PIEDMONT
COMMUNITY HEALTHCARE HMO, INC.

Claims Payment Information

Piedmont's HMO Plans
This plan is a Health Maintenance Organization (HMO) plan. Referrals are never needed to visit an In-Network Specialist Physician, including behavioral health Providers. This Benefit plan is a Network product that allows the Covered Person to receive Services from In-Network Providers. A Covered Person who receives Covered Services from Providers other than In-Network Providers (Out-of-Network Providers) may result in the Benefits not being Covered Services.

A. Out-of-Network Liability and Balance Billing: CMS Description of Item -

Balance billing occurs when an Out-of-Network provider bills an enrollee for charges – other than copayments, coinsurance, or any amounts that may remain on a deductible.

Piedmont Response:
An office visit to an In-Network Physician does not require a prior authorization or notification to Us. An In-Network Physician may perform the following procedures or diagnostic exams in his/her office without a prior authorization from Us:

1. Standard laboratory services referred to an In-Network Provider or in the Physician's office.
2. X-rays.
3. Prescriptions for most medications.
4. Minor surgical procedures.
5. Routine supplies used in conjunction with the Physician's Services. Examples are antiseptics, test supplies, gloves, and ace bandages.

If the In-Network Physician feels that the Covered Person needs to see a Physician or other medical professional who is an Out-of-Network Provider, then the Physician must submit medical information, in writing, to Us. Retroactive requests for consideration at the In-Network Benefit level will not be considered. Covered Services from Out-of-Network Providers must be preauthorized by Us to receive In-Network Benefits. We have the right to determine where the Service can be provided for coverage when an In-Network Provider cannot provide the Covered Service.

There are no benefits provided for Out-of-Plan or Out-of-Network services, except in cases of Emergency services or in cases where We have issued a preauthorized referral. This means that members who go to an Out-of-Network provider, without having a Piedmont preauthorized

referral or being an Emergency situation, will have to pay all charges out of pocket for the services they receive.

Piedmont's payment for Covered Services is based on an Allowable Charge. An Allowable Charge is the amount determined by Us as payable for a Covered Service or the Provider's actual charge for that Service, whichever is less. We will never pay more than the Allowable Charge for any Covered Service. You will only have to pay Your Copayment, Deductible, and/or Coinsurance and will not be Balance Billed by In-Network Providers for amounts above the Allowable Charge.

We do not anticipate a need for You to utilize Providers other than In-Network Providers except in Emergencies and Urgent Care situations, unless the Covered Person is preauthorized to receive the service. In the event a Covered Person receives Covered Services from an Out-of-Network Provider that have been preauthorized, We reserve the right to pay the Allowable Charge, less amounts You must pay under this Policy, for these Covered Services:

- directly to the Covered Person;
- the Out-of-Network Provider; or
- any other person responsible for paying the Out-of-Network Provider's charge. This is subject to applicable Providers that require direct payment (e.g. dentists and oral surgeons who submit valid assignments of Benefits). You are responsible for any difference between the billed amount by the Out-of-Network Provider and Our payment to either You or the Provider, otherwise known as Balance Billing. It is Your responsibility to apply any payment You receive directly from Us to the Out-of-Network Provider's claim.

The Deductible and Coinsurance for Emergency Services received from an Out-of-Network Provider are the same as the Deductible and Coinsurance for Emergency Services received from an In-Network Provider. Additionally, the Maximum Out-of-Pocket amount for In-Network Covered Benefits will apply to any Emergency Services received from an Out-of-Network Provider. Medically Necessary Emergency Services will be covered whether You get care from an In-Network or Out-of-Network Provider. Emergency care You get from an Out-of-Network Provider will be covered as an In-Network service.

Certain services, such as Emergencies, or receiving nonemergency surgical or ancillary services provided by an Out-of-Network Provider at an In-Network Facility, are exempt from Balance Billing.

B. Enrollee Claims Submission: CMS Description of Item - An enrollee, instead of the provider, submits a claim to the issuer, requesting payment for services that have been received.

Piedmont Response:
Piedmont In-Network providers file claims for members after they receive services. If You receive pre-authorized services from an Out-of-Network Provider, You may be responsible for

all claims filing and prior authorization if this Provider does not agree to do so on Your behalf. In addition, you may be balance billed by Out-of-Network Providers. Piedmont's Medical Claim Form is available at https://pchp.net/index.php/member-forms-marketplace.html. The completed Claim Form can be submitted to P.O. Box 21406, Eagan, MN 55121. Written notice of a claim can be given to Us at 2316 Atherholt Road, Lynchburg, VA 24501, or to Piedmont's agent. Notice should include the name of the Subscriber, and Claimant if other than the Subscriber, the Subscriber's member number, the name and address of the Provider, the date of the services, the diagnosis and type of services received, and the charge for each type of service. If You have questions, You can call Piedmont's Customer Service at 434-947-4463 or 800-400-7247.

When We receives a notice of claim, it will send the Subscriber forms for filing proof of loss. If these forms are not given to the Subscriber within 15 days after the giving of such notice, then the Subscriber shall meet the proof of loss requirements by giving Us a written statement of the nature and extent of the loss within the time limit stated in the Proofs of Loss Section.

If the Policy provides for periodic payment for a continuing loss, written proof of loss must be given to Us within 90 days after the end of each period for which We are liable. For any other loss, written proof must be given within 90 days after such loss. If it was not reasonably possible to give written proof in the time required, We will not reduce or deny the claim for this reason if the proof is filed as soon as reasonably possible. In any event, except in the absence of legal capacity, the proof required must be given no later than one year from the time specified. You should follow this procedure when Out-of-Network Providers render services.

Any prescription drug claim submitted by a Covered Person must be submitted on a Piedmont claim form, with receipts and a written explanation attached within 60 days of the date the prescription was filled to be covered. The Prescription Reimbursement Claim Form is available at https://pchp.net/index.php/member-forms-marketplace.html and the completed form can be mailed to CVS/Caremark, P.O. Box 52136 Phoenix, Arizona 85072-2136.

C. Grace Periods and Claims Pending Policies During the Grace Period:

CMS Description of Item - A QHP issuer must provide a grace period of three consecutive months if an enrollee receiving advance payments of the premium tax credit has previously paid at least one full month's premium during the benefit year. During the grace period, the QHP issuer must provide an explanation of the three consecutive month grace period for enrollees with premium tax credits pursuant to 45 CFR 156.270(d).

Piedmont Response:
Only Subscribers and eligible Dependents for whom Piedmont has received the required Premiums shall be entitled to Covered Services. Except as otherwise provided in this paragraph, the Subscriber must pay the required Premium for Coverage in full on or before the 1st day of each month preceding the next month's Coverage. There is one exception. A grace period will be granted for payment of every Premium except the first Premium. The grace period is an additional period of time during which Coverage remains in effect and refers to either the 31-day

grace period for individuals not receiving advance payments of the Advance Premium Tax Credit (APTC), or the three consecutive month grace period required for individuals receiving APTC. Coverage will remain in force during the grace period, unless You provide Us with notice of Your wish to discontinue Coverage in advance of the date of discontinuance.

Grace period for recipients of Advance Premium Tax Credit.
We provide a grace period of three consecutive months for an enrollee, who when failing to timely pay premiums, is receiving APTC. During the grace period, We will:

(1) Pay all appropriate claims for services rendered to the enrollee during the first month of the three consecutive month grace period and may pend claims for services rendered to the enrollee in the second and third months of the three consecutive month grace period. Pend claims is a hold status for the claim. Claims incurred in the second and third months of the three consecutive month grace period, will not be paid until full payment of all Premiums due are received by Us on or before the last day of the three consecutive month grace period.
Also, any drugs filled during the second and third months of the grace period will process at 100% patient responsibility. You may file a paper claim to be reimbursed for the drug cost once the outstanding premium balance has been paid and Your grace period has been reset.

(2) Notify providers of the possibility for denied claims when an enrollee is in the second and third months of the 3-consecutive month grace period.

If the Subscriber does receive APTC, a grace period of three consecutive months is allowed for individuals who have previously paid at least one month's Premium in a Benefit year. During the grace period, We must apply any payment received to the first billing cycle in which payment was delinquent and continue to collect the APTC. If the required Premium payments due are not paid on or before the end of the three consecutive month grace period, the policy will be terminated, and the last day of Coverage will be the last day of the first month of the three consecutive month grace period. Piedmont must pay claims incurred during the first month of the three consecutive month grace period. You will be responsible for any claims incurred after the first month of the three consecutive month grace period, if all payments due are not paid on or before the last day of the three consecutive month grace period. You will be liable to Us for the Premium payment due, including for the grace period, or for the payment of a pro rata premium for the time the policy was in force during any part of the grace period.

Grace period for recipients not receiving advance payments of the premium tax credit.
If the Subscriber does not receive APTC, the grace period will begin on the Premium due date and continue for 31 days, unless You provide Us with notice of Your wish to discontinue Coverage in advance of the date of discontinuance. If You do not make the full payment of any Premium due during the grace period, the Policy will be terminated, and the last day of coverage will be the last day of the Grace Period. You will be liable to Piedmont for the Premium payment due, including for the grace period, or for the payment of a pro rata premium for the time the policy was in force during any part of the grace period.

D. Retroactive Denials: CMS Description of Item - A retroactive denial is the reversal of a previously paid claim, through which the enrollee then becomes responsible for payment.

Piedmont Response:
We may deny a claim after the member has received services from a provider. This could happen in cases of loss of coverage due to non-payment of premium or loss of eligibility of coverage. It could also occur if We perform a retrospective review of medical records or services to determine Medical Necessity.

Members should try to prevent retroactive denials of claims by always paying their premiums on time and notifying the Marketplace of any change in circumstances. The member should also become familiar with Piedmont's prior authorization procedures and covered services to prevent retroactive denials.

E. Enrollee Recoupment of Overpayments: CMS Description of Item - Enrollee recoupment of overpayments is the refund of a premium overpayment by the enrollee due to the over-billing by the issuer.

Piedmont Response:
Premium(s) shall mean the monthly payment due from the Subscriber to Us as specified in the Policy and related documents as a requirement for Subscriber and applicable Dependent(s) to receive coverage. Members should contact Us if they think that they have paid more premium than what they believe is due and therefore ask Us for a refund. If an overpayment is verified by Our billing team, Piedmont will issue the necessary refund payable to the Subscriber of the policy.

F. Medical Necessity and Prior Authorization Timeframes and Enrollee Responsibilities

CMS Description of Item –

1. Medical necessity is used to describe care that is reasonable, necessary, and appropriate, based on evidence-based clinical standards of care.
2. Prior authorization is a process through which an issuer approves a request to access a covered benefit before the insured accesses the benefit.

Piedmont Response:
Medically Necessary services or Medical Necessity refers to those Covered Services that We determines are: (1) consistent with the diagnosis and treatment of the Covered Person's condition; (2) are appropriate given the circumstances and the symptoms; (3) are provided to treat the condition, illness, disease or injury; (4) are in accordance with standards of good medical practice; (5) are not primarily for the convenience of the Covered Person or the

Provider; and (6) with respect to Inpatient care, are provided to treat a condition requiring acute care as a bed patient. We will determine the Medical Necessity of a given service or procedure.

It is the member's responsibility to obtain prior authorization before treatment is received for services that require it. We require Providers (or a Covered Person acting on their own behalf) to make prior authorization arrangements. If you don't get prior authorization, you may have to pay up to the full amount of the charges. The number to call for prior authorization is included on the ID card you receive after you enroll. Prior authorization is not required for Emergencies or Urgent Care situations.

Certain Covered Services will require prior authorization by Us, except in an Emergency or Urgent Care situations(see below). The In-Network Physician will work with You or the Covered Person and Us to handle these prior authorization requirements. Examples of these Services include, but are not limited to, the following:

1. Referrals for Covered Services to all Providers who are Out-of-Network Providers to obtain In-Network Benefits. Failure to obtain the prior authorization will result in the Benefits not being Covered Services;
2. Transplant services;
3. Clinical trials;
4. Durable medical equipment (DME) requires prior authorization depending on the type of equipment or supply (based on CPT code). Repair and replacement of DME follows the same guidelines;
5. Certain medications, including but not limited to:
    - Chemotherapy;
    - Infusion therapy, including ambulatory infusion center setting;
    - Injections;
6. Inpatient Hospital (except for routine vaginal/C-section deliveries at In-Network Hospitals);
7. Partial Hospitalization;
8. Acute rehabilitation;
9. Skilled nursing facility;
10. Long-term acute care Hospital;
11. Inpatient detox, residential treatment, partial hospital and intensive outpatient for substance abuse;
12. Select imaging and advanced imaging services;
13. Certain outpatient surgeries, including those performed in the Outpatient Hospital or ambulatory surgery center setting and oral surgery;
14. Experimental and investigational services;
15. Gender affirmation procedures;
16. Radiation therapy; and
17. Select pain management procedures.

You or Your Provider must submit documentation, including a treatment plan when requested, for Covered Services requiring prior authorization. We will establish that the appropriate criteria have been met and, if so, provide an authorization to the Provider from whom the Covered Person plans to receive Covered Services.

Prior authorization is certification by Piedmont of Medical Necessity and not a guarantee of payment. For Benefits to be Covered Services, on the date You get service:

1. You must be eligible for Benefits;
2. Premium must be paid for the time period that services are given;
3. The service or supply must be a Covered Service under Your Policy;
4. The service cannot be subject to an exclusion under Your Policy; and
5. The Covered Person must not have exceeded any applicable limits under Your Policy.

A Covered Person is not required to receive a referral or prior authorization from their Primary Care Physician or Us before receiving obstetrical or gynecological care from an In-Network Provider specializing in obstetrics or gynecological care, which includes ordering related obstetrical and gynecological items and services that are Covered Benefits.

Piedmont does not require prior authorization for the interhospital transfer of: (1) a newborn infant experiencing a life-threatening emergency condition, or (2) the hospitalized mother of such newborn infant to accompany the infant.

When the Covered Person requires resuscitation, Emergency treatment, or his/her life is endangered, We do not require prior authorization before he/she calls: (1) an Emergency 911 system; or (2) other state, county or municipal Emergency medical system.

Emergency services provided to the Covered Person in the Emergency department of a Hospital or other skilled medical facility are Covered Benefits:

- Regardless of whether the Provider furnishing the Emergency Services is an In-Network Provider with respect to the services;
- Without the need for prior authorization by Piedmont, even if an Out-of-Network Provider provides the Emergency Services;
- Regardless of the final diagnosis rendered to the Covered Person; and
- If an Out-of-Network Provider provides the Emergency Services, without imposing any administrative requirement or limitation on coverage that is more restrictive than the requirements or limitations that apply to Emergency Services received from In-Network Providers.

If an In-Network Physician feels that the Covered Person needs to see a Physician or other medical professional who is an Out-of-Network Provider, then the Physician must submit medical information, in writing, to Us. Retroactive requests for consideration at the In-Network

Benefit level will not be considered. Covered Services from Out-of-Network Providers must be preauthorized by Us in order to receive In-Network Benefits. We have the right to determine where the Service can be provided for Coverage when a In-Network Provider cannot provide the Covered Service.

1. Post-Service and Pre-Service Claims Review:

We will review a:
- Post-service claim within 15 days after Piedmont receives it; and
- Pre-service claim within 15 days after Piedmont receives it.

A "post-service claim" is any claim under this Policy for a Benefit for which the Covered Person does not need approval before receiving the Benefit. Most claims under this Policy are post-service claims.

A "pre-service claim" is any claim under this Policy for a Benefit for which the Covered Person must receive approval (prior authorization) before receiving the Benefit.

We may extend the time to review a claim for an additional 15 days if We: (1) decide that an extension is necessary for reasons beyond Our control; (2) notify You of the reason for the extension in writing before the initial review period ends; and (3) tell You when We expect to make Our final decision. If the extension is because We did not receive necessary information, the extension notice will describe the needed information. You will have 45 days after You receive such an extension notice to provide the information. Our time to review a claim is "tolled" or stops between the date We send the extension notice and the date We receive the requested information.

2. Expedited Decisions for Urgent Care Claims or Requests:

Except as otherwise provided in this Section, We will review an Urgent Care Claim within 72 hours after receipt.

For the purposes this Section, an "Urgent Care Claim" is any claim or urgent request for medical care or treatment for a Benefit for which the application of post-service or pre-service time frames or Our normal prior authorization standards:

- could seriously jeopardize the patient's life, health, or ability to regain maximum function; or
- would, in the opinion of a Physician who is knowledgeable about the patient's medical condition, subject the patient to severe pain that cannot be adequately managed without the Benefit.

We will notify the claimant of a Benefit determination (approval or denial) with respect to an Urgent Care Claim as soon as possible, considering the medical needs, but not later than 72 hours after We receive the claim or request. If the claimant fails to provide enough information to determine whether, or to what extent, Benefits are Covered or payable under this Policy, We will notify the claimant within 24 hours of receipt of the claim or request that additional information is required to make a decision.

We will apply the standard of "a prudent layperson who possesses an average knowledge of health and medicine" when it determines whether Your claim is an Urgent Care Claim. However, if the Physician who is knowledgeable about Your medical condition advises Us that Your claim is an Urgent Care Claim, then We will treat it as such.

We may extend the time to review an Urgent Care Claim up to 48 hours if : (1) We do not receive information that We need to determine whether the claim is covered; and (2) We tell You what information We need to complete Our claims review. We will provide this notice within 24 hours after We receive the Urgent Care Claim. You will have 48 hours to provide the necessary information. For an Urgent Care Claim, We will notify You of Our decision no more than 48 hours after: (1) We receive the requested information; or (2) the extension period ends, whichever is earlier.

G. Drug Exceptions Timeframes and Enrollee Responsibilities:

CMS Description of Item – Issuers' exceptions processes allow enrollees to request and gain access to drugs not listed on the plan's formulary, pursuant to 45 CFR 156.122(c).

Piedmont Response:
We have a process in place for any Covered Person, a designated representative, the prescribing Physician or other prescriber to request and gain access to clinically appropriate drugs not otherwise covered on Our formulary. A Formulary Exception request may be submitted to allow a Covered Person to obtain coverage for a drug by phone or fax.

An Exceptions Request Form is available online at https://pchp.net/index.php/member-forms-marketplace.html. Forms may be faxed to CVS/Caremark at 1-855-245-2134. Exceptions requests may also be communicated by phone to CVS/Caremark at 1-855-582-2022. Please note that this exception process only applies to drugs not included on the formulary. If a Covered Person has been denied coverage for a drug included on the formulary, You have the right to a full and fair appeal of Our decision and should follow the appeal process described later in this Section.

We will act on a standard exception request within one (1) business day of receipt of the request. We will cover the prescription drug only if We agree that it is Medically Necessary and appropriate over the other drugs that are on the formulary. We will make a coverage determination and notify the appropriate requester within 72 hours following receipt of the request. If We approve the coverage of the drug, coverage of the drug will be provided for the

duration of the prescription, including refills. If We deny coverage of the drug, We have a process in place to allow the request to be reviewed by an independent review organization as described under "External Exception Request Review" in this section.

Any Covered Person, a designated representative, the prescribing Physician, or other prescriber may also submit a request for a Prescription Drug that is not on the formulary based on exigent circumstances. Exigent circumstances exist if he/she is suffering from a health condition that may seriously jeopardize life, health, or ability to regain maximum function, or if he/she is undergoing a current course of treatment using a drug not on the formulary. We will make a coverage decision within 24 hours of receipt of the request. If We approve the request, coverage of the drug will be provided for the duration of the exigency. If We deny the request, We have a process in place to allow the request to be reviewed by an independent review organization as described under "External Exception Request Review" in this Section.

External Exception Request Review - If We deny an appeal of a standard or expedited request, We have a process in place to allow the request to be reviewed by an independent review organization. Notification of a decision on an external exception request will be given to the applicable Covered Person, representative, or Physician no later than 72 hours following receipt of the request if the original request was a standard request. If the original request was an expedited request notification will be given no later than 24 hours following receipt of the request. If an external exception request is approved, We will provide coverage for the non-formulary drug for the duration of the prescription, and without additional cost-sharing beyond that provided for formulary Prescription Drugs in the Covered Benefits. For expedited exception requests coverage of the non-formulary drug will be provided for the duration of the need and without additional cost-sharing beyond that provided for formulary Prescription Drugs in the Covered Benefits.

There are two exceptions to the formulary requirement:

• Coverage may be obtained without additional cost-sharing beyond that which is required of formulary Prescription Drugs for a non-formulary drug if We determine, after consulting with the prescribing Physician, the formulary drugs are inappropriate therapy for the condition.

• Coverage may be obtained without additional cost-sharing beyond that which is required of formulary Prescription Drugs for a non-formulary drug if:

- the Covered Person has been taking or using the non-formulary Prescription Drug for at least six months prior to its exclusion from the formulary; and
- The prescribing Physician determines that either the formulary drugs are inappropriate therapy for the condition, or that changing drug therapy presents a significant health risk.

H. Information on Explanation of Benefits (EOBs): CMS Description of Item –

An EOB is a statement an issuer sends the enrollee to explain what medical treatments or services it paid for on an enrollee's behalf, the issuer's payment, and the enrollee's financial responsibility pursuant to the terms of the policy.

Piedmont Response:
We will send an Explanation of Benefits (EOB) document to the member after a claim from your provider is processed. The EOB is not a bill. It is a summary of how Your benefits are applied to a claim. The EOB will provide details on the following items concerning the health care service:

- Our contact information if the member has any questions;
- Claim detail showing the service provided, the provider, the dates of service, billed amounts, provider discounts, allowed amounts, non-covered amounts, other insurance amounts, benefit that is payable, the deductible applied, the copay applied, the coinsurance applied, the member portion due, and code descriptions;
- Accumulator descriptions including the amount, amount met, and amount remaining of Deductibles and Out-of-Pocket Maximums.

I. Coordination of Benefits (COB): CMS Description of Item – Coordination of benefits exists when an enrollee is covered by more than one plan and determines which plan pays first.

Piedmont Response:
Special Coordination of Benefits (COB) rules apply when You or members of Your family have additional Coverage through other health insurance Plans, including but not limited to:

- Group and individual health insurance plans, Health Maintenance Organization (HMO), and other prepaid coverage;
- Labor management trustee plans, union welfare plans, employer welfare plans, employer organization plans, or Employee Benefit organization plans; and
- Coverage under any tax-supported or government program to the extent permitted by law.

When the COB provision applies, the insurance carriers involved will coordinate the Benefits payable. The COB provision is meant to prevent duplicate payments for the same services.

If You have two insurance plans, one of the plans will be considered the primary plan and the other plan will be the secondary plan. The primary plan is the plan which will process claims for Benefits first (as though no other coverage exists), and the secondary Plan will coordinate its payment so as not to duplicate Benefits provided by the primary plan.

Coordination with Group Coverage

Coverage under this plan is always secondary to any group coverage.

Whenever the Benefits under any other plan are payable without regard to benefits payable under this plan, this plan is secondary. Services that are not eligible for Benefits under both plans will not be subject to Coordination of Benefits.

When this plan is secondary, the value of Covered Services will be based on Our Allowable

Charge to determine Our liability. When providing secondary coverage, the aggregate of benefits under both plans for the coordinated services will not exceed Our Allowable Charge for those coordinated services. If Benefits are provided in the form of services by the primary carrier, as with an HMO, the value of the coordinated services is based upon Our Allowable Charge for the service. We may coordinate the Benefits We would have paid so that the sum of Our Benefits and the value of the coordinated services reduced by any applicable Deductible, Copayment or Coinsurance of the primary carrier does not exceed Our Allowable Charge.

No limitations will be extended because of coordination of Benefits. All dollar amount and visit limits still apply, even when We are the secondary carrier. You may not elect to file Your claims only with Us in order to obtain primary Benefits when the other carrier would otherwise be the primary carrier.

Coordination with Plans other than Group Coverage

When a Covered Person is also enrolled in another non-group health plan, one coverage will be primary, and one will be secondary. The decision of which coverage will be primary or secondary is made using the order of Benefit determination rules listed below:

- If the other coverage does not have COB rules substantially similar to Piedmont's, the other coverage will be primary.
- If a Covered Person is enrolled as: (1) the named Subscriber under one coverage; and (2) a Dependent under another, then generally the one that covers him or her as the named Subscriber will be primary.
- If a Covered Person is the named Subscriber under both coverages, the one that covers him or her for the longer period of time will be primary.
- If the Covered Person is enrolled as a Dependent Child under both coverages (e.g. when both parents cover their Child), typically the coverage of the parent whose birthday falls earliest in the Benefit Year will be the primary.
- Special rules apply when a Covered Person is enrolled as a Dependent Child under two coverages and the Child's parents are separated or divorced. Generally, the coverage of the parent or stepparent with primary custody will be primary. However, if a court order requires one parent to provide for medical expenses for the Child, that parent's coverage will be primary. If a court order that states the parents share joint custody without designating that one of the parents is responsible for medical expenses, the coverage of the parent whose birthday falls earliest in the Benefit Year will be primary.

Coordination with Medicare

Any Benefits covered under both this plan and Medicare will be paid pursuant to Medicare Secondary Payor legislation, regulations, and Centers for Medicare and Medicaid Services

guidelines, subject to federal court decisions. Federal law controls whenever there is a conflict among state law, plan provisions, and federal law.

Except when federal law requires the plan to be the primary payor, the Benefits under this plan for any Covered Person do not duplicate any Benefit provided by Medicare. Where Medicare is the responsible payor, all sums payable by Medicare for services provided to any Covered Person will be reimbursed by or on behalf of the Covered Person to the plan, to the extent the plan has made payment for such services.