# Carrum Health Benefit

Participants in the Plan have access to the Carrum Health Benefit, which provides enhanced coverage for certain planned procedures at participating Centers of Excellence. Through the Carrum Health Benefit, participants have access to specialized providers and facilities selected for their expertise in certain high-risk or high-cost procedures, referred to as "Centers of Excellence".

Subject to limited exceptions described below, the Plan only provides coverage for the following procedures if they are provided through the Carrum Health Benefit:

- Total and partial hip and knee replacement surgery

Participants may also use the Carrum Health Benefit for other procedures or conditions, including:

- Other orthopedic and spine procedures (e.g., hand, wrist, elbow, shoulder, ankle, foot)
- Spinal fusion surgery
- Bariatric (weight loss) surgery
- Cardiac (heart) surgery
- Cancer Care

This section describes the Carrum Health Benefit, including important conditions and restrictions. The Summary of Benefits Coverage table below summarizes coverage of the medical services available through the Carrum Health Benefit. As shown below, certain eligible services performed through the Carrum Health Benefit are covered at 100%, meaning there is no out-of-pocket spend for the participant such as copays or coinsurance.

Summary of Benefits Coverage

| | Carrum Health Benefit | In-Network | Out-of-Network |
|---|---|---|---|
| Outpatient - Hip and knee replacement | 100% covered; No Deductible | No coverage* | No coverage* |
| Inpatient - Hip and knee replacement | 100% covered; No Deductible | 90% covered after Deductible is met | 60% covered after Deductible is met |
| Spinal fusion surgery | 100% covered; No Deductible | 90% covered after Deductible is met | 60% covered after Deductible is met |
| Bariatric (weight loss) surgery | 100% covered; No Deductible | 90% covered after Deductible is met | 60% covered after Deductible is met |
| Other orthopedic procedures (e.g., hand, wrist, elbow, shoulder, ankle, foot) | 100% covered; No Deductible | 90% covered after Deductible is met | 60% covered after Deductible is met |

| | | | |
|---|---|---|---|
| Cardiac (heart) surgery | 100% covered;<br>No Deductible | 90% covered after<br>Deductible is met | 60% covered after<br>Deductible is met |
| Cancer Care | 100% covered;<br>No Deductible | 90% covered after<br>Deductible is met | 60% covered after<br>Deductible is met |

* See the below text under Coverage and Exceptions for Hip and Knee Replacement Surgery for circumstances where coverage is available outside the Carrum Health Benefit.

## About Carrum Health

Carrum Health provides access to Centers of Excellence for planned medical care and coordinates the delivery of care with travel, communication and other non-medical aspects of the program. Carrum Health itself does not render any medical care or advice, and does not recommend any particular medical providers or course of treatment.

To learn more about the Carrum Health Benefit or request a consultation with a Center of Excellence, please contact Carrum Health at 1-888-855-7806, Monday-Friday 9am-8pm EST, or visit carrum.me/StateofMaine. The 'Carrum Health' app is available to download on both iPhone and Android devices.

## How It Works

Plan participants can contact Carrum Health at 1-888-855-7806, Monday-Friday 9am-8pm EST, online at carrum.me/StateofMaine, or by downloading the 'Carrum Health' app on iPhone and Android devices to search for and compare participating Centers of Excellence.

After contacting Carrum Health, a participant is assigned a Care Specialist to determine if the participant may be referred to a Center of Excellence and provide non-medical coordination throughout the entire episode of care. Care Specialist services can include assistance with selection of a Center of Excellence, medical records collection, appointment scheduling, and travel reservations and logistics management. The Care Specialist can also assist the participant with registration for the Carrum Health Benefit through the Carrum Health app and completion of required forms.

Participants are required to agree to Carrum Health's Terms of Service and Member Registration Agreement and must also agree to provide their medical records and any other relevant information to their selected Center of Excellence as needed to schedule a consultative evaluation. Medical records and images may be collected on behalf of participants by their assigned Care Specialists. During the consultation, the Center of Excellence will determine if the participant is an appropriate candidate for the requested procedure. Receiving this consultation does not commit a participant to proceed with the procedure or to use the Carrum Health Benefit.

## Covered Expenses

### *Medical*

The Carrum Health Benefit covers all medical costs charged by the Center of Excellence that are related to the covered procedure with no Copay, Deductible, or Coinsurance.

*Cancer Care*

Cancer care covered through the Carrum Health Benefit includes:

- Comprehensive treatment for breast and thyroid cancer
- CAR (chimeric antigen receptor)-T cell therapy

*Travel*

The Carrum Health Benefit covers the cost of travel to the Center of Excellence including transportation, lodging, meals and incidentals depending on the distance of the Participant from the Center of Excellence and the type of procedure requested. Please contact your Care Specialist or Carrum Health at 1-888-855-7806 or via the Carrum Health app for details regarding what travel benefits may be available with respect to your requested treatment. For transportation, and lodging to be covered under the Carrum Health Benefit, it must be booked by Carrum Health's Patient Care Team. Generally, the Patient Care Team will book travel on behalf of the Participant for:

- Roundtrip transportation for an in-person consultation with a Center of Excellence to the extent requested by the Center of Excellence for the participant only.
- Roundtrip transportation and hotel stay to receive a procedure at a Center of Excellence for the participant and adult travel companion.

Any stipend for meals and incidentals is provided via PayPal or prepaid Mastercard.

A participant will receive a Form 1099 reflecting any taxable travel benefits, such as lodging costs over federal tax limits and daily stipends.

## Coverage Limitations and Disclosures

- To receive coverage under the Carrum Health Benefit, a Center of Excellence must determine that it will provide the requested procedure to the participant. A Center of Excellence may decline to treat a participant as it determines in its discretion, including, but not limited to, failure to:
  - identify a designated adult companion who is willing and able to meet caregiver requirements;
  - be safe to travel to the Center of Excellence for medical care and not requiring emergency care at the time of travel;
  - follow preoperative and postoperative instructions;
  - provide all required medical history, labs, and diagnostic tests;
  - make lifestyle changes required by the Center of Excellence as a condition of obtaining the covered procedure (e.g., stop smoking or lose weight); or
  - refrain from committing an act of physical or verbal abuse or other threatening behavior to the staff of the Center of Excellence.
- To receive coverage under the Carrum Health Benefit, services MUST be scheduled and authorized by Carrum Health. If the participant does not use the Carrum Health Benefit, their care will be covered as outlined in the Summary of Benefits Coverage table above under "In-Network" and "Out-of-Network", as applicable.

- Emergency medical services that are rendered by a Center of Excellence are not covered under the Carrum Health Benefit and are subject to the coverage limits, cost-sharing, and other terms of the Plan.
- Certain examinations, tests, or other medical services may be required before or after the participant visits the Center of Excellence under the Carrum Health Benefit. Any medical services not performed by a participating Center of Excellence facility or physician, including necessary pre-and post-acute care, are not covered under the Carrum Health Benefit and are subject to the coverage limits, cost-sharing, and other terms of the Plan.
- The Carrum Health Benefit applies toward any benefit maximums on the covered procedures under the Plan.
- Carrum Health will provide appropriate documentation for any non-medical benefits paid under the program, which may be subject to taxation as income to the participant, such as the allowance paid for meals and incidentals.
- Coverage under the Carrum Health Benefit may be denied by Carrum Health if:
    1. The participant refuses to complete documentation required to participate in the Carrum Health Benefit, including the Terms of Service and Member Registration Agreement;
    2. A participant requests to be referred to a Center of Excellence after the initial Center of Excellence has determined the participant is not an appropriate candidate for the requested treatment. Note this does not apply when the initial referral to an outpatient facility or ambulatory surgical center (ASC), that cannot treat the participant because their condition was too complex, in which case the participant may be referred to an acute care Center of Excellence; or
    3. The participant violates the Carrum Health Terms of Service or Member Registration Agreement.
    - If coverage under the Carrum Health Benefit is denied by Carrum Health, the participant may (1) appeal the denial in accordance with the Claims and Appeals section of this Plan Document and/or (2) request an exception to the requirement to use the Carrum Health Benefit and instead receive coverage for services subject to standard Plan cost-sharing, limitations, and exclusions.
    - If the Plan would pay secondary in accordance with its coordination of benefits provisions, such secondary coverage will be determined in accordance with the Plan's standard terms and cost-sharing provisions and not under this Carrum Health Benefit.

## Coverage and Exceptions for Hip and Knee Replacement Surgery

- Unless an exception applies as described below, the Plan only provides coverage for hip and knee replacement surgery if the participant receives such treatment through the Carrum Health Benefit. If treatment is not received through the Carrum Health Benefit and no exception has been granted, the participant will be responsible for the entire cost of their treatment.
- Requests for exceptions to using Carrum Health: Participants may request an exception to the requirement that they use the Carrum Health Benefit. If an exception is granted, treatment that was not authorized by Carrum Health may be covered under the Plan subject to standard Plan prior authorization, cost-sharing, and other provisions.
- Participants will be granted an exception for any of the following reasons:
    - Urgent Surgery: Either,

- Participant already received surgery due to a medical emergency or,
- Participant has an urgent need for surgery and has a surgical date set within 30 days

- Participant lives 150 miles or greater from any Center of Excellence

- Medically Unsafe to Travel: Both,
  - Participant lives more than 60 miles from the nearest Carrum Center of Excellence and,
  - travel to the nearest Carrum Health Center of Excellence would be medically unsafe or physically impossible. "Medically unsafe" means travel would result in (i)placing the participant's health in serious jeopardy, (ii) serious impairment to bodily functions, (iii) serious dysfunction of any bodily organ or part, or (iv) injury. "Physically impossible" means the individual has physical limitations that prevent travel to the nearest COE
- Surgical Candidacy: Participant's doctor disagrees with Carrum Center of Excellence's determination that the participant is not an appropriate surgical candidate. The Center of Excellence's determination may be made (1) after consultation with the participant or (2) prior to consultation, based on the participant's failure to meet clinical criteria required for referral.
- Financial Hardship: Both,
  - Participant lives more than 60 miles from the nearest Carrum Health Center of Excellence and,
  - surgery at the Carrum Health Center of Excellence would cause the participant severe financial hardship
  - Examples:
    - Inability to work or loss of hours due to the condition that the surgery is intended to fix without the ability to receive disability coverage, resulting in severe financial hardship
    - Loss of insurance prior to earliest possible surgery date, resulting in a severe financial hardship
    - Disability leave cannot be moved to accommodate Carrum surgery date, resulting in a severe financial hardship
    - Existing obligations as a primary caregiver and travel to a Carrum Center of Excellence would result in unreasonable disruption to caregiver obligations. "Unreasonable disruption" means having to hire a caregiver for 24+ hours over and above caregiver needs of staying with a local surgeon resulting in a severe financial hardship
- Inability to Secure Travel Companion: Both,
  - Participant lives more than 60 miles from the nearest Carrum Health Center of Excellence and,
  - Participant does not have access to an adult travel companion who can safely travel with them to any Carrum Health Center of Excellence

- Please note: An exception is not available due solely to the Carrum Health Center of Excellence's decision to not move forward with surgery due to the participant's failure or refusal to comply with instructions and requirements as specified by the Center of Excellence. However, if the Center of Excellence declined to treat, or recommended conservative treatment, based on the participant's failure to make a lifestyle change, the participant may apply for an exception.
- Process for requesting an exception to using the Carrum Health Benefit: To request an exception, a participant must complete the Exception Initiation Form and send it, along with the required supporting documentation listed in the Exception Initiation Form, to Carrum Health. A participant may request an Exception Initiation Form by contacting Carrum Health at 1-888-855-7806. Please complete the form and submit it via fax to Carrum Health at 650-539-0777, via the Carrum app, or via secure email or U.S. mail. Your Care Specialist, who can be reached at 1-888-855-7806, can walk you through the process of submitting the Exception Initiation Form via the app, secure email, or U.S. mail.
    - Carrum Health will review the Exception Initiation Form to determine whether the submitted information and documentation meets the criteria to grant an exception.
    - Depending on whether the participant has already received treatment when they make their exception request, it will be treated as either a pre-service claim or post-service claim, as described in the Anthem Blue Choice PPO Benefit Booklet (CLAIMS AND APPEALS section).
    - If the participant's exception request is granted, coverage of the treatment will be subject to the standard Plan terms, including any deductibles, coinsurance, or limitations, and the participant must comply with the Plan's standard protocols for authorizing and receiving care including utilization management. The exception request is not a request for prior authorization for coverage of the treatment under the Plan. The participant may still need to receive prior authorization under the Plan for the desired procedure after their exception is granted. If the exception request is denied, no benefits will be payable for services performed outside the Carrum Health Benefit, as outlined earlier. Participants can file an appeal with Carrum Health if they are denied an exception, as described in the Claims and Appeals section of this Plan Document.

---

# Carrum Health Benefit Claims and Appeals

## Initial Claims and Denials under the Carrum Health Benefit

Plan participants can contact Carrum Health at 1-888-855-7806, Monday-Friday 9am-8pm EST, online at carrum.me/stateofmaine, or by downloading the 'Carrum Health' app on iPhone and Android devices to search for and compare participating Centers of Excellence. After contacting Carrum Health, a participant is assigned a Care Specialist to determine if the participant may be referred to a Center of Excellence and provide non-medical coordination throughout the entire episode of care. To receive coverage under the Carrum Health Benefit, services must be scheduled and authorized by Carrum Health.

Participants are required to agree to Carrum Health's Terms of Service and Member Registration Agreement and must also agree to provide their medical records and any other relevant information to

their selected Center of Excellence as needed to schedule a consultative evaluation. During the consultation, the Center of Excellence will determine if the participant is an appropriate candidate for the requested procedure. To receive coverage under the Carrum Health Benefit, a Center of Excellence must determine that it will provide the requested procedure to the participant. A Center of Excellence may decline to treat a participant as it determines in its discretion.

In the case of a failure by a participant (or the participant's authorized representative) to follow the Plan's procedures for requesting authorization to participate in the Carrum Health Benefit, the participant or representative shall be notified of the failure and the proper procedures to be followed. This notification shall be provided to the participant or authorized representative, as appropriate, as soon as possible, but not later than five days following the failure. Notification may be oral, unless written notification is requested by the participant or authorized representative.

Coverage under the Carrum Health Benefit may be denied, in whole or in part, by Carrum Health in the following circumstances:

*Refusal to complete required documentation*

Coverage under the Carrum Health Benefit may be denied by Carrum Health if a participant refuses to complete documentation required to participate in the Carrum Health Benefit, including the Terms of Service and Member Registration Agreement.

Carrum Health will notify the participant (or the participant's authorized representative) within 15 days of the participant's request to participate in the Carrum Health Benefit if the participant has failed to submit any documentation that must be submitted to approve participation in the Carrum Health Benefit. The participant will be given additional time, without a deadline, to submit those forms. If the participant responds without providing the required documentation, Carrum Health will notify the participant that requested participation in the Carrum Health Benefit has been denied within 15 days after receipt by Carrum Health of the participant's response.

*Request for referral to another Center of Excellence*

Coverage under the Carrum Health Benefit may be denied by Carrum Health if a participant requests to be referred to another Center of Excellence after the initial Center of Excellence has determined the participant is not an appropriate candidate for the requested treatment. Note this does not apply when the initial referral is to an outpatient facility or ambulatory surgical center (ASC) that cannot treat the participant because their condition is too complex, in which case the participant may be referred to an acute care Center of Excellence.

Carrum Health will notify the participant (or the participant's authorized representative) within 15 days of the participant's request that this request has been denied. This period may be extended one time for up to 15 days, provided that Carrum Health both determines that such an extension is necessary due to matters beyond the control of Carrum Health and notifies the participant, prior to the expiration of the initial 15-day period, of the circumstances requiring the extension of time and the date by which Carrum Health expects to render a decision. If such an extension is necessary due to a failure of the participant to submit information necessary to decide the claim, the notice of extension will specifically describe the required information, and the participant shall be afforded at least 45 days from receipt of the notice within which to provide the specified information.

*Violation of Terms of Service or Member Registration Agreement*

Coverage under the Carrum Health Benefit may be denied by Carrum Health if a participant violates the Carrum Health Terms of Service or Member Registration Agreement.

Carrum Health will notify the participant (or the participant's authorized representative) within 15 days of learning of the participant's violation of the Carrum Health Terms of Service or Member Registration Agreement that the participant's requested participation in the Carrum Health Benefit has been denied. This period may be extended one time for up to 15 days, provided that Carrum Health both determines that such an extension is necessary due to matters beyond the control of Carrum Health and notifies the participant, prior to the expiration of the initial 15-day period, of the circumstances requiring the extension of time and the date by which Carrum Health expects to render a decision. If such an extension is necessary due to a failure of the participant to submit information necessary to decide the claim, the notice of extension will specifically describe the required information, and the participant shall be afforded at least 45 days from receipt of the notice within which to provide the specified information.

Denial of an Exception Request

To request an exception, a participant must complete the Exception Initiation Form and fax it, along with the required supporting documentation listed in the Exception Initiation Form, to Carrum Health at 1-650-539-0777. A participant may request an Exception Initiation Form by contacting Carrum Health at 1-888-855-7806 or by registering for the Carrum Health Program at carrum.me/stateofmaine.

Carrum Health will review the Exception Initiation Form to determine whether the submitted information and documentation meets the criteria to approve an exception, as listed in the Exception Initiation Form.

In the case of a failure by a participant (or the participant's authorized representative) to follow the Plan's procedures for requesting an exception and the participant has not yet received treatment, the participant or representative shall be notified of the failure and the proper procedures to be followed. This notification shall be provided to the participant or authorized representative, as appropriate, as soon as possible, but not later than five days following the failure. Notification may be oral, unless written notification is requested by the participant or authorized representative.

If the participant has not yet received the requested treatment, Carrum Health will notify the participant (or the participant's authorized representative) of the exception determination within a reasonable period of time appropriate to the medical circumstances, but not later than 15 days after receipt by Carrum Health of the exception request. This period may be extended one time for up to 15 days, provided that Carrum Health both determines that such an extension is necessary due to matters beyond the control of Carrum Health and notifies the participant, prior to the expiration of the initial 15-day period, of the circumstances requiring the extension of time and the date by which Carrum Health expects to render a decision. If such an extension is necessary due to a failure of the participant to submit the information necessary to decide whether the exception should be approved, the notice of extension will specifically describe the required information, and the participant shall be afforded at least 45 days from receipt of the notice within which to provide the specified information.

If the participant has already received treatment when they make their exception request, Carrum Health will notify the participant (or the participant's authorized representative) of the denial of an exception request within a reasonable period of time, but not later than 30 days after receipt of the

exception request. This period may be extended one time for up to 15 days, provided that Carrum Health both determines that such an extension is necessary due to matters beyond the control of Carrum Health and notifies the participant, prior to the expiration of the initial 30-day period, of the circumstances requiring the extension of time and the date by which Carrum Health expects to render a decision. If such an extension is necessary due to a failure of the participant to submit the information necessary to decide the exception request, the notice of extension shall specifically describe the required information, and the participant shall be afforded at least 45 days from receipt of the notice within which to provide the specified information.

## Benefit Notifications

Carrum Health will provide a participant with written or electronic notification of any adverse benefit determination. The notification will include:

- The specific reason or reasons for the adverse determination;
- Reference to the specific Plan provisions on which the determination is based;
- A description of any additional material or information necessary for the participant to perfect the claim and an explanation of why such material or information is necessary;
- If an internal rule, guideline, protocol, or other similar criterion was relied upon in making the adverse determination, either the specific rule, guideline, protocol, or other similar criterion; or a statement that such a rule, guideline, protocol, or other similar criterion was relied upon in making the adverse determination and that a copy of such rule, guideline, protocol, or other criterion will be provided free of charge to the claimant upon request;
- Information sufficient to identify the claim involved (including the date of service, the health care provider, the claim amount (if applicable), and a statement describing the availability, upon request, of the diagnosis code and its corresponding meaning, and the treatment code and its corresponding meaning);
- The reason or reasons for the adverse benefit determination, including the denial code and its corresponding meaning, as well as a description of the Plan's standard, if any, that was used in denying the claim;
- A description of available internal appeals and external review processes, if any, including information regarding how to initiate an appeal; and
- The availability of, and contact information for, any applicable office of health insurance consumer assistance or ombudsman established to assist individuals with the internal claims and appeals and external review processes.

## Appeals

Denials Other than Denied Exception Requests

The Plan requires two levels of appeal with respect to the Carrum Health Benefit. The request for a first-level appeal must be made within 180 days following receipt of the adverse benefit determination, by submitting such request to Carrum Health at appeals@carrumhealth.com. The request for a second-level appeal must be made within 60 days following receipt of the adverse benefit determination on review, by submitting such request to Carrum Health at appeals@carrumhealth.com.

As part of the appeal process, a participant may submit written comments, documents, records, and other information relating to the claim for benefits. The review will take into account all comments,

documents, records, and other information submitted by the participant relating to the claim, without regard to whether such information was submitted or considered in the initial benefit determination. The review will not afford deference to the initial adverse benefit determination and is conducted by an appropriate named fiduciary of the Plan who is neither the individual who made the adverse benefit determination that is the subject of the appeal, nor the subordinate of such individual.

A participant will be provided, upon request and free of charge, reasonable access to, and copies of, all documents, records, and other information relevant to the participant's claim for benefits.

A participant will be provided, free of charge, with any new or additional evidence considered, relied upon, or generated by Carrum Health in connection with the claim or any new or additional rationale for an adverse benefit determination as soon as possible and sufficiently in advance of the date on which the notice of final internal adverse benefit determination is required to be provided to give the participant a reasonable opportunity to respond prior to that date.

When the requested treatment has not yet been provided, Carrum Health will notify the participant of a benefit determination on review no later than 15 days after receipt by Carrum Health of the participant's request for a first-level appeal or second-level appeal, as applicable. When requested treatment has already been provided, Carrum Health will notify the participant of benefit determination on review no later than 30 days after receipt by Carrum Health of the participant's request for a first-level appeal or a second-level appeal, as applicable.

Carrum Health will provide a participant with written or electronic notification of an appeal determination. In the case of an adverse benefit determination, the notification will include:

- The specific reason or reasons for the adverse determination;
- Reference to the specific Plan provisions on which the benefit determination is based;
- A statement that the participant is entitled to receive, upon request and free of charge, reasonable access to, and copies of, all documents, records, and other information relevant to the participant's claim for benefits;
- If an internal rule, guideline, protocol, or other similar criterion was relied upon in making the adverse determination, either the specific rule, guideline, protocol, or other similar criterion; or a statement that such rule, guideline, protocol, or other similar criterion was relied upon in making the adverse determination and that a copy of the rule, guideline, protocol, or other similar criterion will be provided free of charge to the claimant upon request;
- The following statement: "You and your plan may have other voluntary alternative dispute resolution options, such as mediation. One way to find out what may be available is to contact your local U.S. Department of Labor Office and your State insurance regulatory agency."
- Information sufficient to identify the claim involved (including the date of service, the health care provider, the claim amount (if applicable), and a statement describing the availability, upon request, of the diagnosis code and its corresponding meaning, and the treatment code and its corresponding meaning);
- The reason or reasons for the adverse benefit determination, including the denial code and its corresponding meaning, as well as a description of the Plan's standard, if any, that was used in denying the claim, including a discussion of the decision;
- A description of available internal appeals and external review processes, if any, including information regarding how to initiate an appeal; and

- The availability of, and contact information for, any applicable office of health insurance consumer assistance or ombudsman established to assist individuals with the internal claims and appeals and external review processes.

Denied Exception Requests

The Plan requires two levels of appeal with respect to the Carrum Health Benefit. The request for a first-level appeal must be made within 180 days following receipt of the adverse benefit determination, by submitting such request to Carrum Health at appeals@carrumhealth.com. The request for a second-level appeal must be made within 60 days following receipt of the adverse benefit determination on review, by submitting such request to The Office of Employee Health and Wellness at the State of Maine via info.benefits@maine.gov using the subject line - "Carrum Benefit Appeal Request" or mailed to 61 State House Station, Augusta ME 04333-0061.

As part of the appeal process, a participant may submit written comments, documents, records, and other information relating to the claim for benefits. The review will take into account all comments, documents, records, and other information submitted by the participant relating to the claim, without regard to whether such information was submitted or considered in the initial benefit determination. The review will not afford deference to the initial adverse benefit determination and is conducted by an appropriate named fiduciary of the Plan who is neither the individual who made the adverse benefit determination that is the subject of the appeal, nor the subordinate of such individual.

A participant will be provided, upon request and free of charge, reasonable access to, and copies of, all documents, records, and other information relevant to the participant's claim for benefits.

A participant will be provided, free of charge, with any new or additional evidence considered, relied upon, or generated in connection with the claim or any new or additional rationale for an adverse benefit determination as soon as possible and sufficiently in advance of the date on which the notice of final internal adverse benefit determination is required to be provided to give the participant a reasonable opportunity to respond prior to that date.

When the requested treatment has not yet been provided, the participant will be notified of a benefit determination on review no later than 15 days after receipt of the participant's request for a first-level appeal or second-level appeal, as applicable. When requested treatment has already been provided, the participant will be notified of a benefit determination on review no later than 30 days after receipt of the participant's request for a first-level appeal or a second-level appeal, as applicable.

A participant will be provided with written or electronic notification of an appeal determination. In the case of an adverse benefit determination, the notification will include:

- The specific reason or reasons for the adverse determination;
- Reference to the specific Plan provisions on which the benefit determination is based;
- A statement that the participant is entitled to receive, upon request and free of charge, reasonable access to, and copies of, all documents, records, and other information relevant to the participant's claim for benefits;
- If an internal rule, guideline, protocol, or other similar criterion was relied upon in making the adverse determination, either the specific rule, guideline, protocol, or other similar criterion; or a statement that such rule, guideline, protocol, or other similar criterion was relied upon in making

the adverse determination and that a copy of the rule, guideline, protocol, or other similar criterion will be provided free of charge to the claimant upon request;

- The following statement: "You and your plan may have other voluntary alternative dispute resolution options, such as mediation. One way to find out what may be available is to contact your local U.S. Department of Labor Office and your State insurance regulatory agency."
- Information sufficient to identify the claim involved (including the date of service, the health care provider, the claim amount (if applicable), and a statement describing the availability, upon request, of the diagnosis code and its corresponding meaning, and the treatment code and its corresponding meaning);
- The reason or reasons for the adverse benefit determination, including the denial code and its corresponding meaning, as well as a description of the Plan's standard, if any, that was used in denying the claim, including a discussion of the decision;
- A description of available internal appeals and external review processes, if any, including information regarding how to initiate an appeal; and
- The availability of, and contact information for, any applicable office of health insurance consumer assistance or ombudsman established to assist individuals with the internal claims and appeals and external review processes.

No action at law or in equity may be brought to recover under the Carrum Health Benefit under the Plan until all administrative remedies have been exhausted (including the two levels of appeal). If a participant fails to file a timely claim, or if the participant fails to request a review in accordance with the Plan's claim procedures outlined herein, such participant will have no right of review and will have no right to bring any action in any court. The denial of the claim will become final and binding on all persons for all purposes.

Any action at law or in equity with respect to any and all claims relating to the Carrum Health Benefit under the Plan must be brought for recovery within one year from the earlier of (1) the date of an adverse benefit determination on a second-level appeal, if applicable, or (2) the accrual of any claim under or relating to the Carrum Health Benefit that does not result in an adverse benefit determination on a second-level appeal.