasonable procedures of the Plan, without regard to whether all the information necessary to make a benefit determination accompanies the filing.

8.8 Appeal of Adverse Benefit Determination for Health and Disability Claims

A Claimant has the right to appeal an Adverse Benefit Determination regarding Health and Disability Claims as follows:

(a) The Claimant must file a written appeal with the Plan Administrator(or Independent Fiduciary, as applicable) not later than 180 days following receipt by the Claimant of the notice of initial Adverse Benefit Determination (or oral notice if an Urgent Care Claim is involved);

(b) The Claimant will have the opportunity to submit written comments, documents, records, and other information relating to the claim for benefits to the Plan Administrator (or Independent Fiduciary, as applicable);

(c) The Claimant will have the right to have all comments, documents, records, and other information relating to the claim for benefits that have been submitted by the Claimant considered on appeal without regard to whether such comments, documents, records, or information were considered in the initial benefit determination;

(d) The Claimant will have reasonable access to, and copies of, all documents, records, and other information relevant to the claim for benefits free of charge upon request, including (i) documents, records, or other information relied upon for the initial benefit determination, (ii) documents, records, or other information submitted, considered, or generated without regard to whether such documents, records, or other information were relied upon in making the initial benefit determination, (iii) documents, records, or other information that demonstrates compliance with the claims procedure in making the initial benefit determination,

and (iv) documents, records, or other information that constitutes a statement of policy or guidance with respect to the Plan concerning the denied treatment option or benefit for the Claimant's diagnosis, without regard to whether such statement of policy or guidance was relied upon in making the initial benefit determination;

(e) The review of the Adverse Benefit Determination on appeal will not give deference to the original decision;

(f) The review of the Adverse Benefit Determination on appeal will be conducted solely by the Plan Administrator (or Independent Fiduciary, as applicable) who was not involved in the original decision and is not a subordinate of the individual who made the initial decision;

(g) If the initial benefit determination was based in whole or in part on a medical judgment, including determinations with regard to whether a particular treatment, drug or other item is experimental, investigational or not medically necessary or appropriate, the Plan Administrator (or Independent Fiduciary) conducting the appeal will consult with a Health Care Professional with appropriate training and experience in the applicable field of medicine who was not consulted, and is not the subordinate of someone who was consulted, during the initial benefit determination;

(h) The Claimant will have the right to have identified to him the medical or vocational experts whose advice was obtained in connection with the initial Adverse Benefit Determination (without regard to whether the advice was relied upon in making such determination);

(i) As soon as possible and sufficiently in advance of the date on which the notice of Adverse Benefit Determination regarding a Disability Claim on appeal is required to be provided, the Independent Fiduciary or its delegate will provide the Claimant, free of charge, with any new or additional evidence or rationale considered, relied upon, or generated by the Plan in connection with the claim.

The decision on appeal by the Plan Administrator (or Independent Fiduciary, as applicable) will be binding and conclusive upon all persons, and the Claimant will neither be required nor be permitted to pursue further appeals to the Plan Administrator (or Independent Fiduciary). Notwithstanding anything to the contrary in this Section 8.8, an expedited review process is available for Urgent Care Claims. A request for expedited review may be submitted orally or in writing, in which case all necessary information will be transmitted between the Plan Administrator (or Independent Fiduciary, as applicable) and the Claimant by telephone, facsimile, or other similarly expeditious method.

If the Component Program provides for one level of internal review, the decision on review by the Plan Administrator (or Independent Fiduciary, as applicable) will be binding and conclusive upon all persons, and the Claimant will neither be required nor be permitted to pursue further appeals to the Plan Administrator (or Independent Fiduciary, as applicable). If the Component Program provides for a second level of internal review, the Claimant may request a second internal review within the time frame provided by the Component Program, and the second review will be conducted in accordance with the procedure set forth in this Section 8.8. The Plan Administrator's (or Independent Fiduciary's, as

applicable) decision upon second review will be binding and conclusive (except to the extent the Claimant may be entitled to seek external review as described in Section 8.15).

8.9 Special Rules for Appeal of an Adverse Benefit Determination for Health Claims

A Claimant has additional rights with respect to a request for review of an Adverse Benefit Determination involving Health Claims, except to the extent provided otherwise in a Component Program Document.

(a) The Claimant has the right to review his claim file and to present evidence and testimony regarding the claim;

(b) The Plan must provide the Claimant, free of charge, with any new or additional evidence that it considered or generated in connection with the claim as soon as possible so that the Claimant has an opportunity to respond before the date the decision is required on the Claimant's appeal. Similarly, the Plan cannot deny an appeal based on a new or additional rationale until the Claimant has been provided with the rationale, free of charge. This must be done as soon as possible to give the Claimant an opportunity to respond before the date the decision is required on his appeal;

(c) The Plan must continue to provide coverage until the Claimant's appeal has been decided;

(d) The Plan must notify the Claimant of the right to request the diagnostic and treatment codes (and their meanings) in all notices of Adverse Benefit Determination (and notices of final internal Adverse Benefit Determinations) and such information, if requested by the Claimant, will be provided on request. The Plan will not consider a request for diagnosis or treatment codes, in itself, to be a request for an internal appeal or external review; and

(e) If a Claimant's appeal involves an Urgent Care Claim, an expedited appeal may be initiated by telephone. A Claimant may appeal a denial involving an Urgent Care Claim either orally or in writing. All necessary information, including the appeal decision, will be communicated between the Claimant and the Plan by telephone, facsimile, or other similar method. In certain circumstances, a Claimant may be eligible to seek an expedited outside review of a claim involving an Urgent Care Claim, under the outside review procedures described in Section 8.15, except to the extent provided otherwise in a Component Program Document.

8.10 Appeal of Adverse Benefit Determination Regarding Other Claims

A Claimant has the right to appeal an Adverse Benefit Determination regarding Other Claims (i.e., a claim that is an eligibility claim or a claim for a benefit that is not a Health or Disability Claim) as:

(a) The Claimant must submit a written appeal to the Plan Administrator (or Independent Fiduciary, as applicable) not later than 60 days following receipt by the Claimant of notice of the initial Adverse Benefit Determination;

(b) The Claimant will have the opportunity to submit written comments, documents, records, and other information relating to the claim for benefits to the Plan Administrator(or Independent Fiduciary, as applicable);

(c) The Claimant will have the right to have all comments, documents, records, and other information relating to the claim for benefits that have been submitted by the Claimant considered on appeal without regard to whether such comments, documents, records, or information was considered in the initial benefit determination; and

(d) The Claimant will have reasonable access to, and copies of, all documents, records, and other information relevant to the claim for benefits free of charge upon request, including (i) documents, records, or other information relied upon for the benefit determination, (ii) documents, records, or other information submitted, considered, or generated without regard to whether such documents, records, or other information were relied upon in making the initial benefit determination, (iii) documents, records, or other information that demonstrates compliance with the claims procedure in making the initial benefit determination on the Claimant's claim, and (iv) documents, records, or other information that constitutes a statement of policy or guidance with respect to the Plan concerning the denied treatment option or benefit for the Claimant's diagnosis, without regard to whether such statement of policy or guidance was relied upon in making the initial benefit determination;

The decision on appeal by the Plan Administrator (or Independent Fiduciary, as applicable) will be binding and conclusive upon all persons, and the Claimant will generally neither be required nor be permitted to pursue further appeals to the Plan Administrator (or Independent Fiduciary, as applicable).

8.11 Notice of Benefit Determination on Appeal

After a full and fair review, notice on the appeal of the Adverse Benefit Determination will be furnished in writing or electronically to the Claimant. Notice of an Adverse Benefit Determination upon appeal will be provided at the time described in Sections 8.12 (Health Claims), 8.13 (Disability Claims) or 8.14 (Other Claims) below, whichever is applicable with respect to a claim, and will:

(a) Include information identifying the claim, including in the case of a Health Claims subject to HCR, the date or dates of service, the health care provider and the claim amount, if applicable;

(b) State the specific reason or reasons for the Adverse Benefit Determination on appeal, including the opportunity to request the diagnostic and treatment codes and their meanings;

(c) Provide specific reference to pertinent Plan provisions on which the Adverse Benefit Determination on appeal is based;

(d) State that the Claimant is entitled to receive, upon request and free of charge, reasonable access to and copies of all documents, records, and other information relevant to the Claimant's Benefit Claim, including (i) documents,

records, or other information relied upon for the benefit determination, (ii) documents, records, or other information submitted, considered, or generated without regard to whether such documents, records, or other information were relied upon in making the benefit determination, (iii) documents, records, or other information that demonstrates compliance with the claims procedure in making the benefit determination on the Claimant's claim, and (iv) in the case of claims regarding Health or Disability Claims, documents, records, or other information that constitutes a statement of policy or guidance with respect to the Plan concerning the denied treatment option or benefit for the Claimant's diagnosis, without regard to whether such statement of policy or guidance was relied upon in making the benefit determination;

(e) If applicable, describe any additional material or information necessary for the Claimant to perfect the claim and explain why such material or information is necessary;

(f) If applicable, include an explanation of the outside review procedures, including information on how to file a request for outside review and the time limits that apply to the Plan's review procedures;

(g) Disclose the availability of – and contact information for – any applicable office of health insurance consumer assistance or ombudsman established under HCR to assist individuals with the internal and outside review procedures; and

(h) Describe the Claimant's right to request outside review or bring an action under section 502(a) of ERISA, including a description of any applicable contractual limitations period that apples to the Claimant's right to bring such action including the date on which the contractual limitations period expires for the claim if the claim is denied on final appeal.

In the case of an Adverse Benefit Determination regarding Health or Disability Claims, such notice will also state:

(i) If an internal rule, guideline, protocol, or other similar criterion was relied upon in making the Adverse Benefit Determination of a Health Claim, either provide such criterion or state that a copy of the criterion will be provided free of charge to the Claimant upon request;

(ii) In the case of a Disability Claim, either provide the internal rule, guideline, protocol, or other similar criterion relied upon in making the Adverse Benefit Determination or state that such rule, guideline, protocol or other similar criterion do not exist;

(iii) With respect to a Disability Claim, discuss the appeal decision, including an explanation of the basis for disagreeing with or not following (A) the views presented by the Claimant to the Plan of health care professionals treating the Claimant and the vocational professionals who evaluated the Claimant, (B) the views of medical or vocational experts whose advice was obtained on behalf of the Plan in connection with the Claimant's appeal, without regard to whether the advice was relied on in making the adverse benefit determination on appeal, and (C) a disability determination

regarding the Claimant presented by the Claimant to the Plan made by the Social Security Administration;

(iv) If the Adverse Benefit Determination is based on a medical necessity, experimental treatment, or similar exclusion or limit, explain the scientific or clinical judgment for the determination, applying the terms of the Plan to the Claimant's medical circumstances, including a discussion of the decision or state that such explanation will be provided free of charge upon request; and

(v) With respect to a Health Claim, to the extent deemed necessary, include the following statement: "You and your plan may have other voluntary alternative dispute resolution options, such as mediation. One way to find out what may be available is to contact your local U.S. Department of Labor Office and your State insurance regulatory agency."

8.12 Timing of Notice on Appeal of Health Claims

For Urgent Care Claims, notice on appeal will be furnished as soon as possible, taking into account the Claimant's medical exigencies but not later than 72 hours following the appeal. For other Health Claims that are not Disability Claims, such notice will be furnished (a) within a reasonable period of time appropriate to the medical circumstances but not later than 30 days following an appeal of a Pre-Service Claim, and (b) within a reasonable period of time but not later than 60 days following an appeal of a Post-Service Claim. The period of time within which a benefit determination on appeal will be made begins at the time an appeal is filed in accordance with the reasonable procedures of the Plan, without regard to whether all the information necessary to make a benefit determination on appeal accompanies the filing. If a Component Program provides for multiple levels of appeal, notice of an Adverse Benefit Determination upon each level of appeal will be made within the time periods set forth in the Component Program Document.

8.13 Time of Notice on Appeal of Disability Claims

For Disability Claims, such notice will be furnished within a reasonable period of time but not later than 45 days following receipt of the appeal (which period may be extended for up to 45 additional days provided that the Plan Administrator (or Independent Fiduciary, as applicable) both determines that such an extension is necessary due to special circumstances and notifies the Claimant prior to the expiration of the initial 45-day period of the special circumstances requiring an extension and the date by which the Plan Administrator (Independent Fiduciary, as applicable) expects to render the determination on appeal). The period of time within which a benefit determination on appeal will be made begins at the time an appeal is filed in accordance with the reasonable procedures of the Plan, without regard to whether all the information necessary to make a benefit determination on appeal accompanies the filing. In the event an extension of time is necessary due to the Claimant's failure to submit necessary information, the period for making the Adverse Benefit Determination will be tolled from the date on which the notification of the extension is sent to the Claimant until the date on which the Claimant responds to the request for additional information.

8.14 Timing of Notice on Appeal of Other Claims

For Other Claims (i.e., a claim that is an eligibility claim or a claim for a benefit that is not a Health or Disability Claim) notice on appeal will be furnished within a reasonable period of time but not later than 60 days after the receipt of the Claimant's appeal unless the Plan Administrator (or Independent Fiduciary, as applicable) determines that special circumstances require an extension of time for processing the appeal of the initial Adverse Benefit Determination. If the Plan Administrator (or Independent Fiduciary, as applicable) determines that such extension of time is required, written notice of the extension (which will indicate the special circumstances requiring the extension and the date by which the Plan Administrator (or Independent Fiduciary, as applicable) expects to render the determination on appeal) will be furnished to the Claimant prior to the termination of the initial 60-day review period. In no event will such extension exceed a period of 60 days from the end of the initial 60-day appeal period. In the event such extension is due to the Claimant's failure to submit necessary information, the period for making the determination on appeal will be tolled from the date on which the notification of the extension is sent to the Claimant until the date on which the Claimant responds to the request for additional information.

8.15 Outside Review of Adverse Benefit Determinations of Health Claims

A Claimant has additional rights with respect to request for outside review of a Health Claim denial involving (i) medical judgment (excluding those that involve only contractual or legal interpretation without any use of medical judgment), as determined by the external reviewer; or (ii) a rescission of coverage. Requests for outside review under the Plan will be submitted and processed in accordance with this Article VIII, unless a Component Program Document contains its own claims procedures, in which case the Component Program Document's claims procedures will apply with respect to that Component Program. However, if the Component Program Document's outside review procedures do not address or are ambiguous with respect to a particular issue, and this Article VIII would address that issue or ambiguity, then this Article VIII will apply and will control to the extent necessary to resolve the issue or ambiguity.

8.16 Request for Outside Review of Health Claims

A Claimant may file a request ("**Request**") for a review of an Adverse Benefit Determination of a Health Claim involving (i) medical judgment (excluding those that involve only contractual or legal interpretation without any use of medical judgment), as determined by the external reviewer; or (ii) a rescission of coverage, to be made by an independent decision-maker (an "Outside Review"). A Request for Outside Review must be filed within four months after the day the Claimant receives a denial on an appeal or the claim is deemed to be denied on appeal (a "Denial"). If an otherwise applicable filing deadline falls on a Saturday, Sunday, or Federal holiday, the deadline is extended to the next day that is not a Saturday, Sunday, or Federal holiday.

8.17 Preliminary Eligibility Determination for Request

(a) Within five business days after receiving the Request, the Plan Administrator (or Independent Fiduciary, as applicable) must determine whether:

(i) The Claimant had Plan and Component Program coverage at the relevant time with respect to the claim,

(ii) The Denial is not related to ineligibility under the Health Care Component Program,

(iii) The Claimant has completed the Health Care Component Program's internal appeal process to the extent completion is required, and

(iv) The Claimant has provided all information and forms required to process an Outside Review.

If the Plan Administrator (or Independent Fiduciary, as applicable) determines that a Claimant has not met any of these four requirements, the Claimant's Request will be ineligible for an Outside Review.

(b) Within one business day after making these determinations, the Plan Administrator (or Independent Fiduciary, as applicable) will provide the Claimant with a written notice of its determination. If the Claimant's Request is complete but does not meet the requirements for an Outside Review, the notice will include the reasons the Request is ineligible as well as contact information for the Employee Benefits Security Administration. If the Claimant's Request is not complete, the notice will describe the information or materials needed to complete the Request. The Claimant's deadline for completing the Request is the end of the four month period described above or, if later, 48 hours after the Claimant receives the notice that the Request was incomplete.

8.18 Outside Review

If the Claimant's Request qualifies for Outside Review, it will be assigned to one of the qualified independent reviewers with which the Plan Administrator (or Administrative Provider or Insurer, as applicable) has a contract ("IROs"). Within five business days after assigning the Request to the IRO, the Plan Administrator (or Independent Fiduciary, as applicable) must provide the IRO the documents and information that were considered in making the Denial.

The IRO will give the Claimant written notice of the Request's acceptance for Outside Review. The notice will include a statement that the Claimant has ten business days to submit additional written information. The IRO must consider this information in its review. (The IRO also may agree to consider additional information submitted after ten business days.) Within one business day after receiving additional information from the Claimant, the IRO must forward the information to the Plan Administrator (or Independent Fiduciary, as applicable). The Plan Administrator (or Independent Fiduciary, as applicable) may reconsider the Denial on appeal based on this additional information. If the Plan Administrator (or Independent Fiduciary, as applicable) decides to reverse its Denial on appeal and provide coverage or payment, it must provide written notice to the Claimant and to the IRO within one business day after making the decision. The IRO will terminate the Outside Review if it receives this notice.

Unless the Plan Administrator (or Independent Fiduciary, as applicable) reverses its decision, the IRO will review all of the information and documents that the Claimant

submits by the deadline. In reaching its decision, the IRO will make its own independent decision of the claim and will not be bound by any decisions or conclusions reached during the Plan Administrator's (or Independent Fiduciary's, as applicable) internal claim and appeal process.

In addition to the documents and information provided by the Claimant and the Plan Administrator (or Independent Fiduciary, as applicable), the IRO will consider the following information or documents if they are available and the IRO considers them appropriate:

(a) The Claimant's medical records,

(b) The Claimant's attending health care professional's recommendation,

(c) Reports from appropriate health care professionals and other documents submitted by the Plan Administrator (or Independent Fiduciary, as applicable), the Claimant, or the Claimant's treating provider,

(d) The terms of the Plan and Component Program unless the terms are inconsistent with applicable law,

(e) Appropriate practice guidelines, which must include applicable evidence-based standards,

(f) Any applicable clinical review criteria developed and used by the Plan Administrator (or Independent Fiduciary, as applicable), unless the criteria are inconsistent with the terms of the Plan or Component Program or with applicable law, and

(g) The opinion of the IRO's clinical reviewer(s) after considering the information described above to the extent the information or documents are available and the clinical reviewer(s) consider appropriate.

The IRO will provide written notice of its decision to the Claimant and the Plan Administrator (or Independent Fiduciary, as applicable) within 45 days after the IRO receives the Claimant's Request. This notice will contain:

(i) A general description of the reason for the Request and information that identifies the claim, including the date or dates of service, the health care provider, the claim amount (if applicable) the diagnosis code and its meaning, the treatment code and its meaning, and the reason for the previous denial,

(ii) The date the IRO received the Request and the date of its decision,

(iii) References to the evidence or documents (including the specific coverage provisions and evidence-based standards), considered in reaching its decision,

(iv) A discussion of the principal reason(s) for its decision, including the rationale for its decision and any evidence-based standards that were relied on in making its decision,

(v) A statement that the determination is binding except to the extent that other remedies may be available under State or Federal law to the Claimant or the Plan Administrator (or Independent Fiduciary, as applicable),

(vi) A statement that review by a judge may be available to the Claimant, and

(vii) Current contact information, including phone number, for any office of health insurance consumer assistance or ombudsman.

If the Plan Administrator (or Independent Fiduciary, as applicable) receives notice from the IRO that reverses a Denial, the Plan Administrator (or Independent Fiduciary, as applicable) will immediately provide coverage or payment (including immediately authorizing or immediately paying benefits) for the applicable claim unless or until there is a judicial decision otherwise.

The IRO will maintain records of all claims and notices associated with the Outside Review process for six years and make these records available for examination by the Claimant, the Plan Administrator (or Independent Fiduciary, as applicable), or a State or Federal oversight agency upon request (except where disclosure would violate State or Federal privacy laws).

8.19 Expedited Outside Review

A Claimant may file a Request for a faster (expedited) Outside Review in certain circumstances involving emergency services or where a longer review period could put the Claimant in jeopardy. Specifically, the Claimant may file this type of request with respect to:

(a) A Denial that involves a medical condition for which the time allowed for completion of an expedited appeal under the Plant's internal appeal process would seriously jeopardize the Claimant's life or health, or would jeopardize the Claimant's ability to regain maximum function, if the Claimant has filed a request for an expedited internal appeal with the Plan Administrator,

(b) A Denial involving the Claimant's medical condition where the time allowed for completion of a standard Outside Review would seriously jeopardize the Claimant's life or health, or would jeopardize the Claimant's ability to regain maximum function, or

(c) A Denial that concerns an admission, availability of care, continued stay, or a health care item or service for a condition for which the Claimant received emergency services if the Claimant has not been discharged from the facility.

The processing of the Claimant's Request will be substantially the same as described above for other Requests, with the following exceptions:

(i) The decision and notice of eligibility on the preliminary review will be made immediately upon the Plan Administrator's (or Independent Fiduciary, as applicable) receipt of the Claimant's request,

(ii) If the Request is eligible for Outside Review, the Plan Administrator (or Independent Fiduciary, as applicable) will transmit required information and documents to the IRO electronically, by telephone or facsimile, or any other fast, available method; and

(iii) The IRO will provide the Claimant and the Plan Administrator (or Independent Fiduciary, as applicable) with notice of its decision as quickly the Claimant's medical condition or circumstances require, but in no event more than 72 hours after the IRO receives the request for an expedited Outside Review. If the IRO's notice is not provided in writing, within 48 hours after the date of providing that notice, the IRO will provide written confirmation of the decision to the Claimant and the Plan Administrator (or Independent Fiduciary, as applicable).

8.20 Exhaustion Required

Completion of the internal and outside claims procedures described in this Article VIII will be a condition precedent to commencing any legal or equitable action regarding a claim for benefits under the Plan by a Claimant, or by any other person or entity claiming rights through such Claimant. However, the Plan Administrator may waive in writing this completion requirement. A Claimant has two years from the date he is notified of a final decision on appeal or external review to file a legal action. Failure to bring a legal action within this two year period will result in forfeiture of such right.

8.21 HCR Claims Rules

Each Health Care Component subject to HCR as a non-grandfathered plan, as such term is defined in HCR, will comply with the claims rules applicable to non-grandfather plans under HCR and that such claims rules will be described in the Component Program Documents.

8.22 Payment of Benefits

(a) **Time and Form of Payment**. If the Administrative Committee, Plan Administrator, Administrative Provider, Insurer, or Independent Fiduciary, as applicable, or IRO determines that a Claimant is entitled to a benefit hereunder, payment of such benefit will be made to such Claimant (or commence, as applicable) as soon as administratively practicable after the date the Administrative Committee, Plan Administrator, Administrative Provider, Insurer, or Independent Fiduciary, as applicable, or IRO determines that such Claimant is entitled to such benefit or on such other date as may be established pursuant to the terms of the applicable Component Program and, in the absence of such terms in accordance with the following:

(i) Any benefit assigned to a provider of services or to a former Spouse will be paid directly to such provider or former Spouse, or to the Covered Person, whichever the Administrative Committee, Plan Administrator, Administrative Provider, Insurer, or Independent Fiduciary, as applicable, chooses;

(ii) Any benefit payable upon the death of a Covered Person will be paid to the estate of the Covered Person or to the designated beneficiary, whichever the Administrative Committee, Plan Administrator, Administrative Provider, Insurer, or Independent Fiduciary, as applicable, chooses;

(iii) Any benefit payable with respect to a Child covered by a QMCSO (within the meaning of section 609 of ERISA)—other than a benefit described in Subparagraph (i) or (ii) above—will be paid to the custodial parent of such Child, if the Administrative Committee, Plan Administrator, Administrative Provider, Insurer, or Independent Fiduciary, as applicable, so chooses; and

(iv) Any other benefit payable will be paid to the Covered Person (or in the case of a Covered Dependent, the Participant) subject to Section 12.3 (regarding payments to minors or incompetents).

(b) **Special Rules**. The following additional special rules apply to the payment of benefits:

(i) Benefits under an applicable Health Care Component will be paid in accordance with any assignment of rights made by or on behalf of a Covered Person in such Health Care Component as required by a state plan for medical assistance approved under Title XIX of the Social Security Act pursuant to section 1912(a)(1)(A) of such Act; and

(ii) To the extent a state plan for medical assistance approved under Title XIX of the Social Security Act has paid benefits in any case in which a Health Care Component has a legal liability to pay for the items or services constituting such assistance, payment under the Health Care Component will be made in accordance with any state law giving the state the rights to such payment for a Covered Person.

8.23 Authorized Representatives

An authorized representative may act on behalf of a Claimant in pursuing a benefit claim or an appeal of an Adverse Benefit Determination. An individual or entity will only be determined to be a Claimant's authorized representative for such purposes if the Claimant has provided the Plan Administrator (or Administrative Provider, Insurer, or Independent Fiduciary, as applicable) with a written statement identifying such individual or entity as his authorized representative and describing the scope of the authority of such authorized representative; provided that, for an Urgent Care Claim, a Health Care Professional with knowledge of a Claimant's medical condition will be permitted to act as the authorized representative of the Claimant.

In the event a Claimant identifies an individual or entity as his authorized representative in writing to the Plan Administrator but fails to describe the scope of the authority of such authorized representative, the Plan Administrator will assume that such authorized representative has full powers to act with respect to all matters pertaining to the Claimant's benefit claim under the Plan or appeal of an Adverse Benefit Determination with respect to such benefit claim.

End of Article VIII

ARTICLE IX FUNDING OF PLAN

9.1 Source of Benefits

Except for benefits provided by an Insurer or an HMO, benefits under the Plan will be paid from the general assets of the Employer and/or from Participants' contributions as required by the applicable Component Program. HMO and PPO premiums will be paid to the applicable HMO or PPO from the general assets of the Employer and/or from Participants' contributions, within the time required by the applicable Component Program or applicable HMO or PPO contract. Insurance premiums for any Component Program whose benefits are provided through an Insurer will be paid to the applicable Insurer from the general assets of the Employer and/or from Participants' contributions, within the time required by the applicable Component Program or applicable contract with the Insurer. All premiums will be paid within the time prescribed by Department of Labor regulation section 2510.3- 102.

To the extent the benefits provided under the Plan are payable from the general assets of Michaels, nothing in this Plan will require Michaels, the Plan Administrator or the Administrative Committee to maintain any fund or segregate any amount for the benefit of any Participant (except to the extent required by law), and no Participant or other person will have any claim against, right to, or security or other interest in, any fund, account or asset of Michaels from which any payment under the Plan may be made.

Plan benefits and expenses will first be paid out of assets attributable to Participant contributions and compensation reduction agreements; however, the Administrative Committee will not be required to separately account for such amounts.

9.2 Participant Contributions

(a) **Amount**. Participants' contributions will be determined by the Employer and will be set forth in each Component Program Document or otherwise communicated to Participants in accordance with applicable law. Upon enrollment of a Participant in, amendment of coverage under, or enrollment of a Dependent in any Component Program, the Participant will be advised of any required contributions under that Component Program. Further, Participants' contributions may be changed by and in the sole discretion of the Employer (subject to the rules regarding changes in Participant contributions under the Cafeteria Component Programs), and each Participant will be advised of any change in the amount of contributions as provided in the applicable Component Program or, in the absence of such provision, in writing no later than 31 days prior to the effective date of the change. A COBRA Beneficiary will be required to contribute any additional amount determined in accordance with the Component Program and Section 5.6.

(b) **Payment**. Participants will pay their contributions in the manner and within the time period set forth by the applicable Component Program.

(c) **Certain Amounts Pre-Tax**. Subject to the terms and conditions set forth in Article IV regarding the Cafeteria Component Programs, Participants will be permitted to elect to pay for coverage under certain Component Programs on a pre-tax

basis. If a Participant makes such an election, the Participant's Compensation will be reduced, and an amount equal to the reduction will be contributed by the Employer and applied to the Participant's share of any cost of coverage under the applicable Component Program.

End of Article IX

ARTICLE X ADMINISTRATION OF PLAN

10.1 Plan Administrator

Michaels is the Plan Administrator and has appointed the Administrative Committee to act on its behalf as Plan Administrator. The general administration of the Plan will be vested in the Plan Administrator. For purposes of ERISA, the Plan Administrator will be the "Plan Administrator" and the named "fiduciary" with respect to the general administration of the Plan.

10.2 Discretion to Interpret Plan

The Plan Administrator will have full and absolute discretion to construe and interpret all provisions of the Plan and the Component Programs, including the discretion to resolve ambiguities, inconsistencies, or omissions conclusively; provided, however, that all such discretionary interpretations and decisions will be applied in a uniform and nondiscriminatory manner to all Participants, beneficiaries, and Covered Dependents who are similarly situated. All decisions of the Plan Administrator upon all matters within the scope of its authority will be binding and conclusive upon all persons.

10.3 Powers and Duties

In addition to the powers described in Section 10.2 and all other powers specifically granted under the Plan, the Plan Administrator will have all powers necessary or proper to administer the Plan and to discharge its duties under the Plan, and it will have full and absolute discretion in its exercise thereof. The Plan Administrator's powers will include the following:

(a) To make and enforce any rules, regulations, and procedures it deems necessary or proper for the orderly and efficient administration of the Plan;

(b) To enter into an Administrative Agreement with any individual or entity to perform services relating to one or more Component Programs;

(c) To delegate its duties to any individual or entity;

(d) Unless such authority is delegated to an Administrative Provider pursuant to Sections 10.5 and 10.7 (or an or Insurer), to interpret and decide all matters of fact in granting or denying benefits and claims under the Plan (except for the decision on an appeal of a denial of benefits which pursuant to Article VIII is vested in an Independent Fiduciary), its interpretation and decision thereof to be final and conclusive on all persons claiming benefits under the Plan;

(e) To determine eligibility under the terms of the Plan, its determination thereof to be final and conclusive on all persons;

(f) Unless such authority is delegated to an Administrative Provider pursuant to Sections 10.5 and 10.7 (or an Insurer), to determine the amount of and authorize the payment of benefits under the Plan, its determination and authorization thereof to be final and conclusive on all persons;

(g) To prepare and distribute information explaining the Plan;

(h) To obtain from the Employer, Employees, beneficiaries, and Dependents any information it deems necessary for the proper administration of the Plan;

(i) To appoint an Administrative Provider as set forth in Section 10.7;

(j) To sue or cause suit to be brought in the name of the Plan;

(k) To determine the manner in which the assets of this Plan, or any part thereof; will be held, invested, and disbursed;

(l) To make applications to legal reserve life insurance companies for policies to meet any of the requirements of the Plan or any Component Program; and

(m) Subject to the provisions of Article VIII, to establish a claims procedure, including a procedure for the review of any claims denied by an Administrative Provider.

10.4 Expenses; Records

The Employer will pay the reasonable expenses incident to the administration of the Plan, including the compensation of any legal counsel, accountants, advisors, or other technical or clerical assistance as may be required; and any other expenses incidental to the operation of the Plan that the Plan Administrator determines are proper. Expenses of the Plan may be prorated, as determined by the Plan Administrator, among Michaels and Participating Employers. The Plan Administrator will keep appropriate records and will make available to any Participant or beneficiary for examination during business hours any records pertaining to that individual's interest in the Plan.

10.5 Delegation by Plan Administrator

(a) **Delegation**. As noted above, the Plan Administrator has appointed the Administrative Committee to act on its behalf as Plan Administrator. The Plan Administrator may also delegate any of its powers, duties, and responsibilities with respect to the operation and administration of the Plan, including the administration of claims, the authority to authorize payment of benefits, the review of denied or modified claims, and the discretion to decide matters of fact and to interpret Plan provisions an Administrative Provider. The Plan Administrator also may employ, and authorize any of its delegates to employ, persons to render advice regarding any fiduciary responsibility hereunder. All delegations will be terminable by the Plan Administrator upon such notice as it deems appropriate. Except as may otherwise be specifically provided in the applicable Component Program Document, in the case of any insured Component Program, the applicable Insurer is hereby delegated the powers and duties of the Plan Administrator, including, without limitation, the discretion to interpret the Plan provisions, with respect to such insured Component Program.

(b) **Liability and Indemnification**. Upon designation and acceptance of such delegation, employment, or authorization, the Plan Administrator will have no liability for the acts or omissions of any such designee except as required by law. However, if the delegate is an individual employee of Michaels, Michaels will

indemnify and hold harmless such individual against all expenses and liabilities arising out of their administrative functions or fiduciary responsibilities hereunder, including any expenses and liabilities caused by or resulting from an act or omission constituting the negligence of such individual in the performance of such functions or responsibilities, but excluding expenses and liabilities arising out of the individual's gross negligence or willful misconduct. Expenses against which the individual will be indemnified include the amounts of any settlement, judgment, costs, counsel fees, and related charges reasonably incurred. Notwithstanding the foregoing provisions of this Paragraph (b), this indemnification will not apply to any expense incurred without the consent or approval of Michaels, unless Michaels waives the consent or approval in writing.

10.6 Reliance on Reports, Certificates, and Participant Information

The Plan Administrator will be entitled to rely conclusively upon all tables, valuations, certificates, opinions, and reports furnished by an actuary, accountant, controller, counsel, insurance company, Administrative Provider, or other person employed or engaged for such purposes. Moreover, the Plan Administrator and the Employer will be entitled to rely upon information furnished to the Plan Administrator or the Employer by a Covered Person, including such person's current mailing address.

10.7 Administrative Provider

The Plan Administrator has appointed one or more Administrative Providers. Subject to the direction and ultimate discretion of the Plan Administrator and the terms of the applicable Administrative Agreement, the Administrative Provider will have the duties and powers necessary to process claims and make payments under the Plan (in addition to any duties and powers described in Section 10.3), including the following:

(a) To act under the direction and control of the Plan Administrator;

(b) To determine eligibility for participation in the Plan and entitlement to benefits thereunder;

(c) To receive, review, verify, and investigate all requests for benefits under the Plan;

(d) In the discretion of the Administrative Provider, to decide matters of fact, determine eligibility for benefits, and to determine the amount, manner, and timing of benefit payments under the Plan;

(e) To inform the Plan Administrator as to the amount and timing of payments for benefits and expenses under the Plan;

(f) To prescribe procedures to be followed by Participants in filing requests for benefits under the Plan;

(g) To secure from the Employer, the Plan Administrator, and the Participants, beneficiaries, and Covered Dependents any information necessary for the proper processing and payment of benefits under the Plan;

(h) To furnish the Employer and the Plan Administrator, upon request, with reasonable and appropriate reports with respect to the processing and payment of benefits under the Plan;

(i) To maintain records relating to requests for benefits, processing of benefits, and payment or denial of requests for benefits; and

(j) To do such other acts as may be necessary or requested by the Plan Administrator to handle the processing and payment of benefits under the Plan.

End of Article X

ARTICLE XI
AMENDMENT AND TERMINATION OF PLAN

11.1 Right to Amend

Benefits under the Plan are neither "vested" nor "accrued". Michaels reserves the absolute and unconditional right to amend the Plan and any or all Component Programs incorporated herein from time to time, either prospectively or retroactively, on behalf of Michaels and each Participating Employer, including the right to reduce or eliminate benefits provided pursuant to the provisions of the Plan or any Component Program as such provisions currently exist or may hereafter exist, and the right to amend prospectively or retroactively. All amendments to the Plan and/or a Component Program may be effectuated by an action of the Board; provided, however, that any amendments to the Plan and/or a Component Program that do not have a significant cost impact on Michaels may also be made by the Administrative Committee. Any oral or written statements or representations made by the Employer, an Administrative Provider, or any other individual or entity that alter, modify, amend, or are inconsistent with the written terms of the Plan will be invalid and unenforceable and may not be relied upon by any Participant, Employee, beneficiary, Dependent, service provider, or other individual or entity.

11.2 Right to Terminate; Automatic Termination

The Employer hopes and expects to continue the Plan. However, Michaels reserves the absolute and unconditional right to terminate the Plan and any Component Programs, in whole or in part, on behalf of itself and each Participating Employer. In addition, a Participating Employer may terminate its participation in the Plan or any Component Program, in whole or in part.

11.3 Effect of Amendment or Termination

If the Plan is amended or terminated, each Covered Person and beneficiary will have no further rights hereunder and the Employer will have no further obligations hereunder, except as otherwise specifically provided under the terms of the Plan and each Component Program; provided, however, that no modification, alteration, amendment, suspension, or termination will be made that would diminish any vested accrued benefits arising from incurred but unpaid claims of Covered Persons or beneficiaries existing prior to the effective date of such modification, alteration, amendment, suspension, or termination.

11.4 Merger or Consolidation

If the Employer does not survive any dissolution, merger, consolidation, or reorganization, the Plan will terminate with respect to the Employer and its Employees unless the Plan is continued by the successor to the Employer and such successor agrees to be bound by the terms and conditions of the Plan.

End of Article XI

ARTICLE XII MISCELLANEOUS PROVISIONS

12.1 No Guarantee of Employment

Nothing herein will alter the presumption of employment at will. Nothing herein will be construed to be a contract between the Employer and an Employee, or to be consideration for or an inducement of the employment of any employee by the Employer. Nothing herein will grant any Employee the right to be retained in the service of the Employer or limit in any way the right of the Employer to discharge or terminate the service of any individual at any time, without regard to the effect such discharge or termination may have on any rights under the Plan.

12.2 Assignment and Payment of Benefits

Rights and benefits under the Plan will not be assignable, either before or after services and supplies are provided; provided, that a Covered Person may direct that benefit payments be made directly to a medical provider. Further, in the absence of a written agreement with a Provider, the Plan reserves the right to make benefit payments to the provider or the Covered Person. Payment to either party discharges the Plan's responsibility to the Covered Person for benefits available under the Plan. The fact that benefit payment is directed or made directly to the Provider will not give the Provider status as a Covered Person, and any dispute regarding the amount of such payment must be resolved by the Covered Person through the Plan's internal claims procedure (*i.e.*, the Provider may not invoke the internal claims procedure on behalf of the Covered Person).

12.3 Payments to Minors and Incompetents

If a Covered Person entitled to receive any benefits under the Plan is a minor, is determined by the Plan Administrator to be incompetent, or is adjudged by a court of competent jurisdiction to be legally incapable of giving valid receipt and discharge for benefits provided under the Plan, the Plan Administrator may pay such benefits to the duly appointed guardian or conservator of such person or to any third party who is authorized (as determined by the Plan Administrator) to receive any benefit under the Plan for the Covered Person. Such payment will fully discharge all liabilities and obligations of the Plan Administrator under the Plan with respect to such benefits.

12.4 No Vested Right to Benefits

No Covered Person nor anyone claiming through such Covered Person will have any right to or interest in any benefits hereunder, except as specifically provided herein.

12.5 Non-alienation of Benefits

Except as provided in Section 3.5(d) (regarding QMCSO coverage), Section 12.2 (Assignment and Payment of Benefits), Section 12.7 (regarding incorrect information), and Section 12.9 (regarding compromise of claims), or except as the Plan Administrator may otherwise permit by rule or regulation, no interest in or benefit payable under the Plan will be subject in any manner to anticipation, alienation, sale, transfer, assignment, pledge, encumbrance, or charge, and any attempt by a Covered Person to anticipate, alienate, sell, transfer, assign, pledge, encumber, or charge the same will be void and of no effect;

nor will any interest in or benefit payable under the Plan be in any way subject to any legal or equitable process, including garnishment, attachment, levy, seizure, or lien. This provision will be construed to provide each Covered Person, or other person claiming any interest or benefit in the Plan through a Covered Person, with the maximum protection afforded such Covered Person's interest in the Plan (and benefits thereunder) by law against alienation or encumbrance, and against any legal and equitable process, including attachment, garnishment, levy, seizure, or lien.

12.6 Unknown Whereabouts

Each Participant will inform the Plan Administrator or its delegate of his current mailing address and the current mailing address of his Covered Dependents and beneficiaries. If a Participant fails to inform the Plan Administrator of his current mailing address or the current mailing address of each Covered Dependent or beneficiary, neither the Plan Administrator, any Administrative Provider, nor the Employer will be responsible for any late payment or loss of benefits, nor for failure of any notice to be provided or provided timely under the terms of the Plan to such individual. In addition, any communication, statement or notice addressed to a Participant at the last mailing address provided by such Participant to the Plan Administrator will be binding upon such person for all purposes of the Plan, and the Plan Administrator will not be obligated to search for or ascertain the whereabouts of any such Participant.

12.7 Incorrect Information, Fraud, Concealment, or Error

(a) **Recovery Due to Errors**. If, because of a human or systems error, or because of incorrect information provided by or correct information omitted by fraud, misrepresentation, or concealment of any relevant fact (as determined by the Plan Administrator) by any Covered Person, beneficiary, or other individual—the Plan: enrolls any individual in a Component Program; provides continuation coverage pursuant to Article V; pays a claim under the Plan; incurs a liability for failure to enroll, provide continuation coverage, or pay a benefit claim, or for terminating enrollment or continuation coverage; or makes any overpayment or erroneous payment, the Plan Administrator will be entitled to recover from such Covered Person, beneficiary, or other individual the benefit paid or the liability incurred, together with all expenses incidental to or necessary for such recovery. This recovery may be by whatever means the Plan Administrator chooses, including by offset against benefits otherwise properly due hereunder.

(b) **No Diminished Right to Benefits**. Human or systems error will not deprive an Employee or a Dependent of coverage or affect the amount of benefits to which a Covered Person or beneficiary is otherwise entitled under the terms of the Plan.

12.8 Medical Responsibilities

With regard to Component Programs providing medical and other health-related benefits, all responsibility for medical decisions concerning any treatment, drug, service, or supply for a Covered Person rests with the Covered Person and such Covered Person's treating physician. Neither the Employer, the Plan, the Plan Administrator, nor an Administrative Provider has any responsibility for any such medical decision or for any act or omission of any physician, hospital, pharmacist, nurse, or other provider of medical goods or services; each may rely upon the representations of any physician, hospital, pharmacist, nurse, or

other provider of goods or services without any duty to verify independently the truth of such representations. A decision concerning any treatment, drug, service, or supply, or any other decision made by a Covered Person or medical provider, will in no way affect the decision by the Plan Administrator or its delegate whether a benefit is payable under the Plan with respect to such treatment, drug, service, or supply.

12.9 Compromise of Claims

A claim for benefits may be compromised on any terms acceptable to both the Participant and the Plan Administrator.

12.10 Electronic Administration

The Plan may be administered electronically by use of telephonic and/or computer resources. It is specifically contemplated that, where the Plan refers to communications such as designations, writings, notices, elections, and the like, these communications may occur electronically pursuant to such procedures as the Plan Administrator may establish.

12.11 Reimbursement of Michaels for Excess Benefit Payment

If, due to error or otherwise, an individual receives a benefit payment under this Plan any portion of which is in excess of the benefit, if any, to which the individual may be entitled under the terms of the Component Program Document, such individual will reimburse the Plan or Michaels for the full amount of the excess benefit payment. Such individual will also hold the Plan and Michaels harmless for any liability either of them may incur for a failure to withhold federal or state income taxes or payroll taxes from the excess benefit payment. If the individual fails to repay Michaels or Plan for the excess benefit payment, the Plan will be entitled to recover such excess benefit payment by reducing the amount of any future benefit payments to which the individual or any member of his family may be entitled under the Plan.

12.12 Required Documentation

Whenever the Plan requires or permits a Participant to give notice to the Plan or to Michaels, or to make an election or apply for coverage or payment of benefits or otherwise to communicate with the Plan or Michaels or representative of either of said parties ("Plan Communication"), the Plan Administrator may impose reasonable requirements regarding the form and timing of any such Plan Communication including, but not limited to, the use of standard forms, and the imposition of requirements that any such Plan Communication be delivered not less than a reasonable period of time prior to the effective date of any such Plan Communication, and may require the Participant to provide substantiation of information related to Plan participation. Such forms and other requirements, including requirements regarding substantiation of information, may be changed from time to time by the Plan Administrator or authorized personnel in the Human Resources Department of Michaels and such personnel similarly may approve forms or requirements imposed by third parties engaged to provide services to the Plan.

12.13 No Reliance

Benefits under the Plan are payable only to the extent provided by the Plan document and such other documents as are contemplated by this instrument to be a part of this Plan.

No eligible Employee, Participant, or assignee will be entitled to rely on any verification of coverage or description of coverage given or alleged to have been given to such person which is inconsistent with the terms of the Plan.

12.14 Execution of Receipts and Releases

Any payment to or on behalf of any Participant or to his dependent, beneficiary or legal representative ("payee"), in accordance with the provisions of the Plan, will to the extent thereof be in full satisfaction of all claims hereunder against the Plan, the Plan Administrator, and Michaels. The Plan Administrator may require such payee, as a condition precedent to such payment, to execute a receipt and release therefor in such form as the Plan Administrator will determine.

12.15 No Conversion Privilege

Except as provided in an insurance policy which serves as a Component Program Document, Participants will have no right or ability to convert coverage provided under the Plan to an individual policy upon terminating participation in the Plan.

12.16 Extension of Deadlines

The Plan's deadlines contained within Article VIII (regarding the Claims Procedures), and various other statutory deadlines are temporarily extended as set forth in IRS Notice 2020- 23, EBSA Disaster Relief Notice 2020-01, the joint notice of the IRS and DOL published May 4, 2020, titled "**Extension of Certain Timeframes for Employee Benefit Plans, Participants, and Beneficiaries Affected by the COVID–19 Outbreak**," Disaster Relief Notice 2021-01, and subsequent guidance. Such deadlines shall include but are not limited to HIPAA special enrollment, COBRA qualifying event notifications, COBRA elections and payments, and claims procedure deadlines, including initial filing and appeal of adverse benefit determination. Such deadlines began as of March 1, 2020. The deadlines have a "tolling period" that ends on the **earlier** of one year from the date of the original deadline for such Participant would have begun running or until 60 days after the end of the National Emergency declared by the Federal government as a result of the national emergency due to the COVID 19 pandemic (the "**Outbreak Period**"). COBRA elections are also subject to the timelines set forth in the American Rescue Plan Act. Effective July 10, 2023, the Outbreak Period extensions will end and the above deadlines will revert to their normal time frames unless provided otherwise in the Component Program Documents.

12.17 Entire Plan

This document (together with any other documents incorporated by reference herein) constitutes the entire Plan and there are no oral terms or conditions to the contrary. Any change, modification, or amendment to the Plan must comply with the requirements of Article XI of the Plan.

End of Article XII

ARTICLE XIII FMLA COVERAGE

13.1 FMLA Compliance

To the extent required by the FMLA, each Health Care Component that is a group health plan within the meaning of section 5000(b)(1) of the Code or section 607(1) of ERISA (*e.g.*, the Medical Plan component, the Dental Plan component, the Vision Plan component, and the Health Flexible Spending Account Program component, and the Employee Assistance Program component) will provide for continuation of coverage and reinstatement of coverage for a Participant and his eligible Covered Dependents if such Participant takes a leave of absence from the Employer pursuant to the rights afforded him under the FMLA and complies with the requirements imposed upon him under the FMLA and Section 3.6 of this Plan as a condition to such rights. The provisions of this Article XIII will supersede and entirely replace any provisions regarding requirements under the FMLA which are in a Component Program Document to the extent that such provisions in the Component Program Document conflict with this Article XIII.

End of Article XIII

ARTICLE XIV USERRA

14.1 USERRA Compliance

To the extent required by USERRA, each Health Care Component that is a "health plan," as defined by section 4303(7) of USERRA (*e.g.*, the Medical Plan component, the Dental Plan component, the Vision Plan component, and the Health Flexible Spending Account Program component, and the Employee Assistance Program component), will provide for continuation of coverage and reinstatement of coverage for a Participant and his eligible Covered Dependents if such Participant takes a leave of absence from the Employer for "services in the uniformed services," as defined by section 4303(13) of USERRA and complies with the requirements imposed upon him under USERRA and Section 3.6 of this Plan. The provisions of this Article XIV will supersede and entirely replace any provisions regarding requirements under USERRA which are in a Component Program Document to the extent that such provisions in the Component Program Document conflict with this Article XIV.

End of Article XIV

ARTICLE XV
HIPAA PRIVACY COMPLIANCE

15.1 Scope of Article

The Plan is a "hybrid entity," as such term is defined in section 164.103 of the Regulations, which requires among other things that the Plan (a) designate those of its components that constitute "health care components," as such term is defined in section 164.103 of the Regulations, (b) document such designation as required pursuant to section 164.530(j) of the Regulations, and (c) establish adequate separation between such Health Care Components and the Non-Health Care Components as required by section 164.504 of the Regulations. The terms of this Article will only apply with respect to the designated Health Care Components of the Plan identified in Section 2.1(rr). References to the "Plan" in this Article will also include any other group health plans or plans providing "health care" within the meaning of HIPAA that (i) are sponsored by the Employer and (ii) provide that they will constitute, or have been designated by the Plan Administrator as constituting, along with the Health Care Components of the Plan, a single covered entity for purposes of compliance with the Privacy Rules of HIPAA and the Regulations. In addition, certain capitalized terms used in this Article that are not defined herein will have the meaning ascribed to such terms under the Regulations. This Article will be interpreted in accordance with the Privacy Rules as now in effect or as hereafter amended. Any ambiguity in the interpretation of this Article will be construed in a manner that permits the Plan and the Employer to comply with the Privacy Rules.

15.2 Provision of PHI to the Employer Pursuant to an Authorization

The Health Care Components of the Plan may at any time disclose PHI to the Employer, and the Employer may use and disclose PHI received from the Health Care Components of the Plan, if such disclosure and use is pursuant to and in accordance with a valid authorization from the individual who is the subject of such information.

15.3 Provision of SHI or Enrollment Information to the Employer

The Employer may receive, use, and disclose PHI from the Health Care Components of the Plan if the information consists solely of SHI and if the Employer certifies to the fiduciaries of the Plan (*i.e.*, the Plan Administrator) that the information is being requested for one or more of the following:

(a) For the purpose of enabling the Employer to obtain premium bids from health insurers for providing health insurance coverage under the Health Care Components of the Plan;

(b) For purposes of determining whether and, if so, how to modify or amend the Health Care Components of the Plan;

(c) For purposes of determining whether and, if so, how to terminate the Health Care Components of the Plan, in whole or in part; or

(d) For such other purposes consistent with the Regulations as may be necessary for the administration of the Health Care Components of the Plan.

The Employer may receive, use, and disclose PHI from the Health Care Components of the Plan if the information consists of enrollment or disenrollment information (*i.e.*, indicates whether the individual is participating in the Plan or is enrolled in or has disenrolled from a health insurance issuer or HMO offered under the Plan).

15.4 General Provision of PHI to the Employer

The Employer may receive PHI from the Health Care Components of the Plan and use such PHI if (i) Michaels on behalf of itself and the Participating Employers certifies in writing to the Plan's fiduciaries (*i.e.*, the Plan Administrator) that the Plan incorporates the restrictive provisions described in items (a) through (l) below and the separation requirements described in Section 15.5 below, and (ii) except as described in Section 15.2, the Employer agrees to comply with the following restrictions and requirements regarding the PHI that is provided by the Health Care Components of the Plan to the Employer:

(a) The Employer will not use or further disclose the information other than as permitted or required by the Plan documents or as required by law or the Regulations;

(b) The Employer will ensure that any agents to whom it provides PHI received from the Plan agree to the same restrictions and conditions that apply to the Employer with respect to such information;

(c) The Employer will not use or disclose the information for employment-related actions and decisions or in connection with any other benefit or employee benefit plan of the Employer;

(d) The Employer will report to the Plan any use or disclosure of the information that is inconsistent with the uses or disclosures provided for of which it becomes aware;

(e) The Employer will make available to Covered Persons PHI in accordance with section 164.524 of the Regulations;

(f) The Employer will agree to requests by Covered Person to restrict the use or disclosure of PHI as required by HIPAA;

(g) The Employer will provide Covered Persons with the right to amend their PHI and will incorporate any amendments to Covered Persons' PHI in accordance with section 164.526 of the Regulations;

(h) The Employer will provide Covered Persons with an accounting of disclosures of their PHI for reasons other than treatment, payment, or health care operations or pursuant to an authorization, in accordance with section 164.528 of the Regulations, or as otherwise required by HIPAA;

(i) The Employer will make its internal practices, books, and records relating to the use and disclosure of PHI received from the Health Care Components of the Plan available to the Secretary of Health and Human Services for purposes of

determining compliance by the Health Care Components of the Plan with the Regulations;

(j) If feasible, the Employer will return or destroy all PHI received from the Health Care Components of the Plan that the Employer still maintains in any form and retain no copies of such information when no longer needed for the purpose for which disclosure was made, or, if such return or destruction is not feasible, the Employer will limit further uses and disclosures to those purposes that make the return or destruction of the information infeasible;

(k) The Employer will ensure the adequate separation required pursuant to Section 15.6 below; and

(l) The Employer will notify the Plan of any "Breach" as defined in section 164.402 of the Regulations by the Employer or an agent of the Employer without unreasonable delay and in no case later than 60 calendar days of the discovery of the Breach.

15.5 Adequate Separation

At all times, there will be adequate separation (i) between the Plan and the Employer and (ii) between the Health Care Components and the Non-Health Care Components in accordance with the requirements imposed pursuant to section 164.504(f)(2)(iii) of the Regulations. In order to comply with such adequate separation requirements:

(a) Except as described in Sections 15.2 and 15.3, the only employees, classes of employees, or other persons under the control of the Employer to be given access to PHI disclosed to the Employer or who receive PHI relating to treatment or payment under, the health care operations of, or other matters pertaining to the Health Care Components of the Plan in the ordinary course of business are: (i) those individuals employed by or providing services to the division of the Employer's Human Resources Department that deals with the administration, enrollment, and processing of benefit claims under the Health Care Components of the Plan, (ii) the Plan's fiduciaries (*i.e.*, the Plan Administrator), (iii) the Plan's Privacy Officer, (iv) the Plan's Contact Person, and (v) the Employer's internal legal counsel.

(b) The access to and use by the Employer and the other individuals and entities described in item (a) above is restricted to (i) the administrative functions that the Employer performs in connection with the operation and administration of the Health Care Components of the Plan (including, but not limited to, assisting eligible Employees, Spouses, or Dependents with enrollment or claims issues, negotiating with Administrative Providers, obtaining payment for benefits under the Health Care Components of the Plan, and procuring or obtaining reimbursement under a stop-loss insurance policy with respect to the Plan), (ii) the plan sponsor functions described in Section 15.3 above, (iii) uses and disclosures described in an authorization by the Covered Person, and (iv) uses and disclosures that are described to Covered Persons in the Plan's notice of privacy practices, as required by section 164.520 of the Regulations.

(c) In the event that any person described in item (a) of this Section fails to comply with any of the requirements of this Section or of Section 15.4 above, the noncompliance will be reported to the Privacy Officer in a report describing the name of the noncompliant person and a summary of the details regarding such person's noncompliance. Upon receipt of such report, the Privacy Officer will solicit a response from the person who has been reported as noncompliant, giving such person the opportunity to contest the charge of noncompliance or to offer justification or other reasons why sanctions should not be imposed with respect to the noncompliance. The Privacy Officer will, after considering all details, facts, and circumstances relating to an alleged act of noncompliance for which sanctions may be imposed pursuant to this item (c), determine if a sanction should be imposed (which sanction may range from a warning to recommended dismissal from employment). Upon determination of a sanction and if the sanction may be imposed under the authority of the Privacy Officer, the sanction will be imposed. If the sanction requires action of the Employer, the Privacy Officer will confer with the appropriate managers of the Employer. If the Employer, following consideration of a proposed sanction from the Privacy Officer for noncompliance with the requirements of Sections 15.4 and 15.5 by a person or entity, determines not to impose such sanction, the Employer will advise the Privacy Officer. In such event, the Privacy Officer must consider and propose an alternative sanction for the noncompliant person or entity.

15.6 Privacy Officer

Michaels will appoint a Privacy Officer for the Plan. Michaels may remove the Plan's then existing Privacy Officer at any time upon written notice provided that Michaels has appointed a successor Privacy Officer to serve. The Privacy Officer's duties and responsibilities focus upon the operation and administration of the Health Care Components of the Plan in connection with HIPAA and the Regulations (including activities conducted via the services of Insurers, Business Associates, and employees and agents of the Employer) and the activities of Michaels regarding the Health Care Components of the Plan in its capacity as sponsor of the Plan. In order to carry out such general powers, duties, and responsibilities, the Privacy Officer will have the following specific powers, duties, and responsibilities:

(a) To develop and propose to the Plan fiduciaries (*i.e.*, the Plan Administrator) a comprehensive privacy policy for the Health Care Components of the Plan;

(b) To perform initial and periodic privacy risk assessments with respect to the Health Care Components of the Plan;

(c) To develop and maintain appropriate authorization forms, information notices, and materials reflecting the legal practices and requirements of the Health Care Components of the Plan regarding the privacy of PHI;

(d) To develop and implement initial and ongoing privacy training and orientation to all employees of the Employer who may have access to PHI in connection with the Health Care Components of the Plan;

(e) To oversee the development, implementation, and ongoing compliance of all Business Associate agreements with the Plan;

(f) To establish with the Employer's management and operations a mechanism to identify all of the Employer's plans and benefit arrangements that are "covered entities" for purposes of the laws governing PHI;

(g) To establish rules to determine when to allow Covered Persons to review or receive a report on their PHI privacy activity under the Health Care Components of the Plan;

(h) To work cooperatively with the Human Resources Department and other applicable offices/personnel of the Employer and Business Associates in overseeing Covered Persons' rights to inspect, amend, and restrict access to their PHI when appropriate;

(i) To establish and administer a complaint procedure pursuant to which Covered Persons may redress alleged violations of their privacy rights;

(j) To apply sanctions for failure to comply with the privacy provisions of the Plan, the, HIPAA, or the Regulations as specified in this Article;

(k) To review system-related information security plans maintained by the Employer to the extent necessary or appropriate; and

(l) To serve as information privacy consultant to the Employer with respect to the Health Care Components of the Plan.

15.7 Contact Person

Michaels will appoint a Contact Person (which may be the same individual or entity as is serving as the Privacy Officer). Michaels may remove the Plan's then existing Contact Person at any time upon written notice provided that if Michaels has not appointed a successor Contact Person to serve, the Privacy Officer will serve as the Contact Person.

15.8 Disciplinary Proceedings

The purpose of this Section 15.8 is to establish appropriate disciplinary sanctions and proceedings as required by the Regulations.

(a) Any complaint brought pursuant to the Plan's complaint procedures that involves an alleged failure to comply with HIPAA, the Regulations, or this Article XV will be referred to the Privacy Officer for consideration as to disciplinary sanctions and proceedings under this Section 15.8.

(b) Similarly, if the Privacy Officer becomes aware of any other failure to comply with HIPAA, the Regulations, or the terms of this Article XV, the Privacy Officer will consider whether such matter is appropriate for disciplinary sanctions and proceedings under this Section 15.8.

(c) If the complaint or other failure involves the actions of a Business Associate, the appropriate disciplinary sanctions and proceedings will be conducted under the terms of the Business Associate agreement. If the complaint or other failure involves the actions of the individuals responsible for the administration of the

Health Care Components of the Plan identified in Section 15.5(a) the appropriate disciplinary sanctions and proceedings will be conducted under Section 15.5(c). If the complaint or other failure involves the actions of any other employee or any agent of the Employer, the appropriate disciplinary sanctions and proceedings will be conducted under this Section 15.8.

(d) In the case of either an unresolved complaint or other failure described in Paragraph (a) and (b) above, the Privacy Officer will solicit a response from the person or agent who has been reported as noncompliant, giving the person or agent the opportunity to contest the charge of noncompliance or to offer justification or other reasons why disciplinary sanctions should not be imposed with respect to the noncompliance.

(e) The Privacy Officer will, after considering all details, facts, and circumstances relating to such an alleged act of noncompliance, determine if a disciplinary sanction is warranted (which sanction may range from a warning to dismissal from employment, or, in the case of an agent, termination of the agency agreement). Upon determination of a disciplinary sanction, and if the sanction may be imposed under the authority of the Privacy Officer, the disciplinary sanction will be imposed.

(f) If the disciplinary sanction requires approval of the Employer, the Privacy Officer will confer with the appropriate managers of the Employer. If the Employer, following consideration of a recommended disciplinary sanction from the Privacy Officer, determines not to impose such disciplinary sanction, the Employer will advise the Privacy Officer. In such event, the Privacy Officer must consider and propose an alternative disciplinary sanction for the noncompliant person or agent. The Privacy Officer will ensure that the imposed disciplinary sanction is adequately communicated to the violator and is enforced.

(g) In the event that a disciplinary sanction triggers any rights of appeal (for instance, under a collective bargaining agreement), all such rights of appeal will be available to the violator. In the case of any such appeal proceedings, the identity of the individual whose privacy rights were violated will be removed to the extent feasible.

15.9 Implementation Authority

The Employer will have the authority to enter into and enforce on behalf of the Plan such contracts and agreements (specifically including Business Associate agreements) as may be appropriate or necessary to cause the Plan to satisfy its obligations under HIPAA and the Regulations.

15.10 Indemnification

Michaels will indemnify and hold harmless each employee of the Employer who is identified in Section 15.5(a) as a person who is to be given access to or receive PHI against any and all expenses and liabilities arising out of such employee's administrative functions or fiduciary responsibilities in connection with violations of HIPAA and the Regulations, including but not limited to, any expenses and liabilities that are caused by or result from an act or omission constituting the negligence of such employee in the

performance of such functions or responsibilities but excluding expenses and liabilities arising out of such employee's own gross negligence or willful misconduct. Expenses against which such person will be indemnified include, but are not limited to, the amounts of any settlement, judgment, costs, counsel fees, and related charges reasonably incurred in connection with a claim asserted or a proceeding brought. This Section will not, however, apply to, and Michaels will not indemnify against, any expense that was incurred without the consent or approval of Michaels, unless such consent or approval has been waived in writing by Michaels. This Section will also not apply to any sanctions or disciplinary action imposed pursuant to Section 15.8.

End of Article XV

ARTICLE XVI
HIPAA SECURITY COMPLIANCE

16.1 Purpose of Article XVI

The purpose of this Article XVI is to (a) cause the Plan to implement security measures designed to ensure the confidentiality, integrity, and availability of all ePHI, received, maintained, or transmitted to or by the Plan, (b) cause the Plan to require that the Employer will reasonably and appropriately safeguard ePHI created, received, maintained, or transmitted to or by the Employer on behalf of the Plan, and (c) establish the office of Security Officer, who will be responsible for the Plan's Security Standards compliance. This Article XVI is to be construed and interpreted in accordance with such purposes. References to the "Plan" in this Article will also include any other group health plans or plans providing "health care" within the meaning of HIPAA that (i) are sponsored by the Employer and (ii) provide that they will constitute, or have been designated by the Plan Administrator as constituting, along with the Health Care Components of the Plan, a single covered entity for purposes of compliance with the security rules of HIPAA and the Regulations. In addition, certain capitalized terms used in this Article that are not defined herein will have the meaning ascribed to such terms under the Regulations. This Article will be interpreted in accordance with the Security Standard as now in effect or as hereafter amended. Any ambiguity in the interpretation of this Article will be construed in a manner that permits the Plan and the Employer to comply with the Security Standard.

16.2 Implementation of Security Standards

The Plan will do all of the following in accordance with the Regulations:

(a) The Plan will ensure the Confidentiality, Integrity, and Availability of all ePHI that it creates, receives, maintains, or transmits.

(b) The Plan will protect against any reasonably anticipated threats or hazards to the Security or Integrity of such information.

(c) The Plan will protect against any reasonably anticipated uses or disclosures of such information that are not permitted or required under the Privacy Rules.

(d) The Plan will ensure compliance with the Security Standards by its Workforce.

(e) The Plan will implement each Security Standard and implementation specification thereunder that is designated as "Required" in the Regulations and/or Appendix A to Subpart C of Part 146 thereof, as provided in Sections 16.4, 16.5, 16.6, and 16.7 below.

(f) The Plan will take the following steps with regard to each Security Standard and implementation specification thereunder that is designated as "Addressable" in the Regulations, as provided in Sections 16.4, 16.5, 16.6, and 16.7 below.

(i) The Plan will assess whether each implementation specification in the Security Standard is a reasonable and appropriate safeguard in its environment, when analyzed with reference to the likely contribution to protecting the Plan’s ePHI; and

(ii) As applicable to the Plan, the Plan will implement the implementation specification if reasonable and appropriate or, if implementing the implementation specification is not reasonable and appropriate:

(A) Document why it would not be reasonable and appropriate to implement the implementation specification; and

(B) Implement an equivalent alternative measure if reasonable and appropriate;

(g) The Plan will ensure that its Business Associate contracts comply with the requirements of section 164.314 of the Regulations and other requirements of HIPAA; and

(h) The Plan will periodically review the Security Measures implemented to comply with the Security Standards and modify such measures as needed in order to continue provision of reasonable and appropriate protection of ePHI as described in the Plan.

16.3 Provision of Electronic Protected Health Information to the Employer

The Employer may receive and use ePHI only if the Employer agrees to comply with and enforce the following restrictions and requirements regarding the ePHI that is provided by the Plan to the Employer:

(a) The Employer will implement Administrative, Physical, and Technical Safeguards that reasonably and appropriately protect the Confidentiality, Integrity, and Availability of the ePHI that it creates, receives, maintains, or transmits on behalf of the Plan as required by the Regulations;

(b) The Employer will ensure that the adequate separation required pursuant to Section 15.5 is supported by reasonable and appropriate Security Measures and as required by the Regulations;

(c) The Employer will ensure that any agent to whom it provides ePHI that it creates, receives, maintains, or transmits on behalf of the Plan agrees to implement reasonable and appropriate Security Measures to protect such information; and

(d) The Employer agrees to report to the Plan any Security Incident of which it becomes aware in accordance with the Regulations.

16.4 Implementation of Administrative Safeguards

The Plan will in accordance with section 164.308 of the Regulations:

(a) Implement policies and procedures to prevent, detect, contain, and correct security violations.

(b) Perform initial and periodic assessments of the potential risks and vulnerabilities to the Confidentiality, Integrity, and Availability of ePHI held by the Plan.

(c) Implement Security Measures sufficient to reduce risks and vulnerabilities to a reasonable and appropriate level.

(d) Develop appropriate sanctions policies and procedures and apply appropriate sanctions against members of the Plan's Workforce who fail to comply with the terms of this Article XVI.

(e) Implement procedures to regularly review records of Information System activity, such as audit logs, access reports, and Security Incident tracking reports.

(f) Implement policies and procedures to ensure that all members of the Plan's Workforce have appropriate access to ePHI and to prevent those Workforce members who do not have access thereunder from obtaining access to ePHI.

(g) Implement policies and procedures for authorizing access to ePHI that are consistent with the applicable requirements of the Privacy Rules.

(h) Implement a security awareness and training program for all members of the Plan's Workforce (including management).

(i) Implement policies and procedures to address Security Incidents.

(j) Identify and respond to suspected or known Security Incidents; mitigate, to the extent practicable, harmful effects of Security Incidents that are known to the Plan; and document Security Incidents and their outcomes.

(k) Establish (and implement as needed) policies and procedures for responding to an emergency or other occurrence that damages systems that contain ePHI.

(l) Establish and implement procedures to create and maintain retrievable exact copies of ePHI.

(m) Establish (and implement as needed) procedures to restore any loss of data.

(n) Establish (and implement as needed) procedures to enable continuation of critical business processes for protection of the security of ePHI while operating in emergency mode.

(o) Perform a periodic technical and nontechnical evaluation, based initially upon the standards implemented under the Security Standards and subsequently in response to environmental or operational changes affecting the security of ePHI, that establishes the extent to which the Plan's security policies and procedures comply with the Security Standards.

(p) Oversee the implementation and compliance of the security provisions of all Business Associate agreements with the Plan, to ensure that the Plan's Business Associates will appropriately safeguard ePHI created, received, maintained, or transmitted on behalf of the Plan.

(q) Implement policies and procedures to limit physical access to the Plan's Information Systems and the Facility or Facilities in which they are housed, while ensuring that properly authorized access is allowed.

(r) Review all other Security Standards and implementations specifications that are identified as Addressable under section 164.308 of the Regulations and not specifically described above to determine their appropriateness for the Plan and implement the same or a modification thereof.

16.5 Implementation of Physical Safeguards

The Plan will in accordance with section 164.310 of the Regulations:

(a) Implement policies and procedures that specify the proper functions to be performed, the manner in which those functions are to be performed, and the physical attributes of the surroundings of a specific Workstation or class of Workstation that can access ePHI.

(b) Implement Physical Safeguards for all Workstations that access ePHI, to restrict access to authorized Users.

(c) Implement policies and procedures that govern the receipt and removal of hardware and Electronic Media that contain ePHI into and out of the Facility and the movement of these items within the Facility.

(d) Implement policies and procedures to address final disposition of ePHI and/or the hardware or Electronic Media on which it is stored.

(e) Implement procedures for removal of ePHI from Electronic Media before the media are made available for re-use.

(f) Review all other Security Standards and implementations specifications that are identified as Addressable under section 164.310 of the Regulations and not specifically described above to determine their appropriateness for the Plan and implement the same or a modification thereof.

16.6 Implementation of Technical Safeguards

The Plan will in accordance with section 164.312 of the Regulations:

(a) Implement technical policies and procedures for electronic Information Systems that maintain ePHI to allow access only to those persons or software programs that have been granted access rights in accordance with the Security Standards.

(b) Assign unique names and/or numbers for identifying and tracking the identity of Users of the Plan's ePHI.

(c) Establish (and implement as needed) procedures for obtaining necessary ePHI during an emergency.

(d) Implement hardware, software, and/or procedural mechanisms that record and examine activity in Information Systems that contain or use ePHI.

(e) Implement policies and procedures to protect ePHI from improper alteration or destruction.

(f) Implement procedures to verify that a person or entity seeking access to ePHI is the one claimed.

(g) Implement technical Security Measures to guard against unauthorized access to ePHI that is being transmitted over an electronic communications network.

(h) Review all other Security Standards and implementations specifications that are identified as Addressable under section 164.312 of the Regulations and not specifically described above to determine their appropriateness for the Plan and implement the same or a modification thereof.

16.7 Implementation of Policies and Procedures and Documentation Requirements

The Plan will in accordance with section 164.316 of the Regulations:

(a) Implement reasonable and appropriate policies and procedures to comply with the standards, implementation specifications, or other requirements of the Security Standards, taking into account (i) the size, complexity, and capabilities of the Plan, (ii) the Plan's technical infrastructure, hardware, and software security capabilities, (iii) the costs of the Security Measures, and (v) the probability and criticality of potential risks to ePHI.

(b) Maintain in written or electronic form the policies and procedures implemented by the Plan to comply with the provisions of this Article XVI as required by the Security Standards.

(c) Maintain in written or electronic form records of any actions, activities, or assessments taken by the Plan that are required by this Article XVI or the Security Standards to be so maintained.

(d) Retain the documentation required by this Article XVI for a period of six (6) years from the date of its creation or the date when it was last in effect, whichever is later.

(e) Make the documentation required by this Article XVI available to those members of the Plan's Workforce responsible for implementing such policies and procedures.

(f) Periodically review the Plan policies and procedures and update them as needed in response to environmental or operational changes affecting the security of ePHI.

16.8 Security Officer

The Plan Administrator will appoint a Security Officer for the Plan. The Plan Administrator may remove the Plan's then existing Security Officer at any time upon written notice provided that the Plan Administrator has appointed a successor Security Officer to serve. The Plan's Security Officer's duties and responsibilities focus upon the operation and administration of the Plan in connection with the Security Standards, HIPAA, and the Regulations (including activities conducted via the services of Insurers, Business Associates, and employees and agents of the Employer) and activities of Michaels regarding the Plan in its capacity as sponsor of the Plan.

16.9 Implementation Authority

The Employer will have the authority to enter into and enforce on behalf of the Plan such contracts and agreements (including, specifically, Business Associate agreements) as may be appropriate or necessary to cause the Plan to satisfy its obligations under HIPAA and the Regulations.

16.10 Indemnification

Michaels will indemnify and hold harmless each member of the Plan's Workforce who has access to or receive ePHI against any and all expenses and liabilities arising out of such employee's administrative functions or fiduciary responsibilities in connection with violations of HIPAA and the Regulations, including but not limited to, any expenses and liabilities that are caused by or result from an act or omission constituting the negligence of such employee in the performance of such functions or responsibilities, but excluding expenses and liabilities arising out of such employee's own gross negligence or willful misconduct. Expenses against which such person will be indemnified include, but are not limited to, the amounts of any settlement, judgment, costs, counsel fees, and related charges reasonably incurred in connection with a claim asserted or a proceeding brought. This Section will not, however, apply to, and Michaels will not indemnify against, any expense that was incurred without the consent or approval of Michaels, unless such consent or approval has been waived in writing by Michaels. This Section will also not apply to any sanctions or disciplinary action imposed pursuant to this Article XVI.

End of Article XVI

ARTICLE XVII
HEALTH FLEXIBLE SPENDING ACCOUNT PROGRAM

17.1 Establishment of Program

This Article XVII constitutes a separate plan document that sets forth the terms of the Health Flexible Spending Account Program. This Article XVII is intended to qualify as a medical reimbursement plan under section 105 of the Code and will be interpreted in a manner consistent with such Code section and the Treasury regulations thereunder. Eligible Employees who elect to participate in this Health Flexible Spending Account Program may submit claims for the reimbursement of Medical Expenses. All amounts reimbursed under this Health Flexible Spending Account Program will be periodically paid from amounts allocated to the Participant's Health Flexible Spending Account. Periodic payments reimbursing Participants from the Health Flexible Spending Account will in no event occur less frequently than monthly.

With respect to an Employee who becomes employed by CHST or its Affiliates pursuant to a business transaction, such as a stock or asset sale, salary reduction contributions made by that Employee under a prior employer's Health Flexible Spending Account program may be assumed by and continued under this Health Flexible Spending Account Program to the extent provided in any applicable business transaction documents or as determined by the Plan Administrator.

17.2 Definitions

For the purposes of this Article XVII and the Plan, the terms below have the following meaning:

(a) "**Health Flexible Spending Account**" means, with respect to a Plan Year, the fund established for Participants pursuant to this Article XVII to which part of their Compensation may be allocated pursuant to Section 4.1 and from which all allowable Medical Expenses may be reimbursed.

(b) "**Health Flexible Spending Account Program**" means the plan of benefits contained in this Article XVII, which provides for the reimbursement of eligible Medical Expenses incurred by a Participant or his Dependents, except that Medical Expenses incurred by the Participant's Stepchild or Domestic Partner who is not the Participant's federal tax dependent within the meaning of Code section 152 (determined without regard to sections 152(b)(1), (b)(2), and (d)(1)(B)), will not be eligible for reimbursement under this Health Flexible Spending Account Program.

(c) "**Highly Compensated Participant**" means, for the purposes of this Article XVII and determining discrimination under section 105(h) of the Code, a Participant who is:

(i) One of the 5 highest paid officers;

(ii) A shareholder who owns (or is considered to own applying the rules of section 318 of the Code) more than 10 percent in value of the stock of the Employer; or

(iii) Among the highest paid 25 percent of all Employees (other than exclusions permitted by section 105(h)(3)(B) of the Code for those individuals who are not Participants).

(d) "**Medical Expenses**" means any expense for medical care within the meaning of section 213 of the Code and the rulings and Treasury regulations thereunder, and not otherwise used by the Participant as a deduction in determining his tax liability under the Code. Medical Expenses include an over-the-counter medicine or drug (including insulin) regardless of whether a prescription has been obtained for the over-the-counter medicine or drug. However, a Participant may not be reimbursed for (i) the cost of other health coverage such as premiums paid under plans maintained by the employer of the Participant's Spouse or individual policies maintained by the Participant or his Spouse or Dependent, or (ii) "qualified long-term care services" as defined in section 7702B(c) of the Code. In addition, to the extent the Health Flexible Spending Account operates as a limited scope program under Section 17.4, a Participant may only be reimbursed for dental and vision expenses which constitute medical care within the meaning of section 213 of the Code. A Participant also may not be reimbursed for Medical Expenses incurred by the Participant's Stepchild or Domestic Partner unless the Stepchild or Domestic Partner is the Participant's federal tax dependent within the meaning of Code section 152 (determined without regard to sections 152(b)(1), (b)(2), and (d)(1)(B) of the Code).

The definitions of Article II are hereby incorporated by reference to the extent necessary to interpret and apply the provisions of this Health Flexible Spending Account Program.

17.3 Forfeitures

Any monies remaining in a Participant's Health Flexible Spending Account for a Plan Year at the end of such Plan Year (and after the processing of all claims for such Plan Year pursuant to Section 17.7) that are attributable to contributions made during such Plan Year will be forfeited; provided, however, that a Participant may roll over up to $500 (as adjusted pursuant to Internal Revenue Service Notice 2020-33) of unused amounts in his Health Flexible Spending Account remaining at the end of a Plan Year to the immediately following Plan Year .

The Plan Administrator, in its sole discretion, will determine how forfeitures are allocated, from among the following options: (a) retained by the Employer, (b) used to defray expenses of administering the Cafeteria Component Program; (c) used to reduce Compensation reduction amounts for the immediately following Plan Year, or (d) returned to Participants on a reasonable and uniform basis (but not based on individual claims experience). If not retained by the Employer or used to defray expenses of administering the Cafeteria Component Program, the forfeitures will be allocated among Participants on a reasonable and uniform basis.

17.4 Limitation on Allocations and Reimbursements

The Plan Administrator may limit the amount of Compensation that may be allocated to the Health Flexible Spending Account by a Participant in or on account of any Plan Year. Any such minimum or maximum will be set forth in the Annual Enrollment materials, which

are hereby incorporated by reference; provided, however, the maximum amount of Compensation that may be allocated to the Health Flexible Spending Account by a Participant in or on account of any Plan Year is $2,500 (as indexed for inflation for Plan Years beginning after 2013). This maximum amount is not reduced by any amounts rolled over pursuant to Section 17.3.

In addition, to the extent specified by the Plan Administrator and communicated to eligible Employees, the Health Flexible Spending Account may be a "limited scope" program, where Participants may only be reimbursed for dental and vision expenses which qualify as medical care within the meaning of section 213 of the Code; provided, however, that in the event an eligible Employee is an HSA Eligible Participant for a Plan Year (e.g., enrolls in the Consumer Choice medical plan option under the Medical Program) and also enrolls in this Health Flexible Spending Account, then this Health Flexible Spending Account will automatically operate as a limited scope program for such Plan Year.

17.5 Nondiscrimination Requirements

(a) **General Rule**. It is the intent of this Health Flexible Spending Account Program not to discriminate in favor of "highly compensated individuals" or "highly compensated participants" as defined in section 105 of the Code in violation of the Code and the Treasury regulations thereunder.

(b) **Correction**. If the Administrative Committee deems it necessary to avoid discrimination under this Health Flexible Spending Account, it may, but will not be required to, reject any elections or reduce contributions or benefits in order to assure compliance with this Section 17.5. Any act taken by the Administrative Committee under this Section 17.5 will be carried out in a uniform and nondiscriminatory manner. If the Administrative Committee decides to reject any elections or reduce contributions or benefits, it will be done in the following manner. First, the benefits designated for the Health Flexible Spending Account Program by the highly compensated individual or participant that elected to contribute the highest amount to such program for the Plan Year will be reduced until the nondiscrimination tests set forth in this Section 17.5 or the Code are satisfied, or until the amount designated for the fund equals the amount designated for the fund by the next highly compensated individual or participant who has elected the second highest contribution to the Health Flexible Spending Account Program for the Plan Year. This process will continue until the nondiscrimination tests set forth in this Section 17.5 or the Code are satisfied. Contributions which are not utilized to provide benefits to any Participant by virtue of any administrative act under this paragraph will be forfeited.

17.6 Coordination With Cafeteria Component Program

All Participants under the Plan are eligible to elect to participate in the Cafeteria Component Program and receive benefits under this Health Flexible Spending Account Program. The enrollment under the Cafeteria Component Program will constitute enrollment under this Health Flexible Spending Account Program. In addition, other matters concerning contributions, elections, claims for benefits and the like will be governed by the general provisions of the Plan and the terms of the Component Program Documents.

17.7 Health Flexible Spending Account Claims

(a) **Reimbursement of Medical Expenses**. All Medical Expenses incurred by a Participant that are eligible for reimbursement pursuant to Section 17.2(d) will be reimbursed during a Plan Year even though the submission of such a claim occurs after his participation hereunder ceases; but provided that the Medical Expenses were incurred during the applicable Plan Year and during the portion of such Plan Year when he was a Participant in the Health Flexible Spending Account Program. If a Participant revokes an election to participate in the Health Care Flexible Spending Account Program following a Change in Status and has a contribution balance, he may continue to submit claims for Medical Expenses incurred during the portion of a Plan Year in which he was a Participant until the balance is depleted.

(b) **Maintain Account Balance Available**. The Administrative Committee will direct the reimbursement to each eligible Participant for all allowable Medical Expenses, up to a maximum of the amount of Compensation designated by the Participant to be contributed to the Health Flexible Spending Account Program for the Plan Year. The maximum amount designated by the Participant will be made available to the Participant throughout the Plan Year without regard to the amount of contributions that have been made by the Participant to the Health Flexible Spending Account Program. Furthermore, a Participant will only be entitled to reimbursements for amounts that are not paid or reimbursed under any health care plan covering the Participant and/or his Spouse or Dependents.

(c) **Claim Filing Deadline**. Claims for the reimbursement of Medical Expenses incurred in any Plan Year will be paid as soon after a claim has been filed with the Administrative Provider as is administratively practicable; provided, however, that, except as provided otherwise under the Component Program Document, if a Participant fails to submit a claim for a Medical Expense incurred during a Plan Year by the March 31 immediately following the end of such Plan Year, such Medical Expense claim will not be considered for reimbursement by the Administrative Provider. Any dispute concerning a claim for the reimbursement of Medical Expenses will be subject to the claims provisions of Article VIII of this Plan concerning Post-Service Claims except as otherwise provided in a Component Program Document.

(d) **Manner of Payment**. Reimbursement payments under this Health Flexible Spending Account Program will be made directly to the Participant. However, in the Administrative Provider's discretion, payments may be made directly to the service provider.

(e) **Substantiation**. All claims must be substantiated in accordance with this Section or the terms of the Component Program Documents prior to payment or reimbursement of any Medical Expenses. In general, all claims must be substantiated by information from a third-party that is independent of the Employee and his Dependents. In addition, all claims generally must set forth:

(i) The person(s) on whose behalf the Medical Expense was incurred;

(ii) The nature and date of the expenses so incurred;

(iii) The amount of the requested reimbursement;

(iv) The name of the person, organization or entity to whom the expense was or is to be paid and taxpayer identification number;

(v) A statement that such expenses have not otherwise been reimbursed and that the Participant will not seek reimbursement through any other source and if reimbursed from the Health Care Flexible Spending Account, such amount will not be claimed as a tax deduction;

(vi) Other such details about the expenses that may be requested by the Administrative Committee on the reimbursement request form or otherwise.

The application will be accompanied by those documents listed above from an independent third party, along with any other documentation that the Administrative Committee may request (for instance, an EOB which contains all necessary information). There can be no self-substantiation of an expense by a Participant (*i.e.*, cancelled checks to a doctor are not sufficient, standing alone).

End of Article XVII

ARTICLE XVIII
DEPENDENT CARE FLEXIBLE SPENDING ACCOUNT PROGRAM

18.1 Establishment of Program

This Article XVIII constitutes a separate plan document that sets forth the terms of the Dependent Care Flexible Spending Account Program. This Article XVIII is intended to qualify as a dependent care assistance program under section 129 of the Code and will be interpreted in a manner consistent with such Code section. In addition, the Dependent Care Flexible Spending Account Program will not be considered an "employee welfare benefit plan" or a "group health plan" subject to ERISA or HIPAA, nor an "accident and health plan" within the meaning of section 105(e) of the Code. The purpose of the Dependent Care Flexible Spending Account Program is to provide Employees with a choice of Compensation received in cash or reimbursements of certain Employment- Related Dependent Care Expenses that are excludable from gross income under section 129 of the Code. Participants who elect to participate in the Dependent Care Flexible Spending Account Program may submit claims for the reimbursement of Employment- Related Dependent Care Expenses. All amounts reimbursed under this Dependent Care Flexible Spending Account Program will be paid from amounts allocated to the Participant's Dependent Care Spending Account.

With respect to an Employee who becomes employed by Michaels or its Affiliates pursuant to a business transaction, such as a stock or asset sale, salary reduction contributions made by that Employee under a prior employer's dependent care flexible spending account program may be assumed by and continued under this Dependent Care Flexible Spending Account Program to the extent provided in any applicable business transaction documents or as determined by the Plan Administrator.

18.2 Definitions

For the purposes of this Article XVIII and the Plan, the terms below will have the following meaning:

(a) "**Dependent Care Spending Account**" means the account (bookkeeping or otherwise) established for a Participant pursuant to this Article XVIII to which part of his Compensation may be allocated pursuant to Section 4.1 and from which Employment-Related Dependent Care Expenses of the Participant may be reimbursed. The Dependent Care Spending Account is exclusively established and owned by Michaels. No interest will be paid on any amounts allocated to a Dependent Care Spending Account.

(b) "**Dependent Care Flexible Spending Account Program**" means the program of benefits contained in this Article XVIII, which provides for the reimbursement of eligible expenses for the care of the Qualifying Dependents of Participants.

(c) "**Earned Income**" means earned income as defined under section 32(c)(2) of the Code, but excluding such amounts paid or incurred by the Employer for dependent care assistance to the Participant. A Participant's Spouse who is not employed, but is a student or incapable of caring for himself during any month of the Plan Year will be deemed to be gainfully employed and have Earned Income as provided in section 21(d)(2) of the Code.

(d) "**Employment-Related Dependent Care Expenses**" means the amounts paid for expenses of a Participant for those services which if paid by the Participant would be considered employment related expenses under section 21(b)(2) of the Code. Generally, they will include expenses for household services or for the care of a Qualifying Dependent, to the extent that such expenses are incurred to enable the Participant to be gainfully employed for any period for which there are one or more Qualifying Dependents with respect to such Participant. The determination of whether an amount qualifies as an Employment-Related Dependent Care Expense will be made by the Administrative Provider subject to the following rules:

(i) If such amounts are paid for expenses incurred outside the Participant's household, they will constitute Employment-Related Dependent Care Expenses only if incurred for a Qualifying Dependent as defined in Section 18.2(e)(i) (or deemed to be, as described in Section 18.2(e)(i) pursuant to Section 18.2(e)(iii)), or for a Qualifying Dependent as defined in Section 18.2(e)(ii) (or deemed to be, as described in Section 18.2(e)(ii) pursuant to Section 18.2(e)(iii)) who regularly spends at least 8 hours per day in the Participant's household;

(ii) If the expense is incurred outside the Participant's home at a facility that provides care for a fee, payment, or grant for more than 6 individuals who do not regularly reside at the facility, the facility must comply with all applicable state and local laws and regulations, including licensing requirements, if any; and

(iii) Employment-Related Dependent Care Expenses of a Participant will not include amounts paid to or incurred for Dependent care provided by (i) a child (within the meaning of section 152(f)(1) of the Code) of such Participant who is under the age of 19 at the close of the taxable year in which the services are performed, (ii) an individual who is a dependent of such Participant or such Participant's Spouse for whom a personal exemption is allowed under section 151(c) of the Code, (iii) a Participant's Spouse, or (iv) a parent of a Participant's under age 13 qualifying child (as defined in section 152(a)(1) of the Code).

(iv) Employment-Related Dependent Care Expenses will not include expenses for which the Participant is reimbursed through insurance or any other plan.

(e) "**Qualifying Dependent**" means, for Dependent Care Spending Account Program purposes:

(i) A Participant's Dependent who is a qualifying child (within the meaning of section 152(a)(1) of the Code) under the age of 13;

(ii) A Participant's Spouse or Dependent (*i.e.*, a qualifying child or relative), if such Dependent qualifies as the Participant's federal tax dependent within the meaning of 152 of the Code (determined without regard to sections 152(b)(1), (b)(2), and (d)(1)(B) of the Code which contain certain exceptions to the definition of Dependent, and without regard to section 152(d)(1)(B) of the Code, which contains a gross income limitation for a

qualifying relative)), who is physically or mentally incapable of caring for himself or herself and resides with the Participant for more than half the year; or

(iii) A child that is deemed to be a Qualifying Dependent described in paragraph (i) or (ii) above, whichever is appropriate, pursuant to section 21(e)(5) of the Code (regarding children of divorced parents).

Whether an individual is a Qualifying Dependent is determined on a daily basis.

The definitions of Article II are hereby incorporated by reference to the extent necessary to interpret and apply the provisions of this Dependent Care Flexible Spending Account Program.

18.3 Dependent Care Spending Accounts

The Administrative Committee will establish a Dependent Care Spending Account for each Participant who elects to direct a portion of his Compensation to purchase Dependent Care Flexible Spending Account Program benefits. Unless Michaels chooses to establish a trust or other funding vehicle to fund the Dependent Care Expense Program, no separate fund or account will be maintained for any Dependent Care Spending Account, and the benefits provided under the Dependent Care Expense Program will be funded solely by the general assets of the Participating Employers.

18.4 Amount Allocated to Dependent Care Spending Accounts

A Participant's Dependent Care Spending Account will be increased each pay period by the amount of his Compensation he has elected to contribute to his Dependent Care Spending Account pursuant to elections made under Article IV. A Participant's Dependent Care Spending Account will be reduced by the amount of any Employment-Related Dependent Care Expense reimbursements paid or incurred on behalf of a Participant pursuant to Section 18.11. Generally, the sum of the contributions which have been allocated to the Participant's Dependent Care Spending Account for a Plan Year minus the reimbursements paid or incurred during the Plan Year at any given point in time will be the amount available to the Participant for the reimbursement of Employment-Related Dependent Care Expenses. If a Participant revokes an election to participate in the Dependent Care Flexible Spending Account Program following a Change in Status and has a contribution balance, he may continue to submit claims for Employment-Related Dependent Care Expenses incurred during the Plan Year until the balance is depleted.

18.5 Allowable Dependent Care Assistance Reimbursement

Subject to limitations contained in Section 18.8, and to the extent of the amount allocated to the Participant's Dependent Care Spending Account, a Participant who incurs Employment-Related Dependent Care Expenses will be entitled to receive from the Employer full reimbursement for the entire amount of such expense incurred during the Plan Year, even if submission of such claim occurs after his participation under the Dependent Care Flexible Spending Account Program ceases; provided, however that the Participant must comply with the claim submission deadlines set forth in Section 18.11. If a Participant terminates employment prior to the end of the Plan Year, the Plan Administrator will only consider Employment-Related Dependent Care Expenses incurred

on or before the date of employment termination for reimbursement; provided, however, that for the 2021 Plan Year Employment-Related Dependent Care Expenses incurred after the date of employment termination and before the end of the Plan year will be eligible for reimbursement and the Participant must submit such claims for reimbursement within the time specified by the Administrative Committee. In general, a claim is deemed to be "incurred" when the care is provided (see Section 18.11(a)).

18.6 Annual Statement of Benefits

On or before January 31st of each calendar year, a written statement in accordance with section 129(d)(7) of the Code will be provided to a Participant who elected coverage under the Dependent Care Flexible Spending Account Program. The statement will include all Employment-Related Dependent Care Expenses paid to or on behalf of such Participant for the prior calendar year.

18.7 Forfeitures

The amount in a Participant's Dependent Care Spending Account as of the end of any Plan Year (and after the processing of all claims for such Plan Year pursuant to Section 18.11) will be forfeited. In such event, the Participant will have no further claim to such amount for any reason. Any forfeitures will be used to defray administrative expenses associated with operating the Plan.

18.8 Limitation on Payments

Notwithstanding any provision contained in this Article XVIII to the contrary, amounts paid from a Participant's Dependent Care Spending Account in or on account of any taxable year of the Participant will not exceed the lesser of the following:

(a) The maximum amount identified in section 129(a)(2) of the Code, which as of the Effective Date is $5,000 ($2,500 if a separate tax return is filed by a Participant who is married as determined under the rules of paragraphs (3) and (4) of section 21(e) of the Code).

(b) Earned Income limitations described in section 129(b) of the Code.

The Plan Administrator may (i) further limit the amount of Compensation and (ii) set minimum levels of Compensation that may be allocated to such Participant's Dependent Care Spending Account by a Participant in or on account of any Plan Year. Any such minimum or maximum will be set forth in the open enrollment materials, and such minimum or maximum is hereby incorporated by reference.

Expenses for which the Participant claims the dependent care tax credit under section 21 of the Code cannot be reimbursed through the Dependent Care Spending Account.

18.9 Nondiscrimination Requirements

(a) **Eligibility**. It is the intent of this Dependent Care Spending Account that contributions or benefits not discriminate in favor of "highly compensated employees" or "key employees" as defined under section 129(d) of the Code.

(b) **Benefits**. It is the intent of this Dependent Care Spending Account that not more than 25 percent of the amounts paid by the Employer for dependent care assistance during the Plan Year will be provided to key employees (*i.e.*, shareholders or owners (or their Spouses or Dependents), each of whom (on any day of the Plan Year) owns more than 5 percent of the stock or of the capital or profits interest in the Employer).

(c) **Correction**. If the Administrative Committee deems it necessary to avoid discrimination or possible taxation to a group of employees in whose favor discrimination may not occur in violation of section 129 of the Code it may, but will not be required to, reject any elections or reduce contributions or non-taxable benefits in order to assure compliance with this Section 18.9. Any act taken by the Administrative Committee under this Section 18.9 will be carried out in a uniform and nondiscriminatory manner. If the Administrative Committee decides to reject any elections or reduce contributions or benefits, it will be done in the following manner. First, the benefits designated for the Dependent Care Flexible Spending Account Program by the affected Participant that elected to contribute the highest amount to such program for the Plan Year will be reduced until the nondiscrimination tests set forth in this Section 18.9 are satisfied, or until the amount designated for the account equals the amount designated for the account of the affected Participant who has elected the second highest contribution to the Dependent Care Flexible Spending Account Program for the Plan Year. This process will continue until the nondiscrimination tests set forth in this Section 18.9 are satisfied. Contributions which are not utilized to provide benefits to any Participant by virtue of any administrative act under this paragraph will be forfeited.

18.10 Coordination With Cafeteria Component Program

All Participants under the Plan are eligible to elect to participate in the Cafeteria Component Program and receive benefits under this Dependent Care Flexible Spending Account Program. The enrollment and termination of participation under the Cafeteria Component Program will constitute enrollment and termination of participation under this Dependent Care Flexible Spending Account Program. In addition, other matters concerning contributions, elections, claims for reimbursement, and the like will be governed by the general provisions of the Plan. An ambiguity between this Article XVIII will be resolved in the sole discretion of Michaels.

18.11 Dependent Care Spending Account Claims

(a) **Reimbursement of Employment-Related Dependent Care Expenses**. All eligible Employment-Related Dependent Care Expenses incurred by a Participant during the Plan Year will be reimbursed from his Dependent Care Spending Account even if the submission of such a claim occurs after his participation under the Dependent Care Flexible Spending Account Program ceases, if the Participant timely files for reimbursement as described in (d) below. In general, a claim is incurred when the care is provided. A Participant's Compensation reductions and election to participate in the Dependent Care Flexible Spending Account Program will automatically terminate as of his termination of employment.

(b) **Manner of Payment**. Reimbursement payments under this Dependent Care Flexible Spending Account Program will be made directly to the Participant. However, in the Administrative Provider's discretion, payments may be made directly to the service provider. Expenses cannot be reimbursed from the Dependent Care Spending Account until they have been incurred. Expenses are incurred when the care is provided and not when the Participant is formally billed for, charged for or pays for the care.

(c) **Substantiation of Claims**. All claims must be substantiated in accordance with this Section or the terms of the Component Program Documents prior to payment or reimbursement of any Employment-Related Dependent Care Expenses. In general, all claims must be substantiated by information from a third party that is independent of the eligible Employee and his Dependents. In addition, the Administrative Provider may require that each Participant who desires to receive reimbursement under this program for Employment-Related Dependent Care Expenses submit a statement which may contain some or all of the following information:

(i) The Dependent or Dependents for whom the services were performed;

(ii) The person(s) on whose behalf the Employment-Related Dependent Care Expense was incurred;

(iii) The nature and date of the expenses so incurred;

(iv) The amount of the requested reimbursement;

(v) The name of the person, organization or entity to whom the expense was or is to be paid and the taxpayer identification number for such entity (or Social Security number, if a person);

(vi) The relationship, if any, of the person performing the services for the Participant

(vii) If the services were performed by a child of the Participant, the age of the child;

(viii) A statement as to where the services were performed;

(ix) If any of the services were performed outside the home, a statement as to whether the Dependent for whom the services were performed spends at least 8 hours a day in the Participant's household;

(x) If the services were being performed in a day care center, a statement:

(A) That the day care center complies with all applicable laws and regulations of the state of residence;

(B) That the day care center provides care for more than 6 individuals (other than individuals residing at the center); and

(C) of the amount of fee paid to the provider.

(xi) If the Participant is married, a statement containing the following:

(A) The Spouse's salary or wages if he or she is employed; or

(B) If the Participant's Spouse is not employed, that

(1) He or she is incapacitated; or

(2) He or she is a full-time student attending an educational institution and the months during the year which he or she attended such institution.

(xii) If the services were performed for a Dependent described in Section 18.2(e)(ii) (other than a Spouse of the Participant), a statement:

(A) That such Dependent is the Participant's federal tax dependent within the meaning of Code section 152 (determined without regard to sections 152(b)(1), (b)(2), and (d)(1)(B)); and

(B) That such Dependent is incapacitated;

(xiii) A statement that such expenses have not otherwise been reimbursed and that the Participant will not seek reimbursement through any other source; and that if reimbursed through the Dependent Care Spending Account, Participant will not claim the dependent care tax credit under section 21 of the Code for such expense; and

(xiv) Other such details about the expenses that may be requested by the Administrative Provider on the reimbursement request form or otherwise.

The application for reimbursement will be accompanied by those documents listed above from an independent third party, along with any other documentation that the Administrative Provider may request. There can be no self-substantiation of an expense by a Participant (*i.e.*, cancelled checks to a babysitter are not sufficient, standing alone).

(d) **Claim Filing Deadline**. Except as provided in the Component Program Document, if a Participant fails to submit a claim to the Administrative Provider by March 31 immediately following the end of the Plan Year, those claims will not be considered for reimbursement by the Administrative Provider. Any dispute concerning a claim for the reimbursement of Employment Related Dependent Care Expenses will be subject to the claims provisions of Article VIII of this Plan concerning non-health and non-disability claims unless otherwise provided in a Component Program Document.

End of Article XVIII

ARTICLE XIX HEALTH SAVINGS ACCOUNTS

19.1 Establishment of Health Savings Account

A Health Savings Account or HSA may be established by an HSA Eligible Participant (e.g., a Participant who enrolls in the Consumer Choice medical plan option under the Medical Program), in his sole discretion, with an Approved HSA Vendor. The terms of participation in the HSA (including, but not limited to, investments, account administration, and accepted rollovers) will be determined by such Approved HSA Vendor except, to the extent that such terms are not set forth by such Approved HSA Vendor or such terms do not comply with section 223 of the Code or other Internal Revenue Service guidance addressing health savings accounts, the terms of participation in the HSA will be governed by Code section 223 and such other Internal Revenue Service guidance.

19.2 Contributions to Health Savings Account

(a) **Employee Contributions**. An HSA Eligible Participant who has established an HSA with an Approved HSA Vendor may make contributions to such HSA on a pre-tax basis through the Cafeteria Program as set forth in Article IV. Such contributions will be subject to any limitations set forth by the Approved HSA Vendor except, to the extent that such Approved HSA Vendor has failed to set forth any limitations on contributions or such limitations conflict with section 223 of the Code or other Internal Revenue Service guidance addressing health savings accounts, the terms of Code section 223 or such other Internal Revenue Service guidance will govern.

(b) **Employer Contributions**. The Employer may, but is not required to, make contributions through the Cafeteria Program to an HSA established with an Approved HSA Vendor by an HSA Eligible Participant. Employer HSA contributions, if any, will only be deposited in an HSA maintained by an Approved HSA Vendor. Such contributions will be subject to the nondiscrimination requirements of section 125 of the Code and any applicable limits on Employer Contributions set forth in section 223 of the Code or other Internal Revenue Service guidance.

19.3 Distributions from Health Savings Account

(a) **Transfer or Rollover of HSA Balance to Non-Approved HSA Vendor**. An HSA Eligible Participant may, at any time, transfer or rollover his HSA account balance to a vendor that is not an Approved HSA Vendor. However, any Employee contributions made by or on behalf of an HSA Eligible Participant to a health savings account maintained by a vendor that is not an Approved HSA Vendor must be made on an after-tax basis by the HSA Eligible Participant, and may not be made pre-tax through the Cafeteria Program or through the Employer's payroll system. Further, Employer HSA contributions, if any, will only be deposited in an HSA established with and maintained by an Approved HSA Vendor.

(b) **Other Distributions or Rollovers. (Including Rollovers to Approved HSA Vendors)**. Distributions and rollovers (other than a rollover described in

Paragraph (a) above) from an HSA established by an HSA Eligible Participant will be governed by section 223 of the Code, applicable Internal Revenue Service guidance, and the Approved HSA Vendor (to the extent that any limitations or requirements established by the Approved HSA Vendor do not conflict with section 223 of the Code or other applicable Internal Revenue Service guidance). Taxation of such distributions and/or rollovers will be determined under Code section 223 and other applicable Internal Revenue Service guidance. Each HSA Eligible Participant has sole control and is exclusively responsible for expending HSA funds.

19.4 Responsibilities of HSA Eligible Participant

A health savings account is an individual account established by an HSA Eligible Participant with a vendor. Although HSA contributions made by or on behalf of an HSA Eligible Participant who has established an HSA with an Approved HSA Vendor may be made on a pre-tax basis through the Cafeteria Program, an HSA is not intended to be an "employee welfare benefit plan" within the meaning of ERISA, and is not a benefit program established or maintained by the Employer. Other than contributions made by the Employer or forwarded through its payroll department, the Employer will not monitor HSA contributions (including determinations as to whether such contributions exceed the statutory limits), investments of HSA account balances, or distributions or rollovers from the HSA. Such determinations and monitoring are the responsibility of the HSA Eligible Participant.

End of Article XIX

APPENDIX A MICHAELS STORES, INC. EMPLOYEE BENEFIT PLAN

The following Component Programs are incorporated into and made a part of the Michaels Stores, Inc. Employee Benefit Plan (the "**Plan**"), as amended and restated effective July 1, 2023:

- Medical Plan
- Dental Plan
- Vision Plan
- Cafeteria Plan
  - Health Flexible Spending Account Program
  - Dependent Care Flexible Spending Account Program
- Critical Illness Program
- Life Plan
- Accidental Death and Dismemberment Plan
- Long-Term Disability Plan
- Short-Term Disability Plan
- Employee Assistance Program
- Health Savings Accounts Established by HSA Eligible Participants*

This Appendix A may be updated from time to time without a formal amendment to the Plan.

* These are individual accounts maintained by Eligible Participants that are not part of the Plan. The Plan simply allows eligible Participants to make pre-tax contributions to such Health Savings Accounts under the Cafeteria Component Program. As such no Form 5500 reporting is required for the Health Savings Accounts.

APPENDIX B PARTICIPATING EMPLOYERS*[1]

1. Aaron Brothers, Inc.
2. Artistree, Inc.
3. Michaels Stores Procurement Company
4. Lamrite West, Inc.
5. Darice Product Development LLC
6. Michaels Product Development LLC

[1] *This Appendix B may be updated from time to time without a formal amendment to the Plan.

APPENDIX C
IDENTIFIYING FULL-TIME EMPLOYEES FOR MEDICAL COVERAGE[2]

Purpose

The purpose of this Appendix C is to identify Full-Time Employees for purposes of (a) eligibility for the Plan's group medical benefits; and (b) Code section 4980H and the Treasury Regulations thereunder. This Plan uses the monthly measurement period for Full-Time Employees, as defined below, and uses the "look-back measurement method" for determining the full-time status of Part-Time Employees, Seasonal Employees and Variable Employees, as defined below, as provided under Code section 4980H, the applicable Treasury Regulations, and other IRS guidance.

All employees who are determined to be Full-Time Employees, for purposes of the Plan's group medical benefits with respect to a given period of time, are eligible for such group medical benefits coverage during that period of time.

Definitions

For purposes of this Appendix, the following terms have the following meanings:

(a) **"Administrative Period"** means a Standard Administrative Period or an Initial Administrative Period.

(b) **"Controlled or Affiliated Group"** means the group of organizations consisting of the Company and any other entity that is part of a controlled group or affiliated service group with the Company within the meaning of Code Sections 414(b), (c), (m), or (o).

(c) **"Full-Time Employee"** means an Employee who is reasonably expected, to work on average at least 30 Hours of Service per week.

(d) **"Hour of Service"** means (1) each hour for which an employee is paid, or entitled to payment, for the performance of duties for the Employer, and (2) each hour for which an Employee is paid, or entitled to payment, by the Employer for a period of time during which no duties are performed due to vacation, holiday, illness, incapacity (including disability), layoff, jury duty, military duty, or leave of absence (as defined in 29 CFR section 2530.200b-2(a)).

(i) The term "Hour of Service" does not include any hour for services to the extent the compensation for those services constitutes income from sources without the United States, within the meaning of Code sections 861 through 863 and the Treasury Regulations thereunder.

(ii) An Hour of Service for one organization is treated as an Hour of Service for all other organizations that are part of the same Controlled or Affiliated Group for all periods during which those organizations are part of the same Controlled or

[2] This Appendix C may be amended from time to time without the need for a formal amendment to the Plan in which case an updated Appendix C will be attached hereto

Affiliated Group.

(iii) Hours of Service for all employees are credited using actual Hours of Service from records of hours worked and hours for which payment is made or due. Hours of service for Salaried Employees are determined using equivalency method.

(iv) For purposes of determining an employee's average Hours of Service during a Measurement Period when an employee is on Special Unpaid Leave, the average Hours of Service for that Measurement Period are determined by computing the average after excluding any periods of Special Unpaid Leave during that Measurement Period and by using that average as the average for the entire Measurement Period.

(e) **"Initial Administrative Period"** means, with respect to a New Employee who is a Part-Time Employee, Seasonal Employee, or Variable-Hour Employee, the two, full calendar months immediately following the Initial Measurement Period, provided, however, that in no case will coverage begin later than the first day of the 13th calendar month after the New Employee's Start Date.

(f) **"Initial Measurement Period"** means, with respect to a New Employee who is a Part-Time Employee, Seasonal Employee, or Variable-Hour Employee, the eleven (11) month period beginning on the first day of the calendar month after the New Employee's Start Date.

(g) **"Initial Stability Period"** means, with respect to a New Employee who is a Part-Time Employee, Seasonal Employee, or Variable-Hour Employee, the 12-month period beginning on the first day of the calendar month following the completion of both the Initial Measurement Period and the Initial Administrative Period.

(h) **"Measurement Period"** means an Initial Measurement Period or a Standard Measurement Period.

(i) **"Minimum Value"** means, with respect to an employer-sponsored group health plan, that the plan's share of the total allowed cost of benefits provided to a plan participant (the minimum value percentage) is at least sixty percent (60%).

(j) **"New Employee"** means an Employee who is not Full-Time (i.e., is a Part-Time Employee, Seasonal Employee or Variable-Hour Employee) who has been employed for less than one complete Standard Measurement Period.

(k) **"Ongoing Employee"** means a Part-Time Employee, Seasonal Employee or Variable-Hour Employee who has been employed for at least one complete Standard Measurement Period.

(l) **"Part-Time Employee"** means a New Employee whom the Employer reasonably expects to be employed on average less than 30 Hours of Service per week during the employee's Initial Measurement Period, based on the facts and circumstances at the New Employee's Start Date. Although no single factor is determinative, the following factors may be relevant in determining whether a New Employee is a Part-Time Employee:

(1) Whether the employee is replacing an employee who was (or was not) a Full-Time

Employee.

(2) The extent to which Hours of Service of Ongoing Employees in the same or comparable positions have varied above and below an average of 30 Hours of Service per week during recent Measurement Periods.

(3) Whether the job was advertised or otherwise communicated to the new hire or otherwise documented (for example, through a contract or job description) as requiring Hours of Service that would average 30 (or more) Hours of Service per week or less than 30 Hours of Service per week.

(4) The anticipated length of the Employee's Period of Employment shall not be considered.

(m) **"Period of Employment"** means the period of time beginning on the first date for which an employee is credited with an Hour of Service for the Employer or any member of the Controlled or Affiliated Group and ending on the last date on which the employee is credited with an Hour of Service for the Employer or any member of the Controlled or Affiliated Group, both dates inclusive. An employee may have one or more Periods of Employment with the same employer.

(n) **"Seasonal Employee"** means a New Employee who is hired into a position for which the customary annual employment is six months or less, occurring at approximately the same time each year.

(o) **"Special Unpaid Leave"** means unpaid leave that is subject to FMLA, subject to USERRA, or on account of jury duty.

(p) **"Stability Period"** means either a Standard Stability Period or an Initial Stability Period.

(q) **"Standard Administrative Period"** means the sixty (60) day period beginning on May 1 each year and ending the following June 30.

(r) **"Standard Measurement Period"** means the 12-month period beginning May 1 each year and ending the following April 30.

(s) **"Standard Stability Period"** means the 12-month period beginning July 1 each year and ending the following June 30.

(t) **"Start Date"** means the first date on which an employee is credited with an Hour of Service with the Employer or a member of the Controlled or Affiliated Group.

(u) **"Variable-Hour Employee"** means a New Employee if, based on the facts and circumstances at the employee's Start Date, the Employer cannot determine whether the employee is reasonably expected to be employed on average at least 30 Hours of Service per week during the Initial Measurement Period because the employee's hours are variable or otherwise uncertain. For purposes of determining whether an employee is a Variable-Hour Employee, the Employer may not take into account the likelihood that the employee may terminate employment before the end of the Initial Measurement Period. Although no single factor is determinative, the following factors may be relevant in determining whether a New Employee is a Variable-Hour Employee:

(1) Whether the employee is replacing an employee who was a Full-Time Employee or a Variable-Hour Employee.

(2) The extent to which the Hours of Service of employees in the same or comparable positions have actually varied above and below an average of 30 Hours of Service per week during recent Measurement Periods.

(3) Whether the job was advertised or otherwise communicated to the New Employee or otherwise documented (for example, through a contract or job description) as requiring hours of service that would average at least 30 hours of service per week, average less than 30 hours of service per week, or might vary above and below an average of 30 hours of service per week.

Terms not specifically defined in this Appendix C have the meanings set forth in the Plan.

Identification of Eligible Employees

To be eligible for group medical benefits coverage, an employee must be considered a Full-Time Employee, as defined in this Appendix C. Employees who are expected to be Full-Time Employees on their Start Date will be eligible for coverage on the first of the month following 30 days of employment. For an employee who is not expected to be a Full-Time Employee on their Start Date such employee will be classified as a Part-Time Employee, Seasonal Employee or Variable-Hour Employee and such employee's status as a Full-Time Employee, will be determined under this Appendix C based on whether the employee is: (1) an Ongoing Employee; or (2) a New Employee.

(a) **Employees Who Are Considered Full-Time Employees**. An Employee who is reasonably expected at his or her Start Date to be a Full-Time Employee (and is not a Seasonal Employee) is considered a Full-Time Employee beginning on the Employee's Start Date. If such New Employee elects group medical benefits coverage, such coverage begins on the first of the calendar month coinciding with or next following his or her completion of 30 days of employment with the Employer. The Employee's status as a Full-Time Employee will be determined separately for each calendar month.

***Example**:* Sarah starts work on December 15, 2023, and is reasonably expected to work on average 30 Hours of Service per week. She is considered a Full-Time Employee, and if she elects group medical benefits coverage, such coverage will begin on February 1, 2024 (the first of the calendar month after completion of 30 days of employment with the Employer). Sarah's status as a Full-Time Employee will be determined separately for each calendar month.

(1) **Factors for Determining Full-Time Employee Status at the Start Date**. Although no single factor is determinative, the following factors may be relevant in determining whether a New Employee (who is not a Seasonal Employee) is reasonably expected at his or her Start Date to be a Full-Time Employee:

(A) Whether the employee is replacing an employee who was (or was not) a Full-Time Employee.

(B) The extent to which Hours of Service of Ongoing Employees in the same or comparable positions have varied above and below an average of 30 Hours of Service per week during recent Measurement Periods.

(C) Whether the job was advertised or otherwise communicated to the

employee or otherwise documented (for example, through a contract or job description) as requiring hours of service that would average 30 or more Hours of Service per week or less than 30 Hours of Service per week.

(2) **Change in Employment Status**. If a Full-Time Employee transfers to a Part-Time Employee, Seasonal Employee or Variable-Hour Employee position his eligibility for group medical benefits coverage will cease at the end of the month in which the Employee incurs a change in status and the Employee's future eligibility for group medical benefits will be determined under the rules regarding New Employees or Ongoing Employees. At the time of employment transition, the Employee will be offered the opportunity to continue his coverage pursuant to COBRA.

(b) **Employees Who are not Considered Full-Time.** An Employee who is not a Full-Time Employee on their Start Date will be classified as a Part-Time Employee, Seasonal Employee or Variable-Hour Employee.

New Employees. New Employees are Part-Time Employees, Seasonal Employees or Variable-Hour Employees who have not been employed with the Employer for a complete Standard Measurement Period (i.e., a 12-month period beginning May 1 and ending April 30). The Employer will measure the Hours of Service that Part-Time Employees, Seasonal Employees, and Variable Hour Employees work during an Initial Measurement Period to determine Full-Time Employee status during an Initial Stability Period.

Initial Measurement Period	**Initial Administrative Period**	**Initial Stability Period (i.e., Eligibility Period)**
11-month period beginning on the first of the calendar month following the Start Date	2 calendar months, immediately following the Initial Measurement Period provided, however, that in no case will coverage begin later than the first day of the 13th calendar month after the New Employee's Start Date	12-month period, beginning on the first of the calendar month immediately following the Initial Administrative Period
• The Employer reviews whether an employee worked on average at least 30 Hours of Service per week during the 11-month period beginning on the first of the calendar month after the employee's Start Date. • The Employer reviews this during the Initial Administrative Period. • If the employee works on average at least 30 Hours of Service per week during the Initial Measurement Period, the employee is a Full-Time Employee and therefore eligible for group medical benefits coverage during the Initial Stability Period. If the employee is eligible and elects group medical benefits coverage, such coverage will begin on the first day of the Initial Stability Period. • If the employee does not work on average at least 30 Hours of Service per week during the 11-month Initial Measurement Period, the employee is not a Full-Time Employee and therefore is not eligible for group medical benefits coverage during the Initial Stability Period, except to the extent provided under provisions of this Appendix regarding Ongoing Employees.		

Example: Al starts work on November 15, 2023. On that date, the Employer cannot determine whether Al is reasonably expected to work on average 30 Hours of Service per week during the 11-month year period beginning December 1, 2023. During the 11- month-period beginning December 1, 2023, Al actually works on average 30 Hours of Service per week. He is first eligible for group medical benefits coverage for the 12- month Initial Stability Period that runs from January 1, 2024, through December 31, 2024. If he elects group medical benefits coverage, that coverage will begin on January 1, 2024.

(1) **Change in Employment Status during the Initial Measurement Period.** Notwithstanding the above provisions, if a New Employee who is a Part-Time Employee, Seasonal Employee, or Variable-Hour Employee experiences a change in employment status (i.e., a change in position or hourly schedule) so that the New Employee is reasonably expected to work on average at least 30 Hours of Service per week and, as such, is a Full-Time Employee, the New Employee will be considered a Full-Time Employee and eligible for group medical benefits coverage as of the first day of the month following 30 days of employment as a Full-Time Employee; provided, the employee has worked at least 30 days at the time of the change in employment status. If the employee has not worked at least 30 days at the time of the change in employment status, such eligibility for group medical benefits will follow the general rule and the employee will be eligible for such coverage the first of the month following the completion of 30 days of employment.

Example: Bonnie is hired on December 14, 2023, and it is reasonably expected at that time that she will work fewer than 30 Hours of Service per week. On March 15, 2024, she is promoted to a position which requires her to work at least 30 Hours of Service per week. Bonnie will be considered a Full-Time Employee and eligible for group medical benefits coverage beginning on May 1, 2024. If she elects coverage, such coverage will begin on May 1, 2024.

(2) **Transition to Ongoing Employee**. Once a New Employee who is a Part-Time Employee, Seasonal Employee, or Variable-Hour Employee has been employed for an entire Standard Measurement Period (i.e., May 1 – April 30), he or she becomes an Ongoing Employee, and his or her status as a Full-Time Employee is governed by the provisions of this Appendix regarding Ongoing Employees.

(i) **Full-Time During the Initial Measurement Period but Not the First Standard Measurement Period.** If the employee is determined not to be a Full-Time Employee for the Standard Measurement Period that overlaps or immediately follows the employee's Initial Measurement Period, the employee will continue to be considered a Full-Time Employee, and thus an eligible employee, for each calendar month during the Initial Stability Period, if the employee was determined to be a Full-Time Employee during the employee's Initial Measurement Period.

(ii) **Full-Time During the First Standard Measurement Period but Not During the Initial Measurement Period.** If the employee is determined to be a Full-Time Employee for the Standard Measurement Period that overlaps or immediately follows the employee's Initial Measurement

Period, the employee will be considered a Full-Time Employee, and thus an eligible employee, for each calendar month during the entire Standard Stability Period associated with the employee's first Standard Measurement Period, even though that Standard Stability Period may overlap an Initial Stability Period associated with an Initial Measurement Period during which the employee was determined not to be a Full-Time Employee.

(iii) **Full-Time During Both the Initial Measurement Period and the First Standard Measurement Period.** If the employee is considered a Full-Time Employee, and thus an eligible employee, during both the employee's Initial Stability Period and the employee's first Standard Stability Period, the employee will be considered a Full-Time Employee, and thus an eligible employee, during any period between the end of the Initial Stability Period and the beginning of the employee's first Standard Stability Period.

Once the employee works a full 12-month Standard Measurement Period (May 1 through April 30) and the immediately following Standard Administrative Period (May 1 through June 30) on or after the date of the change in employment status, the employee's Full-Time Employee status (and eligibility) will be determined as described above for Ongoing Employees.

Ongoing Employees. Ongoing Employees are employees who have been employed with the Employer for a complete Standard Measurement Period (i.e., a 12-month beginning May 1 and ending April 30).

Standard Measurement Period	**Standard Administrative Period**	**Standard Stability Period (i.e., Eligibility Period)**
May 1 – April 30	May 1 – June 30	July 1 – June 30
• The Employer reviews whether an employee worked on average at least 30 Hours of Service per week during the 12-month period May 1 – April 30. • The Employer reviews this during the Standard Administrative Period. • If an employee works on average at least 30 Hours of Service per week during the 12-month period May 1 – April 30, the employee is an ongoing Full-Time Employee and eligible to elect group medical benefits coverage during the next following July 1 through June 30. If an employee is a Full-Time Employee and the employee elects group medical benefits coverage, such coverage will begin July 1. • If an employee does not work on average at least 30 Hours of Service per week during the 12-month period May 1 – April 30, the employee is not a Full-Time Employee and therefore is not eligible for group medical benefits coverage during the next following July 1 – June 30.		

***Example 1*:** John has been employed with the Employer since 2005, so he is an Ongoing Employee. He worked on average at least 30 Hours of Service per week from May 1,

2023, through April 30, 2024. He is eligible for group medical benefits coverage from July 1, 2024, through June 30, 2025.

***Example 2*:** Beth has been employed with the Employer since 2005, so she is an Ongoing Employee. Beth did not work on average at least 30 Hours of Service per week from May 1, 2023, through April 30, 2024, so she is not eligible for group medical benefits coverage from July 1, 2024 through June 30, 2025. But, Beth does work on average 30 Hours of Service per week from May 1, 2024, through April 30, 2025, so she is eligible for group medical benefits coverage from July 1, 2025 through June 30, 2026.

Rehired Employees. A Part-Time Employee, Variable Employee or Seasonal Employee who is terminated and rehired in a capacity other than a Full-Time Employee will be treated as a New Employee upon rehire only if the employee was not credited with an Hour of Service with the Employer or any member of the Controlled or Affiliated Group for a period of at least thirteen (13) consecutive weeks immediately preceding the date of rehire. For purposes of applying these rehire rules, the duration of the Period of Employment immediately preceding a period during which an Employee was not credited with any Hours of Service is determined after application to that Period of Employment of the rules on Special Unpaid Leave, if and to the extent those rules are applicable.









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