PIEDMONT
COMMUNITY HEALTHCARE HMO, INC.

Transparency in Coverage

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 Subscriber and Dependent(s) to receive Services from In-Network Providers. A Subscriber or Dependent who receives Covered Services from Providers other than In-Network Providers (Out-of-Network Providers) may result in a denial of benefits.

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 an authorization or notification to Piedmont. An In-Network Physician may perform the following procedures or diagnostic exams in his/her office without a preauthorization from Piedmont:

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 Your In-Network Physician feels that You need to see a Physician or other medical professional who is not an In-Network Provider, then Your Physician must submit medical information, in writing, to Piedmont. 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 Piedmont to receive In-Network Benefits. Piedmont has the right to determine where the Service can be provided for coverage when an In-Network Provider cannot render the 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 Piedmont has 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.

Balance Billing - Piedmont's payment for Covered Services is based on an Allowable Charge. When Services are received from an In-Network Provider who has agreed to Piedmont's negotiated rate, Subscribers are not responsible for the difference between the negotiated rate and the billed amount. This amount is "written off" by the an In-Network Provider. For Out-of-Network Covered Services, the Benefit payable is based on an Allowable Charge that Piedmont has determined to be applicable to Out-of-Network Providers. Balance billing is when the Out-of-Network Provider bills you for the amounts over and above Piedmont's Allowable Charge. You are responsible for the amounts above the Allowable Charge in addition to any Copayment, Deductible and/or Coinsurance amounts. Balance billed amounts do not count towards the Out-of-Pocket Limit maximum.

The Copayment amounts and Coinsurance percentages for Emergency services received from an Out-of-Network Provider are the same as the Copayment amounts and Coinsurance percentages for Emergency services received from an In-Network Provider. Medically Necessary 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, but you may have to pay the difference between the Out-of-Network Provider's charge and the maximum allowed amount, as well as any applicable Coinsurance, Copayment or Deductible. Allowable Charge means the amount determined by Piedmont as payable for a specified Covered Service or the Provider's actual charge for that Service, whichever is less. Piedmont will not pay more than its 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. When seeing an Out-of-Network Provider due to a Piedmont preauthorized referral or an Emergency, Subscribers are responsible for billed charges in excess of the Allowable Charge. Amounts above the Allowable Charge do not apply toward the maximum Out-of-Pocket Limit

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 preauthorization 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 Claim Form can be submitted to P.O. Box 14408, Cincinnati, OH 45250-0408.

Written notice of a claim can be given to Piedmont 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 Piedmont 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 Piedmont 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 Piedmont within 90 days after the end of each period for which Piedmont is 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, Piedmont shall 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.

Any claim submitted by a Subscriber or Dependent 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 under this Policy.

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, and then only for the period(s) for which such payment(s) is/are received. 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 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 Piedmont with notice of your wish to discontinue Coverage in advance of the date of discontinuance.

Grace period for recipients of advance payments of the premium tax credit.
Piedmont provides a grace period of three consecutive months for an enrollee, who when failing to timely pay premiums, is receiving advance payments of the premium tax credit. During the grace period, Piedmont 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 Piedmont on or before the last day of the three consecutive month grace period.

(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, Piedmont 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 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.

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 Piedmont 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:
Piedmont 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 Piedmont performs a retrospective review of medical records or services to determine Medical Necessity. A retrospective review could also include determining that a true emergency situation existed for Emergency Room or Urgent Care Center visits.

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 preauthorization procedures 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 Piedmont as specified in the Policy and related documents as a requirement for Subscriber and applicable Dependent(s) to receive coverage. Members should contact Piedmont if they think that they have paid more premium than what they believe is due and therefore ask Piedmont for a refund. If an overpayment is verified by Piedmont's 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/or 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 Piedmont determines are: (1) consistent with the diagnosis and treatment of the Subscriber'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 Subscriber or the Provider; and

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

It is the member's responsibility to obtain preauthorization before treatment is received for services that require it. Piedmont requires Providers (or Subscriber or Dependent acting on their own behalf) to make preauthorization arrangements during regular business hours. Piedmont's preauthorization is not required for Emergencies anytime or Urgent Care situations after hours.

Certain Covered Services will require preauthorization by Piedmont, except in an Emergency or Urgent Care situations after hours (see below). Your In-Network Physician will work with you and Piedmont to handle these preauthorization requirements. Examples of these Services include, but are not limited to, the following:

1. Referrals for Covered Services to all Providers who are not In-Network Providers to obtain In-Network Benefits. Failure to obtain the preauthorization will result in the Benefits not being Covered Services;
2. Transplant services;
3. Non-Emergent ambulance transport services;
4. Outpatient substance use disorder services/treatment;
5. Clinical trials;
6. Durable medical equipment (DME) requires preauthorization depending on the type of equipment or supply (based on CPT code). Repair and replacement of DME follows the same guidelines. Contact Piedmont Customer Service or view Piedmont's website for further information;
7. Certain medications, including but not limited to:
    - Botulinum toxin;
    - Chemotherapy;
    - Infusion therapy, including ambulatory infusion center setting;
    - Injections, including but not limited to intravitreal injections and viscosupplementation;
8. Inpatient Hospital (except for routine vaginal/C-section deliveries at In-Network Hospitals;
9. Partial Hospitalization;
10. Acute rehabilitation;
11. Skilled nursing facility;
12. Long-term acute care Hospital;
13. Substance abuse treatment;
14. Magnetic resonance imaging (MRI) (except breast MRI);
15. Magnetic resonance angiography (MRA);
16. Magnetic resonance cholangiopancreatography (MRCP);
17. Positron emission tomography (PET) scans;
18. Bone scans;

19. Certain outpatient surgeries, including those performed in the Outpatient Hospital or ambulatory surgery center setting and oral surgery;
20. Ablation procedures (no preauthorization needed for cardiac ablation procedures), and radiofrequency ablation, including those performed in-office;
21. Endoscopic retrograde cholangiopancreatography (ERCP);
22. Sclerotherapy;
23. Wireless capsule endoscopy;
24. All tertiary care services, including transplant services; and
25. Home infusion services.

You or your Provider must submit documentation, including a treatment plan when requested, to Piedmont for Services requiring preauthorization. Piedmont will establish that the appropriate criteria have been met and, if so, provide an authorization to the Provider from whom you plan to receive Services.

A Subscriber or Dependent is not required to receive a referral or preauthorization from their the Primary Care Physician or Piedmont 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.

When you require resuscitation, Emergency treatment, or your life is endangered, Piedmont does not require prior authorization before you call: (1) an Emergency 911 system; or (2) other state, county or municipal Emergency medical system.

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

(a) Without regard to whether the Provider furnishing the Emergency services is an In-Network Provider with respect to the services;

(b) Without the need for preauthorization by Piedmont, even if an Out-of-Network Provider provides the Emergency Services; and

(c) 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 your In-Network Physician feels that you need to see a Physician or other medical professional who is not an In-Network Provider and you believe these Services may be eligible for In-Network Benefits, then your Physician must submit medical information, in writing, to Piedmont. 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

Piedmont in order to receive In-Network Benefits. Piedmont has the right to determine where the Service can be provided for Coverage when a In-Network Provider cannot render the Service.

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

Piedmont will review a:

- Post-service claim within: 30 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 Subscriber or Dependent 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 Subscriber or Dependent must receive approval (preauthorization) before receiving the Benefit.

Piedmont may extend the time to review a claim for an additional 15 days if it: (1) decides that an extension is necessary for reasons beyond Piedmont's control; (2) notifies you of the reason for the extension in writing before the initial review period ends; and (3) tells you when Piedmont expects to make its final decision. If the extension is because Piedmont 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. Piedmont's time to review a claim is "tolled" or stops between the date it sends the extension notice and the date Piedmont receives the requested information.

2. Urgent Care Claims Review:

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

For the purposes this Section, an "Urgent Care Claim" is any claim for a Benefit for which the application of post-service or pre-service time frames:

- 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.

Piedmont 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 exigencies, but not later than

72 hours after Piedmont receives 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.

Piedmont 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 Piedmont that your claim is an Urgent Care Claim, then Piedmont will treat it as such.

Piedmont may extend the time to review an Urgent Care Claim up to 48 hours if it: (1) does not receive information that it needs to determine whether the claim is covered; and (2) tells you what information Piedmont needs to complete its claims review. Piedmont will provide this notice within 24 hours after it receives its Urgent Care Claim. You will have 48 hours to provide the necessary information. For an Urgent Care Claim, Piedmont will notify you of its decision no more than 48 hours after: (1) Piedmont receives 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:
Piedmont has a process in place for any Subscriber or Dependent, a designated representative, the prescribing Physician or other prescriber to request and gain access to clinically appropriate drugs not otherwise covered on Piedmont's formulary. A Formulary Exception request may be submitted to allow a Subscriber or Dependent 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.

Piedmont 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 your 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 Subscriber or Dependent, 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 You are suffering from a health condition that may seriously jeopardize Your life, health, or ability to regain maximum function, or if You are 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 Your request. If We approve Your request, coverage of the drug will be provided for the duration of the exigency. If We deny Your 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 Piedmont denies 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. You or Your authorized representative must have exhausted the health plan's internal appeal process (set forth above), with the exception of adverse benefit determinations related to cancer. Piedmont includes language and instructions in the exceptions denial letter that will assist members and providers with requesting independent external review. Notification of a decision on an external exception request will be given to the Member, 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, the Plan will provide Coverage for the non-formulary drug for the duration of the prescription, including refills and without additional cost-sharing beyond that provided for formulary prescription drugs in the Member's covered benefits. For expedited exception requests Coverage of the non-formulary drug will be provided for the duration of the exigency and without additional cost-sharing beyond that provided for formulary prescription drugs in the Member's covered benefits.

There are two exceptions to the formulary requirement:

• You may obtain Coverage without additional cost sharing beyond that which is required of formulary prescription drugs for a non-formulary drug if Piedmont determines, after consulting with the prescribing Physician, the formulary drugs are inappropriate therapy for your condition.

• You may obtain Coverage without additional cost sharing beyond that which is required of formulary prescription drugs for a non-formulary drug if:

- You have 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 your 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 and/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:
Piedmont will send an Explanation of Benefits (EOB) document to the member after the member receives a service. The EOB will provide details on the following items concerning the health care service:

- Piedmont 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 also covered by another 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 a health maintenance organization, 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 Subscriber or Dependent 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 Subscriber or Dependent 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 Subscriber 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 Subscriber 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 Subscriber 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 Subscriber or Dependent age 65 and older, or otherwise eligible for Medicare, do not duplicate any benefit for which he or she are entitled under Medicare. Where Medicare is the responsible payor, all sums payable by Medicare for services provided to any Subscriber or Dependent shall be reimbursed by or on behalf of the Subscriber or Dependent to the plan, to the extent the plan has made payment for such services.