Ninnescah Valley Health Systems Inc. Medical Plan

Plan Document and Summary Plan Description

Effective: January 01, 2023

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ARTICLE I
ESTABLISHMENT OF THE PLAN: ADOPTION OF THE PLAN DOCUMENT AND SUMMARY PLAN DESCRIPTION

THIS PLAN DOCUMENT AND SUMMARY PLAN DESCRIPTION ("Plan Document"), made by **Ninnescah Valley Health Systems, Inc.** (the Company" or the "Plan Sponsor") as of January 01, 2023, hereby sets forth the provisions of the Ninnescah Valley Health Systems Inc. Medical Plan (the "Plan"). Any wording which may be contrary to Federal Laws or Statutes is hereby understood to meet the standards set forth in such. Also, any changes in Federal Laws or Statutes which could affect the Plan are also automatically a part of the Plan, if required.

1.01 Effective Date
The Plan Document is effective as of the date first set forth above, and each amendment is effective as of the date set forth therein (the "Effective Date").

1.02 Adoption of the Plan Document
The Plan Sponsor, as the settlor of the Plan, hereby adopts this Plan Document as the written description of the Plan. This Plan Document represents both the Plan Document and the Summary Plan Description, which is required by sections 402 and 102 of the Employee Retirement Income Security Act of 1974, 29 U.S.C. et seq. ("ERISA"). This Plan Document amends and replaces any prior statement of the health care coverage contained in the Plan or any predecessor to the Plan.

IN WITNESS WHEREOF, the Plan Sponsor has caused this Plan Document to be executed.

Ninnescah Valley Health Systems, Inc.
By: Christine Jennings
Name: Christine Jennings
Title: CHRO

Date: 3-12-2024

ARTICLE II
INTRODUCTION AND PURPOSE; GENERAL PLAN INFORMATION

2.01 Introduction and Purpose

The Plan Sponsor has established the Plan for the benefit of eligible Employees, in accordance with the terms and conditions described herein. Plan benefits are self–funded through a benefit fund or a trust established by the Plan Sponsor with contributions from Participants and/or the Plan Sponsor. Participants in the Plan may be required to contribute toward their benefits. Contributions received from Participants are used to cover Plan costs and are expended immediately.

The Plan Sponsor's purpose in establishing the Plan is to help offset, for eligible Employees, the economic effects arising from a non-occupational injury or sickness. To accomplish this purpose, the Plan Sponsor must be cognizant of the necessity of containing health care costs through effective plan design, and of abiding by the terms of the Plan Document, to allow the Plan Sponsor to allocate the resources available to help those individuals participating in the Plan to the maximum feasible extent.

The purpose of this Plan Document is to set forth the terms and provisions of the Plan that provide for the payment or reimbursement of all or a portion of certain expenses for eligible benefits. The Plan Document is maintained by **Ninnescah Valley Health Systems, Inc.** and may be inspected at any time during normal working hours by any Participant.

2.02 General Plan Information

Name of Plan:
Ninnescah Valley Health Systems, Inc. Medical Plan

Plan Sponsor:
Ninnescah Valley Health Systems, Inc.
750 West D Avenue
Kingman, KS 67068
Phone: 620-532-3147

Plan Administrator:
(Named Fiduciary)
Ninnescah Valley Health Systems, Inc.
750 West D Avenue
Kingman, KS 67068
Phone: 620-532-3147

Plan Sponsor ID No. (EIN):
480761700

Source of Funding:
Self-Funded

Plan Status:
Non-Grandfathered

Applicable Law:
ERISA

Plan Year:
January 1st to December 31st

Plan Number:
501

Plan Type:
Medical
Prescription

Third Party Administrator:
Insurance Administrator of America, LLC.
1934 Olney Ave., Suite 200
Cherry Hill, NJ 08003
Phone: 856-470-1200
Fax: 800-238-0519
Email: claims@iaatpa.com
Website: www.iaatpa.com

Participating Employer(s):
Ninnescah Valley Health Systems, Inc.
750 West D Avenue
Kingman, KS 67068
Phone: 620-532-3147

Agent for Service of Process:
Preston Sauers
Chief Executive Officer
750 West D Avenue
Kingman, KS 67068
Phone: 620-532-3147

The Plan shall take effect for each Participating Employer on the Effective Date, unless a different date is set forth above opposite such Participating Employer's name.

2.03 Non-English Language Notice

This Plan Document contains a summary in English of a Participant's plan rights and benefits under the Plan. If a Participant has difficulty understanding any part of this Plan Document, he or she may contact the Plan Administrator at the contact information above.

2.04 Legal Entity; Service of Process

The Plan is a legal entity. Legal notice may be filed with, and legal process served upon, the Plan Administrator.

2.05 Not a Contract

This Plan Document and any amendments constitute the terms and provisions of coverage under this Plan. The Plan Document shall not be deemed to constitute a contract of any type between the Company and any Participant or to be consideration for, or an inducement or condition of, the employment of any Employee. Nothing in this Plan Document 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; provided, however, that the foregoing shall not be deemed to modify the provisions of any collective bargaining agreements which may be entered into by the Company with the bargaining representatives of any Employees.

2.06 Mental Health Parity

Pursuant to the Mental Health Parity Act (MHPA) of 1996 and the Mental Health Parity and Addiction Equity Act of 2008 (MHPAEA), collectively, the mental health parity provisions in Part 7 of ERISA, this Plan applies its terms uniformly and enforces parity between covered health care benefits and covered mental health

and substance disorder benefits relating to financial cost sharing restrictions and treatment duration limitations. For further details, please contact the Plan Administrator.

2.07 Non-Discrimination

No eligibility rules or variations in contribution amounts will be imposed based on an eligible Employee's and his or her Dependent's/Dependents' health status, medical condition, claims experience, receipt of health care, medical history, genetic information, evidence of insurability, disability, or any other health status related factor. Coverage under this Plan is provided regardless of an eligible Employee's and his or her Dependent's/Dependents' race, color, national origin, disability, age, sex, gender identity or sexual orientation. Variations in the administration, processes or benefits of this Plan that are based on clinically indicated reasonable medical management practices, or are part of permitted wellness incentives, disincentives and/or other programs do not constitute discrimination.

2.08 Applicable Law

This is a self-funded benefit plan coming within the purview of the Employee Retirement Income Security Act of 1974 ("ERISA"). The Plan is funded with Employee and/or Employer contributions. As such, when applicable, Federal law and jurisdiction preempt State law and jurisdiction.

2.09 Discretionary Authority

The Plan Administrator shall have sole, full and final discretionary authority to interpret all Plan provisions, including the right to remedy possible ambiguities, inconsistencies and/or omissions in the Plan and related documents; to make determinations in regards to issues relating to eligibility for benefits; to decide disputes that may arise relative to a Participant's rights; and to determine all questions of fact and law arising under the Plan.

2.10 Important Updates Regarding COVID-19 Relief – Tolling of Certain Plan Deadlines

In accordance with 85 FR 26351, "Extension of Certain Timeframes for Employee Benefit Plans, Participants, and Beneficiaries Affected by the COVID-19 Outbreak," notwithstanding any existing Plan language to the contrary, the Plan will disregard the period from March 1, 2020 until sixty (60) days after (1) the end of the public health emergency relating to COVID-19 and declared pursuant to 42 U.S.C. § 247d or (2) such other date announced by the Departments of Treasury and/or Labor, for purposes of determining the following periods and dates:

1. The 30-day period (or 60-day period, if applicable) to request special enrollment under ERISA section 701(f) and Internal Revenue Code section 9801(f);
2. The 60-day election period for COBRA continuation coverage under ERISA section 605 and Internal Revenue Code section 4980B(f)(5);
3. The date for making COBRA premium payments pursuant to ERISA section 602(2)(C) and (3) and Internal Revenue Code section 4980B(f)(2)(B)(iii) and (C);
4. The date for individuals to notify the Plan of a qualifying event or determination of disability under ERISA section 606(a)(3) and Internal Revenue Code section 4980B(f)(6)(C);
5. The date within which individuals may file a benefit claim under the Plan's claims procedure pursuant to 29 CFR 2560.503-1;
6. The date within which Claimants may file an appeal of an Adverse Benefit Determination under the Plan's claims procedure pursuant to 29 CFR 2560.503-1(h);
7. The date within which Claimants may file a request for an external review after receipt of an Adverse Benefit Determination or Final Internal Adverse Benefit Determination pursuant to 29 CFR 2590.715-2719(d)(2)(i) and 26 CFR 54.9815-2719(d)(2)(i); and
8. The date within which a Claimant may file information to perfect a request for external review upon a finding that the request was not complete pursuant to 29 CFR 2590.715-2719(d)(2)(ii) and 26 CFR 54.9815-2719(d)(2)(ii).

This period may also be disregarded in determining the applicable date for the Plan's duty to provide a COBRA election notice under ERISA section 606(c) and Internal Revenue Code section 4980B(f)(6)(D), however, note that the Plan intends to continue to follow all established COBRA parameters.

In no instance will the duration of an extension granted under this section exceed one calendar year.

This provision will expire on July 10, 2023.

ARTICLE III
DEFINITIONS

The following words and phrases shall have the following meanings when used in the Plan Document. Some of the terms used in this document begin with a capital letter, even though the term normally would not be capitalized. These terms have special meaning under the Plan. Most terms will be listed in the Definitions section, but some terms are defined within the provision the term is used. Becoming familiar with the terms defined in the Definitions section will help to better understand the provisions of this Plan.

The following definitions are not an indication that charges for particular care, supplies or services are eligible for payment under the Plan, however they may be used to identify ineligible expenses; please refer to the appropriate sections of the Plan Document for that information.

"Accident"
"Accident" shall mean a sudden and unforeseen event, or a deliberate act resulting in unforeseen consequences.

"Accidental Bodily Injury" or "Accidental Injury"
"Accidental Bodily Injury" or "Accidental Injury" shall mean an Injury sustained as the result of an Accident, due to a traumatic event, or due to exposure to the elements.

"Actively at Work" or "Active Employment"
An Employee is "Actively at Work" or in "Active Employment" on any day the Employee performs in the customary manner all of the regular duties of employment. An Employee will be deemed Actively at Work on each day of a regular paid vacation or on a regular non-working day, provided the covered Employee was Actively at Work on the last preceding regular work day. An Employee shall be deemed Actively at Work if the Employee is absent from work due to a health factor, as defined by HIPAA, subject to the Plan's Leave of Absence provisions (including any State-mandated leave). An Employee will not be considered under any circumstances Actively at Work if he or she has effectively terminated employment.

"ADA"
"ADA" shall mean the American Dental Association.

"Adverse Benefit Determination"
"Adverse Benefit Determination" shall mean any of the following:

1. A denial in benefits.
2. A reduction in benefits.
3. A rescission of coverage, even if the rescission does not impact a current claim for benefits.
4. A termination of benefits.
5. A failure to provide or make payment (in whole or in part) for a benefit, including any such denial, reduction, termination, or failure to provide or make payment that is based on a determination of a Participant's eligibility to participate in the Plan.
6. A denial, reduction, or termination of, or a failure to provide or make payment (in whole or in part) for, a benefit resulting from the application of any utilization review.
7. A failure to cover an item or service for which benefits are otherwise provided because it is determined to be Experimental or Investigational or not Medically Necessary or appropriate.

Explanation of Benefits (EOB)
"Explanation of Benefits" shall mean a statement a health plan sends to a Participant which shows charges, payments and any balances owed. It may be sent by mail or e-mail. An Explanation of Benefits may serve as an Adverse Benefit Determination.

"Affordable Care Act (ACA)"
The "Affordable Care Act (ACA)" means the health care reform law enacted in March 2010. The law was enacted in two parts: the Patient Protection and Affordable Care Act was signed into law on March 23, 2010 and was amended by the Health Care and Education Reconciliation Act on March 30, 2010. The name "Affordable Care Act" is commonly used to refer to the final, amended version of the law. In this document, the Plan uses the name Affordable Care Act (ACA) to refer to the health care reform law.

"AHA"
"AHA" shall mean the American Hospital Association.

"Alternate Recipient"
"Alternate Recipient" shall mean any Child of a Participant who is recognized under a Medical Child Support Order as having a right to enrollment under this Plan as the Participant's eligible Dependent. For purposes of the benefits provided under this Plan, an Alternate Recipient shall be treated as an eligible Dependent, but for purposes of the reporting and disclosure requirements under ERISA, an Alternate Recipient shall have the same status as a Participant.

"AMA"
"AMA" shall mean the American Medical Association.

"Ambulatory Surgical Center"
"Ambulatory Surgical Center" shall mean any public or private State licensed and approved (whenever required by law) establishment with an organized medical staff of Physicians, with permanent facilities that are equipped and operated primarily for the purpose of performing Surgical Procedures, with continuous Physician services and registered professional nursing service whenever a patient is in the facility, and which does not provide service or other accommodations for patients to stay overnight.

"Approved Clinical Trial"
"Approved Clinical Trial" means a phase I, II, III or IV trial that is federally funded by specified Agencies (National Institutes of Health (NIH), Centers for Disease Control and Prevention (CDCP), Agency for Healthcare Research and Quality (AHRO), Centers for Medicare and Medicaid Services (CMS), Department of Defense (DOD) or Veterans Affairs (VA), or a non-governmental entity identified by NIH guidelines) or is conducted under an Investigational new drug application reviewed by the Food and Drug Administration (FDA) (if such application is required).

The Affordable Care Act requires that if a "qualified individual" is in an "Approved Clinical Trial," the Plan cannot deny coverage for related services ("routine patient costs").

A "qualified individual" is someone who is eligible to participate in an "Approved Clinical Trial" and either the individual's doctor has concluded that participation is appropriate or the Participant provides medical and scientific information establishing that their participation is appropriate.

"Routine patient costs" include all items and services consistent with the coverage provided in the plan that is typically covered for a qualified individual who is not enrolled in a clinical trial. Routine patient costs do not include 1) the Investigational item, device or service itself; 2) 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; and 3) a service that is clearly inconsistent with the widely accepted and established standards of care for a particular Diagnosis. Plans are not required to provide benefits for routine patient care services provided outside of the Plan's Network area unless Out-of-Network benefits are otherwise provided under the Plan.

"Calendar Year"
"Calendar Year" shall mean the 12 month period from January 1 through December 31 of each year.

"Cardiac Care Unit"
"Cardiac Care Unit" shall mean a separate, clearly designated service area which is maintained within a Hospital and which meets all the following requirements:

1. It is solely for the treatment of patients who require special medical attention because of their critical condition.
2. It provides within such area special nursing care and observation of a continuous and constant nature not available in the regular rooms and wards of the Hospital.
3. It provides a concentration of special lifesaving equipment immediately available at all times for the treatment of patients confined within such area.
4. It contains at least two beds for the accommodation of critically ill patients.
5. It provides at least one professional Registered Nurse, who continuously and constantly attends the patient confined in such area on a 24 hour a day basis.

"CDC"
"CDC" shall mean Centers for Disease Control and Prevention.

"Centers of Excellence"
"Centers of Excellence" shall mean medical care facilities that have met stringent criteria for quality care in the specialized procedures of organ transplantation. These centers have the greatest experience in performing transplant procedures and the best survival rates. The Plan Administrator shall determine what Network Centers of Excellence are to be used.

Any Participant in need of an organ transplant may contact the Third Party Administrator to initiate the Pre Certification process resulting in a referral to a Center of Excellence. The Third Party Administrator acts as the primary liaison with the Center of Excellence, patient and attending Physician for all transplant admissions taking place at a Center of Excellence.

If a Participant chooses not to use a Center of Excellence, the payment for services will be limited to what would have been the cost at the nearest Center of Excellence.

Additional information about this option, as well as a list of Centers of Excellence, will be given to covered Employees and updated as requested.

"Certified IDR Entity"
"Certified IDR Entity" shall mean an entity responsible for conducting determinations under the No Surprises Act and that has been properly certified by the Department of Health and Human Services, the Department of Labor, and the Department of the Treasury.

"Child" and/or "Children"
"Child" and/or "Children" shall mean, in addition to the Employee's own blood descendant of the first degree or lawfully adopted Child, a Child placed with a covered Employee in anticipation of adoption, a covered Employee's Child who is an Alternate Recipient under a Qualified Medical Child Support Order as required by the Federal Omnibus Budget Reconciliation Act of 1993, any stepchild, an "eligible foster child," which is defined as an individual placed with the Employee by an authorized placement agency or by judgment, decree or other order of a court of competent jurisdiction or any other Child for whom the Employee has obtained legal guardianship. A "legal guardian" is a person recognized by a court of law as having the duty of taking care of the person and managing the property and rights of a minor child.

"CHIP"
"CHIP" refers to the Children's Health Insurance Program or any provision or section thereof, which is herein specifically referred to, as such act, provision or section may be amended from time to time.

“CHIPRA”
“CHIPRA” refers to the Children’s Health Insurance Program Reauthorization Act of 2009 or any provision or section thereof, which is herein specifically referred to, as such act.

“Chiropractic Care”
“Chiropractic Care” shall mean the detection and correction, by manual or mechanical means, of the interference with nerve transmissions and expressions resulting from distortion, misalignment or dislocation of the spinal (vertebrae) column.

“Claimant”
A participant of the Plan, or entity acting on the participant’s behalf, authorized to submit claims to the Plan for processing, and/or appeal an Adverse Benefit Determination.

“Claim Determination Period”
“Claim Determination Period” shall mean each Calendar Year.

“Class III Obesity”
“Class III Obesity” shall mean a diagnosed condition in which an individual's body mass index (BMI) is equal to or greater than 40.0 kg/m². The excess weight must cause a condition such as physical trauma, pulmonary, and circulatory insufficiency, diabetes, or heart disease.

“Clean Claim”
A “Clean Claim” is one that can be processed in accordance with the terms of this document without obtaining additional information from the service Provider or a third party. It is a claim which has no defect or impropriety. A defect or impropriety shall include a lack of required sustaining documentation as set forth and in accordance with this document, or a particular circumstance requiring special treatment which prevents timely payment as set forth in this document, and only as permitted by this document, from being made. A Clean Claim does not include claims under investigation for fraud and abuse or claims under review for Medical Necessity or other coverage criteria, or fees under review for application of the Maximum Allowable Charge, or any other matter that may prevent the charge(s) from being Covered Expenses in accordance with the terms of this document.

Filing a Clean Claim. A Provider submits a Clean Claim by providing the required data elements on the standard claims forms, along with any attachments and additional elements or revisions to data elements, attachments and additional elements, of which the Provider has knowledge. The Plan Administrator may require attachments or other information in addition to these standard forms (as noted elsewhere in this document and at other times prior to claim submittal) to ensure charges constitute Covered Expenses as defined by and in accordance with the terms of this document. The paper claim form or electronic file record must include all required data elements and must be complete, legible, and accurate. A claim will not be considered to be a Clean Claim if the Participant has failed to submit required forms or additional information to the Plan as well.

“CMS”
“CMS” shall mean Centers for Medicare and Medicaid Services.

“COBRA”
“COBRA” shall mean the Consolidated Omnibus Budget Reconciliation Act of 1985, as amended.

“Coinsurance”
“Coinsurance” shall mean a cost sharing feature of many plans which requires a Participant to pay out-of-pocket a prescribed portion of the cost of Covered Expenses. The defined Coinsurance that a Participant must pay out-of-pocket is based upon his or her health plan design. Coinsurance is established as a predetermined percentage of the Maximum Allowable Charge for covered services and usually applies after a Deductible is met in a Deductible plan.

“Copayment” or “Copay”
“Copayment” or “Copay” shall mean a dollar amount per visit, the Participant pays to the Provider for health care expenses. In most plans, the Participant pays this after he or she meets his or her Deductible limit.

"Cosmetic Surgery”
“Cosmetic Surgery” shall mean any Surgery, service, Drug or supply designed to improve the appearance of an individual by alteration of a physical characteristic which is within the broad range of normal but which may be considered unpleasing or unsightly, except when necessitated by an Injury.

“Covered Expense(s)”
“Covered Expense(s)” shall mean a service or supply provided in accordance with the terms of this document, whose applicable charge amount does not exceed the Maximum Allowable Charge for an eligible Medically Necessary service, treatment or supply, meant to improve a condition or Participant’s health, which is eligible for coverage in accordance with this Plan. When more than one treatment option is available, and one option is no more effective than another, the Covered Expense is the least costly option that is no less effective than any other option.

All treatment is subject to benefit payment maximums shown in the Summary of Benefits and as determined elsewhere in this document.

“Custodial Care”
“Custodial Care” shall mean care or confinement provided primarily for the maintenance of the Participant, essentially designed to assist the Participant, whether or not totally disabled, in the activities of daily living, which could be rendered at home or by persons without professional skills or training. This care is not reasonably expected to improve the underlying medical condition, even though it may relieve symptoms or pain. Such care includes, but is not limited to, bathing, dressing, feeding, preparation of special diets, assistance in walking or getting in and out of bed, supervision over medication which can normally be self-administered and all domestic activities.

“Deductible”
“Deductible” shall mean the amount of expenses for covered services that a Participant must pay for him or herself before the Plan will begin its payments.

“Dentist”
“Dentist” shall mean an individual holding a D.D.S. or D.M.D. degree, licensed to practice dentistry in the jurisdiction where such services are provided.

“Dependent”
“Dependent” shall mean one or more of the following person(s):

1. An Employee’s lawfully married spouse who is not divorced or legally separated from the Employee.
2. An Employee’s common law spouse, based upon a common law marriage which is legally recognized in the jurisdiction in which the Employee has his or her principal residence.
3. An Employee’s Child who is less than 26 years of age. ***NOTE****: Coverage for a Dependent Child will continue until the end of the calendar month he or she turns 26 years of age.*
4. An Employee’s Child, regardless of age, who was continuously covered prior to attaining the limiting age as stated in the numbers above, who is mentally or physically incapable of sustaining his or her own living. Written proof of such incapacity and dependency satisfactory to the Plan must be furnished and approved by the Plan within 31 days after the date the Child attains the limiting age as stated in the numbers above. The deadline for submission of written proof of incapacity and dependency is 31 days following the original eligibility date for a new or re-enrolling Employee. The Plan may require, at reasonable intervals, subsequent proof satisfactory to the Plan during the next two years after such date. After such two year period, the Plan may require such proof, but not more often than once each year.

The Plan Administrator has discretionary authority to interpret these terms, and determine spousal status as defined herein, to the extent allowed by law.

The Plan reserves the right to require documentation, satisfactory to the Plan Administrator, which establishes a Dependent relationship.

NOTE: Tax treatment for certain dependents. *Federal tax law generally does not recognize former spouses, legally separated spouses, or the children of these partners, as dependents under the federal tax code unless the spouse, partner, or child otherwise qualifies as a dependent under the Internal Revenue Code §152. Therefore, the Employer may be required to automatically include the value of the health care coverage provided to any of the aforementioned individuals, who may be covered under this Plan as eligible Dependents, as additional income to the Employee.*

"Detoxification"
"Detoxification" shall mean the process whereby an alcohol intoxicated person or person experiencing the symptoms of Substance Use is assisted, in a facility licensed by the Department of Health, through the period of time necessary to eliminate, by metabolic or other means, the intoxicating alcohol, alcohol dependency factors or alcohol in combination with drugs as determined by a licensed Physician, while keeping the physiological risk to the patient at a minimum.

"Diagnosis"
"Diagnosis" shall mean the act or process of identifying or determining the nature and cause of a Disease or Injury through evaluation of patient history, examination, and review of laboratory data. Diagnosis shall also mean the findings resulting from such act or process.

"Diagnostic Service"
"Diagnostic Service" shall mean a test or procedure performed for specified symptoms to detect or to monitor a Disease or condition. It must be ordered by a Physician or other professional Provider.

"Drug"
"Drug" shall mean insulin and prescription legend drugs. A prescription legend drug is a Federal legend drug (any medicinal substance which bears the legend: "Caution: Federal law prohibits dispensing without a prescription") or a State restricted drug (any medicinal substance which may be dispensed only by prescription, according to State law) and which, in either case, is legally obtained from a licensed drug dispenser only upon a prescription of a currently licensed Physician.

"Durable Medical Equipment"
"Durable Medical Equipment" shall mean equipment which meets all of the following requirements:

1. Can withstand repeated use.
2. Is primarily and customarily used to serve a medical purpose.
3. Generally is not useful to a person in the absence of an Illness or Injury.
4. Is appropriate for use in the home.

"Emergency"
"Emergency" shall mean a situation where necessary treatment is required as the result of a sudden and severe medical event or acute condition. An Emergency includes poisoning, shock, and hemorrhage. Other Emergencies and acute conditions may be considered on receipt of proof, satisfactory to the Plan, per the Plan Administrator's discretion, that an Emergency did exist. The Plan may, at its own discretion, request satisfactory proof that an Emergency or acute condition did exist.

"Emergency Medical Condition"
"Emergency Medical Condition" shall mean a medical condition 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 a condition described in clause (i), (ii), or (iii) of section 1867(e)(1)(A) of the Social Security Act (42 U.S.C. 1395dd(e)(1)(A)). In that provision of the Social Security Act, clause (i) refers to 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; clause (ii) refers to serious impairment to bodily functions; and clause (iii) refers to serious dysfunction of any bodily organ or part.

"Emergency Services"
"Emergency Services" shall mean, with respect to an Emergency Medical Condition, the following:

1. An appropriate medical screening examination (as required under section 1867 of the Social Security Act, 42 U.S.C. 1395dd) that is within the capability of the emergency department of a Hospital or of an Independent Freestanding Emergency Department, as applicable, including ancillary services routinely available to the emergency department to evaluate such Emergency Medical Condition; and
2. Within the capabilities of the staff and facilities available at the Hospital or the Independent Freestanding Emergency Department, as applicable, such further medical examination and treatment as are required under section 1867 of the Social Security Act (42 U.S.C. 1395dd), or as would be required under such section if such section applied to an Independent Freestanding Emergency Department, to stabilize the patient (regardless of the department of the Hospital in which such further examination or treatment is furnished).

When furnished with respect to an Emergency Medical Condition, Emergency Services shall also include an item or service provided by a Non-Network Provider or Non-Participating Health Care Facility (regardless of the department of the Hospital in which items or services are furnished) after the Participant is stabilized and as part of Outpatient observation or an Inpatient or Outpatient stay with respect to the visit in which the Emergency Services are furnished, until such time as the Provider determines that the Participant is able to travel using non-medical transportation or non-emergency medical transportation, and the Participant is in a condition to, and in fact does, give informed consent to the Provider to be treated as a Non-Network Provider.

"Employee"
"Employee" shall mean an individual who is actively employed by the Employer in a regularly scheduled work week ordinarily equaling or exceeding thirty (30) hours per week.

The following classifications are not included in this definition of Employee and are excluded:

- PRN
- Seasonal

"Employer"
"Employer" is Ninnescah Valley Health Systems, Inc..

"ERISA"
"ERISA" shall mean the Employee Retirement Income Security Act of 1974, as amended.

"Essential Health Benefits"
"Essential Health Benefits" shall mean, under section 1302(b) of the Affordable Care Act, those health benefits to include at least 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.

The determination of which benefits provided under the plan are Essential Health Benefits shall be made in accordance with the benchmark plan of the State of Utah as permitted by the Departments of Labor, Treasury, and Health and Human Services.

“Exclusion”
“Exclusion” shall mean conditions or services that this Plan does not cover.

“Experimental” and/or “Investigational”
“Experimental” and/or “Investigational” (“Experimental”) shall mean services or treatments that are not widely used or accepted by most practitioners or lack credible evidence to support positive short or long-term outcomes from those services or treatments, and that are not the subject of, or in some manner related to, the conduct of an Approved Clinical Trial, as such term is defined herein; these services are not included under or as Medicare reimbursable procedures, and include services, supplies, care, procedures, treatments or courses of treatment which meet either of the following requirements:

1. Do not constitute accepted medical practice under the standards of the case and by the standards of a reasonable segment of the medical community or government oversight agencies at the time rendered.
2. Are rendered on a research basis as determined by the United States Food and Drug Administration and the AMA’s Council on Medical Specialty Societies.

A drug, device, or medical treatment or procedure is Experimental if one of the following requirements is met:

1. If the drug or device cannot be lawfully marketed without approval of the U.S. Food and Drug Administration and approval for marketing has not been given at the time the drug or device is furnished.
2. If reliable evidence shows that the drug, device or medical treatment or procedure is the subject of ongoing Phase I, II, or III clinical trials or under study to determine all of the following:

    a. Maximum tolerated dose.
    b. Toxicity.
    c. Safety.
    d. Efficacy.
    e. Efficacy as compared with the standard means of treatment or Diagnosis.

3. If reliable evidence shows that the consensus among experts regarding the drug, device, or medical treatment or procedure is that further studies or clinical trials are necessary to determine all of the following:

    a. Maximum tolerated dose.
    b. Toxicity.
    c. Safety.
    d. Efficacy.
    e. Efficacy as compared with the standard means of treatment or Diagnosis.

Reliable evidence shall mean one or more of the following:

1. Only published reports and articles in the authoritative medical and scientific literature.
2. The written protocol or protocols used by the treating facility or the protocol(s) of another facility studying substantially the same drug, device, or medical treatment or procedure.
3. The written informed consent used by the treating facility or by another facility studying substantially the same drug, device, or medical treatment or procedure.

Notwithstanding the above, a prescription drug for a treatment that has been approved by the Food and Drug Administration (FDA) but is used as a non-approved treatment shall not be considered Experimental/Investigational for purposes of this Plan and shall be afforded coverage to the same extent

as any other prescription drug; provided that the drug is recognized by one of the following as being Medically Necessary for the specific treatment for which it has been prescribed:

1. The American Medical Association Drug Evaluations.
2. The American Hospital Formulary Service Drug Information.
3. The United States Pharmacopeia Drug Information.
4. A clinical study or review article in a reviewed professional journal.

The Plan Administrator retains maximum legal authority and discretion to determine what is Experimental.

"Family Unit"
"Family Unit" shall mean the Employee and his or her Dependents covered under the Plan.

"FDA"
"FDA" shall mean Food and Drug Administration.

"Final Internal Adverse Benefit Determination"
"Final Internal Adverse Benefit Determination" shall mean an Adverse Benefit Determination that has been upheld by the Plan at the conclusion of the internal claims and appeals process, or an Adverse Benefit Determination with respect to which the internal claims and appeals process has been deemed exhausted.

"Final Post-Service Appeal"
A post-service appeal, which constitutes the last internal appeal available to the Claimant, to be filed with the Plan Administrator, Plan Sponsor, and/or other named fiduciary assigned authority and the duty to otherwise handle appeals. The term "Final Post-Service Appeal" shall only refer to such appeals if medical services and/or supplies have already been provided. Upon filing, adjudication and conclusion of this appeal, external review becomes available to the Claimant; otherwise in accordance with applicable terms found within the Plan Document and applicable law. The Plan Administrator, Plan Sponsor, and/or other named fiduciary assigned authority and the duty to otherwise handle appeals, reserves the right to allocate certain discretionary authority as it applies to adjudication of Final Post-Service Appeals to the Plan Appointed Claim Evaluator (PACE).

"FMLA"
"FMLA" shall mean the Family and Medical Leave Act of 1993, as amended.

"FMLA Leave"
"FMLA Leave" shall mean a Leave of Absence, which the Company is required to extend to an Employee under the provisions of the FMLA.

"Generic Drug"
"Generic Drug" shall mean a prescription drug which has the equivalency of the brand name drug with the same use and metabolic disintegration. This Plan will consider as a Generic Drug any Food and Drug Administration approved generic pharmaceutical dispensed according to the professional standards of a licensed pharmacist and clearly designated by the pharmacist as being generic.

"GINA"
"GINA" shall mean the Genetic Information Nondiscrimination Act of 2008 (Public Law No. 110-233), which prohibits group health plans, issuers of individual health care policies, and employers from discriminating on the basis of genetic information.

"Habilitation/Habilitative Services"
"Habilitation/Habilitative Services" shall mean health care services that help a person keep, learn, or improve skills and functioning for daily living. Examples include therapy for a child who is not walking or talking at the expected age. These services may include physical and occupational therapy, speech-language pathology and other services for people with disabilities in a variety of Inpatient and/or Outpatient settings.

"HIPAA"
"HIPAA" shall mean the Health Insurance Portability and Accountability Act of 1996, as amended.

"Home Health Care"
"Home Health Care" shall mean the continual care and treatment of an individual if all of the following requirements are met:

1. The institutionalization of the individual would otherwise have been required if Home Health Care was not provided.
2. The Home Health Care is the result of an Illness or Injury.

"Home Health Care Agency"
"Home Health Care Agency" shall mean an agency or organization which provides a program of Home Health Care and which meets one of the following requirements:

1. Is approved as a Home Health Agency under Medicare.
2. Is established and operated in accordance with the applicable laws in the jurisdiction in which it is located and, where licensing is required, has been licensed and approved by the regulatory authority having the responsibility for licensing.
3. Meets all of the following requirements:
    a. It is an agency which holds itself forth to the public as having the primary purpose of providing a Home Health Care delivery system bringing supportive services to the home.
    b. It has a full-time administrator.
    c. It maintains written records of services provided to the patient.
    d. Its staff includes at least one Registered Nurse (R.N.) or it has nursing care by a Registered Nurse (R.N.) available.
    e. Its employees are bonded and it provides malpractice insurance.

"Hospice Care Plan"
"Hospice Care Plan" shall mean a plan of terminal patient care that is established and conducted by a Hospice Agency and supervised by a Physician.

"Hospice Care Services and Supplies"
"Hospice Care Services and Supplies" shall mean those provided through a Hospice Agency and under a Hospice Care Plan and include inpatient care in a Hospice Unit or other licensed facility, home care and family counseling during the bereavement period.

"Hospice Unit"
"Hospice Unit" shall mean a facility or separate Hospital unit, that provides treatment under a Hospice Care Plan and admits at least two unrelated persons who are expected to die within six months.

"Hospital"
"Hospital" shall mean an Institution that meets all of the following requirements:

1. It provides medical and Surgical facilities for the treatment and care of Injured or Sick persons on an Inpatient basis.
2. It is under the supervision of a staff of Physicians.
3. It provides 24 hour a day nursing service by Registered Nurses.
4. It is duly licensed as a Hospital, except that this requirement will not apply in the case of a State tax supported Institution.
5. It is not, other than incidentally, a place for rest, a place for the aged, a nursing home or a custodial or training type Institution, or an Institution which is supported in whole or in part by a Federal government fund.
6. It is accredited by the Joint Commission on Accreditation of Hospitals sponsored by the AMA and the AHA.

The requirement of surgical facilities shall not apply to a Hospital specializing in the care and treatment of mentally ill patients, provided such Institution is accredited as such a facility by the Joint Commission on Accreditation of Hospitals sponsored by the AMA and the AHA.

"Hospital" shall also have the same meaning, where appropriate in context, set forth in the definition of "Ambulatory Surgical Center".

"HRSA"
"HRSA" shall mean Health Resources and Services Administration.

"Illness"
"Illness" shall mean any disorder which does not arise out of, which is not caused or contributed to by, and which is not a consequence of, any employment or occupation for compensation or profit; however, if evidence satisfactory to the Plan is furnished showing that the individual concerned is covered as an Employee under any workers' compensation law, occupational disease law or any other legislation of similar purpose, or under the maritime doctrine of maintenance, wages, and cure, but that the disorder involved is one not covered under the applicable law or doctrine, then such disorder shall, for the purposes of the Plan, be regarded as an Illness.

"Impregnation and Infertility Treatment"
"Impregnation and Infertility Treatment" shall mean any services, supplies or Drugs related to the Diagnosis or treatment of infertility.

"Incurred"
A Covered Expense is "Incurred" on the date the service is rendered or the supply is obtained. With respect to a course of treatment or procedure which includes several steps or phases of treatment, Covered Expenses are Incurred for the various steps or phases as the services related to each step are rendered and not when services relating to the initial step or phase are rendered. More specifically, Covered Expenses for the entire procedure or course of treatment are not Incurred upon commencement of the first stage of the procedure or course of treatment.

"Independent Freestanding Emergency Department"
"Independent Freestanding Emergency Department" means a health care facility that is geographically separate and distinct, and licensed separately, from a Hospital under applicable state law, and which provides any Emergency Services.

"Injury"
"Injury" shall mean an Accidental Bodily Injury, which does not arise out of, which is not caused or contributed to by, and which is not a consequence of, any employment or occupation for compensation or profit.

"Inpatient"
"Inpatient" shall mean any person who, while confined to a Hospital, is assigned to a bed in any department of the Hospital other than its outpatient department and for whom a charge for Room and Board is made by the Hospital.

"Institution"
"Institution" shall mean a facility, operating within the scope of its license, whose purpose is to provide organized health care and treatment to individuals, such as a Hospital, Ambulatory Surgical Center, Psychiatric Hospital, community mental health center, Residential Treatment Facility, psychiatric treatment facility, Substance Use Treatment Center, alternative birthing center, or any other such facility that the Plan approves.

"Intensive Care Unit"
"Intensive Care Unit" shall have the same meaning set forth in the definition of "Cardiac Care Unit."

“Intensive Outpatient Services”
“Intensive Outpatient Services” shall mean programs that have the capacity for planned, structured, service provision of at least two hours per day and three days per week. The range of services offered could include group, individual, family or multi-family group psychotherapy, psychoeducational services, and medical monitoring. These services would include multiple or extended treatment/rehabilitation/counseling visits or professional supervision and support. Program models include structured “crisis intervention programs”, “psychiatric or psychosocial rehabilitation,” and some “day treatment”.

“Leave of Absence”
“Leave of Absence” shall mean a Leave of Absence of an Employee that has been approved by his or her Participating Employer, as provided for in the Participating Employer’s rules, policies, procedures and practices.

“Mastectomy”
“Mastectomy” shall mean the surgical removal of all or part of a breast.

“Maximum Allowable Charge”
The “Maximum Allowable Charge” shall mean the amount payable for a specific covered item under this Plan. The Maximum Allowable Charge will be a negotiated rate, if one exists.

For claims subject to the No Surprises Act (see “No Surprises Act – Emergency Services and Surprise Bills” within the section “Summary of Benefits,”) if no negotiated rate exists, the Maximum Allowable Charge will be the Qualifying Payment Amount, or an amount deemed payable by a Certified IDR Entity or a court of competent jurisdiction, if applicable.

If none of the above factors is applicable, the Maximum Allowable Charge will be determined by the Plan to be the Medicare reimbursement rates presently utilized by the Centers for Medicare and Medicaid Services (“CMS”) either multiplied by 125%, or multiplied by a percentage that the particular Provider and/or others in the area customarily accept from all payers.

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:

- Visium Medicare Equivalency tables (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);
- Visium Approximation tool (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
- Visium Care Crosswalk (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).

If and only if none of the factors above is applicable, the Plan Administrator will exercise its discretion to determine the Maximum Allowable Charge based on any of the following: Medicare cost data, amounts actually collected by Providers in the area for similar services, or average wholesale price (AWP) or manufacturer’s retail pricing (MRP). These ancillary factors will take into account generally-accepted billing standards and practices.

When more than one treatment option is available, and one option is no more effective than another, the least costly option that is no less effective than any other option will be considered within the Maximum Allowable Charge. The Maximum Allowable Charge will be limited to an amount which, in the Plan Administrator’s discretion, is charged for services or supplies that are not unreasonably caused by the treating Provider, including errors in medical care that are clearly identifiable, preventable, and serious in

their consequence for patients. A finding of Provider negligence or malpractice is not required for services or fees to be considered ineligible pursuant to this provision.

"Medical Child Support Order"
"Medical Child Support Order" shall mean any judgment, decree or order (including approval of a domestic relations settlement agreement) issued by a court of competent jurisdiction that meets one of the following requirements:

1. Provides for child support with respect to a Participant's Child or directs the Participant to provide coverage under a health benefits plan pursuant to a State domestic relations law (including a community property law).
2. Is made pursuant to a law relating to medical child support described in §1908 of the Social Security Act (as added by Omnibus Budget Reconciliation Act of 1993 §13822) with respect to a group health plan.

"Medical Record Review"
"Medical Record Review" is the process by which the Plan, based upon a Medical Record Review and audit, determines that a different treatment or different quantity of a Drug or supply was provided which is not supported in the billing, then the Plan Administrator may determine the Maximum Allowable Charge according to the Medical Record Review and audit results.

"Medically Necessary"
"Medically Necessary", "Medical Necessity" and similar language refers to health care services ordered by a Physician exercising prudent clinical judgment provided to a Participant for the purposes of evaluation, Diagnosis or treatment of that Participant's Sickness or Injury. Such services, to be considered Medically Necessary, must be clinically appropriate in terms of type, frequency, extent, site and duration for the Diagnosis or treatment of the Participant's Sickness or Injury. The Medically Necessary setting and level of service is that setting and level of service which, considering the Participant's medical symptoms and conditions, cannot be provided in a less intensive medical setting. Such services, to be considered Medically Necessary must be no more costly than alternative interventions, including no intervention and are at least as likely to produce equivalent therapeutic or diagnostic results as to the Diagnosis or treatment of the Participant's Sickness or Injury without adversely affecting the Participant's medical condition. The service must meet all of the following requirements:

1. Its purpose must be to restore health.
2. It must not be primarily custodial in nature.
3. It is ordered by a Physician for the Diagnosis or treatment of a Sickness or Injury.
4. The Plan reserves the right to incorporate CMS (Medicare) guidelines in effect on the date of treatment as additional criteria for determination of Medical Necessity and/or Covered Expense.

For Hospital stays, this means that acute care as an Inpatient is necessary due to the kind of services the Participant is receiving or the severity of the Participant's condition and that safe and adequate care cannot be received as an Outpatient or in a less intensified medical setting. The mere fact that the service is furnished, prescribed or approved by a Physician does not necessarily mean that it is "Medically Necessary". In addition, the fact that certain services are specifically excluded from coverage under this Plan because they are not "Medically Necessary" does not mean that all other services are "Medically Necessary".

To be Medically Necessary, all of the above criteria must be met. The Plan Administrator has the discretionary authority to decide whether care or treatment is Medically Necessary based on recommendations of the Plan Administrator's own medical advisors, the findings of the American Medical Association or similar organization, or any other sources that the Plan Administrator deems appropriate.

“Medically Necessary Leave of Absence”
“Medically Necessary Leave of Absence” shall mean a Leave of Absence by a full-time student Dependent at a postsecondary educational institution that meets all of the following requirements:

1. Commences while such Dependent is suffering from an Illness or Injury.
2. Is Medically Necessary.
3. Causes such Dependent to lose student status for purposes of coverage under the terms of the Plan.

“Medicare”
“Medicare” shall mean the program of health care for the aged established by Title XVIII of the Social Security Act of 1965, as amended.

“Mental Health Parity Act of 1996 (MHPA) and Mental Health Parity and Addiction Equity Act of 2008 (MHPAEA), Collectively, the Mental Health Parity Provisions in Part 7 of ERISA
“The Mental Health Parity Provisions” shall mean in the case of a group health plan (or health insurance coverage offered in connection with such a plan) that provides both medical and surgical benefits and mental health or Substance Use Disorder benefits, such plan or coverage shall ensure that all of the following requirements are met:

1. The financial requirements applicable to such mental health or Substance Use Disorder benefits are no more restrictive than the predominant financial requirements applied to substantially all medical and surgical benefits covered by the Plan (or coverage).
2. There are no separate cost sharing requirements that are applicable only with respect to mental health or Substance Use Disorder benefits, if these benefits are covered by the group health plan (or health insurance coverage is offered in connection with such a plan).
3. The treatment limitations applicable to such mental health or Substance Use Disorder benefits are no more restrictive than the predominant treatment limitations applied to substantially all medical and surgical benefits covered by the Plan (or coverage).
4. There are no separate treatment limitations that are applicable only with respect to mental health or Substance Use Disorder benefits, if these benefits are covered by the group health plan (or health insurance coverage offered in connection with such a plan).

“Mental Disorder,” “Behavioral Disorder,” or “Neurodevelopmental Disorder”
“Mental Disorder,” “Behavioral Disorder,” or “Neurodevelopmental Disorder” shall mean any Disease or condition, regardless of whether the cause is organic, that is classified as a "Mental Disorder,” “Behavioral Disorder,” or “Neurodevelopmental Disorder" in the current edition of International Classification of Diseases, published by the U.S. Department of Health and Human Services, is listed in the current edition of Diagnostic and Statistical Manual of Mental Disorders, published by the American Psychiatric Association or other relevant State guideline or applicable sources. The fact that a disorder is listed in any of these sources does not mean that treatment of the disorder is covered by the Plan.

“National Medical Support Notice” or “NMSN”
“National Medical Support Notice” or “NMSN” shall mean a notice that contains all of the following information:

1. The name of an issuing State child support enforcement agency.
2. The name and mailing address (if any) of the Employee who is a Participant under the Plan or eligible for enrollment.
3. The name and mailing address of each of the Alternate Recipients (i.e., the Child or Children of the Participant) or the name and address of a State or local official may be substituted for the mailing address of the Alternate Recipients(s).
4. Identity of an underlying child support order.

“Network” or "In-Network”
“Network” or “In-Network” shall mean the medical Provider Network the Plan contracts to access discounted fees for service for Participants. The Network Provider will be identified on the Participants identification card.

“No-Fault Auto Insurance”
“No-Fault Auto Insurance” is the basic reparations provision of a law or automobile insurance policy providing for payments without determining fault in connection with automobile Accidents.

“Non-Network” or “Out-of-Network”
“Non-Network” or “Out-of-Network” shall mean the facilities, Providers and suppliers that do not have an agreement with a designated Network to provide care to Participants.

“Nurse”
“Nurse” shall mean an individual who has received specialized nursing training and is authorized to use the designation Registered Nurse (R.N.), Licensed Vocational Nurse (L.V.N.) or Licensed Practical Nurse (L.P.N.), and who is duly licensed by the State or regulatory agency responsible for such license in the State in which the individual performs the nursing services.

“Open Enrollment Period”
“Open Enrollment Period” shall mean the time frame specified by the Plan Administrator.

“Other Plan”
“Other Plan” shall include, but is not limited to:

1. Any primary payer besides the Plan.
2. Any other group health plan.
3. Any other coverage or policy covering the Participant.
4. Any first party insurance through medical payment coverage, personal injury protection, no-fault coverage, uninsured or underinsured motorist coverage, including any similar coverage under a different name in a particular state.
5. Any policy of insurance from any insurance company or guarantor of a responsible party.
6. Any policy of insurance from any insurance company or guarantor of a third party.
7. Workers’ compensation or other liability insurance company.
8. Any other source, including but not limited to crime victim restitution funds, any medical, disability or other benefit payments, and school insurance coverage.

“Outpatient”
“Outpatient” shall mean treatment including services, supplies, and medicines provided and used at a Hospital under the direction of a Physician to a person not admitted as a registered bed patient; or services rendered in a Physician’s office, laboratory, or x-ray facility, an Ambulatory Surgical Center, or the patient’s home.

“Partial Hospitalization”
“Partial Hospitalization” shall mean medically directed intensive, or intermediate short-term mental health and Substance Use treatment, for a period of less than twenty-four (24) hours but more than four (4) hours in a day in a licensed or certified facility or program.

“Participant”
“Participant” shall mean any Employee, Dependent, or individual that is covered under the Plan through COBRA continuation who is eligible for benefits (and enrolled) under the Plan.

“Participating Health Care Facility”
“Participating Health Care Facility” shall mean a Hospital or Hospital Outpatient department, critical access Hospital, Ambulatory Surgical Center, or other Provider as required by law, which has a direct or indirect

contractual relationship with the Plan with respect to the furnishing of a healthcare item or service. A single direct contract or case agreement between a health care facility and a plan constitutes a contractual relationship for purposes of this definition with respect to the parties to the agreement and particular individual(s) involved.

"Patient Protection and Affordable Care Act (PPACA)"
The "Patient Protection and Affordable Care Act (PPACA)" means the health care reform law enacted in March 2010, Public Law 111-148; PPACA, together with the Health Care and Education Reconciliation Act, is commonly referred to as Affordable Care Act (ACA). (See "Affordable Care Act").

"Physician"
"Physician" shall mean a Doctor of Medicine (M.D.), Doctor of Osteopathy (D.O.), Doctor of Dental Surgery (D.D.S.), Doctor of Podiatry (D.P.M.), Doctor of Chiropractic (D.C.), Psychologist (Ph.D.), psychiatrist or midwife.

"Plan Appointed Claim Evaluator (PACE)"
An entity appointed by the Plan Administrator, Plan Sponsor, and/or other named fiduciary assigned authority and the duty to otherwise handle appeals, with authority to make final, binding (insofar and to the same extent as a decision by the Plan Administrator, Plan Sponsor, and/or other named fiduciary assigned authority and the duty to otherwise handle appeals, would be deemed to be binding), claims processing decisions in response to Final Post-Service Appeals. In instances where the Plan Administrator, Plan Sponsor, and/or other named fiduciary assigned authority and the duty to otherwise handle appeals, delegates fiduciary authority to the PACE, the PACE may exercise the same level of discretionary authority as that which the Plan Administrator, Plan Sponsor, and/or other named fiduciary assigned authority and the duty to otherwise handle appeals, may otherwise exercise. The PACE's fiduciary duties extend only to those determinations actually made by the PACE. The PACE may perform other tasks on behalf of and in consultation with the Plan Administrator, Plan Sponsor, and/or other named fiduciary assigned authority and the duty to otherwise handle appeals, but the PACE shall only be deemed to be a fiduciary when making final determinations regarding plan coverage and claims examined via Final Post-Service Appeal. The PACE shall at all times strictly abide by and make determination in accordance with the terms of the Plan and applicable law, in light of the facts, law, medical records, and all other information submitted to the PACE.

"Plan Year"
"Plan Year" shall mean a period commencing on the Effective Date or any anniversary of the adoption of this Plan and continuing until the next succeeding anniversary.

"Pre-Admission Tests"
"Pre-Admission Tests" shall mean those Diagnostic Services done prior to a scheduled Surgery, provided that all of the following requirements are met:

1. The tests are approved by both the Hospital and the Physician.
2. The tests are performed on an Outpatient basis prior to Hospital admission.
3. The tests are performed at the Hospital into which confinement is scheduled, or at a qualified facility designated by the Physician who will perform the Surgery.

"Pregnancy"
"Pregnancy" shall mean carrying a child, resulting childbirth, miscarriage or non-elective abortion. The Plan considers Pregnancy as a Sickness for the purpose of determining benefits.

"Preventive Care"
"Preventive Care" shall mean certain Preventive Care services.

To comply with the ACA, and in accordance with the recommendations and guidelines, plans shall provide In-Network coverage for all of the following:

1. Evidence-based items or services rated A or B in the United States Preventive Services Task Force recommendations.
2. Recommendations of the Advisory Committee on Immunization Practices adopted by the Director of the Centers for Disease Control and Prevention.
3. Comprehensive guidelines for infants, children, and adolescents supported by the Health Resources and Services Administration (HRSA).
4. Comprehensive guidelines for women supported by the Health Resources and Services Administration (HRSA).

Copies of the recommendations and guidelines may be found at the following websites:
https://www.healthcare.gov/coverage/preventive-care-benefits/;
https://www.uspreventiveservicestaskforce.org/uspstf/recommendation-topics/uspstf-a-and-b-recommendations;
https://www.cdc.gov/vaccines/hcp/acip-recs/index.html;
https://www.aap.org/en-us/Documents/periodicity_schedule.pdf;
https://www.hrsa.gov/womensguidelines/.

For more information, Participants may contact the Plan Administrator / Employer.

"Primary Care Physician (PCP)"
"Primary Care Physician (PCP)" shall mean family practitioners, general practitioners, internists, OBGYNs, pediatricians, and office-based nurse practitioners and physician's assistants. All other Physicians are considered specialists.

"Prior Plan"
"Prior Plan" shall mean the coverage provided on a group or group type basis by the group insurance policy, benefit plan or service plan that was terminated on the day before the Effective Date of the Plan and replaced by the Plan.

"Prior to Effective Date" or "After Termination Date"
"Prior to Effective Date" or "After Termination Date" are dates occurring before a Participant gains eligibility from the Plan, or dates occurring after a Participant loses eligibility from the Plan (unless continuation of benefits applies).

"Privacy Standards"
"Privacy Standards" shall mean the applicable standards for the privacy of individually identifiable health information, pursuant to HIPAA.

"Provider"
"Provider" shall mean a Physician, a licensed speech or occupational therapist, licensed professional physical therapist, physiotherapist, audiologist, speech language pathologist, licensed professional counselor, certified nurse practitioner, certified psychiatric/mental health clinical nurse, or other practitioner or facility defined or listed herein, or approved by the Plan Administrator. All facilities must meet the standards as set forth within the applicable definitions of the Plan as it relates to the relevant provider type.

"Psychiatric Hospital"
"Psychiatric Hospital" shall mean an Institution constituted, licensed, and operated as set forth in the laws that apply to Hospitals, which meets all of the following requirements:

1. It is primarily engaged in providing psychiatric services for the Diagnosis and treatment of mentally ill persons either by, or under the supervision of, a Physician.
2. It maintains clinical records on all patients and keeps records as needed to determine the degree and intensity of treatment provided.
3. It is licensed as a Psychiatric Hospital.
4. It requires that every patient be under the care of a Physician.

5. It provides 24 hour a day nursing service.

The term Psychiatric Hospital does not include an Institution, or that part of an Institution, used mainly for nursing care, rest care, convalescent care, care of the aged, Custodial Care or educational care.

"Qualified Medical Child Support Order" or "QMCSO"
"Qualified Medical Child Support Order" or "QMCSO" shall mean a Medical Child Support Order, in accordance with applicable law, and which creates or recognizes the existence of an Alternate Recipient's right to, or assigns to an Alternate Recipient the right to, receive benefits for which a Participant or eligible Dependent is entitled under this Plan.

"Qualifying Payment Amount"
"Qualifying Payment Amount" means the median of the contracted rates recognized by the Plan, or recognized by all plans serviced by the Plan's Third Party Administrator (if calculated by the Third Party Administrator), for the same or a similar item or service provided by a Provider in the same or similar specialty in the same geographic region. If there are insufficient (meaning fewer than three) contracted rates available to determine a Qualifying Payment Amount, said amount will be determined by referencing a state all-payer claims database or, if unavailable, any eligible third-party database in accordance with applicable law.

"Recognized Amount"
"Recognized Amount" shall mean, except for Non-Network air ambulance services, an amount determined under an applicable all-payer model agreement, or if unavailable, an amount determined by applicable state law. If no such amounts are available or applicable and for Non-Network air ambulance services generally, the Recognized Amount shall mean the lesser of a Provider's billed charge or the Qualifying Payment Amount.

"Rehabilitation"
"Rehabilitation" shall mean treatment(s) designed to facilitate the process of recovery from Injury, Illness, or Disease to as normal a condition as possible.

"Rehabilitation Hospital"
"Rehabilitation Hospital" shall mean an Institution which mainly provides therapeutic and restorative services to Sick or Injured people. It is recognized as such if one or more of the following requirements are met:

1. It carries out its stated purpose under all relevant Federal, State and local laws.
2. It is accredited for its stated purpose by either the Joint Commission on Accreditation of Hospitals or the Commission on Accreditation for Rehabilitation Facilities.
3. It is approved for its stated purpose by Medicare.

"Residential Treatment Facility"
"Residential Treatment Facility" shall mean a facility licensed or certified as such by the jurisdiction in which it is located to operate a program for the treatment and care of Participants diagnosed with alcohol, drug or Substance Use disorders or mental illness.

"Room and Board"
"Room and Board" shall mean a Hospital's charge for any of the following:

1. Room and linen service.
2. Dietary service, including meals, special diets and nourishment.
3. General nursing service.
4. Other conditions of occupancy which are Medically Necessary.

"Security Standards"
"Security Standards" shall mean the final rule implementing HIPAA's Security Standards for the Protection of Electronic Protected Health Information (PHI), as amended.

"Service Waiting Period"
"Service Waiting Period" shall mean an interval of time during which the Employee is in the continuous, Active Employment of his or her Participating Employer.

"Skilled Nursing Facility"
"Skilled Nursing Facility" shall mean a facility that fully meets all of the following requirements:

1. It is licensed to provide professional nursing services on an Inpatient basis to persons convalescing from Injury or Sickness. The service must be rendered by a Registered Nurse (R.N.) or by a Licensed Practical Nurse (L.P.N.) under the direction of a Registered Nurse. Services to help restore patients to self-care in essential daily living activities must be provided.
2. Its services are provided for compensation and under the full-time supervision of a Physician.
3. It provides 24 hour per day nursing services by licensed nurses, under the direction of a full-time Registered Nurse.
4. It maintains a complete medical record on each patient.
5. It has an effective utilization review plan.
6. It is not, other than incidentally, a place for rest, the aged, drug addicts, alcoholics, mentally disabled, Custodial Care, educational care or care of Mental Disorders, Behavioral Disorders, or Neurodevelopmental Disorders.
7. It is approved and licensed by Medicare.

"Substance Use" and/or "Substance Use Disorder"
"Substance Use" and/or "Substance Use Disorder" shall mean any disease or condition that is classified as a Substance Use Disorder as listed in the current edition of the International Classification of Diseases, published by the U.S. Department of Health and Human Services, as listed in the current edition of Diagnostic and Statistical Manual of Mental Disorders, published by the American Psychiatric Association, or other relevant State guideline or applicable sources.

The fact that a disorder is listed in any of the above publications does not mean that treatment of the disorder is covered by the Plan.

"Substance Use Treatment Center"
"Substance Use Treatment Center" shall mean an Institution which provides a program for the treatment of Substance Use monitored by a Physician. This Institution must meet one or more of the following requirements:

1. Affiliated with a Hospital under a contractual agreement with an established system for patient referral.
2. Accredited as such a facility by the Joint Commission on Accreditation of Hospitals.
3. Licensed, certified or approved as an alcohol or Substance Use treatment program or center by a State agency having legal authority to do so.

"Surgery"
"Surgery" shall mean any of the following:

1. The incision, excision, debridement or cauterization of any organ or part of the body, and the suturing of a wound.
2. The manipulative reduction of a fracture or dislocation or the manipulation of a joint including application of cast or traction.
3. The removal by endoscopic means of a stone or other foreign object from any part of the body or the diagnostic examination by endoscopic means of any part of the body.
4. The induction of artificial pneumothorax and the injection of sclerosing solutions.
5. Arthrodesis, paracentesis, arthrocentesis and all injections into the joints or bursa.

6. Obstetrical delivery and dilatation and curettage.
7. Biopsy.

"Surgical Procedure"
"Surgical Procedure" shall have the same meaning set forth in the definition of "Surgery."

"Third Party Administrator"
"Third Party Administrator" shall mean the claims administrator which provides customer service and claims payment services only and does not assume any financial risk or obligation with respect to those claims. The Third Party Administrator is not an insurer of health benefits under this Plan, is not a fiduciary of the Plan, and does not exercise any of the discretionary authority and responsibility granted to the Plan Administrator. The Third Party Administrator is not responsible for Plan financing and does not guarantee the availability of benefits under this Plan.

"Uniformed Services"
"Uniformed Services" shall mean the Armed Forces, the Army National Guard and the Air National Guard, when engaged in active duty for training, inactive duty training, or full-time National Guard duty, the commissioned corps of the Public Health Service, and any other category of persons designated by the President of the United States in time of war or Emergency.

"USERRA"
"USERRA" shall mean the Uniformed Services Employment and Reemployment Rights Act of 1994 ("USERRA").

All other defined terms in this Plan Document shall have the meanings specified in the Plan Document where they appear.

ARTICLE IV
ELIGIBILITY FOR COVERAGE

4.01 Eligibility for Individual Coverage

Each Employee will become eligible for coverage under this Plan with respect to himself or herself on the first day of the month, following completion of a Service Waiting Period of 60 days, provided the Employee has begun work for his or her Participating Employer. Each Employee who was covered under the Prior Plan, if any, will be eligible on the Effective Date of this Plan. Any Service Waiting Period or portion thereof satisfied under the Prior Plan, if any, will be applied toward satisfaction of the Service Waiting Period of this Plan. If a covered Employee's employment is terminated and the Employee returns to Active Employment within 13 weeks from the date of termination, the Service Waiting Period will be waived and coverage will take effect on the first day the Employee returns to Active Employment.

4.02 Eligibility Dates for Dependent Coverage

Each Employee will become eligible for coverage under this Plan for his or her Dependents on the latest of the following dates:

1. His or her date of eligibility for coverage for himself or herself under the Plan.
2. The date coverage for his or her Dependents first becomes available under any amendment to the Plan, if such coverage was not provided under the Plan on the Effective Date of the Plan.
3. The first date upon which he or she acquires a Dependent.
4. If applicable, for a Dependent child the date the Dependent Child becomes eligible due to a qualifying status change event, as outlined in the Section 125 plan.

In no event will any Dependent Child be covered as a Dependent of more than one Employee who is covered under the Plan.

In order for the Employee's Dependent to be covered under the Plan the Employee must be enrolled for coverage under the Plan.

"Michelle's Law" prohibits a group health plan, or a health insurance issuer that provides health insurance coverage in connection with a group health plan, from terminating coverage of a Dependent Child due to a qualifying "Medically Necessary Leave of Absence" from, or other change in enrollment at, a postsecondary educational institution prior to the earlier of:

1. The date that is one year after the first day of the Medically Necessary Leave of Absence.
2. The date on which such coverage would otherwise terminate under the terms of the Plan.

In order to be a Medically Necessary Leave of Absence the student's leave must meet all of the following requirements:

1. Commence while the Dependent Child is suffering from a serious Illness or Injury.
2. Be Medically Necessary.
3. Cause the Dependent Child to lose student status for purposes of coverage under the terms of the parents' plan or coverage.

A Child is a "Dependent Child" under the law if he or she meets one of the following requirements:

1. Is a Dependent Child of a Participant under the terms of the Plan or coverage.
2. Was enrolled in the Plan or coverage, on the basis of being a student at a postsecondary educational institution, immediately before the first day of the Medically Necessary Leave of Absence.

A treating Physician of the Dependent Child must certify that the Dependent Child is suffering from a serious Illness or Injury and that the Leave of Absence (or other change of enrollment) described is Medically Necessary.

4.03 Effective Dates of Coverage; Conditions

The coverage for which an individual is eligible under this Plan will become effective on the date specified below, subject to the conditions of this section.

1. Enrollment Application (paper or electronic as applicable). Coverage for an Employee or his or her Dependents must be requested by the Employee on a form (either paper or electronic as applicable) furnished by the Plan Administrator and will become effective on the date such Employee or Dependents are eligible, provided the Employee has enrolled for such coverage on a form satisfactory to the Plan Administrator within the 30 day period immediately following the date of eligibility.

2. Birth of Dependent Child. A newborn Child of an Employee will be considered eligible and will be covered from the moment of birth for Injury or Illness, including the Medically Necessary care and treatment of medically diagnosed congenital defects, birth abnormalities and prematurity, Routine Newborn Care and Well Baby Care **if written notification to add the Child is received by the Plan Administrator within** 30 days **following the Child's date of birth**. If written notification to add a newborn Child is received by the Plan Administrator AFTER the 30 day period immediately following the Child's date of birth, the Child is considered a Late Enrollee and not eligible for the Plan until the next Annual Open Enrollment Period. A newborn Child of a Dependent Child is not eligible for this Plan unless the newborn Child meets the definition of an Eligible Dependent.

3. Newly Acquired Dependents. If an Employee acquires a Dependent while the Employee is eligible for coverage for Dependents, coverage for the newly acquired Dependent shall be effective on the date the Dependent becomes eligible, provided application is made to the Plan within 30 days of the date of eligibility and any required contributions are made.

4. Requirement for Employee Coverage. No coverage for Dependents of an Employee will become effective unless the Employee is, or simultaneously becomes, eligible for coverage for themselves under the Plan.

5. Coverage as Both Employee and Dependent. No person may be simultaneously covered under this Plan as both an Employee and a Dependent.

6. Medicaid Coverage. An individual's eligibility for any State Medicaid benefits will not be taken into account by the Plan in determining that individual's eligibility under the Plan.

7. FMLA Leave. Regardless of any requirements set forth in the Plan, the Plan shall at all times comply with FMLA.

4.04 Special and Open Enrollment

The Plan provides special enrollment periods that allow Employee's to enroll in the Plan, even if they declined enrollment during an initial or subsequent eligibility period.

4.05 Loss of Other Coverage

If an Employee declined enrollment for himself or herself or his or her Dependents (including his or her spouse) because of other health coverage, he or she may enroll for coverage for himself or herself and/or his or her Dependents if the other health coverage is lost. The Employee must make written application for special enrollment within 60 days of the date the other health coverage was lost. For example, if the Employee loses his or her other health coverage on September 15, he or she must notify the Plan Administrator and apply for coverage by close of business on November 15.

The following conditions apply to any eligible Employee and Dependents:

An Employee may enroll during this special enrollment period if the following requirements are met:

1. If the Employee is eligible for coverage under the terms of this Plan.
2. The Employee is not currently enrolled under the Plan.
3. When enrollment was previously offered, the Employee declined because of coverage under another group health plan or health insurance coverage. The Employee must have provided a written statement that other health coverage was the reason for declining enrollment under this Plan.
4. If the other coverage was terminated due to loss of eligibility for the coverage (including due to legal separation, divorce, death, termination of employment, or reduction in the number of hours), or because employer contributions for the coverage were terminated.

An Employee who is already enrolled in a benefit package may enroll in another benefit package under the Plan if a Dependent of that Employee has a special enrollment right in the Plan because the Dependent lost eligibility for other coverage.

The Employee is not eligible for this special enrollment right if either of the following apply:

1. The other coverage was COBRA Continuation Coverage and the Employee did not exhaust the maximum time available to him or her for that COBRA coverage.
2. The other coverage was lost due to non-payment of requisite contribution / premium or for cause (such as making a fraudulent claim or an intentional misrepresentation of a material fact in connection with the Other Plan).

If the conditions for special enrollment are satisfied, coverage for the Employee and/or his or her Dependent(s) will be effective at 12:01 A.M. on the first day of the first calendar month following the date of loss of other coverage.

4.05A New Dependent

If an Employee acquires a new Dependent as a result of marriage, legal guardianship, a foster child being placed with the Employee, birth, adoption, or placement for adoption, he or she may be able to enroll himself or herself and his or her Dependents during a special enrollment period. The Employee must make written or electronic application, as applicable, for special enrollment no later than 30 days after he or she acquires the new Dependent. For example, if the Employee is married on September 15, he or she must notify the Plan Administrator and apply for coverage by close of business on October 15.

The following conditions apply to any eligible Employee and Dependents:

An Employee may enroll himself or herself and/or his or her eligible Dependents during this special enrollment period if both of the following conditions are met:

1. The Employee is eligible for coverage under the terms of this Plan.
2. The Employee has acquired a new Dependent through marriage, legal guardianship, a foster child being placed with the Employee, birth, adoption, or placement for adoption.

If the conditions for special enrollment are satisfied, coverage for the Employee and his or her Dependent(s) will be effective at 12:01 A.M. for the following events:

1. For a marriage, on the first day of the month following the date the completed request for enrollment is received..
2. For a legal guardianship, on the date on which such Child is placed in the covered Employee's home pursuant to a court order appointing the covered Employee as legal guardian for the Child.

3. In the case of a foster child being placed with the Employee, on the date on which such Child is placed with the Employee by an authorized placement agency or by judgment, decree or other order of a court of competent jurisdiction.
4. For a birth, on the date of birth.
5. For an adoption or placement for adoption, on the date of the adoption or placement for adoption.

4.05B Additional Special Enrollment Rights
Employees and Dependents who are eligible but not enrolled are entitled to enroll under one of the following circumstances:

1. The Employee's or Dependent's Medicaid or State Child Health Insurance Plan (i.e. CHIP) coverage has terminated as a result of loss of eligibility and the Employee requests coverage under the Plan within 60 days after the termination.
2. The Employee or Dependent become eligible for a contribution / premium assistance subsidy under Medicaid or a State Child Health Insurance Plan (i.e. CHIP), and the Employee requests coverage under the Plan within 60 days after eligibility is determined.

If the conditions for special enrollment are satisfied, coverage for the Employee and/or his or her Dependent(s) will be effective at 12:01 A.M. on the first day following the above-described additional special enrollment events.

4.05C Open Enrollment
Participants may enroll for coverage during Open Enrollment Periods. Coverage for Participants enrolling during an Open Enrollment Period will become effective on January 1, as long as all other eligibility requirements have been met. If the other eligibility requirements have not been met, coverage for Participants enrolling during an Open Enrollment Period will become effective as stated in the provision, "Eligibility for Individual Coverage".

"Open Enrollment Period"
"Open Enrollment Period" shall mean the time frame specified by the Plan Administrator.

4.06 Relation to Section 125 Cafeteria Plan
This Plan may also allow additional changes to enrollment due to change in status events under the employer's Section 125 Cafeteria Plan. Refer to the employer's Section 125 Cafeteria Plan for more information.

4.07 Qualified Medical Child Support Orders
The Plan Administrator shall enroll for immediate coverage under this Plan any Alternate Recipient who is the subject of a Medical Child Support Order that is a "Qualified Medical Child Support Order" ("QMCSO"), not including an ex-stepchild or ex-stepchildren, if such an individual is not already covered by the Plan as an eligible Dependent, once the Plan Administrator has determined that such order meets the standards for qualification set forth below.

To be considered a Qualified Medical Child Support Order, the Medical Child Support Order must contain the following information:

1. The name and last known mailing address (if any) of the Participant and the name and mailing address of each such Alternate Recipient covered by the order.
2. A reasonable description of the type of coverage to be provided by the Plan to each Alternate Recipient, or the manner in which such type of coverage is to be determined.
3. The period of coverage to which the order pertains.
4. The name of this Plan.

In addition, a National Medical Support Notice shall be deemed a QMCSO if all of the following requirements are met:

1. It contains the information set forth in the Definitions section in the definition of “National Medical Support Notice”.
2. It identifies either the specific type of coverage or all available group health coverage. If the Employer receives a NMSN that does not designate either specific type(s) of coverage or all available coverage, the Employer and the Plan Administrator will assume that all are designated.
3. It informs the Plan Administrator that, if a group health plan has multiple options and the Participant is not enrolled, the issuing agency will make a selection after the NMSN is qualified, and, if the agency does not respond within 20 days, the Child will be enrolled under the Plan’s default option (if any).
4. It specifies that the period of coverage may end for the Alternate Recipient(s) only when similarly situated dependents are no longer eligible for coverage under the terms of the Plan, or upon the occurrence of certain specified events.

However, such an order need not be recognized as “qualified” if it requires the Plan to provide any type or form of benefit, or any option, not otherwise provided to the Participants and eligible Participants without regard to this section, except to the extent necessary to meet the requirements of a State law relating to Medical Child Support Orders, as described in Social Security Act §1908 (as added by Omnibus Budget Reconciliation Act of 1993 §13822).

Upon receiving a Medical Child Support Order, the Plan Administrator shall, as soon as administratively possible, perform the following:

1. Notify the Participant and each Alternate Recipient covered by the Order (at the address included in the Order) in writing of the receipt of such Order and the Plan’s procedures for determining whether the Order qualifies as a QMCSO.
2. Make an administrative determination if the order is a QMCSO and notify the Participant and each affected Alternate Recipient of such determination.

Upon receiving a National Medical Support Notice, the Plan Administrator shall perform the following:

1. Notify the State agency issuing the notice with respect to the Child whether coverage of the Child is available under the terms of the Plan and, if so:

    a. Whether the Child is covered under the Plan.
    b. Either the effective date of the coverage or, if necessary, any steps to be taken by the custodial parent or by the official of a State or political subdivision to effectuate the coverage.

2. Provide to the custodial parent (or any State official serving in a substitute capacity) a description of the coverage available and any forms or documents necessary to effectuate such coverage.

To give effect to this requirement, the Plan Administrator shall perform the following:

1. Establish reasonable, written procedures for determining the qualified status of a Medical Child Support Order or National Medical Support Notice.
2. Permit any Alternate Recipient to designate a representative for receipt of copies of the notices that are sent to the Alternate Recipient with respect to the Order.

A Participant of this Plan may obtain, without charge, a copy of the procedures governing QMCSO determinations from the Plan Administrator.

4.08 Acquired Companies

Eligible Employees of an acquired company who are Actively at Work and were covered under the Prior Plan of the acquired company will be eligible for the benefits under this Plan on the date of acquisition. Any waiting period previously satisfied under the prior health plan will be applied toward satisfaction of the

Service Waiting Period of this Plan. In the event that an acquired company did not have a health plan, all eligible Employees will be eligible on the date of the acquisition.

4.09 Genetic Information Nondiscrimination Act ("GINA")

"GINA" prohibits group health plans, issuers of individual health care policies, and employers from discriminating on the basis of genetic information.

The term "genetic information" means, with respect to any individual, information about any of the following:

1. Such individual's genetic tests.
2. The genetic tests of family members of such individual.
3. The manifestation of a Disease or disorder in family members of such individual.

The term "genetic information" includes participating in clinical research involving genetic services. Genetic tests would include analysis of human DNA, RNA, chromosomes, proteins, or metabolites that detect genotypes, mutations, or chromosomal changes. Genetic information is a form of Protected Health Information (PHI) as defined by and in accordance with the Health Insurance Portability and Accountability Act of 1996 (HIPAA), and is subject to applicable Privacy and Security Standards.

Family members as it relates to GINA include dependents, plus all relatives to the fourth degree, without regard to whether they are related by blood, marriage, or adoption. Underwriting as it relates to GINA includes any rules for determining eligibility, computing premiums or contributions, and applying pre-existing condition limitations. Offering reduced premiums or other rewards for providing genetic information would be impermissible underwriting.

GINA will not prohibit a health care Provider who is treating an individual from requesting that the patient undergo genetic testing. The rules permit the Plan to obtain genetic test results and use them to make claims payment determinations when it is necessary to do so to determine whether the treatment provided to the patient was medically advisable and/or necessary.

The Plan may request, but not require, genetic testing in certain very limited circumstances involving research, so long as the results are not used for underwriting, and then only with written notice to the individual that participation is voluntary and will not affect eligibility for benefits, premiums or contributions. In addition, the Plan will notify and describe its activity to the Health and Human Services secretary of its activities falling within this exception.

While the Plan may collect genetic information after initial enrollment, it may not do so in connection with any annual renewal process where the collection of information affects subsequent enrollment. The Plan will not adjust premiums or increase group contributions based upon genetic information, request or require genetic testing or collect genetic information either prior to or in connection with enrollment or for underwriting purposes.

ARTICLE V
TERMINATION OF COVERAGE

5.01 Termination Dates of Individual Coverage

The coverage of any Employee for himself or herself under this Plan will terminate on the earliest to occur of the following dates:

1. The date of termination of the Plan.
2. The last day of the month in, or with respect to which, he or she requests that such coverage be terminated, provided such request is made on or before such date, unless prohibited by law (i.e., when election changes cannot be made due to Internal Revenue Code Section 125 "change in status" guidelines). ***NOTE:*** *The Employer offers these benefits in conjunction with a cafeteria plan under Section 125 of the Internal Revenue Code and a voluntary termination must comply with the requirements of the Code and the cafeteria plan*.
3. The last day of the month for which the Employee has made a contribution, in the event of his or her failure to make, when due, any contribution for coverage for himself or herself to which he or she has agreed in writing.
4. The last day of the month in which the Employee ceases to be eligible for such coverage under the Plan.
5. The last day of the month in which the termination of employment occurs.
6. Immediately after an Employee or his or her Dependent submits, or has knowledge of the submission of, a fraudulent claim or any fraudulent information to the Plan, including enrollment information.

5.01A Termination Dates of Dependent Coverage

The coverage for any Dependents of any Employee who are covered under the Plan will terminate on the earliest to occur of the following dates:

1. The date of termination of the Plan.
2. Upon the discontinuance of coverage for Dependents under the Plan.
3. The date of termination of the Employee's coverage for himself or herself under the Plan.
4. The date of the expiration of the last period for which the Employee has made a contribution, in the event of his or her failure to make, when due, any contribution for coverage for Dependents to which he or she has agreed in writing.
5. In the case of a Child age 26 or older for whom coverage is being continued due to mental or physical inability to earn his or her own living, the earliest to occur of:
    a. Cessation of such inability.
    b. Failure to furnish any required proof of the uninterrupted continuance of such inability or to submit to any required examination.
    c. Upon the Child's no longer being dependent on the Employee for his or her support.
6. The last day of the month in which such person ceases to be a Dependent, as defined herein, except as may be provided for in other areas of this section.
7. Immediately after an Employee or his or her Dependent submits, or has knowledge of the submission of, a fraudulent claim or any fraudulent information to the Plan, including enrollment information.

NOTE: *The Employer offers these benefits in conjunction with a cafeteria plan under Section 125 of the Internal Revenue Code and a voluntary termination must comply with the requirements of the Code and the cafeteria plan.*

ARTICLE VI
CONTINUATION OF COVERAGE

6.01 Employer Continuation Coverage
Coverage will be continued for eligible Participants should any of the following occur:

1. State-mandated family or medical leave; coverage will continue as required by the applicable state law in which the Employee is domiciled.
2. In the event of an unpaid Leave of Absence that does not meet the requirements of FMLA Leave, coverage will continue through the last day of the month following 30 days of unpaid leave.

The above noted leave(s) run concurrently with FMLA, USERRA or any State-mandated family or medical leave, and/or any other applicable leaves of absence. At the end of the period(s) listed above, the Participant's coverage will be deemed to have terminated for purposes of Continuation of Coverage under COBRA.

6.02 Continuation During Family and Medical Leave Act (FMLA) Leave
Regardless of the established leave policies mentioned above, the Plan shall at all times comply with FMLA. During any leave taken under FMLA, the Employee will maintain coverage under this Plan on the same conditions as coverage would have been provided if the covered Employee had been continuously employed during the entire leave period.

6.02A Leave Entitlements
Eligible employees who work for a covered employer can take up to 12 weeks of unpaid, job-protected leave in a 12-month period for the following reasons:

- The birth of a child or placement of a child for adoption or foster care with the eligible employee(s).
- To bond with a child (leave must be taken within 1 year of the child's birth or placement) with the eligible employee(s).
- To care for the employee's spouse, child, or parent who has a qualifying serious health condition.
- For the employee's own qualifying serious health condition that makes the employee unable to perform the employee's job.
- For qualifying exigencies related to the foreign deployment of a military member who is the employee's spouse, child, or parent.

Spouses employed by the same employer are jointly entitled to a combined total of 12 workweeks of FMLA leave for the birth and care of the newborn child, for placement of a child for adoption or foster care, and to care for a parent who has a serious health condition. Leave for birth and care or placement for adoption or foster care must conclude within 12 months of the birth or placement.

An eligible employee who is a covered servicemember's spouse, child, parent, or next of kin may also take up to 26 weeks of FMLA leave in a single 12-month period to care for the servicemember with a serious injury or illness.

An employee does not need to use leave in one block. When it is medically necessary or otherwise permitted, employees may take leave intermittently or on a reduced schedule.
Employees may choose, or an employer may require, use of accrued paid leave while taking FMLA leave. If an employee substitutes accrued paid leave for FMLA leave, the employee must comply with the employer's normal paid leave policies.

6.02B Benefits and Protections
While employees are on FMLA leave, employers must continue health insurance coverage as if the employees were not on leave. Upon return from FMLA leave, most employees must be restored to the same job or one nearly identical to it with equivalent pay, benefits, and other employment terms and conditions.

An employer may not interfere with an individual's FMLA rights or retaliate against someone for using or trying to use FMLA leave, opposing any practice made unlawful by the FMLA, or being involved in any proceeding under or related to the FMLA.

6.02C Eligibility Requirements

An employee who works for a covered employer must meet three criteria in order to be eligible for FMLA leave. The employee must meet all of the following requirements:

- Have worked for the employer for at least 12 months.
- Have at least 1,250 hours of service in the 12 months before taking leave.*
- Work at a location where the employer has at least 50 employees within 75 miles of the employee's worksite.

*Special "hours of service" requirements apply to airline flight crew employees.

6.02D Requesting Leave

Generally, employees must give 30-days' advance notice of the need for FMLA leave. If it is not possible to give 30-days' notice, an employee must notify the employer as soon as possible and, generally, follow the employer's usual procedures.

Employees do not have to share a medical diagnosis, but must provide enough information to the employer so it can determine if the leave qualifies for FMLA protection. Sufficient information could include informing an employer that the employee is or will be unable to perform his or her job functions, that a family member cannot perform daily activities, or that hospitalization or continuing medical treatment is necessary. Employees must inform the employer if the need for leave is for a reason for which FMLA leave was previously taken or certified.

Employers can require a certification or periodic recertification supporting the need for leave. If the employer determines that the certification is incomplete, it must provide a written notice indicating what additional information is required.

6.02E Employer Responsibilities

Once an employer becomes aware that an employee's need for leave is for a reason that may qualify under the FMLA, the employer must notify the employee if he or she is eligible for FMLA leave and, if eligible, must also provide a notice of rights and responsibilities under the FMLA. If the employee is not eligible, the employer must provide a reason for ineligibility.

Employers must notify its employees if leave will be designated as FMLA leave, and if so, how much leave will be designated as FMLA leave.

6.02F Enforcement

Employees may file a complaint with the U.S. Department of Labor, Wage and Hour Division, or may bring a private lawsuit against an employer.

The FMLA does not affect any federal or state law prohibiting discrimination or supersede any state or local law or collective bargaining agreement that provides greater family or medical leave rights.
For additional information or to file a complaint:
1-866-4-USWAGE
(1-866-487-9243) TTY: 1-877-889-5627
https://www.dol.gov/whd/
U.S. Department of Labor Wage and Hour Division
WH1420a - REV 04/16

6.03 Continuation During USERRA

Participants who are absent from employment because they are in the Uniformed Services, and who are on active military duty, must be offered the right to continue health care benefits. If the military leave orders are for a period of 30 days or less, Participants cannot be required to pay more than the normal Participant contribution amount. After this period, Participants may elect to continue their coverage under this Plan for up to 24 months and Participants cannot be required to pay more than 102 percent of the full contribution amount during that time. If a Participant elected to continue coverage under USERRA before December 10, 2004, the maximum period for continuing coverage is 18 months.

To continue coverage, Participants must comply with the terms of the Plan, and pay their contributions, if any. In addition, USERRA also requires that, regardless of whether a Participant elected to continue his or her coverage under the Plan, his or her coverage and his or her Dependents' coverage be reinstated immediately upon his or her return to employment, so long as he or she meets certain requirements contained in USERRA. Participants should contact their participating Employer for information concerning their eligibility for USERRA and any requirements of the Plan.

6.04 Continuation During COBRA – Introduction

The right to this form of continued coverage was created by a Federal law, under the Consolidated Omnibus Budget Reconciliation Act of 1985, as amended ("COBRA"). COBRA Continuation Coverage can become available to Participants when they otherwise would lose their group health coverage. It also can become available to other members of the Participant's family who are covered under the Plan when they otherwise would lose their group health coverage. The entire cost (plus a reasonable administration fee) must be paid by the person. Coverage will end in certain instances, including if the Participant or their covered Dependents fail to make timely payment of contributions or premiums. Participants should check with their Employer to see if COBRA applies to them and/or their covered dependents.

To the extent the Plan does not fully or accurately reflect applicable COBRA regulations, the Plan will at all times comply with such regulations, including but not limited to continuation coverage in connection with a business reorganization or employer withdrawal from a multiemployer plan.

Participants may have other options available when group health coverage is lost. For example, a Participant may be eligible to buy an individual plan through the Health Insurance Marketplace. By enrolling in coverage through the Marketplace, the Participant may qualify for lower costs on his or her monthly premiums and lower out-of-pocket costs. Participants can learn more about many of these options at www.healthcare.gov. Additionally, the Participant may qualify for a 30-day special enrollment period for another group health plan for which the Participant is eligible (such as a spouse's plan), even if that plan generally doesn't accept late enrollees.

6.04A COBRA Continuation Coverage

"COBRA Continuation Coverage" is a continuation of Plan coverage when coverage otherwise would end because of a life event known as a "Qualifying Event". Life insurance, accidental death and dismemberment benefits, and weekly income or long term disability benefits (if a part of the Employer's plan) are not considered for continuation under COBRA.

6.04B Qualifying Events

A qualifying event is any of those listed below if the Plan provided that the Participant would lose coverage (i.e., cease to be covered under the same terms and conditions as in effect immediately before the qualifying event) in the absence of COBRA continuation coverage. After a Qualifying Event, COBRA Continuation Coverage must be offered to each person who is a "Qualified Plan Participant". The Employee, the Employee's spouse, and the Employee's Dependent Children could become Qualified Plan Participants if coverage under the Plan is lost because of the Qualifying Event.

A covered Employee (meaning an Employee covered under the Plan) will become a Qualified Plan Participant if he or she loses his or her coverage under the Plan because either one of the following Qualifying Events happens:

1. The hours of employment are reduced.
2. The employment ends for any reason other than gross misconduct.

The spouse of a covered Employee will become a Qualified Plan Participant if he or she loses his or her coverage under the Plan because any of the following Qualifying Events happens:

1. The Employee dies.
2. The Employee's hours of employment are reduced.
3. The Employee's employment ends for any reason other than his or her gross misconduct.
4. The Employee becomes entitled to Medicare benefits (under Part A, Part B, or both).
5. The Employee becomes divorced or legally separated from his or her spouse.

Dependent Children will become Qualified Plan Participants if they lose coverage under the Plan because any of the following Qualifying Events happens:

1. The parent-covered Employee dies.
2. The parent-covered Employee's hours of employment are reduced.
3. The parent-covered Employee's employment ends for any reason other than his or her gross misconduct.
4. The parent-covered Employee becomes entitled to Medicare benefits (Part A, Part B, or both).
5. The parents become divorced or legally separated.
6. The Child stops being eligible for coverage under the Plan as a Dependent Child.

6.04C Employer Notice of Qualifying Events

When the Qualifying Event is the end of employment (for reasons other than gross misconduct), reduction of hours of employment, death of the covered Employee, commencement of a proceeding in bankruptcy with respect to the Employer, or the covered Employee's becoming entitled to Medicare benefits (under Part A, Part B, or both), the Employer must notify the COBRA Administrator of the Qualifying Event.

6.04D Employee Notice of Qualifying Events

Each covered Employee or Qualified Plan Participant is responsible for providing the COBRA Administrator with any of the following notices, in writing, either by U.S. First Class Mail or hand delivery:

1. Notice of the occurrence of a Qualifying Event that is a divorce or legal separation of a covered Employee (or former Employee) from his or her spouse.
2. Notice of the occurrence of a Qualifying Event that is an individual's ceasing to be eligible as a Dependent Child under the terms of the Plan.
3. Notice of the occurrence of a second Qualifying Event after a Qualified Plan Participant has become entitled to COBRA Continuation Coverage with a maximum duration of 18 (or 29) months.
4. Notice that a Qualified Plan Participant entitled to receive COBRA Continuation Coverage with a maximum duration of 18 months has been determined by the Social Security Administration ("SSA") to be disabled at any time during the first 60 days of COBRA Continuation Coverage.
5. Notice that a Qualified Plan Participant, with respect to whom a notice described above has been provided, has subsequently been determined by the SSA to no longer be disabled.

The COBRA Administrator is:

Insurance Administrator of America, LLC.
COBRA Administrator
1934 Olney Ave, Suite 200
Cherry Hill, NJ 08003
Phone: 856-470-1200
Fax: 800-238-0514
Email: cobra@iaatpa.com

A form of notice is available, free of charge, from the COBRA Administrator and must be used when providing the notice.

6.04E Deadline for providing the notice

For Qualifying Events described above, the notice must be furnished by the date that is 60 days after the latest of:

1. The date on which the relevant Qualifying Event occurs.
2. The date on which the Qualified Plan Participant loses (or would lose) coverage under the Plan as a result of the Qualifying Event.
3. The date on which the Qualified Plan Participant is informed, through the furnishing of the Plan's SPD or the general notice, of both the responsibility to provide the notice and the Plan's procedures for providing such notice to the COBRA Administrator.

For the disability determination described above, the notice must be furnished by the date that is 60 days after the latest of:

1. The date of the disability determination by the SSA (Total Disability).
2. The date on which a Qualifying Event occurs.
3. The date on which the Qualified Plan Participant loses (or would lose) coverage under the Plan as a result of the Qualifying Event.
4. The date on which the Qualified Plan Participant is informed, through the furnishing of the Plan's SPD or the general notice, of both the responsibility to provide the notice and the Plan's procedures for providing such notice to the COBRA Administrator.

In any event, this notice must be furnished before the end of the first 18 months of COBRA Continuation Coverage.

For a change in disability status described above, the notice must be furnished by the date that is 30 days after the later of:

1. The date of the final determination by the SSA that the Qualified Plan Participant is no longer disabled.
2. The date on which the Qualified Plan Participant is informed, through the furnishing of the Plan's SPD or the general notice, of both the responsibility to provide the notice and the Plan's procedures for providing such notice to the COBRA Administrator.

The notice must be postmarked (if mailed), or received by the COBRA Administrator (if hand delivered), by the deadline set forth above. If the notice is late, the opportunity to elect or extend COBRA Continuation Coverage is lost, and if the person is electing COBRA Continuation Coverage, his or her coverage under the Plan will terminate on the last date for which he or she is eligible under the terms of the Plan, or if the person is extending COBRA Continuation Coverage, such Coverage will end on the last day of the initial 18-month COBRA coverage period.

6.04F Who Can Provide the Notice

Any individual who is the covered Employee (or former Employee), a Qualified Plan Participant with respect to the Qualifying Event, or any representative acting on behalf of the covered Employee (or former Employee) or Qualified Plan Participant, may provide the notice, and the provision of notice by one individual shall satisfy any responsibility to provide notice on behalf of all related Qualified Plan Participants with respect to the Qualifying Event.

6.04G Required Contents of the Notice

The notice must contain the following information:

1. Name and address of the covered Employee or former employee.

2. Identification of the initial Qualifying Event and its date of occurrence, if the person is already receiving COBRA Continuation Coverage and wishes to extend the maximum coverage period.
3. A description of the Qualifying Event (for example, divorce, legal separation, cessation of Dependent status, entitlement to Medicare by the covered Employee or former Employee, death of the covered Employee or former Employee, disability of a Qualified Plan Participant or loss of disability status).
4. In the case of a Qualifying Event that is divorce or legal separation, name(s) and address(es) of spouse and Dependent Child or Children covered under the Plan, date of divorce or legal separation, and a copy of the decree of divorce or legal separation.
5. In the case of a Qualifying Event that is Medicare entitlement of the covered Employee or former Employee, date of entitlement, and name(s) and address(es) of spouse and Dependent Child or Children covered under the Plan.
6. In the case of a Qualifying Event that is a Dependent Child's cessation of Dependent status under the Plan, name and address of the Child, reason the Child ceased to be an eligible Dependent (for example, attained limiting age).
7. In the case of a Qualifying Event that is the death of the covered Employee or former Employee, the date of death, and name(s) and address(es) of spouse and Dependent Child or Children covered under the Plan.
8. In the case of a Qualifying Event that is disability of a Qualified Plan Participant, name and address of the disabled Qualified Plan Participant, name(s) and address(es) of other family members covered under the Plan, the date the disability began, the date of the SSA's determination, and a copy of the SSA's determination.
9. In the case of a Qualifying Event that is loss of disability status, name and address of the Qualified Plan Participant who is no longer disabled, name(s) and address(es) of other family members covered under the Plan, the date the disability ended and the date of the SSA's determination.
10. A certification that the information is true and correct, a signature and date.

If a copy of the decree of divorce or legal separation or the SSA's determination cannot be provided by the deadline for providing the notice, complete and provide the notice, as instructed, by the deadline and submit the copy of the decree of divorce or legal separation or the SSA's determination within 30 days after the deadline. The notice will be timely if done so. However, no COBRA Continuation Coverage, or extension of such Coverage, will be available until the copy of the decree of divorce or legal separation or the SSA's determination is provided.

If the notice does not contain all of the required information, the COBRA Administrator may request additional information. If the individual fails to provide such information within the time period specified by the COBRA Administrator in the request, the COBRA Administrator may reject the notice if it does not contain enough information for the COBRA Administrator to identify the plan, the covered Employee (or former Employee), the Qualified Plan Participants, the Qualifying Event or disability, and the date on which the Qualifying Event, if any, occurred.

6.04H Electing COBRA Continuation Coverage

Complete instructions on how to elect COBRA Continuation Coverage will be provided by the COBRA Administrator within 14 days of receiving the notice of the Qualifying Event. The individual then has 60 days in which to elect COBRA Continuation Coverage. The 60 day period is measured from the later of the date coverage terminates or the date of the notice containing the instructions. If COBRA Continuation Coverage is not elected in that 60 day period, then the right to elect it ceases.

Each Qualified Plan Participant 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.

In the event that the COBRA Administrator determines that the individual is not entitled to COBRA Continuation Coverage, the COBRA Administrator will provide to the individual an explanation as to why he or she is not entitled to COBRA Continuation Coverage.

6.04I Waiver Before the End of the Election Period

If, during the election period, a Qualified Beneficiary waives COBRA continuation coverage, the waiver can be revoked at any time before the end of the election period. Revocation of the waiver is an election of COBRA continuation coverage. However, if a waiver is later revoked, coverage need not be provided retroactively (that is, from the date of the loss of coverage until the waiver is revoked). Waivers and revocations of waivers are considered made on the date they are sent to the Plan Administrator or its designee, as applicable.

6.04J Duration of COBRA Continuation Coverage

COBRA Continuation Coverage will be available up to the maximum time period shown below. Generally, multiple Qualifying Events which may be combined under COBRA will not continue coverage for more than 36 months beyond the date of the original Qualifying Event. When the Qualifying Event is "entitlement to Medicare", the 36 month continuation period is measured from the date of the original Qualifying Event. For all other Qualifying Events, the continuation period is measured from the date of the Qualifying Event, not the date of loss of coverage.

When the Qualifying Event is the death of the covered Employee (or former Employee), the covered Employee's (or former Employee's) becoming entitled to Medicare benefits (under Part A, Part B, or both), a divorce or legal separation, or a Dependent Child's losing eligibility as a Dependent Child, COBRA Continuation Coverage lasts for up to a total of 36 months.

When the Qualifying Event is the end of employment or reduction of the covered Employee's hours of employment, and the covered Employee became entitled to Medicare benefits less than 18 months before the Qualifying Event, COBRA Continuation Coverage for Qualified Plan Participants other than the covered Employee lasts until 36 months after the date of Medicare entitlement. For example, if a covered Employee becomes entitled to Medicare eight months before the date on which his or her employment terminates, COBRA Continuation Coverage for his or her spouse and Children can last up to 36 months after the date of Medicare entitlement, which is equal to 28 months after the date of the Qualifying Event (36 months minus 8 months).

Otherwise, when the Qualifying Event is the end of employment (for reasons other than gross misconduct) or reduction of the covered Employee's hours of employment, COBRA Continuation Coverage generally lasts for only up to a total of 18 months. There are two ways in which this 18-month period of COBRA Continuation Coverage can be extended.

6.04K Disability Extension of COBRA Continuation Coverage

If an Employee or anyone in an Employee's family covered under the Plan is determined by the SSA to be disabled and the Employee notifies the COBRA Administrator as set forth above, the Employee and his or her 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 COBRA Continuation Coverage. An extra fee will be charged for this extended COBRA Continuation Coverage.

6.04L Second Qualifying Event Extension of COBRA Continuation Coverage

If an Employee's family experiences another Qualifying Event while receiving 18 months of COBRA Continuation Coverage, the spouse and Dependent Children in the family can get up to 18 additional months of COBRA Continuation Coverage, for a maximum of 36 months, if notice of the second Qualifying Event properly is given to the Plan as set forth above. This extension may be available to the spouse and any Dependent Children receiving COBRA Continuation Coverage if the covered 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.

6.04M Shorter Duration of COBRA Continuation Coverage

COBRA Continuation Coverage also may end before the end of the maximum period on the earliest of the following dates:

1. The date the Employer ceases to provide a group health plan to any Employee.
2. The date on which coverage ceases by reason of the Qualified Plan Participant's failure to make timely payment of any required contributions or premium.
3. The date that the Qualified Plan Participant first becomes, after the date of election, covered under any other group health plan (as an Employee or otherwise), or entitled to either Medicare Part A or Part B (whichever comes first) (except as stated under COBRA's special bankruptcy rules).
4. The first day of the month that begins more than 30 days after the date of the SSA's determination that the Qualified Plan Participant is no longer disabled, but in no event before the end of the maximum coverage period that applied without taking into consideration the disability extension.

6.04N Contribution and/or Premium Requirements

Once COBRA Continuation Coverage is elected, the individual must pay for the cost of the initial period of coverage within 45 days. Payments will then be subsequently due on the first day of each month. COBRA Continuation Coverage will be canceled and will not be reinstated if any payment is made late; however, the Plan Administrator must allow for a 30 day grace period during which a late payment may still be made without the loss of COBRA Continuation Coverage.

6.04O Additional Information

Questions concerning the Plan or COBRA continuation coverage rights should be addressed to the contact or contacts identified below. For more information about a Participant's rights under the Employee Retirement Income Security Act (ERISA), including COBRA, HIPAA, the Affordable Care Act, 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) or visit https://www.dol.gov/agencies/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.

Insurance Administrator of America, LLC.
COBRA Administrator
1934 Olney Ave, Suite 200
Cherry Hill, NJ 08003
Phone: 856-470-1200
Fax: 800-238-0514
Email: cobra@iaatpa.com

6.04P Current Addresses

In order to protect the rights of the Employee's family, the Employee should keep the COBRA Administrator (who is identified above) informed of any changes in the addresses of family members.

ARTICLE VII
GENERAL LIMITATIONS AND EXCLUSIONS

Some health care services are not covered by the Plan. This section applies to all benefits provided under any section of this Plan. This Plan does not cover any charge for care, supplies, treatment, and/or services for the following:

Abortion. For or related to an abortion, except where the life of the mother is endangered by the continued Pregnancy or for medical complications that arise from an abortion, or if the Pregnancy is the result of rape or incest.

Acupuncture Treatments.

Alcohol. Involving a Participant who has taken part in any activity made illegal due to the use of alcohol. It is not necessary that an arrest occur, criminal charges be filed, or, if filed, that a conviction result. Proof beyond a reasonable doubt is not required to be deemed an activity made illegal due to the use of alcohol or a state of intoxication. Expenses will be covered for Injured Participants other than the person partaking in an activity made illegal due to the use of alcohol, and expenses may be covered for Substance Use treatment as specified in this Plan, if applicable. This Exclusion does not apply if the injury (a) resulted from being the victim of an act of domestic violence, or (b) resulted from a medical condition (including both physical and mental health conditions).

Alternative Medicine. For holistic or homeopathic treatment, naturopathic services, and thermography, including drugs.

Biofeedback. That are in connection with biofeedback.

Chelation Therapy. Charges for chelation therapy, except as treatment of heavy metal poisoning.

Completion of Claims Forms or Preparation of Medical Records.

Complications of Non-Covered Services. That are required as a result of complications from a service not covered under the Plan, unless expressly stated otherwise.

Confined Persons. That are Incurred while confined and/or arising from confinement in a prison, jail or other penal institution.

Cosmetic or Plastic Surgery. Except (1) reconstructive Surgery after a covered Surgical Procedure, (2) Surgery required because of an Injury that occurred while you were participating in the Plan, (3) Medically Necessary treatments, or (4) Surgery to correct a congenital or functional anomaly or disfiguring Disease which arises during your coverage under the Plan.

Counseling. Charges for marriage, career, or legal counseling.

Custodial Care. For assistance in the activities of daily living, including but not limited to eating, bathing, dressing or other custodial services or self-care activities, homemaker services and services primarily for rest, domiciliary or convalescent care.

Deductible Applicable. That are not payable due to the application of any specified Deductible provisions contained herein.

Dental Care. For normal dental care benefits, including any dental, gum treatments, or oral surgery, except as otherwise specifically provided herein.

Dental Implants. For dental implants unless services are performed in conjunction with a Medically Necessary Covered Expense.

Diversional Therapy.

Educational, Scholastic, and Vocational Testing and Training. ***NOTE:*** *This Exclusion does not apply to ADD or ADHD or to Diabetic Nutritional counseling.*

Environmental Change. Charges for environmental change, including hospital or physician charges connected with prescribing an environmental change.

Error. That are required to treat injuries that are sustained or an Illness that is contracted, including infections and complications, while the Participant was under, and due to, the care of a Provider wherein such Illness, Injury, infection or complication is not reasonably expected to occur. This Exclusion will apply to expenses directly or indirectly resulting from the circumstances of the course of treatment that, in the opinion of the Plan Administrator, in its sole discretion, unreasonably gave rise to the expense.

Examinations. Any health examination required by any law of a government to secure insurance or school admissions or professional or other licenses, except as required under applicable federal law.

Excess. That are not payable under the Plan due to application of any Plan maximum or limit or because the charges are in excess of the Maximum Allowable Charge based upon the Plan Administrator's determination as set forth by and within the terms of this document.

Exercise Programs. Charges for exercise programs for treatment of any condition, except as specified herein.

Experimental and/or Investigational. That is Experimental/Investigational.

Facility Permitted Leave. Charges for room and board in a facility for days on which the covered person is permitted to leave (a weekend pass, for example).

Foot Care. For treatment of weak, strained, flat, unstable or unbalanced feet, metatarsalgia or bunions (except open cutting operations, please see Podiatry services in the Medical Benefits section), and treatment of corns, calluses or toenails (unless needed in treatment of a metabolic or peripheral-vascular disease).

Foreign Travel. That are received outside of the United States if travel is for the purpose of obtaining medical services.

Government. That are expenses to the extent paid, or which the Participant is entitled to have paid or obtain without cost, in accordance with the laws or regulations of any government. This does not apply to Medicaid or when otherwise prohibited by law.

Government-Operated Facilities. That meet the following requirements:

1. Services furnished to the Participant in any veteran's Hospital, military Hospital, Institution or facility operated by the United States government or by any State government or any agency or instrumentality of such governments.
2. Services or supplies which can be paid for by any government agency, even if the patient waives his rights to those services or supplies.

NOTE: *This Exclusion does not apply to treatment of non-service related disabilities or for Inpatient care provided in a military or other Federal government Hospital to Dependents of active duty armed service*

personnel or armed service retirees and their Dependents. This Exclusion does not apply where otherwise prohibited by law.

Growth Hormones. For growth hormones, unless otherwise approved by the Plan Administrator.

Hair Loss. Charges for wigs, artificial hairpieces, artificial hair transplants, or any drug – prescription or otherwise – used to eliminate baldness or stimulate hairgrowth.

Hearing Aids. Charges for hearing aids, which includes examinations for the prescription, fitting, and/or repair of hearing aids.

Hospital Provider-Employee Services. Charges for professional services billed by a professional provider who is an employee of a hospital or any other facility and who is paid by the hospital or other facility for the service provided.

Hypnosis. Charges for expenses related to hypnosis.

Illegal Acts. That are received as a result of Injury or Sickness caused by or contributing to by engaging in an illegal act or occupation; by committing or attempting to commit any crime, criminal act, assault or other felonious behavior; or by participating in a riot or public disturbance. This Exclusion does not apply if the Injury resulted from being the victim of an act of domestic violence or a medical (including both physical and mental health) condition.

Illegal Drugs or Medications. For a Participant for Injury or Sickness Incurred while the Participant was voluntarily taking or being under the influence of any controlled substance, Drug, hallucinogen or narcotic not administered on the advice of a Physician, even if the cause of the Illness or Injury is not related to the use of the controlled substance, drug, hallucinogen or narcotic. This Exclusion will apply even if the Participant has a prescription for the drug and the drug is legal in the state where the Participant lives. Expenses will be covered for Injured Participants other than the person using controlled substances and expenses will be covered for Substance Use treatment as specified in this Plan. This Exclusion does not apply if the Injury (a) resulted from being the victim of an act of domestic violence, or (b) resulted from a documented medical condition (including both physical and mental health conditions).

Immediate Family Member. That are rendered by a member of the immediate Family Unit or person residing in the same household.

Immunizations. For immunizations and vaccinations for the purpose of travel outside of the United States.

Incurred by Other Persons. For expenses actually Incurred by other persons.

Infertility. Charges for services, supplies, or treatment related to or the treatment of infertility and artificial reproductive procedures, including, but not limited to: artificial insemination, invitro fertilization, surrogate mother (unless the surrogate is a covered person, in which case expenses under subsection Women's Preventative Services and/or Pregnancy Expenses, will be covered in accordance with this Plan's provisions), fertility drugs, embryo implantation, or gamete intrafallopian transfer (GIFT).

Please note: the exclusion does not apply to expenses for infertility testing for employees and their covered spouse. Covered expenses are limited to the actual testing for a diagnosis of infertility.

Inpatient Services for Diagnostic Purpose. Charges for inpatient room and board in connection with a hospital confinement primarily for diagnostic tests, unless it is determined by the plan that inpatient care is medically necessary.

Long Term Care. That are related to long term custodial care.

Marijuana. For marijuana or marijuana-derived substances or compounds (like THC/CBD oil), even if the Participant has a prescription and marijuana is legal under the laws of in the state in which he or she lives.

Massage Therapy.

Megavitamin Therapy.

Military Service. For conditions which are determined by the Veteran's Administration to be connected to active service in the military of the United States, except to the extent prohibited or modified by law.

Missed Appointments. Charges for missed appointments.

Negligence. For Injuries resulting from negligence, misfeasance, malfeasance, nonfeasance or malpractice on the part of any licensed Physician.

No Legal Obligation. That are provided to a Participant for which the Provider of a service customarily makes no direct charge, or for which the Participant is not legally obligated to pay, or for which no charges would be made in the absence of this coverage, including but not limited to fees, care, supplies, or services for which a person, company or any other entity except the Participant or this benefit plan, may be liable for necessitating the fees, care, supplies, or services.

Non-Prescription Drugs. That are for drugs for use outside of a Hospital or other Inpatient facility that can be purchased over-the-counter and without a Physician's written prescription. Drugs for which there is a non-prescription equivalent available. This does not apply to the extent the non-prescription drug must be covered under Preventive Care, subject to the Affordable Care Act and FFCRA, as amended. Please Note: Language regarding the FFCRA will be removed as of May 12, 2023.

Not Acceptable. That are not accepted as standard practice by the American Medical Association (AMA), American Dental Association (ADA), or the Food and Drug Administration (FDA).

Not Actually Rendered. That are not actually rendered.

Not Medically Necessary. For care and treatment that is not Medically Necessary (including Drugs) in the care of Treatment of an Injury or Sickness.

Not Specifically Covered. That are not specifically covered under this Plan.

Obesity. For medical and surgical services, initial and repeat, intended for the treatment or control of obesity including Class III Obesity (BMI is equal to or greater than 40.0 kg/m^2), including: medical and surgical services to alter appearances or physical changes that are the result of any Surgery performed for the management of obesity or Class III Obesity; gastric and intestinal bypass, stapling, bubble and similar procedures; and weight loss programs or treatments (i.e. physical fitness programs, and nutritional or dietary counseling except to the extent covered under the Preventive benefit subject to the provisions of the Affordable Care Act (ACA), whether prescribed or recommended by a Physician or under medical supervision. Elements of this Exclusion do not apply to the extent that coverage is required under the Affordable Care Act (ACA).

Occupational. Any condition for which benefits of any nature are payable or are found to be eligible, either by adjudication or settlement, under any Worker's Compensation law, Employer's liability law, or occupational disease law, even though the covered person fails to claim rights to such benefits or fails to enroll or purchase such coverage. This does not include a covered person that is a sole proprietor, partner, or executive officer that is not required by law to have workers' compensation or similar coverage and does not have such coverage.

Orthoses and Orthotic Devices. Prefabricated foot orthoses; cranial banding and/or cranial orthoses. Other similar devices are excluded.
If the Member is given the device postoperatively for synostotic plagiocephaly, the Plan will cover cranial banding or orthosis and will be subject to any limitations and maximums for Prosthetic Devices.

In addition, the following are excluded: orthosis shoes, shoe additions, procedures for foot orthopedic shoes, shoe modifications and transfers; orthoses primarily used for cosmetic rather than functional reasons; and orthoses primarily for improved athletic performance or sports participation.

Other than Attending Physician. That are other than those certified by a Physician who is attending the Participant as being required for the treatment of Injury or Disease, and performed by an appropriate Provider.

Outpatient Prescription Drugs. Charges for outpatient prescription drugs, except as specifically indicated in Prescription Drug Benefits.

Penalty. Any charge which has been refused by another plan covering the covered person as a penalty assessed due to non-compliance with that plan's rules and regulations, if shown on the primary carrier's explanation of benefits.

Personal Comfort Items and/or Luxury Services and Supplies. For personal comfort items or other equipment, such as, but not limited to air conditioners, air-purification units, humidifiers, electric healing units, orthopedic mattresses, blood pressure instruments, scales, elastic bandages or stockings, non-prescription drugs and medicines, and first-aid supplies and non-hospital adjustable beds and luxury services such as, but not limited to, mineral baths, massages, telephones, radios and televisions.

Personal Injury Insurance. That are in connection with an automobile accident for which benefits payable hereunder are, or would be otherwise covered by, mandatory no-fault automobile insurance or any other similar type of personal injury insurance required by state or federal law, without regard to whether or not the Participant actually had such mandatory coverage. Any claims which arise in connection with an automobile accident for which the policy provides an option for medical coverage are excluded. Benefits will be excluded to the maximum amount of first party medical coverage available under the applicable state law, regardless of a Participant's election of lesser coverage. This Exclusion does not apply if the Injured person is a passenger in a non-family owned vehicle or a pedestrian.

Postage, Shipping, Handling Charges, Etc. For any postage, shipping or handling charges which may occur in the transmittal of information to the Third Party Administrator; including interest or financing charges.

Premarital Lab Work. Charges related to premarital lab work.

Prescription Drugs. Charges for prescription drugs that are covered under the Prescription Drug Benefits or for the Prescription Drug copay applicable thereto. Outpatient prescription drugs are paid under the Prescription Drug Benefits and under no other provision of the Plan.

Primal Therapy.

Prior to Coverage or After Coverage. That are rendered or received prior to or after any period of coverage hereunder, except as specifically provided herein.

Private Duty Nursing. Charges for inpatient private duty nursing.

Professional (and Semi-Professional) Athletics (Injury/Illness). For charges in connection with any Injury or Illness arising out of or in the course of any employment for wage or profit; or related to professional or semi-professional athletics, including practice.

Prohibited by Law. That are to the extent that payment under this Plan is prohibited by law.
Prophylactic Surgery. Charges for prophylactic surgery, except when medically necessary for the prevention of breast or ovarian cancer.

Provider Error. That are required as a result of unreasonable Provider error.

Psychodrama.

Recreational Therapy.

Repair of Purchased Equipment. For maintenance and repairs needed due to misuse or abuse are not covered.

Replacement Braces. For replacement of braces of the leg, arm, back, neck, or artificial arms or legs, unless there is sufficient change in the Participant's physical condition to make the original device no longer functional.

Rolfing.

Sales Tax or Other Tax Imposed by Law.

Sexual Dysfunction. For any services or supplies for the treatment of male or female sexual dysfunction such as, but not limited to, treatment of erectile dysfunction (including penile implants), anorgasmy, and premature ejaculation.

Sex Therapy.

Structural Changes. Charges for structural changes to a house or vehicle.

Subrogation, Reimbursement, and/or Third Party Responsibility. That are of an Injury or Sickness not payable by virtue of the Plan's subrogation, reimbursement, and/or third party responsibility provisions. Benefits will be paid in accordance with the Plan's Coordination of Benefits provisions.

Surgical Sterilization Reversal. For reversal of surgical sterilization.

Timely Filing. Claims not submitted within the plan's filing limit deadlines.

Travel and Transportation Expenses. For travel and transportation expenses, including mileage and lodging expenses, unless specifically provided in the Plan Document or under the Transplant benefit.

Unreasonable. That are not reasonable in nature or in charge (see definition of Maximum Allowable Charge), or are required to treat Illness or Injuries arising from and due to a Provider's error, wherein such Illness, Injury, infection or complication is not reasonably expected to occur. This Exclusion will apply to expenses directly or indirectly resulting from circumstances that, in the opinion of the Plan Administrator in its sole discretion, gave rise to the expense and are not generally foreseeable or expected amongst professionals practicing the same or similar type(s) of medicine as the treating Provider whose error caused the loss(es).

Vision Care. Expenses for the following:

1. For radial keratotomy or other plastic surgeries on the cornea in lieu of eyeglasses.
2. Vision therapy (orthoptics) and supplies.
3. Eyeglasses or contact lenses, except for aphakic patients, and soft lenses or sclera shells intended for use in the treatment of Disease or Injury.

Vitamins and/or Minerals. For diet foods or supplements, and other nutritional supplies unless specifically authorized as a benefit in the Plan or Medically Necessary for certain conditions and to the extent required by the Affordable Care Act (ACA).

War. That are Incurred as a result of war or any act of war, whether declared or undeclared, or any act of aggression including but not limited to a riot or civil disobedience, when the Participant is a member of the armed forces of any country, or during service by a Participant in the armed forces of any country. This Exclusion does not apply to any Participant who is not a member of the armed forces.

Weekend Hospital Admission. Charges for hospital admission on Friday, Saturday, or Sunday unless the admission is due to an emergency medical condition, or surgery is scheduled within twenty-four (24) hours. If neither situation applies, hospital expenses will be payable commencing on the date of actual surgery.

Work-Related, Sports-Related or School-Related Physical Examinations.

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

ARTICLE VIII
PLAN ADMINISTRATION

The Plan is administered by the Plan Administrator. The Plan Administrator has retained the services of the Third Party Administrator to provide certain claims processing and other technical services. The claims processing and other technical services delegated to the Third Party Administrator notwithstanding, the Plan Administrator reserves the unilateral right and power to administer and to interpret, construe and construct the terms and provisions of the Plan, including without limitation, correcting any error or defect, supplying any omission, reconciling any inconsistency and making factual determinations.

8.01 Plan Administrator

The Plan is administered by the Plan Administrator within the purview of ERISA, and in accordance with these provisions. An individual or entity may be appointed by the Plan Sponsor to be Plan Administrator and serve at the convenience of the Plan Sponsor. If the Plan Administrator resigns, dies, is otherwise unable to perform, is dissolved, or is removed from the position, the Plan Sponsor shall appoint a new Plan Administrator as soon as reasonably possible.

The Plan Administrator shall administer this Plan in accordance with its terms and establish its policies, interpretations, practices, and procedures. It is the express intent of this Plan that the Plan Administrator shall have maximum legal discretionary authority to construe and interpret the terms and provisions of the Plan, to make determinations regarding issues which relate to eligibility for benefits (including the determination of what services, supplies, care and treatments are Experimental), to decide disputes which may arise relative to a Participant's rights, and to decide questions of Plan interpretation and those of fact relating to the Plan. The decisions of the Plan Administrator as to the facts related to any claim for benefits and the meaning and intent of any provision of the Plan, or its application to any claim, shall receive the maximum deference provided by law and will be final and binding on all interested parties. Benefits under this Plan will be paid only if the Plan Administrator decides, in its discretion, that the Participant is entitled to them.

If due to errors in drafting, any Plan provision does not accurately reflect its intended meaning, as demonstrated by prior interpretations or other evidence of intent, or as determined by the Plan Administrator in its sole and exclusive judgment, the provision shall be considered ambiguous and shall be interpreted by the Plan Administrator in a fashion consistent with its intent, as determined by the Plan Administrator. The Plan may be amended retroactively to cure any such ambiguity, notwithstanding anything in the Plan to the contrary.

The foregoing provisions of this Plan may not be invoked by any person to require the Plan to be interpreted in a manner which is inconsistent with its interpretations by the Plan Administrator. All actions taken and all determinations by the Plan Administrator shall be final and binding upon all persons claiming any interest under the Plan subject only to the claims appeal procedures of the Plan.

8.02 Duties of the Plan Administrator

The duties of the Plan Administrator include the following:

1. To administer the Plan in accordance with its terms.
2. To determine all questions of eligibility, status and coverage under the Plan.
3. To interpret the Plan, including the authority to construe possible ambiguities, inconsistencies, omissions and disputed terms.
4. To make factual findings.
5. To decide disputes which may arise relative to a Participant's rights and/or availability of benefits.
6. To prescribe procedures for filing a claim for benefits, to review claim denials and appeals relating to them and to uphold or reverse such denials.
7. To keep and maintain the Plan documents and all other records pertaining to the Plan.
8. To appoint and supervise a Third Party Administrator to pay claims.
9. To perform all necessary reporting as required by ERISA.

10. To establish and communicate procedures to determine whether a Medical Child Support Order is a QMCSO.
11. To delegate to any person or entity such powers, duties and responsibilities as it deems appropriate.
12. To perform each and every function necessary for or related to the Plan's administration.

8.03 Discretionary Authority

The Plan is administered by the Plan Administrator (which may be the Plan Sponsor or another entity appointed by the Plan Sponsor for this purpose), in accordance with the provisions of the Employee Retirement Income Security Act of 1974, as amended ("ERISA"). The Plan Administrator (or the PACE insofar as it relates to Final Post-Service Appeals) shall have sole, full and final discretionary authority to interpret all Plan provisions, including the right to remedy possible ambiguities, inconsistencies and/or omissions in the Plan and related documents; to make determinations in regards to issues relating to eligibility for benefits; to decide disputes that may arise relative to a Participant's rights; and to determine all questions of fact and law arising under the Plan.

The Plan Administrator, Plan Sponsor, and/or any other fiduciary appointed by the Plan Sponsor for this purpose, reserves the right to allocate certain discretionary authority as it applies to assessment and final determinative authority on and regarding Final Post-Service Appeal[s], to the "PACE."

The PACE's fiduciary duties extend only to those determinations actually made by the PACE, and with which the Plan Administrator, Plan Sponsor and/or any other fiduciary appointed to act on behalf of the Plan complies. An entity that may perform services as the PACE may perform other tasks on behalf of and in consultation with the Plan Administrator and/or Plan Sponsor, but not as the PACE, and the PACE shall only be deemed to be a fiduciary when making final determinations regarding plan coverage and claims examined via Final Post-Service Appeal. All other matters, including but not limited to other appeals that are "not" Final Post-Service Appeals, and matters the Plan Administrator, Plan Sponsor and/or any other fiduciary appointed to act on behalf of the Plan is prohibited from referring to the PACE in accordance with applicable law and/or pre-existing contract.

The PACE shall at all times strictly abide by and make determination(s) in accordance with the terms of the Plan and applicable law. In instances where the Plan Administrator, Plan Sponsor, and/or any other fiduciary appointed by the Plan Sponsor for this purpose, delegates fiduciary authority to the PACE to make a determination regarding a Final Post-Service Appeal, the PACE shall have discretion to interpret the terms of this Plan, and the PACE possesses all duties and rights otherwise ascribed to the Plan Administrator, Plan Sponsor, and/or any other fiduciary appointed by the Plan Sponsor for this purpose, in this limited scope only. In such instances, the PACE's determinations will be final and binding on all interested parties, and failure to comply with said determination by the Plan Administrator, Plan Sponsor and/or any other fiduciary appointed to act on behalf of the Plan, shall absolve the PACE of any and all fiduciary (and other) liability, responsibility, obligations, and/or duties.

8.04 Duties and Rights of the PACE

When the PACE is assigned by the Plan Administrator, Plan Sponsor and/or any other fiduciary appointed to act on behalf of the Plan, the task of making a determination, regarding a Final Post-Service Appeal, the PACE shall possess the rights and exercise the duties otherwise ascribed to the Plan Administrator, Plan Sponsor, and/or other named fiduciary assigned authority and the duty to otherwise handle appeals, only insofar as it relates to said Final Post-Service Appeals. Assignment is achieved by and when the Plan Administrator, Plan Sponsor and/or any other fiduciary appointed to act on behalf of the Plan advances a request for a Final Post-Service Appeal, received by the Plan or its authorized agent(s), to the PACE with instructions to provide a directive regarding the Final Post-Service Appeal.

8.05 Amending and Terminating the Plan

This Plan was established for the exclusive benefit of the Employees with the intention it will continue indefinitely; however, as the settlor of the Plan, the Plan Sponsor, through its directors and officers, may, in its sole discretion, at any time, amend, suspend or terminate the Plan in whole or in part. This includes

amending the benefits under the Plan or the trust agreement (if any). All amendments to this Plan shall become effective as of a date established by the Plan Sponsor.

Any amendment to the Plan that is not made effective at the beginning of a normal Plan Year by integration into a full Plan Document restatement, including suspension and/or termination, shall follow the amendment procedure outlined in this section. The amendment procedure is accomplished by a separate, written amendment decided upon and/or enacted by resolution of the Plan Sponsor's directors or officers (in compliance with its articles of incorporation or bylaws and if these provisions are deemed applicable), or by the sole proprietor in his or her own discretion if the Plan Sponsor is a sole proprietorship, but always in accordance with applicable Federal and State law, including – where applicable – notification rules provided for and as required by ERISA.

If the Plan is terminated, the rights of the Participants are limited to expenses Incurred before termination. In connection with the termination, the Plan Sponsor may establish a deadline by which all claims must be submitted for consideration. Benefits will be paid only for Covered Expenses Incurred prior to the termination date and submitted in accordance with the rules established by the Plan Sponsor. Upon termination, any Plan assets will be used to pay outstanding claims and all expenses of Plan termination. As it relates to distribution of assets upon termination of the Plan, any contributions paid by Participants will be used for the exclusive purpose of providing benefits and defraying reasonable expenses related to Plan administration, and will not inure to the benefit of the Employer.

8.06 Summary of Material Modification (SMM)

A Summary of Material Modifications reports changes in the information provided within the Summary Plan Description. Examples include a change to Deductibles, eligibility or the addition or deletion of coverage.

The Plan Administrator shall notify all covered Employees of any plan amendment considered a Material Modification by the Plan as soon as administratively feasible after its adoption, but no later than within 210 days after the close of the Plan Year in which the changes became effective. If said Material Modification is affected by amendment as described above, distribution of a copy of said written amendment, within all applicable time limits, shall be deemed sufficient notification to satisfy the Plan's Summary of Material Modifications requirements.

NOTE: *The Affordable Care Act (ACA) requires that if a Plan's Material Modifications are not reflected in the Plan's most recent Summary of Benefits and Coverage (SBC) then the Plan must provide written notice to Participants at least 60 days before the effective date of the Material Modification.*

8.07 Summary of Material Reduction (SMR)

A Summary of Material Reduction (SMR) is a type of SMM. A Material Reduction generally means any modification that would be considered by the average participant to be an important reduction in covered services or benefits. Examples include reductions in benefits or increases in Deductibles or Copayments.

The Plan Administrator shall notify all eligible Employees of any plan amendment considered a Material Reduction in covered services or benefits provided by the Plan as soon as administratively feasible after its adoption, but no later than 60 days after the date of adoption of the reduction. Eligible Employees and beneficiaries must be furnished a summary of such reductions, and any changes so made shall be binding on each Participant. The 60 day period for furnishing a summary of Material Reduction does not apply to any Employee covered by the Plan who would reasonably expect to receive a summary through other means within the next 90 days.

If said Material Reduction is affected by amendment as described above, distribution of a copy of said written amendment, within all applicable time limits, shall be deemed sufficient notification to satisfy the Plan's Summary of Material Reduction requirements.

Material Reduction disclosure provisions are subject to the requirements of ERISA and the Health Insurance Portability and Accountability Act of 1996 (HIPAA) and any related amendments.

8.08 Misuse of Identification Card

If an Employee or covered Dependent permits any person who is not a covered member of the Family Unit to use any identification card issued, the Plan Sponsor may give Employee written notice that his (and his family's) coverage will be terminated in accordance with the Plan's provisions.

ARTICLE IX
CLAIM PROCEDURES; PAYMENT OF CLAIMS

9.01 Introduction
The procedures outlined below must be followed by Participants to obtain payment of health benefits under this Plan.

9.02 Health Claims
All claims and questions regarding health claims should be directed to the Third Party Administrator. The Plan Administrator shall be ultimately and finally responsible for adjudicating such claims and for providing full and fair review of the decision on such claims in accordance with the following provisions and with ERISA. Benefits under the Plan will be paid only if the Plan Administrator decides in its discretion that the Participant is entitled to them. The responsibility to process claims in accordance with the Plan Document may be delegated to the Third Party Administrator; provided, however, that the Third Party Administrator is not a fiduciary of the Plan and does not have the authority to make decisions involving the use of discretion.

Each Participant claiming benefits under the Plan shall be responsible for supplying, at such times and in such manner as the Plan Administrator in its sole discretion may require, written proof that the expenses were Incurred or that the benefit is covered under the Plan. If the Plan Administrator in its sole discretion shall determine that the Participant has not Incurred a Covered Expense or that the benefit is not covered under the Plan, or if the Participant shall fail to furnish such proof as is requested, no benefits shall be payable under the Plan.

A call from a Provider who wants to know if an individual is covered under the Plan, or if a certain procedure is covered by the Plan, prior to providing treatment is not a “claim,” since an actual claim for benefits is not being filed with the Plan. These are simply requests for information, and any response is not a guarantee of benefits, since payment of benefits is subject to all Plan provisions, limitations and Exclusions. Once treatment is rendered, a Clean Claim must be filed with the Plan (which will be a “Post service Claim”). At that time, a determination will be made as to what benefits are payable under the Plan.

A Participant has the right to request a review of an Adverse Benefit Determination. If the claim is denied at the end of the appeal process, as described below, the Plan's final decision is known as a Final Internal Adverse Benefit Determination. If the Participant receives notice of a Final Internal Adverse Benefit Determination, or if the Plan does not follow the claims procedures properly, the Participant then has the right to request an independent external review. The external review procedures are described below.

The claims procedures are intended to provide a full and fair review. This means, among other things, that claims and appeals will be decided in a manner designed to ensure the independence and impartiality of the persons involved in making these decisions.

Benefits will be payable to a Participant, or to a Provider that has accepted an Assignment of Benefits as consideration in full for services rendered.

According to Federal regulations which apply to the Plan, there are four types of claims: Pre-service (Urgent and Non-urgent), Concurrent Care and Post service. However, as noted below, because of this Plan’s design, there are no Pre-service Urgent Care Claims which may be filed with the Plan.

1. Pre-service Claims. A “Pre-service Claim” is a claim for a benefit under the Plan where the Plan conditions receipt of the benefit, in whole or in part, on approval of the benefit in advance of obtaining medical care. However, if the Plan does not require the Participant to obtain approval of a medical service prior to getting treatment, then there is no “Pre-service Claim”. The Participant simply follows the Plan’s procedures with respect to any notice which may be required after receipt of treatment, and files the claim as a Post-service Claim.

A "Pre-service Urgent Care Claim" is any claim for medical care or treatment with respect to which the application of the time periods for making non urgent care determinations could seriously jeopardize the life or health of the Participant or the Participant's ability to regain maximum function, or, in the opinion of a Physician with knowledge of the Participant's medical condition, would subject the Participant to severe pain that cannot be adequately managed without the care or treatment that is the subject of the claim.

If a Participant needs medical care for a condition which could seriously jeopardize his or her life, obtain such care without delay, and communicate with the Plan as soon as reasonably possible.

The Plan does not require the Participant to obtain approval of any urgent care or emergency medical services or admissions prior to getting treatment for an urgent care or emergency situation, so there are no "Pre-service Urgent Care Claims" under the Plan. The Participant simply follows the Plan's procedures with respect to any notice which may be required after receipt of treatment, and files the claim as a Post-service Claim.

Pre-admission certification of a non-emergency Hospital admission is a "claim" only to the extent of the determination made – that the type of procedure or condition warrants Inpatient confinement for a certain number of days. The rules regarding Pre-service Claims will apply to that determination only. Once a Participant has the treatment in question, the claim for benefits relating to that treatment will be treated as a Post-service Claim.

2. Concurrent Claims. A "Concurrent Claim" arises when the Plan has approved an on-going course of treatment to be provided over a period of time or number of treatments, and either:

    a. The Plan determines that the course of treatment should be reduced or terminated.
    b. The Participant requests extension of the course of treatment beyond that which the Plan has approved.

    If the Plan does not require the Participant to obtain approval of a medical service prior to getting treatment, then there is no need to contact the Plan Administrator to request an extension of a course of treatment. The Participant simply follows the Plan's procedures with respect to any notice which may be required after receipt of treatment, and files the claim as a Post-service Claim.

3. Post-service Claims. A "Post-service Claim" is a claim for a benefit under the Plan after the services have been rendered.

9.02A When Claims Must Be Filed

Post-service health claims (which must be Clean Claims) must be filed with the Third Party Administrator within 365 days of the date charges for the service(s) and/or supplies were Incurred. Claims filed later than that date shall be denied. Benefits are based upon the Plan's provisions at the time the charges were Incurred.

A Pre-service claim (including a Concurrent claim that also is a Pre-service claim) is considered to be filed when the request for approval of treatment or services is received by the Third Party Administrator in accordance with the Plan's procedures.

A Post-service Claim is considered to be filed when the following information is received by the Third Party Administrator, together with the industry standard claim form:

1. The date of service.
2. The name, address, telephone number and tax identification number of the Provider of the services or supplies.
3. The place where the services were rendered.
4. The Diagnosis and procedure codes.

5. Any applicable pre-negotiated rate.
6. The name of the Plan.
7. The name of the covered Employee.
8. The name of the patient.

Upon receipt of this information, the claim will be deemed to be initiated with the Plan.

The Third Party Administrator will determine if enough information has been submitted to enable proper consideration of the claim (a Clean Claim). If not, more information may be requested as provided herein. This additional information must be received by the Third Party Administrator within 45 days (48 hours in the case of Pre-service Urgent Care Claims) from receipt by the Participant of the request for additional information. **Failure to do so may result in claims being declined or reduced.**

9.02B Timing of Claim Decisions

The Plan Administrator shall notify the Participant, in accordance with the provisions set forth below, of any Adverse Benefit Determination (and, in the case of Pre-service claims and concurrent claims, of decisions that a claim is payable in full) within the following timeframes:

1. Pre-service Urgent Care Claims:

    a. If the Participant has provided all of the necessary information, as soon as possible, taking into account the medical exigencies, but not later than 72 hours after receipt of the claim.
    b. If the Participant has not provided all of the information needed to process the claim, then the Participant will be notified as to what specific information is needed as soon as possible, but not later than 24 hours after receipt of the claim.
    c. The Participant will be notified of a determination of benefits as soon as possible, but not later than 48 hours, taking into account the medical exigencies, after the earliest of:
        i. The Plan's receipt of the specified information.
        ii. The end of the period afforded the Participant to provide the information.
    d. If there is an Adverse Benefit Determination, a request for an expedited appeal may be submitted orally or in writing by the Participant. All necessary information, including the Plan's benefit determination on review, may be transmitted between the Plan and the Participant by telephone, facsimile, or other similarly expeditious method. Alternatively, the Participant may request an expedited review under the external review process.

2. Pre-service Non-urgent Care Claims:
    a. If the Participant has provided all of the information needed to process the claim, in a reasonable period of time appropriate to the medical circumstances, but not later than 15 days after receipt of the claim, unless an extension has been requested, then prior to the end of the 15 day extension period.
    b. If the Participant has not provided all of the information needed to process the claim, then the Participant will be notified as to what specific information is needed as soon as possible. The Participant will be notified of a determination of benefits in a reasonable period of time appropriate to the medical circumstances, either prior to the end of the extension period (if additional information was requested during the initial processing period), or by the date agreed to by the Plan Administrator and the Participant (if additional information was requested during the extension period).
3. Concurrent Claims:
    a. Plan Notice of Reduction or Termination. If the Plan Administrator is notifying the Participant of a reduction or termination of a course of treatment (other than by Plan amendment or termination), notification will occur before the end of such period of time or number of treatments. The Participant will be notified sufficiently in advance of the reduction or termination to allow the Participant to appeal and obtain a determination on review of that Adverse Benefit Determination before the benefit is reduced or terminated. This rule does not apply if benefits are reduced or eliminated due to plan amendment or

termination. A similar process applies for claims based on a rescission of coverage for fraud or misrepresentation.

b. Request by Participant Involving Urgent Care. If the Plan Administrator receives a request from a Participant to extend the course of treatment beyond the period of time or number of treatments that is a claim involving urgent care, as soon as possible, taking into account the medical exigencies, but not later than 24 hours after receipt of the claim, as long as the Participant makes the request at least 24 hours prior to the expiration of the prescribed period of time or number of treatments. If the Participant submits the request with less than 24 hours prior to the expiration of the prescribed period of time or number of treatments, the request will be treated as a claim involving urgent care and decided within the urgent care timeframe.

c. Request by Participant Involving Non-urgent Care. If the Plan Administrator receives a request from the Participant to extend the course of treatment beyond the period of time or number of treatments that is a claim not involving urgent care, the request will be treated as a new benefit claim and decided within the timeframe appropriate to the type of claim (either as a Pre-service Non-urgent claim or a post-service claim).

d. Request by Participant Involving Rescission. With respect to rescissions, the following timetable applies:

i.	Notification to Participant	30 days
ii.	Notification of Adverse Benefit Determination on appeal	30 days

4. Post-service Claims:
   a. If the Participant has provided all of the information needed to process the claim, in a reasonable period of time, but not later than 30 days after receipt of the claim, unless an extension has been requested, then prior to the end of the 15 day extension period.
   b. If such an extension is necessary due to a failure of the Participant to submit the information necessary to decide the claim, the notice of extension shall specifically describe the required information, and the Participant shall be afforded at least 45 days from receipt of the notice within which to provide the specified information.
   c. If the Participant has not provided all of the information needed to process the claim and additional information is requested during the initial processing period, then the Participant will be notified of a determination of benefits prior to the end of the extension period, unless additional information is requested during the extension period, then the Participant will be notified of the determination by a date agreed to by the Plan Administrator and the Participant.
5. Extensions:
   a. Pre-service Urgent Care Claims. No extensions are available in connection with Pre-service urgent care claims.
   b. Pre-service Non-urgent Care Claims. This period may be extended by the Plan for up to 15 days, provided that the Plan Administrator both determines that such an extension is necessary due to matters beyond the control of the Plan and notifies the Participant, prior to the expiration of the initial 15 day processing period, of the circumstances requiring the extension of time and the date by which the Plan expects to render a decision.
   c. Post-service Claims. This period may be extended by the Plan for up to 15 days, provided that the Plan Administrator both determines that such an extension is necessary due to matters beyond the control of the Plan and notifies the Participant, prior to the expiration of the initial 30 day processing period, of the circumstances requiring the extension of time and the date by which the Plan expects to render a decision.
6. Calculating Time Periods. The period of time within which a benefit determination is required to be made shall begin at the time a claim is deemed to be filed in accordance with the procedures of the Plan.

9.02C Notification of an Adverse Benefit Determination

The Plan Administrator shall provide a Participant with a notice, either in writing or electronically (or, in the case of Pre-service urgent care claims, by telephone, facsimile or similar method, with written or electronic notice following within 3 days), containing the following information:

1. Information sufficient to allow the Participant to identify the claim involved (including date of service, the health care Provider, the claim amount, if applicable, and a statement describing the availability, upon request, of the Diagnosis code and its corresponding meaning, and the treatment code and its corresponding meaning).
2. A reference to the specific portion(s) of the Plan Document upon which a denial is based.
3. Specific reason(s) for a denial, including the denial code and its corresponding meaning, and a description of the Plan's standard, if any, that was used in denying the claim.
4. A description of any additional information necessary for the Participant to perfect the claim and an explanation of why such information is necessary.
5. A description of the Plan's review procedures and the time limits applicable to the procedures, including a statement of the Participant's right to bring a civil action under Section 502(a) of ERISA following an Adverse Benefit Determination on final review.
6. A statement that the Participant is entitled to receive, upon request and free of charge, reasonable access to, and copies of, all documents, records and other information relevant to the Participant's claim for benefits.
7. Upon request, the identity of any medical or vocational experts consulted in connection with a claim, even if the Plan did not rely upon their advice (or a statement that the identity of the expert will be provided, upon request).
8. Any rule, guideline, protocol or similar criterion that was relied upon in making the determination (or a statement that it was relied upon and that a copy will be provided to the Participant, free of charge, upon request).
9. In the case of denials based upon a medical judgment (such as whether the treatment is Medically Necessary or Experimental), either an explanation of the scientific or clinical judgment for the determination, applying the terms of the Plan to the Participant's medical circumstances, or a statement that such explanation will be provided to the Participant, free of charge, upon request.
10. In a claim involving urgent care, a description of the Plan's expedited review process.

9.03 Appeal of Adverse Benefit Determinations

9.03A Full and Fair Review of All Claims

In cases where a claim for benefits is denied, in whole or in part, and the Participant believes the claim has been denied wrongly, the Participant may appeal the denial and review pertinent documents. The claims procedures of this Plan provide a Participant with a reasonable opportunity for a full and fair review of a claim and Adverse Benefit Determination. More specifically, the Plan provides:

1. A 180 day timeframe following receipt of a notification of an initial Adverse Benefit Determination within which to appeal the determination. The Plan will not accept appeals filed after a 180 day timeframe.
2. Participants the opportunity to submit written comments, documents, records, and other information relating to the claim for benefits.
3. Participants the opportunity to review the Claim file and to present evidence and testimony as part of the internal claims and appeals process.
4. For a review that does not afford deference to the previous Adverse Benefit Determination and that is conducted by an appropriate named fiduciary of the Plan, who shall be neither the individual who made the Adverse Benefit Determination that is the subject of the appeal, nor the subordinate of such individual.
5. For a review that takes into account all comments, documents, records, and other information submitted by the Participant relating to the claim, without regard to whether such information was submitted or considered in the prior benefit determination.

6. That, in deciding an appeal of any Adverse Benefit Determination that is based in whole or in part upon a medical judgment, the Plan fiduciary shall consult with a health care professional who has appropriate training and experience in the field of medicine involved in the medical judgment, who is neither an individual who was consulted in connection with the Adverse Benefit Determination that is the subject of the appeal, nor the subordinate of any such individual.
7. Upon request, the identity of medical or vocational experts whose advice was obtained on behalf of the Plan in connection with a claim, even if the Plan did not rely upon their advice.
8. If applicable, a discussion of the basis for disagreeing with the disability determination made by either (a) the Social Security Administration; or (b) an independent medical expert that has conducted a full medical review of the Claimant if presented by the Claimant in support of the claim.
9. That a Participant will be provided, free of charge: (a) reasonable access to, and copies of, all documents, records, and other information relevant to the Participant's claim in possession of the Plan Administrator or Third Party Administrator; (b) information regarding any voluntary appeals procedures offered by the Plan; (c) information regarding the Participant's right to an external review process; (d) any internal rule, guideline, protocol or other similar criterion relied upon, considered or generated in making the adverse determination; and (e) an explanation of the scientific or clinical judgment for the determination, applying the terms of the Plan to the Participant's medical circumstances.
10. That a Participant will be provided, free of charge, and sufficiently in advance of the date that the notice of Final Internal Adverse Benefit Determination is required, with new or additional evidence considered, relied upon, or generated by the Plan in connection with the claim, as well as any new or additional rationale for a denial at the internal appeals stage, and a reasonable opportunity for the Participant to respond to such new evidence or rationale.

9.03B Requirements for First Level Appeal

The Participant must file the appeal in writing (although oral appeals are permitted for Pre-service urgent care claims) within 180 days following receipt of the notice of an Adverse Benefit Determination.

For Pre-service Claims. All Pre-service claims must be sent to the utilization review administrator. Oral appeals should be submitted in writing as soon as possible after it has been initiated. To file any appeal in writing, the Participant's appeal must be addressed as follows:

Insurance Administrator of America, LLC.
P.O. Box 5082
Mt. Laurel, NJ
Phone: 856-470-1200
Fax: 1-800-238-0519
Email/Website: claims@iaatpa.com

For Post-service Claims. To file any appeal in writing, the Participant's appeal must be addressed as follows:

Insurance Administrator of America, LLC.
P.O. Box 5082
Mt. Laurel, NJ
Phone: 856-470-1200
Fax: 1-800-238-0519
Email/Website: claims@iaatpa.com

It shall be the responsibility of the Participant or authorized representative to submit an appeal under the provisions of the Plan. Any appeal must include:

1. The name of the Employee/Participant.
2. The Employee/Participant's social security number.
3. The group name or identification number.

4. All facts and theories supporting the claim for benefits.
5. A statement in clear and concise terms of the reason or reasons for disagreement with the handling of the claim.
6. Any material or information that the Participant has which indicates that the Participant is entitled to benefits under the Plan.

9.03C Timing of Notification of Benefit Determination on Review

The Plan Administrator shall notify the Participant of the Plan's benefit determination on review within the following timeframes:

1. Pre-service Urgent Care Claims: As soon as possible, taking into account the medical exigencies, but not later than 72 hours after receipt of the appeal.
2. Concurrent Claims: The response will be made in the appropriate time period based upon the type of claim: Pre-service Urgent, Pre-service Non-urgent or Post-service.
3. Post-service Claims: Within a reasonable period of time, but not later than 30 days per internal appeal.

Calculating Time Periods. The period of time within which the Plan's determination is required to be made shall begin at the time an appeal is filed in accordance with the procedures of this Plan, without regard to whether all information necessary to make the determination accompanies the filing.

9.03D Manner and Content of Notification of Adverse Benefit Determination on Review

The Plan Administrator shall provide a Participant with notification, with respect to Pre-service urgent care claims, by telephone, facsimile or similar method, and with respect to all other types of claims, in writing or electronically, of a Plan's Adverse Benefit Determination on review, setting forth:

1. Information sufficient to allow the Participant to identify the claim involved (including date of service, the health care Provider, the claim amount, if applicable, and a statement describing the availability, upon request, of the Diagnosis code and its corresponding meaning, and the treatment code and its corresponding meaning).
2. A reference to the specific portion(s) of the plan provisions upon which a denial is based.
3. Specific reason(s) for a denial, including the denial code and its corresponding meaning, and a description of the Plan's standard, if any, that was used in denying the claim, and a discussion of the decision.
4. A description of any additional information necessary for the Participant to perfect the claim and an explanation of why such information is necessary.
5. A description of available internal appeals and external review processes, including information regarding how to initiate an appeal.
6. A description of the Plan's review procedures and the time limits applicable to the procedures. This description will include information on how to initiate the appeal and a statement of the Participant's right to bring a civil action under section 502(a) of ERISA following an Adverse Benefit Determination on final review.
7. Upon request, the identity of any medical or vocational experts consulted in connection with a claim, even if the Plan did not rely upon their advice (or a statement that the identity of the expert will be provided, upon request).
8. Any rule, guideline, protocol or similar criterion that was relied upon, considered, or generated in making the determination will be provided free of charge. If this is not practical, a statement will be included that such a rule, guideline, protocol or similar criterion was relied upon in making the determination and a copy will be provided to the Participant, free of charge, upon request.
9. In the case of denials based upon a medical judgment (such as whether the treatment is Medically Necessary or Experimental), either an explanation of the scientific or clinical judgment for the determination, applying the terms of the Plan to the Participant's medical circumstances, will be provided. If this is not practical, a statement will be included that such explanation will be provided to the Participant, free of charge, upon request.

10. Information about the availability of, and contact information for, an applicable office of health insurance consumer assistance or ombudsman established under applicable federal law to assist Participants with the internal claims and appeals and external review processes.
11. The following statement: “You and your Plan may have other voluntary alternative dispute resolution options, such as mediation. One way to find out what may be available is to contact your local U.S. Department of Labor Office and your State insurance regulatory agency”.

9.03E Furnishing Documents in the Event of an Adverse Determination
In the case of an Adverse Benefit Determination on review, the Plan Administrator shall provide such access to, and copies of, documents, records, and other information described in the section relating to “Manner and Content of Notification of Adverse Benefit Determination on Review” as appropriate.

9.03F Decision on Review
The decision by the Plan Administrator or other appropriate named fiduciary of the Plan on review will be final, binding and conclusive and will be afforded the maximum deference permitted by law. All claim review procedures provided for in the Plan must be exhausted before any legal action is brought.

9.03G Requirements for Second Level Appeal
The Participant must file an appeal regarding a Pre-service or Post-service claim and applicable Adverse Benefit Determination in writing within 60 days following receipt of the notice of the first level Adverse Benefit Determination.

9.03H Two Levels of Appeal
This Plan requires two levels of appeal (Pre-service or Post-service) by a Claimant before the Plan’s internal appeals are exhausted. For each level of appeal, the Claimant and the Plan are subject to the same procedures, rights, and responsibilities as stated within this Plan. Each level of appeal is subject to the above-outlined submission and response guidelines.

Once a Claimant receives an Adverse Benefit Determination in response to an initial claim for benefits, the Claimant may appeal that Adverse Benefit Determination, which will constitute the initial appeal. If the Claimant receives an Adverse Benefit Determination in response to that initial appeal, the Claimant may appeal that Adverse Benefit Determination as well, which will constitute the final internal appeal. If the Claimant receives an Adverse Benefit Determination in response to the Claimant’s second appeal, such Adverse Benefit Determination will constitute the Final Internal Adverse Benefit Determination, and the Plan’s internal appeals procedures will have been exhausted.

9.03I Final Internal Adverse Benefit Determination
Upon receipt, review, adjudication and conclusion of a Final Post-Service Appeal, if it is determined by the Plan fiduciary – either the Plan Administrator, Plan Sponsor, and/or other named fiduciary assigned authority and the duty to otherwise handle appeals, or the PACE – that benefits and/or coverage is not available from the Plan as it relates to claims for benefits submitted to the Plan; when such a final adverse benefit determination is made, by either the Plan Administrator, Plan Sponsor, and/or other named fiduciary assigned authority and the duty to otherwise handle appeals, or the PACE, the determination will be final and binding on all interested parties.

9.03J External Review Process
The Federal external review process does not apply to a denial, reduction, termination, or a failure to provide payment for a benefit based on a determination that a participant or beneficiary fails to meet the requirements for eligibility under the terms of a group health plan.

The Federal external review process does not apply to a denial, reduction, termination, or a failure to provide payment for a benefit based on a determination that a Claimant or beneficiary fails to meet the requirements for eligibility under the terms of a group health plan.

The Federal external review process, in accordance with the current Affordable Care Act regulations and other applicable law, applies only to:

1. Any eligible Adverse Benefit Determination (including a Final Internal Adverse Benefit Determination) by a plan or issuer that involves medical judgment (including, but not limited to, those based on the plan's or issuer's requirements for Medical Necessity, appropriateness, health care setting, level of care, or effectiveness of a covered benefit; its determination that a treatment is Experimental or Investigational; its determination whether a Claimant or beneficiary is entitled to a reasonable alternative standard for a reward under a wellness program; its determination whether a plan or issuer is complying with the nonquantitative treatment limitation provisions of Code section 9812 and § 54.9812-1, which generally require, among other things, parity in the application of medical management techniques), as determined by the external reviewer.
2. An Adverse Benefit Determination that involves consideration of whether the Plan is complying with the surprise billing and cost-sharing protections set forth in the No Surprises Act.
3. A rescission of coverage (whether or not the rescission has any effect on any particular benefit at that time).

Standard external review

Standard external review is an external review that is not considered expedited (as described in the "expedited external review" paragraph in this section).

1. Request for external review. The Plan will allow a claimant to file a request for an external review with the Plan if the request is filed within four months after the date of receipt of a notice of a Final Internal Adverse Benefit Determination. If there is no corresponding date four months after the date of receipt of such a notice, then the request must be filed by the first day of the fifth month following the receipt of the notice. For example, if the date of receipt of the notice is October 30, because there is no February 30, the request must be filed by March 1. 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.

2. Preliminary review. Within five business days following the date of receipt of the external review request, the Plan will 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 item or service was requested or, in the case of a retrospective review, was covered under the Plan at the time the health care item or service was provided.
    b. The Adverse Benefit Determination or the Final Internal Adverse Benefit Determination does not relate to the claimant's failure to meet the requirements for eligibility under the terms of the Plan (e.g., worker classification or similar determination).
    c. The claimant has exhausted the Plan's internal appeal process (unless the claimant is not required to exhaust the internal appeals process under the final regulations) and rendered the appeal available for standard external review.
    d. The claimant has provided all the information and forms required to process an external review. Within one business day after completion of the preliminary review, the Plan will issue a notification in writing to the claimant. If the request is complete but not eligible for external review, such notification will include the reasons for its ineligibility and contact information for the Employee Benefits Security Administration (toll-free number 866-444-EBSA (3272)). If the request is not complete, such notification will describe the information or materials needed to make the request complete and the Plan will allow a claimant to perfect the request for external review within the four-month filing period or within the 48 hour period following the receipt of the notification, whichever is later.

3. Referral to Independent Review Organization. The Plan will assign an independent review organization (IRO) that is accredited by URAC or by a similar nationally-recognized accrediting

organization to conduct the external review. Moreover, the Plan will take action against bias and to ensure independence. Accordingly, the Plan will contract with (or direct the Claims Processor to contract with, on its behalf) at least 3 IROs for assignments under the Plan and rotate claims assignments among them (or incorporate other independent unbiased methods for selection of IROs, such as random selection). In addition, the IRO may not be eligible for any financial incentives based on the likelihood that the IRO will support the denial of benefits.

4. Reversal of Plan's decision. Upon receipt of a notice of a final external review decision reversing the Adverse Benefit Determination or Final Internal Adverse Benefit Determination, the Plan will provide coverage or payment for the claim without delay, regardless of whether the plan intends to seek judicial review of the external review decision and unless or until there is a judicial decision otherwise.

Expedited external review

1. Request for expedited external review. The Plan will allow a claimant to make a request for an expedited external review with the Plan at the time the claimant receives:

    a. An Adverse Benefit Determination if the Adverse Benefit Determination involves a medical condition of the claimant for which the timeframe for completion of a standard internal appeal under the final regulations would seriously jeopardize the life or health of the claimant or would jeopardize the claimant's ability to regain maximum function and the claimant has filed a request for an expedited internal appeal.
    b. A Final Internal Adverse Benefit Determination, if the claimant has a medical condition where the timeframe for completion of a standard external review would seriously jeopardize the life or health of the claimant or would jeopardize the claimant's ability to regain maximum function, or if the Final Internal Adverse Benefit Determination concerns an admission, availability of care, continued stay, or health care item or service for which the claimant received Emergency Services, but has not been discharged from a facility.

2. Preliminary review. Immediately upon receipt of the request for expedited external review, the Plan will determine whether the request meets the reviewability requirements set forth above for standard external review. The Plan will immediately send a notice that meets the requirements set forth above for standard external review to the claimant of its eligibility determination.

3. Referral to Independent Review Organization. Upon a determination that a request is eligible for external review following the preliminary review, the Plan will assign an IRO pursuant to the requirements set forth above for standard review. The Plan will provide or transmit all necessary documents and information considered in making the Adverse Benefit Determination or Final Internal Adverse Benefit Determination to the assigned IRO electronically or by telephone or facsimile or any other available expeditious method. The assigned IRO, to the extent the information or documents are available and the IRO considers them appropriate, will consider the information or documents described above under the procedures for standard review. In reaching a decision, the assigned IRO will review the claim de novo and is not bound by any decisions or conclusions reached during the Plan's internal claims and appeals process.

4. Notice of final external review decision. The Plan's (or Claim Processor's) contract with the assigned IRO will require the IRO to provide notice of the final external review decision, in accordance with the requirements set forth above, as expeditiously as the claimant's medical condition or circumstances require, but in no event more than 72 hours after the IRO receives the request for an expedited external review. If the notice is not in writing, within 48 hours after the date of providing that notice, the assigned IRO will provide written confirmation of the decision to the claimant and the Plan.

9.04 Appointment of Authorized Representative

A Participant is permitted to appoint an authorized representative to act on his or her behalf with respect to a benefit claim or appeal of a denial. An assignment of benefits by a Participant to a Provider will not constitute appointment of that Provider as an authorized representative. To appoint such a representative, the Participant must complete a form which can be obtained from the Plan Administrator or the Third Party Administrator. However, in connection with a claim involving Urgent Care, the Plan will permit a health care professional with knowledge of the Participant's medical condition to act as the Participant's authorized representative without completion of this form. In the event a Participant designates an authorized representative, all future communications from the Plan will be with the representative, rather than the Participant, unless the Participant directs the Plan Administrator, in writing, to the contrary.

9.05 Autopsy

The Plan reserves the right to have an autopsy performed upon any deceased Participant whose condition, Sickness, or Injury is the basis of a claim. This right may be exercised only where not prohibited by law.

9.06 Payment of Benefits

All benefits under this Plan are payable, in U.S. Dollars, to the covered Employee whose Sickness or Injury, or whose covered Dependent's Sickness or Injury, is the basis of a claim. In the event of the death or incapacity of a covered Employee and in the absence of written evidence to this Plan of the qualification of a guardian for his or her estate, this Plan may, in its sole discretion, make any and all such payments to the individual or Institution which, in the opinion of this Plan, is or was providing the care and support of such Employee.

9.06A Assignments

For this purpose, the term "Assignment of Benefits" (or "AOB") is defined as an arrangement whereby a Participant of the Plan, at the discretion of the Plan Administrator, assigns its right to seek and receive payment of eligible Plan benefits, less Deductible, Copayments and Coinsurance amounts, to a medical Provider. If a Provider accepts said arrangement, the Provider's rights to receive Plan benefits are equal to those of the Participant, and are limited by the terms of this Plan Document. A Provider that accepts this arrangement indicates acceptance of an AOB and Deductibles, Copayments, and Coinsurance amounts, as consideration in full for treatment rendered.

The Plan Administrator may revoke an AOB at its discretion and treat the Participant of the Plan as the sole beneficiary. Benefits for medical expenses covered under this Plan may be assigned by a Participant to the Provider as consideration in full for services rendered; however, if those benefits are paid directly to the Participant, the Plan will be deemed to have fulfilled its obligations with respect to such benefits. The Plan will not be responsible for determining whether any such assignment is valid. Payment of benefits which have been assigned may be made directly to the assignee unless a written request not to honor the assignment, signed by the Participant, has been received before the proof of loss is submitted, or the Plan Administrator – at its discretion – revokes the assignment.

No Participant shall at any time, either during the time in which he or she is a Participant in the Plan, or following his or her termination as a Participant, in any manner, have any right to assign his or her right to sue to recover benefits under the Plan, to enforce rights due under the Plan or to any other causes of action which he or she may have against the Plan or its fiduciaries. A medical Provider which accepts an AOB does as consideration in full for services rendered and is bound by the rules and provisions set forth within the terms of this document.

9.06B Non U.S. Providers

Medical expenses for care, supplies, or services which are rendered by a Provider whose principal place of business or address for payment is located outside the United States (a "Non U.S. Provider") are payable under the Plan, subject to all Plan Exclusions, limitations, maximums and other provisions, under the following conditions:

1. Benefits may not be assigned to a Non U.S. Provider.

2. The Participant is responsible for making all payments to Non U.S. Providers, and submitting receipts to the Plan for reimbursement.
3. Benefit payments will be determined by the Plan based upon the exchange rate in effect on the Incurred Date.
4. The Non U.S. Provider shall be subject to, and in compliance with, all U.S. and other applicable licensing requirements.
5. Claims for benefits must be submitted to the Plan in English.

9.06C Recovery of Payments

Occasionally, benefits are paid more than once, are paid based upon improper billing or a misstatement in a proof of loss or enrollment information, are not paid according to the Plan's terms, conditions, limitations or Exclusions, or should otherwise not have been paid by the Plan. As such, this Plan may pay benefits that are later found to be greater than the Maximum Allowable Charge. In this case, this Plan may recover the amount of the overpayment from the source to which it was paid, primary payers, or from the party on whose behalf the charge(s) were paid. As such, whenever the Plan pays benefits exceeding the amount of benefits payable under the terms of the Plan, the Plan Administrator has the right to recover any such erroneous payment directly from the person or entity who received such payment and/or from other payers and/or the Participant or Dependent on whose behalf such payment was made.

A Participant, Dependent, Provider, another benefit plan, insurer, or any other person or entity who receives a payment exceeding the amount of benefits payable under the terms of the Plan or on whose behalf such payment was made, shall return or refund the amount of such erroneous payment to the Plan within 30 days of discovery or demand. The Plan Administrator shall have no obligation to secure payment for the expense for which the erroneous payment was made or to which it was applied.

The person or entity receiving an erroneous payment may not apply such payment to another expense. The Plan Administrator shall have the sole discretion to choose who will repay the Plan for an erroneous payment and whether such payment shall be reimbursed in a lump sum. When a Participant or other entity does not comply with the provisions of this section, the Plan Administrator shall have the authority, in its sole discretion, to deny payment of any claims for benefits by the Participant and to deny or reduce future benefits payable (including payment of future benefits for other Injuries or Illnesses) under the Plan by the amount due as reimbursement to the Plan. The Plan Administrator may also, in its sole discretion, deny or reduce future benefits (including future benefits for other Injuries or Illnesses) under any other group benefits plan maintained by the Plan Sponsor. The reductions will equal the amount of the required reimbursement.

Providers and any other person or entity accepting payment from the Plan or to whom a right to benefits has been assigned, in consideration of services rendered, payments and/or rights, agrees to be bound by the terms of this Plan and agree to submit claims for reimbursement in strict accordance with their State's health care practice acts, ICD or CPT standards, Medicare guidelines, HCPCS standards, or other standards approved by the Plan Administrator or insurer. Any payments made on claims for reimbursement not in accordance with the above provisions shall be repaid to the Plan within 30 days of discovery or demand or incur prejudgment interest of 1.5% per month. If the Plan must bring an action against a Participant, Provider or other person or entity to enforce the provisions of this section, then that Participant, Provider or other person or entity agrees to pay the Plan's attorneys' fees and costs, regardless of the action's outcome.

Further, Participants and/or their Dependents, beneficiaries, estate, heirs, guardian, personal representative, or assigns (Participants) shall assign or be deemed to have assigned to the Plan their right to recover said payments made by the Plan, from any other party and/or recovery for which the Participant(s) are entitled, for or in relation to facility-acquired condition(s), Provider error(s), or damages arising from another party's act or omission for which the Plan has not already been refunded.

The Plan reserves the right to deduct from any benefits properly payable under this Plan the amount of any payment which has been made for any of the following circumstances:

1. In error.
2. Pursuant to a misstatement contained in a proof of loss or a fraudulent act.
3. Pursuant to a misstatement made to obtain coverage under this Plan within two years after the date such coverage commences.
4. With respect to an ineligible person.
5. In anticipation of obtaining a recovery if a Participant fails to comply with the Plan's Third Party Recovery, Subrogation and Reimbursement provisions.
6. Pursuant to a claim for which benefits are recoverable under any policy or act of law providing for coverage for occupational injury or disease to the extent that such benefits are recovered. This provision (6) shall not be deemed to require the Plan to pay benefits under this Plan in any such instance.

The deduction may be made against any claim for benefits under this Plan by a Participant or by any of his covered Dependents if such payment is made with respect to the Participant or any person covered or asserting coverage as a Dependent of the Participant.

If the Plan seeks to recoup funds from a Provider, due to a claim being made in error, a claim being fraudulent on the part of the Provider, and/or the claim that is the result of the Provider's misstatement, said Provider shall, as part of its assignment to benefits from the Plan, abstain from billing the Participant for any outstanding amount(s).

9.06D Medicaid Coverage

A Participant's eligibility for any State Medicaid benefits will not be taken into account in determining or making any payments for benefits to or on behalf of such Participant. Any such benefit payments will be subject to the State's right to reimbursement for benefits it has paid on behalf of the Participant, as required by the State Medicaid program; and the Plan will honor any Subrogation rights the State may have with respect to benefits which are payable under the Plan.

9.06E Limitation of Action

A Participant cannot bring any legal action against the Plan for a claim of benefits until 180 days after all appeal processes have been exhausted. After 180 days, if the Participant wants to bring a legal action against the Plan, he or she must do so within one year of the date he or she is notified of the final decision on the final appeal or he or she will lose any rights to bring such an action against the Plan.

ARTICLE X
COORDINATION OF BENEFITS

Coordination of the Benefit Plans
Coordination of benefits sets out rules for the order of payment of Covered Expenses when two or more plans, including Medicare, are paying. When a Participant is covered by this Plan and another plan, the plans will coordinate benefits when a claim is received.

Standard Coordination of Benefits
The plan that pays first according to the rules will pay as if there were no other plan involved. The secondary and subsequent plans will pay the balance due up to 100% of the total allowable charges.

10.01 Benefits Subject to This Provision
This provision shall apply to all benefits provided under any section of this Plan.

10.02 Excess Insurance
If at the time of Injury, Illness or disability there is available, or potentially available any coverage (including but not limited to coverage resulting from a judgment at law or settlements), the benefits under this Plan shall apply only as an excess over such other sources of coverage.

The Plan's benefits shall be excess to any of the following:

1. The responsible party, its insurer, or any other source on behalf of that party.
2. Any first party insurance through medical payment coverage, personal injury protection, no-fault coverage, uninsured or underinsured motorist coverage.
3. Any policy of insurance from any insurance company or guarantor of a third party, including but not limited to an employer's policy.
4. Workers' compensation or other liability insurance company.
5. Any other source of coverage, including, but not limited to, the following:

    - Crime victim restitution funds
    - Civil restitution funds
    - No-fault restitution funds such as vaccine injury compensation funds
    - Any medical, applicable disability or other benefit payments
    - School insurance coverage

10.03 Vehicle Limitation
When medical payments are available under any vehicle insurance, the Plan shall pay excess benefits only, without reimbursement for vehicle plan and/or policy deductibles. This Plan shall always be considered secondary to such plans and/or policies. This applies to all forms of medical payments under vehicle plans and/or policies regardless of their names, titles or classification.

10.04 Effect on Benefits

10.04A Application to Benefit Determinations
The plan that pays first according to the rules in the section entitled "Order of Benefit Determination" will pay as if there were no Other Plan involved. The secondary and subsequent plans will pay the balance due up to 100% of the total Covered Expenses. When there is a conflict in the rules, this Plan will never pay more than 50% of Covered Expenses when paying secondary. Benefits will be coordinated on the basis of a Claim Determination Period.

When medical payments are available under automobile insurance, this Plan will pay excess benefits only, without reimbursement for automobile plan Deductibles. This Plan will always be considered secondary

regardless of the individual's election under personal injury protection (PIP) coverage with the automobile insurance carrier regarding priority of payment.

When some "Other Plan" provides benefits in the form of services (rather than cash payments), the Plan Administrator shall assess the value of said benefit(s) and determine the reasonable cash value of the service or services rendered, by determining the amount that would be payable in accordance with the terms of the Plan.

In certain instances, the benefits of the Other Plan will be ignored for the purposes of determining the benefits under this Plan. This is the case when all of the following occur:

1. The Other Plan would, according to its rules, determine its benefits after the benefits of this Plan have been determined.
2. The rules in the section entitled "Order of Benefit Determination" would require this Plan to determine its benefits before the Other Plan.

10.04B Order of Benefit Determination

For the purposes of the section entitled "Application to Benefit Determinations", the rules establishing the order of benefit determination are:

1. A plan without a coordinating provision will always be the primary plan.
2. The benefits of a plan which covers the person on whose expenses a claim is based other than as a Dependent shall be determined before the benefits of a plan which covers such person as a Dependent.
3. If the person for whom claim is made is a dependent child covered under both parents' plans, the plan covering the parent whose birthday (month and day of birth, not year) falls earlier in the year will be primary, except:

    a. When the parents were never married, are separated, or are divorced, the benefits of a plan which covers the child as a Dependent of the parent with custody will be determined before the benefits of a plan which covers the child as a Dependent of the parent without custody.
    b. When the parents are divorced and the parent with custody of the child has remarried, the benefits of a plan which covers the child as a Dependent of the parent with custody shall be determined before the benefits of a plan which covers that child as a Dependent of the stepparent, and the benefits of a plan which covers that child as a Dependent of the stepparent will be determined before the benefits of a plan which covers that child as a Dependent of the parent without custody.

    Notwithstanding the above, if there is a court decree which would otherwise establish financial responsibility for the child's health care expenses, the benefits of the plan which covers the child as a Dependent of the parent with such financial responsibility shall be determined before the benefits of any Other Plan which covers the child as a Dependent child.

4. When the rules above do not establish an order of benefit determination, the benefits of a plan which has covered the person on whose expenses a claim is based for the longer period of time shall be determined before the benefits of a plan which has covered such person for the shorter period of time.
5. To the extent required by Federal and State regulations, this Plan will pay before any Medicare, Tricare, Medicaid, State child health benefits or other applicable State health benefits program.

10.05 Right to Receive and Release Necessary Information

For the purpose of determining the applicability of and implementing the terms of this provision or any provision of similar purpose of any Other Plan, this Plan may, without the consent of or notice to any person, release to or obtain from any insurance company, or other organization or individual, any information with respect to any person, which the Plan deems to be necessary for such purposes. Any person claiming benefits under this Plan shall furnish to the Plan such information as may be necessary to implement this provision.

10.06 Facility of Payment

Whenever payments which should have been made under this Plan in accordance with this provision have been made under any Other Plans, the Plan Administrator may, in its sole discretion, pay any organizations making such other payments any amounts it shall determine to be warranted in order to satisfy the intent of this provision, and amounts so paid shall be deemed to be benefits paid under this Plan and, to the extent of such payments, this Plan shall be fully discharged from liability.

10.07 Right of Recovery

In accordance with the Recovery of Payments provision, whenever payments have been made by this Plan with respect to Covered Expenses in a total amount, at any time, in excess of the maximum amount of payment necessary at that time to satisfy the intent of this Article, the Plan shall have the right to recover such payments, to the extent of such excess, from any one or more of the following as this Plan shall determine: any person to or with respect to whom such payments were made, or such person's legal representative, any insurance companies, or any other individuals or organizations which the Plan determines are responsible for payment of such Covered Expenses, and any future benefits payable to the Participant or his or her Dependents. Please see the Recovery of Payments Sections above for more details.

ARTICLE XI
MEDICARE

11.01 Applicable to Active Employees and Their Spouses Ages 65 and Over
An Active Employee and his or her spouse (ages 65 and over) may, at the option of such Employee, elect or reject coverage under this Plan. If such Employee elects coverage under this Plan, the benefits of this Plan shall be determined before any benefits provided by Medicare. If coverage under this Plan is rejected by such Employee, benefits listed herein will not be payable even as secondary coverage to Medicare.

11.02 Applicable to All Other Participants Eligible for Medicare Benefits
To the extent required by Federal regulations, this Plan will pay before any Medicare benefits. There are some circumstances under which Medicare would be required to pay its benefits first. In these cases, benefits under this Plan would be calculated as secondary payor (as described under the Article entitled "Coordination of Benefits"). The Participant will be assumed to have full Medicare coverage (that is, both Part A & B) whether or not the Participant has enrolled for the full coverage. If the Provider accepts assignment with Medicare, covered expenses will not exceed the Medicare approved expenses.

11.03 Applicable to Medicare Services Furnished to End Stage Renal Disease ("ESRD") Participants Who Are Covered Under This Plan
If any Participant is enrolled in Medicare coverage because of ESRD, the benefits of the Plan will be determined before Medicare benefits for the first 30 months of the Participant's Medicare entitlement, regardless of the date of enrollment, unless applicable Federal law provides to the contrary, in which event the benefits of the Plan will be determined in accordance with such law.

**__NOTE:__ If an active Employee or Dependent obtains Medicare Part B upon qualifying for Medicare coverage, they should contact the Insurance Administrator of America, LLC. for additional details regarding potential premium reimbursement.*

ARTICLE XII
THIRD PARTY RECOVERY, SUBROGATION AND REIMBURSEMENT

12.01 Payment Condition

The Plan, in its sole discretion, may elect to conditionally advance payment of benefits in those situations where an Injury, Illness or disability is caused in whole or in part by, or results from the acts or omissions of Participants, and/or their Dependents, beneficiaries, estate, heirs, guardian, personal representative, or assigns (collectively referred to hereinafter in this section as "Participant(s)") 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 crime victim restitution funds, civil restitution funds, no-fault restitution funds (including vaccine injury compensation funds), uninsured motorist, underinsured motorist, medical payment provisions, third party assets, third party insurance, and/or guarantor(s) of a third party, any medical, applicable disability, or other benefit payments, and school insurance coverage (collectively "Coverage").

Participant(s), his or her attorney, and/or legal guardian of a 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 100% of the Plan's conditional payment of benefits or 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. The Plan shall have an equitable lien on any funds received by the Participant(s) and/or their 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 Participant(s) agrees to include the Plan's name as a co-payee on any and all settlement drafts. Further, by accepting benefits the Participant(s) 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 Participant shall be a trustee over those Plan assets.

In the event a Participant(s) settles, recovers, or is reimbursed by any Coverage, the Participant(s) agrees to reimburse the Plan for all benefits paid or that will be paid by the Plan on behalf of the Participant(s). When such a recovery does not include payment for future treatment, the Plan's right to reimbursement extends to all benefits paid or that will be paid by the Plan on behalf of the Participant(s) for charges Incurred up to the date such Coverage or third party is fully released from liability, including any such charges not yet submitted to the Plan. If the Participant(s) fails to reimburse the Plan out of any judgment or settlement received, the Participant(s) will be responsible for any and all expenses (fees and costs) associated with the Plan's attempt to recover such money. Nothing herein shall be construed as prohibiting the Plan from claiming reimbursement for charges Incurred after the date of settlement if such recovery provides for consideration of future medical expenses.

If there is more than one party responsible for charges paid by the Plan, or 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 Participant(s) is/are only one or a few, that unallocated settlement fund is considered designated as an "identifiable" fund from which the plan may seek reimbursement.

12.02 Subrogation

As a condition to participating in and receiving benefits under this Plan, the Participant(s) 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 Participant(s) is entitled, regardless of how classified or characterized, at the Plan's discretion, if the Participant(s) fails to so pursue said rights and/or action.

If a Participant(s) receives or becomes entitled to receive benefits, an automatic equitable lien attaches in favor of the Plan to any claim, which any Participant(s) may have against any Coverage and/or party causing the Illness or Injury to the extent of such conditional payment by the Plan plus reasonable costs of collection. The 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 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.

The Plan may, at its discretion, in its own name or in the name of the Participant(s) 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 Participant(s) fails to file a claim or pursue damages against:

1. The responsible party, its insurer, or any other source on behalf of that party.
2. Any first party insurance through medical payment coverage, personal injury protection, no-fault coverage, uninsured or underinsured motorist coverage, including any similar coverage under a different name in a particular state.
3. Any policy of insurance from any insurance company or guarantor of a third party, including but not limited to an employer's policy.
4. Workers' compensation or other liability insurance company.
5. Any other source of Coverage, including, but not limited to, the following:

    - Crime victim restitution funds
    - Civil restitution funds
    - No-fault restitution funds such as vaccine injury compensation funds
    - Any medical, applicable disability or other benefit payments
    - School insurance coverage

the Participant(s) authorizes the Plan to pursue, sue, compromise and/or settle any such claims in the Participant's/Participants' and/or the Plan's name and agrees to fully cooperate with the Plan in the prosecution of any such claims. The Participant(s) 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.

12.03 Right of Reimbursement

The Plan shall be entitled to recover 100% of the benefits paid or payable benefits Incurred, that have been paid and/or will be paid by the Plan, or were otherwise Incurred by the Participant(s) prior to and until the release from liability of the liable entity, as applicable, without deduction for attorneys' fees and costs or application of the common fund doctrine, made whole doctrine, or any other similar legal or equitable theory, and without regard to whether the Participant(s) is fully compensated by his or her 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 and extends until the date upon which the liable party is released from liability. If the Participant's/Participants' 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 Participant are deemed held in constructive trust and should not be dissipated or disbursed until such time as the Participant's obligation to reimburse the Plan has been satisfied in accordance with these provisions. The 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. Additionally, the Participant shall indemnify the Plan against any of the Participant's attorney's fees, costs, or other expenses related to the Participant's recovery for which the Plan becomes responsible by any means other than the Plan's explicit written consent.

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 Participant(s), 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 Participant(s).

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.

12.04 Participant is a Trustee Over Plan Assets

Any 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 Participant understands that he or she is required to:

1. 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.
2. Instruct his or her attorney to ensure that the Plan and/or its authorized representative is included as a payee on all settlement drafts.
3. In circumstances where the Participant is not represented by an attorney, instruct the insurance company or any third party from whom the 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.
4. 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 Participant disputes this obligation to the Plan under this section, the Participant or any of its 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 attorneys' fees, for which he or she exercises control, in an account segregated from their general accounts or general assets until such time as the dispute is resolved.

No 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.

12.05 Release of Liability

The Plan's right to reimbursement extends to any incident related care that is received by the Participant(s) (Incurred) prior to the liable party being released from liability. The Participant's/Participants' obligation to reimburse the Plan is therefore tethered to the date upon which the claims were Incurred, not the date upon which the payment is made by the Plan. In the case of a settlement, the Participant has an obligation to review the "lien" provided by the Plan and reflecting claims paid by the Plan for which it seeks reimbursement, prior to settlement and/or executing a release of any liable or potentially liable third party, and is also obligated to advise the Plan of any incident related care incurred prior to the proposed date of settlement and/or release, which is not listed but has been or will be incurred, and for which the Plan will be asked to pay.

12.06 Excess Insurance

If at the time of Injury, Illness or disability there is available, or potentially available any Coverage (including but not limited to Coverage resulting from a judgment at law or settlements), the benefits under this Plan shall apply only as an excess over such other sources of Coverage, except as otherwise provided for under the Plan's Coordination of Benefits section.

The Plan's benefits shall be excess to any of the following:

1. The responsible party, its insurer, or any other source on behalf of that party.
2. Any first party insurance through medical payment coverage, personal injury protection, no-fault coverage, uninsured or underinsured motorist coverage.
3. Any policy of insurance from any insurance company or guarantor of a third party, including but not limited to an employer's policy.
4. Workers' compensation or other liability insurance company.
5. Any other source of Coverage, including, but not limited to, the following:

    - Crime victim restitution funds
    - Civil restitution funds
    - No-fault restitution funds such as vaccine injury compensation funds
    - Any medical, applicable disability or other benefit payments
    - School insurance coverage

12.07 Separation of Funds

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

12.08 Wrongful Death

In the event that the Participant(s) dies as a result of his or her 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, and the entity pursuing said claim shall honor and enforce these Plan rights and terms by which benefits are paid on behalf of the Participant(s) and all others that benefit from such payment.

12.09 Obligations

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

1. 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.
2. To provide the Plan with pertinent information regarding the Sickness, Disease, disability, or Injury, including accident reports, settlement information and any other requested additional information.
3. To take such action and execute such documents as the Plan may require to facilitate enforcement of its subrogation and reimbursement rights.
4. To do nothing to prejudice the Plan's rights of subrogation and reimbursement.
5. To promptly reimburse the Plan when a recovery through settlement, judgment, award or other payment is received.
6. To notify the Plan or its authorized representative of any incident related claims or care which may be not identified within the lien (but has been Incurred) and/or reimbursement request submitted by or on behalf of the Plan.
7. To notify the Plan or its authorized representative of any settlement prior to finalization of the settlement.
8. To not settle or release, without the prior consent of the Plan, any claim to the extent that the Participant may have against any responsible party or Coverage.

9. To instruct his or her attorney to ensure that the Plan and/or its authorized representative is included as a payee on any settlement draft.
10. In circumstances where the Participant is not represented by an attorney, instruct the insurance company or any third party from whom the Participant obtains a settlement to include the Plan or its authorized representative as a payee on the settlement draft.
11. To make good faith efforts to prevent disbursement of settlement funds until such time as any dispute between the Plan and Participant over settlement funds is resolved.

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

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

12.10 Offset

If timely repayment is not made, or the Participant and/or his or her attorney fails to comply with any of the requirements of the Plan, the Plan has the right, in addition to any other lawful means of recovery, to deduct the value of the Participant's amount owed to the Plan. To do this, the Plan may refuse payment of any future medical benefits and any funds or payments due under this Plan on behalf of the Participant(s) in an amount equivalent to any outstanding amounts owed by the Participant to the Plan. This provision applies even if the Participant has disbursed settlement funds.

12.11 Minor Status

In the event the Participant(s) 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 or her 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.

12.12 Language Interpretation

The Plan Administrator retains sole, full and final discretionary authority to construe and interpret the language of this provision, to determine all questions of fact and law arising under this provision, and to administer the Plan's subrogation and reimbursement rights with respect to this provision. The Plan Administrator may amend the Plan at any time without notice.

12.13 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.

ARTICLE XIII
MISCELLANEOUS PROVISIONS

13.01 Clerical Error/Delay
Clerical errors made on the records of the Plan and delays in making entries on such records shall not invalidate coverage nor cause coverage to be in force or to continue in force. Rather, the Effective Dates of coverage shall be determined solely in accordance with the provisions of this Plan regardless of whether any contributions with respect to Participants have been made or have failed to be made because of such errors or delays. Upon discovery of any such error or delay, an equitable adjustment of any such contributions will be made.

13.02 Conformity With Applicable Laws
Any provision of this Plan that is contrary to any applicable law, equitable principle, regulation or court order (if such a court is of competent jurisdiction) will be interpreted to comply with said law, or, if it cannot be so interpreted, shall be automatically amended to satisfy the law's minimum requirement, including, but not limited to, stated maximums, Exclusions, or statutes of limitations. It is intended that the Plan will conform to the requirements of ERISA, as it applies to Employee welfare plans, as well as as well as any other applicable law.

13.03 Fraud
Under this Plan, coverage may be retroactively canceled or terminated (rescinded) if a Participant acts fraudulently or intentionally makes material misrepresentations of fact. It is a Participant's responsibility to provide accurate information and to make accurate and truthful statements, including information and statements regarding family status, age, relationships, etc. It is also a Participant's responsibility to update previously provided information and statements. Failure to do so may result in coverage of Participants being canceled, and such cancellation may be retroactive.

If a Participant, or any other entity, submits or attempts to submit a claim for or on behalf of a person who is not a Participant of the Plan; submits a claim for services or supplies not rendered; provides false or misleading information in connection with enrollment in the Plan; or provides any false or misleading information to the Plan as it relates to any element of its administration; that shall be deemed to be fraud. If a Participant is aware of any instance of fraud, and fails to bring that fraud to the Plan Administrator's attention, that shall also be deemed to be fraud. Fraud will result in immediate termination of all coverage under this Plan for the Participant and their entire Family Unit of which the Participant is a member.

A determination by the Plan that a rescission is warranted will be considered an Adverse Benefit Determination for purposes of review and appeal. A Participant whose coverage is being rescinded will be provided a 30 day notice period as described under the Affordable Care Act (ACA) and regulatory guidance. Claims Incurred after the retroactive date of termination shall not be further processed and/or paid under the Plan. Claims Incurred after the retroactive date of termination that were paid under the Plan will be treated as erroneously paid claims under this Plan.

13.04 Headings
The headings used in this Plan Document are used for convenience of reference only. Participants are advised not to rely on any provision because of the heading.

13.05 Pronouns
Unless the context otherwise demands, words importing any gender shall be interpreted to mean any or all genders.

13.06 Word Usage
Wherever any words are used herein in the singular or plural, they shall be construed as though they were in the plural or singular, as the case may be, in all cases where they would so apply.

13.07 No Waiver or Estoppel

No term, condition or provision of this Plan shall be deemed to have been waived, and there shall be no estoppel against the enforcement of any provision of this Plan, except by written instrument of the party charged with such waiver or estoppel. No such written waiver shall be deemed a continuing waiver unless specifically stated therein, and each such waiver shall operate only as to the specific term or condition waived and shall not constitute a waiver of such term or condition for the future or as to any act other than the one specifically waived.

13.08 Plan Contributions

The Plan Administrator shall, from time to time, evaluate the funding method of the Plan and determine the amount to be contributed by the Participating Employer and the amount to be contributed (if any) by each Participant.

The Plan Sponsor shall fund the Plan in a manner consistent with the provisions of the Internal Revenue Code, ERISA, and such other laws and regulations as shall be applicable to the end that the Plan shall be funded on a lawful and sound basis; but, to the extent permitted by governing law, the Plan Administrator shall be free to determine the manner and means of funding the Plan.

Notwithstanding any other provision of the Plan, the Plan Administrator's obligation to pay claims otherwise allowable under the terms of the Plan shall be limited to its obligation to make contributions to the Plan as set forth in the preceding paragraph. Payment of said claims in accordance with these procedures shall discharge completely the Company's obligation with respect to such payments.

In the event that the Company terminates the Plan, then as of the effective date of termination, the Employer and eligible Employees shall have no further obligation to make additional contributions to the Plan and the Plan shall have no obligation to pay claims Incurred after the termination date of the Plan.

13.09 Right to Receive and Release 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 the acceptability of any applicant or Participant for benefits from this Plan. In so acting, the Plan Administrator shall be free from any liability that may arise with regard to such action. Any Participant claiming benefits under this Plan shall furnish to the Plan Administrator such information as may be necessary to implement this provision.

13.10 Written Notice

Any written notice required under this Plan which, as of the Effective Date, is in conflict with the law of any governmental body or agency which has jurisdiction over this Plan shall be interpreted to conform to the minimum requirements of such law.

13.11 Right of Recovery

In accordance with the Recovery of Payments provision, whenever payments have been made by this Plan in a total amount, at any time, in excess of the Maximum Amount of benefits payable under this Plan, the Plan shall have the right to recover such payments, to the extent of such excess, from any one or more of the following as this Plan shall determine: any person to or with respect to whom such payments were made, or such person's legal representative, any insurance companies, or any other individuals or organizations which the Plan determines are responsible for payment of such amount, and any future benefits payable to the Participant or his or her Dependents. See the Recovery of Payments provision for full details.

13.12 Statements

All statements made by the Company or by a Participant will, in the absence of fraud, be considered representations and not warranties, and no statements made for the purpose of obtaining benefits under this document will be used in any contest to avoid or reduce the benefits provided by the document unless

contained in a written application for benefits and a copy of the instrument containing such representation is or has been furnished to the Participant.

Any Participant who knowingly and with intent to defraud the Plan, files a statement of claim containing any materially false information, or conceals for the purpose of misleading, information concerning any material fact, commits a fraudulent act. The Participant may be subject to prosecution by the United States Department of Labor. Fraudulently claiming benefits may be punishable by a substantial fine, imprisonment, or both.

13.13 Protection Against Creditors

To the extent this provision does not conflict with any applicable law, no benefit payment under this Plan shall be subject in any way to alienation, sale, transfer, pledge, attachment, garnishment, execution or encumbrance of any kind, and any attempt to accomplish the same shall be void. If the Plan Administrator shall find that such an attempt has been made with respect to any payment due or to become due to any Participant, the Plan Administrator in its sole discretion may terminate the interest of such Participant or former Participant in such payment. And in such case the Plan Administrator shall apply the amount of such payment to or for the benefit of such Participant or former Participant, his or her spouse, parent, adult Child, guardian of a minor Child, brother or sister, or other relative of a Dependent of such Participant or former Participant, as the Plan Administrator may determine, and any such application shall be a complete discharge of all liability with respect to such benefit payment. However, at the discretion of the Plan Administrator, benefit payments may be assigned to health care providers.

13.14 Binding Arbitration

***NOTE**: The Employee is enrolled in a plan provided by the Employer that is subject to ERISA. Any dispute involving an Adverse Benefit Determination must be resolved under ERISA's claims procedure rules, and is not subject to mandatory binding arbitration. The individual may pursue voluntary binding arbitration after he or she has completed an appeal under ERISA. If the individual has any other dispute which does not involve an Adverse Benefit Determination, this Binding Arbitration provision applies.*

Any dispute or claim, of whatever nature, arising out of, in connection with, or in relation to this Plan, or breach or rescission thereof, or in relation to care or delivery of care, including any claim based on contract, tort or statute, must be resolved by arbitration if the amount sought exceeds the jurisdictional limit of the small claims court. Any dispute regarding a claim for damages within the jurisdictional limits of the small claims court will be resolved in such court.

The Federal Arbitration Act shall govern the interpretation and enforcement of all proceedings under this binding arbitration provision. To the extent that the Federal Arbitration Act is inapplicable, or is held not to require arbitration of a particular claim, State law governing agreements to arbitrate shall apply.

The Participant and the Plan Administrator agree to be bound by this Binding Arbitration provision and acknowledge that they are each giving up their right to a trial by court or jury.

The Participant and the Plan Administrator agree to give up the right to participate in class arbitration against each other. Even if applicable law permits class actions or class arbitrations, the Participant waives any right to pursue, on a class basis, any such controversy or claim against the Plan Administrator and the Plan Administrator waives any right to pursue on a class basis any such controversy or claim against the Participant.

The arbitration findings will be final and binding except to the extent that State or Federal law provides for the judicial review of arbitration proceedings.

The arbitration is begun by the Participant making written demand on the Plan Administrator. The arbitration will be conducted by Judicial Arbitration and Mediation Services ("JAMS") according to its applicable Rules and Procedures. If, for any reason, JAMS is unavailable to conduct the arbitration, the arbitration will be

conducted by another neutral arbitration entity, by mutual agreement of the Participant and the Plan Administrator, or by order of the court, if the Participant and the Plan Administrator cannot agree.

The costs of the arbitration will be allocated per the JAMS Policy on Consumer Arbitrations. If the arbitration is not conducted by JAMS, the costs will be shared equally by the parties, except in cases of extreme financial hardship, upon application to the neutral arbitration entity to which the parties have agreed, in which cases, the Plan Administrator will assume all or a portion of the costs of the arbitration.

13.15 Unclaimed Self-Insured Plan Funds

In the event a benefits check issued by the Third Party Administrator for this self-insured Plan is not cashed within one year of the date of issue, the check will be voided and the funds will be retained by to this Plan and applied to the payment of current benefits and administrative fees under this Plan. In the event a Participant subsequently requests payment with respect to the voided check, the Plan Sponsor for the self-insured Plan shall make such payment under the terms and provisions of the Plan as in effect when the claim was originally processed. Unclaimed self-insured Plan funds may be applied only to the payment of benefits (including administrative fees) under the Plan pursuant to ERISA and any other applicable State law(s).

ARTICLE XIV
SUMMARY OF BENEFITS

14.01 General Limits

Payment for any of the expenses listed below is subject to all Plan Exclusions, limitations and provisions. All coverage figures, if applicable, are after the out of pocket Deductible has been satisfied.

See the Utilization Management section for more information regarding Pre-Certification and/or Notification requirements.

14.01A Network and Non-Network Provider Arrangement

The Plan contracts with medical Provider Networks to access discounted fees for service for Participants. Hospitals, Physicians and other Providers who have contracted with the medical Provider Networks are called "Network Providers." Those who have not contracted with the Networks are referred to in this Plan as "Non-Network Providers". This arrangement results in the following benefits to Participants:

1. The Plan provides different levels of benefits based on whether the Provider Participants use is a Network or Non-Network Provider. Unless one of the exceptions shown below applies, if a Participant elects to receive medical care from the Non-Network Provider, the benefits payable are generally lower than those payable when a Network Provider is used. The following exceptions apply:

    a. In the event a Network Provider is treating a Participant at a Network facility and services are rendered by a Non-Network Provider for diagnostic testing, x-rays, laboratory services or anesthesia during such treatment, then charges of the Non-Network Provider will be paid as though the services were provided by a Network Provider.
    b. The Network Provider level of benefits is payable for any Participant who cannot access Network Providers because they reside outside the Network service area. The Network service area is defined as 50 miles.
    c. The Network Provider level of benefits is payable when a Participant receives Emergency care either out-of-area or at a Non-Network Hospital for an Accident Bodily Injury or True Medical Emergency.
2. Except as outlined in "No Surprises Act – Emergency Services and Surprise Bills" below, if the charge billed by a Non-Network Provider for any covered service is higher than the Maximum Allowable Charge determined by the Plan, Participants are responsible for the excess unless the Provider accepts assignment of benefits as consideration in full for services rendered. Since Network Providers have agreed to accept a negotiated discounted fee as full payment for their services, Participants are not responsible for any billed amount that exceeds that fee. The Plan Administrator reserves the right to revoke any previously-given assignment of benefits or to proactively prohibit assignment of benefits to anyone, including any Provider, at its discretion.

3. To receive benefit consideration, Participants may need to submit claims for services provided by Non-Network Providers to the Third Party Administrator. Network Providers have agreed to bill the Plan directly, so that Participants do not have to submit claims themselves.

Benefits available to Network Providers are limited such that if a Network Provider advances or submits charges which exceed amounts that are eligible for payment in accordance with the terms of the Plan, or are for services or supplies for which Plan coverage is not available, or are otherwise limited or excluded by the Plan, benefits will be paid in accordance with the terms of the Plan.

If a Participant receives information with respect to an item or service from the Plan, its representative, or a database maintained by the Plan or its representative indicating that a particular Provider is an In-Network Provider and the Participant receives such item or service in reliance on that information, the Participant's Coinsurance, Copayment, Deductible, and out-of-pocket maximum will be calculated as if the Provider had been In-Network despite that information proving inaccurate.

14.02 Balance Billing

In the event that a claim submitted by a Network or Non-Network Provider is subject to a medical bill review or medical chart audit and some or all of the charges in connection with such claim are repriced because of billing errors and/or overcharges, it is the Plan's position that the Participant should not be responsible for payment of any charges denied as a result of the medical bill review or medical chart audit, and should not be balance billed for the difference between the billed charges and the amount determined to be payable by the Plan Administrator, although the Plan has no control over any Provider's actions, including balance billing.

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

The Participant is responsible for any applicable payment of Coinsurances, Deductibles, and out-of-pocket maximums and may be billed for any or all of these.

14.03 Choice of Providers

The Plan is not intended to disturb the Physician-patient relationship. Each Participant has a free choice of any Physician or surgeon, and the Physician-patient relationship shall be maintained. Physicians and other health care Providers are not agents or delegates of the Plan Sponsor, Company, Plan Administrator, Employer or Third Party Administrator. The delivery of medical and other health care services on behalf of any Participant remains the sole prerogative and responsibility of the attending Physician or other health care Provider. The Participant, together with his or her Physician, is ultimately responsible for determining the appropriate course of medical treatment, regardless of whether the Plan will pay for all or a portion of the cost of such care.

14.04 Network Provider Information

The Network Providers are merely independent contractors; neither the Plan nor the Plan Administrator make any warranty as to the quality of care that may be rendered by any Network Provider.

A current list of Network Providers is available, without charge, through the Third Party Administrator's website (located at www.iaatpa.com). If the Participant does not have access to a computer at his or her home, he or she may access this website at his or her place of employment. If the Participant has any questions about how to do this, he or she should contact the Human Relations Department. The Network Provider list changes frequently; therefore, it is recommended that a Participant verify with the Provider that the Provider is still a Network Provider before receiving services. Please refer to the Participant identification card for the PPO website address.

14.05 Claims Audit

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

The analysis will be employed to identify charges billed in error and/or charges that exceed the Maximum Allowable Charge or services that are not Medically Necessary and may include a patient medical billing records review and/or audit of the patient's medical charts and records.

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

Despite the existence of any agreement to the contrary, the Plan Administrator has the discretionary authority to reduce any charge to the Maximum Allowable Charge, in accord with the terms of this Plan Document.

14.06 Continuity of Care

In the event a Participant is a continuing care patient receiving a course of treatment from a Provider which is In-Network or otherwise has a contractual relationship with the Plan governing such care and that contractual relationship is terminated, not renewed, or otherwise ends for any reason other than the Provider's failure to meet applicable quality standards or for fraud, the Participant shall have the following rights to continuation of care.

The Plan shall notify the Participant in a timely manner, but in no event later than 7 calendar days after termination that the Provider's contractual relationship with the Plan has terminated, and that the Participant has rights to elect continued transitional care from the Provider. If the Participant elects in writing to receive continued transitional care, Plan benefits will apply under the same terms and conditions as would be applicable had the termination not occurred, beginning on the date the Plan's notice of termination is provided and ending 90 days later or when the Participant ceases to be a continuing care patient, whichever is sooner.

For purposes of this provision, "continuing care patient" means an individual who:

1. is undergoing a course of treatment for a serious and complex condition from a specific Provider,
2. is undergoing a course of institutional or Inpatient care from a specific Provider,
3. is scheduled to undergo non-elective surgery from a specific Provider, including receipt of postoperative care with respect to the surgery,
4. is pregnant and undergoing a course of treatment for the Pregnancy from a specific Provider, or
5. is or was determined to be terminally ill and is receiving treatment for such illness from a specific Provider.

Note that during continuation, although Plan benefits will be processed as if the termination had not occurred and the law requires the Provider to continue to accept the previously-contracted amount, the contract itself will have terminated, and thus the Plan may be unable to protect the Participant if the Provider pursues a balance bill.

14.07 No Surprises Act – Emergency Services and Surprise Bills

For Non-Network claims subject to the No Surprises Act ("NSA"), Participant cost-sharing will be the same amount as would be applied if the claim was provided by a Network Provider and will be calculated as if the Plan's Covered Expense was the Recognized Amount, regardless of the Plan's actual Maximum Allowable Charge. The NSA prohibits Providers from pursuing Participants for the difference between the Maximum Allowable Charge and the Provider's billed charge for applicable services, with the exception of valid Plan-appointed cost-sharing as outlined above. Any such cost-sharing amounts will accrue toward In-Network Deductibles and out of pocket maximums.

Benefits for claims subject to the NSA will be denied or paid within 30 days of receipt of an initial claim, and if approved will be paid directly to the Provider.

Claims subject to the NSA are those which are submitted for:

- Emergency Services;
- Non-emergency services rendered by a Non-Network Provider at a Participating Health Care Facility provided the Participant has not validly waived the applicability of the NSA; and
- Covered Non-Network air ambulance services.

14.08 Summary of Medical Benefits

The following benefits are per Participant per Calendar Year. All benefits are subject to the Maximum Allowable Charge.

14.08A Option A PPO Plan

Benefits	Option A PPO Plan		
	*Domestic: Kingman Healthcare Center	*Participating	*Non-Participating
***In-Network Services** *(Participating)* Allowables are based on the Negotiated Rate established in a contractual arrangement with a Provider and/or Facility.			
***Out-of-Network Services** *(Non-Participating)* **- Payments are subject to the "Maximum Allowable Charge"** "Maximum Allowable Charge" shall mean the benefit payable for a specific coverage item or benefit under the Plan. Maximum Allowable Charge(s) may be the lesser of: 1. The Usual and Customary amount; 2. The allowable charge specified under the terms of the Plan; 3. 125% of the Medicare Reimbursement Rate; or 4. The actual billed charges for the covered services. The Plan will reimburse the actual charge billed if it is less than the Usual and Customary amount. The Plan has the discretionary authority to decide if a charge is Usual and Customary and for a Medically Necessary and Reasonable service. The Maximum Allowable Charge will not include any identifiable billing mistakes including, but not limited to, up-coding, duplicate charges, and charges for services not performed.			
Lifetime Maximum	Unlimited	Unlimited	Unlimited
Plan Year Maximum	Unlimited	Unlimited	Unlimited
Deductible *(Per Calendar Year)*			
Individual	$1,000	$1,500	$2,500
Per Family Unit	$2,000	$3,000	$5,000
Deductible shares between Domestic and Participating; does not share between Non-Participating			
Charges tracking to the last quarter of the year (October, November, December) are applied to the following year's deductible. This does not apply to Non-Participating			
Coinsurance *(Per Calendar Year)*			
Individual	$500	$1,000	$2,500
Family Unit	$1,000	$2,000	$5,000
Medical Out of Pocket Maximum *(Shares between Domestic and Participating)* *(Includes Deductible and Coinsurance)*			
Individual	$1,500	$2,500	$5,000
Family Unit	$3,000	$5,000	$10,000
Total Out of Pocket Maximum *(Includes Copays, prescription drugs, deductible and coinsurance)*			
Individual	$5,000	$6,350	N/A
Family Unit	$10,000	$12,700	N/A
Deductible, Coinsurance, and Copayments are included in the Out of Pocket Maximum.			
Cost containment penalties do not apply toward the deductible and out-of-pocket maximum and are never paid at 100%,			
Out-of-Pocket Maximum shares between Domestic and Participating; does not share between Non-Participating			
The Plan will pay the designated percentage of covered charges until out-of-pocket amounts are reached, at which time the Plan will pay 100% of the remainder of Covered charges for the rest of the Plan Year unless otherwise stated.			
Services received at Non-Participating providers while traveling or Dependents living outside the Participating area will be covered at the participating Provider rate.			
Co-Payments			
Teladoc Medical and Mental Health	Covered 100%	Covered 100%	N/A
Physician Visits	Covered 100% after $15 copay	Covered 100% after $35 copay	Covered 30% after deductible
Specialist Visits	Covered 100% after $15 copay	Covered 100% after $35 copay	Covered 30% after deductible
Urgent Care Visits	Covered 100% after $15 copay	Covered 100% after $35 copay	Covered 30% after deductible

Emergency Services			
Ambulance Service	Covered 50% after Participating deductible		
Emergency Room Services	$75 copay then 80% after deductible	$100 copay then 50% after deductible	Covered 30% after deductible
Non-Participating covered at Participating benefits for True Emergency only			
The Emergency room co-payment is waived if the patient is admitted to the Hospital on an emergency basis. The utilization review administrator must be notified within 48 hours of the admission (please refer to your ID Card for telephone number), even if the patient is discharged within 48 hours of the admission.			
Covered Services			
Accident Injury Services	Pays 100% up to $1,000 per person per Calendar Year then standard benefits apply.		
Initial treatment and follow-up care within ninety (90) days of an injury			
Allergy Injections/Testing	Covered 100% after $15 copay	Covered 100% after $35 copay	Covered 30% after deductible
Chiropractic Care	Covered 100% after $15 copay	Covered 100% after $35 copay	Covered 100% after $35 copay
Diabetic Self-Management Education	Covered 100% after $15 copay	Covered 100% after $35 copay	Covered 30% after deductible

Benefits	Option A PPO Plan		
	*Domestic: Kingman Healthcare Center	*Participating	*Non-Participating
Dialysis Treatment *(Outpatient)*	Covered 80% after deductible	Covered 50% after deductible	Covered 30% after deductible
Durable Medical Equipment	Covered 80% after deductible	Covered 50% after deductible	Covered 30% after deductible
Hearing Aid	Not Covered	Not Covered	Not Covered
Home Health Care	Covered 80% after deductible	Covered 50% after deductible	Covered 30% after deductible
Hospice Care *(Provided as part of Hospice Care Program)*	Covered 80% after deductible	Covered 50% after deductible	Covered 30% after deductible
Hospital Inpatient Care *(Pre-certification Required)*			
Inpatient Admission	Covered 80% after deductible	Covered 50% after deductible	Covered 30% after deductible
Inpatient Physician Services	Covered 80% after deductible	Covered 50% after deductible	Covered 30% after deductible
Maternity Benefits			
Inpatient Hospital Charges *(Pre-certification Required)*	Covered 80% after deductible	Covered 50% after deductible	Covered 30% after deductible
Obstetric Care/Physician Charges	Covered 100%	Covered 100%	Covered 30% after deductible
Ultrasound	Covered 100%	Covered 100%	Covered 30% after deductible
Mental Health/Alcohol and Drug Use/Applied Behavioral Analysis (ABA) *(Pre-certification Required)*			
Inpatient	Covered 80% after deductible	Covered 50% after deductible	Covered 30% after deductible
Outpatient	Covered 100% after $15 copay	Covered 100% after $35 copay	Covered 30% after deductible
Office	Covered 100% after $15 copay	Covered 100% after $35 copay	Covered 30% after deductible
ABA Only Home	Covered 80% after deductible	Covered 50% after deductible	Covered 30% after deductible
Nutritional Counseling	Covered 100% after $15 copay	Covered 100% after $35 copay	Covered 30% after deductible
Organ & Corneal Transplants	Covered 80% after deductible	Covered 50% after deductible	Covered 30% after deductible
Prosthetic Devices	Covered 80% after deductible	Covered 50% after deductible	Covered 30% after deductible
Skilled Nursing Facility, Rehabilitation Hospital, Sub-Acute Facility *(Pre-certification Required)*	Covered 80% after deductible	Covered 50% after deductible	Covered 30% after deductible
Specialty Drugs	Not Covered	Not Covered	Not Covered
Preventive Well Care as defined by PPACA			
Breastfeeding Support, Supplies & Counseling	Covered 100%	Covered 100%	Covered 30% after deductible
Colonoscopy & Colorectal Screening (ex. Cologuard)	Covered 100%	Covered 100%	Covered 30% after deductible
Contraceptive Methods & Counseling	Covered 100%	Covered 100%	Covered 30% after deductible
GYN Exams/ PAP	Covered 100%	Covered 100%	Covered 30% after deductible
Immunization	Covered 100%	Covered 100%	Covered 30% after deductible
Mammograms	Covered 100%	Covered 100%	Covered 30% after deductible
Prostate Cancer Screening	Covered 100%	Covered 100%	Covered 30% after deductible
Routine Adult Physicals	Covered 100%	Covered 100%	Covered 30% after deductible
Tubal Ligation Services	Covered 100%	Covered 100%	Covered 30% after deductible
Well Child Exams	Covered 100%	Covered 100%	Covered 30% after deductible
Well Child Immunizations and Lead Screening	Covered 100%	Covered 100%	Covered 30% after deductible

Surgical Benefits			
Ambulatory Surgical Center/Free Standing Facility	Covered 80% after deductible	Covered 50% after deductible	Covered 30% after deductible
Anesthesia at Ambulatory Surgical Center/Free Standing Facility	Covered 80% after deductible	Covered 50% after deductible	Covered 30% after deductible
Physician Services at Ambulatory Surgical Center/Free Standing Facility	Covered 80% after deductible	Covered 50% after deductible	Covered 30% after deductible
Physician Office	Covered 80% after deductible	Covered 50% after deductible	Covered 30% after deductible
Hospital Inpatient Surgery	Covered 80% after deductible	Covered 50% after deductible	Covered 30% after deductible
Anesthesia Hospital Inpatient	Covered 80% after deductible	Covered 50% after deductible	Covered 30% after deductible
Physician Services Hospital Inpatient	Covered 80% after deductible	Covered 50% after deductible	Covered 30% after deductible
Hospital Outpatient Surgery	Covered 80% after deductible	Covered 50% after deductible	Covered 30% after deductible
Anesthesia Hospital Outpatient	Covered 80% after deductible	Covered 50% after deductible	Covered 30% after deductible
Physician Services Hospital Outpatient	Covered 80% after deductible	Covered 50% after deductible	Covered 30% after deductible
Bariatric Surgery	Not Covered	Not Covered	Not Covered

Benefits	Option A PPO Plan		
	***Domestic: Kingman Healthcare Center**	***Participating**	***Non-Participating**
X-Rays, Ultrasound and Lab Tests - Charge By Place of Service			
Physicians Office/Independent Facility/Hospital - Outpatient Testing	Covered 100% up to a combined maximum of $300 for each covered person each Calendar Year, then covered 80% after deductible	Covered 100% up to a combined maximum of $300 for each covered person each Calendar Year, then covered 50% after deductible	Covered 30% after deductible
Advanced Radiology Imaging (MRI, MRA, CAT Scan, PET Scan, etc.) - Charge By Place of Service			
Physicians Office/Independent Facility/Hospital - Outpatient Testing	Covered 100% up to a combined maximum of $300 for each covered person each Calendar Year, then covered 80% after deductible	Covered 100% up to a combined maximum of $300 for each covered person each Calendar Year, then covered 50% after deductible	Covered 30% after deductible
Therapy Services			
Physical	Covered 80% after deductible	Covered 50% after deductible	Covered 30% after deductible
Occupational	Covered 80% after deductible	Covered 50% after deductible	Covered 30% after deductible
Speech	Covered 80% after deductible	Covered 50% after deductible	Covered 30% after deductible
Respiratory	Covered 80% after deductible	Covered 50% after deductible	Covered 30% after deductible
Cardiac Rehabilitation	Covered 80% after deductible	Covered 50% after deductible	Covered 30% after deductible
Chemotherapy	Covered 80% after deductible	Covered 50% after deductible	Covered 30% after deductible
Radiation Therapy	Covered 80% after deductible	Covered 50% after deductible	Covered 30% after deductible
Infusion Therapy	Covered 80% after deductible	Covered 50% after deductible	Covered 30% after deductible
Vision Care Benefits			
Eye Exam, One in 12 Months *(Includes Refractions)*:	Covered 100% after $15 copay	Covered 100% after $35 copay	Covered 30% after deductible
Screening exams for children under 5 (five) years of age are covered 100%			

14.08B Option B HSA Plan

Benefits	Option B HSA HDHP Plan		
	*Domestic: Kingman Healthcare Center	*Participating	*Non-Participating
***In-Network Services** *(Participating)* Allowables are based on the Negotiated Rate established in a contractual arrangement with a Provider and/or Facility.			
***Out-of-Network Services** *(Non-Participating)* **- Payments are subject to the "Maximum Allowable Charge"** "Maximum Allowable Charge" shall mean the benefit payable for a specific coverage item or benefit under the Plan. Maximum Allowable Charge(s) may be the lesser of: 1. The Usual and Customary amount; 2. The allowable charge specified under the terms of the Plan; 3. 125% of the Medicare Reimbursement Rate; or 4. The actual billed charges for the covered services. The Plan will reimburse the actual charge billed if it is less than the Usual and Customary amount. The Plan has the discretionary authority to decide if a charge is Usual and Customary and for a Medically Necessary and Reasonable service. The Maximum Allowable Charge will not include any identifiable billing mistakes including, but not limited to, up-coding, duplicate charges, and charges for services not performed.			
Lifetime Maximum	Unlimited	Unlimited	Unlimited
Plan Year Maximum	Unlimited	Unlimited	Unlimited
Deductible *(Per Calendar Year)*			
Individual	$3,000	$3,000	$5,000
Per Family Unit	$6,000	$6,000	$10,000
Deductible shares between Domestic and Participating; does not share between Non-Participating			
Out of Pocket Maximum			
Individual	$6,350	$6,350	N/A
Family Unit	$12,700	$12,700	N/A
Deductible, Coinsurance, and Copayments are included in the Out of Pocket Maximum.			
Cost containment penalties do not apply toward the deductible and out-of-pocket maximum and are never paid at 100%,			
Out-of-Pocket Maximum shares between Domestic and Participating; does not share between Non-Participating			
The Plan will pay the designated percentage of covered charges until out-of-pocket amounts are reached, at which time the Plan will pay 100% of the remainder of Covered charges for the rest of the Plan Year unless otherwise stated.			
Services received at Non-Participating providers while traveling or Dependents living outside the Participating area will be covered at the participating Provider rate.			
Co-Payments			
Teladoc Medical and Mental Health	Covered 100% after deductible	Covered 100% after deductible	N/A
Physician Visits	Covered 100% after deductible and $15 copay	Covered 100% after deductible and $35 copay	Covered 30% after deductible
Specialist Visits	Covered 100% after deductible and $15 copay	Covered 100% after deductible and $35 copay	Covered 30% after deductible
Urgent Care Visits	Covered 100% after deductible and $15 copay	Covered 100% after deductible and $35 copay	Covered 30% after deductible
Emergency Services			
Ambulance Service	Covered 100% after deductible		
Emergency Room Services	Covered 100% after deductible and $75 copay	Covered 100% after deductible and $100 copay	Covered 30% after deductible
Non-Participating covered at Participating benefits for True Emergency only			
The Emergency room co-payment is waived if the patient is admitted to the Hospital on an emergency basis. The utilization review administrator must be notified within 48 hours of the admission (please refer to your ID Card for telephone number), even if the patient is discharged within 48 hours of the admission.			

Covered Services			
Accident Injury Services	Covered 100% after deductible		Covered 30% after deductible
Initial treatment and follow-up care within ninety (90) days of an injury			
Allergy Injections/Testing	Covered 100% after deductible and $15 copay	Covered 100% after deductible and $35 copay	Covered 30% after deductible
Chiropractic Care	Covered 100% after deductible and $15 copay	Covered 100% after deductible and $35 copay	Covered 100% after deductible and $35 copay
Diabetic Self-Management Education	Covered 100% after deductible and $15 copay	Covered 100% after deductible and $35 copay	Covered 30% after deductible
Dialysis Treatment *(Outpatient)*	Covered 100% after deductible	Covered 100% after deductible	Covered 30% after deductible
Durable Medical Equipment	Covered 100% after deductible	Covered 100% after deductible	Covered 30% after deductible
Hearing Aid	Not Covered	Not Covered	Not Covered
Home Health Care	Covered 100% after deductible	Covered 100% after deductible	Covered 30% after deductible
Hospice Care *(Provided as part of Hospice Care Program)*	Covered 100% after deductible	Covered 100% after deductible	Covered 30% after deductible

Benefits	Option B HSA HDHP Plan		
	*Domestic: Kingman Healthcare Center	*Participating	*Non-Participating
Hospital Inpatient Care *(Pre-certification Required)*			
Inpatient Admission	Covered 100% after deductible	Covered 100% after deductible	Covered 30% after deductible
Inpatient Physician Services	Covered 100% after deductible	Covered 100% after deductible	Covered 30% after deductible
Maternity Benefits			
Inpatient Hospital Charges *(Pre-certification Required)*	Covered 100% after deductible	Covered 100% after deductible	Covered 30% after deductible
Obstetric Care/Physician Charges	Covered 100% after deductible	Covered 100% after deductible	Covered 30% after deductible
Ultrasound	Covered 100% after deductible	Covered 100% after deductible	Covered 30% after deductible
Mental Health/Alcohol and Drug Use/Applied Behavioral Analysis (ABA) *(Pre-certification Required)*			
Inpatient	Covered 100% after deductible	Covered 100% after deductible	Covered 30% after deductible
Outpatient	Covered 100% after deductible and $15 copay	Covered 100% after deductible and $35 copay	Covered 30% after deductible
Office	Covered 100% after deductible and $15 copay	Covered 100% after deductible and $35 copay	Covered 30% after deductible
ABA Only Home	Covered 100% after deductible	Covered 100% after deductible	Covered 30% after deductible
Nutritional Counseling	Covered 100% after deductible and $15 copay	Covered 100% after deductible and $35 copay	Covered 30% after deductible
Organ & Corneal Transplants	Covered 100% after deductible	Covered 100% after deductible	Covered 30% after deductible
Prosthetic Devices	Covered 100% after deductible	Covered 100% after deductible	Covered 30% after deductible
Skilled Nursing Facility, Rehabilitation Hospital, Sub-Acute Facility *(Pre-certification Required)*	Covered 100% after deductible	Covered 100% after deductible	Covered 30% after deductible
Specialty Drugs	Not Covered	Not Covered	Not Covered
Preventive Well Care as defined by PPACA			
Breastfeeding Support, Supplies & Counseling	Covered 100%	Covered 100%	Covered 30% after deductible
Colonoscopy & Colorectal Screening (ex. Cologuard)	Covered 100%	Covered 100%	Covered 30% after deductible
Contraceptive Methods & Counseling	Covered 100%	Covered 100%	Covered 30% after deductible
GYN Exams/ PAP	Covered 100%	Covered 100%	Covered 30% after deductible
Immunization	Covered 100%	Covered 100%	Covered 30% after deductible
Mammograms	Covered 100%	Covered 100%	Covered 30% after deductible
Prostate Cancer Screening	Covered 100%	Covered 100%	Covered 30% after deductible
Routine Adult Physicals	Covered 100%	Covered 100%	Covered 30% after deductible
Tubal Ligation Services	Covered 100%	Covered 100%	Covered 30% after deductible
Well Child Exams	Covered 100%	Covered 100%	Covered 30% after deductible
Well Child Immunizations and Lead Screening	Covered 100%	Covered 100%	Covered 30% after deductible

Surgical Benefits			
Ambulatory Surgical Center/Free Standing Facility	Covered 100% after deductible	Covered 100% after deductible	Covered 30% after deductible
Anesthesia at Ambulatory Surgical Center/Free Standing Facility	Covered 100% after deductible	Covered 100% after deductible	Covered 30% after deductible
Physician Services at Ambulatory Surgical Center/Free Standing Facility	Covered 100% after deductible	Covered 100% after deductible	Covered 30% after deductible
Physician Office	Covered 100% after deductible	Covered 100% after deductible	Covered 30% after deductible
Hospital Inpatient Surgery	Covered 100% after deductible	Covered 100% after deductible	Covered 30% after deductible
Anesthesia Hospital Inpatient	Covered 100% after deductible	Covered 100% after deductible	Covered 30% after deductible
Physician Services Hospital Inpatient	Covered 100% after deductible	Covered 100% after deductible	Covered 30% after deductible
Hospital Outpatient Surgery	Covered 100% after deductible	Covered 100% after deductible	Covered 30% after deductible
Anesthesia Hospital Outpatient	Covered 100% after deductible	Covered 100% after deductible	Covered 30% after deductible
Physician Services Hospital Outpatient	Covered 100% after deductible	Covered 100% after deductible	Covered 30% after deductible
Bariatric Surgery	Not Covered	Not Covered	Not Covered
X-Rays, Ultrasound and Lab Tests - Charge By Place of Service			
Physicians Office/Independent Facility/Hospital - Outpatient Testing	Covered 100% after deductible	Covered 100% after deductible	Covered 30% after deductible
Advanced Radiology Imaging (MRI, MRA, CAT Scan, PET Scan, etc.) - Charge By Place of Service			
Physicians Office/Independent Facility/Hospital - Outpatient Testing	Covered 100% after deductible	Covered 100% after deductible	Covered 30% after deductible

Benefits	Option B HSA HDHP Plan		
	*Domestic: Kingman Healthcare Center	*Participating	*Non-Participating
Therapy Services			
Physical	Covered 100% after deductible	Covered 100% after deductible	Covered 30% after deductible
Occupational	Covered 100% after deductible	Covered 100% after deductible	Covered 30% after deductible
Speech	Covered 100% after deductible	Covered 100% after deductible	Covered 30% after deductible
Respiratory	Covered 100% after deductible	Covered 100% after deductible	Covered 30% after deductible
Cardiac Rehabilitation	Covered 100% after deductible	Covered 100% after deductible	Covered 30% after deductible
Chemotherapy	Covered 100% after deductible	Covered 100% after deductible	Covered 30% after deductible
Radiation Therapy	Covered 100% after deductible	Covered 100% after deductible	Covered 30% after deductible
Infusion Therapy	Covered 100% after deductible	Covered 100% after deductible	Covered 30% after deductible
Vision Care Benefits			
Eye Exam, One in 12 Months *(Includes Refractions)*:	Covered 100% after deductible and $15 copay	Covered 100% after deductible and $35 copay	Covered 30% after deductible
Screening exams for children under 5 (five) years of age are covered 100%			

ARTICLE XV
MEDICAL BENEFITS

15.01 Medical Benefits

These medical benefits will be payable as shown in the Summary of Benefits or as otherwise outlined in this Plan. Subject to the Plan's provisions, limitations and Exclusions, the following are covered major medical benefits:

Accident Expense Benefit. Initial treatment and follow-up care within ninety (90) days of an injury will be payable, subject to any applicable maximum benefit as specified on the Schedule of Benefits.

Advanced Imaging. Charges for advanced imaging including: Computed Tomographic (CT) studies, Coronary CT angiography, MRI/MRA, nuclear cardiology, nuclear medicine, and PET scans. Covered Expenses include the readings of these medical tests/scans.

Air Ambulance (Emergency Only).

Benefits are provided for air ambulance transportation only if the Plan Administrator determines that the Participant's condition, the type of service required for the treatment of the Participant's condition, and the type of facility required to treat the Participant's condition justify the use of air ambulance instead of another means of transport. This Plan will only cover air ambulance transportation when no other method of transportation is appropriate (including emergency ground transport).

This Plan will cover rotary and fixed wing aircraft, excluding all fixed wing charter flights, for air ambulance services.

Only charges Incurred for the first trip to a Hospital, or from one Hospital to another Hospital, shall be included.

The determination of whether air ambulance transport for a service, supply, or treatment is or is not Medically Necessary may include findings of the American Medical Association and the Plan Administrator's own medical advisors. The Plan Administrator has the discretionary authority to decide whether care or treatment is Medically Necessary.

Allergy Services. Charges related to the treatment of allergies.

Ambulance (Emergency Only). Covered Expenses for professional ambulance, including approved available water and rail transportation to a local Hospital, or transfer to the nearest facility having the capability to treat the condition if the transportation is connected with an Inpatient confinement.

Ambulatory Surgical Center. Services of an Ambulatory Surgical Center for Medically Necessary care provided.

Anesthesia. Anesthesia, anesthesia supplies, and administration of anesthesia by facility staff.

Applied Behavior Analysis (ABA) Therapy. Charges for ABA therapy for treatment of Autism Spectrum Disorder (ASD).

Birthing Center. Services of a birthing center for Medically Necessary care provided within the scope of its license.

Blood/Blood Derivatives. Charges for blood and blood plasma (if not replaced by or for the patient), including blood processing and administration services. The Plan shall also cover processing, storage, and administrative services for autologous blood (a patient's own blood) when a Participant is scheduled for Surgery that can be reasonably expected to require blood.

Cataract Surgery. Cataract surgery and one set of lenses (contacts or frame-type) following the surgery.

Chemotherapy. Charges for chemotherapy, including materials and services of technicians.

Chiropractic Care. Spinal adjustment and manipulation, x-rays for manipulation and adjustment, and other modalities performed by a Physician or other licensed practitioner, as limited in the Summary of Benefits.

Contraceptives. The charges for all Food and Drug Administration (FDA) approved contraceptives Drugs and methods, in accordance with Health Resources and Services Administration (HRSA) guidelines.

Dental Services – Accident Only. Charges made for a continuous course of dental treatment.

Diabetic Education. Services and supplies used in Outpatient diabetes self-management programs are covered under this Plan when they are provided by a Physician.

Dialysis (Outpatient).

Durable Medical Equipment. Charges for rental, up to the purchase price, of Durable Medical Equipment, including glucose home monitors for insulin dependent diabetics. At its option, and with its advance written approval, the Plan may cover the purchase of such items when it is less costly and more practical than rental. The Plan does not pay for any of the following:

1. Any purchases without its advance written approval.
2. Replacements or repairs. ***NOTE:*** *The Plan covers repair and replacement of Durable Medical Equipment when Medically Necessary due to a physiological change to the patient, due to normal wear and tear of an item or the existing equipment is damaged and cannot be made serviceable.*
3. The rental or purchase of items which do not fully meet the definition of "Durable Medical Equipment".

Eye Examination. Charges for an eye examination, including a refraction test/vision test.

Gene Therapy. Gene therapies and adoptive cellular therapies, as well as associated services and supplies, for Participants if Medically Necessary.

Glaucoma. Treatment of glaucoma.

Habilitative Services. These services include:

1. **Occupational Therapy.** Treatment or services rendered by a registered occupational therapist, under the direct supervision of a Physician, in a home setting or at a facility or Institution whose primary purpose is to provide medical care for an Illness or Injury, or at a free-standing outpatient facility.
2. **Physical Therapy.** Treatment or services rendered by a physical therapist, under direct supervision of a Physician, in a home setting or a facility or Institution whose primary purpose is to provide medical care for an Illness or Injury, or at a free-standing duly licensed outpatient therapy facility.
3. **Speech-Language Pathology.** Treatment for speech delays and disorders.

See the Summary of Benefits for treatment and/or frequency limitations.

Hermaphroditism. Treatment of congenital hermaphroditism is a covered expense.

Home Health Care. Charges for Home Health Care services and supplies are covered only for care and treatment of an Illness or Injury when Hospital or Skilled Nursing Facility confinement would otherwise be

required. The Diagnosis, care, and treatment must be certified by the attending Physician and be contained in a home health care plan. Charges by a Home Health Care Agency any of the following:

1. Registered Nurses or Licensed Practical Nurses.
2. Certified home health aides under the direct supervision of a Registered Nurse.
3. Registered therapist performing physical, occupational or speech therapy.
4. Physician calls in the office, home, clinic or outpatient department.
5. Medical social service consultations.
6. Services, Drugs and medical supplies which are Medically Necessary for the treatment of the Participant that would have been provided in the Hospital, but not including Custodial Care.
7. Rental of Durable Medical Equipment or the purchase of this equipment if economically justified, whichever is less.

NOTE: *Transportation services are not covered under this benefit.*

Hospice Care. Charges relating to Hospice Care, provided the Participant has a life expectancy of 6 months or less, subject to the maximums, if any, stated in the Summary of Benefits. Covered Hospice expenses are limited to:

1. Room and Board for confinement in a Hospice.
2. Ancillary charges furnished by the Hospice while the patient is confined therein, including rental of Durable Medical Equipment which is used solely for treating an Injury or Sickness.
3. Medical supplies, Drugs and medicines prescribed by the attending Physician, but only to the extent such items are necessary for pain control and management of the terminal condition.
4. Physician services and nursing care by a Registered Nurse, Licensed Practical Nurse or a Licensed Vocational Nurse (L.V.N.).
5. Home health aide services.
6. Home care furnished by a Hospital or Home Health Care Agency, under the direction of a Hospice, including Custodial Care if it is provided during a regular visit by a Registered Nurse, a Licensed Practical Nurse or a home health aide.
7. Medical social services by licensed or trained social workers, Psychologists or counselors.
8. Nutrition services provided by a licensed dietitian.
9. Respite care.
10. Bereavement counseling, which is a supportive service provided by the Hospice team to Participants in the deceased's family after the death of the terminally ill person, to assist the Participants in adjusting to the death. Benefits will be payable per Participant if the following requirements are met:

    a. On the date immediately before his or her death, the terminally ill person was in a Hospice Care Program and a Participant under the Plan.
    b. Charges for such services are Incurred by the Participants within 6 months of the terminally ill person's death.

    The Hospice Care program must be reviewed in writing by the attending Physician every 30 days. Hospice Care ceases if the terminal Illness enters remission.

Hospital. Charges made by a Hospital for:

1. Inpatient Treatment

    a. Daily semi private Room and Board charges.
    b. Intensive Care Unit (ICU) and Cardiac Care Unit (CCU) Room and Board charges.
    c. General nursing services.
    d. Medically Necessary services and supplies furnished by the Hospital, other than Room and Board.

2. Outpatient Treatment

    a. Emergency room.
    b. Treatment for chronic conditions.
    c. Physical therapy treatments.
    d. Hemodialysis.
    e. X-ray, laboratory and linear therapy.

Implantable Hearing Devices. For services or supplies in connection with implantable hearing devices, including, but not limited to, cochlear implants and exams for their fitting, for Participants who are certified as deaf or hearing impaired by a Provider.

Laboratory and Pathology Services. Charges for x-rays, diagnostic tests, labs, and pathology services.

Mastectomy. The Federal Women's Health and Cancer Rights Act, signed into law on October 21, 1998, contains coverage requirements for breast cancer patients who elect reconstruction in connection with a Mastectomy. The new Federal law requires group health plans that provide Mastectomy coverage to also cover breast reconstruction Surgery and prostheses following Mastectomy.

As required by law, the Participant is being provided this notice to inform him or her about these provisions. The law mandates that individuals receiving benefits for a Medically Necessary Mastectomy will also receive coverage for:

1. Reconstruction of the breast on which the Mastectomy has been performed.
2. Surgery and reconstruction of the other breast to produce a symmetrical appearance.
3. Prostheses and physical complications from all stages of Mastectomy, including lymphedemas; in a manner determined in consultation with the attending Physician and the patient.

This coverage will be subject to the same annual Deductible and Coinsurance provisions that currently apply to Mastectomy coverage, and will be provided in consultation with the Participant and his or her attending Physician.

Medical Foods. Medical foods are considered a covered charge if intravenous therapy (IV) or tube feedings are Medically Necessary. Medical foods taken orally are not covered under the Plan, except for PKU formula when Medically Necessary.

Medical Supplies. Dressings, casts, splints, trusses, braces and other Medically Necessary medical supplies, with the exception of dental braces or corrective shoes.

Mental Health and Substance Use Benefits. Benefits are available for Inpatient or Outpatient care for mental health and Substance Use conditions, including individual and group psychotherapy, psychiatric tests, and expenses related to the Diagnosis when rendered by a covered Provider.

Benefits are available for, but not limited to, Residential Treatment Facility, Partial Hospitalization, and Intensive Outpatient Services.

Midwife Services. Benefits for midwife services performed by a certified nurse midwife (CNM) who is licensed as such and acting within the scope of his/her license. This Plan will not provide benefits for lay midwives or other individuals who become midwives by virtue of their experience in performing deliveries.

Newborn Care. Hospital and Physician nursery care for newborns who are Children of the Employee or spouse and properly enrolled in the Plan, as set forth below. Benefits will be provided under the mother's coverage:

1. Hospital routine care for a newborn during the Child's initial Hospital confinement at birth.

2. The following Physician services for well-baby care during the newborn's initial Hospital confinement at birth:

    a. The initial newborn examination and a second examination performed prior to discharge from the Hospital.
    b. Circumcision.

NOTE: *The Plan will cover Hospital and Physician nursery care for an ill newborn as any other medical condition, provided the newborn is properly enrolled in the Plan. These benefits are provided under the mother's coverage.*

Nursing Services. Services of a Registered Nurse or Licensed Practical Nurse.

Nutritional Counseling. Charges for nutritional counseling for the management of a medical condition that has a specific diagnostic criteria that can be verified. The nutritional counseling must be prescribed by a Physician.

Off-Label Drug Use. Charges for the use of an FDA-approved drug for a purpose other than that for which it is approved, but only when the drug is not excluded by the plan and the plan sponsor determines in its sole discretion that the drug is appropriate and generally accepted for the condition being treated, subject to the maximum benefit shown on the Schedule of Benefits.

Oral Surgery. Oral surgery in relation to the bone, including tumors, cysts and growths not related to the teeth, and extraction of soft tissue impacted teeth by a Physician or Dentist. Removal of bony impacted wisdom teeth is covered.

Osseous Surgery. For osseous surgery.

Ostomy Care. Patient education programs that are medically necessary regarding ostomy care.

Phase III Oncology Clinical Trials. Charges for a drug, device, supply, treatment, procedure, or service that is part of a scientific study of cancer therapy in a Phase III clinical trial sponsored by the National Cancer Institute or institution of similar stature. Trials must have Institutional Review Board (IRB) approval by a qualified IRB.

Charges that are not covered: Costs for services that are not primarily for the care of the patient (ie. lab services performed solely to collect data for the trial), and costs for services provided in a clinical trial that are funded by another source.

Physician Services. Services of a Physician for Medically Necessary care, including office visits, home visits, Hospital Inpatient care, Hospital Outpatient visits and exams, clinic care and surgical opinion consultations.

Podiatry Services. Surgical podiatry services, including incision and drainage of infected tissues of the foot, removal of lesions of the foot, removal or debridement of infected toenails, surgical removal of nail root, and treatment of fractures or dislocations of bones of the foot.

Pregnancy Expenses. Dependent Children are eligible for coverage for any expenses in connection with Pregnancy.

Under the Newborns' and Mothers' Health Protection Act of 1996, group health plans and health insurance issuers 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 cesarean section. However, Federal law generally does not prohibit the mother's or newborn's attending Provider, after consulting with the mother, from discharging the mother or her newborn earlier

than 48 hours (or 96 hours as applicable). In any case, plans and issuers may not, under Federal law, require that a Provider obtain authorization from the Plan or the issuer for prescribing a length of stay not in excess of 48 hours (or 96 hours). In no event will an "attending Provider" include a plan, Hospital, managed care organization, or other issuer.

Benefits are payable in the same manner as for medical or surgical care of an Illness, shown in the Summary of Benefits and this section, and subject to the same maximums, if any.

Prescription Drugs. Prescription drugs dispensed in a provider's office.

Preventive Care. Charges for preventive care services. This Plan intends to comply with the Affordable Care Act's (ACA) requirement to offer In-Network coverage for certain preventive services without cost-sharing.

Benefits mandated through the ACA legislation include preventive care such as immunizations, screenings, and other services that are listed as recommended by the United States Preventive Services Task Force (USPSTF), the Health Resources Services Administration (HRSA), and the Federal Centers for Disease Control (CDC).

See the following websites for more details:
https://www.healthcare.gov/coverage/preventive-care-benefits/;
https://www.uspreventiveservicestaskforce.org/uspstf/recommendation-topics/uspstf-a-and-b-recommendations;
https://www.cdc.gov/vaccines/hcp/acip-recs/index.html;
https://www.aap.org/en-us/Documents/periodicity_schedule.pdf;
https://www.hrsa.gov/womensguidelines/.

NOTE: *The preventive care services identified through the above links are recommended services. These guidelines and recommendations are subject to change and may require that additional services be covered under Preventive Care in the future. It is up to the Provider and/or Physician of care to determine which services to provide; the Plan Administrator has the authority to determine which services will be covered. Preventive Care services will be covered at 100% for Non-Network Providers if there is no Network Provider who can provide a required preventive service.*

Preventive and Wellness Services for Adults and Children - In compliance with section (2713) of the Affordable Care Act, benefits are available for evidence-based items or services that have in effect a rating of "A" or "B" in the current recommendations of the United States Preventive Services Task Force (USPSTF).

Immunizations that have in effect a recommendation from the Advisory Committee on Immunization Practices (ACIP) of the Centers for Disease Control and Prevention (CDC) with respect to the individual involved.

With respect to infants, Children, and adolescents, evidence-informed Preventive Care and screenings as provided for in the comprehensive guidelines supported by the Health Resources and Services Administration.

Women's Preventive Services - With respect to women, such additional Preventive Care and screenings as provided for in comprehensive guidelines supported by the Health Resources and Services Administration (HRSA) not otherwise addressed by the recommendations of the United States Preventive Service Task Force (USPSTF), which will be commonly known as HRSA's Women's Preventive Services Required Health Plan Coverage Guidelines. The HRSA has added the following eight categories of women's services to the list of mandatory preventive services:

1. Well-woman visits.

2. Gestational diabetes screening.
3. Human papillomavirus (HPV) Deoxyribonucleic Acid (DNA) testing.
4. Sexually transmitted infection counseling.
5. Human Immunodeficiency Virus (HIV) screening and counseling.
6. Food and Drug Administration (FDA)-approved contraception methods and contraceptive counseling.
7. Breastfeeding support, supplies and counseling.
8. Domestic violence screening and counseling.

A description of Women's Preventive Services can be found at: http://www.hrsa.gov/womensguidelines/ or at the websites listed above.

Private Duty Nursing. Outpatient only.

Prosthetics, Orthotics, Supplies and Surgical Dressings. Prosthetic devices (other than dental) to replace all or part of an absent body organ or part, including replacement due to natural growth or pathological change, but not including charges for repair or maintenance. This benefit includes Orthotic devices, but orthopedic shoes and other supportive devices for the feet and non-custom molded shoe inserts are excluded. Custom molded shoe inserts will be considered a covered expense. See also the General Limitations and Exclusions section for limitations.

Please Note: Prosthetic Appliances and Devices-External. External and internal power enhancements or power controls for prosthetic limbs and terminal devices; and Myoelectric prostheses peripheral nerve stimulators, are covered.

Pulmonary Rehabilitation. Medically necessary outpatient pulmonary rehabilitation programs.

Radiation Therapy. Charges for radiation therapy and treatment.

Routine Patient Costs for Participation in an Approved Clinical Trial. Charges for any Medically Necessary services, for which benefits are provided by the Plan, when a Participant is participating in a phase I, II, III or IV clinical trial, conducted in relation to the prevention, detection or treatment of a life-threatening Disease or condition, as defined under Affordable Care Act (ACA), provided:

1. The clinical trial is approved by any of the following:

    a. The Centers for Disease Control and Prevention of the U.S. Department of Health and Human Services.
    b. The National Institute of Health.
    c. The U.S. Food and Drug Administration.
    d. The U.S. Department of Defense.
    e. The U.S. Department of Veterans Affairs.
    f. An Institutional review board of an Institution that has an agreement with the Office for Human Research Protections of the U.S. Department of Health and Human Services.

2. The research Institution conducting the Approved Clinical Trial and each health professional providing routine patient care through the Institution, agree to accept reimbursement at the applicable Covered Expense, as payment in full for routine patient care provided in connection with the Approved Clinical Trial.

The following items are excluded from approved clinical trial coverage under this Plan:

1. The cost of an Investigational new drug or device that is not approved for any indication by the U.S. Food and Drug Administration, including a drug or device that is the subject of the Approved Clinical Trial.

2. The cost of a service that is not a health care service, regardless of whether the service is required in connection with participation in an Approved Clinical Trial.
3. The cost of a service that is clearly inconsistent with widely accepted and established standards of care for a particular Diagnosis.
4. A cost associated with managing an Approved Clinical Trial.
5. The cost of a health care service that is specifically excluded by the Plan.
6. Services that are part of the subject matter of the Approved Clinical Trial and that are customarily paid for by the research institution conducting the Approved Clinical Trial.

If one or more participating Providers do participate in the Approved Clinical Trial, the qualified Participant must participate in the Approved Clinical Trial through a participating, Network Provider, if the Provider will accept the Participant into the trial.

The Plan does not cover routine patient care services that are provided outside of this Plan's health care Provider Network unless Non-Network benefits are otherwise provided under this Plan.

Second Surgical Opinions. Charges for second surgical opinions.

Skilled Nursing Facility. Charges made by a Skilled Nursing Facility or a convalescent care facility as defined in the Plan, up to the limits set forth in the Summary of Benefits, in connection with convalescence from an Illness or Injury for which the Participant is confined. For information on Inpatient medical benefits for mental health or Substance Use Disorders, please refer to the "Mental Health and Substance Use Benefits" in the Medical Benefits section above.

Sleep Disorders. Charges for sleep studies and treatment of sleep apnea and other sleep disorders, including charges for sleep apnea monitors.

Sterilization. All Food and Drug Administration (FDA) approved charges related to sterilization procedures, to the extent required by the Affordable Care Act (ACA).

Surcharges. Any surcharge or assessment on covered expenses, required by state or federal law to be paid by the plan for services, supplies, and/or treatments rendered by a health care provider shall be a covered expense subject to the covered person's obligations under the Plan.

Surgery. Surgical operations and procedures, unless otherwise specifically excluded under the Plan, and limited as follows:

1. Multiple procedures adding significant time or complexity will be allowed at:
    1. One hundred percent (100%) of the full Maximum Allowable Charge fee value for the first or major procedure.
    2. Fifty percent (50%) of the Maximum Allowable Charge fee value for the secondary and subsequent procedures.
    3. Bilateral procedures which add significant time or complexity, which are provided at the same operative session, will be allowed at one hundred percent (100%) of Maximum Allowable Charge fee value for the major procedure, and fifty percent (50%) of the Maximum Allowable Charge fee value for the secondary or lesser procedure.
2. The Maximum Allowable Charge for services rendered by an assistant surgeon will be limited to twenty percent (20%) of the Maximum Allowable Charge identified for the surgeon's service
3. No benefit will be payable for incidental procedures, such as appendectomy during an abdominal Surgery, performed during a single operative session.

Surgical Treatment of Jaw. Surgical treatment of Diseases, Injuries, fractures and dislocations of the jaw by a Physician or Dentist.

Temporomandibular Joint Disorder (TMJ). Charges for the Diagnosis and treatment of, or in connection with, temporomandibular joint disorders, myofascial pain dysfunction or orthognathic treatment.

The following are non-covered expenses: charges to alter vertical dimension or to restore abraded dentition, and orthodontia.

Telehealth. Charges for any Medically Necessary services, for which benefits are otherwise provided by the Plan, when those services are provided via audio or video communications.

Therapy Services. Services for individual therapy are covered on an Inpatient or Outpatient basis. They are services or supplies used for the treatment of an Illness or Injury and include:

1. **Autism Spectrum Disorder Treatment.** Charges for treatment of Autism Spectrum Disorder (ASD).
2. **Cardiac Therapy.** Charges for cardiac therapy.
3. **Occupational Therapy.** Rehabilitation treatment or services rendered by a registered occupational therapist, under the direct supervision of a Physician, in a home setting or at a facility or Institution whose primary purpose is to provide medical care for an Illness or Injury, or at a free-standing outpatient facility.
4. **Physical Therapy.** Rehabilitation treatment or services rendered by a physical therapist, under direct supervision of a Physician, in a home setting or a facility or Institution whose primary purpose is to provide medical care for an Illness or Injury, or at a free-standing duly licensed outpatient therapy facility.
5. **Respiration Therapy.** Respiration therapy services.
6. **Speech Therapy.** Speech therapy, for Rehabilitation purposes, by a Physician or qualified speech therapist, when needed due to a Sickness or Injury (other than a functional Mental Disorder, Behavioral Disorder, or Nervous Neurodevelopmental Disorder) or due to Surgery performed as the result of a Sickness or Injury, excluding speech therapy services that are educational in any part or due to articulation disorders, tongue thrust, stuttering, lisping, abnormal speech development, changing an accent, dyslexia, hearing loss which is not medically documented or similar disorders.

See the Summary of Benefits for treatment and/or frequency limitations.

Tobacco Smoking Cessation. Nicotine withdrawal programs, facilities, drugs or supplies.

Transplants. Organ or tissue transplants are covered for the following human to human organ or tissue transplant procedures:

1. Bone marrow.
2. Heart.
3. Lung.
4. Heart and lung.
5. Liver.
6. Pancreas.
7. Kidney.
8. Cornea.

In addition, the Plan will cover any other transplant that is not Experimental.

Covered expenses will be considered the same as any other Sickness for Employees or Dependents as a recipient of an organ or tissue transplant. Covered expenses include:

1. Organ or tissue procurement from a cadaver consisting of removing, preserving and transporting the donated part.
2. Services and supplies furnished by a Provider.
3. Drug therapy treatment to prevent rejection of the transplanted organ or tissue.

ARTICLE XVI
UTILIZATION MANAGEMENT

"Utilization Management" consists of several components to assist Participants in staying well: providing optimal management of chronic conditions, support, and service coordination during times of acute or new onset of a medical condition. The scope of the program includes Hospital admission pre-certification, continued stay review, length of stay determination, discharge planning, and case management. These programs are designed to ensure that Medically Necessary, high quality patient care is provided and enables maximum benefits under the Plan. In order to maximize Plan reimbursements, please read the following provisions carefully.

16.01 Services that Require Pre-Certification

The following services will require Pre-Certification (or reimbursement from the Plan may be reduced):

1. Inpatient hospitalization.
2. Transplant candidacy evaluation and transplant (organ and/or tissue).
3. Rehab program (such as Cardiac, Pain Management, Pulmonary).
4. Skilled Nursing Facility stays.
5. Long Term Acute Care
6. Inpatient Mental/Nervous facility based programs
7. Inpatient substance use

Remember that although the Plan will automatically pre-certify a maternity length of stay that is 48 hours or less for a vaginal delivery or 96 hours for a cesarean delivery, it is important that the Participant has his or her Physician call to obtain Pre-Certification if there is a need to have a longer stay.

The Pre-Certification process is limited to determining the Medical Necessity of the procedure. This does not verify eligibility for benefits nor guarantee benefit payments under the Plan. It is the Participant's responsibility to verify that the above services have been pre-certified as outlined below.

Notification is requested for the following services:

1. All observation stays in excess of 23 hours.

This Plan is a plan, which contains a Participating Provider Organization. This Plan has entered into an agreement with certain Hospitals, Physicians and other health care providers, which are called Participating Providers. Because these Participating Providers have agreed to charge reduced fees to persons covered under the Plan, the Plan can afford to reimburse a higher percentage of their fees.

Therefore, when a Participant uses a Participating Provider, that Participant will receive a higher payment from the Plan than when a Non-participating Provider is used. It is the Participant's choice as to which Provider to use.

Under the following circumstances, the higher Network payment will be made for certain Non-Network services:

1. Emergency medical care requiring immediate care.
2. Emergency ambulance transportation.

Please note affirmation that a treatment, service, or supply is of a type compensable by the Plan is not a guarantee that the particular treatment, service, or supply in question, upon receipt of a Clean Claim and review by the Plan Administrator, will be eligible for payment.

16.02 Pre-Certification or Notification Procedures and Contact Information

The Utilization Management Service is simple and easy for Participants to use. Whenever a Participant is advised that services requiring Pre-Certification are needed, it is the Participant's responsibility to call the pre-certification department at its toll free number, which is . The review process will continue, as outlined below, until the completion of the treatment plan and/or the Participant's discharge from the Hospital.

Urgent Care or Emergency Admissions:
If a Participant needs medical care for a condition which could seriously jeopardize his or her life, he or she should obtain such care without delay, and communicate with the Plan as soon as reasonably possible.

If a Participant must be admitted on an Emergency basis, the Participant, or an individual acting on behalf of the Participant, should follow the Physician's instructions carefully and contact the pre-certification department as follows:

1. For Emergency admissions after business hours on Friday, on a weekend or over a holiday weekend, a call to the pre-certification department must be made within 72 hours after the admission date, but no later than the first business day following the Emergency admission, by or on behalf of the covered patient.
2. For Emergency admissions on a weekday, a call to the pre-certification department must be made within 24 hours after the admission date, by or on behalf of the covered patient.

The Plan does not require the Participant to obtain approval of a medical service prior to getting treatment for an urgent care or Emergency situation, so there are no "Pre-service Urgent Care Claims" under the Plan. The Participant simply follows the Plan's procedures with respect to any notice which may be required after receipt of treatment, and files the claim as a Post-service Claim.

Non-Emergency Admissions:
For Hospital stays that are scheduled in advance, a call to the pre-certification department should be completed as soon as possible before actual services are rendered. Once the pre-certification call is received, it will be routed to an appropriate review specialist who will create an online patient file. The review specialist will contact the Participant's attending Physician to obtain information and to discuss the specifics of the admission request. If appropriate, alternative care will be explored with the Physician.

If, after assessing procedure necessity, the need for an Inpatient confinement is confirmed, the review specialist will determine the intensity of management required and will remain in contact with the Physician or Hospital during the confinement.

If, at any time during the review process, Medical Necessity cannot be validated, the review specialist will refer the episode to a board certified Physician advisor who will immediately contact the attending Physician to negotiate an appropriate treatment plan. At the end of the Hospital confinement, the review specialist is also available to assist with discharge planning and will work closely with the attending Physician and Hospital to ensure that medically appropriate arrangements are made.

Outpatient Services:
A Participant is required to contact the pre-certification department when the Physician requests certain outpatient procedures and services. The Summary of Benefits indicates which outpatient procedures and services require Pre-Certification.

16.03 Alternate Course of Treatment

Certain types of conditions, such as spinal cord Injuries, cancer, AIDS or premature births, may require long term, or perhaps lifetime, care. The claims selected will be evaluated as to present course of treatment and alternate care possibilities.

If the Plan Administrator should determine that an alternate, less expensive, course of treatment is appropriate, and if the attending Physician agrees to the alternate course of treatment, all Medically

Necessary expenses stated in the treatment plan will be eligible for payment under the Plan, subject to the applicable benefit maximum(s) set forth in this Plan, even if these expenses normally would not be eligible for payment under the Plan. In the event the Participant and the attending Physician select a more expensive course of treatment, coverage under the Plan will be based upon the charge allowed for the alternate, less expensive, course of treatment.

16.04 Pre-Admission Testing

If a Participant is to be admitted to a Hospital for non-Emergency Surgery or treatment, one set of laboratory tests and x-ray examinations performed on an Outpatient basis within 7 days prior to such Hospital admission will be paid, with no Deductible, at 100% of the Maximum Allowable Charge, provided that the following conditions are met:

1. The tests are related to the performance of the scheduled Surgery or treatment.
2. The tests have been ordered by a Physician after a condition requiring Surgery or treatment has been diagnosed and Hospital admission has been requested by the Physician and confirmed by the Hospital.
3. The Participant is subsequently admitted to the Hospital, or confinement is cancelled or postponed because a Hospital bed is unavailable or if, after the tests are reviewed, the Physician determines that the confinement is unnecessary.
4. The tests are performed in the Hospital where the confinement will take place and accepted in lieu of duplicate tests rendered during confinement.

16.05 Case Management

Case management is a preemptive coordination of a Participant's care in cases where the medical condition is or is expected to be serious, chronic, or when the cost of treatment is expected to be significant. This program provides for a case manager who monitors Participants and explores, discusses and recommends coordinated and/or alternate types of appropriate Medically Necessary care. Case management is a voluntary service. There are no reductions of benefits or penalties if the patient and family choose not to participate. Each treatment plan is individually tailored to a specific patient and should not be seen as appropriate or recommended for any other patient, even one with the same Diagnosis.

ARTICLE XVII
PRESCRIPTION DRUG BENEFITS

Plan A - PPO Plan

Prescription Drug Benefit		
Rx Out of Pocket Maximum Combined with Medical		N/A
Retail *(Benefit limited to 34 day supply*)*		
Generic	$20	N/A
Brand	$55	N/A
Non-Preferred	$80	N/A
Specialty	Not Covered	N/A
Preventative Medications as defined by PPACA	$0	N/A
**The quantity per prescription shall be greater of a 34 day supply or 100 unit dosage, if defined as a maintenance drug*		
Mail Order *(90-Day Supply)*		
Generic	$40	N/A
Brand	$137.50	N/A
Non-Preferred	$200	N/A
Specialty	Not Covered	N/A
Preventative Medications as defined by PPACA	$0	N/A

Plan B – HSA Plan

Prescription Drug Benefit		
Rx Deductible and Out of Pocket Maximum Combined with Medical		N/A
Retail *(Benefit limited to 34 day supply*)*		
Generic	$20 copay after deductible	N/A
Brand	$55 copay after deductible	N/A
Non-Preferred	$80 copay after deductible	N/A
Specialty	Not Covered	N/A
Preventative Medications as defined by PPACA	$0	N/A
**The quantity per prescription shall be greater of a 34 day supply or 100 unit dosage, if defined as a maintenance drug*		
Mail Order *(90-Day Supply)*		
Generic	$40 copay after deductible	N/A
Brand	$137.50 copay after deductible	N/A
Non-Preferred	$200 copay after deductible	N/A
Specialty	Not Covered	N/A
Preventative Medications as defined by PPACA	$0	N/A

Participants will be issued an identification card to use at the pharmacy at time of purchase. Participants will be held fully responsible for the consequences of any pharmacy identification card after termination of coverage. No reimbursement will be made when the identification card is not used.

The Mail Order Option is available for maintenance medications (those that are taken for long periods of time, such as Drugs sometimes prescribed for heart Disease, high blood pressure, asthma, etc.). Because of volume buying, the mail order pharmacy is able to offer Participants significant savings on their prescriptions.

The Copayment is applied to each charge and is shown on the Summary of Benefits, above.

17.01 Covered Expenses

The following are covered under the Plan:

Acne Control. Drugs that help manage the severity and frequency of acne outbreaks that cannot be purchased over-the-counter.

Allergy Sera. Charges for allergy sera.

Bee Sting Kits. Charges for EPI PEN and Ana Kit.

Compounded Prescriptions. All compounded prescriptions containing at least one prescription ingredient in a therapeutic quantity.

Contraceptives. All Food and Drug Administration (FDA)- approved contraceptives Drugs and methods, in accordance with the Health Resources and Services Administration (HRSA) guidelines. ***NOTE:*** *All other contraceptive methods are covered under the Preventive Care benefit in the medical plan.*

Diabetes. Insulins, insulin syringes and needles, diabetic supplies – legend, and glucose test strips, when prescribed by a Physician.

Imitrex Injection. Charges for Imitrex injections (migraine auto-injector).

Immunizations. Immunization agents or biological sera.

Legend Drugs.

Required by Law. All Drugs prescribed by a Physician that require a prescription either by Federal or State law, except injectables (other than insulin) and the Drugs excluded below.

17.02 Limitations

The benefits set forth in this Article will be limited to:

1. Dosages.
    a. With respect to the Pharmacy Option, any one prescription is limited to the greater of a 34 day supply.
    b. With respect to the Mail Order Option, any one prescription is limited to the greater of a 90 day supply.
2. Refills.
    a. Refills only up to the number of times specified by a Physician.
    b. Refills up to one year from the date of order by a Physician.

17.03 Exclusions

In addition to the General Limitations and Exclusions set forth in Article VII, the following are not covered by the Plan:

Administration. Any charge for the administration of a covered Drug.

Anorexiants. Anorexiants (weight loss Drugs).

Anti-Aging Products. Drugs intended to affect the structure or function of the skin that cannot be purchased over-the-counter.

Blood and Blood Plasma. Charges for blood and blood plasma.

Consumed Where Dispensed. Any Drug or medicine that is consumed or administered at the place where it is dispensed.

Devices. Devices of any type, even though such devices may require a prescription, including, but not limited to, therapeutic devices, artificial appliances, braces, support garments or any similar device.

Drug Efficacy Study Implementation (DESI) Drugs. Charges for DESI Drugs.

Excess Prescription Refill. Any prescription refilled in excess of the number specified by the physician or any refill dispensed after one (1) year from the physician's original order. Dispensing limitation: the amount normally prescribed by a physician, but not to exceed a thirty-four (34) day supply or a one hundred (100) unit does, whichever is greater.

Experimental Drugs. Experimental Drugs and medicines, even though a charge is made to the Participant.

Fertility Agents. Charges for fertility agents.

Fluoride Supplements. Except as required by the USPSTF A & B Recommendations.

Growth Hormones. For growth hormones, unless otherwise approved by the Plan Administrator.

Hemantics.

Immunizations. Immunization agents or biological sera.

Impotency. A charge for impotency medication, including Viagra.

Institutional Medication. A Drug or medicine that is to be taken by a Participant, in whole or in part, while confined in an Institution, including any Institution that has a facility for dispensing Drugs and medicines on its premises.

Investigational Use Drugs. A Drug or medicine labeled "Caution – limited by Federal law to investigational use".

Medical Devices and Supplies. Charges for legend and over the counter medical devices and supplies.

Minerals.

Norplant Implants.

No Charge. A charge for drugs which may be properly received without charge under local, State or Federal programs.

Non-Insulin Syringes/Needles. Charges for non-insulin syringes and needles.

Non-Prescription Drug or Medicine. A drug or medicine that can legally be bought without a prescription, except for injectable insulin, except to the extent required by the FFCRA, as amended. Please Note: Language regarding the FFCRA will be removed as of May 12, 2023.

Occupational. Prescriptions necessitated due to an occupational activity or event occurring as a result of an activity for wage or profit which an eligible person is entitled to receive without charge under any workers' compensation or similar law.

Over-the-Counter Drugs. Charges for over the counter drugs except to the extent required by the FFRCA, as amended and the Affordable Care Act. Please Note: Language regarding the FFCRA will be removed as of May 12, 2023.

Proton Pump Inhibitors.

Rogaine. Charges for Rogaine (topical minoxidil).

Specialty Drugs. Specialty Pharmaceutical Drugs are no longer included in your Major Medical Plan. Notwithstanding the foregoing, the Plan MAY cover the charges for a Specialty Pharmaceutical Drug for one 30 day period during a calendar year for each Specialty Pharmaceutical Drug when an urgent fill of medication is required, unless otherwise excluded elsewhere in the Plan.

Specialty Pharmaceutical Drug(s) are those federal legend drugs that are any drug, regardless of route of administration, which are classified by the pharmacy benefit manager as "specialty" medications. A drug is considered a "specialty" medication if it includes one or more of the following characteristics:

-Requires patient participation in a medical management program that includes review of medication use, patient training, coordination of care and management of successful use.
- Continual monitoring and training is needed
- A FDA-mandated Risk Evaluation and Mitigation Strategy program is utilized in order to approve medication
- Medication has particular handling, distribution, and/or administration requirements
- Medication has a high cost
- Medication is administered orally, inhaled, infused or injected
- Medication is used to target chronic or complex diseases
- Medication can be produced through biological processes
- Medication is used to treat rare diseases and is referred to as orphan drugs

Smoking Deterrents. A charge for Drugs or aids for smoking cessation, including, but not limited to, nicotine gum and smoking cessation patches.

Vitamins. Vitamins, except pre-natal vitamins.

ARTICLE XVIII
FEDERAL LAWS

Certain Federal laws apply to most group health programs. The following is an overview of the laws and their impact. The effect of these laws on the Plan is reflected in the provisions of the Plan. Should there be any conflict between the law and Plan provisions, the law will prevail.

HEALTH INSURANCE PORTABILITY AND ACCOUNTABILITY ACT OF 1996 (H.R. 3103, 1996)
The Health Insurance Portability and Accountability Act (HIPAA) amended ERISA and was enacted, among other things, to improve portability and continuity of health care coverage.

HIPAA also requires that Participants and beneficiaries receive a summary of any change that is a "Material Reduction in covered services or benefits under a group health plan" within 60 days after the adoption of the modification or change, unless the Plan Sponsor provides summaries of modifications or changes at regular intervals of 90 days or less.

PREGNANCY DISCRIMINATION ACT OF 1978
Most Employers must provide coverage for Pregnancy expenses in the same manner as coverage is provided for any other Illness. This requirement applies to Pregnancy expenses of an Employee or a covered Dependent spouse of an Employee.

FAMILY AND MEDICAL LEAVE ACT OF 1993 (P.L. 103-3)
If a covered employee ceases active employment due to an Employer-approved Family Medical Leave of Absence in accordance with the requirements of Public Law 103, coverage availability will continue under the same terms and conditions which would have applied had the Employee continued in active employment. Contributions will remain at the same Employer/Employee levels as were in effect on the date immediately prior to the leave (unless contribution levels change for other Employees in the same classification).

OMNIBUS BUDGET RECONCILIATION ACT OF 1993 (OBRA 1993: PL 103-66)
OBRA 1993 requires that an eligible Dependent Child of an Employee will include a Child who is adopted by the Employee or placed with him for adoption prior to age 18 and a Child for whom the Employee or covered Dependent spouse is required to provide coverage due to a Medical Child Support Order (MCSO) which is determined by the Plan Sponsor to be a Qualified Medical Child Support Order (QMCSO). A QMCSO will also include a judgment, decree or order issued by a court of competent jurisdiction or through an administrative process established under State law and having the force and effect of law under State law and which satisfies the QMCSO requirements of ERISA (section 609(a)).

Participants may obtain a copy of the QMCSO procedures from the Plan Sponsor or Plan Administrator without charge.

NEWBORNS' AND MOTHERS' HEALTH PROTECTION ACT OF 1996
The Newborns' and Mothers' Health Protection Act of 1996 establishes restrictions on the extent to which group health plans and health insurance issuers may limit the length of stay for mothers and newborn Children following delivery, as follows:

> **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 Children 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 (i.e., 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 or 96 hours. However, to use certain providers or Facilities, or to reduce your out-of-pocket costs, you may be required to give notification. For information on notification, contact your Plan Administrator.

WOMEN'S HEALTH AND CANCER RIGHTS ACT OF 1998
If you are receiving covered benefits for a mastectomy, you should know that your Plan complies with the Women's Health and Cancer Rights Act of 1998. The Act provides for:

1. Reconstruction of the breast(s) on which a covered mastectomy has been performed.
2. Surgery and reconstruction of the other breast to produce a symmetrical appearance.
3. Prostheses and physical complications related to all stages of covered mastectomy, including lymphedema.

All applicable benefit provisions still apply, including existing Deductibles, Copays and/or coinsurance.

GENETIC INFORMATION NONDISCRIMINATION ACT OF 2008 ("GINA")
GINA prohibits the group health Plan from:

1. Adjusting premiums or contribution amounts for the group as a whole on the basis of Genetic Information.
2. Requesting or requiring an individual or a Family member to undergo a genetic test. However, subject to certain conditions, the Plan may request that an individual voluntarily undergo a genetic test as part of a research study as long as the results are not used for underwriting purposes.
3. Requesting, requiring or purchasing Genetic Information for underwriting purposes (which includes eligibility rules or determinations, computation of premium or contribution amounts and other activities related to the creation, renewal or replacement of coverage). The Plan is also prohibited from requesting, requiring or purchasing Genetic Information with respect to any individual prior to such individual's enrollment under the Plan or coverage. However, if the Plan obtains Genetic Information incidental to the collection of other information prior to enrollment, it will not be in violation of GINA as long as it is not used for underwriting purposes.

GINA allows the group health Plan to obtain and use the results of genetic tests for purposes of making payment determinations.

What is "Genetic Information" under GINA?

Under GINA, the term "Genetic Information" includes:

1. Information about an individual or his or her Family member's genetic tests (defined as analyses of the individual's DNA, RNA, chromosomes, proteins, or metabolites that detect genotypes, mutations or chromosomal changes).
2. The manifestation of a Disease or disorder in the Family members of the individual. Family members are broadly defined under GINA to include individuals who are Dependents, as well as any other first, second, third or fourth degree relative. Further, Genetic Information includes that information of any fetus or embryo carried by a pregnant woman.
3. Information obtained through genetic services (that is genetic tests, genetic counseling or genetic education) or participation in clinical research that includes genetic services.

Genetic Information does not include the sex or age of an individual.

MENTAL HEALTH PARITY AND ADDICTION EQUITY ACT OF 2008 (MHPAEA)
Requires that, if a group health plan provides coverage for mental health conditions or for substance use disorders, then benefits for such conditions must be provided in the same manner as benefits for any Illness. Also, the Plan may not have separate cost-sharing arrangements that apply only to mental health or substance use disorder benefits.

MEDICAID AND THE CHILDREN'S HEALTH INSURANCE PROGRAM (CHIP) OFFER FREE OR LOW-COST HEALTH COVERAGE TO CHILDREN AND FAMILIES
If you are eligible for health coverage from your Employer, but are unable to afford the premiums, some States have premium assistance programs that can help pay for coverage. These States use funds from their Medicaid or CHIP programs to help people who are eligible for Employer-sponsored health coverage, but need assistance in paying their health premiums.

If you or your Dependents are already enrolled in Medicaid or CHIP and you live in a State listed below, you can contact your State Medicaid or CHIP office to find out if premium assistance is available.

If you or your Dependents are NOT currently enrolled in Medicaid or CHIP, and you think you or any of your Dependents might be eligible for either of these programs, you can contact your State Medicaid or CHIP office or dial **1-877-KIDS NOW** or www.insurekidsnow.gov to find out how to apply. If you qualify, you can ask the State if it has a program that might help you pay the premiums for an Employer-sponsored plan.

Once it is determined that you or your Dependents are eligible for premium assistance under Medicaid or CHIP, your Employer's health plan is required to permit you and your Dependents to enroll in the Plan - as long as you and your Dependents are eligible, but not already enrolled in the Employer's Plan. This is called a "Special Enrollment" opportunity, and **you must request coverage within 60 days of being determined eligible for premium assistance.**

For additional information please contact the Third Party Administrator.

Third Party Administrator:	**Insurance Administrator of America, LLC.**
(aka Claims Processor)	**1934 Olney Ave., Suite 200**
	Cherry Hill, NJ 08003
	Phone: 856-470-1200
	Fax: 800-238-0519
	Email: claims@iaatpa.com

ARTICLE XIX
HIPAA PRIVACY

Commitment to Protecting Health Information
The Plan will comply with the Standards for Privacy of Individually Identifiable Health Information (i.e., the "Privacy Rule") set forth by the U.S. Department of Health and Human Services ("HHS") pursuant to the Health Insurance Portability and Accountability Act of 1996 ("HIPAA"). Such standards control the dissemination of "protected health information" ("PHI") of Participants. Privacy Standards will be implemented and enforced in the offices of the Employer and Plan Sponsor and any other entity that may assist in the operation of the Plan.

The Plan is required by law to take reasonable steps to ensure the privacy of the Participant's PHI, and inform him/her about:

1. The Plan's disclosures and uses of PHI.
2. The Participant's privacy rights with respect to his or her PHI.
3. The Plan's duties with respect to his or her PHI.
4. The Participant's right to file a complaint with the Plan and with the Secretary of HHS.
5. The person or office to contact for further information about the Plan's privacy practices.

Within this provision capitalized terms may be used, but not otherwise defined. These terms shall have the same meaning as those terms set forth in 45 CFR Sections 160.103 and 164.501. Any HIPAA regulation modifications altering a defined HIPAA term or regulatory citation shall be deemed incorporated into this provision.

Definitions

- **Breach** means an unauthorized acquisition, access, use or disclosure of Protected Health Information ("PHI") or Electronic Protected Health Information ("ePHI") that violates the HIPAA Privacy Rule and that compromises the security or privacy of the information.
- **Protected Health Information ("PHI")** means individually identifiable health information, as defined by HIPAA, that is created or received by the Plan and that relates to the past, present, or future physical or mental health or condition of an individual; the provision of health care to an individual; or the past, present, or future payment for the provision of health care to an individual; and that identifies the individual or for which there is a reasonable basis to believe the information can be used to identify the individual. PHI includes information of persons living or deceased.

How Health Information May be Used and Disclosed
In general, the Privacy Rules permit the Plan to use and disclose, the minimum necessary amount, an individual's PHI, without obtaining authorization, only if the use or disclosure is for any of the following:

1. To carry out payment of benefits.
2. If the use or disclosure falls within one of the limited circumstances described in the rules (e.g., the disclosure is required by law or for public health activities).

Primary Uses and Disclosures of PHI

1. Treatment, Payment and Health Care Operations: The Plan has the right to use and disclose a Participant's PHI for all activities as included within the definitions of Treatment, Payment, and Health Care Operations and pursuant to the HIPAA Privacy Rule.
2. Business Associates: The Plan contracts with individuals and entities (Business Associates) to perform various functions on its behalf. In performance of these functions or to provide services, Business Associates will receive, create, maintain, use, or disclose PHI, but only after the Plan and the Business Associate agree in writing to contract terms requiring the Business Associate to appropriately safeguard the Participant's information.

3. Other Covered Entities: The Plan may also disclose or share PHI with other insurance carriers (such as Medicare, etc.) in order to coordinate benefits, if a Participant has coverage through another carrier.

Disclosure of 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:

1. Not use or further disclose PHI other than as permitted or required by the plan document or as required by law (as defined in the Privacy Standards).
2. 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.
3. Maintain the confidentiality of all PHI, unless an individual gives specific consent or authorization to disclose such data or unless the data is used for health care payment or Plan operations.
4. Receive PHI, in the absence of an individual's express authorization, only to carry out Plan administration functions.
5. Not use or disclose genetic information for underwriting purposes.
6. 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.
7. Make available PHI in accordance with section 164.524 of the Privacy Standards (45 CFR 164.524).
8. 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).
9. 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).
10. 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.

Required Disclosures of PHI

1. Disclosures to Participants: The Plan is required to disclose to a Participant most of the PHI in a Designated Record Set when the Participant requests access to this information. The Plan will disclose a Participant's PHI to an individual who has been assigned as his or her representative and who has qualified for such designation in accordance with the relevant State law. Before disclosure to an individual qualified as a personal representative, the Plan must be given written supporting documentation establishing the basis of the personal representation.
   The Plan may elect not to treat the person as the Participant's personal representative if it has a reasonable belief that the Participant has been, or may be, subjected to domestic violence, abuse, or neglect by such person, it is not in the Participant's best interest to treat the person as his or her personal representative, or treating such person as his or her personal representative could endanger the Participant.
2. Disclosures to the Secretary of the U.S. Department of Health and Human Services: The Plan is required to disclose the Participant's PHI to the Secretary of the U.S. Department of Health and Human Resources when the Secretary is investigating or determining the Plan's compliance with the HIPAA Privacy Rule.

Participant's Rights
The Participant has the following rights regarding PHI about him/her:

1. Request Restrictions: The Participant has the right to request additional restrictions on the use or disclosure of PHI for treatment, payment, or health care operations. The Participant may request that the Plan restrict disclosures to family members, relatives, friends or other persons identified by him or her who are involved in his or her care or payment for his or her care. The Plan is not required to agree to these requested restrictions.
2. Right to Receive Confidential Communication: The Participant has the right to request that he or she receive communications regarding PHI in a certain manner or at a certain location. The request must be made in writing and how the Participant would like to be contacted. The Plan will accommodate all reasonable requests.
3. Right to Receive Notice of Privacy Practices: The Participant is entitled to receive a paper copy of the plan's Notice of Privacy Practices at any time. To obtain a paper copy, contact the Privacy Officer.
4. Accounting of Disclosures: The Participant has the right to request an accounting of disclosures the Plan has made of his or her PHI. The request must be made in writing and does not apply to disclosures for treatment, payment, health care operations, and certain other purposes. The Participant is entitled to such an accounting for the six years prior to his or her request. Except as provided below, for each disclosure, the accounting will include: (a) the date of the disclosure, (b) the name of the entity or person who received the PHI and, if known, the address of such entity or person; (c) a description of the PHI disclosed, (d) a statement of the purpose of the disclosure that reasonably informs the Participant of the basis of the disclosure, and certain other information. If the Participant wishes to make a request, please contact the Privacy Officer.
5. Access: The Participant has the right to request the opportunity to look at or get copies of PHI maintained by the Plan about him/her in certain records maintained by the Plan. If the Participant requests copies, he or she may be charged a fee to cover the costs of copying, mailing, and other supplies. If a Participant wants to inspect or copy PHI, or to have a copy of his or her PHI transmitted directly to another designated person, he or she should contact the Privacy Officer. A request to transmit PHI directly to another designated person must be in writing, signed by the Participant and the recipient must be clearly identified. The Plan must respond to the Participant's request within 30 days (in some cases, the Plan can request a 30 day extension). In very limited circumstances, the Plan may deny the Participant's request. If the Plan denies the request, the Participant may be entitled to a review of that denial.
6. Amendment: The Participant has the right to request that the Plan change or amend his or her PHI. The Plan reserves the right to require this request be in writing. Submit the request to the Privacy Officer. The Plan may deny the Participant's request in certain cases, including if it is not in writing or if he or she does not provide a reason for the request.
7. Other uses and disclosures not described in this section can only be made with authorization from the Participant. The Participant may revoke this authorization at any time.

Questions or Complaints
If the Participant wants more information about the Plan's privacy practices, has questions or concerns, or believes that the Plan may have violated his or her privacy rights, please contact the Plan using the following information. The Participant may submit a written complaint to the U.S. Department of Health and Human Services or with the Plan. The Plan will provide the Participant with the address to file his or her complaint with the U.S. Department of Health and Human Services upon request.

The Plan will not retaliate against the Participant for filing a complaint with the Plan or the U.S. Department of Health and Human Services

Contact Information

Privacy Officer Contact Information:

Ninnescah Valley Health, Inc.
750 West D Avenue
Kingman, KS 67068
Phone: 620-532-3147

ARTICLE XX
HIPAA SECURITY

Disclosure of Electronic Protected Health Information ("Electronic PHI") to the Plan Sponsor for Plan Administration Functions

STANDARDS FOR SECURITY OF INDIVIDUALLY IDENTIFIABLE HEALTH INFORMATION ("SECURITY RULE")

The Security Rule imposes regulations for maintaining the integrity, confidentiality and availability of protected health information that it creates, receives, maintains, or maintains electronically that is kept in electronic format (ePHI) as required under the Health Insurance Portability and Accountability Act (HIPAA).

Definitions

- "*Electronic Protected Health Information*" (ePHI) is defined in Section 160.103 of the Security Standards (45 C.F.R. 160.103) and means individually identifiable health information transmitted or maintained in any electronic media.
- "Security Incidents" is defined within Section 164.304 of the Security Standards (45 C.F.R. 164.304) and means the attempted or successful unauthorized access, use, disclosure, modification, or destruction of information or interference with systems operation in an information system.

Plan Sponsor Obligations
To enable the Plan Sponsor to receive and use Electronic PHI for Plan Administration Functions (as defined in 45 CFR §164.504(a)), the Plan Sponsor agrees to:

1. Implement administrative, physical, and technical safeguards that reasonably and appropriately protect the confidentiality, integrity and availability of the Electronic PHI that it creates, receives, maintains, or transmits on behalf of the Plan.
2. Ensure that adequate separation between the Plan and the Plan Sponsor, as required in 45 CFR § 164.504(f)(2)(iii), is supported by reasonable and appropriate Security Measures.
3. Ensure that any agent, including a subcontractor, to whom the Plan Sponsor provides Electronic PHI created, received, maintained, or transmitted on behalf of the Plan, agrees to implement reasonable and appropriate administrative, physical, and technical safeguards to protect the confidentiality, integrity, and availability of the Electronic PHI and report to the Plan any security incident of which it becomes aware.
4. Report to the Plan any security incident of which it becomes aware.
5. Establish safeguards for information, including security systems for data processing and storage.
6. 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.
7. 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:
    a. The following Employees, or classes of Employees, or other persons under control of the Plan Sponsor, shall be given access to the PHI to be disclosed:
        i. Privacy Officer.
        ii. Director of Employee Benefits.
        iii. Employee Benefits Department employees.
        iv. Information Technology Department.
        v. CEO.
        vi. CFO.
        vii. Chief Human Resources Officer.
        viii. Executive Assistant.

b. The access to and use of PHI by the individuals identified above shall be restricted to the plan administration functions that the Plan Sponsor performs for the Plan.

Disclosure of Summary Health Information to the 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 Participant. 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" 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.

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 un-enrolled from a health insurance issuer or health maintenance organization offered by the Plan to the Plan Sponsor.

Disclosure of PHI to Obtain Stop-loss or Excess Loss Coverage
The Plan Sponsor may hereby authorize and direct the Plan, through the Plan Administrator or the Third Party Administrator, to disclose PHI to stop-loss carriers, excess loss carriers or managing general underwriters ("MGUs") for underwriting and other purposes in order to obtain and maintain stop-loss or excess loss coverage related to benefit claims under the Plan. Such disclosures shall be made in accordance with the Privacy Standards.

Resolution of Noncompliance
In the event that any authorized individual of the Employer's workforce uses or discloses Protected Health Information other than as permitted by the Privacy Standards, the incident shall be reported to the Privacy Officer. The Privacy Officer shall take appropriate action, including:

1. Investigation of the incident to determine whether the breach occurred inadvertently, through negligence, or deliberately; whether there is a pattern of breaches; and the degree of harm caused by the breach.
2. Applying appropriate sanctions against the persons causing the breach, which, depending upon the nature of the breach, may include oral or written reprimand, additional training, or termination of employment.
3. Mitigating any harm caused by the breach, to the extent practicable.
4. Documentation of the incident and all actions taken to resolve the issue and mitigate any damages.
5. Training Employees in privacy protection requirements and appoint a Privacy Officer responsible for such protections.
6. Disclosing the Participant's PHI to the Secretary of the U.S. Department of Health and Health and Human Resources when the Secretary is investigating or determining the Plan's compliance with the HIPAA Privacy Rule.

ARTICLE XXI
PARTICIPANT'S RIGHTS

As a Participant in the Plan, the Participant is entitled to certain rights and protections under ERISA. ERISA provides that all Participants are entitled to:

Receive Information About the Plan and Benefits
Examine, without charge, at the Plan Administrator's office and at other specified locations, such as worksites and union halls (if any), all documents governing the Plan, including insurance contracts, collective bargaining agreements (if any), and copies 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 Security Administration.

Obtain, upon written request to the Plan Administrator, copies of documents governing the operation of the Plan, including insurance contracts and collective bargaining agreements (if any), and copies of the latest annual report (Form 5500 Series) and updated summary plan description. The 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 the Employee and eligible Dependents if there is a loss of coverage under the Plan as a result of a Qualifying Event. The Employee or eligible Dependents may have to pay for such coverage. Review this Plan Document and the documents governing the Plan on the rules governing the Participant's COBRA Continuation Coverage rights.

Prudent Actions by Plan Fiduciaries
In addition to creating rights for Participants, ERISA imposes duties upon the people who are responsible for the operation of the Plan. The people who operate the Plan, called "fiduciaries" of the Plan, have a duty to do so prudently and in the interest of the Participants and beneficiaries. No one, including the Employer, the union (if any), or any other person, may fire the Employee or otherwise discriminate against the Employee in any way to prevent the Employee from obtaining a welfare benefit or exercising the Participant's rights under ERISA.

Enforce the Participant's Rights
If a Participant's claim for a welfare benefit is denied or ignored, in whole or in part, the Participant has 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 the Participant can take to enforce the above rights. For instance, if the Participant requests a copy of Plan documents or the latest annual report from the Plan and do not receive them within 30 days, the Participant may file suit in a Federal court. In such a case, the court may require the Plan Administrator to provide the materials and pay the Participant up to $110 a day until the Participant receives the materials, unless the materials were not sent because of reasons beyond the control of the Plan Administrator. If the Participant has a claim for benefits which is denied or ignored, in whole or in part, the Participant may file suit in a State or Federal court. In addition, if the Participant disagrees with the Plan's decision or lack thereof concerning the qualified status of a domestic relations order or a Medical Child Support Order, the Participant may file suit in Federal court. If it should happen that Plan fiduciaries misuse the Plan's money, or if the Participant is discriminated against for asserting his or her rights, the Participant may seek assistance from the U.S. Department of Labor, or the Participant may file suit in a Federal court. The court will decide who would pay court costs and legal fees. If the Participant is successful, the court may order the person the Participant sued to pay these costs and fees. If the Participant loses, the court may order the Participant to pay these costs and fees, for example, if it finds the Participant's claim is frivolous.

Assistance with the Participant's Questions

If the Participant has any questions about the Plan, the Participant should contact the Plan Administrator. If the Participant has any questions about this statement or about rights under ERISA, or needs assistance in obtaining documents from the Plan Administrator, the Participant should contact the nearest Office of the Employee Benefits Security Administration, U.S. Department of Labor, listed in the telephone directory or the Division of Technical Assistance and Inquiries, Employee Benefits Security Administration, U.S. Department of Labor, 200 Constitution Avenue, N.W., Washington, D.C., 20210. The Participant may also obtain certain publications about his or her rights and responsibilities under ERISA by calling the publications hotline of the Employee Benefits Security Administration.

ARTICLE XXII
ADDENDUM

- Covered Benefits: COVID-19 diagnostic testing will be covered in accordance with the guidelines of the CDC. All copays, deductibles and coinsurance will be waived when performed by a physician, urgent care, or hospital center.

- Treatment for services for COVID-19 are subject to standard cost sharing as outlined in the schedule of benefits

- Telemedicine visits covered at 100% – for any reason (until amended otherwise)

- Removal of Prescription Refill limitations on maintenance medications to assure an adequate supply in the event of self quarantine

- Continued Eligibility: Health Benefits are to be continued based on any of the following criteria.

    - Sick leave, accrued vacation, FMLA, State based FMLA, Cobra, disability or a company approved leave of absence for an employee deemed not actively at work due to self-quarantine.

    - Employees must return to work immediately following a quarantine period in order to continue actively at work status. In the event they do not return to work, standard termination provisions apply

    - Employees may be required to maintain contributions at the discretion of the employer.

An employer approved reduction of hours and/or remote work responsibility, will allow for continuation of benefits the same as any other active employee.

Please note: this addendum will end on May 12th, 2023.