Your Medical Plan

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If you are eligible for health care coverage, MPTN provides coverage for a broad range of expenses, including hospitalization, surgery, doctor visits, prescription drugs, vision care and mental health and alcohol/substance abuse treatment.

This Plan Document and SPD supersedes all earlier descriptions of the plans, as of January 1, 2023.

Because the benefits and other programs described in this Plan Document and SPD may change, MPTN will provide updated information as necessary and as required by tribal, federal or other applicable law. You will be notified of any material reduction in covered services under the health care plans within 60 days after the change is adopted.

Reference Based Pricing

For certain claims that are not considered in-network, the Plan will seek to reach an agreement with the hospital and/or facility regarding allowable Plan charges and reimbursement rates. In the event that no such agreement can be reached, the Plan's liability for any allowed claim will be limited to the Maximum Allowable Amount. Notwithstanding anything to the contrary in this document, in the event that a determination of the Plan's reimbursement amount in accordance with the methodology outlined herein results in an amount that exceeds the actual changes for the services and/or supplies, the Plan's reimbursement amount for that claim will be deemed to be equal to (and may not exceed) the actual charges billed for the claim. The Plan will communicate with the provider(s) regarding the reference-based pricing. In the event you receive a bill more than what you owe, the plan sponsor will resolve it on your behalf.

Services subject to Reference Based Pricing include, but are not limited to, facilities, dialysis, and ambulance.

Facilities include services such as:

- Any inpatient services at a hospital, skilled nursing facility or behavioral health facility.
- Any outpatient services performed at, or operated by, a hospital, skilled nursing facility or behavior health facility.
- Emergency room.
- Other hospital, skilled nursing facility or behavioral health facility including:
    - Hospital rehabilitation (physical therapy, for example),
    - Hospital cardiac or pulmonary rehabilitation, and
    - Hospital inpatient or outpatient services.
- Any outpatient or ambulatory surgical facility including endoscopy facilities.
- Any outpatient CT, MRI, PET scan or Lithotripter services.

Balance Billing

In the event that a claim submitted by a provider is subject to a medical bill review or medical chart audit and that some or all of the charges in connection with such claim are repriced because of billing errors and/or overcharges, it is the plan's position that the participant should not be responsible for payment of any charges denied as a result of the medical bill review or medical chart audit, and should not be balance billed for the difference between the billed charges and the amount determined to be payable by the plan administrator. However, balance billing is legal in many jurisdictions, and the plan has no control over providers that engage in balance billing practices.

In addition, with respect to services rendered by a provider being paid in accordance with a discounted rate, it is the plan's position that the participant should not be responsible for the difference between the amount charged by the network provider and the amount determined to be payable by the plan administrator, and should not be balance billed for such difference. Again, the plan has no control over any network provider that engages in balance billing practices, except to the extent that such practices are contrary to the contract governing the relationship between the plan and the provider.

The participant is responsible for any applicable payment of coinsurances, deductibles, and out-of-pocket maximums and may be billed for any or all of these.

Claims Audit

In addition to the plan's medical record review process, the plan administrator may use its discretionary authority to utilize an independent bill review and/or claim audit program or service for a complete claim. While every claim may not be subject to a bill review or audit, the plan administrator has the sole discretionary authority for selection of claims subject to review or audit.

The analysis will be employed to identify charges billed in error and/or charges that are not usual and customary and/or medically necessary and reasonable, if any, and may include a patient medical billing records review and/or audit of the patient's medical charts and records.

Upon completion of an analysis, a report will be submitted to the plan administrator or its agent to identify the charges deemed in excess of the Maximum Allowable Amount or other applicable provisions, as outlined in this Plan Document and SPD.

Despite the existence of any agreement to the contrary, the plan administrator has the discretionary authority to reduce any charge to the Maximum Allowable Amount, in accord with the terms of this Plan Document and SPD.

Benefit Summary

The Benefit Summaries show your contributions for coverage, deductibles, maximum benefits and other plan details. If you have questions about coverage under your plan, contact Pequot Plus Health Benefit Services at 1-888-779-6872 before you receive medical services.

For More Information …

This section describes your medical coverage. For more information about prescription drug, dental, vision, and mental health and alcohol/ substance abuse coverage, see the sections describing those benefits.

Your Health Care Option at a Glance

MPTN provides an attractive package of competitive health care benefits to help with your health care needs and protect you from the potentially high cost of care. These benefits include coverage for the following types of health care expenses:

- Medical,
- Prescription drug,
- Vision,
- Dental, and
- Mental health and alcohol/substance abuse.

For more information about prescription drug, vision, dental, and mental health and alcohol/substance abuse coverage, see the sections describing those benefits.

The charts in this section show the most common medical services covered under the Pequot Open Plan. This is not a complete list. You will find more details in the sections describing those benefits. Please note that the health care options and benefits provided under the Open Plan are subject to change.

For more information about how the Pequot Open Plan works, see the *Open Access Plan* section.

Cause Defined

"Cause" is defined by the Pequot Open Plan as a continuous treatment prescribed within a clinical treatment plan for a specific diagnosis.

Understanding Deductibles and Maximums

For more information about how deductibles and maximums work, see "Out-of-Network Coverage" in the *Open Access Plan* section

Pequot Open Plan (Non-Bargaining Unit Plan)

The chart in this section explains your health care options for the Pequot Open Plan in effect as of January 1, 2023.

The amounts shown in this comparison reflect what you pay.	Benefits
Annual Deductible **(applies to annual out-of-pocket maximum)**	
• Team Member • Team Member + Child or Spouse • Family	$1,250 $2,500 $3,750
Annual Out-of-Pocket Maximum** **(penalties for lack of pre-certification and non-covered expenses do not apply)**	**Includes deductibles, coinsurance and copays**
• Team Member • Team Member + Child or Spouse • Family	$3,750 $7,500 $11,250
Pre-Certification Penalty (for failure to pre-certify medically necessary procedures) (Expenses will not apply to out-of-pocket.)	20%, up to the first $5,000 of covered expenses or zero reimbursement, depending on the network

Preventive Care	
Routine Physicals (one per plan year)	no cost to you, no deductible*
Annual Gynecological Exam (One routine exam and Pap smear per plan year, 16 years and older)	no cost to you, no deductible*
Routine Mammogram • Ages 20 to 40 years: One routine mammogram every 24 months • Ages 40 and older: One every 12 months	no cost to you, no deductible*
Routine Colonoscopy (Age 45 and older: One every five years)	no cost to you, no deductible*
Routine Immunizations (Up to age 19); and *Routine Immunizations* (Age 19 and older) as recommended by the Advisory Committee on Immunization Practices (ACIP)***	no cost to you, no deductible*
Routine Pediatric Care	no cost to you, no deductible*
Maternity Care	
Hospital Services	10% of Maximum Allowable Amount after deductible
Pre-Natal and Post-Natal Care	10% of Maximum Allowable Amount after deductible
Birthing Facility Fee	10% of Maximum Allowable Amount after deductible
Outpatient Care	
Physician Office Visits (does not include charges for telephone calls between patient and physician, when there is a charge for such calls)	$25 copay per visit, no deductible
Urgent Care (hospital-based) – Urgent Care visit charge only; for other services performed see that section.	$50 copay per visit, no deductible
Walk-In Center (non-hospital-associated) – office visit only; for other services performed see that section.	$25 copay per visit, no deductible
X-rays, Ultrasounds, CT and PET Scans, MRIs, and SPECTs	10% of Maximum Allowable Amount after deductible

Restorative Physical and Occupational Therapy	$25 copay per visit, no deductible
Chiropractic Care	$25 copay per visit, no deductible Maximum 25 visits per year
Acupuncture, when deemed medically necessary (maximum $500 per plan year)	$25 copay per visit, no deductible
Cardiac Rehabilitation (Up to 60 visits per year)	$25 copay per visit, no deductible
Speech Therapy (must be physician approved)	$25 copay per visit, no deductible
Allergy Testing and Injections	10% of Maximum Allowable Amount after deductible
Chemotherapy	10% of Maximum Allowable Amount after deductible
Contraceptive Management (16 years and older)	10% of Maximum Allowable Amount after deductible
Diagnostic Procedures (performed in a hospital or for outpatient surgical care)	10% of Maximum Allowable Amount after deductible
Laboratory Tests (outpatient)	covered 100%†
Ambulatory Surgical Facility Fee	10% of Maximum Allowable Amount after deductible
Pre-Admission Testing	10% of Maximum Allowable Amount after deductible
Second Surgical Opinion	$25 copay, no deductible
Inpatient Care • Room and Board Limited to 120 days per calendar year (semi-private room) • Inpatient physician services • Miscellaneous inpatient services and supplies	$250 copay per cause, plus 10% of Maximum Allowable Amount, after deductible
Skilled Nursing Facility • Medical care only; no custodial care • Limited to 365 days maximum per confinement	• 10% of Maximum Allowable Amount after deductible • $250 copay unless transferred directly from inpatient
Expenses related to surgery (inpatient or outpatient)	

Anesthesia Services	10% of Maximum Allowable Amount after deductible
Assistant Surgical Services	10% of Maximum Allowable Amount after deductible
Cast and Dressing Services	10% of Maximum Allowable Amount after deductible
Elective Surgery • With Pre-certification • Without Pre-certification, if deemed medically necessary	 10% of Maximum Allowable Amount after deductible 10% of Maximum Allowable Amount after 20% pre-certification penalty, up to first $5,000 of covered expenses, after deductible
Emergency Surgery	10% of Maximum Allowable Amount after deductible
Maternity Surgery (including physician attendance)	10% of Maximum Allowable Amount after deductible
Ambulance for Emergency	20% of Maximum Allowable Amount no deductible
Durable Medical Equipment (Some items may require pre-certification)	10% of Maximum Allowable Amount after deductible
Emergency Room Services **(at a hospital emergency room for sudden or serious illness or accident)** – ER visit charge only; for other services performed see that section.	$100 copay per visit, no deductible
Home Health (when skilled services are required) • Combined with special duty nursing, limited to 120 days per calendar year • Physician House Calls	 10% of Maximum Allowable Amount after deductible Not covered
Hospice Care	10% of Maximum Allowable Amount after deductible
Accident-Related Dental Services	10% of Maximum Allowable Amount after deductible

- Hearing aids: Maximum of $2000 paid every 36 months.

- Wigs: $100 and 1 wig every 3 years

**For annual physicals and preventive screenings covered under the Affordable Care Act.*

***The annual out-of-pocket maximum includes deductibles, coinsurance and copays for medical and prescription drugs. Expenses incurred in the last quarter of the year do not carry over to the next year.*

***http://www.immunize.org/catg.d/p2011.pdf

†Ask Provider to send to a network Laboratory

Deductible

The annual deductible is the amount you and each covered family member must pay each plan year for covered medical and prescription drug expenses before the plan begins to pay benefits. After you satisfy the annual deductible requirement, the plan reimburses a percentage of covered expenses.

Certain services, such as preventive services provided by physicians, are not subject to the deductible. For more information, see “Your Health Care Options at a Glance” in the *Your Medical Plan* section. Amounts you pay as copays do not count toward your deductible.

A family deductible is met when the accumulation of all individual family member’s deductibles combined, not exceeding each member’s individual deductible, meet the total family deductible amount. A new deductible applies each year.

Out-of-Pocket Maximum

The out-of-pocket maximum limits the amount you and your family pay for covered medical expenses each year. Essentially, the out-of-pocket maximum protects you against having to pay extraordinary medical bills in a given year.

Once your share of covered expenses reaches the out-of-pocket maximum, the plan pays 100% of the eligible charges for any additional covered expenses for the rest of the plan year.

The annual out-of-pocket maximum includes deductibles, coinsurance and copays for medical and prescription drugs.

The following expenses do not count toward your out-of-pocket maximum:

- Penalty for non-certified hospital stays and non-certified outpatient services requiring pre-certification
- Expenses above the Maximum Allowable Amount
- Expenses not covered by the Plan
- Balance billed amounts
- Dental coinsurance
- Vision care expenses

Cost of Coverage

You pay a weekly contribution for coverage based on the level of coverage you select:

- Team Member,
- Team Member + Child
- Team Member + Spouse, or
- Family coverage.

Your cost for coverage is included with your enrollment materials.

Contributions may be adjusted periodically to accommodate changes in the cost of coverage. At each annual enrollment period, you will be notified of the coming year’s contribution rates.

Regular part-time team members are eligible for employee only health and dental coverage. Regular part-time team members have the opportunity to buy-up health and dental for their spouse and/or dependents.

What's Covered

This section describes the benefits covered by the Pequot Open Plan. Coverage amounts are subject to change.

The plan pays benefits for covered services, treatment, supplies and facilities that are medically necessary or appropriate (as determined by the medical utilization reviewer) to diagnose, treat, or monitor a sickness, injury, mental illness, substance abuse, or general symptoms. In some cases, services are covered by the plan only if they are medically necessary and appropriate and if they are approved in advance by the medical utilization company. For more information, see **"Pre-Certification**" within the *Open Access Plan* section.

To be considered medically necessary, services, treatment, supplies and facilities must:

- Not be maintenance therapy or maintenance treatment. Its purpose must be to restore health.
- Not be primarily custodial in nature.
- Not be a listed item or treatment not allowed for reimbursement by the Centers for Medicare and Medicaid Services (CMS).

The plan reserves the right to incorporate CMS guidelines in effect on the date of treatment as additional criteria for determination of medical necessity and/or an allowable expense. For more information, please see the definition of Medically Necessary in the *Terms to Know* section.

Some examples of services covered by the MPTN Medical Plan include the following:

- Outpatient care, such as:
    - Office visits
    - Specialist visits
    - Preventive care, such as physicals, well-child care, and screening tests
    - Diagnostic testing, including lab tests and x-rays
    - Outpatient surgery
    - Emergency care
    - Prescription drugs
    - Outpatient mental health and alcohol/substance abuse care
    - Physical/occupational therapy
    - Home health care
    - Chiropractic care
    - Durable medical equipment
- Inpatient care, such as:
    - Inpatient surgery
    - Room and board for semi-private hospital accommodations
    - Intensive care
    - Inpatient mental health/chemical dependency or detoxification care
    - Inpatient hospice care
    - Transplants

If You Have Other Coverage

The medical option available through MPTN has a coordination of benefits feature. The coordination of benefits rules prevent duplication of payments when you or your family members are covered by another group medical plan, including government coverage such as TRICARE, Medicare or medical coverage under the "no fault" or payment provisions of an automobile insurance contract. For more information, see "If You Have Other Coverage" in the *Health Care Benefits* section.

Some of the services listed above may be subject to deductibles and copays. In addition, you should have your health care provider call the beneficiary services telephone number on the back of your benefits card to determine whether a particular service requires pre-certification. Services requiring pre-certification are covered at a lower rate or may not be covered at all if the pre-certification is not obtained in advance.

Maximum Allowable Amount

For physicians and ancillary services:

The maximum benefit payable for a specific coverage item or benefit under the Plan. The Maximum Allowable Amount will be a negotiated rate, if one exists. If and only if there is no negotiated rate for a given claim, the Plan Administrator will exercise its discretion to determine the Maximum Allowable Amount based on any of the following: Medicare reimbursement rates, Medicare cost data, amounts actually collected by providers in the area for similar services, or average wholesale price (AWP) or manufacturer's retail pricing (MRP). These ancillary factors will take into account generally-accepted billing standards and practices.

For hospitals/facilities:

The "Maximum Allowable Amount" shall mean the benefit payable for a specific coverage item or benefit under this Plan. The Maximum Allowable Amount will be a negotiated rate, if one exists; if no negotiated rate exists, the Maximum Allowable Amount will be determined by the Plan to be the Medicare reimbursement rates utilized by the Centers for Medicare and Medicaid Services ("CMS"), based on current-year CMS data for the year in which the date of service occurs, multiplied by 140%.

If no Medicare reimbursement rate is available for a given item of service or supply, Medicare reimbursement rates will be calculated based on one of the following:

1. Prices established by CMS utilizing standard Medicare Payment methods and/or based upon supplemental Medicare or Medicaid pricing data for items Medicare doesn't cover based on data from CMS;
2. Prices established by CMS utilizing standard Medicare payment methods and/or based upon prevailing Medicare rates in the community for non-Medicare facilities for similar services and/or supplies provided by similarly skilled and trained providers of care; or
3. Prices established by CMS utilizing standard Medicare payment methods for items in alternate settings based on Medicare rates provided for similar services and/or supplies paid to similarly skilled and trained providers of care in traditional settings.

No member shall be entitled to and in no event will the Plan's maximum liability for any claim exceed the Maximum Allowable Amount.

For all Covered Expenses:

When more than one treatment option is available, and one option is no more effective than another, the least costly option that is no less effective than any other option will be considered within the Maximum Allowable Amount. The Maximum Allowable Amount will be limited to an amount which, in the Plan Administrator's discretion, is charged for services or supplies that are not unreasonably caused by the treating provider, including errors in medical care that are clearly identifiable, preventable, and serious in their consequence for patients. A finding of provider negligence or malpractice is not required for services or fees to be considered ineligible pursuant to this provision.

Mastectomy Care and Reconstructive Surgery

The MPTN Medical Plan covers expenses associated with reconstructive surgery following a mastectomy, expenses for reconstructive surgery on the other breast to achieve symmetry, the cost of prostheses, and the costs for treatment of physical complications at any stage of the mastectomy, including lymphedemas.

Dialysis Savings & Support

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SCHEDULE OF MEDICAL BENEFITS

Outpatient Dialysis Treatment	100% of the lesser of (i) the Usual, Customary, and Reasonable Outpatient Dialysis Charge as defined below, (ii) the maximum allowable charge after all applicable deductibles and cost-sharing; and (iii) such charge as is negotiated between the Plan Administrator and the provider of Outpatient Dialysis Treatment.

Outpatient Dialysis Treatment. When used in this document, the term “Outpatient Dialysis Treatment” shall mean any and all products, services, and/or supplies provided to Plan members/participants/beneficiaries for purposes of, or related to, outpatient dialysis.

DISCRETIONARY AUTHORITY

The Plan Administrator shall perform its duties as the Plan Administrator and in its sole discretion shall determine appropriate courses of action in light of the reason and purpose for which this Plan is established and maintained. In particular, the Plan Administrator shall have full and sole discretionary authority to interpret all plan documents and to make all interpretive and factual determinations as to whether any individual is entitled to receive any benefit under the terms of this Plan. Any construction of the terms of any plan document and any determination of fact adopted by the Plan Administrator shall be final and legally binding on all parties. To the extent permitted by law, the Plan Administrator shall have the discretionary authority to rely conclusively upon all tables, valuations, certificates, opinions and reports which are furnished by accountants, counsel or other experts employed or engaged by the Plan Administrator.

Assignments

No benefit, right or interest of any member under the Plan shall be subject to anticipation, alienation, sale, transfer, assignment, pledge, encumbrance, charge, garnishment, execution or levy of any kind, either voluntary or involuntary, including any liability for, or subject to, the debts, liabilities or other obligations of such person. Any attempt to anticipate, alienate, sell, transfer, assign, pledge, encumber, charge, garnish, execute or levy upon, or otherwise dispose of any right to benefit payable hereunder or legal causes of action, shall be void. Notwithstanding the foregoing, the Plan may choose to remit payments directly to providers with respect to covered benefits, if authorized by the member, but only as a convenience to the member. Providers are not, and shall not be construed as, “participants,” “beneficiaries” or “claimants” under this Plan and have no rights to receive benefits from the Plan or to pursue legal causes of action on behalf of (or in place of) participants under any circumstances.

What's Not Covered

Some medical services and supplies are not covered under the plan. If you have a question about whether a service or supply is covered, call the Pequot Plus Health Benefit Services at 1-888-779-6872 to check. The plan administrator makes the final determination as to which charges are excluded, based on the policies that govern the Pequot Open Plan.

If your request for benefits is denied, you may appeal. For more information on appealing a claim, see "Claims Review and Appeals Procedures" in the *Rules and Regulations* section.

The following items are excluded by the Pequot Open Plan:

- Services, supplies or first aid items not prescribed or performed by a physician or another professional health care provider, as determined by the plan.
- Services, supplies or treatments not recognized by the plan as generally accepted and medically necessary for the diagnosis and/or treatment of an active illness or injury.
- Charges for procedures, surgical or otherwise, which are specifically listed by the American Medical Association, the American Dental Association, or any other such professional body as having no medical value.
- Services or supplies which are not medically necessary as determined by the medical utilization company and/or plan administrator.
- Cosmetic or reconstructive procedures and any related services or supplies which alter appearance but do not restore or improve impaired physical function, except when performed for:
    - Repair within one year of an accident which occurred while covered under the plan,
    - Replacement of tissue or diseased tissue surgically removed or altered while covered under the plan, or
    - Treatment (that is simply cosmetic in nature) of a birth defect in a child who has been continuously covered under the plan since the date of birth.
- Wigs or hairpieces except when prescribed by a physician as a prosthetic for hair loss due to:
    - Burns resulting in permanent alopecia,
    - Chemotherapy, or
    - Radiation therapy.
- Services that are performed by a person who is related to the participant as a spouse, parent, child, brother or sister, whether the relationship exists by virtue of "blood" or "in law".
- Housing, hotel or motel expenses, or home reconstruction arising out of special medical needs in the place where the patient resides.
- Personal hygiene and convenience items (for example, air conditioners or humidifiers); physical fitness equipment or supplies made or used for physical fitness, athletic training or general health up-keep.
- Formula and Nutritional Supplements
    - Enteral tube feedings are not covered for individuals who are capable of adequate oral intake.
    - Food supplements, specialized infant formulas, vitamins and/or minerals taken orally are not covered even if they are required to maintain weight or strength.
    - Diet supplements.
- Telephone consultations, charges because a person fails to keep a scheduled appointment, or charges to complete a claim form.
- Custodial care, such as help in walking, getting out of bed, or any service that could be performed by a non-professional person, including rest care or nursing home care and personal comfort items.
- Routine non-surgical foot care (unless diabetic), or the treatment of flat or pronated feet, calluses, toe nails (unless ingrown), weak or fallen arches, weak feet metatarsalgia, or chronic foot strain.
- Foot Orthotics and shoe inserts.
- Tax, shipping and handling for DME items, etc.

Time During Approved Family Medical Leaves

If you take an approved Family Medical Leave, the plan provisions and benefits that apply when you return from that leave will be equivalent to the benefit you would have had if you had not taken leave.

- Charge for hospitalization when such confinement occurs primarily for physical therapy, hydrotherapy, convalescent or rest care.
- Services and supplies for dental care, except as specified.
- Hospital admissions primarily for care which can be safely done on an outpatient basis.
- Services or supplies incurred after a concurrent review determines the services and supplies are no longer medically necessary.
- Treatment or surgery for obesity, weight reduction, or weight control, including food supplements, gastric bypass, lap band, and reversal of gastric bypass or removal of lap band.
- Charges for recreational therapy and art/music therapy.
- Educational therapy for non-medical self care or self-help education and/or training and any related diagnostic testing or for medical social services.
- Services pertaining to a Learning Disability or to Dyslexia.
- Services pertaining to Developmental Delays, including, but not limited to:
    - Occupational Therapy,
    - Physical Therapy, or
    - Speech Therapy.

- Marriage counseling.
- Nutritional counseling (except for Diabetic Counseling, six, life-time visit max).
- Genetic counseling or testing when performed for investigational purposes except when medically necessary, or as covered under the preventive care benefit, for the following conditions:
    - For the purpose of identifying and treating a specific hereditary disease,
    - Prenatal testing when the family history has established the child is at-risk for a genetic disease.

- Treatment or surgery to change gender or to improve or restore sexual function unless of organic cause.
- Charges related to or in connection with fertility studies, sterility studies, procedures to test, restore or enhance fertility, including artificial inseminations, in vitro fertilization and/or GIFT procedures or surrogacy.
- Services or supplies for the reversal of sterilization.
- Alternative/Complementary Treatment
    - Hypnosis,
    - Holistic, homeopathic or naturopathic medicine, or
    - Other treatment that is not accepted medical practice as determined by the plan.

- Tobacco Addiction Services, except to the extent covered under the preventive care benefits of the plan.
- Treatment and/or surgery of temporomandibular joint syndrome (TMJ), including the use of intra-oral prosthetic devices or any method to alter vertical dimension.
- Charges due to abortion, except for charges incurred when:
    - the mother's life would be endangered if the fetus is carried to term,
    - medical complications have arisen from an abortion, or
    - arising from incest or rape.
- An artificial heart, lung, liver or pancreas or any other artificial organ or any associated expense, except as related to transplants of human organs.
- Charges for pregnancy, childbirth or related medical conditions for dependents other than the employee or the covered spouse, except as covered undertake preventive care benefits of the plan.
- Charges that are not payable under the plan due to application of any plan maximum or limit or because the charges are in excess of the Maximum Allowable Amount, or are for services not deemed to be reasonable or Medically Necessary, based upon the plan administrator's determination as set forth by and within the terms of this document.
- Any charge for care, supplies, treatment, and/or services for any condition, illness, injury or complication thereof arising out of or in the course of employment, including self-employment, or an activity for wage or profit; *If you are covered as a dependent under this plan and you are self-employed or employed by an employer that does not provide health benefits, make sure that you have other medical benefits to provide for your medical care in the event that you are hurt on the job. In most cases workers compensation insurance will cover your costs, but if you do not have such coverage you may end up with no coverage at all*. Any services covered by Workers' Compensation or employer's liability laws.

- Any services that are covered by an auto insurance policy.
- Illness or injury resulting from participation in war (whether declared or not declared), act of war, riot, civil disturbance, or general uprising and occurring after this coverage begins.
- Services for which the patient is not legally obligated to pay.
- Services or supplies received in a dental or medical department maintained by or on behalf of another employer, mutual benefit association, labor union, trust or similar group.
- Services provided before the patient's coverage begins.
- Expenses incurred on account of a dependent during or in connection with a hospital confinement that began before the date the dependent becomes covered by the Pequot Open Plan.
- Services covered under any other group, blanket or franchise insurance coverage, other health insurance plan, union welfare plan, labor management trusteed plan, tax-supported or government plan.
- Services required by a third party, government agency or authority, or court judgment, whether or not medically necessary, including but not limited to immigration physical, court ordered detoxification or counseling of any type, except when such treatment is pre-certified by the medical utilization company for the plan.
- Charges for which payment is made by any other plans as defined by and in connection with the coordination of benefits provision of this plan.
- Any charge for care, supplies, treatment, and/or services to a plan participant, arising from taking part in any activity made illegal due to the use of alcohol. Expenses will be covered for injured plan participants other than the person partaking in an activity made illegal due to the use of alcohol, and expenses may be covered for substance abuse treatment as specified in this plan, if applicable. This exclusion does not apply if the injury (a) resulted from being the victim of an act of domestic violence, or (b) resulted from a medical condition (including both physical and mental health conditions);
- Any charge for services, supplies, care or treatment to a participant for injury or sickness incurred while the participant was voluntarily taking or was under the influence of any controlled substance, drug, hallucinogen or narcotic not administered on the advice of a Physician. Expenses will be covered for injured participants other than the person using controlled substances and expenses will be covered for substance abuse treatment as specified in this plan. This exclusion does not apply if the injury (a) resulted from being the victim of an act of domestic violence, or (b) resulted from a medical condition (including both physical and mental health conditions).
- Any charge for care, supplies, treatment, and/or services that are experimental or investigative;
- **Illegal Acts**: Any charge for care, supplies, treatment, and/or services arising from or caused during the commission of any illegal act for which the participant could be incarcerated for any period of time. It is not necessary for an arrest to occur, charges to be filed, incarceration to occur, or a conviction to be had for this exclusion to apply. This exclusion does not apply if the injury (a) resulted from being the victim of an act of domestic violence, or (b) resulted from a medical condition (including both physical and mental health conditions);
- Any charge for care, supplies, treatment, and/or services that are the result of intentionally **self-inflicted** injuries or illnesses. This exclusion does not apply if the injury (a) resulted from being the victim of an act of domestic violence, or (b) resulted from a medical condition (including both physical and mental health conditions);
- Any charge for care, supplies, treatment, and/or services of an injury or sickness not payable by virtue of the plan's subrogation, reimbursement, and/or third-party responsibility provisions;
- Charges that arise in connection with a fraudulent, materially false or misleading statement of claim submitted by any person who knowingly intends to defraud or deceive the plan's authorized representatives.
- Any service or treatment that takes place after the patient ended previous treatment against physician or medical staff advice.
- Immunizations over the age of 18 unless otherwise specified in this Plan Document and SPD. Immunizations for travel, needed for the participant's job, to take part in school, camp and sports activities; or by employers or third parties, regardless of age are not covered.
- Charges arising from care, supplies, treatment, and/or services that are incurred by the participant on or after the date coverage terminates, even if payments have been predetermined for a course of treatment submitted before the termination date, unless otherwise deemed to be covered in accordance with the terms of the plan or applicable law and/or regulation.
- Charges arising from care, supplies, treatment, and/or services that are amounts applied toward satisfaction of deductibles and expenses that are defined as the participant's responsibility in accordance with the terms of the plan.
- Charges arising from care, supplies, treatment, and/or services that are expenses actually incurred by other persons.

- Charges arising from care, supplies, treatment, and/or services that are for injuries resulting from negligence, misfeasance, malfeasance, nonfeasance or malpractice on the part of any caregiver, institution, or provider, as determined by the plan administrator, in its discretion, in light of applicable laws and evidence available to the plan administrator.
- Charges arising from care, supplies, treatment, and/or services that are incurred at a time when no coverage is in force for the applicable participant and/or dependent.
- Charges arising from care, supplies, treatment, and/or services that are not specified as covered under any provision of this plan.
- Charges arising from care, supplies, treatment, and/or services that are to the extent that payment under this plan is prohibited by law.
- Charges arising from care, supplies, treatment, and/or services that are required as a result of unreasonable provider error.
- Charges arising from care, supplies, treatment, and/or services that are not “reasonable” and are required to treat illness or injuries arising from and due to a provider’s error, wherein such illness, injury, infection or complication is not reasonably expected to occur. This exclusion will apply to expenses directly or indirectly resulting from circumstances that, in the opinion of the plan administrator in its sole discretion, gave rise to the expense and are not generally foreseeable or expected amongst professionals practicing the same or similar type(s) of medicine as the treating provider whose error caused the loss(es).
- Balance billed amounts.

With respect to any injury which is otherwise covered by the plan, the plan will not deny benefits otherwise provided for treatment of the injury if the injury results from being the victim of an act of domestic violence or a documented medical condition. To the extent consistent with applicable law, this exception will not require this plan to provide particular benefits other than those provided under the terms of the plan.