

Plan Endorsement #24-SP

GROUP # A17112
EFFECTIVE DATE January 1, 2024
EMPLOYER ID# 46-5646073 PLAN #s 501
NAME OF PLAN Aperion Care Inc. Employee Benefits Plan
TYPE OF PLAN ACP 16 Plan

The following wording is hereby added to the Plan:

Aperion Care Inc., of Lincolnwood, Illinois hereby establishes a plan for payment of certain expenses for the benefit of its eligible employees to be known as Aperion Care Inc. Employee Benefits Plan. The attached document serves as the summary plan description, plan description and plan document for the Plan.

Aperion Care Inc. has caused this Plan to take effect as of 12:01 A.M. Central Time on January 1, 2024 at Lincolnwood, Illinois.

APPROVED AND ATTESTED:

BY _____ TITLE _____

DATE _____

APERION CARE INC.

4655 West Chase Avenue
Lincolnwood, IL 60712
Phone: (847) 262-3800

ACP 16 PLAN

This booklet describes the Medical benefits for Eligible Employees of Aperion Care Inc.

Information Applicable to Plan 501

Employer Identification Number
46-5646073

**The Benefits In This Booklet Are Effective
January 1, 2024**

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KEY INFORMATION

EMPLOYER/COMPANY/PLAN ADMINISTRATOR/PLAN SPONSOR CONTACT INFORMATION:

Aperion Care Inc.
4655 West Chase Avenue
Lincolnwood, IL 60712
Phone: (847) 262-3800

EMPLOYER/COMPANY IDENTIFICATION NUMBER (EIN) AS ASSIGNED BY THE INTERNAL REVENUE SERVICE (IRS):

46-5646073

PLAN NAME:

Aperion Care Inc. Employee Benefits Plan

PLAN CONTACT INFORMATION:

Human Resources Department
Aperion Care Inc.
4655 West Chase Avenue
Lincolnwood, IL 60712
Phone: (847) 262-3800

PLAN NUMBER:

501

STOP LOSS COVERAGE:

The Company has purchased specific and aggregate stop-loss reinsurance coverage.

GROUP NUMBER:

A17112

SPD EFFECTIVE DATE:

January 1, 2024

PLAN YEAR:

The financial records of the Plan are kept on a Plan Year basis. The Plan Year ends the last day of each December.

TYPE OF PLAN:

Medical and Prescription Drugs

NAME, ADDRESS AND TELEPHONE NUMBER OF THE CLAIMS PROCESSOR:

Allied Benefit Systems, LLC

P.O. Box 211651

Eagan, MN 55121

Phone: (312) 906-8080 or (800) 288-2078 (outside IL)

PRIVACY OFFICERS UNDER THE HEALTH INSURANCE PORTABILITY AND ACCOUNTABILITY ACT OF 1996, AS AMENDED (HIPAA):

The following employees, or classes of employees, or other persons under control of the Plan Sponsor, shall be given access to the protected health information (PHI) to be disclosed:

- Human Resources Manager.
- Staff designated by Human Resources Manager.
- Chief Financial Officer.
- Staff designated by Chief Financial Officer.

ELIGIBILITY:

- Employees: A person directly employed in the regular business of, and compensated for, services by the Company, who is employed on average at least 30 hours of service per week. This definition specifically excludes independent contractors.
- Retirees: This Plan does not cover Retirees or their Dependents.
- Dependents Including:
 - Dependent Children: Child(ren) from birth to the last day of the month they attain age 26 consisting of natural children, stepchildren, foster children, adopted children, children placed for adoption, and children for whom You are the court-appointed legal guardian.
 - Spouse: This Plan defines “marriage” as both 1) a legal union between one man and one woman as husband and wife, legally married in a jurisdiction (domestic or foreign) that recognizes their marriage, and 2) a legal union between two persons of the same sex, legally married in a jurisdiction (domestic or foreign) that recognizes their marriage. Marriage does not include a civil union, domestic partnership or any other similar arrangement.
 - Domestic Partners: This Plan does not cover Domestic Partners.

WORKING SPOUSE COVERAGE PROVISION:

No surcharge will be levied if the spouse of an eligible Employee is eligible for coverage through his employer and chooses coverage from this Plan.

ENROLLMENT:

- **Enrollment Waiting Period:**

All Employees shall be eligible on the first day of the month following 30 days of employment.

- **Open Enrollment Period:**

Each year, a period of time may be designated as an Open Enrollment period. Except for Special Enrollment or Late Enrollment, if applicable, it is only during this period that an Employee or Dependent who did not enroll during their initial eligibility period may enroll in a Plan. It is also only during this period that an Employee who is currently covered under one Plan may switch to another. Coverage will become effective on the date specified by Your Employer.

- **Late Enrollment Period:**

This Plan does not have a Late Enrollment period.

TERMINATION OF COVERAGE:

- **Employee:** The coverage of any Employee covered under this Plan shall terminate on the earliest of the following:
 - The date the Employee ceases to be eligible for coverage under the Plan, as listed in the Key Information section; or
 - The date of termination of the Plan.
- **Dependent children (attaining age 26):** The coverage of Dependent children attaining age 26 covered under this Plan shall terminate on the earliest of the following:
 - The last day of the month such individual ceases to meet the definition of Dependent, as listed in the Key Information section; or
 - The date the Employee's coverage terminates under the Plan.
- **Dependent (all others):** The coverage of any Dependent (other than identified above) covered under this Plan shall terminate on the earliest of the following:
 - The date such individual ceases to meet the definition of Dependent, as listed in the Key Information section, or
 - The date the Employee's coverage terminates under the Plan.

PRE-CERTIFICATION PROGRAM

Your Plan also includes a **Pre-Certification Program**. The toll-free number You must use for pre-certification is shown on Your member ID card. **Failure to follow the guidelines listed below will subject Your benefits to a Penalty for Non-Compliance as discussed in this section and referenced in the Schedule of Covered Services and Provisions.**

The following service require pre-certification:

1. Inpatient Hospital admissions.
2. **Oncology Treatment**
 - a. **Chemotherapy (Including oral)**
 - b. **Radiation Therapy**
 - c. **Oncology and transplant related injections, infusions and treatment (e.g., CAR-T, endocrine and immunotherapy), excluding supportive drugs (e.g., antiemetic and antihistamine)**

If Your Physician recommends any service listed above, please follow these steps:

1. Notify Your Physician that You participate in a Pre-Certification Program. Please note that this applies even if this Plan is the secondary payer under Coordination of Benefits.
2. You or Your Physician must call the number shown on Your member ID card 2 weeks before or, if less than 2 weeks, as soon as scheduled for an elective Hospital admission or any of the services listed above.
3. If You have an emergency admission, pre-certification is required within 48 hours or the next business day following admission.

The following information will be needed to pre-certify:

Regarding Patient:	Regarding Employee:
Name	Name
Address	Address
Telephone #	Telephone #
Date of Birth	Date of Birth
Relationship to Employee	Gender
Physician's Name	Social Security Number
Physician's Phone Number	Name of Employer
Hospital/Address	Name of Claims Processor: <i>Allied Benefit Systems, LLC</i>

4. A nurse may call Your Physician to review a proposed Inpatient admission or other listed service. If admission is necessary, an assigned length of stay will be determined. If additional days are later thought to be necessary, these additional days must also be pre-certified.

5. When You or Your Physician call to pre-certify an Inpatient admission or other listed service, the call will be logged so that:
 - a. The facility can verify that pre-certification has been done and can track expected length of stay.
 - b. The Claims Processor can verify that the pre-certification requirements have been met when the claim is received for processing.

Note: Pre-Certification assists in determining medical necessity and the best place for treatment. This service, however, does not guarantee payment, which is subject to eligibility and coverage at the time services are rendered.

PENALTY FOR NON-COMPLIANCE:

Unless prohibited under federal law, any non-compliance penalty specified in the Schedule of Covered Services and Provisions will apply under one or more of the following circumstances: a) a pre-certification call is not made according to the instructions within this section; b) an Inpatient stay exceeds the amount of days pre-certified; or c) a patient is admitted as an Inpatient when treatment could have been performed on an Outpatient basis.

This penalty will be applied in addition to any applicable Deductible and will not be applied to any Out-of-Pocket Maximum as specified in the “Schedule of Covered Services and Provisions”. The penalty will be applied to covered services that were incurred during the days that were not pre-certified.

PRE-NOTIFICATION

The following procedures are generally not covered by the Plan unless medically appropriate. Therefore, it is strongly recommended that a pre-notification of the following procedures be obtained before treatment. The toll-free number You should use for pre-notification is 855-442-3477.

Procedures for which pre-notification is recommended are:

1. Non-orthopedic imaging for CT, MRI, and PET Scans.
2. Neoplasm biopsies.



SCHEDULE OF COVERED SERVICES AND PROVISIONS

The Affordable Care Plan (ACP) simplifies the way that You receive health care benefits. Covered Services are covered at specified levels “without” Preferred Provider Networks that adjust and discount benefit payments. The ACP will reimburse Covered Services up to the Maximum Allowable Amount, as defined in the Definitions section. Some exceptions may apply. See the “Balance Billing” section of this SPD for more information.

I. MEDICAL CARE BENEFITS:

COVERED SERVICES and PROVISIONS	ACP Benefits
<p>Calendar Year Deductible (<i>taken before benefits are payable unless waived</i>)</p> <p><i>This is an embedded Deductible, meaning each covered family member only needs to satisfy his or her individual Deductible, not the entire Family Deductible, prior to receiving plan benefits. The balance of the Family Deductible can be satisfied by one member or a combination of remaining family members.</i></p>	<p>\$2,000 per person \$4,000 per family</p>
<p>Deductible Carry-Over</p>	<p>N/A</p>
<p>Out-of-Pocket Maximum per Calendar Year (Co-insurance and deductibles count towards the Out-of-Pocket Maximum)</p> <p><i>After amount is reached, the Plan will pay 100% of the amount that Medicare would pay a provider for Covered Services (100% for Prescription Drugs), for the remainder of that Calendar Year. The following expenses do not apply to and are not affected by the Out-of-Pocket Maximum.</i></p> <ul style="list-style-type: none"> “Non-compliance penalty” (for failure to abide by pre-certification requirements). Any out-of-pocket expenses that are for non-covered services or for services that are in excess of any Plan maximum or limit. Any balance billed amounts. <p><i>This is an embedded Out-of-Pocket Maximum, meaning each covered family member only needs to satisfy his or her individual Out-of-Pocket Maximum, not the entire family Out-of-Pocket maximum, prior to receiving Plan benefits paid at 100%. The balance of the family Out-of-Pocket Maximum can be satisfied by one member or a combination of remaining family members.</i></p>	<p>\$6,450 per person \$12,900 per family</p>
<p>Calendar Year Benefit Maximum</p>	<p>Unlimited</p>
<p>Precertification Penalty for Non-Compliance: Certain benefits are subject to a 50% reduction up to a Maximum penalty of \$500 per occurrence (<i>in addition to Deductible</i>) for failure to follow the Pre-Certification Program provisions. Please refer to Pre-Certification Program section and to the Mental Nervous/Substance Use Disorder Section for additional information.</p>	<p>Allied Customer Care 1-855-442-3477</p>
<p>Claims Filing Limit</p>	<p>All charges, and corresponding requested documentation, must be submitted within 1 year of the date incurred.</p>
<p>Coordination of Benefits</p>	<p>If it is determined that this Plan is the Secondary Payer, Benefits will be adjusted and reduced (standard). Benefits payable from both plans shall not exceed 100% of the Maximum Allowable Amount.</p>


II. PRESCRIPTION DRUG BENEFIT:

COVERED SERVICES and PROVISIONS	
<p><i>Your Discount Prescription Drug Benefit is administered by Caremark. For prescription drug questions please call Allied Customer Care at 1-855-442-3477 or visit www.caremark.com</i></p>	
<p>If doctor requests brand only when a generic is available, the member will be charged the generic Co-Insurance plus the cost difference between the brand and generic medication. The amount of this cost difference does not apply to the Deductibles or Out-of-Pocket Maximums.</p>	
<p>Specialty Drug Benefit</p>	<p>Not Covered through Caremark; Subject to Calendar Year Deductible and coinsurance.</p> <p>Please contact Allied Benefit Systems, LLC at 1-855-442-3477</p>
<p>Discount Drug Card Benefit</p>	<p>Prescription drugs to be purchased from pharmacy at a reduced cost and applied toward the Calendar Year Deductible. Once the deductible is met, You pay 10% co-insurance at the point of sale.</p> <p>Co-insurance for prescription drugs applies toward Your Out-of-Pocket Maximum. After Your Out-of-Pocket Maximum is met, the Plan will pay 100% of Your prescription costs.</p>
<p><i><u>Note:</u> Certain prescriptions shall be covered at 100%, and no co-pay will apply as per Federal Regulations</i></p>	

III. PREVENTIVE CARE SERVICES:

COVERED SERVICES and PROVISIONS	ACP Benefits
<p>The Affordable Care Plan (ACP) simplifies the way that You receive health care benefits. Covered Services are covered at specified levels “without” Preferred Provider Networks that adjust and discount benefit payments. The ACP will reimburse Covered Services up to the Maximum Allowable Amount, as defined in the Definitions section. <i>Some exceptions may apply.</i> See the “Balance Billing” section of this SPD for more information.</p>	
<p>Preventive Care Services - <i>(must be billed with a routine diagnosis).</i></p> <p>This plan includes coverage for physical exams, immunizations, tests, labs, x-rays, pap smears and analysis, PSA test, bone density tests (for women age 60 and older, every 5 Calendar years).</p> <p><i>This benefit also covers all services referenced within the Recommendations of the United States Preventive Service Task Force, Recommendations of the Advisory Committee On Immunization Practices (ACIP) that have been adopted by the Director of the Centers for Disease Control and Prevention and appear on the Immunization Schedules of the Centers for Disease Control and Prevention, the Comprehensive Guidelines Supported by the Health Resources and Services Administration (HRSA), as well as referenced in the Guidelines for Women’s Preventative Services adopted by the United States Department of Health and Human Services, based on recommendations by the Institute of Medicine.</i></p> <p>This benefit specifically does not cover executive physicals, heart scans, full body scans, CAT scans, MRIs, PET or other similar tests.</p>	<p>100% of the Maximum Allowable Amount <u>Deductible Waived</u></p>
<p>Preventive Care Services – Enhanced - <i>(must be billed with a routine diagnosis).</i></p> <ul style="list-style-type: none"> • Mammograms (including 3D), once every Calendar year (age 40 or older) • Choice between a sigmoidoscopy or a colonoscopy once every 5 Calendar years (age 45 or older) 	<p>100% of the Maximum Allowable Amount <u>Deductible Waived</u></p>
<p>Family Planning - Permanent Procedures for Women</p> <p><i>Includes:</i></p> <ul style="list-style-type: none"> • Sterilization. 	<p>100% of the Maximum Allowable Amount <u>Deductible Waived</u></p>
<p>Family Planning – Temporary Procedures</p> <p><i>Including but not limited to injections, implants, and intrauterine contraceptives including administration, insertion, and removal.</i></p>	<p>100% of the Maximum Allowable Amount <u>Deductible Waived</u></p>
<p>Breast Pumps and Supplies (Includes one breast pump per pregnancy and certain covered supplies purchased through a retail supplier).</p>	<p>100% of the Maximum Allowable Amount <u>Deductible Waived</u></p>

IV. PHYSICIAN SERVICES:

COVERED SERVICES and PROVISIONS	ACP Benefits
<p>The Affordable Care Plan (ACP) simplifies the way that You receive health care benefits. Covered Services are covered at specified levels "without" Preferred Provider Networks that adjust and discount benefit payments. The ACP will reimburse Covered Services up to the Maximum Allowable Amount, as defined in the Definitions section. Some exceptions may apply. See the "Balance Billing" section of this SPD for more information.</p>	
 <p>Teladoc provides access to a national network of U.S. board-certified doctors and pediatricians who are available on-demand 24 hours a day, 7 days a week, 365 days a year to diagnose, treat and prescribe medication (when necessary) for many medical issues via phone, by calling 1-855-442-3477, or online video consultations by accessing www.teladoc.com. Teladoc does not replace the existing primary care physician relationship, but enhances it as a convenient, affordable alternative for medical care.</p>	<p>100% <u>Deductible Waived</u></p>
<p>Virtual Physician charges</p>	<p>Paid same as any other service according to type of service and provider.</p>
<p>Physician Office Visits - Exam charge only <i>Unless listed separately within this schedule. Includes allergy injections, serum, and administration.</i></p>	<p>100% of the Maximum Allowable Amount <u>Deductible Waived</u></p>
<p>Urgent Care - Includes all services done during or in connection with the Urgent Care visit.</p>	<p>90% of the Maximum Allowable Amount</p>
<p>Second Surgical Opinion</p>	<p>100% of the Maximum Allowable Amount <u>Deductible Waived</u></p>
<p>Surgery and Other Physician Services Incurred at a Physician's Office</p>	<p>100% of the Maximum Allowable Amount <u>Deductible Waived</u></p>
<p>Emergency Room Physician Care</p>	<p>100% of the Maximum Allowable Amount <u>Deductible Waived</u></p>
<p>Physical and Occupational Therapy <i>All services rendered by physical therapists/occupational therapists are limited to a combined maximum of 20 visits for office and Outpatient facility services, per Plan Participant per Calendar Year. However, this Calendar Year visit maximum does not apply to covered therapy services for autism.</i></p>	<p>100% of the Maximum Allowable Amount <u>Deductible Waived</u></p>
<p>Speech Therapy <i>Limited to a maximum of 20 visits for office and Outpatient facility services, per Plan Participant per Calendar Year. However, this Calendar Year visit maximum does not apply to covered therapy services for autism.</i></p>	<p>100% of the Maximum Allowable Amount <u>Deductible Waived</u></p>

IV. PHYSICIAN SERVICES:

COVERED SERVICES and PROVISIONS	ACP Benefits
<p>The Affordable Care Plan (ACP) simplifies the way that You receive health care benefits. Covered Services are covered at specified levels “without” Preferred Provider Networks that adjust and discount benefit payments. The ACP will reimburse Covered Services up to the Maximum Allowable Amount, as defined in the Definitions section. Some exceptions may apply. See the “Balance Billing” section of this SPD for more information.</p>	
<p>All Care Rendered by a Chiropractor <i>All services provided by a chiropractor are limited to a combined maximum of 20 visits per Plan Participant per Calendar Year, regardless of the place of service or services provided. Does not include labs and x-rays; please see Section V for additional benefit coverage information.</i></p>	<p>100% of the Maximum Allowable Amount <u>Deductible Waived</u></p>
<p>Anesthesia and its Administration (Inpatient/Outpatient)</p>	<p>100% of the Maximum Allowable Amount <u>Deductible Waived</u></p>
<p>Other Physician Services <i>Does not include labs and X-rays; please see Section V for additional benefit coverage information.</i></p>	<p>100% of the Maximum Allowable Amount <u>Deductible Waived</u></p>

V. OUTPATIENT/OFFICE (PHYSICIAN’S OFFICE AND FACILITY)


LABORATORY/RADIOLOGY/PATHOLOGY SERVICES, INCLUDING ADMINISTRATION AND MRI, PET, AND CT SCANS:

COVERED SERVICES and PROVISIONS	ACP Benefits
<p>The Affordable Care Plan (ACP) simplifies the way that You receive health care benefits. Covered Services are covered at specified levels “without” Preferred Provider Networks that adjust and discount benefit payments. The ACP will reimburse Covered Services up to the Maximum Allowable Amount, as defined in the Definitions section. Some exceptions may apply. See the “Balance Billing” section of this SPD for more information.</p>	
<p>Office Diagnostic Tests, Radiology, and Pathology Administration and Interpretation Services <i>Does not include above services performed in conjunction with the following:</i></p> <ul style="list-style-type: none"> • Urgent Care Services. • Emergency Room Services. <p><i>Does not include MRI, PET or CT scans.</i></p>	<p>100% of the Maximum Allowable Amount <u>Deductible Waived</u></p>
<p>Outpatient/Independent Laboratory Diagnostic Tests, Radiology, and Pathology Administration and Interpretation Services <i>Does not include above services performed in conjunction with the following:</i></p> <ul style="list-style-type: none"> • Emergency Room Services. <p><i>Does not include MRI, PET or CT scans.</i></p>	<p>90% of the Maximum Allowable Amount</p>
<p>Office Imaging Services (MRI, PET, and CT scans)</p>	<p>100% of the Maximum Allowable Amount <u>Deductible Waived</u></p>
<p>Outpatient/Independent Laboratory Imaging Services (MRI, PET, and CT scans)</p>	<p>90% of the Maximum Allowable Amount</p>

VI. FACILITY SERVICES:

COVERED SERVICES and PROVISIONS	ACP Benefits
<p>The Affordable Care Plan (ACP) simplifies the way that You receive health care benefits. Covered Services are covered at specified levels "without" Preferred Provider Networks that adjust and discount benefit payments. The ACP will reimburse Covered Services up to the Maximum Allowable Amount, as defined in the Definitions section. Some exceptions may apply. See the "Balance Billing" section of this SPD for more information.</p>	
<p>Emergency Room Services</p> <p><i>Note: See the "Balance Billing" section for more information regarding Emergency Room Services.</i></p>	<p>90% of the Maximum Allowable Amount</p>
<p>Inpatient Hospital Services</p> <p>Coverage is limited to:</p> <ul style="list-style-type: none"> • Room and board not to exceed the semi-private room rate. • Necessary services and supplies including an intensive care unit and a cardiac care unit. <p>Notice and consent rules may apply to certain post-stabilization items and services. See Emergency Room Services in the "Definitions" section.</p> <p><i>Note: Room and board subject to the payment of semi-private room rate, unless the Hospital only has private rooms.</i></p>	<p>90% of the Maximum Allowable Amount</p>
<p>Pre-Admission Testing</p>	<p>90% of the Maximum Allowable Amount</p>
<p>Ambulatory Surgical Facility Charges for Outpatient Surgical Procedures</p>	<p>90% of the Maximum Allowable Amount</p>
<p>Outpatient Hospital Facility Charges</p>	<p>90% of the Maximum Allowable Amount</p>
<p>Renal Dialysis</p>	<p>90% of the Maximum Allowable Amount</p>
<p>Urgent Care Services Performed at a Hospital or Facility (includes Physician charges)</p>	<p>90% of the Maximum Allowable Amount</p>

VII. MENTAL HEALTH AND SUBSTANCE USE SERVICES:

COVERED SERVICES and PROVISIONS	ACP Benefits
<p>The Affordable Care Plan (ACP) simplifies the way that You receive health care benefits. Covered Services are covered at specified levels “without” Preferred Provider Networks that adjust and discount benefit payments. The ACP will reimburse Covered Services up to the Maximum Allowable Amount, as defined in the Definitions section. Some exceptions may apply. See the “Balance Billing” section of this SPD for more information.</p>	
 <h1 data-bbox="378 485 1419 569">BEHAVIORAL HEALTH</h1>	
<p>BEHAVIOR HEALTH ENHANCED BENEFIT (Mental/Nervous/Substance Use Disorders)</p>	
<p>Treatment Through Allied Care Solutions</p> <p><i>Allied Care Solutions is Your single source for Support, Resources and Information. This program is designed to help You manage life’s daily challenges. We can refer You to professional counselors and services that can help You and Your eligible family members resolve a broad range of personal concerns, such as marriage and relationships, stress and anxiety, depression, substance abuse, anger management, family problems, grief and loss, legal and financial services and dependent care. Allied Care Solutions is a no-cost confidential program that is available to You and Your family 24 hours a day, 365 days a year. At some point in our lives, each of us faces a problem or situation that is difficult to resolve. Your Company understands how work and personal challenges can affect Your well-being and encourages You to call Allied Care Solutions at 1-855-442-3477 or visit http://www.alliedbenefit.com/acs.aspx (user name is Your Company name).</i></p> <p>Contact Allied Care Solutions at 1-855-442-3477.</p> <p>By calling Allied Care Solutions, You may be eligible to receive certain services payable at no cost to You with no claims submission required.</p>	
<p>Treatment for Mental/Nervous and Substance Use Disorders - Outpatient</p>	<p><i>Paid same as any other service according to type of service, provider and place of service.</i></p>
<p>Treatment for Mental/Nervous and Substance Use Disorders not provided through Allied Care Solutions referenced above – Inpatient <i>Please see the definitions of Physician and Hospital for further detail.</i></p>	<p><i>Paid same as any other service according to type of service, provider and place of service.</i></p>

VIII. OTHER COVERED SERVICES:

COVERED SERVICES and PROVISIONS	ACP Benefits
<p>The Affordable Care Plan (ACP) simplifies the way that You receive health care benefits. Covered Services are covered at specified levels “without” Preferred Provider Networks that adjust and discount benefit payments. The ACP will reimburse Covered Services up to the Maximum Allowable Amount, as defined in the Definitions section. Some exceptions may apply. See the “Balance Billing” section of this SPD for more information.</p>	
<p>Other Covered Services/Items</p>	<p>90% of the Maximum Allowable Amount Unless included in a separate category.</p>
<p>Abortion - only if mother’s life is endangered if pregnancy is carried to term.</p>	<p>90% of the Maximum Allowable Amount</p>
<p>Acupuncture (in lieu of anesthesia administered in conjunction with a surgery)</p>	<p>90% of the Maximum Allowable Amount</p>
<p>Artificial Limbs, Eyes and Larynx</p>	<p>90% of the Maximum Allowable Amount</p>
<p>Assisted Reproduction</p>	<p>Not Covered.</p>
<p>Autism Spectrum Disorders For those diagnosed with this disorder, the following treatments are covered:</p> <ul style="list-style-type: none"> • Psychiatric and Psychological care, meaning direct, consultative, or diagnostic services provided by a licensed psychiatrist or psychologist; • Habilitative or rehabilitative care, meaning professional, counseling, and guidance services and treatment programs, including applied behavior analysis, that are intended to develop, maintain, and restore the functioning of an individual. <p>Autism spectrum disorders means pervasive developmental disorders as defined in the most recent edition of the Diagnostic and Statistical Manual of Mental Disorders, including autism, Asperger’s disorder, and pervasive developmental disorder not otherwise specified.</p>	<p>90% of the Maximum Allowable Amount Except as may be covered differently for specific services listed elsewhere in the schedule.</p>
<p>Casts, Splints, Trusses, and Braces</p>	<p>90% of the Maximum Allowable Amount</p>
<p>Chemotherapy</p>	<p>90% of the Maximum Allowable Amount</p>
<p>Contact Lenses or Glasses Following Cataract Surgery Limited to first pair of either contact lenses or glasses following cataract surgery for initial replacement of natural lenses.</p>	<p>90% of the Maximum Allowable Amount</p>
<p>Dental Treatment</p>	<p>See Oral Surgery benefit</p>
<p>Durable Medical Equipment Includes:</p> <ul style="list-style-type: none"> • Cost to rent up to the purchase price. • Insulin pump, glucose monitors and other diabetic supplies when Medically Necessary and not covered through Your prescription drug vendor. • Equipment for administration of oxygen. • Equipment repair or replacement. 	<p>90% of the Maximum Allowable Amount</p>
<p>Family Planning - Men’s Permanent Procedures Includes:</p> <ul style="list-style-type: none"> ○ Male vasectomy. 	<p>90% of the Maximum Allowable Amount</p>
<p>Foot Orthotics</p>	<p>Not Covered</p>
<p>Gender Affirming Surgery (including any associated labs and x-rays)</p>	<p>90% of the Maximum Allowable Amount</p>

VIII. OTHER COVERED SERVICES:

COVERED SERVICES and PROVISIONS	ACP Benefits
<p>The Affordable Care Plan (ACP) simplifies the way that You receive health care benefits. Covered Services are covered at specified levels “without” Preferred Provider Networks that adjust and discount benefit payments. The ACP will reimburse Covered Services up to the Maximum Allowable Amount, as defined in the Definitions section. Some exceptions may apply. See the “Balance Billing” section of this SPD for more information.</p>	
<p>Home Health Care <i>Limited to a maximum of 60 home care visits per Plan Participant per Calendar year. Each 4 hours of service by a home health aide in a 24 hour period will be considered 1 home health visit. One visit by any other provider of services will be counted as 1 visit.</i></p>	<p>90% of the Maximum Allowable Amount</p>
<p>Hospice Care <i>Includes all necessary services for the patient if prescribed by a Physician, and the patient’s life expectancy is 6 months or less.</i></p>	<p>90% of the Maximum Allowable Amount</p>
<p>Infertility Testing <i>Limited to Covered Expenses necessary to diagnose this condition, but not any charges in connection with the promotion of conception. Infertility means the inability to conceive a child, or the inability to sustain a successful pregnancy.</i></p>	<p>90% of the Maximum Allowable Amount</p>
<p>Infusion therapy and injections</p>	<p>90% of the Maximum Allowable Amount</p>
<p>Mastectomy Related Treatment <i>Includes charges in accordance with the provisions detailed under the definition of “Reconstructive Breast Surgery.”</i></p>	<p>90% of the Maximum Allowable Amount</p>
<p>Nutritional Counseling, regardless of underlying covered condition</p>	<p>90% of the Maximum Allowable Amount</p>
<p>Obesity Surgery or Non-Surgical Obesity Treatment</p>	<p>Not Covered</p>
<p>Oral Surgery Excludes teeth and is limited to a maximum benefit payment of \$5,000 per Calendar Year. <i>NOTE: Maximum benefit limitation does not apply to Dependent children under age 19.</i></p>	<p>90% of the Maximum Allowable Amount</p>
<p>Organ or Tissue Transplant Procedures <i>The Plan Participant, who is the transplant recipient, must receive 2 opinions with regard to the need for transplant surgery. The opinions must be in writing by board-certified specialists in the involved field of surgery. The specialists must certify that alternative procedures, services or courses of treatment would not be effective in the treatment of the condition.</i></p>	<p>90% of the Maximum Allowable Amount</p>
<p>Orthotics</p>	<p>Not Covered</p>
<p>Orthopedic Shoes</p>	<p>Not Covered</p>
<p>Prescription Drugs if not available through the Prescription Drug Benefit. Must be Medically Necessary.</p>	<p>90% of the Maximum Allowable Amount</p>
<p>Private Duty Nursing Services</p>	<p>Not Covered</p>
<p>Professional Ambulance Service <i>Transportation from the city or town in which the Plan Participant becomes disabled, to and from the nearest Hospital qualified to provide treatment for the accidental bodily Injury or disease. Note: See the “Balance Billing” section for more information regarding Air Ambulance services.</i></p>	<p>90% of the Maximum Allowable Amount</p>

VIII. OTHER COVERED SERVICES:

COVERED SERVICES and PROVISIONS	ACP Benefits
<p>The Affordable Care Plan (ACP) simplifies the way that You receive health care benefits. Covered Services are covered at specified levels “without” Preferred Provider Networks that adjust and discount benefit payments. The ACP will reimburse Covered Services up to the Maximum Allowable Amount, as defined in the Definitions section. Some exceptions may apply. See the “Balance Billing” section of this SPD for more information.</p>	
<p>Prosthetic Medical Appliances <i>Limited to charges for the purchase, maintenance, or repair of internal and external permanent or temporary aids and supports for defective body parts.</i></p>	<p>90% of the Maximum Allowable Amount</p>
<p>Routine Newborn Nursery Care <i>(including circumcision)</i></p>	<p>90% of the Maximum Allowable Amount</p>
<p>Skilled Nursing Facility <i>Includes Extended Care Facility. Limited to 60 days per Plan Participant per Calendar Year.</i></p>	<p>90% of the Maximum Allowable Amount</p>
<p>Sleep Studies (home)</p>	<p>90% of the Maximum Allowable Amount</p>
<p>Sleep Studies (In-lab, facility) <i>In order to be eligible, the following criteria must be met:</i></p> <ul style="list-style-type: none"> • Excessive daytime sleepiness • Epworth sleepiness scale ≥ 10 • Witnessed snoring <p><i>Along with one of the following comorbid conditions:</i></p> <ul style="list-style-type: none"> • Chronic obstructive pulmonary disease • Neuromuscular disease • Stroke • Epilepsy • Congestive heart failure • BMI > 45 • Periodic limb movement disorder • Narcolepsy • Central or complex sleep apnea 	<p>90% of the Maximum Allowable Amount</p>
<p>TMJ <i>(Temporomandibular Joint Dysfunction)</i></p>	<p>Not Covered</p>
<p>Wigs <i>for hair loss resulting from the treatment of cancer.</i></p>	<p>90% of the Maximum Allowable Amount</p>
<p>Please Refer to the Pre-Certification Program, Prescription Drug Benefit, and Exclusions sections for additional coverage details.</p>	

PRESCRIPTION DRUG BENEFIT

Prescription drug benefits are provided through the pharmacy benefit plan manager listed in the Prescription Drug Benefit section of the Schedule of Covered Services and Provisions. Benefits will be paid as stated in the Schedule of Covered Services and Provisions for charges made by a participating pharmacy for treatment of a Plan Participant's Illness or Injury. A covered charge is considered made on the date the prescription is dispensed by the pharmacist.

GENERAL PHARMACY BENEFIT

Prescriptions Covered:

1. Acne medications.
2. ADD and narcolepsy drugs.
3. Diabetic medications and supplies including:
 - a. Antihyperglycemics, injectable
 - b. Blood glucose testing devices (e.g., lancing devices).
 - c. Diabetic testing agents for glucose testing of blood/urine.
 - d. Glucose elevating agents (e.g., Glucagon).
 - e. Insulin (includes pre-filled syringes).
 - f. Insulin delivery devices (e.g., pens).
 - g. Insulin needles and syringes.
 - h. Lancets.
4. Emergency allergic reaction kits (e.g., Epipen, Epipen Jr.).
5. Legend prescription drugs (except DESI drugs) are covered unless specified otherwise in this Prescription Drug Benefit section (includes Schedule II, III, IV, and V Controlled Substances).
6. Lovenox - injectable.
7. Other drugs which under applicable state laws may only be dispensed with a prescription.
8. Prenatal vitamins that require a prescription.
9. Preventive care (covered at 100%) as required by federal law.
10. Smoking cessation drugs – Limited to a 168 day supply per Plan Participant per Calendar Year with generic nicotine replacement products (nicotine patch, gum and lozenges) and/or a 168 day supply per Plan Participant per Calendar Year with generic Zyban or Chantix. Over-the-counter (OTC) products require a prescription for coverage to apply.
11. Contraceptives for women approved by the Food and Drug Administration and as required by federal law (covered at 100%), including but not limited to:
 - a. Diaphragms/Kits.

- b. Emergency.
 - c. Extended cycle oral.
 - d. Implants (e.g., Implanon).
 - e. Injectable (e.g., Depo Provera).
 - f. Intrauterine Devices (IUD).
 - g. Oral/transdermal/intravaginal ring (e.g., Ortho-Evra, Nuvaring).
12. Injectable medications other than specifically listed as covered.

Enhanced Prescriptions Coverage:

- A. Fluoride supplements (that require a prescription and are not covered under preventive care).

Prescriptions Not Covered Under Prescription Drug Benefit:

1. *Anorexients.*
2. *Anti—obesity.*
3. *Any OTC medication, unless specified otherwise.*
4. *Biological sera.*
5. *Blood products.*
6. *Blood serum.*
7. *Charges for the administration or injection of any drug.*
8. *Cosmetic Drugs including anti-wrinkle agents, hair growth stimulants, hair removal products.*
9. *Drugs labeled, “Caution - limited by federal law to investigational use” or experimental drugs, even though a charge is made to the individual.*
10. *Experimental medications which do not have a National Drug Code Number (NDC).*
11. *Fertility agents.*
12. *Immunization agents that require a prescription and are not covered under preventive care.*
13. *Prescriptions which a Plan Participant is entitled to receive without charge under Workers’ Compensation laws.*
14. *Therapeutic devices or appliances including hypodermic needles, syringes, support garments, ostomy supplies, durable medical equipment, and non-medical substances regardless of intended use.*
15. *Growth hormone for short stature diagnosis.*
16. *Non-legend drugs other than those listed above.*
17. *Impotence medications.*

MAIL ORDER DRUG BENEFIT

This benefit offers a mail order service which delivers required prescription drugs directly to Your home after a per prescription co-pay has been made (see Schedule of Covered Services and Provisions for co-pay amount). The mail order drug benefit permits up to a 91-day supply of medication and up to one year of refills upon authorization.

You should receive a packet providing complete details on how to use Your mail order drug benefit. If You have any questions regarding this aspect of Your coverage, please contact Your Human Resources Department.

SPECIALTY DRUG BENEFIT

Specialty medications are required to be purchased through Allied's specialty pharmacy program. Typically, these medications are very costly, require special storage or handling, are for long term use, or require careful monitoring and management. You will be notified by the pharmacy at the time of purchase if a particular drug is in this specialty pharmacy program, or You may call the pharmacy vendor (see Your member ID card) as soon as a drug has been prescribed to determine how it must be dispensed. Please contact Allied's customer service team (see Your member ID card) to determine how the specialty drug that has been prescribed must be dispensed. Please refer to previous pages for coverage provisions.

TRAVEL AND LODGING EXPENSES

Travel and lodging expenses are covered under the Plan when necessary to obtain any type of care covered by the Plan when the care is not available from any provider or facility within 100 miles from the patient's principal residence. Coverage of travel and lodging expenses will be limited to the closest provider or facility capable of providing the service(s) at issue, and coverage of travel and lodging expenses will only be provided in connection with obtaining services that are lawfully provided in the jurisdiction where they are performed.

Travel shall be reimbursed between the patient's home and the provider or facility for round trip (air, train or bus) transportation costs, including local transportation (such as taxi, rideshare, or public transit) when required. Only transportation costs that are reasonable in amount (for example, coach class only) will be covered. If traveling by auto to the facility, reasonable mileage, parking and toll costs are reimbursed. Reasonable mileage reimbursement shall be limited to the tax-free cap authorized by the Federal government for medical travel, as adjusted (up or down) for inflation.

Reimbursement of expenses incurred by the patient for lodging is limited to a maximum rate of \$50 per night. If a traveling companion is necessary to enable the patient to receive medical care, the companion's reasonable travel and lodging expenses will also be covered, with lodging expenses also reimbursed at a maximum rate of \$50 per night. Travel & lodging reimbursement is limited to a total cap of \$10,000 per Calendar/Plan Year, which is the combined maximum for both the patient and companion and applies collectively to all trips taken in a Calendar/Plan Year.

Third-party documentation, such as receipts, must be provided to substantiate any claimed reimbursement of travel and lodging expenses.

EXCLUSIONS

No payment will be made under this Plan for expenses incurred by a Plan Participant based on the below exclusions (*unless specifically stated within the Schedule of Covered Services and Provisions*):

1. for or in connection with an Injury or Illness for which the Employee or Dependent is entitled to benefits under any Workers' Compensation, Occupational Disease, or similar law;
2. for care and treatment of an Injury or Illness arising out of, or in the course of, any employment for wage or profit;
3. in a Hospital owned or operated by the United States Government or for services or supplies furnished by or for any other government unless payment is legally required;
4. for charges which the Plan Participant is not legally required to pay or for charges which would not have been made if no coverage had existed;
5. This Exclusion is intentionally left blank;
6. which are for care or treatment which is not Medically Necessary;
7. for custodial care (Expenses incurred to assist a person in daily living activities are considered costs for custodial care. Costs for medical maintenance services and supplies in connection with custodial care due to age, mental or physical conditions, are not covered if such care cannot reasonably be expected to improve a medical condition.);
8. due to accidental bodily Injury or Illness resulting from participation in an insurrection or riot, or participation in the commission of an assault or felony;
9. for purchase or rental of personal comfort items or supplies of common use; for purchase or rental of blood pressure kits, exercise cycles, air purifiers, air conditioners, water purifiers, hypo-allergenic pillows, mattresses or waterbeds, escalators, elevators, saunas, steamrooms and/or swimming pools;
10. for non-medical expenses such as preparing medical reports, itemized bills or charges for mailing;
11. for training, educational instructions or materials, even if they are performed or prescribed by a Physician;
12. for legal fees and expenses incurred in obtaining medical treatment;
13. for genetic testing and counseling (except as may be specifically stated as covered elsewhere in this document) unless Medically Necessary;
14. for Friday and Saturday admissions unless due to a Medical Emergency or if surgery is scheduled within the 24 hour period immediately following admission;
15. for treatment by a Physician, Registered Nurse (R.N.), Licensed Practical Nurse (L.P.N) if the Physician or nurse is related by blood, marriage, or by legal adoption to either the Plan Participant or a spouse, or ordinarily resides with the Plan Participant;

16. for charges that are not payable under the Plan due to application of any Plan maximum or limit, or are for services not deemed to be eligible based upon the Plan Administrator's determination as set forth by and within the terms of this document;
17. for failure to provide any additional documentation or information as may be requested pursuant to the "Procedures For Filing Claims" section of this Plan;
18. for charges for travel or accommodations, whether or not recommended by a Physician, unless specifically stated as covered;
19. for charges incurred before coverage was effective or after it was terminated;
20. for charges incurred as a result of radioactive contamination or the hazardous properties of nuclear material;
21. except as stated in the Schedule of Covered Services and Provisions, 1) for treatment of or to the teeth, the nerves or roots of the teeth, and 2) for the repair or replacement of a denture;
22. for research studies not reasonably necessary to the treatment of an Illness or Injury;
23. This Exclusion is intentionally left blank;
24. This Exclusion is intentionally left blank;
25. for treatment for sexual dysfunction or inadequacy (except as may be indicated under the "Prescription Drug Benefit"), including implants and related hormone treatment;
26. for vitamins (except prescription pre-natal and pediatric vitamins); for over-the-counter drugs regardless of being prescribed by a Physician, unless required by federal law;
27. for routine foot care such as removal of corns, calluses or toenails, except in the treatment of a peripheral-vascular disease when recommended by a medical doctor or doctor of osteopathy;
28. for splints or braces for non-medical purposes (i.e. supports worn primarily during participation in sports or similar physical activities);
29. for any form of medication or treatment not prescribed in relation to an Injury, Illness or pregnancy, unless stated as covered elsewhere in this document;
30. for growth hormones for children with short stature (short stature based upon heredity and not caused by a diagnosed medical condition);
31. on account of any declared or undeclared act of war;
32. for charges in connection with Cosmetic Surgery/Treatment, except to correct deformities resulting from Injuries sustained in an accident; or due to an Illness such as breast cancer (including all services mandated by federal provisions related to mastectomy treatment – see definition of "Reconstructive Breast Surgery Coverage"); or to correct a functional disorder (functional disorders do not include mental or emotional distress related to a physical condition); or unless treatment is for correction of a functional abnormal congenital condition;

33. This Exclusion is intentionally left blank;
34. for expenses incurred for cryo-preservation and storage of sperm, eggs and embryos;
35. for charges incurred outside the United States if travel to such a location was for the primary purpose of obtaining medical services, drugs or supplies;
36. for special education services (unless specifically referenced in the Schedule of Covered Services);
37. for experimental or investigational services; or, for treatment not deemed clinically acceptable by (1) the National Institute of Health; or (2) the FDA; or (3) the Centers for Medicare and Medicaid Services (CMS); or (4) the AMA; or a similar national medical organization of the United States;
38. for routine eye examinations, unless required by federal law; for eyeglasses or contact lenses, or the fitting of eyeglasses or contact lenses, except as stated in the Schedule of Covered Services and Provisions; for any procedure, treatment or exam in connection with refractive disorders; for eye surgery such as radial keratotomy;
39. for routine hearing examinations, unless required by federal law;
40. for hearing aids, or the fitting thereof;
41. for instruction or activities for weight reduction or weight control, including charges for vitamins, diet supplements, or physical fitness programs even if the services are performed or prescribed by a Physician (except as referenced in the Schedule of Covered Services);
42. for surgery or treatment for obesity (except as referenced in the Schedule of Covered Services);
43. for surgical reversal of elective sterilizations; for elective abortions;
44. for chelation (metallic ion) therapy, except as approved by the Food and Drug Administration;
45. for "nicotine patches" or other forms of anti-smoking medication (except as stated in the "Prescription Drug Benefit");
46. for care and treatment for hair loss including wigs, hair transplants, hair implants or any drug that promises hair growth, whether or not prescribed by a Physician, except for wigs after chemotherapy;
47. for any service for assisted reproduction (including in vitro fertilization, uterine embryo lavage, embryo transfer, artificial insemination, gamete intrafallopian tube transfer, zygote intrafallopian tube transfer, and low tubal ovum transfer); however, diagnosis and treatment of medical conditions (such as endometriosis) that may contribute to the condition of infertility are covered;
48. for services and supplies received from a medical or dental department maintained by or on behalf of an employer, a mutual benefit association, trustee or similar person or group;
49. This Exclusion is intentionally left blank;

50. for marital counseling services;
51. This Exclusion is intentionally left blank;
52. This Exclusion is intentionally left blank;
53. This Exclusion is intentionally left blank;
54. This Exclusion is intentionally left blank;
55. for TMJ (*Temporomandibular Joint Dysfunction*);
56. for all charges, payment by this Plan will not exceed the Maximum Allowable Amount for such incurred expenses (except as specifically stated in the Schedule of Covered Services and "Balance Billing" section);
57. due to accidental bodily Injury or Illness resulting from invasions, acts of foreign enemies, hostilities, civil war, rebellion, insurrection, military or usurped, or martial law or confiscation by order of any government or public authority;
58. for expenses for injuries incurred in the commission of a criminal act involving the use of alcohol or illegal drugs;
59. for charges incurred as the result of a motor vehicle accident while the Plan Participant was insured or eligible for health benefits under a "No-Fault" automobile policy, only to the extent of such coverage, unless required by law;
60. for provider charges claimed as a result of purported lost discounts;
61. for hypnosis;
62. for private duty nursing;
63. for charges for oral nutrition including infant formula;
64. for costs or charges associated with organ or tissue procurement with respect to an organ or tissue transplant.

DEFINITIONS

Certain words and terms used herein shall be defined as follows:

AIR AMBULANCE

Medical transport by a rotary wing air ambulance or fixed wing air ambulance that is otherwise covered by the Plan.

AMBULATORY SURGICAL CENTER

Any private or public establishment with: a) an organized medical staff of Physicians; b) permanent facilities that are equipped and operated primarily for the purpose of performing Outpatient surgical procedures; c) continuous Physician services and registered professional nursing services whenever a patient is in the facility and which does not provide services or other accommodations for patients to stay overnight.

ASSIGNMENT OF BENEFITS

An arrangement whereby the Plan Participant assigns their right to seek and receive payment of eligible Plan benefits. Plan Participants cannot assign, pledge, borrow against or otherwise promise any benefits payable under the Plan before receipt of the benefit. However, benefits will be provided to a Participant's qualified dependent if required by a Qualified Medical Child Support Order or National Medical Support Notice. In addition, subject to the written direction of a Participant, all or a portion of benefits provided by the Plan may, at the option of the Plan and unless a Participant requests otherwise in writing, be paid directly to the person rendering such service. The payment of benefits directly to a provider of services, if any, is done as a convenience to the Plan Participant and does not constitute an assignment of rights or benefits under the Plan. Providers of services are not, and shall not be construed as, either "Participants" or "beneficiaries" 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 and beneficiaries under any circumstances. Any payment made by the Plan in good faith pursuant to this provision shall fully discharge the Plan and the Employer to the extent of such payment.

CALENDAR YEAR

That period of time commencing at 12:01 a.m. on January 1st and ending at 12:01 a.m. on the next succeeding January 1st. Each succeeding like period will be considered a new Calendar Year.

CASE MANAGEMENT PROGRAM

A program of medical management typically utilized in situations involving extensive and on-going medical treatment, which provides a comprehensive and coordinated delivery of services under the oversight of a medically responsible individual or agency. Such programs may provide benefits not normally covered under Plan provisions in lieu of in-Hospital treatment.

If, at any point in the progress of a given medical situation, after having considered the opinions of the Plan Participant (and/or his legally responsible representatives), the Plan Participant's Physician and/or other medical authorities, the Plan Administrator determines that the benefits of this Plan may be best utilized through the implementation of a Case Management Program, the Plan reserves the right to require that further benefits be provided only under the administration of such a program.

CLAIMS PROCESSOR

The entity providing consulting services to the Company in connection with the operation of the Plan and performing other functions, including processing of claims. The Claims Processor is Allied Benefit Systems, LLC, **P.O. Box 211651, Eagan, MN 55121.**

COMPANY

See the Key Information section at the beginning of this document.

COSMETIC SURGERY/TREATMENT

Surgery or treatment that is intended to improve the appearance of a patient or to preserve or restore a pleasing appearance and does not meaningfully promote the proper function of the body or prevent or treat illness or disease (except when necessary to improve a deformity arising from, or directly related to, a congenital abnormality, a personal injury resulting from an accident or trauma, or a disfiguring disease).

COVERED SERVICE

A service or supply provided in accordance with the terms of this Summary Plan Description.

DEDUCTIBLE/CO-INSURANCE

The amount of eligible expense incurred in any Calendar Year, which must be satisfied by the Plan Participant before benefits are paid. Upon receipt of satisfactory proof that a Plan Participant has incurred covered services as a result of an Injury or Illness, the Plan, after deducting the Deductible amount shown in the Schedule of Covered Services and Provisions from the covered services first incurred during that Calendar Year, will pay benefits at the appropriate Co-Insurance level as shown in the Schedule of Covered Services and Provisions.

DEPENDENTS

Spouse of the Employee who is a resident of the same country in which the Employee resides. For additional information, see the Key Information section at the beginning of this document.

Children from birth to the last day of the month they attain age 26. The term "*child*" or "*children*" include children that are specified within the Key Information section at the beginning of this document.

A child who is physically or mentally incapable of self-support upon attaining age 26 may be continued under the health care benefits, while remaining incapacitated and unmarried, subject to the covered Employee's own coverage continuing in effect. To

continue a child under this provision, the Company must receive proof of incapacity within 31 days after coverage would otherwise terminate. Additional proof will be required from time to time.

DOMESTIC PARTNER

See the Key Information section at the beginning of this document.

ELECTIVE SURGICAL PROCEDURE

Any non-emergency surgical procedure which may be scheduled at a patient's convenience without jeopardizing the patient's life or causing serious impairment to the patient's bodily functions and which is performed while the patient is confined in a Hospital as an Inpatient or in an Ambulatory Surgical Center.

EMERGENCY ROOM SERVICES

"Emergency Room Services" is defined as, with respect to a Medical Emergency, an appropriate medical screening examination that is within the capability of the emergency department of a Hospital or an independent freestanding emergency department, including ancillary services routinely available to the emergency department to evaluate such Medical Emergency, and such further medical examination and treatment, to the extent they are within the capabilities of the staff and facilities available at the Hospital or the independent freestanding emergency department, to stabilize the patient. Covered Services that are furnished after a patient has stabilized and as part of Outpatient observation or an Inpatient or Outpatient stay with respect to the visit in which the Emergency Room Services described in the first sentence are furnished will also be considered Emergency Room Services unless the following conditions are satisfied:

- The attending emergency Physician or treating provider determines that the patient is able to travel using nonmedical transportation or nonemergency medical transportation to an available provider or facility located within a reasonable travel distance, taking into account the individual's medical condition. The attending emergency physician's or treating provider's determination is binding on the facility for purposes of this requirement.
- The provider or facility furnishing such additional items and services satisfies the notice and consent criteria prescribed by federal law with respect to such items and services;
- The patient is in a condition to receive the notice and consent, as determined by the attending emergency Physician or treating provider using appropriate medical judgment, and to provide informed consent under such section, in accordance with applicable state law.
- The provider or facility satisfies any additional requirements or prohibitions as may be imposed under state law.

Coverage for Emergency Room Services will be provided consistent with the No Surprises Act and the terms of this Plan.

EMPLOYEE

See the Key Information section at the beginning of this document.

EMPLOYER

See the Key Information section at the beginning of this document.

ENROLLMENT DATE

The first day of coverage or, if there is a Waiting Period, the first day of the Waiting Period.

ESSENTIAL HEALTH BENEFITS

“Essential Health Benefits” include the following general categories and the items and services covered within the categories: Ambulatory patient services; emergency services; hospitalization; maternity and newborn care; mental health and substance use disorder services, including behavioral health treatment; prescription drugs; rehabilitative and habilitative services and devices; laboratory services; preventive and wellness services and chronic disease management; and pediatric services, including oral and vision care.

EXTENDED CARE FACILITY

An institution (or a distinct part of an institution) which: (a) provides for Inpatients (1) 24-hour nursing care and related services for patients who require medical or nursing care, or (2) service for the rehabilitation of injured or sick persons; (b) has policies developed with the advice of (and subject to review by) professional personnel to cover nursing care and related services; (c) has a Physician, a registered professional nurse or a medical staff responsible for the execution of such policies; (d) requires that every patient be under the care of a Physician and makes a Physician available to furnish medical care in case of emergency; (e) maintains clinical records on all patients and has appropriate methods for dispensing drugs and biologicals; (f) has at least one registered professional nurse employed full time; (g) provides for periodic review by a group of Physicians to examine the need for admissions, adequacy of care, duration of stay and medical necessity of continuing confinement of patients; (h) is licensed pursuant to law, or is approved by appropriate authority as qualifying for licensing and is also approved by Medicare; (i) is not primarily a place for the elderly, a place for rest, or a place for custodial or educational care.

FAMILY DEDUCTIBLE

If the amount of covered services incurred by family members and applied toward the Deductible totals the amount shown in the Schedule of Covered Services and Provisions, the Deductible amount shall be waived for all other members of that family unit for that Calendar Year.

GENDER NEUTRAL WORDING

A masculine pronoun in this document shall at all times be considered synonymous with a feminine pronoun unless the context indicates otherwise.

GENETIC INFORMATION

The term "genetic information" is defined as 1) an individual's own genetic tests, 2) the genetic tests of family members of such individual, and 3) the manifestation of a disease or disorder in family members of such individual. The term "genetic information" also encompasses family medical history. The term "genetic information" additionally extends to genetic information of any fetus carried by a pregnant woman. With respect to an individual or family member utilizing an assisted reproductive technology, genetic information includes the genetic information of any embryo legally held by the individual or family member. The term "genetic information" further extends to dependents and family members defined as first-degree, second-degree, third-degree, or fourth-degree relatives of the individual. The term additionally includes participation in clinical research involving genetic services.

HOME HEALTH CARE AGENCY

A public or private agency that is primarily engaged in providing skilled nursing and other therapeutic services and is either (1) licensed or certified as a home health agency by the governing jurisdiction; or (2) certified as a home health agency by Medicare.

HOSPICE

A facility established to furnish terminally ill patients a coordinated program of Inpatient and home care of a palliative and supportive nature. A hospice must be approved as meeting established standards, including any legal licensing requirements.

HOSPITAL

An institution which meets all of the following requirements; (a) maintains permanent and full-time facilities for bed care of resident patients; (b) has a doctor in regular attendance; (c) continuously provides 24 hour a day nursing services by Registered Nurses (R.N.); (d) is primarily engaged in providing diagnostic and therapeutic services and facilities for medical and surgical care of Injuries or Illnesses on a basis other than a rest home, nursing home, convalescent home, or a home for the aged; (e) maintains facilities on the premises for surgery; (f) is operating lawfully as a Hospital in the jurisdiction where it is located; and (g) is either accredited by the Joint Commission on the Accreditation of Healthcare Organizations or is Medicare approved.

In addition, the term "Hospital" shall mean, as defined by Medicare, a Psychiatric Hospital, which is qualified to participate in and is eligible to receive payments under and in accordance with the provisions of Medicare; or, which meets the following requirements; (a) is licensed by the jurisdiction in which it operates; and (b) is accredited by the Joint Commission on the Accreditation of Healthcare Organizations.

HOSPITAL INTENSIVE CARE/CARDIAC CARE UNIT

Only a section, ward or wing within the Hospital which is distinguishable from other Hospital facilities because it (a) is operated solely for the purpose of providing room and

board and professional care and treatment for critically ill patients, including constant observation and care by a Registered Nurse (R.N.) or other highly trained Hospital personnel, and (b) has special supplies and equipment necessary for such care and treatment, available on a standby basis for immediate use.

HOSPITAL SEMI-PRIVATE

The room and board charge is not to exceed the semi-private room rate. The difference between the semi-private room rate and the private room rate will be the patient's responsibility and will not apply to, or be affected by, any Out-of-Pocket Maximum provision. However, if 1) a private room is required due to Medical Necessity, or 2) the Hospital only has private rooms, the full private room charge will be considered.

ILLNESS

Only non-occupational sickness, disease, mental infirmity, or pregnancy (including surrogacy), all of which require treatment by a Physician.

INJURY

Only non-occupational bodily Injury which requires treatment by a Physician.

INPATIENT

A Plan Participant shall be considered to be an "Inpatient" if he is treated at a Hospital and is confined for 23 or more consecutive hours. The term "Inpatient" shall also apply to those situations where "partial hospitalization" (defined as an on-going period of treatment involving full use of Hospital facilities excepting only room and board service) is recommended by the patient's Physician as an alternative to Hospital confinement.

LATE ENROLLMENT

An enrollment which takes place other than during the first period during which an individual was eligible for coverage, or other than during a period of Special Enrollment or Open Enrollment. See the Key Information section at the beginning of this document for applicability.

LIFETIME

Shall mean, "while covered under the Plan". Under no circumstances will the word "Lifetime" mean "during the lifetime of the Plan Participant".

MAXIMUM ALLOWABLE AMOUNT

Shall mean the maximum benefit payable for a specific coverage item or benefit under the Plan. The Maximum Allowable Amount will be determined and established by the Plan, at the Plan Administrator's discretion, as the lesser reimbursement rate calculated using normative data and submitted information such as, but not limited to, any one or more of the following:

- Medicare reimbursement rates (presently utilized by the Centers for Medicare and Medicaid Services (“CMS”));
- 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:
 - 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;
 - 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
 - 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.
 - Medicare cost data as reflected in the applicable individual provider’s cost report(s);
- Market-based pricing data, relying on commercial benchmarks, CMS data, contractual allowable amounts, historical claims data, provider insights and geographic adjustments;
- Amounts the provider specifically agrees to accept as payment in full through negotiation;
- Network agreement pricing; and
- Medicare cost-to-charge ratios or other information regarding the actual cost to provide the service or supply.

The Plan Administrator may in its discretion, taking into consideration specific circumstances, deem a greater amount payable than the lesser of the aforementioned amounts. The Plan Administrator may take any or all of such factors into account but has no obligation to consider any particular factor. The Plan Administrator may also account for unusual circumstances or complications requiring additional or a lesser amount of time, skill and experience in connection with a particular service or supply, industry standards and practices as they relate to similar scenarios, and the cause of Injury or Illness necessitating the service(s) and/or charge(s).

In all instances, 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 and/or malpractice is not required for services or fees to be considered ineligible pursuant to this provision.

The determination that fees for services are includable in the Maximum Allowable Amount will be made by the Plan Administrator, taking into consideration, but not limited to, the findings and assessments of the following entities: (a) The National Medical Associations, Societies, and organizations; and (b) The Food and Drug Administration. To

be includable in the Maximum Allowable Amount, services and fees must be in compliance with generally accepted billing practices for unbundling or multiple procedures.

The Plan Administrator has the discretionary authority to decide if a charge is covered under this Plan. The Maximum Allowable Amount will not include any identifiable billing mistakes including, but not limited to, up-coding, duplicate charges, and charges for services no performed.

MEDICAL EMERGENCY

A “Medical Emergency” is defined as a medical condition, including a Mental/Nervous or Substance Use Disorder, manifesting itself by acute symptoms of sufficient severity (including severe pain) so that a prudent layperson, who possesses an average knowledge of health and medicine, could reasonably expect the absence of immediate medical attention to result in 1) a condition placing the health of the individual (or, with respect to a pregnant woman, the health of the woman or her unborn child) in serious jeopardy; 2) serious impairment to bodily functions; or 3) serious dysfunction of any bodily organ or part.

MEDICALLY NECESSARY

Health care services, supplies or treatment which, in the judgment of the attending Physician, is appropriate and consistent with the diagnosis and which, in accordance with generally accepted medical standards, could not have been omitted without adversely affecting the patient’s condition or the quality of medical care rendered.

MENTAL/NERVOUS AND SUBSTANCE USE DISORDER SERVICES

Services for diagnoses that are listed in the Diagnostic and Statistical Manual of Mental Disorders published by the American Psychiatric Association that is current as of the date services are rendered.

NAMED FIDUCIARY

The person or entity who has the complete authority to control and manage the operation and administration of the Plan. The Named Fiduciary for the Plan is the Employer, who is the sponsor of this Plan.

In exercising its fiduciary responsibilities, the Employer shall have sole, full and final discretionary authority to determine eligibility for benefits, review denied claims for benefits, construe and interpret all Plan provisions, construe disputed Plan terms, select managed care options, determine all questions of fact and law arising under this Plan, and to administer the Plan’s subrogation and reimbursement rights. The Employer shall be deemed to have properly exercised such authority unless it has abused its discretion by acting arbitrarily and capriciously.

Any other individual or entity exercising any discretionary authority with respect to the Plan shall also be deemed to have properly exercised such authority unless it has abused its discretion by acting arbitrarily and capriciously.

OPEN ENROLLMENT

Each year, a period of time may be designated as an “Open Enrollment” period. Except for Special Enrollment or Late Enrollment, if applicable, it is only during this period that an Employee or Dependent who did not enroll during their initial eligibility period may enroll in a Plan. It is also only during this period that an Employee who is currently covered under one Plan may switch to another. Coverage will become effective on the date specified by Your Employer. See the Key Information section at the beginning of this document for applicability, as well as Your Employer for details.

OUT-OF-POCKET MAXIMUM

The “Out-of-Pocket Maximum” is the total amount of co-pays, co-insurance and deductibles for which the Plan Participant or covered family is responsible during the course of a Calendar Year. These amounts are shown in the “Schedule of Covered Services and Provisions,” along with expenses not applicable towards the Out-of-Pocket maximum.

OUTPATIENT

A Plan Participant shall be considered to be an “Outpatient” if he is treated at a Hospital and is confined less than 23 consecutive hours.

PHYSICIAN

A Physician who is duly qualified and licensed and/or certified by the state in which he is resident to practice medicine, perform surgery and to prescribe drugs, or who is licensed to practice as a dentist, podiatrist, chiropractor, psychologist, social worker or practitioner of healing arts, and who is practicing within the scope of his license and/or certification.

PLACEMENT FOR ADOPTION

The assumption and retention of a legal obligation for total or partial support in anticipation of adoption.

PLAN

The benefits and provisions for payment of same as described herein are the Employer Plan as described in the Key Information section at the beginning of this document. This is a Group Health Plan.

PLAN ADMINISTRATOR

The entity responsible for the day-to-day functions and overall management of the Plan. The Plan Administrator may employ persons or firms to process claims and perform other Plan connected services. The Plan Administrator is the Company.

PLAN PARTICIPANT

A covered Employee or a covered Dependent. No person is eligible for health care benefits both as an Employee and as a Dependent under this Plan. When the Company employs both husband and wife, any Dependent children may become covered hereunder only as Dependents of one spouse.

PLAN YEAR

The 12-month period defined in the Key Information section at the beginning of this document. Fiscal records are maintained for a Plan Year ending as of the date specified under the Key Information section.

QUALIFIED MEDICAL CHILD SUPPORT ORDER

A legal order requiring the coverage of specified child(ren) under an individual's medical plan benefits. If Your employer determines that a separated or divorced spouse or any state child support or Medicaid agency has obtained a legal QMCSO, and Your current plan offers dependent coverage, You will be required to provide coverage for any child(ren) named in the QMCSO. If You do not enroll the child(ren), Your employer must enroll the child(ren) upon application from Your separated/divorced spouse, the state child support agency or Medicaid agency and withhold from Your pay Your share of the cost of such coverage. You may not drop coverage for the child(ren) unless You submit written evidence to Your employer that the child support order is no longer in effect. The plan may make benefit payments for the child(ren) covered by a QMCSO directly to the custodial parent or legal guardian of such child(ren). ERISA preemption of state laws does not apply to Qualified Medical Child Support Orders and provisions of state laws requiring medical child support. Group health plans may not deny enrollment of a child under the health coverage of the child's parent on the ground that the child is born out of wedlock, not claimed as a dependent on the parent's tax return, or not in residence with the parent or in the applicable service area. Additional information concerning "QMCSO" procedures are available from the Plan Administrator at no charge upon request.

RECOGNIZED AMOUNT

For purposes of Covered Services that are subject to balance billing protections (see the "Balance Billing" section for more details) the Recognized Amount is the amount used to calculate the Covered Person's cost share for such services. The Recognized Amount is typically the lesser of the billed charge or the qualifying payment amount. The methodology for determining the qualifying payment amount is set by federal regulations at 29 CFR 2590.716-6, and is adjusted from time to time*.

*In some situations, different rules will apply and the Recognized Amount, as defined by federal rules at 29 CFR 2590.2590.716-3, will be used instead. The Recognized Amount takes into account whether a particular state has adopted an all-payer model agreement, or whether state law applies for setting fees. If neither an all-payer model agreement nor state law legally applies, the Recognized Amount would, in most cases, be the lesser of the qualifying payment amount or the amount the provider actually billed.

RECONSTRUCTIVE BREAST SURGERY COVERAGE

Medical benefits under the Plan will be administered according to the terms of the Women's Health and Cancer Rights Act of 1998. The Plan will provide to Plan Participants who are receiving Plan benefits in connection with such mastectomy coverage for: (1) all stages of reconstruction of the breast on which the mastectomy has been performed; (2) surgery and reconstruction of the other breast to produce symmetrical appearance; and (3) prostheses and physical complications of mastectomy, including lymphedemas; in a manner determined in consultation with the attending physician and the patient. The coverage will be subject to the terms of the Plan established for other coverage under the Plan, including the annual deductible and coinsurance provisions.

RETIREE

See the Key Information section at the beginning of this document.

SECOND SURGICAL OPINION

Shall mean a written statement on the necessity for the performance of a covered surgical procedure. This Second Surgical Opinion must be given by a board-certified specialist who, by the nature of the Physician's specialty, qualifies the Physician to consider the surgical procedure being proposed and who is otherwise not associated with the surgeon who initially recommended the surgery.

SPECIAL BENEFIT RATE FOR SERVICES SUBJECT TO BALANCE BILLING PROTECTIONS

With regard to services that are subject to balance billing protections (see the "Balance Billing" section for more detail), the Special Benefit Rate is the amount used to calculate the benefit payable to the provider for Covered Services. The Special Benefit Rate will equal (i) the Recognized Amount, (ii) an amount agreed to by the Plan and the provider, (iii) or the amount determined payable in accordance with the independent dispute resolution process set forth in section 716(c) or 717(b) of ERISA.

SPECIAL ENROLLMENT

An enrollment which takes place during the 30-day period following the date of the event which triggers the Special Enrollment period. See "Eligibility" section for details.

WAITING PERIOD

The period of time before an individual is eligible to be covered under the terms of a group health plan. Any period before a Late Enrollment, Open Enrollment or Special Enrollment is not a Waiting Period.

YOU, YOUR, YOURSELF

A covered Employee or a covered Dependent. No person is eligible for health care benefits both as an Employee and as a Dependent under this Plan. When the Company employs both husband and wife, any Dependent children may become covered hereunder only as Dependents of one spouse.

ELIGIBILITY

WHO IS ELIGIBLE

See the Key Information section at the beginning of this document.

NON-DISCRIMINATION

In regard to the offering of coverage, the Plan will not discriminate against any individual on the basis of health status, medical condition (physical or mental), claims experience, receipt of health care, medical history, genetic information, evidence of insurability or disability. No otherwise eligible individual will be refused the opportunity to enroll in the Plan due to participation in any particular activity, regardless of its hazardous nature. The Plan will not discriminate against similarly situated individuals in regard to eligibility or benefits (however, this does not limit the Plan's ability to treat participants classifiable through non-health related criteria as different groups in different ways.) The Plan will not knowingly discriminate against any individual on the basis of health factors. However, the Plan may impose coverage limits or exclusions on all similarly situated individuals which may have an effect on only some individuals.

EMPLOYEE COVERAGE

For date of eligibility, please see the Key Information section at the beginning of this document. Providing a new employee is actively at work on at least the first day of employment, the Plan will not exclude absences from work due to health related reasons from credit towards the waiting period, if applicable, as referenced in the Key Information section.

DEPENDENT COVERAGE

Each Dependent of the eligible Employee becomes eligible for Dependent coverage under the Plan on the later of the following:

1. The date the Employee is eligible; or
2. The date the individual becomes a Dependent of the Employee if on that date the Employee is covered.

INDIVIDUAL EFFECTIVE DATE

All persons become covered, as they become eligible subject to the following:

1. All Employees, who are eligible Employees, shall be covered on the day they become eligible, as discussed in the Key Information section at the beginning of this document.
2. Dependents shall be covered simultaneously with Employees covering them as Dependents.
3. Coverage for a spouse will begin from the date of marriage. Coverage for a newborn birth child will begin from the date of birth. Coverage for a child placed under legal guardianship, an adopted child or a child placed for

adoption with the Employee will begin from the date of Placement for Adoption. Coverage for a stepchild or foster child will begin from the date the child meets the definition of “Dependent.” With respect to a spouse, the spouse must be formally enrolled and appropriate coverage arranged within 30 days from date of marriage. With respect to a newborn birth child, the child must be formally enrolled and appropriate coverage arranged within 30 days from birth. With respect to a child placed under legal guardianship, an adopted child or child placed for adoption, the child must be formally enrolled and appropriate coverage arranged within 30 days from the date of Placement For Adoption. With respect to a stepchild or a foster child, the child must be formally enrolled and appropriate coverage arranged within 30 days from the date that the child meets the definition of “Dependent.”

OPEN ENROLLMENT

See the Key Information section at the beginning of this document for applicability.

LATE ENROLLMENT

See the Key Information section at the beginning of this document for applicability.

SPECIAL ENROLLMENT

The Plan permits a Special Enrollment period for an Employee (or a Dependent), who is eligible for coverage, but not enrolled, to enroll if the Employee (or Dependent) had other coverage and loses it, or if a person becomes a Dependent of the Employee through marriage, birth, adoption or Placement for Adoption. A person who enrolls during a Special Enrollment period is not treated as a late enrollee.

An individual may be eligible for Special Enrollment if the Employee, at the time coverage is declined, provides a statement, in writing, indicating the reason for declining coverage. To be eligible for Special Enrollment, the Employee must have declined coverage due to coverage under another plan. However, Special Enrollment will be available to Employees that decline coverage without having coverage under another plan and subsequently enroll in other coverage and lose that coverage. The Employee must have had an opportunity for Late Enrollment, Open Enrollment or Special Enrollment under this Plan but again chose not to enroll. Special Enrollment is also available to an Employee or Dependent who becomes eligible for a premium assistance subsidy under Medicaid or a state Children’s Health Insurance (CHIP) program with respect to this Plan.

If the Employee declined coverage because the other coverage was COBRA coverage, then the COBRA coverage must be exhausted before Special Enrollment will be available. If the other coverage is not COBRA coverage, then to be eligible for Special Enrollment, the other coverage must be lost due to a loss of eligibility, or employer contributions must have ended. Loss of eligibility includes a loss of coverage due to:

- divorce;
- legal separation;

- death;
- termination of employment, or reduction in hours of employment;
- relocating outside of an HMO's service area (only if there is no access to other coverage through the HMO);
- a plan no longer offering benefits to a class of similarly situated individuals even if the plan continues to provide coverage to other individuals;
- the Employee or Dependent is covered under a Medicaid plan or under a state CHIP program, and coverage of the employee or dependent under such a plan/program is terminated as a result of loss of eligibility for such coverage.

An Employee who is already enrolled in a benefit option may enroll in another benefit option under the Plan if their Dependent has a Special Enrollment right because the Dependent lost other health coverage.

Under Special Enrollment, the Employee must request enrollment, in writing within 30 days after the exhaustion of COBRA, or termination of the other coverage (other than Medicaid or Children's Health Insurance, see below), or the date of the marriage, birth, adoption or placement for adoption. If eligible, enrollment in the Plan, in cases of marriage, birth or adoption/Placement for Adoption, will be effective as of the date of the event; otherwise, coverage will be available no later than the first day of the first month beginning after the completed request for enrollment is received.

Under Special Enrollment, the Employee must request enrollment, in writing within 60 days after the termination of Medicaid or Children's Health Insurance (CHIP) coverage, or when eligible for a premium assistance subsidy under Medicaid or a state CHIP program. If eligible, enrollment in the Plan will be effective no later than the first day of the first month beginning after the completed request for enrollment is received.

TERMINATION OF COVERAGE

See the Key Information section at the beginning of this document for details.

EMPLOYER POLICIES AND PROCEDURES

Except as required under the Americans with Disabilities Act, the Family and Medical Leave Act or the Uniformed Services Employment and Reemployment Rights Act, the Employer's policies and procedures regarding waiting periods, continuation of coverage or reinstatement of coverage shall apply during the following situations: Employer certified disability, leave of absence, layoff, reinstatement, hire or rehire. Whether an Employee averages the requisite hours of service to be eligible for coverage shall be determined in accordance with the policies and procedures of the Employer

INDIVIDUALS PARTICIPATING IN APPROVED CLINICAL TRIALS

The Plan may not 1) deny a Qualified Individual participation in an Approved Clinical Trial, 2) deny (or limit or impose additional conditions on) coverage of Routine Patient Costs for items and services furnished in connection with the Approved Clinical Trial, or 3) discriminate against the Qualified Individual based on his/her participation in the Approved Clinical Trial.

The following definitions are applicable under this provision:

Qualified Individual

A Plan Participant who meets the following conditions:

A. The Plan Participant is eligible to participate in an Approved Clinical Trial according to the trial protocol with respect to treatment of cancer or other Life-Threatening Disease or Condition, and

B. Either:

- The referring health care professional is a participating health care provider and has concluded that the Plan Participant's participation in such trial would be appropriate, or
- The Plan Participant provides medical and scientific information establishing that the Plan Participant's participation in such trial would be appropriate.

Approved Clinical Trial

A phase I, phase II, phase III, or phase IV clinical trial that is conducted in relation to the prevention, detection, or treatment of cancer or other Life-Threatening Disease or Condition, or Mental/Nervous and Substance Use Disorder Services, and is described in any of the following subparagraphs:

- Federally funded trials. The study or investigation is approved or funded (which may include funding through in-kind contributions) by one or more of the following:
 1. The National Institutes of Health.
 2. The Centers for Disease Control and Prevention.
 3. The Agency for Health Care Research and Quality.
 4. The Centers for Medicare & Medicaid Services.
 5. A cooperative group or center of any of the entities described in clauses 1 through 4 above or the Department of Defense or the Department of Veterans Affairs.
 6. A qualified non-governmental research entity identified in the guidelines issued by the National Institutes of Health for center support grants.

7. Any of the following entities in clauses 7a. through 7c. below if the following conditions are met: the study or investigation has been reviewed and approved through a system of peer review that the Secretary of Health and Human Services determines to be comparable to the system of peer review of studies and investigations used by the National Institutes of Health, and assures unbiased review of the highest scientific standards by qualified individuals who have no interest in the outcome of the review.
 - a. The Department of Veterans Affairs.
 - b. The Department of Defense.
 - c. The Department of Energy.
- The study or investigation is conducted under an investigational new drug application reviewed by the Food and Drug Administration.
- The study or investigation is a drug trial that is exempt from having such an investigational new drug application.

Routine Patient Costs

All items and services consistent with the coverage provided by the Plan that is typically covered for a Qualified Individual who is not enrolled in a clinical trial. However, Routine Patient Costs do not include:

- the investigational item, device, or service, itself;
- items and services that are provided solely to satisfy data collection and analysis needs and that are not used in the direct clinical management of the patient; or
- a service that is clearly inconsistent with widely accepted and established standards of care for a particular diagnosis.

Life-Threatening Disease or Condition

Any disease or condition from which the likelihood of death is probable unless the course of the disease or condition is interrupted.

BALANCE BILLING

This Plan does not contain a network of Hospitals or Physicians. The Plan Administrator, in its sole discretion, uses various methodologies for determining the Plan's reimbursable amount for Covered Services from these providers. The Plan's liability for any Covered Service will be limited to the Maximum Allowable Amount. In the event that a determination of the Plan's reimbursement amount results in an amount that exceeds the actual charges 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 Maximum Allowable Amount; however, the provider(s) has the right to not accept the amount determined by the Plan as payment in full, and may bill you the difference.. This is called "balance billing."

If you are balance billed, contact Zelis Member Advocacy Team at: 877-259-3194 for possible assistance.

Although you may be balance billed, you are protected from balance billing in certain circumstances described below.

BALANCE BILLING PROTECTIONS

For Covered Services received on or after January 1, 2022, in situations involving Emergency Room Services or Air Ambulance services, federal rules apply to prevent You from being balance billed. In the following situations, Your cost-sharing obligations will be based on the Recognized Amount:

Emergency Room Services. For Covered Services that are Emergency Room Services, You are not responsible for amounts that exceed Your co-pay, Coinsurance and/or Deductible.

Air Ambulance. For Covered Services that are Air Ambulance services, You are not responsible for amounts that exceed Your co-pay, Coinsurance and/or Deductible.

The benefits will be reimbursed based on the Special Benefit Rate (see the Definitions section).

A note about Notice and Consent (where required). In certain situations described above, You can still be balance billed by a provider or facility so long as the provider provides to You proper notice, and You (or Your authorized representative) consent to waive Your rights to balance billing protections prior to the Covered Service.

If You believe You have been wrongly billed, You may contact the No Surprises Help Desk at 1-800-985-3059 from 8 am to 8 pm EST, 7 days a week, to submit Your question or a complaint. You can also submit a complaint online at:

<https://www.cms.gov/nosurprises/consumers/complaints-about-medical-billing>.

Visit <https://www.cms.gov/nosurprises> for more information about Your rights under federal law.

PROCEDURES FOR FILING CLAIMS

Remember to Pre-Certify by calling the toll-free number shown on Your ID card if required by Your Plan.

KEY POINTS TO REMEMBER

The claims filing address You must use for filing all medical claims is shown on Your ID card.

1. Each bill should be itemized as to services, show payment status, and include the name of the patient, the Employee's social security number or unique identification number ("UID"), and the name and/or group number of the Employer.
2. It is Your responsibility to see that all bills are submitted as indicated above. Proper payment cannot be made without the proper bills.
3. All charges, and corresponding requested documentation, must be submitted within the time frame specified in the Schedule of Covered Services and Provisions. Failure to do so will result in the denial of the charges.
4. From time to time, additional information may be requested to process Your claim. Any additional information, i.e. other insurance payments or information, completed claim forms or subrogation forms, accident details, police reports, etc. must be submitted by You or Your provider(s) when requested within the time frame specified in the Schedule of Covered Services and Provisions. Your failure to do so will result in the denial of the claim.
5. Only clean claims will be adjudicated by the Plan. A clean claim is one that is complete and accurate, does not require further information for processing from the provider, patient, or any other person or entity, and leaves no issues regarding the Plan's responsibility for payment.
6. Urgent care claims: The Plan will defer to the attending provider regarding the decision as to whether the claim constitutes an urgent care claim. Clean urgent care claims will be determined by the Plan as soon as possible (taking into account medical exigencies), but not later than 72 hours after receipt of the claim. For incomplete or incorrectly filed urgent care claims, You will be notified of the proper procedures to follow as soon as possible but no later than 24 hours after receipt of the claim.

FILING A HOSPITAL CLAIM

When a Plan Participant is admitted as an Inpatient or is treated as an Outpatient, secure an itemized Hospital bill, including an admitting diagnosis. Check Your bill for any possible errors and then submit the charges as indicated above.

Always retain a copy of the hospital bill for Your records.

MISCELLANEOUS CLAIMS FILING CONSIDERATIONS

It is necessary to keep separate records of Your expenses with respect to each of Your Dependents and Yourself. The following items are important and should be carefully kept to be submitted with Your claim:

1. All Physician's bills should show the following:
 - a. Name of patient and adequate membership information
 - b. Dates and charges for services, and payment status of each
 - c. Types of service rendered and procedure codes
 - d. Diagnosis information

2. Prescription drug expenses should show the following:
 - a. Name of patient and adequate membership information
 - b. Prescription number and name of drug
 - c. Cost of the drug and date of purchase. Cash register receipts and canceled checks cannot be accepted for payment.
 - d. Generic Drugs should be indicated on the drug bill

3. Bills for all other covered medical charges, such as for ambulance service, durable medical equipment, etc. should show the following:
 - a. Name of patient and adequate membership information
 - b. Date of service
 - c. Charge and description of each service/item
 - d. Diagnosis information

Always retain a copy of the bill for Your records.

THIS PLAN AND MEDICARE

1. Individuals who have earned the required number of quarters for Social Security benefits within the specified time frame are eligible for Medicare Part A at no cost. Participation in Medicare Part B is available to all individuals who make application and pay the full cost of the coverage.
2. When an Employee becomes entitled to Medicare coverage and is still actively at work, the Employee may continue health coverage under this Plan at the same level of benefits and contribution rate that applied before reaching Medicare entitlement.
3. When a Dependent becomes entitled to Medicare coverage and the Employee is still actively at work, the Dependent may continue health coverage under this Plan at the same level of benefits and contribution rate that applied before reaching Medicare entitlement.
4. If the Employee is still actively at work, and the Employee and/or Dependent are also enrolled in Medicare, this Plan shall pay as the primary plan. Medicare will pay as secondary plan.
5. If the Employee and/or Dependent elect to discontinue health coverage and enroll under the Medicare program, no benefits will be paid under this Plan. Medicare will be the only payor.

This section is subject to the terms of the Medicare laws and regulations. Any changes in these related laws and regulations will apply to the provisions of this section.

GENERAL PROVISIONS

ADMINISTRATION OF THE PLAN

The Plan is administered through the Office of the Company. The Company has retained the services of an independent Claims Processor experienced in claims processing. Fiscal records are maintained for a Plan Year ending as of the date specified under the Key Information section at the beginning of this document.

The Plan is a legal entity. Legal notices may be filed with, and legal process served upon, the Plan Administrator at the address specified in the Key Information section at the beginning of this document.

APPEALING A CLAIM

CLAIMS PROCEDURES

An explanation of benefits or other written or electronic notification will be provided by the Plan Administrator showing the calculation of the total amount payable for the claim, charges not payable, and the reason. If the claim is denied or reduced in whole or in part, it is considered an "Adverse Benefit Determination." An Adverse Benefit Determination also includes a rescission of coverage, whether or not the rescission has an adverse effect on any particular benefit at the time of the rescission. A rescission is a cancellation or discontinuance of coverage that has retroactive effect, except to the extent it is attributable to a failure to timely pay required premiums or contributions towards the cost of coverage. An Adverse Benefit Determination is subject to the provisions detailed below.

The Plan Administrator will notify the claimant of an Adverse Benefit Determination within 30 days after receipt of the claim. However, in certain cases an extension of up to 15 days may be utilized if the Plan Administrator determines that the extension is necessary due to matters beyond the control of the Plan and the claimant is notified prior to the expiration of the initial 30 day period of the circumstances requiring the extension of time and the date by which the Plan Administrator expects to render a decision. If such an extension is necessary due to a failure of claimant to submit the information necessary to decide the claim, the notice of extension shall specifically describe the required information, and the claimant shall be given at least 45 days within which to provide the specified information. A notice of Adverse Benefit Determination will include the following:

- Sufficient information to identify the claim involved, including the date(s) of service, health care provider, and claim amount.
- The specific reason or reasons for the Adverse Benefit Determination, as well as the Plan's standard that was used in denying the claim, if applicable, and including identifying denial codes and providing their meaning.
- Reference to specific Plan provisions on which the Adverse Benefit Determination is based.

- A description of any additional material or information necessary for the claimant to perfect the claim and an explanation of why such material or information is necessary.
- A description of the Plan's first level appeal procedures and the time limits applicable to such procedures, including information on how to initiate an appeal, the contact information for the Employee Benefits Security Administration (1-866-444-EBSA (3272)) to assist individuals with the first level claim and appeal process and second level (external) appeal process if applicable (see below), and a statement of claimant's right to bring a civil action under Section 502(a) of ERISA following a determination on appeal.
- 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 will be set forth in the notice of Adverse Benefit Determination; or the notice will contain a statement that such a rule, guideline, protocol, or other similar criterion was relied upon in making the Adverse Benefit Determination and that a copy of such rule, guideline, protocol, or other criterion will be provided free of charge to the claimant upon request.
- If the Adverse Benefit Determination is based on a medical necessity or experimental treatment or similar exclusion or limit, either an explanation of the scientific or clinical judgment for the determination, applying the terms of the Plan to the claimant's medical circumstances, will be set forth in the notice of Adverse Benefit Determination, or the notice will contain a statement that such explanation will be provided free of charge upon request.

FIRST LEVEL APPEALS PROCEDURE

If You receive an Adverse Benefit Determination, You or Your authorized representative may appeal the determination by filing a written application with the Plan Administrator. In appealing an Adverse Benefit Determination, the Plan Administrator will provide You or Your authorized representative:

- The opportunity to submit written comments, documents, records, and other information relating to the claim for benefits.
- Upon request and free of charge, reasonable access to, and copies of, all documents, records, the claim file, and other information relevant to the claim.
- A full and fair review that takes into account all comments, documents, records, and other information submitted by You relating to the claim, without regard to whether such information was submitted or considered in the initial benefit determination. You must also be provided, free of charge, with any new or additional evidence considered, relied upon, or generated by the Plan Administrator, as well as any new or additional rationale relied upon by the Plan Administrator in reaching its determination on appeal, that differs from that which the Plan Administrator relied on in its Adverse Benefit

Determination. Such evidence and/or rationale must be provided as soon as possible and sufficiently in advance of the date on which the Plan Administrator's determination is required to be provided to give You a reasonable opportunity to respond prior to that date.

- A full and fair review that does not afford deference to the initial benefit determination and is conducted by an appropriate named fiduciary of the Plan who is neither the individual who made the initial Adverse Benefit Determination that is the subject of the appeal, nor the subordinate of such individual.
- In deciding an appeal of an Adverse Benefit Determination that is based in whole or in part on a medical judgment, including determinations with regard to whether a particular treatment, drug, or other item is experimental, investigational, or not medically necessary or appropriate, that the appropriate named fiduciary shall consult with a health care professional who has appropriate training and experience in the field of medicine involved in the medical judgment and that the health care professional consulted shall neither be an individual who was consulted in connection with the initial Adverse Benefit Determination that is the subject of the appeal, nor the subordinate of any such individual.
- Upon request, the identification of medical or vocational experts whose advice was obtained on behalf of the Plan in connection with a claimant's Adverse Benefit Determination, without regard to whether the advice was relied upon in making the benefit determination.

A first level appeal must be filed within 180 days after the Adverse Benefit Determination is received. The Plan Administrator will notify You or Your authorized representative of its determination within 60 days after receipt of an appeal.

The Plan Administrator's determination:

- Will contain sufficient information to identify the claim involved, including the date(s) of service, health care provider, claim amount, denial codes and their meaning, as well as the Plan's standard used in denying the claim.
- Will be in writing, setting forth specific reasons for the decision and reference to the specific Plan provisions upon which the determination is based.
- Will contain a statement that You are entitled to receive, upon request and free of charge, reasonable access to, and copies of, all documents, records, and other information relevant to the claim for benefits.
- Will contain a statement of Your right to bring an action under Section 502(a) of ERISA if a second level (external) review is inapplicable.
- Will contain a description of the Plan's second level (external) review process (applicable solely where the Plan's underlying determination involved 1) a rescission of coverage, 2) medical judgment, or 3) a surprise medical bill or surprise air ambulance bill under the No Surprises Act), including information

on how to initiate a second level appeal, and the contact information for the Employee Benefits Security Administration to assist individuals with the second level review process (1-866-444-EBSA (3272)), as well as a statement of Your right to bring a civil action under Section 502(a) of ERISA following the determination of the external review.

- If an internal rule, guideline, protocol, or other similar criterion was relied upon in making the Adverse Benefit Determination, either the specific rule, guideline, protocol, or other similar criterion will be set forth in the determination; or the determination will contain a statement that such rule, guideline, protocol, or other similar criterion was relied upon in making the Adverse Benefit 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.
- If the Adverse Benefit Determination is based on a medical necessity or experimental treatment or similar exclusion or limit, either an explanation of the scientific or clinical judgment for the determination, applying the terms of the Plan to the claimant's medical circumstances, will be set forth in the determination or the determination will contain a statement that such explanation will be provided free of charge upon request.

If the Plan does not strictly adhere to all the requirements of the first level claims and appeals process with respect to a claim, You are deemed to have exhausted the first level claims and appeals process (unless the Plan's failure to strictly adhere to these requirements is 1) *de minimis*, 2) non-prejudicial, 3) attributable to good cause or matters beyond the Plan's control, 4) in the context of an ongoing good faith exchange of information, and 5) not reflective of a pattern or practice of non-compliance). Accordingly, upon such a failure, You may initiate a second level (external) review (see below) or, if not applicable, pursue any available remedies under applicable law.

To the extent the Plan contends that it did not commit a procedural violation based on the five criteria referenced immediately above, You will be entitled, upon written request, to an explanation of the Plan's basis for such an assertion (to be provided within ten days), so that You can make an informed judgment about whether to seek immediate review from an external reviewer or, if not applicable, a court of law. Finally, if the external reviewer or the court of law (as applicable) rejects Your request for immediate review on the basis that the Plan did not engage in a violation, You have the right to resubmit and pursue the first level claims and appeals process.

If the Plan denies Your first level appeal, in whole or in part, and You choose to bring a civil action, such action must be filed within 365 days of the date of the Plan's denial of Your first level appeal. This 365 day time period, however, will be temporarily suspended to the extent You are entitled to file a second level (external) appeal (see below) and do in fact file such an appeal. Under such circumstances, this 365 day time period will be suspended from the date You submit a request for a second level (external) appeal that is both complete and eligible until the date of the Independent Review Organization's decision (see below).

SECOND LEVEL (EXTERNAL) APPEALS PROCEDURE

If the Plan denies Your first level appeal, in whole or in part, such denial is called a Final Internal Adverse Benefit Determination. You or Your authorized representative may file a second level (external) appeal of the Final Internal Adverse Benefit Determination where the Plan's underlying determination involved 1) a rescission of coverage, 2) medical judgment, or 3) a surprise medical bill or surprise air ambulance bill under the No Surprises Act. To file a second level appeal, You must file a written application with the Plan Administrator.

A second level appeal must be filed within 4 months after the Final Internal Adverse Benefit Determination is received. If the last filing date would fall on a Saturday, Sunday, or Federal holiday, the last filing date is extended to the next day that is not a Saturday, Sunday, or Federal holiday. The Plan reserves the right to charge a nominal filing fee, as allowed by applicable law.

Preliminary review. Within 5 business days following the date of receipt of the second level (external) review request, the Plan must complete a preliminary review of the request to determine whether:

- a. The claimant is or was covered under the Plan at the time the health care service was requested or, in the case of a retrospective review, was covered under the Plan at the time the health care service was provided;
- b. The Plan's underlying determination involved 1) a rescission of coverage, 2) medical judgment, or 3) a surprise medical bill or surprise air ambulance bill under the No Surprises Act;
- c. The claimant has exhausted the Plan's first level appeal process; and
- d. The claimant has provided all the information and forms required to process a second level review.

Within one business day after completion of the preliminary review, the Plan must issue a notification in writing to the claimant. If the request is complete but not eligible for a second level review, such notification must include the reasons for its ineligibility and contact information for the Employee Benefits Security Administration (toll-free number 866-444-EBSA). If the request is not complete, such notification must describe the information or materials needed to make the request complete, and the Plan must allow a claimant to perfect the request for the second level review within the four-month filing period or within the 48 hour period following the receipt of the notification, whichever is later.

Referral to Independent Review Organization. The Plan must assign an independent review organization ("IRO") to conduct the second level (external) review. The assigned IRO will timely notify the claimant in writing of the acceptance for the second level review. This notice will include a statement that the claimant may submit in writing to the IRO within 10 business days following the date of receipt of the notice additional information that the IRO must consider when conducting the second level review. The IRO is not required to, but may, accept and consider additional information submitted after 10 business days.

Within 5 business days after the date of assignment of the IRO, the Plan must provide to the assigned IRO the documents and any information considered in making the Final Internal Adverse Benefit Determination. If the Plan fails to timely provide the documents and information, the IRO may terminate the second level review and make a decision to reverse the Final Internal Adverse Benefit Determination. Within one business day after making the decision, the IRO must notify the claimant and the Plan.

Upon receipt of any information submitted by the claimant, the IRO must within one business day forward the information to the Plan. Upon receipt of any such information, the Plan may reconsider its Final Internal Adverse Benefit Determination that is the subject of the second level review. The second level review may be terminated as a result of the reconsideration only if the Plan decides, upon completion of its reconsideration, to reverse its Final Internal Adverse Benefit Determination and provide coverage or payment. Within one business day after making such a decision, the Plan must provide written notice of its decision to the claimant and the IRO. The IRO must terminate the second level review upon receipt of the notice from the Plan.

The IRO will review all of the information and documents timely received. In reaching a decision, the IRO will review the claim without deference to the Plan and not be bound by any decisions or conclusions reached during the Plan's internal claims and appeals process. The IRO may also consider the following additional information:

- The claimant's medical records;
- The attending health care professional's recommendation;
- Reports from other health care professionals and other documents submitted by the Plan, claimant or claimant's treating provider;
- The terms of the Plan to ensure that the IRO's decision is not contrary to the terms of the Plan, unless the terms are inconsistent with applicable law;
- Appropriate practice guidelines, including evidence-based standards and other guidelines developed by the Federal government, national or professional medical societies, boards and associations;
- Any applicable clinical review criteria developed and used by the Plan, unless such criteria are inconsistent with the terms of the Plan or applicable law; and
- The opinion of the IRO's clinical reviewer(s) to the extent the information or documents are available and the clinical reviewer(s) considers appropriate;

The IRO must provide written notice of its second level review decision within 45 days after it receives the request for the second level review. The notice must be provided to both the claimant and the Plan, and must include the following:

- A general description of the reason for the request for the review with enough information to identify the claim, and reason for the Final Internal Adverse Benefit Determination;
- The date the IRO received the assignment to conduct the second level review;
- The date of the IRO's decision;

- References to the evidence or documentation, including specific coverage provisions and evidence-based standards, considered in reaching its decision;
- A discussion of the principal reason(s) for its decision, including the rationale and any evidence-based standards used;
- A statement that the determination is binding, except to the extent other legal remedies may be available under Federal or state law to the Plan or claimant;
- A statement that judicial review may be available to the claimant; and
- Current contact information for the Employee Benefits Security Administration (toll-free number 866-444-EBSA (3272)).

The IRO must maintain records of all claims and notices associated with the second level review process for 6 years. An IRO must make such records available for examination by the claimant, Plan, or state or federal oversight agency upon request, except where such disclosure would violate state or federal privacy laws.

Reversal of the Plan’s decision. Upon receipt of a notice of a final external review decision reversing the Final Internal Adverse Benefit Determination, the Plan must immediately pay the claim.

For questions about Your appeal rights or for assistance, You can contact the Employee Benefits Security Administration at 1-866-444-EBSA (3272).

ASSIGNMENTS

No benefit, right or interest of any Plan Participant 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 Services, if authorized by the Plan Participant, but only as a convenience to the Plan Participant. 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) Plan Participants under any circumstances.

CLAIM AUDIT

Once a written claim for benefits is received, the Plan Administrator, at its discretion, may elect to have such claim reviewed or audited for accuracy. This process may include, but not be limited to, identifying charges for items/services that may not be covered or may not have been delivered, duplicate charges and charges beyond the Maximum Allowable Amount as determined by the Plan Administrator.

COMPLIANCE

The Plan shall comply with all federally mandated benefit laws and regulations pertaining to employee benefit plans. The intent of the Plan is to assure full compliance with all appropriate federal laws, rules and regulations and any act or omission through negligence or otherwise which results in any such violation, shall be construed as unintentional. The Claims Processor shall be fully discharged from liability under this Plan.

CONTACT INFORMATION FOR THE PLAN ADMINISTRATOR, NAMED FIDUCIARY, AND AGENT FOR SERVICE OF LEGAL PROCESS

Same as Employer.

CONTRIBUTIONS

The benefits provided under the terms of this Plan are purchased through Employer contributions. At the discretion of the Company, Employees may be required to contribute on a payroll deduction basis.

ERISA AMENDMENTS

Any provision of this Plan that is in conflict with ERISA, which governs this Plan, shall be deemed amended to conform to the minimum requirements of the law.

FUNDING

This Plan is a Company sponsored self-funded reimbursement program for the benefits described in the Key Information section at the beginning of this document.

LIENS

To the full extent permitted by law, all rights and benefits accruing under this Plan shall be exempt from execution, attachment, garnishment, or other legal or equitable process, for the debts or liabilities of any Employee.

This Plan is not a substitute for and does not affect any requirement for coverage by Workers' Compensation Insurance.

NO WAIVER

A failure to enforce any provision of this Plan shall not affect any right thereafter to enforce any such provision, nor shall such failure affect any right to enforce any other provision of this Plan.

PLAN IS NOT A CONTRACT

The Plan shall not be deemed to constitute a contract between the Company and any Employee or to be a consideration for, or an inducement or condition of, the employment of any Employee. Nothing in the Plan shall be deemed to give any Employee the right to be retained in the service of the Company or to interfere with the right of the Company to discharge any Employee at any time.

PLAN AMENDMENT, MODIFICATION OR TERMINATION

The Company reserves the right to amend, modify, revoke or terminate the Plan, in whole or in part, at any time and such amendment, modification, revocation or termination of the Plan shall be made by a written Plan endorsement signed by an authorized representative of the Company. Any such changes to the Plan, which affect participants, will be communicated to such participants by the Plan Administrator. Upon termination of the Plan, the rights of participants to benefits are limited to claims incurred and due up to the date of termination.

PROHIBITION ON RESCISSION

The Plan cannot rescind coverage except in the case of fraud or an intentional misrepresentation of a material fact. A rescission is a cancellation or discontinuance of coverage that has retroactive effect, unless it is attributable to a failure to pay timely required premiums or contributions towards the cost of coverage. The Plan must provide 30 calendar days advance notice to an individual before coverage may be rescinded.

REIMBURSEMENT AND SUBROGATION PROVISIONS

PAYMENT CONDITION

The Plan, in its sole discretion, may elect to conditionally advance payment of benefits in those situations where an illness, injury, or disability is caused in whole or in part by, or results from the acts or omissions of, a Plan Participant or a third party, where any party besides the Plan may be responsible for expenses arising from an incident, and/or other funds are available, including but not limited to no-fault, uninsured motorist, underinsured motorist, medical payment provisions, third party assets, third party insurance, and/or grantor(s) of a third party (collectively "Coverage").

However, such payment of benefits by the Plan shall be made only if the Plan Participant first provides a reimbursement agreement in writing. Notwithstanding the foregoing, payment of any claim in the absence of a signed reimbursement agreement shall not invalidate the obligation of the Plan Participant to otherwise reimburse the Plan.

The Plan Participant (including his attorney, and/or legal guardian of a covered minor or incapacitated individual) agrees that acceptance of the Plan's conditional payment of medical benefits is constructive notice of these provisions in their entirety and agrees to maintain the full extent of payment from any one or combination of first and third party sources in trust, without disruption except for reimbursement to the Plan or the Plan's assignee. By accepting benefits, the Plan Participant agrees the Plan shall have an equitable lien on any funds received by the Plan Participant and/or his attorney from any source and said funds shall be held in trust until such time as the obligations under this provision are fully satisfied. The Plan Participant agrees to include the Plan's name as a co-payee on any and all settlement drafts. Further, by accepting benefits, the Plan Participant understands that any recovery obtained pursuant to this section is an asset of the

Plan to the extent of the amount of benefits paid by the Plan and that the Plan Participant shall be a trustee over those Plan assets.

In the event a Plan Participant settles, recovers, or is reimbursed by any Coverage, the Plan Participant agrees to reimburse the Plan for all benefits paid or that will be paid by the Plan on behalf of the Plan Participant. If the Plan Participant fails to reimburse the Plan out of any judgment or settlement received, the Plan Participant will be responsible for any and all expenses (fees and costs) associated with the Plan's attempt to recover such money.

If there is more than one party responsible for charges paid by the Plan, or who may be responsible for charges paid by the Plan, the Plan will not be required to select a particular party from whom reimbursement is due. Furthermore, unallocated settlement funds meant to compensate multiple injured parties of which the Plan Participant is only one, that unallocated settlement fund is considered designated as an "identifiable" fund from which the Plan may seek reimbursement.

SUBROGATION

As a condition to participating in and receiving benefits under this Plan, the Plan Participant agrees to assign to the Plan the right to subrogate and pursue any and all claims, causes of action or rights that may arise against any person, corporation and/or entity and to any Coverage to which the Plan Participant is entitled, regardless of how classified or characterized, at the Plan's discretion.

If a Plan Participant receives or becomes entitled to receive benefits, an automatic equitable lien attaches in favor of the Plan to any claim, which any Plan Participant may have against any Coverage and/or party causing the Illness, Injury or disability to the extent of such conditional payment by the Plan plus reasonable costs of collection. The Plan Participant is obligated to notify the Plan or its authorized representative of any settlement prior to finalization of the settlement, execution of a release, or receipt of applicable funds. The Plan Participant is also obligated to hold any and all funds so received in trust on the Plan's behalf and function as a trustee as applied to those funds until the Plan's rights described herein are honored and the Plan is reimbursed.

The Plan may, at its discretion, in its own name or in the name of the Plan Participant commence a proceeding or pursue a claim against any party or Coverage for the recovery of all damages to the full extent of the value of any such benefits or conditional payments advanced by the Plan.

If the Plan Participant fails to file a claim or pursue damages against:

- a) the responsible party, its insurer, or any other source on behalf of that party;
- b) any first party insurance through medical payment coverage, personal injury protection, no-fault coverage, uninsured or underinsured motorist coverage;

- c) any policy of insurance from any insurance company or guarantor of a third party;
- d) worker's compensation or other liability insurance company; or
- e) any other source, including but not limited to crime victim restitution funds, any medical, disability or other benefit payments, and school insurance coverage;

The Plan Participant authorizes the Plan to pursue, sue, compromise and/or settle any such claims in the Plan Participant's and/or the Plan's name and agrees to fully cooperate with the Plan in the prosecution of any such claims. The Plan Participant assigns all rights to the Plan or its assignee to pursue a claim and the recovery of all expenses from any and all sources listed above.

RIGHT OF REIMBURSEMENT

The Plan shall have the specific right of first recovery ("reimbursement"), and as such, shall be entitled to recover 100% of the benefits paid, without deduction for attorneys' fees and costs or application of the common fund doctrine, make whole doctrine, or any other equitable and/or legal theory, without regard to whether the Plan Participant is fully compensated by his recovery from all sources. The Plan shall have an equitable lien which supersedes all common law or statutory rules, doctrines, and laws of any state prohibiting assignment of rights which interferes with or compromises in any way the Plan's equitable lien and right to reimbursement. The obligation to reimburse the Plan in full exists regardless of how the judgment or settlement is classified and whether or not the judgment or settlement specifically designates the recovery or a portion of it as including medical, disability, or other expenses. If the Plan Participant's recovery is less than the benefits paid, then the Plan is entitled to be paid all of the recovery achieved. Any funds received by the Plan Participant are deemed held in constructive trust and should not be dissipated or disbursed until such time as the Plan Participant's obligation to reimburse the Plan has been satisfied in accordance with these provisions. The Plan Participant is also obligated to hold any and all funds so received in trust on the Plan's behalf and function as a trustee as it applies to those funds until the Plan's rights described herein are honored and the Plan is reimbursed.

No court costs, experts' fees, attorneys' fees, filing fees, or other costs or expenses of litigation may be deducted from the Plan's recovery without the prior, express written consent of the Plan.

The Plan's right of subrogation and reimbursement will not be reduced or affected as a result of any fault or claim on the part of the Plan Participant, whether under the doctrines of causation, comparative fault or contributory negligence, or other similar doctrine in law. Accordingly, any lien reduction statutes, which attempt to apply such laws and reduce a subrogating Plan's recovery will not be applicable to the Plan and will not reduce the Plan's reimbursement rights.

These rights of subrogation and reimbursement shall apply without regard to whether any separate written acknowledgment of these rights is required by the Plan and signed by the Plan Participant.

This provision shall not limit any other remedies of the Plan provided by law. These rights of subrogation and reimbursement shall apply without regard to the location of the event that led to or caused the applicable sickness, injury, disease or disability.

PLAN PARTICIPANT IS A TRUSTEE OVER PLAN ASSETS

Any Plan Participant who receives benefits and is therefore subject to the terms of this section is hereby deemed a recipient and holder of Plan assets and is therefore deemed a trustee of the Plan solely as it relates to possession of any funds which may be owed to the Plan as a result of any settlement, judgment or recovery through any other means arising from any injury or accident. By virtue of this status, the Plan Participant understands that he/she is required to:

- a) notify the Plan or its authorized representative of any settlement prior to finalization of the settlement, execution of a release, or receipt of applicable funds;
- b) instruct his/her attorney to ensure that the Plan and/or its authorized representative is included as a payee on all settlement drafts;
- c) in circumstances where the Plan Participant is not represented by an attorney, instruct the insurance company or any third party from whom the Plan Participant obtains a settlement, judgment or other source of coverage to include the Plan or its authorized representative as a payee on the settlement draft; and,
- d) hold any and all funds so received in trust, on the Plan's behalf, and function as a trustee as it applies to those funds, until the Plan's rights described herein are honored and the Plan is reimbursed.

To the extent the Plan Participant disputes his/her obligation to the Plan under this section, the Plan Participant or any of his/her agents or representatives is also required to hold any/all settlement funds, including the entire settlement if the settlement is less than the Plan's interests, and without reduction in consideration of attorney's fees, for which he/she exercises control, in an account segregated from his/her general accounts or general assets until such time as the dispute is resolved.

No Plan Participant, beneficiary, or the agents or representatives thereof, exercising control over Plan assets and incurring trustee responsibility in accordance with this section will have any authority to accept any reduction of the Plan's interest on the Plan's behalf.

SEPARATION OF FUNDS

Benefits paid by the Plan, funds recovered by the Plan Participant, and funds held in trust over which the Plan has an equitable lien exist separately from the property and estate of the Plan Participant(s), such that the death of the Plan

Participant, or filing of bankruptcy by the Plan Participant(s), will not affect the Plan's equitable lien, the funds over which the Plan has a lien, or the Plan's right to subrogation and reimbursement.

WRONGFUL DEATH

In the event that the Plan Participant dies as a result of his injuries and a wrongful death or survivor claim is asserted against a third party or any Coverage, the Plan's subrogation and reimbursement rights shall still apply.

OBLIGATIONS

It is the Plan Participant's obligation at all times, both prior to and after payment of medical benefits by the Plan:

- a) to cooperate with the Plan, or any representatives of the Plan, in protecting its rights, including discovery, attending depositions, and/or cooperating in trial to preserve the Plan's rights;
- b) to provide the Plan with pertinent information regarding the Illness, Injury, or disability, including accident reports, settlement information and any other requested additional information;
- c) to take such action and execute such documents as the Plan may require to facilitate enforcement of its subrogation and reimbursement rights, including providing to the Plan an executed reimbursement agreement;
- d) to do nothing to prejudice the Plan's rights of subrogation and reimbursement;
- e) to promptly reimburse the Plan when a recovery through settlement, judgment, award or other payment is received; and
- f) to not settle or release, without the prior consent of the Plan, any claim to the extent that the Plan Participant may have against any responsible party or Coverage.

If the Plan Participant and/or his attorney fails to reimburse the Plan for all benefits paid or to be paid, as a result of said injury or condition, out of any proceeds, judgment or settlement received, the Plan Participant will be responsible for any and all expenses (whether fees or costs) associated with the Plan's attempt to recover such money from the Plan Participant.

The Plan's rights to reimbursement and/or subrogation are in no way dependent upon the Plan Participant's cooperation or adherence to these terms.

OFFSET

Failure by the Plan Participant and/or his attorney to comply with any of these requirements may, at the Plan's discretion, result in a forfeiture of payment by the Plan of medical benefits, and any funds, or payments due under this Plan on behalf of the Plan Participant may be withheld until the Plan Participant satisfies his obligation.

MINOR STATUS

In the event the Plan Participant is a minor as that term is defined by applicable law, the minor's parents or court-appointed guardian shall cooperate in any and all actions by the Plan to seek and obtain requisite court approval to bind the minor and his estate insofar as these subrogation and reimbursement provisions are concerned.

If the minor's parents or court-appointed guardian fail to take such action, the Plan shall have no obligation to advance payment of medical benefits on behalf of the minor. Any court costs or legal fees associated with obtaining such approval shall be paid by the minor's parents or court-appointed guardian.

SEVERABILITY

In the event that any section of this provision is considered invalid or illegal for any reason, said invalidity or illegality shall not affect the remaining sections of this provision and Plan. The section shall be fully severable. The Plan shall be construed and enforced as if such invalid or illegal sections had never been inserted in the Plan.

RIGHT TO RECEIVE AND RELEASE NECESSARY INFORMATION

For the purpose of determining the applicability of and implementing the terms of these benefits, the Plan Administrator may, without the consent of or notice to any person, release or obtain any information necessary to determine acceptability of any applicant for participation in the Plan.

In so acting, the Plan Administrator shall be free from any liability that may arise with regard to such action. Any person claiming benefits under this Plan shall furnish to the Plan Administrator such information as may be necessary to implement this provision.

RIGHTS OF RECOVERY

Whenever payments have been made by the Plan which are in excess of the maximum amount allowed under the Plan or are otherwise not covered under any provision of the Plan, the Claims Processor or Plan Administrator shall have the right to recover such payments from among one or more of the following: any persons to, for or with respect to whom such payments were made; any providers of service; any insurance companies or any other organizations. Current benefit payments may be reduced to satisfy outstanding reimbursements.

SEVERABILITY

Should any provision of this Summary Plan Description be declared invalid or illegal for any reason, such invalidity or illegality shall not affect the remaining portions of the Summary Plan Description. Any remaining portions shall remain in full force and effect, as if this Summary Plan Description did not contain the invalid or illegal provision.

SUBMISSION OF CLAIM

All charges, and corresponding requested documentation, must be submitted by the date specified in the Schedule of Covered Services and Provisions. Failure to do so will result in the denial of the charges.

SUMMARY OF MATERIAL MODIFICATIONS

Plan Participants shall be furnished summary descriptions of material modifications in the terms of this Plan and changes in the information required to be included in the Summary Plan Description pertaining to this Plan not later than 210 days after the end of the Plan Year in which the change is adopted. However, in the case of any modification or change that is a material reduction in covered services or benefits provided under the Plan, Plan Participants will be furnished a summary of such modification or change not later than 60 days after the adoption of the modification or change, unless the Employer provides summaries of modifications or changes at regular intervals of not more than 90 days.

SUMMARY PLAN DESCRIPTION

The Company will issue to each Employee under the Plan, a document that shall summarize the benefits to which the person is entitled, to whom the benefits are payable, and the provisions of the Plan principally affecting the Employee. This document is intended to satisfy the requirement for both a Summary Plan Description and Plan Description as specified under ERISA.

SYSTEM FOR PROCESSING CLAIMS

Claims will be processed on the following basis: 1) first, any non-covered services or services in excess of Plan provisions will be subtracted from billed charges; 2) then, the Maximum Allowable Amount will be applied (if applicable); and 3) then, any Deductible/Co-Insurance or uncollected co-pays will be deducted from the remaining eligible amount prior to payment.

TYPE OF ADMINISTRATION

The Plan is self-administered by the Plan Administrator. The Plan Administrator has hired a Claims Processor to process claims and provide consulting services and ministerial functions.

COORDINATION OF BENEFITS (COB)

The Coordination of Benefits provision is intended to prevent payments of benefits that exceed expenses. It applies when any other plan or plans also cover the person covered by this Plan. When more than one coverage exists, one plan normally pays its benefits in full and the other plans pay a reduced benefit. This Plan will always pay either its benefits in full or a reduced amount which, when added to the benefits payable by the other plan or plans, will not exceed the Maximum Allowable Amount. Only the amount paid by the Plan will be charged against the Plan maximums. See Schedule of Covered Services and Provisions to determine the type of Coordination of Benefits this Plan provides.

To coordinate benefits, it is necessary to determine in what order the benefits of various Plans are payable. This is determined as follows:

1. If a plan does not have a provision for the coordination of benefits, its benefits are payable before this Plan.
2. If a plan covers a person other than as a Dependent, its benefits are payable before this Plan. This includes Medicare covering a person other than as a Dependent (e.g. a retired Employee) and any Medicare Supplement Plan. However, in all instances, federal regulations regarding Medicare as a secondary payer will apply.
3. If a plan covers an active Employee, its benefits are payable before this Plan. This order of determination does not supersede No. 2 above.
4. If an individual is covered as a Dependent under 2 separate plans, the benefits are payable first under the Employee's plan having the earliest birthday in a Calendar Year. However, if the Dependent is a child whose parents are separated or divorced, the "birthday rule" does not apply. The following order to determination will apply:

If the parent with custody has not remarried:

- a) The plan of the parent with custody is primary.
- b) The plan of the parent without custody is secondary.

If the parent with custody has remarried:

- a) The plan of the parent with custody is primary.
- b) The plan of the stepparent with custody is secondary.
- c) The plan of the parent without custody is tertiary (third).

There may be a court decree that makes one parent financially responsible for the health care expenses incurred by the child. If a plan covers the child as a Dependent of that parent, its benefits are payable before those of a plan that covers the child as a Dependent of the parent without financial responsibility.

5. If a plan covers an individual who is also allowed to be covered by this Plan pursuant to COBRA continuation coverage, its benefits are payable before this Plan.
6. If items 1, 2, 3, 4 or 5 do not apply, the benefits of a plan that has covered the person for the longest period of time will be payable before those of the other plan.

To the extent that the Plan would be secondary to Medicare, if a Plan Participant is eligible for Medicare Part A and/or Part B and does not elect to enroll in such Medicare coverage, then Plan benefits will be coordinated based on an estimate of what Medicare would have paid, regardless of whether benefits are actually received from Medicare.

Any other “plan” means and includes, but is not necessarily limited to the following: any policy, contract or other arrangement for group insurance benefits, including any Hospital or medical service organization plan or other service or prepayment plan arranged through any employer, union, trustee, Employee benefit association, government agency or professional association; or any homeowner’s policy or other policy providing liability coverage; or any coverage for students sponsored by or provided through a school or other educational institution; or any individual or non-group health coverage, of which the Plan Administrator is actually aware, including but not limited to a plan or policy purchased or made available through a state or federally managed Health Insurance Marketplace; or any coverage provided by a licensed Health Maintenance Organization (HMO); or any benefits payable under Medicare (to the extent permitted by law); or any government program or any coverage provided by statute.

The term “plan” shall also mean any mandatory “no-fault” automobile insurance coverage providing benefits under a medical expense reimbursement provision for Hospital, medical, or other health care services and treatment because of accidental bodily Injuries arising out of a motor vehicle accident; and any other payment received under any automobile policy.

To administer this provision, the Company has the right to:

1. Release or obtain data needed to determine the benefits payable under this provision
2. Recover any sum paid above the amount that is required by this provision and
3. Repay any party for a payment made by the party, when the Company should have made the payment.

COMPLIANCE REGULATIONS

STATEMENT OF RIGHTS UNDER THE NEWBORNS' AND MOTHERS' HEALTH PROTECTION ACT

Under federal law, group health plans and health insurance issuers offering group health insurance coverage generally may not restrict benefits for any hospital length of stay in connection with childbirth for the mother or newborn child to less than 48 hours following a vaginal delivery, or less than 96 hours following a delivery by cesarean section. However, the plan or issuer may pay for a shorter stay if the attending provider (e.g., Your Physician, nurse midwife or physician assistant), after consultation with the mother, discharges the mother or newborn earlier.

Also, under federal law, plans and issuers may not set the level of benefits or out-of-pocket costs so that any later portion of the 48-hour (or 96 hour) stay is treated in a manner less favorable to the mother or newborn than any earlier portion of the stay.

In addition, a plan or issuer may not, under federal law, require that a Physician or other health care provider obtain authorization for prescribing a length of stay of up to 48 hours (or 96 hours). However, to use certain providers or facilities, or to reduce Your out-of-pocket costs, You may be required to obtain pre-certification. For information on pre-certification, contact Your Plan Administrator.

SOURCE OF INJURY RESTRICTIONS

The Plan will not limit coverage for Injuries or Illnesses resulting from 1) domestic violence, or 2) self-inflicted injury or attempted suicide. Further, the Plan will not limit coverage for Injuries or Illnesses resulting from participation in any activity if such Illness or Injury is as a result of a physical or mental condition.

WELLNESS VS. RISK FACTORS

The Plan will not charge Plan Participants who have adverse health factors, or who participate in certain adverse lifestyle activities, more than those similarly situated Plan Participants who do not have such factors or participate in such activities.* Further, the Plan will not provide rewards to Plan Participants who participate in, or meet the requirements of, positive lifestyle activities in excess of what is offered to those similarly situated Plan Participants who do not participate in, or meet the requirements of, such activities.*

* Except as such differential treatment is allowed through the incorporation of wellness program(s) meeting federally approved guidelines.

FAMILY MEDICAL LEAVE ACT (FMLA)

The following applies to companies with 50 or more employees

If the Plan Participant is entitled to, and elects to take, a family or medical leave solely under the terms of the Family and Medical Leave Act of 1993 (FMLA), the Plan Participant and his covered Dependents shall continue to be covered under this Plan while the Plan

Participant is absent from work on an FMLA leave as if there were no interruption of active employment. Provided the applicable premium is paid, such coverage will continue until the earlier of the expiration of such leave or the date notice is given to the Company that the Plan Participant does not intend to return to work at the end of the FMLA leave.

The Plan Participant may choose not to retain health coverage during the FMLA leave. If he returns to active working status on or before the expiration of the leave, he is entitled to have coverage reinstated on the same basis as it would have been if the leave had not been taken. (Coverage will be reinstated without any additional qualification requirements imposed by this Plan. This Plan's provisions with respect to Deductibles and percentage of payments will apply on the same basis as they did prior to the FMLA leave.)

MILITARY LEAVES

If You are absent from work due to military service, You may elect to continue coverage under the Plan (including coverage for enrolled Dependents) for up to 24 months from the first day of absence (or, if earlier, until the day after the date You are required to apply for or return to active employment with Your Employer under the Uniformed Services Employment and Reemployment Rights Act of 1994 (USERRA)). Your contributions for continued coverage will be the same as for a COBRA beneficiary, except that, if You are absent for 30 days or less, Your contribution will be the same as for similarly situated active participants in the Plan.

Whether or not You continue coverage during military service, You may reinstate coverage under the Plan on Your return to employment under USERRA. The reinstatement will be without any waiting period otherwise required under the Plan, except to the extent that You had not fully completed any required waiting period prior to the start of military service.

GENETIC INFORMATION

The Plan may not adjust premium or contribution amounts for those covered under the Plan on the basis of genetic information. The Plan may also not request, require or purchase genetic information for underwriting purposes (or in connection with any individual prior to such individual's enrollment under the Plan). The term "underwriting" covers rules relating to the determination of eligibility (including enrollment and continued eligibility) for Plan benefits or coverage, the computation of premium or contribution amounts and any activities relating to the creation, renewal, or replacement of the Plan.

This Plan is prohibited from requesting or requiring genetic testing on the part of an individual or his family members. Genetic tests include analysis of human DNA, RNA, chromosomes, proteins, or metabolites that detect genotypes, mutations, or chromosomal changes. The term "genetic test" does not mean an analysis of proteins or metabolites that does not detect genotypes, mutations, or chromosomal changes; or an analysis of proteins or metabolites that is directly related to a manifested disease, disorder, or pathological condition that could reasonably be detected by a health care professional with appropriate training and expertise in the field of medicine involved.

The Plan may obtain and use the results of a genetic test when making payment determinations (so long as only the minimum amount of information is utilized necessary for the determination).

A plan may request (but not require) that a participant undergo a genetic test if 1) the plan clearly indicates that compliance is voluntary, and that noncompliance will have no effect on enrollment status or premium/contribution amounts, 2) no genetic information collected is used for underwriting purposes, and 3) the plan notify the applicable federal government agency that the plan is conducting activities pursuant to this exception and includes a description of the activities.

NOTICE OF CONTINUATION COVERAGE RIGHTS UNDER COBRA

INTRODUCTION

This notice contains important information about Your rights to COBRA continuation coverage, which is a temporary extension of coverage under the Plan. **This notice generally explains COBRA continuation coverage, when it may become available to You and Your family, and what You need to do to protect the right to receive it.**

The right to COBRA continuation coverage was created by a federal law, the Consolidated Omnibus Budget Reconciliation Act of 1985 (COBRA). COBRA continuation coverage can become available to You and other members of Your family when group health coverage would otherwise end. For more information about Your rights and obligations under the Plan and under federal law, You should review the Plan's Summary Plan Description or contact the Plan Administrator.

You may have other options available to You when You lose group health coverage. For example, You may be eligible to buy an individual plan through the Health Insurance Marketplace. By enrolling in coverage through the Marketplace, You may qualify for lower costs on Your monthly premiums and lower out-of-pocket costs. Additionally, You may qualify for a 30-day special enrollment period for another group health plan for which You are eligible (such as a spouse's plan), even if that plan generally doesn't accept late enrollees.

WHAT IS COBRA CONTINUATION COVERAGE?

COBRA continuation coverage is a continuation of Plan coverage when coverage would otherwise end because of a life event. This is also called a “qualifying event”. Specific qualifying events are listed later in this notice. After a qualifying event, COBRA continuation coverage must be offered to each person who is a “qualified beneficiary.” You, Your spouse, and Your dependent children could become qualified beneficiaries if coverage under the Plan is lost because of the qualifying event. Under the Plan, qualified beneficiaries who elect COBRA continuation coverage must pay for COBRA continuation coverage.

If You're an employee, You'll become a qualified beneficiary if You lose Your coverage under the Plan because of the following qualifying events:

- Your hours of employment are reduced, or
- Your employment ends for any reason other than Your gross misconduct.

If You're the spouse of an employee, You will become a qualified beneficiary if You lose Your coverage under the Plan because of the following qualifying events:

- Your spouse dies;
- Your spouse's hours of employment are reduced;
- Your spouse's employment ends for any reason other than his or her gross misconduct;
- Your spouse becomes entitled to Medicare benefits (under Part A, Part B, or both); or
- You become divorced or legally separated from Your spouse.

Your dependent children will become qualified beneficiaries if they lose coverage under the Plan because any of the following qualifying events:

- The parent-employee dies;
- The parent-employee's hours of employment are reduced;
- The parent-employee's employment ends for any reason other than his or her gross misconduct;
- The parent-employee becomes entitled to Medicare benefits (Part A, Part B, or both);
- The parents become divorced or legally separated; or
- The child stops being eligible for coverage under the plan as a "dependent child."

Sometimes, filing a proceeding in bankruptcy under title 11 of the United States Code can be a qualifying event. If a proceeding in bankruptcy is filed with respect to Your employer, and that bankruptcy results in the loss of coverage of any retired employee covered under the Plan, the retired employee will become a qualified beneficiary with respect to the bankruptcy. The retired employee's spouse, surviving spouse, and dependent children will also become qualified beneficiaries if bankruptcy results in the loss of their coverage under the Plan.

WHEN IS COBRA COVERAGE AVAILABLE?

The Plan will offer COBRA continuation coverage to qualified beneficiaries only after the Plan Administrator has been notified that a qualifying event has occurred. When the qualifying event is the end of employment or reduction of hours of employment, death of the employee, commencement of a proceeding in bankruptcy with respect to the employer (if the Plan provides retiree coverage), or the employee's becoming entitled to Medicare benefits (under Part A, Part B, or both), the employer must notify the Plan Administrator of the qualifying event.

For all other qualifying events (divorce or legal separation of the employee and spouse or a dependent child's losing eligibility for coverage as a dependent child), You must notify the Plan Administrator within 60 days after the qualifying event occurs. You must send this notice in writing to the Plan Administrator. IF YOU, YOUR SPOUSE OR YOUR DEPENDENT FAIL TO PROVIDE TIMELY WRITTEN NOTICE TO THE PLAN ADMINISTRATOR AFTER A DIVORCE, LEGAL SEPARATION OR LOSS OF DEPENDENT CHILD ELIGIBILITY, THE RIGHT TO ELECT TO PURCHASE COBRA CONTINUATION COVERAGE IS WAIVED.

HOW IS COBRA COVERAGE PROVIDED?

Once the Plan Administrator receives notice that a qualifying event has occurred, COBRA continuation coverage will be offered to each of the qualified beneficiaries. Each qualified beneficiary will have an independent right to elect COBRA continuation coverage. Covered employees may elect COBRA continuation coverage on behalf of their spouses, and parents may elect COBRA continuation coverage on behalf of their children.

COBRA continuation coverage is a temporary continuation of coverage that generally lasts for 18 months due to employment termination or reduction of hours of work. Certain

qualifying events, or a second qualifying event during the initial period of coverage, may permit a beneficiary to receive a maximum of 36 months of coverage.

There are also ways in which this 18 month period of COBRA continuation coverage can be extended.

DISABILITY EXTENSION OF 18-MONTH PERIOD OF CONTINUATION COVERAGE

If You or anyone in Your family covered under the Plan is determined by the Social Security Administration to be disabled and You notify the Plan Administrator in a timely fashion, You and Your entire family may be entitled to receive up to an additional 11 months of COBRA continuation coverage, for a total maximum of 29 months. The disability would have to have started at some time before the 60th day of COBRA continuation coverage and must last at least until the end of the 18-month period of continuation coverage. A copy of the determination of disability by the Social Security Administration must be sent to the Plan Administrator within 60 days after the date the determination is issued and before the end of the 18-month maximum coverage period that applies to the qualifying event. Any individual who is either the employee, a qualified beneficiary with respect to the qualifying event, or any representative acting on behalf of the employee or qualified beneficiary, may send the written notice to the Plan Administrator. Such individual(s) must further notify the Plan Administrator in writing within 30 days after a determination has been made that the person is no longer disabled. The Plan may require the payment of an amount that is up to 150 percent of the applicable premium for the period of extended coverage as long as the disabled individual is included in the extended coverage period.

SECOND QUALIFYING EVENT EXTENSION OF 18-MONTH PERIOD OF CONTINUATION COVERAGE

If Your family experiences another qualifying event while receiving 18 months of COBRA continuation coverage, the spouse and dependent children in Your family can get up to 18 additional months of COBRA continuation coverage, for a maximum of 36 months, if the Plan is properly notified about the second qualifying event. This extension may be available to the spouse and any dependent children receiving continuation coverage if the employee or former employee dies, becomes entitled to Medicare benefits (under Part A, Part B, or both), or gets divorced or legally separated, or if the dependent child stops being eligible under the Plan as a dependent child, but only if the event would have caused the spouse or dependent child to lose coverage under the Plan had the first qualifying event not occurred.

ARE THERE OTHER COVERAGE OPTIONS BESIDES COBRA CONTINUATION COVERAGE?

Yes, instead of enrolling in COBRA continuation coverage, there may be other coverage options for You and Your family through the Health Insurance Marketplace, Medicaid, or other group health plan coverage options (such as a spouse's plan) through what is called a "special enrollment period." Some of these options may cost less than COBRA continuation coverage. You can learn more about these options at www.HealthCare.gov.

You should compare Your other coverage options with COBRA continuation coverage and choose the coverage that is best for You. For example, if You move to other coverage You

may pay more out of pocket than You would under COBRA because the new coverage may impose a new deductible.

When You lose job-based health coverage, it's important that You choose carefully between COBRA continuation coverage and other coverage options, because once You've made Your choice, it can be difficult or impossible to switch to another coverage option.

WHAT IS THE HEALTH INSURANCE MARKETPLACE?

The Marketplace allows You to find and compare private health insurance options. In the Marketplace, You could be eligible for a new kind of tax credit that lowers Your monthly premiums and cost-sharing reductions (amounts that lower Your out-of-pocket costs for deductibles, coinsurance, and copayments) right away, and You can see what Your premium, deductibles, and out-of-pocket costs will be before You make a decision to enroll. Through the Marketplace You'll also learn if You qualify for free or low-cost coverage from [Medicaid](#) or the [Children's Health Insurance Program \(CHIP\)](#). You can access the Marketplace for Your state at www.HealthCare.gov.

Coverage through the Health Insurance Marketplace may cost less than COBRA continuation coverage.

WHEN CAN I ENROLL IN MARKETPLACE COVERAGE?

You always have 60 days from the time You lose Your job-based coverage to enroll in the Marketplace. That is because losing Your job-based health coverage is a "special enrollment" event. **After 60 days Your special enrollment period will end and You may not be able to enroll, so You should take action right away.** In addition, during what is called an "open enrollment" period, anyone can enroll in Marketplace coverage.

To find out more about enrolling in the Marketplace, such as when the next open enrollment period will be and what You need to know about qualifying events and special enrollment periods, visit www.HealthCare.gov.

IF I SIGN UP FOR COBRA CONTINUATION COVERAGE, CAN I SWITCH TO COVERAGE IN THE MARKETPLACE? WHAT ABOUT IF I CHOOSE MARKETPLACE COVERAGE AND WANT TO SWITCH BACK TO COBRA CONTINUATION COVERAGE?

If You sign up for COBRA continuation coverage, You can switch to a Marketplace plan during a Marketplace open enrollment period. You can also end Your COBRA continuation coverage early and switch to a Marketplace plan if You have another qualifying event such as marriage or birth of a child through something called a "special enrollment period." But be careful though - if You terminate Your COBRA continuation coverage early without another qualifying event, You'll have to wait to enroll in Marketplace coverage until the next open enrollment period, and could end up without any health coverage in the interim.

Once You've exhausted Your COBRA continuation coverage and the coverage expires, You'll be eligible to enroll in Marketplace coverage through a special enrollment period, even if Marketplace open enrollment has ended.

If You sign up for Marketplace coverage instead of COBRA continuation coverage, You cannot switch to COBRA continuation coverage under any circumstances.

WHAT FACTORS SHOULD I CONSIDER WHEN CHOOSING COVERAGE OPTIONS?

When considering Your options for health coverage, You may want to think about:

- **Premiums:** Your previous plan can charge up to 102% of total plan premiums for COBRA coverage. Other options, like coverage on a spouse's plan or through the Marketplace, may be less expensive.
- **Provider Networks:** If You're currently getting care or treatment for a condition, a change in Your health coverage may affect Your access to a particular health care provider. You may want to check to see if Your current health care providers participate in a network as You consider options for health coverage.
- **Drug Formularies:** If You're currently taking medication, a change in Your health coverage may affect Your costs for medication – and in some cases, Your medication may not be covered by another plan. You may want to check to see if Your current medications are listed in drug formularies for other health coverage.
- **Severance payments:** If You lost Your job and got a severance package from Your former employer, Your former employer may have offered to pay some or all of Your COBRA payments for a period of time. In this scenario, You may want to contact the Department of Labor at 1-866-444-3272 to discuss Your options.
- **Service Areas:** Some plans limit their benefits to specific service or coverage areas – so if You move to another area of the country, You may not be able to use Your benefits. You may want to see if Your plan has a service or coverage area, or other similar limitations.
- **Other Cost-Sharing:** In addition to premiums or contributions for health coverage, You probably pay copayments, deductibles, coinsurance, or other amounts as You use Your benefits. You may want to check to see what the cost-sharing requirements are for other health coverage options. For example, one option may have much lower monthly premiums, but a much higher deductible and higher copayments.

IF YOU HAVE QUESTIONS

Questions concerning Your Plan or Your COBRA continuation coverage rights should be addressed to the contact or contacts identified below. For more information about Your rights under the Employee Retirement Income Security Act (ERISA), including COBRA, the Health Insurance Portability and Accountability Act (HIPAA), and other laws affecting group health plans, contact the nearest Regional or District Office of the U.S. Department of Labor's Employee Benefits Security Administration (EBSA) in Your area or visit the EBSA website at www.dol.gov/ebsa. (Addresses and phone numbers of Regional and District EBSA Offices are available through EBSA's website.) For more information about the Marketplace, visit www.HealthCare.gov.

KEEP YOUR PLAN INFORMED OF ADDRESS CHANGES

In order to protect Your family's rights, let the Plan Administrator know about any changes in the addresses of family members. You should also keep a copy, for Your records, of any notices You sent to the Plan Administrator.

PLAN CONTACT INFORMATION

If You have any questions regarding COBRA Continuation Coverage under the Plan, please contact Your Plan Administrator.

ERISA RIGHTS SECTION

As a Plan Participant, You are entitled to certain rights and protection under the Employee Retirement Income Security Act of 1974 (ERISA). ERISA provides that all Plan Participants shall be entitled to:

RECEIVE INFORMATION ABOUT YOUR PLAN AND BENEFITS

Examine without charge, at the Plan Administrator's office and at other specified locations, such as worksites and union halls, all documents governing the Plan, including insurance contracts, and collective bargaining agreements, and a copy of the latest annual report (Form 5500 Series) filed by the Plan with the U.S. Department of Labor and available at the Public Disclosure Room of the Employee Benefits Services Administration (EBSA).

Obtain, upon written request to the Plan Administrator, copies of documents governing the operation of the Plan, including insurance contracts and collective bargaining agreements, and copies of the latest annual report (Form 5500 Series) and updated Summary Plan Description. The Plan Administrator may make a reasonable charge for the copies

Receive a summary of the Plan's annual financial report. The Plan Administrator is required by law to furnish each participant with a copy of this summary annual report.

CONTINUE GROUP HEALTH PLAN COVERAGE

Continue health care coverage for Yourself, spouse or Dependents if there is a loss of coverage under the Plan as a result of a qualifying event. You or Your Dependents may have to pay for such coverage. Review this Summary Plan Description and the documents governing the Plan on the rules governing Your COBRA continuation coverage rights.

PRUDENT ACTIONS BY PLAN FIDUCIARIES

In addition to creating rights for Plan Participants, ERISA imposes duties upon the people who are responsible for the operation of the employee benefit Plan. The people who operate the Plan, called "fiduciaries" of the Plan, have a duty to do so prudently and in the interest of You and other Plan Participants and beneficiaries. No one, including Your employer, Your union, or any other person, may fire You or otherwise discriminate against You in any way to prevent You from obtaining a welfare benefit or exercising Your rights under ERISA.

ENFORCE YOUR RIGHTS

If Your claim for a welfare benefit is denied or ignored, in whole or in part, or if Your coverage was rescinded, You have a right to know why this was done, to obtain copies of documents relating to the decision, without charge, and to appeal any denial, all within certain time schedules.

Under ERISA, there are steps You can take to enforce the above rights. For instance, if You request a copy of Plan documents or the latest annual report from the Plan and do not receive them within 30 days, You may file suit in a Federal court. In such a case, the court may require the Plan Administrator to provide the materials and pay You up to \$110 a day until You receive the materials, unless the materials were not sent because of reasons beyond the control of the administrator. If You have a claim for benefits which is denied or ignored, in whole or in part, or if Your coverage was rescinded, You may file suit in a state or Federal court, subject to the procedures discussed in the Section “APPEALING A CLAIM” under “GENERAL PROVISIONS.” In addition, if You disagree with the Plan’s decision or lack thereof concerning the qualified status of a domestic relations order or a medical child support order, You may file suit in Federal court. If it should happen that Plan fiduciaries misuse the Plan’s money, or if You are discriminated against for asserting Your rights, You may seek assistance from the U.S. Department of Labor, or You may file suit in a Federal court. The court will decide who should pay court costs and legal fees. If You are successful, the court may order the person You have sued to pay these costs and fees. If You lose, the court may order You to pay these costs and fees, for example, if it finds Your claim is frivolous.

ASSISTANCE WITH YOUR QUESTIONS

If You have any questions about Your Plan, You should contact the Plan Administrator. If You have any questions about this statement or about Your rights under ERISA, or if You need assistance in obtaining documents from the Plan Administrator, You should contact the nearest office of the Employee Benefits Services Administration (EBSA), U.S. Department of Labor, listed in Your telephone directory or the Division of Technical Assistance and Inquiries, Employee Benefits Services Administration, U.S. Department of Labor, 200 Constitution Avenue N.W., Washington D.C. 20210. You may also obtain certain publications about Your rights and responsibilities under ERISA by calling the publications hotline of the EBSA.

STANDARDS FOR PRIVACY OF INDIVIDUALLY IDENTIFIABLE HEALTH INFORMATION (THE “PRIVACY STANDARDS”)

ISSUED PURSUANT TO

**The Health Insurance Portability and Accountability Act of 1996, as amended
 (“HIPAA”)**

1. Disclosure of Summary Health Information to the Plan Sponsor

In accordance with the Privacy Standards, the Plan may disclose Summary Health Information to the Plan Sponsor if the Plan Sponsor requests the Summary Health Information for the purpose of (a) obtaining premium bids from health plans for providing health insurance coverage under this Plan or (b) modifying, amending or terminating the Plan.

“Summary Health Information” may be individually identifiable health information and it summarizes the claims history, claims expenses or the type of claims experienced by individuals in the Plan, but it excludes all identifiers that must be removed for the information to be de-identified, except that it may contain geographic information to the extent that it is aggregated by five-digit zip code.

2. Disclosure of Protected Health Information (“PHI”) to the Plan Sponsor for Plan Administration Purposes

In order that the Plan Sponsor may receive and use PHI for Plan Administration purposes, the Plan Sponsor agrees to:

- a. Not use or further disclose PHI other than as permitted or required by the Plan Documents or as required by law (as defined in the Privacy Standards);
- b. Ensure that any agents, including a subcontractor, to whom the Plan Sponsor provides PHI received from the Plan agree to the same restrictions and conditions that apply to the Plan Sponsor with respect to such PHI;
- c. Not use or disclose PHI for employment-related actions and decisions or in connection with any other benefit or employee benefit plan of the Plan Sponsor, except pursuant to an authorization which meets the requirements of the Privacy Standards;
- d. Report to the Plan any PHI use or disclosure that is inconsistent with the uses or disclosures provided for of which the Plan Sponsor becomes aware;
- e. Make available PHI in accordance with Section 164.524 of the Privacy Standards (45 CFR 164.524);
- f. Make available PHI for amendment and incorporate any amendments to PHI in accordance with Section 164.526 of the Privacy Standards (45 CFR 164.526);

- g. Make available the information required to provide an accounting of disclosures in accordance with Section 164.528 of the Privacy Standards (45 CFR 164.528);
- h. Make its internal practices, books and records relating to the use and disclosure of PHI received from the Plan available to the Secretary of the U.S. Department of Health and Human Services (“HHS”), or any other officer or employee of HHS to whom the authority involved has been delegated, for purposes of determining compliance by the Plan with Part 164, Subpart E, of the Privacy Standards (45 CFR 164.500 *et seq*);
- i. If feasible, return or destroy all PHI received from the Plan that the Plan Sponsor still maintains in any form and retain no copies of such PHI when no longer needed for the purpose for which disclosure was made, except that, if such return or destruction is not feasible, limit further uses and disclosures to those purposes that make the return or destruction of the PHI infeasible; and
- j. Ensure that adequate separation between the Plan and the Plan Sponsor, as required in Section 164.504(f)(2)(iii) of the Privacy Standards (45 CFR 164.504(f)(2)(iii)), is established as follows:
 - i. The access to and use of PHI by the individuals described in the Key Information section at the beginning of this document shall be restricted to the Plan Administration functions that the Plan Sponsor performs for the Plan.
 - ii. In the event any of the individuals described in the Key Information section do not comply with the provisions of the Plan Documents relating to use and disclosure of PHI, the Plan Administrator shall impose reasonable sanctions as necessary, in its discretion, to ensure that no further non-compliance occurs. Such sanctions shall be imposed progressively (for example, an oral warning, a written warning, time off without pay and termination), if appropriate, and shall be imposed so that they are commensurate with the severity of the violation.

“Plan Administration” functions are activities that would meet the definitions of treatment, payment and health care operations. “Plan Administration” functions include, but are not limited to quality assurance, claims processing, auditing, monitoring, management, stop loss underwriting, stop loss claims filing, eligibility information requests, medical necessity reviews, certain appeal determinations, utilization review, case management and disease management. It does not include any employment-related functions or functions in connection with any other benefit or benefit plans.

The Plan shall disclose PHI to the Plan Sponsor only upon receipt of a certification by the Plan Sponsor that (a) the Plan Documents have been amended to incorporate the above provisions and (b) the Plan Sponsor agrees to comply with such provisions.

3. Disclosure of Certain Enrollment Information to the Plan Sponsor

Pursuant to Section 164.504(f)(1)(iii) of the Privacy Standards (45 CFR 164.504(f)(1)(iii)), the Plan may disclose to the Plan Sponsor information on whether an individual is participating in the Plan or is enrolled in or has disenrolled from a health insurance issuer or health maintenance organization offered by the Plan to the Plan Sponsor.

4. Other Disclosures and Uses of PHI

With respect to all other uses and disclosures of PHI, the Plan shall comply with the Privacy Standards.

NOTICE OF PRIVACY PRACTICES

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

This Notice of Privacy Practices (“Notice”) describes how protected health information may be used or disclosed by this Plan to carry out treatment, payment, health care operations and for other purposes that are permitted or required by law. This Notice also sets out this Plan’s legal obligations concerning a Plan Participant’s protected health information and describes a Plan Participant’s rights to access, amend and manage that protected health information.

Protected health information (“PHI”) is individually identifiable health information, including demographic information, collected from a Plan Participant or created or received by a health care provider, a health plan, an employer (when functioning on behalf of the group health plan), or a health care clearinghouse and that relates to: (1) a Plan Participant’s past, present or future physical or mental health or condition; (2) the provision of health care to a Plan Participant; or (3) the past, present or future payment for the provision of health care to a Plan Participant.

This Notice has been drafted to be consistent with what is known as the “HIPAA Privacy Rule,” and any of the terms not defined in this Notice should have the same meaning as they have in the HIPAA Privacy Rule.

If You have any questions or want additional information about the Notice or the policies and procedures described in the Notice, please contact the person(s) or office identified under Plan Contact Information in the Key Information section at the beginning of this document:

THE PLAN’S RESPONSIBILITIES

The Plan is required by law to maintain the privacy of a Plan Participant’s PHI. The Plan is obligated to provide the Plan Participant with a copy of this Notice of the Plan’s legal duties and of its privacy practices with respect to the Plan Participant’s PHI, abide by the terms of the Notice that is currently in effect, and notify the Plan Participant in the event of a breach of the Plan Participant’s unsecured PHI. The Plan reserves the right to change the provisions of this Notice and make the new provisions effective for all PHI that is maintained. If the Plan makes a material change to this Notice, a revised Notice will be mailed to the address that the Plan has on record.

When using or disclosing PHI or when requesting PHI from another covered entity, the Plan will make reasonable efforts not to use, disclose or request more than the minimum amount of PHI necessary to accomplish the intended purpose of the use, disclosure or request, taking into consideration practical and technological limitations.

Genetic information shall be treated as health information pursuant to the Health Insurance Portability and Accountability Act. The use or disclosure by the Plan of protected health information that is genetic information about an individual for underwriting purposes under the Plan shall not be a permitted use or disclosure.

However, the minimum necessary standard will not apply in the following situations:

- disclosures to or requests by a health care provider for treatment;
- uses or disclosures made to the individual;
- disclosures made to the Secretary of the U.S. Department of Health and Human Services;
- uses or disclosures that are required by law;
- uses or disclosures that are required for compliance with the HIPAA Privacy Rule; and
- uses or disclosures made pursuant to an authorization.

This Notice does not apply to information that has been de-identified. De-identified information is health information that does not identify an individual and with respect to which there is no reasonable basis to believe that the information can be used to identify an individual. It is not individually identifiable health information.

PERMISSIBLE USES AND DISCLOSURES OF PHI

The following is a description of how the Plan is most likely to use and/or disclose a Plan Participant's PHI.

TREATMENT, PAYMENT AND HEALTH CARE OPERATIONS

The Plan has the right to use and disclose a Plan Participant's PHI for all activities that are included within the definitions of "treatment, payment and health care operations" as described in the HIPAA Privacy Rule.

TREATMENT

The Plan will use or disclose PHI so that a Plan Participant may seek treatment. Treatment is the provision, coordination or management of health care and related services. It also includes, but is not limited to consultations and referrals between one or more of a Plan Participant's providers. For example, the Plan may disclose to a treating specialist the name of a Plan Participant's primary care physician so that the specialist may request medical records from that primary care physician.

PAYMENT

The Plan will use or disclose PHI to pay claims for services provided to a Plan Participant and to obtain stop-loss reimbursements, if applicable, or to otherwise fulfill the Plan's responsibilities for coverage and providing benefits. For example, the Plan may disclose PHI when a provider requests information regarding a Plan Participant's eligibility for coverage under this Plan, or the Plan may use PHI to determine if a treatment that was received was medically necessary.

HEALTH CARE OPERATIONS

The Plan will use or disclose PHI to support its business functions. These functions include, but are not limited to quality assessment and improvement, reviewing provider performance, licensing, stop-loss underwriting, business planning and business development. For example, the Plan may use or disclose PHI: (1) to provide a Plan Participant with information about a disease management program; (2) to respond to a customer service inquiry from a Plan Participant or (3) in connection with fraud and abuse detection and compliance programs.

POTENTIAL IMPACT OF STATE LAW

The HIPAA Privacy Regulations generally do not “preempt” (or take precedence over) state privacy or other applicable laws that provide individuals greater privacy protections. As a result, to the extent state law applies, the privacy laws of a particular state, or other federal laws, rather than the HIPAA Privacy Regulations, might impose a privacy standard under which the Plan will be required to operate. For example, where such laws have been enacted, the Plan will follow more stringent state privacy laws that relate to uses and disclosures of PHI concerning HIV or AIDS, mental health, substance abuse/chemical dependency, genetic testing, reproductive rights, etc.

OTHER PERMISSIBLE USES AND DISCLOSURES OF PHI

The following is a description of other possible ways in which the Plan may (and is permitted to) use and/or disclose PHI.

REQUIRED BY LAW

The Plan may use or disclose PHI to the extent the law requires the use or disclosure. When used in this Notice, “required by law” is defined as it is in the HIPAA Privacy Rule. For example, the Plan may disclose PHI when required by national security laws or public health disclosure laws.

PUBLIC HEALTH ACTIVITIES

The Plan may use or disclose PHI for public health activities that are permitted or required by law. For example, the Plan may use or disclose information for the purpose of preventing or controlling disease, injury, or disability, or it may disclose such information to a public health authority authorized to receive reports of child abuse or neglect. The Plan also may disclose PHI, if directed by a public health authority, to a foreign government agency that is collaborating with the public health authority.

HEALTH OVERSIGHT ACTIVITIES

The Plan may disclose PHI to a health oversight agency for activities authorized by law, such as: audits; investigations; inspections; licensure or disciplinary actions; or civil, administrative, or criminal proceedings or actions. Oversight agencies seeking this information include government agencies that oversee: (1) the health care system; (2) government benefit programs; (3) other government regulatory programs and (4) compliance with civil rights laws.

ABUSE OR NEGLECT

The Plan may disclose PHI to a government authority that is authorized by law to receive reports of abuse, neglect or domestic violence. Additionally, as required by law, the Plan may disclose to a governmental entity, authorized to receive such information, a Plan Participant’s PHI if there is reason to believe that the Plan Participant has been a victim of abuse, neglect, or domestic violence.

LEGAL PROCEEDINGS

The Plan may disclose PHI: (1) in the course of any judicial or administrative proceeding; (2) in response to an order of a court or administrative tribunal (to the extent such disclosure is expressly authorized) and (3) in response to a subpoena, a discovery request, or other lawful process, once the Plan has met all administrative requirements of the HIPAA Privacy Rule. For example, the Plan may disclose PHI in response to a subpoena for such information, but only after first meeting certain conditions required by the HIPAA Privacy Rule.

LAW ENFORCEMENT

Under certain conditions, the Plan also may disclose PHI to law enforcement officials. For example, some of the reasons for such a disclosure may include, but not be limited to: (1) it is required by law or some other legal process; (2) it is necessary to locate or identify a suspect, fugitive, material witness, or missing person or (3) it is necessary to provide evidence of a crime.

CORONERS, MEDICAL EXAMINERS, FUNERAL DIRECTORS, AND ORGAN DONATION ORGANIZATIONS

The Plan may disclose PHI to a coroner or medical examiner for purposes of identifying a deceased person, determining a cause of death or for the coroner or medical examiner to perform other duties authorized by law. The Plan also may disclose, as authorized by law, information to funeral directors so that they may carry out their duties. Further, the Plan may disclose PHI to organizations that handle organ, eye or tissue donation and transplantation.

RESEARCH

The Plan may disclose PHI to researchers when an institutional review board or privacy board has: (1) reviewed the research proposal and established protocols to ensure the privacy of the information and (2) approved the research.

TO PREVENT A SERIOUS THREAT TO HEALTH OR SAFETY

Consistent with applicable federal and state laws, the Plan may disclose PHI if there is reason to believe that the disclosure is necessary to prevent or lessen a serious and imminent threat to the health or safety of a person or the public. The Plan also may disclose PHI if it is necessary for law enforcement authorities to identify or apprehend an individual.

MILITARY ACTIVITY AND NATIONAL SECURITY, PROTECTIVE SERVICES

Under certain conditions, the Plan may disclose PHI if Plan Participants are, or were, Armed Forces personnel for activities deemed necessary by appropriate military command authorities. If Plan Participants are members of foreign military service, the Plan may disclose, in certain circumstances, PHI to the foreign military authority. The Plan also may disclose PHI to authorized federal officials for conducting national security and intelligence activities, and for the protection of the President, other authorized persons or heads of state.

INMATES

If a Plan Participant is an inmate of a correctional institution, the Plan may disclose PHI to the correctional institution or to a law enforcement official for: (1) the institution to provide health care to the Plan Participant; (2) the Plan Participant's health and safety and the health and safety of others or (3) the safety and security of the correctional institution.

WORKERS' COMPENSATION

The Plan may disclose PHI to comply with workers' compensation laws and other similar programs that provide benefits for work-related injuries or illnesses.

EMERGENCY SITUATIONS

The Plan may disclose PHI of a Plan Participant in an emergency situation, or if the Plan Participant is incapacitated or not present, to a family member, close personal friend, authorized disaster relief agency, or any other person previously identified by the Plan Participant. The Plan will use professional judgment and experience to determine if the disclosure is in the best interests of the Plan Participant. If the disclosure is in the best interest of the Plan Participant, the Plan will disclose only the PHI that is directly relevant to the person's involvement in the care of the Plan Participant.

FUNDRAISING ACTIVITIES

The Plan may use or disclose the PHI of a Plan Participant for fundraising activities, such as raising money for a charitable foundation or similar entity to help finance its activities. If the Plan does contact the Plan Participant for fundraising activities, the Plan will give the Plan Participant the opportunity to opt-out, or stop, receiving such communications in the future.

GROUP HEALTH PLAN DISCLOSURES

The Plan may disclose the PHI of a Plan Participant to a sponsor of the group health plan – such as an employer or other entity – that is providing a health care program to the Plan Participant. The Plan can disclose the PHI of the Plan Participant to that entity if that entity has contracted with the Plan to administer the Plan Participant's health care program on its behalf.

UNDERWRITING PURPOSES

The Plan may use or disclose the PHI of a Plan Participant for underwriting purposes, such as to make a determination about a coverage application or request. If the Plan does use or disclose the PHI of the Plan Participant for underwriting purposes, the Plan is prohibited from using or disclosing in the underwriting process the PHI of the Plan Participant that is genetic information.

OTHERS INVOLVED IN YOUR HEALTH CARE

Using its best judgment, the Plan may make PHI known to a family member, other relative, close personal friend or other personal representative that the Plan Participant identifies. Such use will be based on how involved the person is in the Plan Participant's care or in the payment that relates to that care. The Plan may release information to parents or guardians, if allowed by law.

If a Plan Participant is not present or able to agree to these disclosures of PHI, then, using its professional judgment, the Plan may determine whether the disclosure is in the Plan Participant's best interest.

REQUIRED DISCLOSURES OF PHI

The following is a description of disclosures that the Plan is required by law to make.

DISCLOSURES TO THE SECRETARY OF THE U.S. DEPARTMENT OF HEALTH AND HUMAN SERVICES

The Plan is required to disclose PHI to the Secretary of the U.S. Department of Health and Human Services when the Secretary is investigating or determining the Plan's compliance with the HIPAA Privacy Rule.

DISCLOSURES TO PLAN PARTICIPANTS

The Plan is required to disclose to a Plan Participant most of the PHI in a "designated record set" when that Plan Participant requests access to this information. Generally, a designated record set contains medical and billing records, as well as other records that are used to make decisions about a Plan Participant's health care benefits. The Plan also is required to provide, upon the Plan Participant's request, an accounting of most disclosures of his PHI that are for reasons other than treatment, payment and health care operations and are not disclosed through a signed authorization.

The Plan will disclose a Plan Participant's PHI to an individual who has been designated by that Plan Participant as his personal representative and who has qualified for such designation in accordance with relevant state law. However, before the Plan will disclose PHI to such a person, the Plan Participant must submit a written notice of his designation, along with the documentation that supports his qualification (such as a power of attorney).

Even if the Plan Participant designates a personal representative, the HIPAA Privacy Rule permits the Plan to elect not to treat that individual as the Plan Participant's personal representative if a reasonable belief exists that: (1) the Plan Participant has been, or may be, subjected to domestic violence, abuse or neglect by such person; (2) treating such person as his personal representative could endanger the Covered Person, or (3) the Plan determines, in the exercise of its professional judgment, that it is not in its best interest to treat that individual as the Plan Participant's personal representative.

BUSINESS ASSOCIATES

The Plan contracts with individuals and entities (Business Associates) to perform various functions on its behalf or to provide certain types of services. To perform these functions or to provide the services, the Plan's Business Associates will receive, create, maintain, use or disclose PHI, but only after the Plan requires the Business Associates to agree in writing to contract terms designed to appropriately safeguard PHI. For example, the Plan may disclose PHI to a Business Associate to administer claims or to provide service support, utilization management, subrogation or pharmacy benefit management. Examples of the Plan's Business Associates would be its third party administrator, broker, preferred provider organization and utilization review vendor.

OTHER COVERED ENTITIES

The Plan may use or disclose PHI to assist health care providers in connection with their treatment or payment activities or to assist other covered entities in connection with payment activities and certain health care operations. For example, the Plan may disclose PHI to a health care provider when needed by the provider to render treatment to a Plan Participant, and the Plan may disclose PHI to another covered entity to conduct health care operations in the areas of fraud and abuse detection or compliance, quality assurance and improvement activities or accreditation, certification, licensing or credentialing. This also means that the Plan may disclose or share PHI with other insurance carriers in order to coordinate benefits, if a Plan Participant has coverage through another carrier.

PLAN SPONSOR

The Plan may disclose PHI to the Plan Sponsor of the group health plan for purposes of plan administration or pursuant to an authorization request signed by the Plan Participant. Also, the Plan may use or disclose “summary health information” to the Plan Sponsor for obtaining premium bids or modifying, amending or terminating the group health plan. Summary health information summarizes the claims history, claims expenses or types of claims experienced by individuals for whom a Plan Sponsor has provided health benefits under a group health plan and from which identifying information has been deleted in accordance with the HIPAA Privacy Rule.

USES AND DISCLOSURES OF PHI THAT REQUIRE A PLAN PARTICIPANT’S AUTHORIZATION

SALE OF PHI

The Plan will request the written authorization of a Plan Participant before the Plan makes any disclosure that is deemed a sale of the Plan Participant’s PHI, meaning that the Plan is receiving compensation for disclosing the PHI in this manner.

MARKETING

The Plan will request the written authorization of a Plan Participant to use or disclose the Plan Participant’s PHI for marketing purposes with limited exceptions, such as when the Plan has face-to-face marketing communications with the Plan Participant or when the Plan provides promotional gifts of nominal value.

PSYCHOTHERAPY NOTES

The Plan will request the written authorization of a Plan Participant to use or disclose any of the Plan Participant’s psychotherapy notes that the Plan may have on file with limited exception, such as for certain treatment, payment or health care operation functions.

Other uses and disclosures of PHI that are not described previously will be made only with a Plan Participant's written authorization. If the Plan Participant provides the Plan with such an authorization, he/she may revoke the authorization in writing, and this revocation will be effective for future uses and disclosures of PHI. However, the revocation will not be effective for information that has already been used or disclosed, relying on the authorization.

A PLAN PARTICIPANT'S RIGHTS

The following is a description of a Plan Participant's rights with respect to PHI:

RIGHT TO REQUEST A RESTRICTION

A Plan Participant has the right to request a restriction on the PHI the Plan uses or discloses about him/her for treatment, payment or health care operations. The Plan is not required to agree to any restriction that a Plan Participant may request. If the Plan does agree to the restriction, it will comply with the restriction unless the information is needed to provide emergency treatment.

A Plan Participant may request a restriction by contacting the person(s) or office identified under Plan Contact Information in the Key Information section at the beginning of this document. It is important that the Plan Participant directs his request for restriction to this individual or office so that the Plan can begin to process Your request. Requests sent to individuals or offices other than the one indicated might delay processing the request.

The Plan will want to receive this information in writing and will instruct the Plan Participant where to send the request when the Plan Participant's call is received. In this request, it is important that the Plan Participant states: (1) the information whose disclosure he/she wants to limit and (2) how he/she wants to limit the Plan's use and/or disclosure of the information.

RIGHT TO REQUEST CONFIDENTIAL COMMUNICATIONS

If a Plan Participant believes that a disclosure of all or part of his PHI may endanger him/her, that Plan Participant may request that the Plan communicates with him/her regarding PHI in an alternative manner or at an alternative location. For example, the Plan Participant may ask that the Plan only contact the Plan Participant at a work address or via the Plan Participant's work e-mail.

The Plan Participant may request a restriction by contacting the person(s) or office identified under Plan Contact Information in the Key Information section at the beginning of this document. It is important that the request for confidential communications is addressed to this individual or office so that the Plan can begin to process the request. Requests sent to individuals or offices other than the one indicated might delay processing the request.

The Plan will want to receive this information in writing and will instruct the Plan Participant where to send a written request upon receiving a call. This written request should inform the Plan: (1) that he/she wants the Plan to communicate his PHI in an alternative manner or at an alternative location and (2) that the disclosure of all or part of this PHI in a manner inconsistent with these instructions would put the Plan Participant in danger.

The Plan will accommodate a request for confidential communications that is reasonable and that states that the disclosure of all or part of a Plan Participant's PHI could endanger that Plan Participant. As permitted by the HIPAA Privacy Rule, "reasonableness" will (and is permitted to) include, when appropriate, making alternate arrangements regarding payment.

Accordingly, as a condition of granting a Plan Participant's request, he/she will be required to provide the Plan information concerning how payment will be handled. For example, if the Plan Participant submits a claim for payment, state or federal law (or the Plan's own contractual obligations) may require that the Plan disclose certain financial claim information to the Plan Participant under whose coverage a Plan Participant may receive benefits (e.g., an Explanation of Benefits "EOB"). Unless the Plan Participant has made other payment arrangements, the EOB (in which a Plan Participant's PHI might be included) will be released to the Plan Participant.

Once the Plan receives all the information for such a request (along with the instructions for handling future communications), the request will be processed usually within 2 business days or as soon as reasonably possible.

Prior to receiving the information necessary for this request, or during the time it takes to process it, PHI may be disclosed (such as through an EOB). Therefore, it is extremely important that the Plan Participant contact the person(s) or office identified under Plan Contact Information in the Key Information section at the beginning of this document as soon as the Plan Participant determines the need to restrict disclosures of his PHI.

If the Plan Participant terminates his request for confidential communications, the restriction will be removed for all of the Plan Participant's PHI that the Plan holds, including PHI that was previously protected. Therefore, a Plan Participant should not terminate a request for confidential communications if that person remains concerned that disclosure of PHI will endanger him/her.

RIGHT TO INSPECT AND COPY

A Plan Participant has the right to inspect and copy PHI that is contained in a "designated record set." Generally, a designated record set contains medical and billing records, as well as other records that are used to make decisions about a Plan Participant's health care benefits. However, the Plan Participant may not inspect or copy psychotherapy notes or certain other information that may be contained in a designated record set.

To inspect and copy PHI that is contained in a designated record set, the Plan Participant must submit a request by contacting the person(s) or office identified under Plan Contact Information in the Key Information section at the beginning of this document. It is important that the Plan Participant contact this individual or office to request an inspection and copying so that the Plan can begin to process the request. Requests sent to individuals or offices other than the one indicated might delay the processing of the request. If the Plan Participant requests a copy of the information, the Plan may charge a fee for the costs of copying, mailing or other supplies associated with that request.

The Plan may deny a Plan Participant's request to inspect and copy PHI in certain limited circumstances. If a Plan Participant is denied access to information, he/she may request that the denial be reviewed. To request a review, the Plan Participant must contact the person(s) or office identified under Plan Contact Information in the Key Information section at the beginning of this document. A licensed health care professional chosen by the Plan will review the Plan Participant's request and the denial. The person performing this review will not be the same one who denied the Plan Participant's initial request. Under certain conditions, the Plan's denial will not be reviewable. If this event occurs, the Plan will inform the Plan Participant through the denial that the decision is not reviewable.

RIGHT TO AMEND

If a Plan Participant believes that his PHI is incorrect or incomplete, he/she may request that the Plan amend that information. The Plan Participant may request that the Plan amend such information by contacting the person(s) or office identified under Plan Contact Information in the Key Information section at the beginning of this document. Additionally, this request should include the reason the amendment is necessary. It is important that the Plan Participant direct this request for amendment to this individual or office so that the Plan can begin to process the request. Requests sent to individuals or offices other than the one indicated might delay processing the request.

In certain cases, the Plan may deny the Plan Participant's request for an amendment. For example, the Plan may deny the request if the information the Plan Participant wants to amend is not maintained by the Plan, but by another entity. If the Plan denies the request, the Plan Participant has the right to file a statement of disagreement with the Plan. This statement of disagreement will be linked with the disputed information and all future disclosures of the disputed information will include this statement.

RIGHT OF AN ACCOUNTING

The Plan Participant has a right to an accounting of certain disclosures of PHI that are for reasons other than treatment, payment or health care operations. No accounting of disclosures is required for disclosures made pursuant to a signed authorization by the Plan Participant or his personal representative. The Plan Participant should know that most disclosures of PHI will be for purposes of payment or health care operations, and, therefore, will not be subject to this right. There also are other exceptions to this right.

An accounting will include the date(s) of the disclosure, to whom the Plan made the disclosure, a brief description of the information disclosed and the purpose for the disclosure.

A Plan Participant may request an accounting by submitting a request in writing to the person(s) or office identified under Plan Contact Information in the Key Information section at the beginning of this document. It is important that the Plan Participant direct the request for an accounting to this individual or office so that the Plan can begin to process the request. Requests sent to individuals or offices other than the one indicated might delay processing the request.

A Plan Participant's request may be for disclosures made up to 6 years before the date of the request, but not for disclosures made before April 14, 2004. The first list requested within a 12-month period will be free. For additional lists, the Plan may charge for the costs of providing the list. The Plan will notify the Plan Participant of the cost involved and he/she may choose to withdraw or modify the request before any costs are incurred.

RIGHT TO A COPY OF THIS NOTICE

The Plan Participant has the right to request a copy of this Notice at any time by contacting the person(s) or office identified under Plan Contact Information in the Key Information section at the beginning of this document. If You receive this Notice on the Plan's website or by electronic mail, You also are entitled to request a paper copy of this Notice.

COMPLAINTS

A Plan Participant may complain to the Plan if he/she believes that the Plan has violated these privacy rights. The Plan Participant may file a complaint with the Plan by contacting the person(s) or office identified under Plan Contact Information in the Key Information section at the beginning of this document. A copy of a complaint form is available from this contact office.

A Plan Participant also may file a complaint with the Secretary of the U.S. Department of Health and Human Services. Complaints filed directly with the Secretary must: (1) be in writing; (2) contain the name of the entity against which the complaint is lodged; (3) describe the relevant problems and (4) be filed within 180 days of the time the Plan Participant became or should have become aware of the problem.

The Plan will not penalize or in any other way retaliate against a Plan Participant for filing a complaint with the Secretary or with the Plan.

STANDARDS FOR SECURITY OF INDIVIDUALLY IDENTIFIABLE HEALTH INFORMATION (THE “SECURITY STANDARDS”)

1. DEFINITIONS

- a. The term “Electronic Protected Health Information” (“EPHI”) has the meaning set forth in Section 160.103 of the Security Standards (45 C.F.R. 160.103) and generally means individually identifiable health information that is transmitted or maintained in any electronic media.
- b. The term “Security Incidents” has the meaning set forth in Section 164.304 of the Security Standards (45 C.F.R. 164.304) and generally means the attempted or successful unauthorized access, use, disclosure, modification, or destruction of information or interference with systems operations in an information system.

2. PLAN SPONSOR OBLIGATIONS

Where EPHI will be created, received, maintained, or transmitted to or by the Plan Sponsor on behalf of the Plan, the Plan Sponsor shall reasonably safeguard the EPHI as follows:

- a. Plan Sponsor shall implement administrative, physical, and technical safeguards that reasonably and appropriately protect the confidentiality, integrity, and availability of EPHI that Plan Sponsor creates, receives, maintains, or transmits on behalf of the Plan;
- b. Plan Sponsor shall ensure that the adequate separation that is required by Section 164.504 (f) (2) (iii) of the Security Standards (45 C.F.R. 164.504 (f) (2) (iii)) is supported by reasonable and appropriate security measures;
- c. Plan Sponsor shall ensure that any agents, including a subcontractor, to whom it provides EPHI agrees to implement reasonable and appropriate security measures to protect such EPHI; and
- d. Plan Sponsor shall report to the Plan any Security Incidents of which it becomes aware as described below:
 - i.) Plan Sponsor shall report to the Plan within a reasonable time after the Plan Sponsor becomes aware of any Security Incident that results in unauthorized access, use, disclosure, modification, or destruction of the Plan’s EPHI; and
 - ii.) Plan Sponsor shall report to the Plan any other Security Incident on an aggregate basis every quarter, or more frequently upon the Plan’s request.
- e. Plan Sponsor shall make its internal practices, books, and records relating to its compliance with the Security Standards to the Secretary of the U.S. Department of Health and Human Services (“HHS”), or any other officer or employee of HHS to whom the authority involved has been delegated, for purposes of determining compliance by the Plan with the Security Standards.