PLAN DOCUMENT AND SUMMARY PLAN DESCRIPTION

Major Medical Plan

Summary Plan Description (SPD)
This document serves as your Summary Plan Description (SPD) to help you understand your Group Health Plan coverage. It provides a general overview of the benefits, exclusions, and limitations of your Plan. Please note that this SPD is not a contract and should not be considered as such.
Your Group Health Plan is administered in accordance with the Administrative Services Agreement between your Group and Benefit Health Plan, Inc (BHPI). The terms outlined in the Administrative Services Agreement and official Plan documents govern your coverage.

Important Note
BHPI provides administrative claims payment services only. BHPI does not assume any financial risk or obligation for claims.
Please share this SPD with your Eligible Dependents to ensure they are informed about the Plan's details.

How to Use This Document
For your convenience, defined terms are capitalized throughout this document. Definitions for these terms can be found in the section titled "Definitions."
We encourage you to:

1. Read this document carefully to familiarize yourself with your Plan.
2. Understand that different sections of the SPD are interconnected. Reading only one section may not provide complete information.
3. Review the benefits and limitations by referring to the Benefit Summary, Benefit Descriptions, and Exclusions sections.

If you have any questions about your coverage or a claim, please contact the Member Services Department for assistance.

Schedule of Benefits and Benefit Summary
Your Schedule of Benefits is a personalized document outlining your Plan coverage options and applicable membership options.
The Benefit Summary, included in this SPD, provides information about deductible and cost-sharing amounts, benefit limits, and other important coverage details.

Benefit Summary

LifeX Employer Plan MM $1,000 Deductible (MM1000)

Professional Services	PPO in-network benefits Your choice of *PHCS PPO or *Cigna PPO or *Anthem PPO What member pays	Out of network benefits What member pays
Deductible (based on level elected) Individual Family	 $1,000-$7,350 $2,000-$14,700	 $2,000-$14,700 $4,000-$29,400

Coinsurance	20%	50%
Out-of-pocket (including deductible) Individual Family	 $9,200 $18,400	 $18,400 $36,800
Annual Maximum Benefit	Unlimited	Unlimited
PCP Office Visit	$25 Copay	OON Deductible & Coinsurance
Specialist Office Visit (No Referral Needed)	$40 Copay	OON Deductible & Coinsurance
Urgent Care Office Visit	$60 Copay	OON Deductible & Coinsurance
Surgery performed in the Office	20% After Deductible	OON Deductible & Coinsurance
Chiropractic Care 24 visits per plan year	$30 Copay	OON Deductible & Coinsurance
Therapies: Physical, Speech, Occupational & Respiratory 30 visits per plan year	$40 Copay	OON Deductible & Coinsurance
Labs	$25 Copay	OON Deductible & Coinsurance
X-rays	$100 Copay	OON Deductible & Coinsurance
Diagnostic Testing/Advanced Imaging (Precertification Required)	20% After Deductible	OON Deductible & Coinsurance
Telemedicine through OurLiveDoc ONLY Call: 940-LIVE-DOC (940-548-3362) to get started	$0 Copay	Not Covered
Emergency Services (Precertification is required within 48 hours of admission, if admitted)	**Participating Provider**	**Non-Participating**
Emergency Room Care Please note that for a true medical emergency, any provider may be used.	20% After Deductible	OON Deductible & Coinsurance
Ambulance	20% After Deductible	OON Deductible & Coinsurance
Inpatient Hospital Services (Precertification Required)	**Participating Provider**	**Non-Participating**
Inpatient Hospital Care Facility	20% After Deductible	OON Deductible & Coinsurance
Inpatient Hospital Surgical Services	20% After Deductible	OON Deductible & Coinsurance
Inpatient Skilled Nursing Facility 30 days per plan year	20% After Deductible	OON Deductible & Coinsurance
Inpatient Rehabilitation Facility 30 days per plan year	20% After Deductible	OON Deductible & Coinsurance
Organ Transplant	20% After Deductible	Not Covered
Inpatient Hospice	20% After Deductible	OON Deductible & Coinsurance

30 days per plan year		
Outpatient Facility Services (Precertification Required)	**Participating Provider**	**Non-Participating**
Outpatient Surgical Facility Services	20% After Deductible	OON Deductible & Coinsurance
Outpatient Chemotherapy and Radiotherapy 30 days per calendar year	20% After Deductible	Not covered
Infusion/ Injection	20% After Deductible	OON Deductible & Coinsurance
Dialysis (limited to acute temporary dialysis)	20% After Deductible	Not Covered
Preventative Services	**Participating Provider**	**PPO out-network benefits**
Preventative Care including but not limited to: Annual Wellness Exams Labs Immunizations	$0 Copay $0 Deductible	OON Deductible & Coinsurance
Alcohol & Substance Abuse Care (Precertification Required)	**Participating Provider**	**Non-Participating**
Inpatient Care 30 days per plan year	20% After Deductible	OON Deductible & Coinsurance
Outpatient Services 30 visits per plan year	20% After Deductible	OON Deductible & Coinsurance
Maternity Services	**Participating Provider**	**Non-Participating**
Prenatal/Postnatal Office Visit	20% After Deductible	OON Deductible& Coinsurance
Room and Board	20% After Deductible	OON Deductible & Coinsurance
Other Covered Services	**Participating Provider**	**Non-Participating**
Home Health Care Visits (Precertification Required) 60 visits per plan year	20% After Deductible	OON Deductible & Coinsurance
Durable Medical Equipment (Precertification Required)	20% After Deductible	OON Deductible & Coinsurance
Allergy Testing/Injections	20% After Deductible	OON Deductible & Coinsurance
Pharmacy- Retail	**Participating Provider**	**Non-Participating**
Generic Drugs (See Formulary) 30 day-supply at retail for urgent care drugs	$10 Copay	OON Deductible & Coinsurance
Generic Drugs (See Formulary) 30 day-supply maintenance medication at retail. Mail order required for maintenance medication after initial 30 day-supply.	$10 Copay	OON Deductible & Coinsurance
Preferred Brand Name Drugs (See Formulary)	$90 Copay	OON Deductible & Coinsurance

30 day-supply at retail for **urgent care** drugs		
Preferred Brand Name Drugs (See Formulary) 30 day-supply **maintenance** medication at retail. Mail order required for maintenance medication after initial 30 day-supply.	$90 Copay	OON Deductible & Coinsurance
Non-Preferred Brand Name Drugs (See Formulary) 30 day-supply at retail for urgent care drugs	$110 Copay	OON Deductible & Coinsurance
Non-Preferred Brand Name Drugs (See Formulary) 30 day-supply maintenance medication at retail. Mail order required for maintenance medication after initial 30 day-supply.	$110 Copay	OON Deductible & Coinsurance
Specialty Drugs	Patient Assistance Plans Available	Patient Assistance Plans Available
Pharmacy- Mail Order	Participating Provider	Non-Participating
Generic Drugs (See Formulary) 90 day-supply	$20 Copay	OON Deductible & Coinsurance
Preferred Brand Name Drugs (See Formulary) 90 day-supply	$180 Copay	OON Deductible & Coinsurance
Non-Preferred Brand Name Drugs (See Formulary) 90 day-supply	$220 Copay	OON Deductible & Coinsurance
Specialty Drugs	Patient Assistance Plans Available	Patient Assistance Plans Available

Notes:

1. Elective Surgery will not be covered for the first 90 days (about 3 months) of coverage.
2. Failure to obtain precertification will result in penalties. The penalty may be a 50% reduction of allowed charges or denial of claim.

Preventive Care Guide

Adult Wellness

Screenings /Counseling /Medications

1. Abdominal aortic aneurysm one-time screening for men of specified ages who have ever smoked.
2. Alcohol misuse screening and counseling.
3. Aspirin use to prevent cardiovascular disease and colorectal cancer for adults 50 to 59 years with a high cardiovascular risk.
4. Blood pressure screening.
5. Cholesterol screening for adults of certain ages or at higher risk.
6. Colorectal cancer screening for adults 45 to 75.
7. Depression screening.

8. Diabetes (Type 2) screening for adults 40 to 70 years who are overweight.
9. Diet counseling for adults at higher risk for chronic disease.
10. Fall prevention (with exercise or physical therapy and vitamin D use) for adults 65 years and over, living in a community setting.
11. Hepatitis B screening for people at high risk, including people from countries with 2% or more Hepatitis B prevalence, and U.S.-born people not vaccinated as infants and with at least one parent born in a region with 8% or more Hepatitis B prevalence.
12. Hepatitis C screening for adults aged 18 to 79 years.
13. HIV screening for everyone age 15 to 65, and other ages at increased risk.
14. PrEP (pre-exposure prophylaxis) HIV prevention medication for HIV-negative adults at high risk for getting HIV through sex or injection drug use.
15. Lung cancer screening for adults 50 to 80 at high risk for lung cancer due to heavy smoking or have quit in the past 15 years.
16. Obesity screening and counseling.
17. Sexually transmitted infection (STI) prevention counseling for adults at higher risk.
18. Statin preventive medication for adults 40 to 75 at high risk.
19. Syphilis screening for adults at higher risk.
20. Tobacco use screening for all adults and cessation interventions for tobacco users.
21. Tuberculosis screening for certain adults without symptoms at high risk.

Immunization/Vaccines
(Dosage, age, and recommended populations vary)

Chickenpox (Varicella)	Human Papillomavirus (HPV)	Pneumococcal
Diphtheria	Measles	Rubella
Flu (influenza)	Meningococcal	Shingles
Hepatitis A	Mumps	Tetanus
Hepatitis B	Whooping Cough (pertussis)	

Women's Wellness
Screening/Testing

Services for pregnant women or women who may become pregnant.
1. Breastfeeding support and counseling from trained providers, and access to breastfeeding supplies for pregnant and nursing women.
2. Birth control: Food and Drug Administration-approved contraceptive methods, sterilization procedures, and patient education and counseling, as prescribed by a health care provider for women with reproductive capacity.
3. Folic acid supplements for women who may become pregnant.
4. Gestational diabetes screening for women 24 weeks pregnant (or later) and those at high risk of developing gestational diabetes.
5. Gonorrhea screening for all women at higher risk.
6. Hepatitis B screening for pregnant women at their first prenatal visit.
7. Maternal depression screening for mothers at well-baby visits.
8. Preeclampsia prevention and screening for pregnant women with high blood pressure.
9. Rh incompatibility screening for all pregnant women and follow-up testing for women at higher risk.
10. Syphilis screening.
11. Expanded tobacco intervention and counseling for pregnant tobacco users.

12. Urinary tract or other infection screening.
13. Screening for interpersonal and domestic violence.

Screenings /Testing
Other covered preventive services for women

1. Bone density screening for all women over age 65 or women aged 64 and younger that have gone through menopause.
2. Breast cancer genetic test counseling (BRCA) for women at higher risk
3. Breast cancer mammography screenings every 2 years for women 50 and over, and as recommended by a provider for women 40 to 49 or women at higher risk for breast cancer
4. Breast cancer chemoprevention counseling for women at higher risk
5. Cervical cancer screening.
6. Pap test (also called a Pap smear) for women 21 to 65.
7. Chlamydia infection screening for younger women and other women at higher risk.
8. Diabetes screening for women with a history of gestational diabetes who aren't currently pregnant and who haven't been diagnosed with type 2 diabetes before.
9. Domestic and interpersonal violence screening and counseling for all women.
10. Gonorrhea screening for all women at higher risk.
11. HIV screening and counseling for everyone age 15 to 65, and other ages at increased risk.
12. PrEP (pre-exposure prophylaxis) HIV prevention medication for HIV-negative women at high risk for getting HIV through sex or injection drug use.
13. Sexually transmitted infections counseling for sexually active women.
14. Tobacco use screening and interventions.
15. Urinary incontinence screening for women yearly
16. Well-woman visits to get recommended services for all women

Newborn/Child Care
Screenings/Assessments/Supplements

1. Alcohol, tobacco, and drug use assessments for adolescents
2. Autism screening for children at 18 and 24 months
3. Behavioral assessments for children: Age 0 to 11 months, 1 to 4 years, 5 to 10 years, 11 to 14 years, 15 to 17 years
4. Bilirubin concentration screening for newborns
5. Blood pressure screening for children: Age 0 to 11 months, 1 to 4 years, 5 to 10 years, 11 to 14 years, 15 to 17 years
6. Blood screening for newborns
7. Depression screening for adolescents beginning routinely at age 12
8. Developmental screening for children under age 3
9. Dyslipidemia screening for all children once between 9 and 11 years and once between 17 and 21 years, and for children at higher risk of lipid disorders
10. Fluoride supplements for children without fluoride in their water source
11. Fluoride varnish for all infants and children as soon as teeth are present
12. Gonorrhea preventive medication for the eyes of all newborns
13. Hearing screening for all newborns; regular screenings for children and adolescents as recommended by their provider

14. Height, weight, and body mass index (BMI) measurements taken regularly for all children
15. Hematocrit or hemoglobin screening for all children
16. Hemoglobinopathies or sickle cell screening for newborns
17. Hepatitis B screening for adolescents at higher risk
18. HIV screening for adolescents at higher risk
19. Hypothyroidism screening for newborns
20. PrEP (pre-exposure prophylaxis) HIV prevention medication for HIV-negative adolescents at high risk for getting HIV through sex or injection drug use
21. Lead screening for children at risk of exposure
22. Obesity screening and counseling
23. Oral health risk assessment for young children from 6 months to 6 years
24. Phenylketonuria (PKU) screening for newborns
25. Sexually transmitted infection (STI) prevention counseling and screening for adolescents at higher risk
26. Tuberculin testing for children at higher risk of tuberculosis: Age 0 to 11 months, 1 to 4 years, 5 to 10 years, 11 to 14 years, 15 to 17 years
27. Vision screening for all children
28. Well-baby and well-child visits

Immunization/Vaccines
(Dosage, age, and recommended populations vary)

Chickenpox (Varicella)	Human Papillomavirus (HPV)	Poliovirus (inactive)
Diphtheria, tetanus, & pertussis (DTaP)	Flu (influenza)	Measles, Mumps & Rubella (MMR)
Haemophilus influenzae (B)	Meningococcal	Rotavirus
Hepatitis A and B	Pneumococcal	Tetanus

Introduction

Your Rights and Responsibilities as a BHPI Member
As a BHPI member, you have the right to:

- Be treated with respect and dignity.
- Privacy of your personal health information is maintained by BHPI, following state and federal laws.
- Receive information about the benefits, limitations, and exclusions of your health plan, including how to access the network of hospitals, physicians, and other healthcare providers.
- Collaborate with your doctor and other healthcare professionals on decisions regarding your treatment.
- Discuss all your treatment options, regardless of cost or benefit coverage.
- File a complaint or appeal about your health plan, any care you receive, or any benefit determination made by BHPI.
- Make recommendations to BHPI about the rights and responsibilities policy.
- Provide suggestions on how BHPI can better serve you and other members.

You also have the responsibility to:

- Read and familiarize yourself with your health plan coverage, including what is and is not covered, or seek help if needed.

- Understand how your choice of an **In-network** or **Out-of-network Provider** affects your out-of-pocket expenses, especially if your plan has different benefits for In-network and Out-of-network care.
- Provide BHPI with all necessary information to process your claims and deliver the benefits to which you are entitled.
- Give healthcare providers the information needed to appropriately treat you.
- Notify your Group of any life changes affecting coverage, such as a birth, marriage/divorce, or change of address.

About the Plan
This is a health benefit plan with claims administered by BHPI. BHPI works with a network of hospitals, doctors, and healthcare providers who agree to offer services at lower costs. These providers are called In-network or Preferred Providers.

Using the network is optional, but it affects your costs. If you choose Out-of-network Providers for non-emergency care, you may have to pay more than your deductible, copayment, or coinsurance. Out-of-network providers may also bill you for amounts not covered by your plan.
In-network Providers won't charge you extra beyond your deductible, copayment, or coinsurance and will handle your claims for you.
For help finding In-network Providers, managing your benefits, or accessing tools, visit www.benefithealthplan.com, call Member Services using the number on your I.D. card, or check the Important Telephone Numbers section in this document.
How the Plan Components Work
Your **Deductible**, **Copayment**, **Coinsurance** (cost-sharing), and **Out-of-pocket Limit** for In-network and Out-of-network Providers are detailed in the Benefit Summary. Below is an explanation of these key components:

Allowable Charge
The amount BHPI uses to calculate payments for Covered Services. This amount is based on either:
- The **Contracted Amount** for In-network Providers, or
- The **Out-of-network Allowance** for Out-of-network Providers.

Coinsurance
The percentage you must pay for Covered Services after your Deductible is met.

Copayment (Copay)
A fixed dollar amount you pay for a Covered Service. Depending on the services submitted on a claim, multiple Copayments may apply.

Deductible
The amount you are responsible for paying out-of-pocket before the Plan begins covering costs.
- Once the Deductible is met, benefits for the rest of that Benefit Year will not be subject to further Deductible requirements.
- **Copayments** do not count toward the Deductible.
- In-network and Out-of-network Deductibles are separate unless otherwise specified in the Schedule of Benefits Summary.

- Charges paid for prescription drugs using a pharmaceutical discount or copay card may not count toward your Deductible.

Out-of-pocket Limit
The maximum cost-sharing amount each Covered Person or Membership Unit is required to pay during a Benefit Year.

- Separate limits may apply for In-network and Out-of-network Providers unless otherwise specified in the Schedule of Benefits Summary.
- Certain charges do not count toward your Out-of-pocket Limit, such as:
- Charges exceeding the Allowable Charge.
- Charges for Noncovered Services.
- Penalty amounts for failure to comply with Preauthorization requirements.
- Penalty amounts under the Prescription Drug Program.
- Cost-sharing amounts for prescription drugs paid using a pharmaceutical discount or copay card.

Health Savings Account (HSA) Plans
If you have an HSA-eligible High-Deductible Health Plan, the Deductible and Out-of-pocket Limit may be adjusted annually.

- Copays and Coinsurance amounts will apply only after the Deductible is met.

Overview of the Benefit Plan
This document describes the Life X Research Corporation (LIFEX) Benefit Plan (the Plan). No oral interpretations can alter this Plan.

Your employer determines eligibility requirements and validates eligibility for enrollment and coverage under the health plan. For additional information not found in this summary plan description please contact your employer.
Coverage under the Plan begins for eligible employees and designated dependents once the employee and dependents meet the waiting period and all eligibility requirements. Failure to meet the Plan's eligibility or enrollment requirements may result in delayed or denied coverage. Reimbursement may be reduced or denied due to provisions such as coordination of benefits, subrogation, exclusions, timeliness of COBRA elections, utilization review, lack of medical necessity, timely filing of claims, or lack of coverage.

LIFEX fully intends to maintain this Plan indefinitely but reserves the right to terminate, suspend, discontinue, or amend the Plan at any time and for any reason. Changes in the Plan may include benefit coverage, deductibles, maximums, copayments, exclusions, limitations, definitions, eligibility, and other aspects.

Benefits are provided for the covered expenses incurred while the coverage is active. Expenses incurred before coverage begins or after it ends are not covered, even if related to an accident, injury, or disease that occurred while coverage was active. A service or supply expense is incurred on the date it is provided. If the Plan is terminated, amended, or benefits are eliminated, the rights of Covered Persons are limited to Covered Charges incurred before termination, amendment, or elimination.

This document summarizes the Plan rights and benefits for covered Employees and Dependents and includes the following sections:

1. **Eligibility, Effective Date, and Termination** – Explains eligibility for coverage, and when coverage begins and ends.
2. **Schedule of Benefits** – Provides an overview of reimbursement formulas and service limits.
3. **Benefit Descriptions** – Explains benefit applications and covered charges.
4. **Cost Management Services** – Outlines methods to curb unnecessary and excessive charges.
5. **Defined Terms** – Defines specific Plan terms.
6. **Plan Exclusions** – Lists non-covered charges.
7. **Claim Provisions** – Details claim filing rules and appeal processes.
8. **Coordination of Benefits** – Describes payment order when covered under multiple plans.
9. **Third Party Recovery Provision** – Explains the Plan's right to recover payment for charges due to third-party claims.
10. **COBRA Continuation Options** – Details when coverage ceases and continuation options.
11. **ERISA Information** – Explains the Plan's structure and Participants' rights.

Eligibility, Effective Date, and Termination Provisions

Plan Participants should contact the Plan Administrator (BHPI) for additional information, about plan coverage of specific benefits, drugs, treatments, tests, or other aspects.

Eligibility

Your employer determines and validates eligibility for enrollment and coverage under the health Plan. For more details not found in this document, please contact your employer.

Who's Eligible: To qualify for coverage, you must meet your group's requirements regarding employment at LifeX Research Corporation. Those eligible for coverage may be full-time or part-time employees. For detailed eligibility information, contact your Human Resource Department.

- The individual who enrolls for coverage (subscriber) may also enroll Eligible Dependents, including spouses and children meeting the Plan's definition of Eligible Dependent. Refer to the "Definitions" section for more details.

Initial Enrollment: Subscribers and dependents must enroll within 30 days of initial eligibility or during a special enrollment period; otherwise, late enrollment provisions may apply.

Membership Types:

1. Single Membership: Coverage for the Subscriber only.
2. Subscriber-Spouse Membership: Coverage for the Subscriber and spouse.
3. Parent-Child Membership: Coverage for the Subscriber and eligible dependent children.
4. Family Membership: Coverage for the Subscriber, spouse, and eligible dependent children.

Special Enrollment: Special enrollment periods include:

- 30 days for events such as marriage, birth, adoption, or placement for adoption.
- 60 days for coverage loss under Medicaid or SCHIP or new eligibility for premium assistance under these programs.

Subscribers must enroll dependents within the specified periods. Contact your Human Resource Department for more details.

Late Enrollment/Open Enrollment: Late enrollment is allowed only during the Group's open enrollment period. For more information, contact your Human Resource Department.

Adding a Dependent: Dependents may enroll if the employee is covered under the Plan and the dependent meets the definition of an Eligible Dependent. Contact your Human Resource Department for enrollment details.

Effective Date of Coverage: Coverage begins as follows:

- Marriage: First of the month after marriage, if enrolled within 30 days.
- Newborn Children: From the date of birth, if enrolled within 30 days.
- Adopted Children: From placement or custody date, if enrolled within 30 days.
- Loss of Other Coverage: First of the month following the loss, if enrolled within 30 days.

Qualified Medical Child Support Orders (QMCSO):
QMCSOs require coverage for children in cases of divorce, legal separation, or paternity disputes. Affected employees and alternate recipients will be notified of QMCSO determinations. Contact the Plan Administrator for QMCSO procedures.

Active Employees Age 65 and Over:
Active employees and spouses aged 65+ typically retain employer coverage as primary and Medicare as secondary. Electing Medicare as primary coverage may terminate Plan benefits.

Family Medical Leave Act (FMLA): Under FMLA, eligible employees and dependents can continue coverage during approved leave. Employees who terminate coverage during FMLA leave may reenroll upon return. Contact your employer for FMLA eligibility details.

Definitions of Eligible Classes

Employees
Active and Retired Employees:
All Active employees of the Employer are eligible for coverage.

Dependents
A Dependent is any of the following individuals:

1. **Spouse and Children:**
    - **Spouse:** Legally recognized as the covered Employee's husband or wife under state law. Documentation proving marital status may be required.
    - **Children (up to age 26):** Includes natural children, adopted children, children placed for adoption, foster children, and stepchildren living in the Employee's household.
        - Children must be:
        - Primarily dependent on the covered Employee for support.
        - Listed as a dependent on the Employee's tax return.
        - Not offered health insurance by another employer.
        - Coverage ends on the child's 26th birthday.
2. **Children in Legal Guardianship:**

- Includes unmarried children for whom the Employee is the legal guardian.

3. **Children Placed for Adoption:**
   - Refers to children under age 18 placed with the Employee with legal and financial obligations in anticipation of adoption.
4. **Qualified Medical Child Support Order (QMCSO):**
   - Any child who is an alternate recipient under a QMCSO has a right to Dependent coverage. Copies of QMCSO procedures are available from the Plan Administrator.
5. **Disabled Dependent Children:**
   - Children who:
     - Are totally disabled due to mental or physical incapacity.
     - Are incapable of self-sustaining employment.
     - Are primarily dependent on the Employee for support.
     - Remain unmarried.
   - Proof of disability and dependency may be required at intervals, with examinations at the Plan's expense.

Exclusions:
Dependents do not include:

- Individuals living in the Employee's household who do not qualify under the Plan's definitions.
- Legally separated or divorced former Spouses.
- Individuals on active military duty.
- Individuals covered as Employees under the Plan.

If both parents are covered Employees, their children can be enrolled under one parent's coverage, but not both.

Eligibility Requirements for Dependent Coverage
Dependents of an eligible Employee become eligible for coverage on the same day the Employee's coverage begins, provided they meet the Plan's Dependent eligibility criteria.
At any time, the Plan Administrator may require documentation to verify a spouse or child's status as a dependent.

Utilization Review
Benefits are provided only for **Medically Necessary** and **Scientifically Validated** services. All services rendered by health care providers are subject to utilization review by **BHPI**. It is important to note that services are not automatically deemed Medically Necessary simply because they were ordered or provided by a Physician. BHPI will assess whether the services meet the criteria for Medical Necessity or Scientific Validation as outlined by the plan and determine if benefits are available.

Preauthorization Requirements
Preauthorization is mandatory for:

- All **Inpatient Hospital admissions**,
- Surgical procedures, and
- Specific specialized services and supplies.

For **In-network Hospitals**, the facility will notify BHPI about your Inpatient admission. However, if you are admitted to an **Out-of-network Hospital** or a hospital outside your state, it becomes **your responsibility** to ensure that BHPI is informed of your admission.

*For additional details, please refer to the section titled **"Preauthorization Requirements"** in this document.*

Preauthorization Process
The Preauthorization process ensures that health care services and supplies meet the requirements outlined in the plan. **BHPI** requires Preauthorization for hospital stays, surgical procedures, and specialized services or supplies before they are received.
Although hospitals or providers may initiate the Preauthorization process, it is the responsibility of the **Covered Person** to ensure it is completed. Regardless of any Preauthorization, all medical decisions regarding treatment remain the responsibility of the Covered Person and their provider. BHPI does not assume responsibility for treatment or diagnosis, even after Preauthorization, review, or management.
When a Preauthorization request is received, BHPI (or its designated representatives) assesses the appropriateness of the setting, level of medical care, timing, and duration of the service.
To start the process, you, your family member, physician, hospital, or another representative must contact BHPI. Notification can be provided via telephone or in writing. Supporting documentation from the attending provider may be required, demonstrating the **Medical Necessity** of the requested service or supply, and identifying the location where it will be provided.
For ongoing inpatient admissions, continued Preauthorization is required to confirm the care is being delivered in the most appropriate setting.

Important Note: Preauthorization does not guarantee payment. All other plan provisions, such as **Copayments**, **Deductibles**, **Coinsurance**, eligibility, and exclusions, still apply.

Benefits Requiring Preauthorization
The following services, supplies, or drugs require Preauthorization:

- **Advanced Diagnostic Imaging**
- **Durable Medical Equipment ($750 and up)**
- **Hospice Care**
- **Inpatient Hospital Admissions**
- **Inpatient Physical Rehabilitation**
- **Skilled Nursing Care** (in-home or facility-based)
- Services requiring surgical, laboratory, or radiology Preauthorization, as defined by BHPI
- Additional services specified in this document.

For the most current list of services requiring Preauthorization, contact the Member Services Department. Please note that Preauthorization requirements may change over time.

Preauthorization Exceptions
Maternity
Federal law allows a hospital stay of up to **48 hours** following a normal vaginal delivery and **96 hours** after a cesarean section. Preauthorization is not required for initial maternity admission. However, if the hospitalization extends beyond these time limits, Preauthorization will be required.

Emergencies
For emergency medical admissions, BHPI must be notified within **48 hours** of admission or by the next business day. If this notice is not provided, the 48-hour period before and after the admission will be reviewed to determine if the Covered Person's condition hindered their ability to provide notice.

Note: Admission through the emergency room does not automatically qualify as an emergency admission.

Effect on Benefits
Failure to comply with Preauthorization requirements may result in penalties, denial of benefits, and unanticipated costs. Certain surgical or radiology procedures, as well as other Preauthorization programs, require benefit approval before services are provided. Failure to obtain this approval can result in a denial of benefits for the service.
If Preauthorization is not properly obtained, and benefits are denied or reduced (50% reduction of allowed charges), the Covered Person is responsible for the associated costs.
Any reductions in benefits due to Preauthorization failures will not count toward the Deductible or Out-of-pocket Limit.
Note: Benefits are not payable for services determined to be not Medically Necessary.

Filing a Claim
If your healthcare provider is not a Contracting Provider and does not submit the claim for you, you must file the claim yourself. To do so, you can request a Claim form by reaching out to the Member Services Department. All claims submitted must include the following information:

- Correct member ID number
- Patient's name
- Date and time of the accident or illness onset, including whether it occurred at work.
- Diagnosis
- Itemized list of services provided, including service dates, descriptions, and charges.
- Name, address, and professional title (MD, PA, etc.) of the healthcare provider.
- Prescription number (if applicable)
- Name and ID number of any other insurance, including Medicare.

Claims that are incomplete cannot be processed and may be denied for "lack of information" if required details are not provided. Claims should be filed as soon as possible after the service date. Contracting Providers will submit claims on behalf of the Covered Person, but the Covered Person is responsible for providing their identification number for the claim to be filed. Claims not filed by a Contracting Provider in accordance with BHPI's timely filing policy will become the responsibility of the Contracting Provider.
If a non-contracting Provider does not file a claim on your behalf, the Covered Person must file the claim for services provided. All claims must be filed within 180 days of the date of service, unless legal inability prevents you from doing so. If the claim is not filed within this time frame, benefits will not be granted.

All claims should be sent to:
BHPI
P.O. Box 1043
Matthews, NC 28106

If you need assistance in finding the correct plan, please contact the Member Services Department.

Appeal Procedure Definitions

Adverse Benefit Determination: A determination by BHPI or its Utilization Review designee regarding the denial, reduction, or termination of a benefit, or a failure to provide or make payment (in whole or in part) for a benefit. This includes any such determination based on:

- The application of Utilization Review
- A determination that the service is Investigative.
- A determination that the service is not Medically Necessary or appropriate.
- An individual's eligibility for coverage or to participate in a plan.
- An unexpected ("surprise") balance bill from an Out-of-network Provider for emergency and certain non-emergency services

An Adverse Benefit Determination also includes any rescission of coverage, which refers to the cancellation or discontinuation of coverage with retroactive effect, except in cases of failure to timely pay required premiums or contributions for coverage.

Final Internal Adverse Benefit Determination: An Adverse Benefit Determination that has been upheld by BHPI or its Utilization Review designee after completing the internal appeal process as described in this document.

Preservice Claim(s): Any claim for a benefit under the Plan where the terms of the contract require approval of the benefit before medical care is provided. Failure to obtain approval may result in a denial or reduction of benefits.

Post-service Claim(s): Any claim that is not a Preservice Claim or Urgent Care Claim.

Urgent Care Claim: A claim for medical care or treatment where the application of standard time periods for non-urgent care determinations could:

- Seriously jeopardize the life or health of the Covered Person or their ability to regain maximum function; or
- In the opinion of a physician familiar with the claimant's medical condition, would subject the Covered Person to severe pain that cannot be adequately managed without the care or treatment involved in the claim.

How to Appeal an Adverse Benefit Determination

A Covered Person or someone acting on their behalf (the "claimant") has the right to appeal an initial or final Adverse Benefit Determination. A claim appeal must be submitted within six (6) months from the date the claim was processed, or the Adverse Benefit Determination was made. The appeal should include the following:

- Name of the person submitting the appeal and their relationship to the patient
- Reason for the appeal
- Any information that may help resolve the issue.
- Date of service/claim

BHPI will acknowledge receipt of the appeal within 3 days. The claimant does not have the right to be present at the appeal review or have a representative present but may submit additional information for consideration.

If the Adverse Benefit Determination was based on medical judgment (including a Medical Necessity or Investigative determination), BHPI will consult with healthcare professionals who have the appropriate training and experience to make the appeal determination.

Timing of Appeals Determinations

Appeal Type	Timing
Pre-service (non-urgent)	Written notice of appeal determination within 30 calendar days after internal appeal (1st level) and file an external appeal (2nd level) within 4 months after receiving the 1st level appeal decision. External appeal notice will be provided within 45 calendar days from the date the appeal is received.
Post-service	Written notice of appeal determination will be provided to the claimant within 60 calendar days. If additional time is needed, written notice will be provided on or before the 15th day, and the appeal determination will be provided within 4 months after receiving the 1st level appeal decision. External appeal notice will be provided within 45 calendar days from the date the appeal is received.
Expedited Appeal (Urgent Care)	An expedited appeal will be reviewed and determined with notice provided to the claimant within 72 hours of receipt of the appeal.
Concurrent Care	A request for an expedited appeal of a concurrent care denial must be made within 24 hours of the denial. If requested, coverage will continue for health care services pending the appeal review decision, as required by law. The decision time frame for concurrent care will follow the same rules as other expedited appeals. The decision will be considered a Final Adverse Benefit Determination.

Exclusions

Exclusions — Services Not Covered

The services, treatments, and supplies outlined in this section are not covered unless specifically stated in another section of this SPD, an amendment to the SPD, or as required by law.

How to Navigate Exclusions

For ease of use, services, treatments, and supplies have been grouped into categories, with headings that identify related exclusions. Specific exclusions are listed under each heading.

Plan Exclusions

Benefits are not provided for:

1. Services, treatments, or supplies not covered under the Plan.
2. Services deemed **not Medically Necessary** by BHPI.

Note: These exclusions apply even if the service is:

- Recommended or prescribed by a physician.
- The only available treatment for the Covered Person's condition.

Noncovered services include, but are not limited to:

Alternative Treatments

Excluded services and programs include:

- **Therapies and Programs**:
  - Massage therapy (including rolfing), acupuncture, aromatherapy, light therapy, naturopathy, VAX-D therapy, support therapies, dream therapy, activity therapy (e.g., music, dance, art, play), and recreational therapy (unless explicitly covered).
  - Wilderness programs, adventure therapy, camps (including associated activities), and animal-based therapy programs.

    - Vitamin therapy and herbal remedies.
- **Other Noncovered Services**:
    - Services from a massage therapist.
    - Treatments or equipment deemed not cost-effective compared to established alternatives.
    - Whirlpools, contrast baths, paraffin baths, and iontophoresis.

Comfort or Convenience Items

Excluded personal expenses and incidental charges include:

- Guest meals, television, beauty/barber services.
- Supplies or equipment for personal comfort, such as:
    - Educational or safety equipment, hot tubs, saunas, humidifiers, music players, personal computers, pillows, or strollers.
    - Devices for purifying, heating, or cooling air or water.
    - Exercise equipment.
- Home or vehicle modifications:
    - Building, remodeling, or altering a residence.
    - Investigating/remediating harmful contaminants (e.g., mold).
    - Purchasing or customizing vehicles.

Durable Medical Equipment (DME) and Supplies

Excluded items include:

- Enuresis alarms, incontinence devices, external defibrillators, and convenience-based purchases.
- Power seat elevating systems and chairs.
- DME rented or used while confined to a hospital or similar facility if usually provided by the facility.
- Repairs, maintenance, or adjustments not provided by an authorized DME company.
- DME repairs or replacements due to misuse, damage, neglect, or loss.

Experimental or Investigative Services

Benefits are not provided for:

- Services deemed **Investigative** by BHPI, including related services.
- Medical treatments, drugs, or procedures resulting from participation in research programs unless approved by BHPI.

Foot Care

Excluded services include:

- Orthopedic shoes (except for initial purchase when attached to a brace).
- Foot orthotics unless required to prevent diabetes complications or treat congenital anomalies.
- Non-Medically Necessary treatment for corns, calluses, or nail trimming.

Mental Health and Substance Use Disorder Services

Excluded services include:

- Non-medical programs:
    - Education, socialization, or delinquency services.
    - Halfway houses, foster homes, group homes, or treatment groups.
    - Self-help, co-dependency, or probation-related programs.
    - Employee assistance or prevention programs.

- Non-Medically Necessary inpatient or outpatient treatments, including court-ordered programs.
- Other exclusions:
    - Services from non-approved providers.
    - Stress reduction classes or pastoral counseling.
    - Nicotine addiction programs, unless specifically covered.
    - Obesity or gambling-related self-help programs.

Nutrition

The following nutritional services and items are excluded:

- **Dietary Counseling**: Except when part of nutritional management for diabetes, certain conditions covered under ACA Preventive Services, or eating disorders.
- **Enteral Feedings**: Even when they are the sole source of nutrition.
- **Nutritional Care and Supplements**: Including but not limited to:
    - FDA-exempt infant formulas.
    - Supplies, electrolytes, or other nutritional substances.
    - Products such as Neocate, Vivonex, Elecare, Cyclinex-1, ProPhree.
    - Over-the-counter vitamins, minerals, elements, foods (including high-protein and low-carb diets), and other nutritional substances.

Physical Appearance

Excluded services related to physical appearance include:

- **Cosmetic Services**: Unless specifically covered as follows:
    - Resulting from a traumatic injury.
    - To correct a congenital abnormality that severely impairs essential functions.
    - To address scars or deformities caused by cancer or non-cosmetic surgery.
    - Reconstructive surgery to restore or correct bodily functions lost or damaged due to injury or illness.

Note: Benefits are not payable for complications unless the treatment is otherwise covered under the Plan.

Excluded cosmetic procedures include but are not limited to:

- Dermabrasion, liposuction, breast augmentation or reduction (unless medically necessary), breast replacement, treatment of protruding ears, spider veins, tattoo removal or revision, and telangiectasias.
- **Obesity and Weight Reduction**: Excluded regardless of diagnosis.
    - Examples include health or athletic club memberships, physical conditioning programs, and weight loss programs.
    - Surgeries or treatments for weight reduction or obesity are also excluded.

Providers

Excluded charges and services related to providers include:

- **Administrative Charges**:
    - Missed appointments.
    - Claim forms, records, or fees for providing information or documentation.
    - After-hours or technical support fees.
- **Custodial or Domiciliary Care**: Including services from personal care attendants.
- **Immediate Family Services**: Charges for services provided by relatives or immediate family members.

- **Inadequate Documentation**: Claims lacking proper documentation.
- **Non-Approved Facilities and Providers**:
    - Services from facilities or providers not meeting LIFEX standards or accreditation requirements.
    - Out-of-hospital charges while the patient is temporarily out of a hospital.
- **Overhead Expenses**: Such as office supplies, staff charges, or facility expenses.
- **Scope of Practice**: Services outside the provider's licensed or certified scope of practice.
- **Veterans Administration Hospitals**: For conditions related to military service.

Reproductive Services

The following reproductive services are not covered:

- Pregnancy assistance treatments, including but not limited to:
    - Assisted Reproductive Technology (ART), such as artificial insemination, sperm washing, GIFT, ZIFT, and in vitro fertilization.
    - Hormonal or drug therapies for fertility enhancement.
    - Embryo transfer procedures.
    - Reversal of voluntary sterilization.
    - Storage/retrieval of reproductive materials, donor sperm/eggs, and surrogate parenting.
    - Testing and procedures related to infertility treatment (except diagnostic testing for infertility, polycystic ovary disease, and endometriosis).
- Surrogate mother services.
- Voluntary abortions unless medically necessary to safeguard the woman's life or due to viability threats to the unborn child.

Services Payable Under Another Plan

Excluded services include:

- Services available at government expense unless required by law.
- Services covered under Medicare or workers' compensation laws.
- Employment-related injuries or conditions, even if workers' compensation coverage is waived or unavailable.

Travel

The following travel-related expenses are excluded:

- Lodging, meals, or travel costs incurred by the patient or provider for obtaining treatment, except for covered ambulance services or as explicitly identified under the Plan.

Vision and Hearing

Excluded vision and hearing services include:

- **Vision Services**:
    - Eyeglasses or contact lenses, eye exercises, visual therapy, or visual training (orthoptics).
    - Preventive vision exams, extended care packages, and eye refractions (unless covered under preventive services).
    - Charges related to surgical, laser, or nonsurgical procedures altering refractive vision (e.g., correction of myopia or astigmatism).

- **Hearing Services**:
  - Audiological tests, except as covered under Preventive Services.
  - External or implantable hearing devices, except cochlear implants as explicitly covered.
  - Hearing aids and their fitting, unless required by law or the Plan.

Other Exclusions and Limitations
Services
The following services, including related diagnostic testing, are excluded:

- **Primarily Recreational or Educational Services**:
  - Music or art therapy.
  - School-based individualized education programs.
  - Work-hardening therapy or vocational rehabilitation and training.
  - Medical or non-medical self-care or self-help training.
- **Taxes or Surcharges**:
  - Interest, sales taxes, or other surcharges on Covered Services, drugs, supplies, or DME, except those directly assessed on employers or third-party payers.
- **War-Related Expenses**:
  - Any claims resulting from war or acts of war, whether declared or undeclared, civil, or international, including significant armed conflicts.
- **Genetic Testing**:
  - Unless scientifically validated by BHPI medical policy or required by law.
- **Miscellaneous Tests and Treatments**:
  - Food antigens, skin titration, cytotoxicity testing, non-specific candida sensitivity treatment, and auto-urine injections.
- **Snoring**:
  - Reduction or elimination of snoring as the primary treatment purpose.
- **Telemedicine**:
  - Telephone, email, video, or internet consultations, unless in conformance with LIFEX policies and procedures.
- **Blood Services**:
  - Blood, blood plasma, derivatives, fractionates, or services for donors, except for administrative and processing charges for blood provided by organizations like the Red Cross.

Eligibility and Membership
The following are excluded:

- **Dependent Coverage**:
  - Services for dependents under a Single Membership, except for specific provisions for newborns or adopted children.
  - Services for individuals who do not qualify as Eligible Dependents.
  - Services provided before the effective coverage date or after termination.
- **Military Service-Related Illness or Injury**.

No Legal Obligation to Pay
Excluded services include:

- Services provided without a charge or above the amount that would have been charged if coverage did not exist.
- Services typically furnished without charge.

Cost-Related Exclusions

- **Excess Charges**:
  - Charges exceeding the Contracted Amount.
- **Bundled Services**:
  - Separately charged services that are considered part of a total service charge.

Review of Certain Charges

The Plan Administrator reserves the authority to refer any claim to a designated entity of its choosing for a Billing Review. This review may be conducted to identify errors, excess charges, unbundling, medically unlikely edits, or any other factors that could affect claim adjudication. The Plan Administrator retains sole discretion to review and adopt the recommendations of its designee as its own.

Specifically, the Plan Administrator will not, on a line-item basis (e.g., CPT, HRC, HCPCS, etc.), approve reimbursement amounts that exceed the billed charges. Additionally, revenue codes requiring CPT or HCPCS codes will be denied if such codes are not included on a UB-04 or itemized bill.

The Plan Administrator is authorized to rely on all terms and conditions outlined in this Plan Document, as well as all nationally recognized billing and coding edits, when performing a bill review.

Employer-Required Services

Excluded services include:

- Immunizations, blood tests, work physicals, and drug tests required as a condition of employment.

Illegal or Criminal Activities

- Charges incurred due to engagement in illegal occupations or felonies.

Specific Procedures or Tests

- **Heart Scans**:
  - Computed tomography (CT) of the heart or electron beam CT for cardiovascular, cerebrovascular, or peripheral vascular disease screening.

Pharmacy and Medication

- Outpatient prescription drugs or services covered only under the Prescription Drug program.
- Take-home supplies from inpatient facilities.
- Replacement of lost, broken, destroyed, or stolen prescription drug products (limited to one refill per year).
- Over-the-counter supplies, medications, or devices unless otherwise specified.

Non-Medical Services

- Private duty nursing.
- Long-term rehabilitation programs.
- Respite care outside covered hospice benefits.
- Home health aide, skilled nursing care, or hospice services for:
  - Volunteers, pastoral services, legal or financial counseling.

- Patient convenience or for others.
- Home-delivered meals.

Excluded Locations and Providers

- Services provided in places such as:
  - Daycare, schools (except mental health services by an approved provider), libraries, churches, or employee worksites (except immunizations).
- Services provided by doulas.
- Services offered during health fairs or employer wellness events unless approved by BHPI.

Miscellaneous Exclusions

- Services for camp, travel, career, employment, insurance, marriage, adoption, judicial or administrative proceedings, research, or licensing purposes.
- Foreign language or sign language services.
- Driving tests or exams.
- Autopsies.
- Hair analysis or treatment for alopecia or hair loss due to age.
- Wigs, hair prostheses, or hair transplants, regardless of cause.
- Prepaid services through discount programs, coupons, or retail offers.
- Short-term storage of cord blood, breast milk, or other materials unless specifically covered.
- Social services.
- Transportation services unless specifically covered.
- Removal of skin tags.
- Services provided under a direct primary care agreement.
- Treatments for sexual arousal disorders or erectile dysfunction, regardless of cause.

Prescription Drug Benefits

Prescription Drug Benefits are subject to the applicable Copay, Deductible and/or Coinsurance amounts shown in the Benefit Summary. All covered prescription drug products must be:

- Medically Necessary
- be FDA-approved*
- be evaluated for coverage by the Pharmacy and Therapeutics Committee of BHPI or the Pharmacy Benefit Manager
- be dispensed by a registered pharmacist, and
- require a Physician's or Dentist's prescription

**Specific non-FDA-approved drugs may be covered, based on clinical guidelines or evidence as determined by the Pharmacy and Therapeutics Committee, or as required by law.*

A Copay, Deductible and/or Coinsurance will be assessed for each prescribed drug, supply, and/or unit. Covered prescription drug products also include insulin and diabetic supplies, including, but not limited to insulin syringes, test strips, lancet/lancet devices, and continuous glucose monitoring devices and supplies.

Your prescription drug benefit is based on a tiered benefit design that features multiple levels of cost-sharing for different prescription classifications. The tiers may include classifications such as Generic and Brand-name Drugs, Specialty Drugs, and preferred and non-preferred drugs. Sub-classifications may be based on cost or other factors. For example, a Prescription Drug List (PDL), which is a list of covered drugs, classifies drugs as Generic and Brand Name — that classification may include sub-categories of preferred and non-preferred drugs.

Whenever appropriate, Generic Drugs will be used to fill prescriptions. If a bioequivalent Generic Drug is available and has multiple manufacturers or meets other criteria as determined by the PBM or Us, reimbursement for the drug dispensed will be based on the price of the Generic Drug unless prohibited by law. If the Covered Person or the ordering provider requests a Brand Name Drug when a Generic Drug equivalent is available, the Covered Person may be required to pay a penalty equal to the difference in cost between the Brand Name Drug and the Generic Drug. This penalty will be in addition to the applicable Copay, Deductible, and Coinsurance.
NOTE: Prepackaging by the manufacturer may limit the quantity dispensed to an amount which is less than the maximum dispensing amount available under your coverage. If that happens, benefits will be provided in compliance with the manufacturer's packaging guidelines.
Additional terms specifically used in conjunction with your Prescription Drug Benefits are defined at the end of this section.

Generic Drugs Can Save You Money. Generic drugs are drugs that are labeled by their chemical name rather than by a brand name. However, all drugs, whether generic or brand, must meet the same government standards for safety and effectiveness. Why pay more for a brand-name drug if its generic twin is available at a lower cost? Ask your physician to prescribe generic drugs whenever possible.

Accessing Benefits
If the prescription or supply is purchased at an In-network Pharmacy, and you present your LIFEX identification card to the pharmacist at the time of purchase, you will only be required to pay your financial liability at the time the prescription is filled. In-network Pharmacies will file claims to BHPI or to the Pharmacy Benefit Manager (PBM). The Benefit Summary shows your financial liability and the dispensing amount for each benefit tier.

Coordination of Benefits
When You Have Coverage Under More Than One Plan
This Plan includes a Coordination of Benefits (COB) provision. COB provisions apply when a Covered Person has coverage under more than one health Plan. This provision establishes a uniform order in which the Plans pay their Claims, limits the duplication of benefits, and provides for the transfer of information between the Plans.
The order of benefit determination rules described in this section determine which Plan will pay as the primary Plan without regard to any benefits that might be payable by another Plan.
Definitions
Allowable Expense: A health care expense, including Deductibles, Coinsurance, and Copayments, which is covered at least in part by any Plan covering the person. When a Plan provides benefits in the form of services, the reasonable cash value of each service will be considered an Allowable Expense and a benefit paid. An expense that is not covered by any Plan covering the person is not an Allowable Expense. In addition, any expense that a provider by law or in accordance with a contractual agreement is prohibited from charging a Covered Person is not an Allowable Expense. The amount of any benefit reduction by the Primary Plan because a Covered Person has failed to comply with the Plan provisions is not an Allowable Expense. Examples of these types of Plan provisions include second surgical opinions, preauthorization of admissions, and preferred provider arrangements.

Closed Panel Plan: A Plan that provides health care benefits to covered persons primarily in the form of services through a panel of providers that have contracted with or are employed by the Plan,

and that excludes coverage for services provided by other providers, except in cases of emergency or referral by a panel member.

Custodial Parent: The parent awarded custody by a court decree or, in the absence of a court decree, the parent with whom the child resides more than one-half of the calendar year, excluding temporary visitation.

Plan: As used in this section, any of the following that provide benefits or services for medical treatment. If separate contracts are used to provide coordinated coverage for members of a group, the separate contracts are considered parts of the same Plan, and there is no COB among those separate contracts:
a. **Plan includes:** group and nongroup insurance contracts and subscriber contracts, health maintenance organization (HMO) contracts, Closed Panel Plans; other forms of group or group-type coverage (whether insured or uninsured); medical care components of long-term care contracts, such as skilled nursing care; medical benefits coverage in motor vehicle "no-fault" and traditional "fault" type contracts; group and nongroup insurance contracts and subscriber contracts that pay or reimburse for the cost of dental care; and Medicare or any other federal governmental Plan, as permitted by law.
b. **Plan does not include:** hospital indemnity coverage or other fixed indemnity coverage; accident-only coverage other than the medical benefits coverage in motor vehicle "no-fault" and traditional "fault" contracts; uninsured or underinsured coverage under a motor vehicle policy; specified disease or specified accident coverage; limited benefit health coverage, as defined in state law; school accident coverage; disability income insurance; benefits for non-medical components of long-term care policies; Medicare supplement policies; Medicaid policies; and coverage under other federal governmental Plans, unless permitted by law.
Each contract for coverage under a. or b. is a separate Plan. If a Plan has two parts and COB rules apply only to one of the two, each of the parts is treated as a separate Plan.
Primary Plan: The Plan that will determine payment for its benefits first before those of any other Plan without considering any other Plan's benefits.
Secondary Plan: The Plan that will determine its benefits after those of another Plan and may reduce the benefits so that all Plan benefits do not exceed 100% of the total Allowable Expense. The Secondary Plan will not pay more than the Primary Plan's contracted reimbursement rate.
This Plan: The part of the contract providing health care benefits to which the COB provision applies, and which may be reduced because of the benefits of other Plans. A contract may apply one COB provision to certain benefits, such as dental benefits, coordinating only with similar benefits, and may apply another COB provision to coordinate other benefits.

Your ERISA Rights
As a participant in this Group Health Plan, you are entitled to certain rights and protections under ERISA (Employee Retirement Income Security Act of 1974).
ERISA provides that all plan participants shall be entitled to:

Receive Information About Your Plan and Benefits

- **Examine Documents**
  Examine, without charge, at the Plan Administrator's office and at other specified locations, all documents governing the plan, including insurance contracts and collective bargaining agreements, as well as a copy of the latest annual report filed by the Plan with the U.S.

Department of Labor and available at the Public Disclosure Room of the Employee Benefits Security Administration.

- **Request Copies**
  Obtain, upon written request to the Plan Administrator, copies of documents governing the operation of the plan, including insurance contracts, collective bargaining agreements, copies of the latest annual report, and the updated summary plan description. The Plan Administrator may make a reasonable charge for these copies.
- **Annual Financial Report**
  Receive a summary of the plan's annual financial report. The Plan Administrator is required by law to furnish each participant with a copy of this summary annual report.

Continue Group Health Plan Coverage

- **COBRA Rights**
  You may continue health coverage for yourself, your spouse, or dependents if there is a loss of coverage under the Plan because of a Qualifying Event (COBRA). You or your dependents may need to pay for such coverage. Review your Summary Plan Description and the documents governing the Plan for the rules regarding your COBRA continuation rights.

Prudent Actions by Plan Fiduciaries

In addition to creating rights for plan participants, ERISA imposes duties upon the people who are responsible for operating the employee benefit plan. These individuals, referred to as "fiduciaries," must act prudently and in the interest of you and other plan participants and beneficiaries.
No one, including your employer or any other person, may fire you or otherwise discriminate against you in any way to prevent you from obtaining a welfare benefit or exercising your rights under ERISA.

Enforce Your Rights

If your claim for a benefit is denied or ignored, in whole or in part, you have a right to know why this occurred, to obtain copies of documents related to the decision at no charge, and to appeal any denial, all within specific timeframes.
Under ERISA, there are steps you can take to enforce the above rights:

- **Request Documents**
  If you request a copy of the plan documents or the latest annual report from the Plan and do not receive them within 30 days, you may file suit in a federal court. In such a case, the court may require the Plan Administrator to provide the materials and pay you up to $110 a day until you receive them, unless the delay was beyond the administrator's control.
- **File Suit**
  If your claim for benefits is denied or ignored in whole or in part, you may file suit in a state or federal court. Similarly, if you disagree with the Plan's decision or lack thereof concerning the qualified status of a domestic relations order or a medical child support order, you may file suit in a federal court.
- **Address Misconduct or Discrimination**
  If plan fiduciaries misuse the plan's funds, or if you are discriminated against for asserting your rights, you may seek assistance from the U.S. Department of Labor or file suit in a federal court.

The court will decide who should pay costs and fees. If you are successful, the court may order the person you sued to pay these costs and fees. If you lose, the court may order you to pay these costs or fees if it determines your claim is frivolous.

This document applies to participants in the LIFEX Group Health Plan.
For questions or more details, contact BHPI Member Services.
These exclusions may evolve based on amendments or updates to this SPD. For additional details, contact Member Services.
Required Notices

COBRA – Continuing Health Care Coverage on Your Own

When you are no longer eligible for health care coverage through the LifeX Research Corporation, coverage for you and your covered dependents ends. However, you may continue your coverage under the following option.

You may continue **temporary** coverage through your employer. This is called **COBRA Continuation Coverage**. This extension applies to the employee, spouse and eligible dependent children, including children born or adopted after you become eligible for COBRA if they are enrolled within thirty (30) days of their birth, adoption or placement for adoption. The person who lost the group coverage is called a "qualified beneficiary." To maintain coverage for the entire eligibility period, you (or your dependents) must pay the cost of coverage.

Note: If you do not return to employment after the expiration of a leave of absence due to the Family and Medical Leave Act of 1993 (FMLA), you are eligible to continue your existing health coverage after the last day of your FMLA leave through COBRA.

COBRA Continuation Coverage

Generally, the LifeX Research Corporation will notify you and your covered dependents when you are eligible for this temporary extension of your health care coverage. However, there are times when you need to notify the LifeX Research Corporation.

- In the case of your death, **LifeX Research Corporation will notify** your dependents about their eligibility.
- In case of divorce or a loss of dependent status, **you or your former spouse must notify LifeX Research Corporation** within sixty (60) days from the date coverage would otherwise be lost in order to be eligible for this coverage. To notify LifeX Research Corporation, call the LifeX Research Corporation Human Resource Department.

In every case, you (or your covered dependents) must notify LifeX Research Corporation Company of your decision to continue coverage through your employer **within sixty (60) days** of the later of:

(1) the date the notice was provided to you, or

(2) the date your coverage would otherwise end

The length of time this continuation coverage is available to you and/or your dependents depends on the reason you become eligible for this coverage. You or your dependents will be required to pay the entire applicable cost of coverage plus an administrative fee.

Employee Continuation Coverage

If you lose your coverage because of a layoff, reduction in your hours of employment or termination of your employment (for reasons other than gross misconduct), coverage is available to you and your eligible dependents for up to eighteen (18) months. You are responsible for paying the cost of

coverage. Certain other situations increase the number of months available to you or your dependents as follows:

Continuation coverage is extended to twenty-nine (29) months if:

- You or any qualified beneficiary are determined to be disabled by the Social Security Administration at the time coverage is terminated
- You or any qualified beneficiary are determined to be disabled by the Social Security Administration any time during the first sixty (60) days of COBRA coverage
- A child born, adopted or placed for adoption is determined to be disabled within the first sixty (60) days of such birth, adoption or placement for adoption

Dependent Continuation Coverage

Your covered dependents have the right to continue their coverage for up to thirty-six (36) months when they are no longer eligible under your plan because:

- Your plan under which they were covered is canceled due to your death
- You become entitled to Medicare, and your spouse or dependents lose group coverage as a result
- Divorce or legal separation causes a spouse to lose coverage (the date of legal separation and/or divorce, whichever occurs first, is the COBRA change in status event)
- Children no longer meet dependent eligibility requirements under your plan

Level of Coverage

You and your eligible dependents are entitled to continue your coverage under the above plans as the plans existed immediately before a change of status event. The coverage being continued will be the same as the coverage provided to similarly situated individuals to whom a change of status event has not occurred. If the benefits provided under this Plan to similarly situated active employees are changed or eliminated, the employee or eligible dependent whose participation has been extended may participate under any plans as changed or as replaced.

You may continue the COBRA coverage you select until the earliest of the following situations:

- The end of the continuation period that applies to you
- The date your employer no longer provides coverage to any of its similarly situated employees
- The date you do not make payment for COBRA coverage when due
- The date you or your dependents first become covered under another group health care plan (unless that plan includes exclusions or limitations about pre-existing conditions that apply to you)
- The date you or your dependents first become entitled to Medicare
- For individuals during the disability extension, thirty (30) days after the date on which the individual permitting the extension is no longer considered disabled
- The date you or your dependents submit a fraudulent claim

Electing COBRA Coverage

You and/or your covered dependents must elect COBRA continuation coverage within sixty (60) days of the later of:

- The date coverage would otherwise end; or
- The date the notice about continuation election option is received

Failure to inform LifeX Research Corporation of the election **within sixty (60) days** will cause the continuation coverage right to be forfeited (lost). To notify LifeX Research Corporation, call the LifeX Research Corporation Human Resource Department.

An employee or eligible dependent who, during the election period, waives extended participation can revoke the waiver at any time before the end of the election period. However, benefits will be provided retroactively to the date the waiver is revoked.

Unless otherwise specified, your (or your spouse's) election to continue coverage will be considered an election on behalf of all eligible dependents who lose their coverage due to the same change of status event.

An election on behalf of a minor child can be made by the child's parent or legal guardian. An election on behalf of an Employee or eligible dependent who is incapacitated or dies can be made by the legal representative, or the spouse, or the estate (as determined by applicable law) of such eligible individual.

Separate COBRA Elections for Dependents

If you do not elect continuation coverage for yourself, your eligible dependents may elect continuation coverage for themselves, provided they were covered at the time the change of status event occurred.

Cost of COBRA Continuation Coverage

You and/or your dependents will be required to pay the entire, unsubsidized cost plus an administrative fee for continuation coverage. Such cost is subject to change but in no event will it exceed one hundred two (102%) percent of the applicable premium for coverage. For disabled individuals entitled to a maximum of twenty-nine (29) months of extended participation, up to one hundred fifty (150%) percent of the applicable premium will be charged from months nineteen (19) through twenty-nine (29).

Information about current costs for continuation coverage will be provided when a change of status event occurs.

** The following notices are to provide you with information regarding your rights. Please review the information carefully and contact our office with any questions. **

<u>Privacy Notice</u>

THIS NOTICE DESCRIBES HOW MEDICAL INFORMATION ABOUT YOU MAY BE USED AND DISCLOSED, AND HOW YOU CAN GET ACCESS TO THIS INFORMATION. PLEASE REVIEW IT CAREFULLY.

Your Privacy Is Important To Us: Benefit Health Plan, Inc.(BHPI) is committed to protecting the information that we receive from you or about you, and in turn, respecting your privacy. To effectively administer the health care Plan that covers you, BHPI must collect and disclose Protected Health Information. This information is considered private and confidential. We have policies and procedures in place to protect the information against unlawful use and disclosure. This Privacy Notice will explain the type of information we collect; how we use that information; and how we protect that information. BHPI is operating under the conditions of this notice. If any of the elements change, you are entitled to a revised copy of this notice.

What Is "Protected Health Information"?

Protected Health Information includes your name, address, social security number, date of birth, marital status, dependent information, employment information, present or future, physical or mental health conditions, the provision of health care, or the past, present, or future for the provision of health care. This information is collected from applications and claim forms submitted by you and/or your health care provider. For example, whenever a doctor treats you, we will receive a bill from that doctor. The information with that bill may include identifying information about you such as your name, social security number, as well as your diagnosis, procedures, and supplies used. We will use the information on the claim form to pay your provider in accordance with the terms of your Benefits Plan.

Why Does BHPI Collect This Information?

We collect Protected Health Information to accurately identify you, process your claims, perform health care operations, and administer your employer's health plan.

How Is The Information Protected?

At BHPI, we restrict the access of the Protected Health Information only to those employees who need it in order to provide services to you. All information accessed by employees of BHPI, is used on a "minimum necessary" basis. We maintain physical, electronic and procedural safeguards to protect Protected Health Information against unauthorized access and uses. Access to our facilities and files is limited to authorized personnel. Electronic information that we receive and maintain is protected through the use of a variety of technical tools. BHPI has designated a Privacy Officer who has the responsibility for overseeing the implementation and enforcement of policies and procedures to safeguard Protected Health Information against inappropriate access, use, and disclosure, consistent with applicable law.

What Information We May Disclose:

We do not disclose any Protected Health Information to anyone, except with member authorization or as otherwise permitted by law. An authorization is required, from you, for the use or disclosure of psychotherapy notes, for marketing purposes, and for the sale of your Protected Health Information. You are also permitted to revoke authorization at any time. Disclosures by law typically include those described below. When it is necessary for a person's care or treatment, payment of your medical bills, or the operation of the Health Plan or related activities, the Protected Health Information may be used internally, shared with our affiliates, or disclosed to other health care providers, insurers, payers, the Plan Sponsor, and others who may be financially responsible for payment of services or benefits under the Plan. Protected Health Information may

also be disclosed when performing basic Health Care Operations functions necessary to operate a group health plan. Examples of uses and disclosures include conducting plan performance assessments; network or vendor performance assessments; review of the cost impact of benefits design changes; disclosure to underwriters for marketing and underwriting of the plan to obtain reinsurance quotes (genetic information will not be included in the disclosed information); disclosure to stop-loss or reinsurance carriers to obtain claim reimbursements for the Plan; and disclosure to plan consultants who provide legal, actuarial and auditing services to the Plan. These parties are required to keep Protected Health Information confidential as provided by applicable law.

Other Disclosures: If you would like us to disclose your Protected Health Information to yourself or another party, please contact the Privacy officer at BHPI and request an authorization form. If you would like to access your medical records, you should contact the provider that generated the original records, which are more complete than any we may maintain.

Providers are required to give members access to their medical records. If you think that the information in your medical records is wrong or incomplete, contact the provider that was responsible for the service or treatment in question. Where required by law, or if we are the source of the error, we will contact or amend the records we maintain (but not the records maintained by your provider or other third parties).

<u>HIPAA Privacy Rule: The HIPAA Privacy Rule affords you the following rights:</u>

The right to request restrictions on certain uses and disclosures of protected health information as provided by §164.522 (a) of the Privacy Rule; however, the Group Health Care Plan is not required to agree to your restriction.

- The right to receive confidential communication of your Protected Health Information.
- The right to inspect and copy your Protected Health Information.
- The right to request an amendment of your Protected Health Information
- The right to receive an accounting of all non-standard disclosures of your Protected Information
- Right to be notified of breaches of unsecured electronic Protected Health Information
- Right to opt out of fundraising communications, if applicable. If you have any questions or would like additional information, you may contact the Privacy Officer of BHPI at 866-815-6001

If you believe your privacy rights have been violated, you can file a complaint with the Privacy Officer or with the Secretary of Health and Human Services. There will be no retaliation for filing a complaint. BHPI's Privacy Practices are subject to updates as required by federal regulations.

THE WOMEN'S HEALTH AND CANCER RIGHTS ACT (WHCRA)

The Women's Health and Cancer Rights Act of 1998 ("WHCRA") provides certain protections for individuals receiving mastectomy-related benefits. Coverage will be provided in a manner determined in consultation with the attending physician and the patient for:

All stages of reconstruction of the breast on which the mastectomy was performed.

- Surgery and reconstruction of the other breast to produce a symmetrical appearance,
- Prostheses; and
- Treatment of physical complications of the mastectomy, including lymphedemas.

The amount of benefits payable for this coverage is subject to the current Plan provisions, and subject to applicable deductibles and coinsurance provisions under the current Plan.

If you would like more information on WHCRA benefits, please refer to your Summary Plan Description or contact your Plan Administrator.

THE NEWBORNS' AND MOTHERS' HEALTH PROTECTION ACT (NMHPA)

The Newborns' and Mothers' Health Protection Act (NMHPA) was signed into law on September 26, 1996. This law protects newborns and mothers by requiring that they be allowed to stay in a hospital for a certain length of time. Group healthcare plans generally may not, under federal law, restrict benefits for any hospital length of stay in connection with childbirth for the mother or newborn child to less than 48 hours following a vaginal delivery, or less than 96 hours following a cesarean section. However, federal law generally does not prohibit the mother's or newborn's attending provider, after consulting with the mother, from discharging the mother or her newborn earlier than 48 hours (or 96 hours as applicable). In any case, Plans and issuers may not, under federal law, require that a provider obtain authorization from the Plan or the issuer for prescribing a length of stay not in excess of 48 hours (or 96 hours)

MENTAL HEALTH PARITY & ADDICTION EQUITY ACT (MHPAEA)

The Mental Health Parity and Addiction Equity Act of 2008 (MHPAEA) requires parity with respect to how annual and lifetime benefits are applied to mental health and substance abuse benefits. In general, the MHPAEA bars Group Healthcare Plans, insurance companies and HMOs offering mental and substance abuse benefits from setting annual or lifetime dollar limits on mental health benefits.

NOTICE OF EXTENDED COVERAGE TO PARTICIPANTS COVERED UNDER A GROUP HEALTH PLAN (MICHELLE'S LAW)

Federal legislation known as "Michelle's Law" generally extends eligibility for group health benefit plan coverage to a dependent child who is enrolled in an institution of higher education at the beginning of a medically necessary leave of absence if the leave normally would cause the dependent child to lose eligibility for coverage under the plan due to loss of student status. The extension of eligibility protects eligibility of a sick or injured dependent child for up to one year.

There are two definitions that are important for purposes of determining whether the Michelle's Law extension of eligibility applies to a particular child:

1. Dependent child means a child of a plan participant who is eligible under the terms of a group health benefit plan based on his or her student status and who was

enrolled at a post-secondary educational institution immediately before the first day of a medically necessary leave of absence.

2. Medically necessary leave of absence means a leave of absence or any other change in enrollment:

of a dependent child from a post-secondary educational institution that begins while the child is suffering from a serious illness or injury which is medically necessary, and which causes the dependent child to lose student status under the terms of the Plan

For the Michelle's Law extension of eligibility to apply, a dependent child's treating physician must provide written certification of medical necessity (i.e., certification that the dependent child suffers from a serious illness or injury that necessitates the leave of absence or other enrollment change that would otherwise cause loss of eligibility).

If a dependent child qualifies for the Michelle's Law extension of eligibility, the Plan will treat the dependent child as eligible for coverage until the earlier of:

- One year after the first day of the leave of absence
- The date that Plan coverage would otherwise terminate (for reasons other than failure to be a full-time student)

A dependent child on a medically necessary leave of absence is entitled to receive the same Plan benefits as other dependent children covered under the Plan. Further, any change to Plan coverage that occurs during Michelle's Law extension of eligibility will apply to the dependent child to the same extent as it applies to other dependent children covered under the Plan.

Medicaid and the Children's Health Insurance Program (CHIP) Offer
Free or Low-Cost Health Coverage to Children and Families

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

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

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

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

If you live in one of the following states, you may be eligible for assistance paying your employer health plan premiums. The following list of states is current as of January 5, 2022. Contact your State for more information on eligibility.

ALABAMA – Medicaid	ALASKA – Medicaid
Website: http://myalhipp.com/ P phone: 1-855-692-5447	The AK Health Insurance Premium Payment Program Website: http://myakhipp.com/ Phone: 1-866-251-4861 Email: CustomerService@MyAKHIPP.com Medicaid Eligibility: http://dhss.alaska.gov/dpa/Pages/medicaid/default.asp
ARKANSAS – Medicaid	CALIFORNIA - Medicaid
Website: http://myarhipp.com/ Phone: 1-855-MyARHIPP (855-692-7447)	Websites: Health Insurance Premium Payment (HIPP) Program http: dhcs.ca.gov/hipp Phone: 916-445-8322 Email: hipp@dhcs.ca.gov
COLORADO – Health First Colorado (Colorado's Medicaid Program) & Child Health Plan Plus (CHP+)	FLORIDA – Medicaid
Health First Colorado Website: https://www.healthfirstcolorado.com/ Health First Colorado Member Contact Center: 1-800-221-3943/ State Relay 711 CHP+: https:www.colorado.gov/pacific/hcpf/child-health-planplus CHP+ Customer Service: 1-800-359-1991/ State Relay 711	Website: https//www,flmedicaidtplrecovery.com/flmedicaidtplrecovery.com/hippindex.html Phone: 1-877-357-3268
GEORGIA – Medicaid	INDIANA – Medicaid
Website: https://medicaid.georgia.gov/health-insurancepremium- payment-program-hipp Phone: 678-564-1162 ext. 2131	Healthy Indiana Plan for low-income adults 19-64 Website: http://www.in.gov/fssa/hip/ Phone: 1-877-438-4479 All other Medicaid Website: http://www.indianamedicaid.com Phone 1-800-403-0864
IOWA – Medicaid & CHIP (Hawki)	KANSAS – Medicaid
Medicaid Website: https//dhs.iowa.gov/ime/members Medicaid Phone: 800-338-8366 Hawki Website: http://dhs.iowa.gov/Hawki Hawki Phone: 800-257-8563	Website: http://www.kancare.ks.gov Phone: 1-800-792-4884

HIPP Website: https//dhs.iowa.gov/ime/members/ Medicaid-a-to-z/hipp HIPP: 1-888-346-9562	
KENTUCKY – Medicaid	LOUISIANA – Medicaid
Kentucky Integrated Health Insurance Premium Payment Program (KI-HIPP) Website: https://chfs.ky.gov/agencies/dms/member/Pages/kihipp.aspx Phone: 1-855-459-6328 Email: KIHIPP.PROGRAM@ky.gov KCHIP Website: https://kidshealth.ky.gov/Pages/index.aspx Phone: 1-877-524-4718 Kentucky Medicaid Website: https//chfs.ky.gov	Website: www.medicaid.la.gov or www.ldh.la.gov/lahipp Phone: 1-888-695-2447
MAINE – Medicaid	MASSACHUSETTS – Medicaid and CHIP
Website: http://www.maine.gov/dhhs/ofi/publicassistance/index.html Phone: 1-800-442-6003 TTY: Maine relay 711 Private Health Insurance Premium Webpage: https//www.maine.gov. dhhs/ofi/applications-forms	Website: https//www.mass.gov/info-details/masshealth- premium- assistance-pa Phone: 1-800-862-4840
MINNESOTA – Medicaid	MISSOURI – Medicaid
Website: https//mn.gov/dhs/people-we-serve/children-and-servic- es/ other-insurance.jsp Phone: 1-800-657-3739	Website: https://www.dss.mo.gov/mhd/participants/pages/hipp.htm Phone: 573-751-2005
MONTANA – Medicaid	NEBRASKA – Medicaid
Website: http://dphhs.mt.gov/MontanaHealthcarePrograms/HIPP Phone: 1-800-694-3084	Website: http://www.ACCESSNebraska.ne.gov Phone: (855) 632-7633 Lincoln: (402) 473-7000 Omaha: (402) 595-1178
NEVADA – Medicaid	NEW HAMPSHIRE – Medicaid
Medicaid Website: https://dhcfp.nv.gov Medicaid Phone: 1-800-992-0900	Website: https://www.dhhs.nh.gov/oii/hipp.htm Phone: 603-271-5218 Toll free number for the HIPP Program: 800-852-3345 ext. 5218
NEW JERSEY Medicaid & CHIP	NEW YORK – Medicaid
Medicaid Website: http://www.state.nj.us/humanservices/dmahs/clients/Medicaid/ Medicaid Phone: 609-631-2392 CHIP Website: http:www.njfamilycare.org/index.html CHIP Phone: 1-800-701-0710	Website: https://www.health.ny.gov/health_care/medicaid/ Phone: 1-800-541-2831
NORTH CAROLINA – Medicaid	NORTH DAKOTA – Medicaid
Website: https://dma.ncdhhs.gov/ Phone: 919-855-4100	Website: http://www.nd.gov/dhs/services/medicalserv/medicaid/

	Phone: 1-844-854-4825
OKLAHOMA – Medicaid and CHIP	OREGON – Medicaid
Website: http://www.insureoklahoma.org Phone: 1-888-365-3742	Website: http/healthcare.oregon.gov/Pages/index.aspx http://www. oregonhealthcare.gov/index-es.html Phone: 1-800-699-9075
PENNSYLVANIA – Medicaid	RHODE ISLAND – Medicaid
Website: https://www.dhs.pa.gov/Services/Assistance/Pages/ HIPP- Program.aspx Phone: 1-800-692-7462	Website: http://www.eohhs.ri.gov/ Phone: 855-697-4347 or 401-462-0311 (Direct Rite Share Line)
SOUTH CAROLINA – Medicaid	SOUTH DAKOTA – Medicaid
Website: https://www.scdhhs.gov Phone: 1-888-549-0820	Website: http://dss.sd.gov Phone: 1-888-828-0059
TEXAS – Medicaid	UTAH – Medicaid and CHIP
Website: http://gethipptexas.com/ Phone: 1-800-440-0493	Medicaid Website: https://medicaid.utah.gov/ CHIP Website: http://health.utah.gov/chip Phone: 1-877-543-7669
VERMONT– Medicaid	VIRGINIA – Medicaid and CHIP
Website: http://www.greenmountaincare.org/ Phone: 1-800-250-8427	Medicaid Website: http.coverva.org/hipp/ Medicaid Phone: 1-800-432-5924 CHIP Phone: 1-855-242-8282
WASHINGTON – Medicaid	WEST VIRGINIA – Medicaid
Website: http://www.hca.wa.gov/ Phone: 1-800-562-3022	Website: http://mywvhipp.com/ Toll-free phone: 1-855-MyWVHIPP (1-855-699-8447)
WISCONSIN – Medicaid and CHIP	WYOMING – Medicaid
Website: https://www.dhs.wisconsin.gov/publications/p1/p10095.pdf Phone: 1-800-362-3002	Website: https://wyequalitycare.acs-inc.com/ Phone: 307-777-7531

If you have an emergency medical condition and get emergency services from an out-of-network provider or facility, the most the provider or facility may bill you is your plan's in-network cost-sharing amount (such as copayments and coinsurance). You can't be balance billed for these emergency services. This includes services you may get after you're in stable condition, unless you give written consent and give up your protections not to be balanced billed for these post-stabilization services.

For additional information regarding balance billing regulations please contact our office at 844-580-2474

Certain services at an in-network hospital or ambulatory surgical center

When you get services from an in-network hospital or ambulatory surgical center, certain providers there may be out-of-network. In these cases, the most those providers may bill you is your plan's in-network cost-sharing amount. This applies to emergency medicine, anesthesia, pathology, radiology, laboratory, neonatology, assistant surgeon, hospitalist, or intensivist services. These 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 these in-network facilities, out-of-network providers can't balance bill you, unless you give written consent and give up your protections.

You're never required to give up your protections from balance billing. You also aren't required to get care out-of-network. You can choose a provider or facility in your plan's network.

For additional information regarding balance billing regulations please contact our office at 844-580-2474

When balance billing isn't allowed, you also have the following protections:

- You are only responsible for paying your share of the cost (like the copayments, coinsurance, and deductibles that you would pay if the provider or facility was in-network). Your health plan will pay out-of-network providers and facilities directly.
- Your health plan generally must:
    - Cover emergency services without requiring you to get approval for services in advance (prior authorization).
    - Cover emergency services by out-of-network providers.
    - Base what you owe the provider or facility (cost-sharing) on what it would pay an in-network provider or facility and show that amount in your explanation of benefits.
    - Count any amount you pay for emergency services or out-of-network services toward your deductible and out- of- pocket limit.

If you believe you've been wrongly billed, you may contact our office at 844-580-2474.

Visit https://www.dol.gov/agencies/ebsa/laws-and-regulations/laws/no-surprises-act for more information about your rights under federal law.

Benefit Plan Customer Service Directory

Claim Administration, Benefit and Eligibility Verification, Pre-certification/Utilization Review/Case Management

Benefit Health Plan, Inc.
PO BOX 1043
Matthews, NC 28106
www.benefithealthplan.com
customersupport@benefithealthplan.com
Phone: 844-580-2474
Fax: 844-580-2474

Prescription Drug Vendor
ProAct
Phone: 877-635-9545
www.proactrx.com

Medical PPO Networks (members must choose ONE only)

PHCS
PO BOX 3012
Milwaukee, WI 53201
www.multiplan.com

CIGNA
PO BOX 188061
Chattanooga, TN 37422
www.mycigna.com

ANTHEM

LifeX Research Corporation
730 Peachtree St. NE, #570
Atlanta, GA 30308
Phone: 470-485-0146
www.lifexresearch.com

Additional Information as required by ERISA

General Plan Information

Plan Name

LifeX Research Corporation Welfare Benefit Plan

Plan Sponsor

LifeX Research Corporation

730 Peachtree St. NE, #570
Atlanta, GA 30308
Phone: 470-485-0146
www.lifexresearch.com

Employer Identification Number

LifeX Research Corporation Employer Identification Number: 33-2093762

Plan Number

LifeX Research Corporation Welfare Benefit Plan: 501

Type of Plan Included

Self-funded welfare benefit plan

Type of Funding

Employee and Employer Contributions

Claims Administrators for Initial Benefit Determination

Benefit Health Plan, Inc.
PO BOX 1043
Matthews, NC 28106
www.benefithealthplan.com
customersupport@benefithealthplan.com

Phone: 844-580-2474
Fax: 844-580-2474

Plan Administrator's Name, Address, and Telephone Number

LifeX Research Corporation

730 Peachtree St. NE, #570
Atlanta, GA 30308
Phone: 470-485-0146
www.lifexresearch.com

Agent for Service of Legal Process

LifeX Research Corporation at the above address

Plan Fiscal Year (ending date)

Welfare Benefit Plan: December 31st (plan year)

LifeX Research Corporation
Welfare Benefit Plan

BY THIS AGREEMENT, the LifeX Research Corporation Welfare Benefit Plan is hereby adopted as shown.

IN WITNESS WHEREOF, this instrument is executed for the LifeX Research Corporation Welfare Benefit Plan as of January 1, 2025.

_____
Company Authorization (signature)

_____
Company Authorization (print)

_____
Attest

_____
Date