PLAN DOCUMENT AND SUMMARY PLAN DESCRIPTION
FOR

{{Legal Plan Name}}
APEX MEC PLUS PLAN

EFFECTIVE: {{Plan Document Effective Date}}

Claims Administrator
TRES HEALTH, INC.
{{Claims Administrator Address}}
{{Customer Service Phone Number}}

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ARTICLE I -
GENERAL PLAN INFORMATION

TYPE OF ADMINISTRATION

The Plan is a self-funded group health Plan, administrated by the Claims Administrator. The funding for the benefits is derived from contributions by {{Employer Name}} and covered Employees.

PLAN NAME: {{Legal Plan Name}}

PLAN NUMBER: {{Plan Number}}

TAX ID NUMBER: {{Employer TIN}}

PLAN EFFECTIVE DATE: {{Plan Document Effective Date}}

PLAN YEAR: {{Plan Year Start Date}} through {{Plan Year End Date}}. This Plan Year is used for purposes of regulatory filings, to conduct open enrollment, and make any necessary benefit changes.

ACCUMULATOR & VISIT LIMIT RESET: Per calendar year. This means all Deductibles, Maximum Out of Pocket, and visit limits are tracked from 1/1 through 12/31.

WAITING PERIOD: {{Waiting Period (Medical)}}

APPLICABLE LAW: Employee Retirement Income Security Act of 1974, as amended (ERISA).

PLAN SPONSOR
{{Employer Name}}
{{ Employer Street Address}}, {{Employer City}}, {{Employer Situs State}} {{Employer ZIP Code}}
{{Employer Main Contact Phone Number}}

PLAN ADMINISTRATOR
{{Employer Name}}
{{ Employer Street Address}}, {{Employer City}}, {{Employer Situs State}} {{Employer ZIP Code}}
{{Employer Main Contact Phone Number}}

NAMED FIDUCIARY
{{Employer Name}}
{{ Employer Street Address}}, {{Employer City}}, {{Employer Situs State}} {{Employer ZIP Code}}
{{Employer Main Contact Phone Number}}

AGENT FOR LEGAL PROCESS
(In addition, service of legal process may be made upon the Plan Administrator.)
{{Employer Name}}
{{ Employer Street Address}}, {{Employer City}}, {{Employer Situs State}} {{Employer ZIP Code}}
{{Employer Main Contact Phone Number}}

CLAIMS ADMINISTRATOR
Tres Health, Inc.
{{Claims Administrator Address}}
{{Customer Service Phone Number}}

COBRA ADMINISTRATOR
{{Cobra Administrator Name}}
{{Cobra Administrator Address}}
{{Cobra Administrator Phone Number}}

I,_____, certify that I am the _____
Name Title
of {{Employer Name}} for the above-named Plan which has an initial effective date of {{Plan Document Effective Date}} and further certify that I am authorized to sign this Plan Document/Summary Plan Description. I have read and agree with the terms stated herein and am hereby authorizing the implementation of the Plan as of the effective date stated above.

Signature: _____

Print Name: _____ Date: _____

ARTICLE II -
INTRODUCTION

This document is a description of the Plan identified in the General Plan Information section of this document (the Plan). The Employer fully intends to maintain this Plan indefinitely. However, it reserves the right to terminate, suspend, discontinue or amend the Plan at any time and for any reason. No oral interpretations can change this Plan. If the Plan is terminated, amended, or benefits are eliminated, the rights of Covered Persons are limited to Covered Expenses Incurred before termination, amendment or elimination.

Where a court order, administrative order, judgement, new or changed law or regulation applies to the provisions of this Plan, the Plan will be deemed to have been automatically amended (without further action on the part of the Plan Administrator), to ensure that the Plan conforms to such change to the extent applicable. For the avoidance of doubt, it is the intent of the Plan Administrator that the Plan conform at all times to the requirements of any and all controlling law, including by way of example and not exclusion, the Employee Retirement Income Security Act (ERISA) of 1974, as amended. In the event of a conflict between this Plan Document and applicable law, applicable law will prevail but only to the extent to satisfy compliance.

Failure to follow the eligibility or enrollment requirements of this Plan may result in suspension of coverage or no coverage at all. Reimbursement from the Plan can be reduced or denied because of certain provisions in the Plan, such as coordination of benefits, subrogation, Exclusions, timeliness of COBRA elections, eligibility, utilization review or other cost management requirements, lack of Medical Necessity, lack of timely filing of claims or lack of coverage.

The Plan will pay benefits only for the expenses Incurred while this coverage is in force. No benefits are payable for expenses Incurred before coverage began or after coverage terminated. An expense for a service or supply is Incurred on the date the service or supply is furnished.

No action at law or in equity shall be brought to recover under any section of this Plan until the Claims Review Procedures have been exhausted. Specifically, before filing a lawsuit the Covered Person must exhaust all available administrative remedies as described in the Claims Procedures section, unless an exception under applicable law applies. A legal action to obtain benefits must be commenced within one year of the date of the Notice of Determination on the final level of internal or external review, whichever is applicable.

This Plan is an employee welfare benefit plan within the meaning of ERISA. This Plan is a self-funded medical plan intended to meet the requirements of Sections 105(b), 105(h) and 106 of the Code so that the portion of the cost of coverage paid by the Employer, and any benefits received by a Covered Person through this Plan, are not taxable income to the Covered Person. The specific tax treatment of any Covered Person will depend on the individual's personal circumstances; the Plan does not guarantee any particular tax treatment. Covered Persons are solely responsible for any and all federal, state, and local taxes attributable to their participation in this Plan, and the Plan expressly disclaims any liability for such taxes. This Plan is "self-funded," which means benefits are paid from the Employer's general assets and are not guaranteed by an insurance company.

The Plan is administered by the Plan Administrator, within the purview of ERISA and in accordance with these provisions. The Plan Administrator may delegate certain responsibilities for the operation and administration of the Plan. The Plan Administrator shall have the authority to amend or terminate the Plan, to determine its policies, to appoint and remove service Providers, adjust their compensation (if any), and exercise general administrative authority over them. The Plan Administrator has the sole authority and responsibility to review and make final decisions on all claims to benefits hereunder, unless otherwise delegated herein.

This document serves as both the written Plan Document and the Summary Plan Description ("SPD") required under ERISA.

Certain Federal laws apply to most group health programs. The following is an overview of the laws and their impact. Should there be any conflict between the law and Plan provisions, the law will prevail.

Health Insurance Portability and Accountability Act of 1996 ("HIPAA"). 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 Covered Person and beneficiaries receive a summary of any change that is a "Material Reduction in Covered Services or benefits under a group health plan" within sixty (60) days after the adoption of the modification or change, unless the Plan Sponsor provides summaries of modifications or changes at regular intervals of ninety (90) days or less.

Pregnancy Discrimination Act of 1978 ("PDA"). 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 ("FMLA"). So long as the Employer and the applicable Employer division is subject to FMLA, if a covered Employee ceases active employment due to an Employer-approved Family Medical Leave 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"). OBRA 1993 requires that an eligible Dependent Child of an Employee will include a Child who is adopted by the Employee or placed with them for adoption prior to age eighteen (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)). Covered Persons 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 ("NMHPA"). The Newborns' and Mothers' Health Protection Act of 1996 establishes restrictions on the extent to which group health plans generally may not, under federal law, restrict benefits for any Hospital length of stay in connection with childbirth for the mother or newborn child to less than forty-eight (48) hours following a vaginal delivery, or less than ninety-six (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 forty-eight (48) hours (or ninety-six (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 forty-eight (48) hours (or ninety-six (96) hours). All applicable benefit provisions still apply, including Copayments and/or Coinsurance.

The Women's Health and Cancer Rights Act of 1998 ("WHCRA"). The Women's Health and Cancer Rights Act of 1998 (WHCRA) was signed into law on October 21, 1998. For health plans that cover a Mastectomy or Lumpectomy, if an Employee or Dependent receives benefits under the Plan in connection with a Mastectomy or Lumpectomy and they elect breast reconstruction (in a manner determined in consultation with the attending Physician and the patient), coverage will be provided for:

- Reconstruction of the breast on which the Mastectomy or Lumpectomy was performed;
- Surgery and reconstruction of the other breast to produce a symmetrical appearance; and/or
- Prostheses and treatment of physical complications at all stages of the Mastectomy and Lumpectomy, including lymphedemas.

Covered Expenses will be subject to the same annual Deductible, Copayment or Coinsurance provisions that currently apply to Mastectomy and Lumpectomy coverage, and will be provided in consultation with the attending Physician.

Genetic Information Nondiscrimination Act of 2008 ("GINA"). GINA prohibits the 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 their 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; and
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"). The Mental Health Parity and Addiction Equity Act requires that, if a group health plan provides coverage for mental health conditions or for substance use disorders, 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 a Covered Person is eligible for health coverage from their 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 the Employee or eligible Dependents aren't eligible for Medicaid or CHIP, they won't be eligible for these premium assistance programs, but they may be able to buy individual insurance coverage through the Health Insurance Marketplace. For more information, visit www.healthcare.gov. If the Employee or eligible Dependents are already enrolled in Medicaid or CHIP, they can contact the State Medicaid or CHIP office to find out if premium assistance is available. If the Employee or eligible Dependents are NOT currently enrolled in Medicaid or CHIP, and they might be eligible for either of these programs, the State Medicaid or CHIP office can be contacted, or dial 1-877-KIDS NOW or www.insurekidsnow.gov to find out how to apply.

Children's Health Insurance Program Reauthorization Act of 2009 ("CHIPRA"). Employees and their Dependents who are otherwise eligible for coverage under the Plan but who are not enrolled can enroll in the Plan provided that they request enrollment in writing within sixty (60) days from the date of the following loss of coverage or gain in eligibility:

- The eligible person ceases to be eligible for Medicaid or Children's Health Insurance Program (CHIP) coverage; or
- The eligible person becomes newly eligible for a premium subsidy under Medicaid or CHIP.

If eligible, the Dependent (and if not otherwise enrolled, the Employee) may be enrolled under this Plan.

This Dependent special enrollment period is a period of sixty (60) days and begins on the date of the loss of coverage under the Medicaid or CHIP plan OR on the date of the determination of eligibility for a premium subsidy under Medicaid or CHIP. To be eligible for this Special Enrollment, the Employee must request enrollment in writing during this sixty (60) day period. *The effective date of coverage will begin the first day of the first calendar month following the date of loss of coverage or gain in eligibility.*

If a State in which the Employee lives offers any type of subsidy, this Plan shall also comply with any other State laws as set forth in statutes enacted by State legislature and amended from time to time to the extent that the State law is applicable to the Plan, the Employer, and its Employees. **For more information regarding special enrollment rights, contact the Plan Administrator.**

No Surprises Act ("NSA"). The No Surprises Act, part of Title I of the Consolidated Appropriations Act of 2021, prohibits Physicians, Providers, health care facilities and air ambulance companies from balance billing Covered Persons or otherwise holding Covered Persons liable for any more than the applicable cost sharing amounts they would have owed for network care. Specifically, these balance billing protections apply when a Covered Person receives Emergency Services from a Non-Network Provider or facility, when a Covered Person receives non-Emergency Services from a Non-Network Provider at a Network Facility, and when a Covered Person receives non-network air ambulance services.

However, these protections against balance billing do not apply if the Covered Person consents to treatment by a Non-Network Provider (this consent exception generally does not apply in emergency situations).

In addition, this Plan generally will cover Emergency Services without Preauthorization; cover Emergency Services by Non-Network Providers; base cost sharing amounts on network benefits; and count any cost sharing amounts for Emergency Services or non-network services toward a Covered Person's out-of-pocket limit.

If a Covered Person believes they have received a balance bill that is protected under the No Surprises Act, please contact the Claims Administrator for additional information.

Please visit www.dol.gov/agencies/ebsa/laws-and-regulations/laws/no-surprises-act for additional information regarding the No Surprises Act.

In the event of an inconsistency between this Summary Plan Description/Plan Document and the law relative to the No Surprises Act, the law prevails only to the extent required to satisfy compliance.

The Civilian Reservist Emergency Workforce Act of 2021 ("CREW"). Beginning September 29, 2022, the CREW Act provides eligible Employees, who are called to service by the Federal Emergency Management Agency (FEMA) to respond to and perform services responding to natural disasters and emergencies, rights under the Uniformed Employment and Reemployment Rights Act (USERRA). *See USERRA section for additional information regarding benefits and coverage during such leave.*

ARTICLE III -
MEDICAL BENEFITS SCHEDULE

This Plan does not use a Participating Provider Network (PPO) or Third-Party organization for facility services. The PPO Network applies only to Physician and ancillary services Claims, and not to facility service claims.

Apex MEC Plus MEDICAL BENEFITS SCHEDULE			
Claims must be received by the Claims Administrator within ***365 days*** of the date from which service charges were Incurred. Benefits are based on the Plan's provisions in effect at the time the charges were Incurred.			
DEDUCTIBLE, PER CALENDAR YEAR			
Per Covered Person	$0		
Per Family Unit	$0		
MAXIMUM OUT-OF-POCKET AMOUNT, PER CALENDAR YEAR			
Per Covered Person	$7,900		
Per Family Unit	$15,800		
The family maximum out-of-pocket includes Covered Expenses which are used to satisfy the maximum out-of-pocket amount for all family members combined. No one family member must satisfy more than the individual maximum out-of-pocket. The maximum out of pocket includes all Copayments, Coinsurance and Deductibles. The following expenses do not count toward the maximum out of pocket limit outlined above: • Charges in excess of benefit maximums (i.e., visit limits); • Charges in excess of the Reasonable and Allowed Amount; • Penalties assessed due to failure to Preauthorization; and • Charges for non-Covered Service.			
IMPORTANT INFORMATION			
Covered Expenses are limited to the Reasonable and Allowed Amount as defined in this Plan; Covered Expenses are also subject to Medical Necessity and all other provisions, conditions, limitations and exclusions listed in this Plan. The amounts listed below are the amounts the Covered Person is responsible for. For example, if this Benefits Schedule lists a $25 Copayment for a specialist visit, the Covered Person is responsible for the $25 Copayment. Similarly, if this Benefits Schedule lists a 40% Coinsurance for non-network specialist visits, the Covered Person is responsible for 40% Coinsurance (meaning 40% of the Reasonable and Allowed Amount), and the Plan would pay the remaining 60% up to the Reasonable and Allowed Amount.			
DESCRIPTION	**Preauthorization Required**	**NETWORK PROVIDER**	**NON-NETWORK PROVIDER**
Preventive Care			
Routine Well Care – Non-Hospital Based	No	No cost to Covered Person.	Not covered.
For more details on preventive care services, see the Covered Expenses section.			
Physician Services			
Primary Care Office Visit – Includes In-Person & Virtual Limited to three (3) visits per calendar year.	No	$20 Copay/visit.	Not covered.
Specialist Office Visit – Includes In-Person & Virtual	N/A	Not covered.	Not covered.

Other Services Performed in the Physician's Office	N/A	Not covered.	Not covered.
Telemedicine Services w/ MDLive	No	No cost to Covered Person.	N/A
Diagnostic Services and Supplies			
Diagnostic Testing (Lab & Radiology) – Non-Hospital Based	N/A	Not covered.	Not covered.
Diagnostic Testing (Advanced Imaging) – Non-Hospital Based	N/A	Not covered.	Not covered.
Emergency Services			
Urgent Care Limited to three (3) visits per calendar year.	No	$50 Copay/visit.	Not covered.
Outpatient Services			
Outpatient Services or Surgery – Non-Hospital Based	N/A	Not covered.	Not covered.
Any services not listed on this Medical Benefits Schedule are ***not covered.***			

PREAUTHORIZATION

Preauthorization is required as listed in the above column.

All services requiring Preauthorization, are to be authorized in advance, except for emergencies, by contacting the utilization review administrator at the number listed on the Plan ID Card. **If Preauthorization is not obtained prior to treatment or care, the Plan payment for any expenses associated with the treatment or care may be *reduced by 50%* and such reduction will not go toward the maximum out-of-pocket amount.**

IMPORTANT INFORMATION REGARDING REIMBURSEMENT RATES

This Plan does not use a participating provider organization (PPO) for facility services; therefore, claims for facility services, and non-network services (as indicated with an asterisk (*) in the Medical Benefits Schedule) are paid at **reference-based pricing**. See the definition of Reasonable and Allowed Amount in this Plan for additional information regarding reference-based pricing and other reimbursement methodologies.

ARTICLE IV -
PRESCRIPTION DRUG BENEFITS SCHEDULE

PRESCRIPTION DRUG BENEFIT	PREFERRED PHARMACY	NON-PREFERRED PHARMACY
Retail Option – 31 Day Supply		
Preventive Drugs	$0 Copay/drug.	Not covered.
Tier 1 Drugs	10% Coinsurance.	Not covered.
Tier 2 Drugs	Not covered.	Not covered.
Tier 3 Drugs	Not covered.	Not covered.
Retail Option - 35 - 90 Day Supply		
Tier 1 Drugs	10% Coinsurance.	Not covered.
Tier 2 Drugs	Not covered.	Not covered.
Tier 3 Drugs	Not covered.	Not covered.
Mail Order Option – 90 Day Supply		
Tier 1 Drugs	10% Coinsurance.	Not covered.
Tier 2 Drugs	Not covered.	Not covered.
Tier 3 Drugs	Not covered.	Not covered.
Refer to the Prescription Drug Benefits in this Plan for details on the Prescription Drug Program.		
Refer to the Prescription Drug Benefits in this Plan for details on the Prescription Drug Program. Please note that not all drugs are covered. For additional information on Prescription Drugs, including a copy of the Plan's formulary, please call the phone number on the Plan ID card.		

ARTICLE V -
DEFINED TERMS

The following terms have special meanings and when used in this Plan will be capitalized.

Accident means a sudden and unforeseen event, or a deliberate act resulting in unforeseen consequences.

Accidental Injury means an Injury sustained as the result of an Accident and independently of all other causes by an outside traumatic event or due to exposure to the elements.

Active Employee is an Employee or owner of the Employer who on any day performs in the customary manner all of the regular duties of employment. An Employee will be deemed active on each day of a regular paid vacation or on a regular non-working day, provided the covered Employee was working on the last preceding regular workday and not disabled and or on an employer-approved leave of absence. An Employee will not be considered under any circumstances active if they have effectively terminated employment. An Employee who is on an employer-approved leave of absence will be considered an Active Employee until such time that the employer-approved leave of absence ceases.

Adverse Benefit Determination means a denial, reduction, or termination of, or a failure to provide or make a payment (in whole or in part) for a benefit, including any such denial, reduction, termination, or failure to provide or make a payment for a claim that is based on any: (a) determination of an individual's eligibility to participate in a Plan or health insurance coverage; (b) determination that a claimed benefit is not a Covered Service; (c) imposition of a source-of-injury Exclusion, or other limitation on otherwise Covered Services; (d) determination that a claimed benefit is Experimental and/or Investigational, or not Medically Necessary or appropriate; (e) invalid charges; or (f) improper balance, of (g) as otherwise defined in the Plan.

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.

Allowable Expense(s) means any Medically Necessary item of expense, at least a portion of which is covered under this Plan. When some other plan pays first in accordance with the Coordination of Benefits, this Plan's Allowable Expenses shall in no event exceed the other plan's Allowable Expenses. When some other plan provides benefits in the form of services rather than cash payments, the reasonable cash value of each service rendered shall be deemed to be the benefit. Benefits payable under any other plan include the benefits that would have been payable had claim been duly made therefore, whether or not it is actually made.

Alternate Recipient means any Child of a Covered Person who is recognized under a Medical Child Support Order as having a right to enrollment under this Plan as the Covered Person'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 Covered Person.

Ambulatory Surgical Center means 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 Covered Person is in the facility, and which does not provide service or other accommodations for Covered Persons to stay overnight.

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 (AHRQ), 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 Physician has concluded that participation is appropriate, or the Covered Person 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 Covered Person; (3) a service that is clearly inconsistent with the widely accepted and established standards of care for a particular Diagnosis; (4) and/or items and/or services to be paid for and or provided at no cost from a third party (including but not limited to a manufacturer.)

Authorized Representative is a person designated by the Covered Person to act on their behalf and communicate with the Plan with respect to a specific benefit claim or appeal of a denial. This authorization must be made in writing, signed and dated by the Covered Person, and include all information required in the Authorized Representative form.

Certified Independent Dispute Resolution (IDR) Entity means an entity responsible for conducting determinations under the No Surprises Act (NSA) 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 means the Employee's natural child, any stepchild, legally adopted child, or any other Child for whom the Employee has been named Legal Guardian, or 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. For purposes of this definition, a legally adopted child shall include a Child placed in an Employee's physical custody in anticipation of adoption. "Child" shall also mean 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.

Claimant means a Covered Person or an Authorized Representative of a Covered Person making a claim or for whom a claim is made.

Claims Administrator means the entity responsible for administering claims under the plan, identified in the General Plan Information section of this document.

Clean Claim means a claim for a Covered Expense that (a) is timely received by the Claims Administrator; (b) (i) when submitted via paper has all the elements of the UB 04 or CMS 1500 (or successor standard) forms; or (ii) when submitted via an electronic transaction, uses only permitted transaction code sets (e.g., CPT4, ICD9, ICD10, HCPCS) and has all the elements of the standard electronic formats required by applicable Federal authority; (c) is a claim for which the Plan is the primary payor or the Plan's responsibility as a secondary payor has been established; and (d) contains no defect, error or other shortcoming resulting in the need for additional information to adjudicate the claim; and (e) that does not lack necessary substantiating documentation to completely adjudicate the claim.

A Clean Claim does not include a claim that is being reviewed for the Reasonable and Allowed Amount payable under the terms of the Plan. Additionally, any claim over $1,000 must be accompanied by a valid itemization, and submitted to the Claims Administrator before it will be deemed a Clean Claim.

CMS means Centers for Medicare and Medicaid Services.

Coinsurance means a cost sharing feature of many plans. It requires a Covered Person to pay out-of-pocket a prescribed portion of the cost of Covered Expenses. The defined Coinsurance that a Covered Person must pay out-of-pocket is based upon their health plan design. Coinsurance is established as a predetermined percentage of the Reasonable and Allowed Amount for Covered Services.

Copayment or Copay means the dollar amount, together with the Deductible, that the Covered Person pays for certain Covered Expenses. Copayments will not be applied after the Covered Person's maximum out of pocket amount has been reached. The amount of any applicable Copay shall not increase if the Plan, pursuant to its ultimate discretionary authority, settles a dispute with a Provider after a Provider balance bills a Covered Person.

Covered Expense(s)/Covered Service(s) means those Medically Necessary services, supplies and/or treatment that are covered under this Plan. Covered Expense does not necessarily mean the Provider's actual billed charges made nor the specific service or supply furnished to a Covered Person. Charges for services, supplies, and/or treatments meant to treat or correct a preventable condition or cost which arises solely due to a Provider's medical error are not considered Covered Expenses. A finding of Provider negligence and/or malpractice is not required for service(s) and/or fee(s) to be considered not Reasonable and Allowed or not a Covered Expense.

Covered Person means an Employee or Dependent who is covered under this Plan at the time the services are rendered.

Custodial Care means care (including room and board needed to provide that care) that is given principally for personal hygiene or for assistance in daily activities and can, according to generally accepted medical standards, be performed by persons who have no medical training. Examples of Custodial Care are help in walking and getting out of bed; assistance in bathing, dressing, feeding; or supervision over medication which could normally be self-administered.

Deductible means an amount of money that is paid once a calendar year per Covered Person and Family Unit. Typically, there is one Deductible amount per Plan, and it must be paid before any money is paid by the Plan for any medical care.

Dentist means a properly trained person holding a D.D.S. or D.M.D. degree and practicing within the scope of a license to practice dentistry within their applicable geographic venue.

Dependent(s) means, unless otherwise specifically provided in the Plan, a spouse, a natural or adopted child, a child who is in the process of being adopted by the Employee, or a stepchild. Pursuant to the Patient Protection and Affordable Care Act of 2010, coverage must be offered until the end of the month in which the Dependent Child has reached age twenty-six (26).

Diagnosis means the act or process of identifying or determining the nature and cause of an Illness or Injury through evaluation of Covered Person history, examination, and review of laboratory data.

Diagnostic Service means an examination, test, or procedure performed for specified symptoms to obtain information to aid in the assessment of the nature and severity of a medical condition or the identification of a Disease or Injury. The Diagnostic Service must be ordered by a Physician or other professional Provider.

Disease means 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 worker's 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 or Disease.

Durable Medical Equipment means equipment which (a) can withstand repeated use, (b) is primarily and customarily used to serve a medical purpose, (c) generally is not useful to a person in the absence of an Illness or Injury and (d) is appropriate for use in the home.

Emergency Services means a medical screening examination and associated services to treat a condition that requires immediate medical attention that would reasonably expect to result in (a) serious jeopardy to the health of an individual (or in the case of a pregnant person, the health of the unborn child); (b) serious impairment to bodily function; or (c) serious dysfunction of any bodily organ or part. Emergency Services include pre-stabilization services that are provided after a patient is moved out of the emergency department and admitted to a Hospital, as well as any additional services rendered after a patient is stabilized as part of Outpatient observation or an Inpatient or Outpatient stay with respect to the visit in which other Emergency Services are furnished. These services include those provided at an Independent Freestanding Emergency Department as well as a Hospital emergency department. A decision of what constitutes Emergency Services will not be defined solely on the basis of the Diagnosis but rather will be a determination that takes into account the reasonableness of each situation as defined by a prudent layperson.

Employee means the individual employed by the Plan Sponsor who is eligible to participate in the Plan pursuant to the terms as provided by the Plan.

Employer means the Plan Administrator identified in the General Plan Information section of this document, and any entity under common control as elected by the Plan Administrator to participate in the Plan.

ERISA is the Employee Retirement Income Security Act of 1974, as amended.

Errors mean any billing mistakes or improprieties including, but not limited to, up-coding, duplicate charges, charges for care, supplies, treatment, and/or medical care not actually rendered or performed, or charges otherwise determined to be invalid, impermissible or improper based on any applicable law, regulation, rule or professional standard. The Plan Administrator, or its designee, has sole discretion to determine what constitutes an Error under the terms of this Plan.

Excess Charge means a charge or portion thereof billed for care and/or treatment of an Illness or Injury that is not payable under the terms of the Plan because it exceeds the Maximum Allowable Charge, or is determined by the Plan Administrator to be based on Invalid Charges or Errors as defined by this Plan Document. Also, charges for a service or supply furnished by a direct contract Provider in excess of the applicable negotiated rate.

Exclusion means conditions or services that this Plan does not cover.

Experimental and/or Investigational means services, supplies, care and treatment which does not constitute accepted medical practice properly within the range of appropriate medical practice under the standards of the case and by the standards of a reasonably substantial, qualified, responsible, relevant segment of the medical community or government oversight agencies at the time services were rendered.

The Plan Administrator must make an independent evaluation of the experimental/non-experimental standings of specific technologies. The Plan Administrator shall be guided by a reasonable interpretation of Plan provisions. The decisions shall be made in good faith and rendered following a detailed factual background investigation of the claim and the proposed treatment. The decision of the Plan Administrator will be final and binding on the Plan. The Plan Administrator will be guided by the following principles:

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; or

2. If the drug, device, medical treatment or procedure, or the Covered Person informed consent document utilized with the drug, device, treatment or procedure, was reviewed and approved by the treating facility's Institutional Review Board or other body serving a similar function, or if Federal law requires such review or approval; or

3. *Except as provided under the Approved Clinical Trial benefit in the Medical Benefits within the Covered Expenses section*, if reliable evidence shows that the drug, device, medical treatment or procedure is the

subject of on-going phase I or phase II clinical trials, is the research, experimental, study or investigational arm of on-going phase III clinical trials, or is otherwise under study to determine its maximum tolerated dose, its toxicity, its safety, its efficacy or its efficacy as compared with a standard means of treatment or Diagnosis; or

4. If reliable evidence shows that the prevailing opinion among experts regarding the drug, device, medical treatment or procedure is that further studies or Approved Clinical Trials are necessary to determine its maximum tolerated dose, its toxicity, its safety, its efficacy or its efficacy as compared with a standard means of treatment or Diagnosis.

   Reliable evidence means only published reports and articles in the authoritative medical and scientific literature; the written protocol or protocols used by the treating facility or the protocol(s) of another facility studying substantially the same drug, service, medical treatment or procedure; or the written informed consent used by the treating facility or by another facility studying substantially the same drug, device, medical treatment or procedure.

Drugs are considered experimental if they are not commercially available for purchase and/or they are not approved by the Food and Drug Administration for general use.

Family Unit means the covered Employee and the family members who are covered as Dependents under the Plan.

FDA means the Food and Drug Administration.

Final Internal Adverse Benefit Determination means 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.

Home Health Care Agency is an organization that meets all of these tests: its main function is to provide home health care services and supplies; it is federally certified as a Home Health Care Agency; and it is licensed by the state in which it is located, if licensing is required.

Hospital means an Institution that meets all of the following requirements:

1. It provides medical and surgical facilities for the treatment and care of injured or ill persons on an Inpatient basis;
2. It is under the supervision of a staff of Physicians;
3. It provides twenty-four (24) hours a day nursing service by Registered Nurses (R.N.);
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;
7. 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; and
8. In addition to those facilities that meet all of the requirements above, the definition of "Hospital" for purposes of this document, unless otherwise specifically stated, shall also include any facility that solely provides medical care on an Outpatient basis whether affiliated with a Hospital as defined above or not ("independent facilities"), including but not limited to an Ambulatory Surgical Center.

Illness means a bodily disorder, Disease, physical Illness or Mental Disorder. Illness includes Pregnancy, childbirth, miscarriage or Complications of Pregnancy.

Incurred means that 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 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. Independent Freestanding Emergency Departments do not include urgent care centers or clinics.

Injury means an Accidental Injury to the body caused by unexpected external means.

Inpatient means a Covered Person who receives medical care at a Hospital and is admitted as a registered overnight bed patient.

Institution means a facility created and/or maintained for the purpose of practicing medicine and providing organized health care and treatment to individuals, operating within the scope of its license, such as a Hospital, Ambulatory Surgical Center, psychiatric Hospital, community mental health center, residential treatment facility, psychiatric treatment facility, Substance Use Disorder treatment center, alternative birthing center, or any other such facility that the Plan approves.

Legal Guardian means 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.

Lumpectomy means the surgical removal of a small tumor, which may be benign or cancerous.

Mastectomy means the surgical removal of all or part of a breast.

Medical Child Support Order means 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 Covered Person's Child or directs the Covered Person 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.

Medically Necessary or Medical Necessity means health care services or supplies determined by the Claims Administrator in its discretion as necessary to diagnose or treat an Illness, Injury, condition, Disease, or its symptoms, and that meet accepted standards of medicine.

Medicare is the Health Insurance for The Aged and Disabled program under Title XVIII of the Social Security Act, as amended.

Mental or Nervous Disorder means any Disease or condition, regardless of whether the cause is organic, that is classified as a Mental or Nervous Disorder in the current edition of International Classification of Diseases, published by the U.S. Department of Health and Human Services or is listed in the current edition of Diagnostic and Statistical Manual of Mental Disorders, published by the American Psychiatric Association.

National Medical Support Notice (NMSN) means 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 Covered Person 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 Covered Person) 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 Provider or Network Facility means a healthcare institution or healthcare provider who has by contract agreed to provide services at discounted reimbursement rates. 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.

Non-Network Provider or Non-Network Facility means a healthcare institution or healthcare provider who does not have a contractual relationship with the Plan or issuer, respectively, regarding reimbursement of items or services they provide.

Outpatient means a Covered Person who receives medical care at a Hospital but is not admitted as a registered overnight bed patient; this must be for a period of less than twenty-four (24) hours.

Pharmacy means a licensed establishment where covered Prescription Drugs are filled and dispensed by a pharmacist licensed under the laws of the state where they practice.

Physician means a person properly licensed by a state (or foreign jurisdiction where benefits are payable outside of the United States) in which they are authorized to practice medicine within the scope of such legal authority or license.

Plan means the group health benefit plan adopted and maintained by the Plan Sponsor for the benefit of the eligible Employee and as amended from time to time which is identified in the General Plan Information section of this document.

Plan Administrator or Plan Sponsor means the legal entity that adopts, amends, and administers the Plan identified in the General Plan Information section of this document.

Preauthorization means a decision by the Plan that a health care service, treatment plan, Prescription Drug or Durable Medical Equipment is Medically Necessary. Sometimes called prior authorization, prior approval or preauthorization. The Plan may require Preauthorization for certain services before the Covered Person receive them, except in an emergency.

Pregnancy is childbirth and conditions associated with Pregnancy, including complications.

Prescription Drug means any of the following: a Food and Drug Administration-approved drug or medicine which, under Federal law, is required to bear the legend: "Caution: Federal law prohibits dispensing without prescription"; injectable insulin; hypodermic needles or syringes, but only when dispensed upon a written prescription of a licensed Physician. Such drug must be Medically Necessary in the treatment of an Illness or Injury.

Provider means any person or company that provides a health care service including, without limitation, Physicians, Hospitals, Ambulatory Surgical Centers, Pharmacies, Skilled Nursing Facilities, and residential treatment centers.

Reasonable and Allowed Amount means the maximum amount payable by the Plan for a service, supply and/or treatment that is considered a Covered Expense. The Reasonable and Allowed Amount is the lesser of: (1) the Provider's billed charges for the care, service, or supply; (2) the negotiated amount established by a discounting or negotiated agreement; (3) the Reasonable and Customary Charge for the same treatment, service, or supply furnished in the same Geographic Area by a Provider of like service of similar training and experienced as further described below; or (4) an amount equivalent to the following:

1. For inpatient or outpatient facility claims, 150% of the Medicare equivalent allowable amount; and
2. For physician and ancillary claims, 120% of the Medicare equivalent allowable amount.

Reasonable and Customary Charge means an amount equivalent to the lesser of a commercially available database or such other cost or quality-based reimbursement methodologies as may be available and utilized by the Plan from time to time. Determination of the Reasonable and Customary Charge will take into consideration the nature and severity of the condition being treated, medical complications or unusual circumstances that require more time, skill or experience, and the cost and quality data for that Provider. The term "Geographic Area" shall be defined as a metropolitan area, county, zip code, state or such greater area as is necessary to obtain a representative cross-section of Providers, persons, or organizations rendering such treatment, service or supply for which a specific charge is made. For Covered Expenses rendered by a Provider in a Geographic Area where applicable law may dictate the maximum amount that can be billed by the rendering Provider, the Reasonable and Allowed Amount shall mean the lesser of amount established by applicable law for that Covered Expense or the amount determined as set forth above.

The Plan Administrator or its designee has the *ultimate discretionary authority* to determine the Reasonable and Allowed Amount, including establishing the negotiated terms of a Provider arrangement as the Reasonable and Allowed Amount even if such negotiated terms do not satisfy the "lesser of" test described above.

Remote Second Opinion Program means a clinical program, provided by a designee of the Plan Administrator, that offers second opinions and high-touch nurse navigation and clinical support.

Skilled Nursing Facility is a facility that fully meets all of these tests:

1. It is licensed to provide professional nursing services on an Inpatient basis to persons convalescing from Injury or Illness. 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 Covered Persons 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 twenty-four (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 Covered Person.
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 or educational care or care of Mental or Nervous Disorders.
7. It is approved and licensed by Medicare.

This term also applies to charges Incurred in a facility referring to itself as an extended care facility, convalescent nursing home, rehabilitation hospital, long-term acute care facility or any other similar nomenclature.

Substance Use Disorder means any use of alcohol, any drug (whether obtained legally or illegally), any narcotic, or any hallucinogenic or other illegal substance, which produces a pattern of pathological use, causing impairment in social or occupational functioning, or which produces physiological dependency evidenced by physical tolerance or withdrawal. It is the excessive use of a substance, especially alcohol or a drug. The DSM-V definition is applied as follows:

1. A maladaptive pattern of substance use leading to clinically significant impairment or distress, as manifested by one (or more) of the following, occurring within a twelve (12) month period:
   a. Recurrent substance use resulting in a failure to fulfill major role obligations at work, school or home (e.g., repeated absences or poor work performance related to substance use; substance-related absences, suspensions or expulsions from school; neglect of Children or household);
   b. Recurrent substance use in situations in which it is physically hazardous (e.g., driving an automobile or operating a machine when impaired by substance use);
   c. Recurrent substance-related legal problems (e.g., arrests for substance-related disorderly conduct); or

d. Continued substance use despite having persistent or recurrent social or interpersonal problems caused or exacerbated by the effects of the substance (e.g., arguments with spouse about consequences of intoxication, physical fights).

2. The symptoms have never met the criteria for Substance Dependence for this class of substance.

Total Disability (Totally Disabled) means, in the case of a Dependent, incapable of self-sustaining employment by reason of mental or physical handicap, primarily dependent upon the covered Employee for support and maintenance and unmarried. To prove Total Disability, the covered Employee must prove that they have claimed the Dependent on their tax returns.

Unbundling means charges for any items billed separately that are customarily included in a global billing procedure code in accordance with the American Medical Association's CPT® (Current Procedural Terminology) the Healthcare Common Procedure Coding System (HCPCS), and/or the National Correct Coding Initiative (NCCI) codes used by CMS. Charges include routine medical and/or surgical supplies that are included in the general cost of the procedure, nursing care and/or services that are performed within the scope of daily duties; surgery, procedures(s), and/or supplies that are included in a surgical procedure room rate; and C-codes that are packages and have no separate reimbursement surgery/procedures and supplies, and C-codes. The Plan has the sole discretion to determine whether a given line item on a claim is considered Unbundling.

Waiting Period means the time between the first day of employment as an eligible Employee and the first day of coverage under the Plan. This time period is outlined in the General Plan Information section of this Plan.

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

ARTICLE VI -
OVERVIEW OF BENEFITS

MEDICAL BENEFITS

This Plan does not use a Participating Provider Network (PPO) or Third-Party organization for facility services. The PPO Network applies only to Physician and ancillary services Claims, and not to facility service claims.

All benefits described in the Medical Benefits Schedule are subject to the Exclusions and all other conditions and limitations set forth herein including, but not limited to, the Plan Administrator's determination that: care and treatment is Medically Necessary; charges are limited to the Reasonable and Allowed Amount as defined; and services, supplies and care are not Experimental and/or Investigational.

This document is intended to describe the benefits provided under the Plan but, due to the number and wide variety of different medical procedures and rapid changes in treatment standards, it is impossible to describe all Covered Expenses and/or exclusions with specificity. Please contact the Claims Administrator regarding questions about specific supplies, treatments, or procedures.

This Plan pays Covered Expenses pursuant to the Reasonable and Allowed Amount, which is defined in this Plan. **Covered Persons may be responsible for any amounts determined to be in excess of the Reasonable and Allowed Amount.**

Preauthorization of certain services is required by the Plan. Preauthorization provides information regarding Medical Necessity. ***A Preauthorization approval is not a determination by the Plan that a claim will be paid. All claims are subject to the terms and conditions, limitations and Exclusions of the Plan at the time services are provided.***

If Preauthorization is not obtained prior to treatment or care, the Plan payment for any expenses associated with the treatment or care may be *reduced by 50%*. Such reduction will not go toward the maximum out-of-pocket amount.

All services requiring Preauthorization, are to be authorized in advance, except for emergencies, by contacting the phone number outlined on the Plan ID card as soon as possible **prior** to the services being rendered. The Covered Person or their Authorized Representative must identify the services to be rendered and the associated Diagnosis and procedure codes necessary for Preauthorization determinations and service prepricing.

NETWORK ACCESS

Network Providers. This Plan includes access to the "Network" known as the PHCS Network for Value-Driven Health Plans. This Network consists of Physicians, specialists and select ancillary service providers including but not limited to psychiatric services, Diagnostic Services, urgent care clinics, non-acute rehabilitation services, hospice, home health care, and Durable Medical Equipment. Network Providers will be identified as participating providers in Provider search tools available to Covered Persons. Claims from Network Providers will be paid at the negotiated contract rate. The Plan will be required to pay for Covered Expenses at the negotiated contract rate less any cost-sharing obligation (any portion of the Deductible and/or Copayment that has not yet been paid) required to be paid by the Covered Person. Covered Persons may not be balance billed for the difference between the negotiated contract rate and the Provider's billed charges by Network Providers.

Non-Network Providers. For those Providers that do not participate in the network (Non-Network Providers), it is the Plan's position that for Covered Expenses, the Provider should not bill the Covered Person for amounts in excess of the Reasonable and Allowed Amount. However, except as otherwise required by state and federal law, including the No Surprises Act, if the Non-Network Provider's billed charges for any Covered Expense is higher than the Reasonable and Allowed Amount determined by the Plan, Covered Persons may be responsible for the excess.

PATIENT ADVOCACY CENTER

It is the Plan's position that for Covered Expenses, the Provider should not bill the Covered Person for amounts in excess of the Reasonable and Allowed Amount. However, billing for such amounts can occur for Non-Network Provider claims and the Plan has no control over the actions of Non-Network Providers or their decision to pursue Covered Persons for such amounts.

In the event the Covered Person receives a bill for an amount in excess of the Reasonable and Allowed Amount, please immediately email pac@hstechnology.com or call the Patient Advocacy Center toll free at (888) 837-2237.

Please Note: The Patient Advocacy Center provides assistance to Covered Persons with the understanding that (i) the Patient Advocacy Center is not acting in a fiduciary capacity under this Plan, (ii) that the Covered Person must make their own independent decision with respect to any course of action in connection with any bill or balance bill, including whether such course of action is appropriate or proper based on the Covered Person's specific circumstances and objectives, and (iii) the Patient Advocacy Center does not provide legal or tax advice.

SECONDARY COVERAGE

Covered Persons who are eligible for secondary coverage by any other health plan are encouraged to obtain such coverage. Failure to obtain secondary coverage may result in the Covered Person incurring costs, which are not covered by the Plan and which would otherwise be covered by the secondary coverage. The Plan will not pay for any costs which are payable by such secondary coverage when said coverage is primary, except to the extent that such costs are payable in any event by the Plan.

CHOICE OF PROVIDERS

The Plan is not intended to disturb the Physician-patient relationship. Each Covered Person 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, Plan Administrator, Employer or Claims Administrator. The delivery of medical and other health care services on behalf of any Covered Person remains the sole prerogative and responsibility of the attending Physician or other health care Provider. The Covered Person, together with their 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.

ARTICLE VII -
ELIGIBILITY AND ENROLLMENT PROVISIONS

ELIGIBILITY

Eligible Classes of Employees

- All Active Employees of the Employer.

Active Employee Requirement. An Employee must be an Active Employee (as defined by this Plan) for this coverage to take effect.

Eligibility Requirements for Employee Coverage. A person is eligible for Employee coverage from the first day that they:

1. Are a full-time, Active Employee of the Employer. An Employee is considered to be full-time if they normally work at least thirty (30) hours per week and is on the regular payroll of the Employer for that work (i.e., non-variable hour Employee); or is a variable hour Employee who has averaged at least thirty (30) hours per week for a complete measurement period and is currently in a stability period as determined by the Plan Administrator;

2. Are in a class eligible for coverage; and

3. Complete the employment Waiting Period as outlined in the General Plan Information section of this Plan.

A **Waiting Period** is the time between the first day of employment as an eligible Employee and the first day of coverage under the Plan.

Eligible Classes of Dependents. A Dependent is any one of the following persons:

1. A covered **Employee's legal spouse and Children** from birth until the limiting age of twenty-six (26) years. When the Child reaches the limiting age, coverage will end on the last day of the Child's birthday month.

   The term **"spouse"** means a person recognized as the covered Employee's husband or wife by the laws of the state or country in which the marriage was formalized. "Married" means a legal union between two individuals and will not include a common law spouse. The Plan Administrator may require documentation proving a legal marital relationship.

   {{Domestic Partner Exception Granted}}

   The term **"Children"** means natural children, adopted children, Children placed with a covered Employee in anticipation of adoption and stepchildren.

   If a covered Employee is the **Legal Guardian** of a Child or Children, these Children may be enrolled in this Plan as covered Dependents.

   The phrase **"Child placed with a covered Employee in anticipation of adoption"** refers to a Child whom the Employee intends to adopt, whether or not the adoption has become final, who has not attained the age of eighteen (18) as of the date of such placement for adoption. The term "placed" means the assumption and retention by such Employee of a legal obligation for total or partial support of the Child in anticipation of adoption of the Child. The Child must be available for adoption and the legal process must have commenced.

   Any Child of a Covered Person who is an Alternate Recipient under a **Qualified Medical Child Support Order (QMCSO)** shall be considered as having a right to Dependent coverage under this Plan. A Covered

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

Please be advised, the definition of "Dependent" may not be the same definition as established by the Internal Revenue Code (IRC) for individuals that the covered Employee is permitted to pay qualified medical expenses from a Health Savings Account (HSA), or individuals that can be enrolled as an eligible Dependent for tax free benefits. (i.e., non-IRC Section 152 Dependent). There may be tax implications for the Employee if they enroll certain eligible Dependent(s). The Employee should consult their tax advisor with any questions on the tax consequences of benefits for their eligible Dependent(s).

The Plan Administrator may require documentation proving dependency, including birth certificates or initiation of legal proceedings severing parental rights.

2. A covered Dependent Child who reaches the **limiting age** outlined above and is **Totally Disabled**, incapable of self-sustaining employment by reason of mental or physical handicap, primarily dependent upon the covered Employee for support and maintenance and unmarried. The Plan Administrator may require, at reasonable intervals during the two years following the Dependent's reaching the limiting age, subsequent proof of the Child's Total Disability and dependency.

These persons are excluded as Dependents: other individuals living in the covered Employee's home, but who are not eligible as defined and/or outlined above, or any person who is covered under the Plan as an Employee.

If a person covered under this Plan changes status from Employee to Dependent or Dependent to Employee, and the person is covered continuously under this Plan before, during and after the change in status, credit will be given for all amounts applied to maximums.

- If both parents are Employees, their Children will be covered as Dependents of one of the parents, but not of both.

Eligibility Requirements for Dependent Coverage. A family member of an Employee will become eligible for Dependent coverage on the first day that the Employee is eligible for Employee coverage and the family member satisfies the requirements for Dependent coverage.

At any time, the Plan may require proof that a spouse or a Dependent Child qualifies or continues to qualify as a Dependent as defined by this Plan.

EFFECTIVE DATE

Effective Date of Employee Coverage. Coverage will begin with the completion of all eligibility and enrollment requirements as stated under this Plan.

Effective Date of Dependent Coverage. Coverage will begin on the day that the eligibility requirements are met; the Employee is covered under the Plan; and all enrollment requirements are met.

ENROLLMENT

TIMELY, LATE OR OPEN ENROLLMENT

1. **Timely Enrollment.** The enrollment will be "timely" if the completed form is received by the Plan Administrator no later than thirty (30) days after the person becomes eligible for the coverage either initially or under a special enrollment period.

   If two Employees (husband and wife) are covered under the Plan and the Employee who is covering the Dependent Children terminates coverage, the Dependent coverage may be continued by the other covered Employee with no Waiting Period as long as coverage has been continuous.

2. **Late Enrollment.** An enrollment is "late" if it is not made on a "timely" basis or during a special enrollment period. Late enrollees and their Dependents who are not eligible to join the Plan during a special enrollment period may join only during open enrollment.

   If an individual loses eligibility for coverage as a result of terminating employment, a reduction of hours of employment or a general suspension of coverage under the Plan, then upon becoming eligible again due to resumption of employment or due to resumption of Plan coverage, only the most recent period of eligibility will be considered for purposes of determining whether the individual is a late enrollee.

   The time between the date a late enrollee first becomes eligible for enrollment under the Plan and the first day of coverage is not treated as a Waiting Period. Coverage begins as specified in this Plan.

3. **Open Enrollment.** Each year there is an annual open enrollment period designated by the Plan Administrator during which Covered Persons may change their benefit elections under the Plan, and Employees and their Dependents, who are late enrollees, will be able to enroll in the Plan.

   Benefit choices for late enrollees made during the open enrollment period will become effective as of the start of the new plan year. Covered Persons will receive detailed information regarding open enrollment from the Plan Administrator.

   Benefit choices made during the open enrollment period will remain in effect until the next open enrollment period unless there is a special enrollment event or a change in family status during the year (birth, death, marriage, divorce, adoption) or loss of coverage due to loss of a spouse's employment. To the extent previously satisfied, coverage Waiting Periods will be considered satisfied when changing from one benefit option under the Plan to another benefit option under the Plan.

   If an Employee drops spousal coverage during open enrollment in anticipation of divorce, the covered Employee should notify the Plan Administrator.

NOTE: **Enrollment Requirements for Newborn Children.** A newborn child of a covered Employee who is currently enrolled will not be automatically enrolled from the date of birth.

The Employee will be required to enroll the newborn child on a timely basis, as defined in the section "Timely, Late or Open Enrollment" above, or there will be no further payment from the Plan and the parents will be responsible for all costs.

SPECIAL ENROLLMENT RIGHTS

Federal law provides special enrollment provisions under some circumstances. If an Employee is declining enrollment for themself or their Dependents (including their spouse) because of other health insurance or group health plan coverage, there may be a right to enroll in this Plan if there is a loss of eligibility for that other coverage (or if the Employer stops contributing towards the other coverage).

In addition, if an Employee or their Dependents (including their spouse) is losing coverage due to a loss of a government sponsored subsidy (due to ineligibility for coverage or cost of coverage) there may be a right to enroll in this Plan.

However, a request for enrollment must be made within thirty (30) days after the coverage ends (or after the Employer stops contributing towards the other coverage).

In addition, in the case of a birth, adoption or placement for adoption, there may be a right to enroll in this Plan. However, a request for enrollment must be made within thirty (30) days of the date of birth, adoption or placement for adoption or of the date of marriage.

The special enrollment rules are described in more detail below. To request special enrollment or obtain more detailed information of these portability provisions, contact the Plan Administrator.

SPECIAL ENROLLMENT PERIODS

The enrollment date for anyone who enrolls under a special enrollment period is the first date of coverage. The events described below may create a right to enroll in the Plan under a special enrollment period.

1. **Losing other coverage may create a special enrollment right.** An Employee or Dependent who is eligible, but not enrolled in this Plan, may enroll if loss of eligibility for coverage meets all of the following conditions:

    a. The Employee or Dependent was covered under a group health plan or had health insurance coverage at the time coverage under this Plan was previously offered to the individual.
    b. If required by the Plan Administrator, the Employee stated in writing at the time that coverage was offered that the other health coverage was the reason for declining enrollment.
    c. The coverage of the Employee or Dependent who had lost the coverage was under COBRA and the COBRA coverage was exhausted, or was not under COBRA and either the coverage was terminated as a result of loss of eligibility for the coverage or because Employer contributions towards the coverage were terminated. Coverage will begin no later than the first day of the first calendar month following the date of loss.
    d. The Employee or Dependent requests enrollment in this Plan not later than thirty (30) days after the date of exhaustion of COBRA coverage or the termination of non-COBRA coverage due to loss of eligibility or termination of Employer contributions, described above. Coverage will begin no later than the first day of the first calendar month following the date of loss.

    For purposes of these rules, a loss of eligibility occurs if one of the following occurs:

    a. The Employee or Dependent has a loss of eligibility due to the plan no longer offering any benefits to a class of similarly situated individuals (i.e., part-time Employees).
    b. The Employee or Dependent has a loss of eligibility as a result of legal separation, divorce, cessation of Dependent status (such as attaining the maximum age to be eligible as a Dependent Child under the plan), death, termination of employment, or reduction in the number of hours of employment or contributions towards the coverage were terminated.
    c. The Employee or Dependent has a loss of eligibility when coverage is offered through an HMO, or other arrangement, in the individual market that does not provide benefits to individuals who no longer reside, live or work in a service area, (whether or not within the choice of the individual).
    d. The Employee or Dependent has a loss of eligibility when coverage is offered through an HMO, or other arrangement, in the group market that does not provide benefits to individuals who no longer reside, live or work in a service area, (whether or not within the choice of the individual), and no other benefit package is available to the individual.

    If the Employee or Dependent lost the other coverage as a result of the individual's failure to pay premiums or required contributions or for cause (such as making a fraudulent claim or an intentional misrepresentation of a material fact in connection with the plan), that individual does not have a special enrollment right.

2. Acquiring a newly eligible Dependent may create a special enrollment right. If:

    a. The Employee is a Covered Person under this Plan (or has met the Waiting Period applicable to becoming a Covered Person under this Plan and is eligible to be enrolled under this Plan but for a failure to enroll during a previous enrollment period), and
    b. A person becomes a Dependent of the Employee through marriage, birth, adoption or placement for adoption,

then the Dependent (and if not otherwise enrolled, the Employee) may be enrolled under this Plan. In the case of the birth or adoption of a Child, the spouse of the covered Employee may be enrolled as a Dependent of the covered Employee if the spouse is otherwise eligible for coverage. If the Employee is not enrolled at the time of the event, the Employee must enroll under this special enrollment period in order for his eligible Dependents to enroll.

The Dependent special enrollment period is a period of thirty (30) days and begins on the date of birth, adoption or placement for adoption, or on the date of the marriage. To be eligible for this special enrollment, the Dependent and/or Employee must request enrollment during this time period as stated above.

The coverage of the Dependent and/or Employee enrolled in the special enrollment period will be effective:

a. In the case of marriage, as of the first of the month following the date of marriage;
b. In the case of a Dependent's birth, as of the date of birth; or
c. In the case of a Dependent's adoption or placement for adoption, the date of the adoption or placement for adoption.

TERMINATION OF COVERAGE

The Plan Administrator has the right to rescind any coverage of the Employee and/or Dependents for cause, making a fraudulent claim or an intentional material misrepresentation in applying for or obtaining coverage, or obtaining benefits under the Plan. The Plan Administrator may either void coverage for the Employee and/or covered Dependents for the period of time coverage was in effect, may terminate coverage as of a date to be determined at the Plan's discretion, or may immediately terminate coverage. If coverage is to be terminated or voided retroactively (rescission) for fraud or misrepresentation, the Plan will provide at least 30 days advance written notice of such action. The Employer will refund all contributions paid for any coverage rescinded; however, claims paid will be offset from this amount. The Employer reserves the right to collect additional monies if claims are paid in excess of the Employee's and/or Dependent's paid contributions.

When Employee Coverage Terminates. Employee coverage will terminate on the earliest of these dates:

1. The date the Plan is terminated.

2. The last day of the month in which the covered Employee ceases to be in one of the eligible classes. This includes death or termination of active employment of the covered Employee. This also includes failure to satisfy the eligibility requirements of the Plan due to periods of leave unless the plan specifically provides for continuation during these periods.

3. If an Employee fails to make the required premium payment, commits fraud, makes an intentional misrepresentation of material fact in applying for or obtaining coverage, or obtaining benefits under the Plan, or fails to notify the Plan Administrator that they have become ineligible for coverage, then the Employer or Plan will void coverage for the Employee and covered Dependents for the period of time coverage was in effect.

4. As otherwise specified in this Plan.

Note: Except in certain circumstances, a covered Employee may be eligible for COBRA Continuation Coverage. For a complete explanation of when COBRA Continuation Coverage is available, what conditions apply and how to select it, see the COBRA Continuation Coverage section in this Plan.

Continuation During Periods of Employer-Approved Leave(s) of Absence. An eligible Employee may remain eligible under the terms of this Plan during an Employer-approved leave of absence. While continued, coverage will be that which was in force on the last day worked as an Active Employee. However, if benefits reduce for others in

the class, they will also reduce for the covered Employee. The Employer has sole discretion to determine the length of the Employer-approved leave of absence.

Continuation During Family and Medical Leave. Regardless of the established leave policies mentioned above, this Plan shall at all times comply with the Family and Medical Leave Act of 1993 (FMLA) as promulgated in regulations issued by the Department of Labor, if, in fact, FMLA is applicable to the Employer and all of its Employees and locations.

This Plan shall also comply with any other State leave laws as set forth in statutes enacted by State legislature and amended from time to time, to the extent that the State leave law is applicable to the Employer and all of its Employees. Leave taken pursuant to any other State leave law shall run concurrently with leave taken under FMLA, to the extent consistent with applicable law.

If applicable, during any leave taken under the FMLA and/or other State leave law, the Employer 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.

If Plan coverage terminates during the FMLA, coverage will be reinstated for the Employee and their covered Dependents if the Employee returns to work in accordance with the terms of the FMLA and/or other State leave law. Coverage will be reinstated only if the person(s) had coverage under this Plan when the FMLA Leave started, and will be reinstated to the same extent that it was in force when that coverage terminated.

Rehiring a Terminated Employee. A terminated Employee who is rehired by within thirteen (13) consecutive weeks from the date of termination will be credited for time towards the satisfaction of any applicable employment Waiting Period prior to the initial date of termination.

Coverage will begin the first day of the calendar month following the date of rehire or the first day of the calendar month following the satisfaction of any applicable employment Waiting Period, whichever comes first.

A terminated Employee who is rehired after thirteen (13) weeks from the date of termination will be treated as a new hire and be required to satisfy all Eligibility and Enrollment requirements.

Employees on Military Leave. Employees going into or returning from military service may elect to continue Plan coverage as mandated by the Uniformed Services Employment and Reemployment Rights Act (USERRA) under the following circumstances. These rights apply only to Employees and their Dependents covered under the Plan immediately before leaving for military service.

1. The maximum period of coverage of a person and the person's Dependents under such an election shall be the lesser of:

    a. The twenty-four (24) month period beginning on the date on which the person's absence begins; or
    b. The day after the date on which the person was required to apply for or return to a position of employment and fails to do so.

2. A person who elects to continue health plan coverage may pay up to 102% of the full contribution under the Plan, except a person on active duty for thirty (30) days or less cannot be required to pay more than the Employee's share, if any, for the coverage.

3. An Exclusion or Waiting Period may not be imposed in connection with the reinstatement of coverage upon reemployment if one would not have been imposed had coverage not been terminated because of service. However, an Exclusion or Waiting Period may be imposed for coverage of any Illness or Injury determined by the Secretary of Veterans Affairs to have been Incurred in, or aggravated during, the performance of uniformed service.

If the Employee wishes to elect this coverage or obtain more detailed information, contact the Plan Administrator. The Employee may also have continuation rights under USERRA. In general, the Employee must meet the same requirements for electing USERRA coverage as are required under COBRA Continuation Coverage requirements. Coverage elected under these circumstances is concurrent not cumulative. The Employee may elect USERRA continuation coverage for the Employee and their Dependents. Only the Employee has election rights. Dependents do not have any independent right to elect USERRA health plan continuation.

When Dependent Coverage Terminates. A Dependent's coverage will terminate on the earliest of these dates:

1. The date the Plan or Dependent coverage under the Plan is terminated.

2. The last day of the month in which an Employee's coverage under the Plan terminates for any reason including death.

3. The last day of the month in which a covered spouse loses coverage due to loss of eligibility status.

4. The last day of the month in which the Dependent Child ceases to meet the applicable eligibility requirements.

5. If a Dependent commits fraud or makes an intentional misrepresentation of material fact in applying for or obtaining coverage, or obtaining benefits under the Plan, or fails to notify the Plan Administrator that they have become ineligible for coverage, then the Employer or Plan may either void coverage for the Dependent for the period of time coverage was in effect, may terminate coverage as of a date to be determined at the Plan's discretion, or may immediately terminate coverage. If coverage is to be terminated or voided retroactively for fraud or misrepresentation, the Plan will provide at least thirty (30) days' advance written notice of such action; or

6. As otherwise specified in this Plan.

Note: Except in certain circumstances, a covered Dependent may be eligible for COBRA Continuation Coverage. For a complete explanation of when COBRA Continuation Coverage is available, what conditions apply and how to select it, see the COBRA Continuation Coverage section in this Plan.

ARTICLE VIII -
MEDICAL BENEFITS

Medical benefits apply when Covered Expenses are Incurred by a Covered Person for care of an Injury or Illness and while the person is covered for these benefits under the Plan.

PAYMENT OF BENEFITS

All benefits under this Plan are payable, in U.S. Dollars, to the Covered Person whose Illness or Injury is the basis of a claim, unless the Covered Person, in accordance with the terms of this Plan, compensates Hospital or Physician of medical care with an assignment of benefits. Payment of benefits from the Plan to a health care Hospital or Physician pursuant to written direction of the Covered Person is subject to the approval of the Plan Administrator, and shall be made as consideration in full for services rendered. In the event of the death or incapacity of a Covered Person and in the absence of written evidence to this Plan of the qualification of a guardian for their 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 Covered Person.

COVERED EXPENSES

Charges for Covered Expenses are not to exceed the Reasonable and Allowed Amount that are Incurred for the following items of services and supplies when Medically Necessary to diagnose or treat a Covered Person. These charges are subject to all benefit limits, Exclusions, and other provisions of this Plan. Covered Expenses and Medically Necessary are defined terms; see the Defined Terms section in this Plan for definitions of capitalized terms.

1. **Contraceptives.** All Food and Drug Administration approved contraceptive methods when prescribed by a Physician, including but not limited to, intrauterine devices (IUDs), implants, and injections, and any related Physician and facility charges, including complications, and will be payable under the preventive care benefits as shown in the Medical Benefits Schedule section.

   Refer to the separate Prescription Drug Benefit of this Plan regarding prescription coverage of oral contraceptive medications, devices, transdermal, vaginal contraceptives, implantable and injectables, including Physician-prescribed over-the-counter (OTC) contraceptives for female Covered Persons.

2. **Physician Care.** The professional services of a Physician for surgical or medical services provided in their office.

3. **Prescription Medications.** Covered Expenses include drugs that are administered as part of a covered treatment while at a Physician's office and that require a prescription. Coverage does not include paper (script) claims obtained at a retail pharmacy, which are covered under the Prescription Drug benefit.

4. **Preventive Care.** Covered Expenses under medical benefits are payable for routine preventive care as described in the Medical Benefits Schedule. Standard preventive care for adults includes services with an "A" or "B" rating from the United States Preventive Services Task Force or as otherwise identified in applicable law. Examples of standard preventive care include:

   - Screenings for: breast cancer, cervical cancer, colorectal cancer, high blood pressure, Type 2 Diabetes Mellitus, cholesterol, and obesity.
   - Immunizations for adults recommended by the Advisory Committee on Immunization Practices of the Centers for Disease Control and Prevention; and
   - Additional preventive care and screening for women provided for in the guidelines supported by the Health Resources and Services Administration, including the following:
     - Breastfeeding support, supplies, and counseling; and
     - Gestational diabetes screening.

Standard preventive care includes women's contraceptives sterilization procedures, and counseling.

The list of services included as standard preventive care may change from time to time depending upon government guidelines. A current listing of required preventive care can be accessed at:

- www.HealthCare.gov/center/regulations/prevention.html.

Charges for Routine Well Adult Care. Routine well adult care is care by a Physician that is not for an Injury or Illness.

Charges for Routine Well Child Care. Routine well child care is routine care by a Physician that is not for an Injury or Illness. Standard preventive care for Children includes services with an "A" or "B" rating from the United States Preventive Services Task Force. Examples of standard preventive care include:

- Immunizations for Children and adolescents recommended by the Advisory Committee on Immunization Practices of the Centers for Disease Control and Prevention. These may include:
  - Diphtheria,
  - Pertussis,
  - Tetanus,
  - Polio,
  - Measles,
  - Mumps,
  - Rubella,
  - Hemophilus influenza b (Hib),
  - Hepatitis B,
  - Varicella.

Preventive care and screenings for infants, Children and adolescents as provided for in the comprehensive guidelines supported by the Health Resources and Services Administration.

5. **Remote Second Opinion Program.** Given the high rate of misdiagnosis and the variation and waste prevalent in health care, Covered Persons are highly encouraged to utilize this Plan's Remote Second Opinion Program. when they receive a Diagnosis and/or a course of treatment that they are uncertain about, or if they would simply like additional information to better understand what options are available and what may best suit their individual health care needs. Remote Second Opinions are at no cost to the Covered Person, if allowed by applicable law. To engage with the Remote Second Opinion Program, please call (877) 313-1901.

6. **Telehealth Services.** Virtual visits for Covered Expenses that include the Diagnosis and treatment of less serious medical conditions through live audio and video technology. Virtual visits provide communication of medical information in real-time between the patient and a distant Physician or health specialist, through use of live audio and video technology outside of a medical facility (for example, from home or from work).

7. **Urgent Care Facility.** Services and supplies provided by an urgent care facility. Eligible expenses will be payable as shown in the Medical Benefits Schedule.

ARTICLE IX -
MEDICAL MANAGEMENT SERVICES

The Plan has contracted with utilization review vendor in order to assist the Covered Person in determining whether or not proposed services are appropriate for reimbursement under the Plan. The program is not intended to diagnose or treat medical conditions, guarantee benefits, or validate eligibility.

UTILIZATION REVIEW

Utilization review is the process of evaluating if services, supplies or treatment are Medically Necessary, appropriate and priced at the prevailing rates to help ensure cost-effective care. Utilization review can eliminate unnecessary services, hospitalizations, and shorten confinements while improving quality of care and reducing costs to the Covered Person and the Plan.

Preauthorization establishes the Medical Necessity of certain care and services covered under the Plan. It ensures that the preauthorized care and services will not be denied on the basis of Medical Necessity (as defined by this Plan). The Preauthorization process will also establish the reference prices for requested services. However, Preauthorization does not guarantee the payment of benefits. Coverage and benefits are always subject to other requirements and provisions of the Plan, such as, Plan limitations, Exclusions, and eligibility at the time care and services are provided.

If a claim is denied for reasons that involve medical judgement (such as lack of Medical Necessity) the Covered Person may appeal the decision.

PREAUTHORIZATION

All services requiring Preauthorization, are to be authorized in advance, except for emergencies, by contacting the phone number on the Plan ID card as soon as possible **prior** to the services being rendered. They must identify the services to be rendered and the associated Diagnosis and procedure codes necessary for Preauthorization determinations and service prepricing.

The purpose of the program is to determine Medical Necessity, medical appropriateness, health care setting, and level of care.

If Preauthorization is not obtained prior to treatment or care, the Plan payment for any expenses associated with the treatment or care may be *reduced by 50%*. Such reduction will not go toward the maximum out-of-pocket amount.

If a particular course of treatment or medical service is not Preauthorized as Medically Necessary before the Covered Person receives the care or treatment, it means that the charges for the care or treatment may be denied.

Any reduced reimbursement or denied claims, due to failure to follow Preauthorization procedures will not accrue toward the maximum out-of-pocket amount.

The attending Physician does not have to obtain Preauthorization from the Plan for prescribing a maternity length of stay that is forty-eight (48) hours or less for a vaginal delivery or ninety-six (96) hours or less for a cesarean delivery.

HOW THE UTILIZATION REVIEW PROGRAM WORKS

Before a Covered Person enters a Hospital on a non-emergency basis or receives other listed medical services, the utilization review vendor will, in conjunction with the attending Physician, certify the care as Medically Necessary. A non-emergency stay in a Hospital is one that can be scheduled in advance.

The utilization review program is set in motion by a telephone call from, or on behalf of, the Covered Person or the treating Provider. Contact the number on the Plan ID card before services are scheduled to be provided with the following information.

- The name of the Covered Person and relationship to the covered Employee
- The name, Employee identification number and address of the covered Employee
- The name of the Employer
- The name and telephone number of the attending Physician
- The name of the Hospital, proposed date of admission, and proposed length of stay
- The proposed medical services
- The proposed rendering of listed medical services

If there is an emergency admission to the Hospital, the Covered Person, Covered Person's family member, Hospital or attending Physician must contact the number on the Plan ID card **as soon as possible** after admission.

The services will be reviewed and a determination will be made on the Medical Necessity of the care, treatment or service.

Note: *Preauthorization does not guarantee payment of the claim(s) Incurred during the period of authorization. Whether an individual is a Covered Person, whether a charge is eligible for payment, and how much of a charge is paid are determined after the claim for the care, treatment or service is received by the Claims Administrator. All claims are subject to all Plan terms and conditions, limitations, and Exclusions at the time the charges are Incurred. Providers and Covered Persons are informed at the time the Hospital stay is authorized, that authorization does not guarantee payment of claims for the same.*

Concurrent Review and Discharge Planning. Concurrent review of a course of treatment and discharge planning from a Hospital are parts of the utilization review. The utilization review vendor will monitor the Covered Person's Hospital stay or use of other medical services and coordinate with the attending Physician, Hospital and Covered Person either the scheduled discharge or extension of the Hospital stay or extension or cessation of other medical services.

If the attending Physician believes it Medically Necessary for a Covered Person to receive additional services or to stay in the Hospital for a greater length of time than has been Preauthorized, the attending Physician must request the additional services or days.

CASE MANAGEMENT AND ALTERNATIVE BENEFIT

If a Covered Person has an ongoing Illness or Injury, a Case Manager may be assigned to monitor the Covered Person, and to coordinate with the attending Physician and Covered Person to design a treatment plan and coordinate appropriate Medically Necessary care. The case manager will consult with the Covered Person, the family, and the attending Physician to assist in coordinating a plan of care approved by the Covered Person's attending Physician and the Covered Person.

Case management is a voluntary program of the Plan. If the Covered Person chooses not to participate in the case management program, there will be no reductions of benefits or penalties.

Each treatment plan is individualized to a specific Covered Person and is not appropriate or recommended for any other Covered Person, even one with the same Diagnosis. All treatment and care decisions will be the sole determination of the Covered Person and the attending Physician.

Alternative Benefit. The Plan may elect, in its sole discretion, to allow for alternative benefits that are otherwise excluded under the Plan. The Plan's decision to allow alternative benefits shall be determined on a case-by-case basis in conjunction with the treating Provider and the Covered Person. The Plan's determination to provide the benefits in one instance shall not obligate the Plan to provide the same or similar alternative benefits for the same or any other Covered Person, nor shall it be deemed to waive the right of the Plan Administrator to strictly enforce the provisions of the Plan.

The Alternative Benefit must be beneficial to both the Covered Person and the Plan. Alternative benefits, if approved by the Plan Administrator, are subject to all applicable Plan terms and conditions, limitations and Exclusions at the time the charges are Incurred. Once agreement has been reached, the Plan Administrator or its delegate will direct the Claims Administrator to reimburse for Medically Necessary expenses as stated in the alternative treatment plan, even if these expenses normally would not be paid by the Plan. Unless specifically provided to the contrary in the Plan Administrator's instructions, reimbursement for expenses Incurred in connections with the treatment plan shall be subject to all Plan limits and cost sharing provisions.

ARTICLE X -
MEDICAL PLAN EXCLUSIONS

The following charges are not covered under this Plan. All Exclusions related to Prescription Drugs are shown in the Prescription Drug benefits section.

1. **Abortion.** Charges in connection with an abortion.

2. **Acupuncture.** Charges associated with acupuncture.

3. **Administrative Costs.** Charges for failure to keep scheduled appointments, completion of a claim form, obtaining medical records, late payments, telephone charges or information required to process a claim.

4. **Allergy Testing and Injections.** Charges associated with allergy testing and injections.

5. **Ambulance Services.** Charges related to any ambulance service including, but not limited to ground, air or water ambulance services.

6. **Applied Behavioral Analysis Therapy.** Charges related to applied behavioral analysis therapy.

7. **Cardiac Rehabilitation.** Charges for cardiac rehabilitation services.

8. **Chemotherapy.** Charges associated with chemotherapy.

9. **Chiropractic Care.** Charges related to chiropractic care.

10. **Clinical Trials.** Charges associated with participating in a clinical trial.

11. **Complications of Non-Covered Expenses.** Charges Incurred as a result of complications from a treatment not covered under the Plan.

12. **Cosmetic Components of Gender Dysphoria.** Charges for treatment performed as a component of gender transition that are considered cosmetic.

13. **Cosmetic Surgery.** Charges that are Incurred in connection with the care and/or treatment of surgical procedures which are performed for plastic, reconstructive or cosmetic purposes or any other service or supply which are primarily used to improve, alter or enhance appearance, whether or not for psychological or emotional reasons. A treatment will be considered cosmetic for either of the following reasons; (a) its primary purpose is to beautify or (b) there is no documentation of a clinically significant impairment, meaning decrease in function or change in physiology due to Injury, Illness or congenital abnormality.

14. **Custodial Care.** Charges provided mainly as a rest cure, maintenance or Custodial Care.

15. **Dental Care.** Charges for normal dental care benefits, including any dental, gum treatments, or oral surgery.

16. **Diagnostic Services and Supplies.** Charges associated with diagnostic services and/or supplies, unless considered preventive care as defined by applicable law.

17. **Dialysis.** Charges associated with dialysis treatments.

18. **Diabetic Supplies.** Charges for diabetic services, unless covered by other Plan provisions or required by applicable law.

19. **Durable Medical Equipment.** Charges for Durable Medical Equipment.

20. **Educational or Vocational Testing.** Charges related to the education or training program, unless covered by other Plan provisions or required by applicable law.

21. **Emergency Room Services.** Charges Incurred in an emergency room for any reason.

22. **Excess Charges.** Charges for care and treatment of an Injury or Illness that is in excess of the Reasonable and Allowed Amount.

23. **Exercise Programs.** Charges for any exercise programs for treatment of any condition.

24. **Experimental and/or Investigational.** Charges for care and treatment that is either Experimental and/or Investigational, as defined by this Plan.

25. **Eye Care.** Charges for eye examinations, lenses radial keratotomy, Lasik surgery, or other eye surgery to correct refractive disorders.

26. **Foreign Travel.** Charges for care, treatment or supplies out of the U.S. if travel is for the sole purpose of obtaining medical services.

27. **Gender Affirming Surgery Reversal.** Charges for treatment, services, or supplies performed as part of reversal of gender affirming surgery used to treat gender dysphoria.

28. **Gene and Cell Therapy.** Charges associated with any gene and/or cell therapy even if recommended by a Physician and/or considered Medically Necessary.

29. **Genetic Counseling and Testing.** Charges associated with any genetic counseling and/or testing, unless required by applicable law.

30. **Government Coverage**. Charges for care, treatment or supplies furnished by a program or agency funded by any government. This Exclusion does not apply to Medicaid or when otherwise prohibited by applicable law.

31. **Hair Loss.** Charges for care and treatment for hair loss including wigs, hair transplants, or any drug that promises hair growth, whether or not prescribed by a Physician.

32. **Hazardous Activities.** Charges for services, supplies, care, or treatment of an Injury or Illness that results from engaging in a hazardous hobby or recreational activity. A hobby or recreational activity is hazardous if it is an uncommon activity which is characterizes by a constant or recurring threat of danger or risk of bodily harm. The Plan Administrator has the full discretionary authority to determine what is considered a hazardous activity under this Plan.

33. **Hearing Aids and Exams.** Charges for hearing aids or examinations for the prescription, fitting, and/or repair of hearing aids.

34. **Home Health Care.** Charges associated with home health care services.

35. **Hospice Care.** Charges for hospice care services.

36. **Hospital-Based Medications.** Charges for drugs administered in a Hospital or any other Institution (i.e., J-codes).

37. **Illegal Acts.** Charges for any Injury or Illness resulting from, or in consequence of, taking part or attempting to take part in an illegal activity, including but not limited to misdemeanors and felonies. It is not necessary that criminal charges be filed, or, if filed, that a conviction result be imposed for this Exclusion to apply. Proof beyond a reasonable doubt is not required. This Exclusion does not apply if the Injury or Illness resulted from an act of domestic violence or a medical (including both physical and mental health) condition.

38. **Illegal Drugs or Medications.** Charges for an Illness or Injury resulting from the Covered Person voluntarily taking or being under the influence of any controlled substance, drug, hallucinogen, or narcotic not administered on the advice of a Physician. Expenses will be covered for Covered Persons other than the person using the controlled substance. This Exclusion does not apply (a) if the Injury 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).

39. **Imaging Services.** Charges for imaging, including but not limited to, x-rays, ultrasounds, MRIs, CT and PET scans, unless considered preventive care as defined by applicable law.

40. **Immunizations.** Charges for immunizations and vaccinations for the purpose of travel outside of the United States, unless covered by other Plan provisions or required by applicable law.

41. **Infertility.** Charges related to impregnation and infertility treatment: artificial insemination, fertility drugs, G.I.F.T. (Gamete Intrafallopian Transfer), impotency drugs such as Viagra™, in-vitro fertilization, surrogate mother (unless the surrogate is a Covered Person, in which case the preventive and other office services will be covered in accordance with the Plan provisions), donor eggs, collection or purchase of donor semen (sperm) or oocytes (eggs), and freezing of sperm, oocytes, or embryos, or any type of artificial impregnation procedure, whether or not such procedure is successful.

42. **Infusion Therapy.** Charges associated with infusion therapy.

43. **Inpatient Services.** Charges for services performed while a Covered Person was Inpatient in any Institution.

44. **Long Term Care.** Charges related to long term care.

45. **Mailing or Sales Tax.** Charges for mailing, shipping, handling, conveyance and sales tax.

46. **Massage Therapy.** Charges in connection with massage therapy.

47. **Medical Supplies.** Charges for medical supplies.

48. **Mental or Nervous Disorders and Substance Use Disorder Treatment.** Charges associated with the treatment of Mental or Nervous Disorders or Substance Use Disorders unless required by applicable law.

49. **Negligence.** Charges for Injuries or Illness resulting from negligence, misfeasance, malfeasance, nonfeasance or malpractice on the part of any licensed Physician.

50. **No Charge.** Charges for which there would not have been a charge if no coverage had been in force.

51. **Non-Compliance.** Charges in connection with treatments or medications where the Covered Person either is non-compliant with medical orders issued while an Inpatient at, or is discharged against medical advice.

52. **Non-Emergency Hospital Admissions.** Charges for non-medical emergency admissions for surgery on a Friday or a Saturday. This does not apply if surgery is performed within 24 hours of admission.

53. **Non-Emergency Use of Emergency Room.** Charges associated with the use of the emergency room when the Covered Person is not experiencing an emergency.

54. **Not Medically Necessary.** Charges Incurred for services determined to not be Medically Necessary.

55. **Not Specified as Covered.** Charges for any treatments and supplies which are not specified as a Covered Expense under this Plan.

56. **Nutritional Supplements.** Charges for nutritional supplements and/or vitamins, unless covered by other Plan provisions or required by applicable law.

57. **Occupational Injury.** Charges for an Injury or Illness that is occupational – that is, arises from work for wage or profit including self-employment. This Exclusion applies even if the Covered Person:

    a. Has waived their rights to Workers' Compensation benefits;
    b. Was eligible for Workers' Compensation benefits and failed to properly file a claim for such benefits;
    c. The Covered Person is permitted to elect not to be covered under Workers' Compensation but has failed to properly file for such election.

58. **Occupational Therapy.** Charges associated with occupational therapy.

59. **Outpatient Rehabilitation Services.** Charges associated with Outpatient therapy services such as cardiac rehabilitation and respiratory therapy.

60. **Outpatient Services or Surgery.** Charges for Outpatient services or surgery and medical services not performed in a Physician's office.

61. **Personal Convenience Items.** Charges for certain personal convenience items including but not limited to, air conditioners, air-purification units, humidifiers, electric heating units, orthopedic mattresses, blood pressure instruments, scales, elastic bandages or stockings, nonprescription drugs and medicines, and first-aid supplies and nonhospital adjustable beds.

62. **Physical Therapy.** Charges associated with physical therapy services.

63. **Pregnancy**. Charges associated with Pregnancy and complications of Pregnancy, unless considered preventive care as defined by applicable law

64. **Private Duty Nursing**. Charges for private duty nursing.

65. **Professional (and Semi-Professional) Athletics.** 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.

66. **Radiation Services.** Charges associated with radiation therapy.

67. **Self-Inflicted.** Charges due to an intentionally self-inflicted Injury or Illness. This Exclusion does not apply if the Injury or Illness resulted from an act of domestic violence or a medical (including both physical and mental health) condition.

68. **Services Before or After Coverage.** Charges Incurred when the person was not a Covered Person under this Plan.

69. **Skilled Nursing Facility Care.** Charges Incurred for skilled nursing or in a Skilled Nursing Facility.

70. **Sleep Studies.** Charges for sleep studies.

71. **Speech Therapy.** Charges associated with speech therapy.

72. **Sterilization Services.** Charges for reversal of sterilization, or any sterilization procedure, unless considered preventive care as defined by applicable law.

73. **Transplant Services.** Charges for any transplant.

74. **Travel or Accommodations.** Charges for travel or accommodations, whether or not recommended by a Physician.

75. **War.** Charges as a result of war or any act of war, whether declared or undeclared, or any act of aggression, when the Covered Person is a member of the armed forces of any country, or during service by a Covered Person in the armed forces of any country.

ARTICLE XI -
PRESCRIPTION DRUG BENEFITS

The purpose of the Prescription Drug Program is to provide eligible Employees and their Dependents with certain Prescription Drugs approved by the Food and Drug Administration (FDA) and dispensed at a retail or mail in Pharmacy.

The Plan has partnered with a Pharmacy Benefits Manager, to offer Covered Persons covered Prescription Drugs. For a list of covered Prescription Drugs as well as participating pharmacies that have contracted with the Plan to charge Covered Persons reduced fees for covered Prescription Drugs, please contact the Plan Administrator. More information about the Plan's Prescription Drug Program can be found in the Prescription Drug Benefit Schedule.

Participating Pharmacy. Participating pharmacies have contracted with the Plan to charge Covered Persons reduced fees for covered Prescription Drugs.

Prescription Drug Copayments. A Prescription Drug Copayment is applied to each covered Pharmacy drug, specialty medication or mail order drug charge.

MAIL ORDER

The PBM offers a mail order program which allows eligible Covered Persons to receive a ninety (90) day supply of Prescription Drugs for the applicable Copay. The mail order program includes maintenance drugs covered under the Plan.

Any one mail order prescription is limited up to a ninety (90) day supply.

Note: Some quantity limitations and/or prior authorization may apply.

PRIOR AUTHORIZATION (PA)

Prior authorization is required for all new drugs after-market availability for twelve (12) months. There are additional medications that may require Preauthorization, check with the Pharmacy Benefits Manager for the most updated information.

LIMITATIONS TO THIS BENEFIT

1. Certain Prescription Drugs are subject to supply limits. The limit may restrict the amount dispensed for each prescription or refill and/or the amount dispensed for any month's supply (for example, medications used to treat sexual dysfunction), and this is to ensure certain medications are not utilized inappropriately or recommended maximum dosages are not exceeded.
2. Limitations and Exclusions may apply to certain classes of Prescription Drugs where lower cost clinical alternatives exist.
3. Specific rules, including increased supply limits, may apply. Contact the Pharmacy Benefit Manager for more information.

For more information regarding the Prescription Drug program, including what prescription drugs are covered and excluded contact the number on the Plan ID card.

ARTICLE XII -
CLAIMS PROCEDURES

When services are received from a health care Provider, a Covered Person should show their **identification card** to the Provider.

If it is necessary for a Covered Person to submit a claim, they should request an itemized bill which includes procedure (CPT) and diagnostic (ICD) codes from their health care Provider.

To assist the Claims Administrator in processing the claim, the following information must be provided when submitting the claim for processing:

- A copy of the itemized bill;
- Group name and number;
- Provider Billing Identification Number;
- Employee's name and Identification Number;
- Name of Covered Person;
- Name, address, telephone number of the Provider of care;
- Date of service(s);
- Place of service; and
- Amount billed.

Note: A Covered Person can obtain a claim form from the Claims Administrator.

WHERE TO SUBMIT CLAIMS

Claims for expenses should be submitted to the Claims Administrator outlined in the General Plan Information section of this Plan

WHEN CLAIMS SHOULD BE FILED

Claims should be received by the Claims Administrator within 365 days from the date charges for the services were Incurred. Benefits are based on the Plan's provisions in effect at the time the charges were Incurred. Claims received later than that date will be denied.

The Covered Person must provide sufficient documentation (as determined by the Claims Administrator) to support a claim for benefits. The Plan reserves the right to have a Covered Person seek a second opinion. The Plan also encourages Covered Persons to obtain second opinions as outlined in the Covered Expenses section set forth above. **The Plan Administrator will only process Clean Claims as defined by this Plan 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 Plan 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 Plan. 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 Covered Person has failed to submit required forms or additional information to the Plan as well.

TYPES OF CLAIMS

A **claim** means a request for a Plan benefit, made by a Claimant (Covered Person or by an Authorized Representative of a Covered Person that complies with the Plan's procedures for filing benefit claims).

A Claimant may appoint an Authorized Representative to act upon their behalf with respect to the claim. Only those individuals who satisfy the Plan's requirements to be an Authorized Representative will be considered an Authorized Representative. A healthcare Provider is not an Authorized Representative simply by virtue of an assignment of benefits; however, a healthcare Provider can represent the Claimant in claims involving urgent care. Contact the Claims Administrator for information on the Plan's procedures for Authorized Representatives. There are four types of claims:

A **pre-service claim** is a reduction in benefits for certain Covered Services because the Covered Person did not obtain the required Plan approval before receiving the care or treatment. This Plan does require Preauthorization for certain Covered Services or treatments as a condition to receiving benefits under the Plan. The review program is known as Preauthorization. See the Medical Benefits Schedule and Medical Management Services sections in this Plan for more information.

An **urgent care claim** is any pre-service claim where the application of the time periods for review and determination of the pre-service claim could seriously jeopardize the life or health of the Covered Person or the Covered Person's ability to regain maximum function, or – in the opinion of the Covered Person's treating Physician, would subject the Covered Person to severe pain that cannot be managed without the proposed care or treatment.

A **concurrent care determination** is a reduction or termination of a previously approved course of treatment that is to be provided over a period of time or for a previously approved number of treatments. *If case management is appropriate for a Covered Person, case management is not considered a concurrent care determination. Please refer to the Medical Management Services section of this Plan.*

A **post-service claim** is a claim for medical care, treatment, or services that a Claimant has already received.

INITIAL BENEFIT DETERMINATION

All questions regarding claims should be directed to the Claims Administrator. All claims will be considered for payment according to the Plan's terms and conditions, limitations and Exclusions, and industry standard guidelines in effect at the time charges were Incurred. The Plan may, when appropriate or when required by law, consult with relevant health care professionals and access professional industry resources in making decisions about claims involving specialized medical knowledge or judgment.

A claim will not be deemed submitted until it is received by the Claims Administrator.

The initial benefit determination will be made as follows:

Pre-Service Claims for Urgent Care. If the pre-service claim is determined by the Claims Administrator to be a claim involving urgent care, notice of the Plan's decision will be provided to the Covered Person as soon as possible but no later than seventy-two (72) hours after receipt of the pre-service claim by the Claims Administrator.

The exception is if the Covered Person does not provide sufficient information to decide the pre-service claim. In that case, notice requesting specific additional information will be provided to the Covered Person within twenty-four (24) hours of receipt of the pre-service claim.

The Plan's decision regarding the pre-service claim will be made as soon as possible but no later than forty-eight (48) hours after the earlier of:

- The Plan's receipt of the requested information or
- The expiration of the time period set by the Plan for the requested information (at least forty-eight (48) hours).

Pre-Service Claims for Non-Urgent Care. If the pre-service claim is not an urgent care claim, written notice of the Plan's decision will generally be provided to the Covered Person within a reasonable period of time, but no later than fifteen (15) days after receipt of the pre-service claim by the Claims Administrator.

If matters beyond the control of the Claims Administrator so require, one fifteen (15) day extension of time for processing the pre-service claim beyond the initial fifteen (15) days may be taken. Written notice of the extension will be furnished to the Covered Person before the end of the initial fifteen (15) day period. If an extension is required because the Covered Person did not provide the information necessary to make a determination on the claim, the notice of extension will specifically describe the required information.

The time-period for processing the pre-service claim will be deferred beginning on the date this extension notice is sent to the Covered Person and ending on the earlier of:

- The date the Plan receives a response to the request for additional information, or
- The date set by the Plan for a response (which will be at least forty-five (45) days).

Concurrent Care Determination. The initial benefit determination on a concurrent care determination will be made within fifteen (15) days of the Claim Administrator's notice of a concurrent care claim. If additional information is necessary to process the concurrent care claim, the Claims Administrator will make a written request to the Claimant for the additional information within this initial period. The Claimant or the healthcare Provider must submit the requested information within forty-five (45) days of receipt of the request from the Claims Administrator. Failure to submit the requested information within the forty-five (45) day period may result in a denial of the claim or a reduction in benefits.

If additional information is requested, the Plan's time period for making a determination on a concurrent care claim is suspended until the earlier of:

- The date the Plan receives the Claimant's or healthcare Provider's response for additional information, or
- The date set by the Plan for the Claimant or healthcare Provider to respond (which will be at least forty-five (45) days).

A benefit determination on the concurrent care claim will be made within fifteen (15) days of the Plan's receipt of the additional information.

Post-Service Claim. The initial benefit determination on a post-service claim will be made within thirty (30) days of the Claim Administrator's receipt of the claim. If additional information is necessary to process the claim, the Claims Administrator will make a written request to the Claimant for the additional information within this initial period. The Claimant must submit the requested information within forty-five (45) days of receipt of the request from the Claims Administrator. Failure to submit the requested information within the forty-five (45) day period may result in a denial of the claim or a reduction in benefits.

If additional information is requested, the Plan's time period for making a determination on a post-service claim is suspended until the earlier of:

- The date the Plan receives the Claimant's additional information; or
- The date set by the Plan for the Claimant to respond (which will be at least forty-five (45) days).

A benefit determination on the claim will be made within fifteen (15) days of the Plan's receipt of the additional information.

NOTICE OF DETERMINATION

1. The Plan shall provide written or electronic notice of the determination on a claim in a manner meant to be understood by the Claimant. If a claim is denied in whole or in part, notice will include the following:
2. Specific reason(s) for the denial.
3. Reference to the specific Plan provisions on which the denial was based.
4. Description of any additional information necessary for the Claimant to perfect the claim and an explanation of why such information is necessary.

5. Description of the Plan's claims review procedures and the time limits applicable to such procedures. This will include a statement of the Claimant's right to bring a civil action under ERISA section 502(a) following a notice of the determination on final review.
6. Statement that the Claimant 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 claim.

If applicable:

1. Any internal rule, guideline, protocol, or other similar criterion that was relied upon in making the determination on the claim (or a statement that such a rule, guideline, protocol, or criterion was relied upon in making the notice of the determination and that a copy will be provided free of charge to the Claimant upon request).
2. If the notice of the determination is based on the Medical Necessity or Experimental and/or Investigational Exclusion or similar such Exclusion, an explanation of the scientific or clinical judgment for the determination applying the terms of the Plan to the claim, or a statement that such explanation will be provided free of charge, upon request.
3. Identification of medical or vocational experts, whose advice was obtained on behalf of the Plan in connection with a claim.

If the Claimant has questions about the denial, the Claimant may contact the Claims Administrator at the address or telephone number printed on the notice of determination.

An Adverse Benefit Determination also includes a rescission of coverage, which is a retroactive cancellation or discontinuance of coverage due to fraud or intentional misrepresentation. A rescission of coverage does not include a cancellation or discontinuance of coverage that takes effect prospectively, or is a retroactive cancellation or discontinuance because of the Covered Person's failure to timely pay required premiums.

CLAIMS REVIEW PROCEDURE - GENERAL

A Claimant may appeal an Adverse Benefit Determination as follows:

- The Plan offers a one-level internal review process for pre-service claims for urgent care; or
- The Plan offers a two-level internal review procedure for a pre-service claim (non-urgent care), concurrent care claim, and post service claim.

The Plan Administrator will provide for a review that does not give deference to the previous benefit determination and that is conducted by either an appropriate plan fiduciary or the Claims Administrator on the Plan's behalf who was not involved in any of the prior determinations. In addition, the Plan Administrator may:

- Take into account all comments, documents, records and other information submitted by the Claimant related to the claim, without regard as to whether this information was submitted or considered in a prior level of review.
- Provide to the Claimant, free of charge, any new or additional information or rationale considered, relied upon or created by the Plan in connection with the claim. This information or new rationale will be provided sufficiently in advance of the response deadline for the final notice of the determination so that the Claimant has a reasonable amount of time to respond.
- Consult with an independent health care professional who has the appropriate training and experience in the applicable field of medicine related to the Claimant's benefit determination if that determination was based in whole or in part on medical judgment, including determinations on whether a treatment, drug, or other item is Experimental and/or Investigational, or not Medically Necessary. A health care professional is "independent" to the extent the health care professional was not consulted on a prior level of review or is a subordinate of a health care professional who was consulted on a prior level of review. The Plan may consult with vocational or other experts regarding the initial benefit determination.

Note: Providers who have submitted claims to the Plan that are subject to the NSA, cannot avail themselves to the internal and external claims procedure set forth herein. All disputes regarding all payments for claims subject to NSA must be resolved through open negotiating or through a Certified Independent Dispute Resolution (IDR) Entity as outlined in the NSA.

INTERNAL APPEAL PROCEDURE

First Level of Internal Review. To appeal a denial of a claim, the Claimant must submit in writing, a request for a review of the claim. The Claimant should include in the appeal letter: their name, ID number, group health plan name, and a statement of why the Claimant disagrees with the denial. The Claimant may include any additional supporting information, even if not initially submitted with the claim.

The written request for review must be submitted within one hundred eighty (180) days of the Claimant's receipt of an Adverse Benefit Determination.

The written request for review should be addressed to the Claims Administrator.

An appeal will not be deemed submitted until it is received by the Claims Administrator. Failure to appeal the initial denial within the prescribed time period will render that determination final. The Claimant cannot proceed to the next level of internal or external review if the Claimant fails to submit a timely appeal.

The first level of review will be performed by the Claims Administrator on the Plan's behalf. The Claims Administrator will review the information initially received and any additional information provided by the Claimant, and determine if the initial benefit determination was appropriate based upon the terms and conditions of the Plan and other relevant information. The Claims Administrator will send a written or electronic notice of determination to the Claimant within:

- Seventy-two (72) hours of the receipt of the appeal for an urgent care claim;
- Fifteen (15) days of the receipt of the appeal for a pre-service claim or a concurrent care claim; or
- Thirty (30) days of the receipt of the appeal for a post service claim.

Second Level of Internal Review

If the Claimant does not agree with the Claims Administrator's determination from the first level of internal review, the Claimant may submit a second level appeal in writing. The Claimant may request a second level appeal on pre-service claims (non-urgent care) and post-service only along with any additional supporting information.

The written request for review of the first level of internal review must be submitted within sixty (60) days of the Claimant's receipt of the first level of internal review.

The written request for review should be addressed to the Claims Administrator.

An appeal will not be deemed submitted until it is received by the Plan Administrator or the Claims Administrator on the Plan Administrator's behalf. Failure to appeal the determination from the first level of review within the prescribed time period will render that determination final. The Claimant cannot proceed to an external review or file suit if the Claimant fails to submit a timely appeal.

The second level of internal review will be done by the Plan Administrator, or its designee. The Plan Administrator will review the information initially received and any additional information provided by the Claimant, and make a determination on the appeal based upon the terms and conditions of the Plan and other relevant information. The Plan Administrator will send a written or electronic Final Internal Adverse Benefit Determination for the second level of review to the Claimant within:

- Fifteen (15) days of the Plan's receipt of Claimant's second level appeal on a pre-service claim (non-urgent care);

- Fifteen (15) days of the Plan's receipt of Claimant's second level appeal on a concurrent caredetermination; or
- Thirty (30) days of the Plan's receipt of Claimant's second level appeal on a post-service claim.

If the Claimant is not satisfied with the outcome of the final determination on the second level of internal review, the Claimant may be eligible for an external review. The Claimant must exhaust both levels of the internal review procedure before requesting an external review. In certain circumstances, the Claimant may also request an expedited external review.

EXTERNAL REVIEW PROCEDURE

This Plan has an external review procedure that provides for a review conducted by a qualified Independent Review Organization (IRO) that shall be assigned on a random basis.

A Claimant may, by written request made to the Plan within four (4) months from the date of receipt of the notice of the final internal Adverse Benefit Determination or the 1st of the fifth month following receipt of such notice, whichever occurs later, request a review by an IRO of a final Adverse Benefit Determination of a claim, except where such request is limited by applicable law.

A request for external review may be granted only for Adverse Benefit Determinations that involve a:

- Determination that a treatment or services is not Medically Necessary;
- Determination that a treatment is Experimental and/or Investigational;
- Rescission of coverage, whether or not the rescission involved a claim; or
- Determination on whether the Plan is complying with the No Surprises Act, as applicable.

For an Adverse Benefit Determination to be eligible for external review, the Claimant must complete the required forms to process an external review. The Claimant may contact the Claims Administrator for additional information.

The Claimant will be notified in writing within six (6) business days as to whether Claimant's request is eligible for external review and if additional information is necessary to process Claimant's request. If Claimant's request is determined ineligible for external review, notice will include the reasons for ineligibility and contact information for the appropriate oversight agency. If additional information is required to process Claimant's request, Claimant may submit the additional information within the four-month filing period, or forty-eight (48) hours, whichever occurs later.

Claimant should receive written notice from the assigned IRO of Claimant's right to submit additional information to the IRO and the time periods and procedures to submit this additional information. The IRO will make a final determination and provide written notice to the Claimant and the Plan no later than forty-five (45) days from the date the IRO receives Claimant's request for external review. The notice from the IRO should contain a discussion of its reason(s) and rationale for the decision, including any applicable evidence-based standards used, and references to evidence or documentation considered in reaching its decision.

The decision of the IRO is binding upon the Plan and the Claimant, except to the extent other remedies may be available under applicable law.

Before filing a lawsuit, the Claimant must exhaust all available levels of review as described in this section, unless an exception under applicable law applies. A legal action to obtain benefits must be commenced within one year of the date of the notice of determination on the final level of internal or external review, whichever is applicable.

Generally, a Claimant must exhaust the Plan's Claims Procedures in order to be eligible for the external review process. However, in some cases the Plan provides for an expedited external review if:

1. The Claimant receives an Adverse Benefit Determination that involves a medical condition for which the time for completion of the Plan's internal claims and appeal procedures would seriously jeopardize the

Claimant's life or health or ability to regain maximum function and the Claimant has filed a request for an expedited internal review; or

2. The Claimant receives a final Adverse Benefit Determination that involves a medical condition where the time for completion of a standard external review process would seriously jeopardize the Claimant's life or health or the Claimant's ability to regain maximum function, or if the final 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.

Immediately upon receipt of a request for expedited external review, the Plan must determine and notify the Claimant whether the request satisfies the requirements for expedited review, including the eligibility requirements for external review listed above. If the request qualifies for expedited review, it will be assigned to an IRO. The IRO must make its determination and provide a notice of the decision as expeditiously as the Claimant's medical condition or circumstances require, but in no event more than seventy-two (72) hours after the IRO receives the request for an expedited external review. If the original notice of its decision is not in writing, the IRO must provide written confirmation of the decision within 48 hours to both the Claimant and the Plan.

APPOINTMENT OF AUTHORIZED REPRESENTATIVE

A Covered Person may designate another individual to be an Authorized Representative and act on their behalf and communicate with the Plan with respect to a specific benefit claim or appeal of a denial. This authorization must be in writing, signed and dated by the Covered Person, and include all the information required in the Authorized Representative form. The appropriate form can be obtained from the Plan Administrator or the Claims Administrator. The Plan does not recognize the appointment of an Authorized Representative by any other instrument.

Should a Covered Person designate an Authorized Representative, all future communications from the Plan will be conducted with the Authorized Representative instead of the Covered Person, unless the Plan Administrator is otherwise notified in writing by the Covered Person. A Covered Person can revoke the Authorized Representative designation at any time. A Covered Person may authorize only one person as an Authorized Representative at a time.

Recognition as an Authorized Representative is completely separate from a Provider accepting an assignment of benefits, requiring a release of information, or requesting completion of a similar form. An assignment of benefits by a Covered Person shall not be recognized as a designation of the Provider as an Authorized Representative.

CONDITIONS AND LIMITATIONS OF AN ASSIGNMENT OF BENEFITS

The term "Assignment of Benefits" shall mean an arrangement whereby the Covered Person assigns their right to seek and receive payment from the Plan for eligible Covered Expenses to a Provider, in strict accordance with the conditions and limitations of such rights provided under the terms of this Plan.

Conditions and Limitations of an Assignment of Benefits:

1. The validity of an Assignment of Benefits by a Covered Person to a Provider is limited by the terms of this Plan. An Assignment of Benefits is considered valid on the condition that Provider accepts the payment received from the Plan as consideration, in full, for Covered Expenses. This amount does not include any cost sharing amounts (i.e. Copayments, deductibles, or coinsurance), or charges for non-covered services; the Provider may bill the Covered Person directly for these amounts.
2. An Assignment of Benefits cannot be inferred, implied or transferred. An Assignment of Benefits must be made by the Covered Person to the Provider directly through a valid written instrument that is signed and dated by the Covered Person.
3. Unless specifically prohibited by a Covered Person, a Provider with a valid Assignment of Benefits may exhaust, on behalf of the Covered Person, any administrative remedies available under the terms of the Plan, including initiating an internal or external appeal of an adverse benefit determination in accordance

with the terms of the Plan. Notwithstanding the foregoing, the Covered Person does not, under any circumstances, have the right to assign to any Provider (or their representative) through an Assignment of Benefits any right to initiate any cause of action against the Plan that the Covered Person them self may be afforded under applicable law. This includes, but is not limited to, any right to bring suit as such is afforded to Covered Persons under ERISA section 502(a). The assignment of any right to initiate suit against the Plan to a Provider is strictly prohibited.

4. An Assignment of Benefits does not grant the Provider any rights other than those specifically set forth herein.
5. The Plan may disregard an Assignment of Benefits at its discretion and continue to treat the Covered Person as the sole recipient of the benefits available under the terms of the Plan.
6. An Assignment of Benefits by a Participant to a Provider will not constitute the appointment of an authorized representative.
7. The Plan 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.

By submitting a claim to the Plan and accepting payment by the Plan, the Provider is expressly agreeing to the foregoing conditions and limitations of an Assignment of Benefits in addition to the terms of the Plan. The Provider further agrees that the payments received constitute an 'accord and satisfaction' and payment in full for the Covered Expenses. The Provider agrees that the conditions and limitations of an Assignment of Benefits as set forth herein shall supersede any previous terms and/or agreements. The Provider agrees to the specific condition that the patient not be balance billed for any amount beyond applicable cost sharing amounts (i.e., copayments, deductibles, or coinsurance), or charges for non-covered services; the Provider may bill the Covered Person directly for these amounts.

If a Provider refuses to accept an Assignment of Benefits under the conditions and limitations as set forth herein, any Covered Expenses payable under the terms of the Plan will be payable directly to the Covered Person, and the Plan will be deemed to have fulfilled its obligations with respect to such Covered Expense.

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

STATUTE OF LIMITATIONS: VENUE/FORUM

Before filing a lawsuit, the Covered Person must exhaust all available levels of review as described in this section, unless an exception under applicable law applies. Legal action to obtain benefits must be commenced within one (1) year of the date of the Notice of Determination on the final level of internal or external review, whichever is applicable. Further, any legal action brought against the Plan must be brought in Federal court, exclusively in the county and state in which the Plan Administrator is located. The Covered Person, or any Authorized Representative, submits to and accepts the exclusive jurisdiction of such courts for the purpose of such legal action. To the fullest extent permitted by law, the Covered Person, and any Authorized Representative, irrevocably waive any objection which they may now or in the future have as to venue, as well as any claim that any legal action or proceeding brought in such court has been brought in an inconvenient forum.

ARTICLE XIII -
COORDINATION OF BENEFITS

DEFINED TERMS

Allowable Expense(s) means the Reasonable and Allowed Amount for any Medically Necessary, eligible item of expense, at least a portion of which is covered under this Plan. When some other plan pays first in accordance with the Application to Benefit Determinations provision in this section, this Plan's Allowable Expenses shall in no event exceed the other plan's Allowable Expenses.

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. Benefits payable under any other plan include the benefits that would have been payable had the claim been duly made therefore, whether or not it is actually made.

Other plan includes, 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 Covered Person.
4. Any first party insurance through medical payment coverage, personal injury protection, no-fault coverage, uninsured or underinsured motorist coverage.
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.

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 Covered Person 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.

Benefits Subject to This Provision. The following shall apply to the entirety of the Plan and all benefits described therein.

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

The Plan's benefits will be excess to, whenever possible, any of the following:

1. Any primary payer besides the Plan.

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.

4. Workers' compensation or other liability insurance company.

5. Any other source, including but not limited to crime victim restitution funds, any medical, disability or other benefit payments, and school insurance coverage.

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 its name, title or classification.

EFFECT ON BENEFITS

Application to Benefit Determinations. The plan that pays first according to the rules in the provision 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 Allowable Expenses. When there is a conflict in the rules, this Plan will never pay more than 50% of Allowable 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 the secondary carrier regardless of the individual's election under personal injury protection (PIP) coverage with the automobile insurance carrier.

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 provision entitled "Order of Benefit Determination" would require this Plan to determine its benefits before the other plan.

Order of Benefit Determination. For the purposes of the provision 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 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:

4. 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.

5. 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.

6. 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.

7. 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 claim is based for the longer period of time shall be determined before the benefits of a plan which has covered such person the shorter period of time.

8. 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.

Right to Receive and Release Necessary Information. The Plan Administrator may, without notice to or consent of any person, release to or obtain any information from any insurance company or other organization or individual any information regarding coverage, expenses, and benefits which the Plan Administrator, at its sole discretion, considers necessary to determine, implement and apply the terms of this provision or any provision of similar purpose of any other plan. Any Covered Person claiming benefits under this Plan shall furnish to the Plan Administrator such information as requested and as may be necessary to implement this provision.

Facility of Payment. A payment made under any other plan may include an amount that should have been paid under this Plan. 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. Any such amount paid under this provision shall be deemed to be benefits paid under this Plan. The Plan Administrator will not have to pay such amount again and this Plan shall be fully discharged from liability.

Right of Recovery. Whenever payments have been made by this Plan with respect to Allowable 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 Coordination of Benefits section, 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 Allowable Expenses, and any future benefits payable to the Covered Person or their Dependents.

Secondary Coverage. Covered Persons who are eligible for secondary coverage by any other health plan are encouraged to obtain such coverage. Failure to obtain secondary coverage may result in the Covered Person incurring costs, which are not covered by the Plan, and which would otherwise be covered by the secondary coverage. The Plan will not pay for any costs which are payable by such secondary coverage when said coverage is primary, except to the extent that such costs are payable in any event by the Plan.

Exception to Medicaid. In accordance with ERISA, the Plan shall not take into consideration the fact that an individual is eligible for or is provided medical assistance through Medicaid when enrolling an individual in the Plan or making a determination about the payments for benefits received by a Covered Person under the Plan.

Applicable to Active Employees and Spouses Ages 65 and Over. A Covered Person that is an Active Employee and their spouse (ages 65 and over) may, at the option of such Employee, elect or decline coverage under this Plan at open enrollment or some other specified special enrollment period. 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 declined by such Employee, benefits listed herein will not be payable even as secondary coverage to Medicare. The Plan will at all times, when applicable, adhere to the requirements set forth in the Medicare Secondary Payer regulations.

Applicable to All Other Covered Persons Eligible for Medicare Benefits. To the extent required by Federal regulations, this Plan will pay Covered Expenses at the Reasonable and Allowed Amount before Medicare makes any secondary payment for such Covered Expenses. 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 Covered Person will be assumed to have full Medicare coverage (that is, both Parts A & B) whether or not the Covered Person has enrolled for the full coverage. If the Provider accepts assignment with Medicare, Covered Expenses will not exceed the Medicare allowable amount.

Applicable to Medicare Services Furnished to End Stage Renal Disease ("ESRD") Covered Persons Who Are Covered Under This Plan. If any Covered Person is eligible for Medicare benefits because of ESRD, the benefits of the Plan will be determined before Medicare benefits for the first 30 months of Medicare entitlement, unless applicable Federal law provides to the contrary, in which event the benefits of the Plan will be determined in accordance with such law.

ARTICLE XIV -
THIRD PARTY RECOVERY, SUBROGATION AND REIMBURSEMENT

Payment Condition. The Plan, in its sole discretion, may elect to conditionally advance payment of benefits in those situations where an Injury, Illness, Disease or disability is caused in whole or in part by, or results from the acts or omissions of Employees, and/or their Dependents, beneficiaries, estate, heirs, guardian, personal representative, or assigns (collectively referred to hereinafter in this section as "Covered Person(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 no-fault, uninsured motorist, underinsured motorist, medical payment provisions, third party assets, third party insurance, and/or guarantor(s) of a third party (collectively "Coverage").

Covered Person(s), their 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 Covered Person(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 Covered Person(s) agrees to include the Plan's name as a co-payee on any and all settlement drafts. Further, by accepting benefits the Covered Person(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 Covered Person shall be a trustee over those Plan assets.

In the event a Covered Person(s) settles, recovers, or is reimbursed by any Coverage, the Covered Person(s) agrees to reimburse the Plan for all benefits paid or that will be paid by the Plan on behalf of the Covered Person(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 Covered Person(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 Covered Person(s) fails to reimburse the Plan out of any judgment or settlement received, the Covered Person(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 Covered Person(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.

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

If a Covered Person(s) receives or becomes entitled to receive benefits, an automatic equitable lien attaches in the Illness or Injury to the extent of such conditional payment by the Plan plus reasonable costs of collection. The Covered Person 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 Covered Person 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 Covered Person(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 Covered Person(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.

3. Any policy of insurance from any insurance company or guarantor of a third party.

4. Workers' compensation or other liability insurance company.

5. Any other source, including but not limited to crime victim restitution funds, any medical, disability or other benefit payments, and school insurance coverage.

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

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 Covered Person(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 Covered Person(s) is fully compensated by their 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 Covered Person's/Covered Persons' 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 Covered Person are deemed held in constructive trust and should not be dissipated or disbursed until such time as the Covered Person's obligation to reimburse the Plan has been satisfied in accordance with these provisions. The Covered Person is also obligated to hold any and all funds so received in trust on the Plan's behalf and function as a trustee as it applies to those funds until the Plan's rights described herein are honored and the Plan is reimbursed.

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

The Plan's right of subrogation and reimbursement will not be reduced or affected as a result of any fault or claim on the part of the Covered Person(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 Covered Person(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 Illness, Injury, Disease or disability.

Covered Person is a Trustee Over Plan Assets. Any Covered Person 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 Covered Person understands that they are 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 their 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 Covered Person is not represented by an attorney, instruct the insurance company or any third party from whom the Covered Person 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 Covered Person disputes this obligation to the Plan under this section, the Covered Person 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 they exercise control, in an account segregated from their general accounts or general assets until such time as the dispute is resolved.

No Covered Person, 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.

Release of Liability. The Plan's right to reimbursement extends to any incident related care that is received by the Covered Person(s) (Incurred) prior to the liable party being released from liability. The Covered Person's/Covered Persons' 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 Covered Person 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.

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

Reimbursement Due to Surrogacy Arrangement. If a Covered Person enters into a Surrogacy Arrangement, the Covered Person must reimburse the Plan for Covered Expenses received related to conception, Pregnancy, delivery, or postpartum care in connection with that Surrogacy Arrangement. The reimbursed amount shall not exceed the payments or other compensation the Covered Person or another person is entitled to receive under the Surrogacy Arrangement.

A "Surrogacy Arrangement" is one in which a Covered Person agrees to become pregnant and to surrender the baby (or babies) to another person or persons who intend to raise the Child (or Children), whether or not the Covered Person receives payment for being a surrogate.

A Surrogacy Arrangement does not affect a Covered Person's obligation to pay any and all patient responsibility amounts for these services. These amounts will be taken into account at the time of reimbursement.

After a Covered Person surrenders a baby to the legal parents, the Plan is not obligated to pay for any services that the baby receives (the legal parents are financially responsible for any services that the baby receives).

As set forth above, as a condition precedent to the Covered Person receiving benefits under the Plan, the Covered Person automatically assigns to the Plan any right to receive payments that are payable to the Covered Person or any other payee under the Surrogacy Arrangement, regardless of whether those payments are characterized as being for medical expenses. To secure the Plan's rights, the Plan will also have a lien on those payments and on any escrow account, trust, or any other account that holds those payments. Those payments (and amounts in any escrow account, trust, or other account that holds those payments) shall first be applied to satisfy the Plan's lien.

Within 30 days after entering into a Surrogacy Arrangement, the Covered Person must send written notice of the arrangement to the Plan, including all of the following information:

1. Names, addresses and telephone numbers of all parties to the arrangement;

2. Names, addresses and telephone numbers of any escrow or trustee;

3. Names, addresses, and telephone numbers of the intended parents and any other parties who are financially responsible for the services of baby (or babies) receive, including names, addresses, and telephone numbers for any health insurance that will cover the services that the baby (or babies) receive;

4. A signed copy of any contracts and other documents explaining the details of the Surrogacy Arrangement; and

5. Any other information the Plan requests in order to satisfy its rights.

Information must be sent to the Plan Administrator at the address outlined in the General Plan Information section of this document.

The Covered Person must complete and send the Plan all consents, releases, authorizations, lien forms, and other documents that are reasonably necessary for the Plan to determine the existence of any rights the Plan may have under this Surrogacy Arrangement and to satisfy those rights. The Covered Person may not agree to waive, release, or reduce the Plan's rights without the Plan's prior, written consent.

If a Covered Person's estate, parent, guardian, or conservator asserts a claim against a third party based on the Surrogacy Arrangement, the estate, parent, guardian, or conservator and any settlement or judgment recovered by the estate, parent, guardian, or conservator shall be subject to the Plan's liens and other rights to the same extent as if the Covered Person had asserted the claim against the third party. The Plan may assign its rights to enforce its liens and/or other rights.

Wrongful Death. In the event that the Covered Person(s) dies as a result of their 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 Covered Person(s) and all others that benefit from such payment.

Obligations. It is the Covered Person's/Covered Persons' 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 Illness, 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 facilitating 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 Covered Person may have against any responsible party or Coverage.

9. To instruct their 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 Covered Person is not represented by an attorney, instruct the insurance company or any third party from whom the Covered Person 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 Covered Person over settlement funds is resolved.

If the Covered Person(s) and/or their 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, as a result of said Injury or condition, out of any proceeds, judgment or settlement received, the Covered Person(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 Covered Person(s).

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

Offset. If timely repayment is not made, or the Covered Person and/or their 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 Covered Person'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 Covered Person(s) in an amount equivalent to any outstanding amounts owed by the Covered Person to the Plan. This provision applies even if the Covered Person has disbursed settlement funds.

Minor Status. In the event the Covered Person(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 their 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.

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.

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 XV -
COBRA CONTINUATION COVERAGE

INTRODUCTION

The right to COBRA Continuation Coverage was created by a federal law, the Consolidated Omnibus Budget Reconciliation Act of 1985, as amended ("COBRA"). COBRA Continuation Coverage can become available to Covered Persons and Dependents when group health coverage would otherwise end. For more information about a Covered Person's rights and obligations under the Plan as it relates to federal law, review this section thoroughly. For questions please contact the Plan Administrator.

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

WHAT IS COBRA CONTINUATION COVERAGE?

COBRA continuation coverage is a continuation of Plan coverage when coverage otherwise would end because of a life event. This is also known as a "qualifying event." Specific qualifying events are listed later in this section. After a qualifying event, COBRA continuation coverage must be offered to each person who is a "qualified beneficiary." Covered Persons and Dependents could become qualified beneficiaries if coverage under the Plan is lost because of the qualifying event. Under the Plan, qualified beneficiaries who elect COBRA continuation coverage must pay for COBRA continuation coverage.

An eligible Employee who is properly enrolled in the Plan will become a qualified beneficiary if coverage under this Plan is lost due to one of the following qualifying events:

- Hours of employment are reduced; or
- Employment ends for any reason other than gross misconduct.

A spouse of an eligible Employee will become a qualified beneficiary if they lose their coverage under the Plan due to one of the following qualifying events:

- The Active Employee dies;
- The Active Employee's hours of employment are reduced;
- The Active Employee's employment ends for any reason other than their gross misconduct;
- The Active Employee becomes entitled to Medicare benefits (under Part A, Part B, or both); or
- There is a divorce or legal separation from the Active Employee.

Dependent Children will become qualified beneficiaries if they lose coverage under the Plan due to one of the following qualifying events:

- The Active Employee dies;
- The Active Employee's hours of employment are reduced;
- The Active Employee's employment ends for any reason other than their gross misconduct;
- The Active Employee becomes entitled to Medicare benefits (Part A, Part B, or both); or
- Failure to continue to qualify as a Dependent Child as defined by this Plan.

Note: Medicare entitlement means that Covered Persons are eligible for and enrolled in Medicare.

If this Plan provides retiree health coverage, sometimes, filing a proceeding in bankruptcy under Title 11 of the United States Code can be a qualifying event. If a proceeding in bankruptcy is filed with respect to the Employer, and that bankruptcy results in the loss of coverage of any retired Employee covered under the Plan, the retired Employee will become a qualified beneficiary. The retired Employee's spouse, surviving spouse, and Dependent Children also will become qualified beneficiaries if bankruptcy results in the loss of their coverage under the Plan.

WHEN IS COBRA CONTINUATION COVERAGE AVAILABLE?

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

For all other qualifying events (divorce or legal separation of the Employee and spouse or a Dependent Child's losing eligibility for coverage as a Dependent Child), Covered Persons must notify the Plan Administrator within 60 days after the qualifying event occurs. Covered Persons must provide this notice in writing to the Plan Administrator at the address outlined in the General Plan Information section of this document.

Notice must be postmarked (if mailed) or dated (if emailed or hand-delivered) on or before the 60th day following the qualifying event.

HOW IS COBRA CONTINUATION COVERAGE PROVIDED?

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

COBRA continuation coverage is a temporary continuation of coverage that generally lasts for 18 months due to employment termination or reduction of hours of work. Certain qualifying events, or a second qualifying even during the initial period of coverage, may permit a beneficiary to receive a maximum of 36 months of coverage.

There are also ways in which the 18-month period of COBRA continuation coverage can be extended:

Disability Extension of 18-Month Period of Cobra Continuation Coverage. If an Active Employee or Dependent covered under the Plan is determined by the Social Security Administration (SSA) to be disabled and they notify the Plan Administrator in a timely fashion, as outlined below, Covered Persons 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.

Notice of the disability determination must be provided in writing to the Plan Administrator by the date that is 60 days after the latest of:

- The date of the disability determination by the SSA;
- The date on which a qualifying event occurs;
- The date on which the qualified beneficiary loses (or would lose) coverage under the Plan as a result of the qualifying event; or
- The date on which the qualified beneficiary is informed, through the furnishing of the Plan's Summary Plan Description of both the responsibility to provide the notice and the Plan's procedures for providing such notice to the Plan Administrator.

In any event, this notice of disability determination must be furnished before the end of the first 18-months of COBRA continuation coverage. The notice of disability determination must include the name of the qualified beneficiary determined to be disabled by the SSA and the date of the determination. A copy of SSA's Notice of Award Letter must be provided within 30 days after the deadline to provide the notice.

Covered Persons must provide this notice to the Plan Administrator **at the address outlined in the General Plan Information section of this document.**

Second Qualifying Event Extension of 18-Month Period of Cobra Continuation Coverage. If a Covered Person 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 the Plan Administrator is properly notified about the second qualifying event. 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), gets divorced or legally separated, or if the Dependent Child stops being eligible under the Plan. This extension is only available if the second qualifying event would have caused the spouse or Dependent Child to lose coverage under the Plan had the first qualifying event not occurred.

Notice of a second qualifying event must be provided in writing to the Plan Administrator by the date that is 60 days after the latest of:

- The date on which the relevant qualifying event occurs;
- The date on which the qualified beneficiary loses (or would lose) coverage under the Plan as a result of the qualifying event; or
- The date on which the qualifying beneficiary is informed, through the furnishing of the Plan's Summary Plan Description, of both the responsibility to provide the notice and the Plan's procedures for providing such notice to the Plan Administrator.

The notice must include the name of the qualified beneficiary experiencing the second qualifying event, a description of the event and the date of the event. If the extension of coverage is due to a divorce or legal separation, a copy of the decree of divorce or legal separation must be provided within 30 days after the deadline to provide the notice.

Covered Persons must provide this notice to the Plan Administrator at the address outlined in the General Plan Information section of this document.

DOES COBRA CONTINUATION COVERAGE EVER END EARLIER THAN THE MAXIMUM PERIODS ABOVE?

COBRA continuation coverage also may end before the end of the maximum period on the earliest of the following dates:

- The date the Employer ceases to provide a group health plan to any Employee;
- The date on which coverage ceases by reason of the qualified beneficiary's failure to make timely payment of any required premium;
- The date that the qualified beneficiary 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;
- The first day of the month that begins more than 30 days after the date of the SSA's determination that the qualified beneficiary 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; or
- On the same basis that the Plan can terminate for cause the coverage of a similarly situated non-COBRA Covered Person.

HOW DOES ONE PAY FOR COBRA CONTINUATION COVERAGE?

Once COBRA continuation coverage is elected, Qualified Beneficiaries must pay for the cost of the initial period of coverage within 45 days. Payments are then due on the first day of each month to continue coverage for that month. If a payment is not received and/or post-marked within 30 days of the due date, COBRA continuation coverage will be canceled and will not be reinstated.

ARE THERE OTHER COVERAGE OPTIONS BESIDES COBRA CONTINUATION COVERAGE?

Yes. Instead of enrolling in COBRA continuation coverage, there may be other coverage options through the Health Insurance Marketplace, Medicare, Medicaid, Children's Health Insurance Program (CHIP), or other group health plan coverage options (such as a spouse's plan) through what is called a "special enrollment period." Some of these options may cost less than COBRA continuation coverage. Covered Persons can learn more about many of these options at www.HealthCare.gov.

CAN ONE ENROLL IN MEDICARE INSTEAD OF COBRA CONTINUATION COVERAGE AFTER GROUP HEALTH PLAN COVERAGE ENDS?

In general, if a Covered Person does not enroll in Medicare Part A or B when they are first eligible because they are still employed, after the Medicare initial enrollment period, they have an 8-month special enrollment period to sign up for Medicare Part A or B, beginning on the earlier of:

- The month after the employment ends; or
- The month after group health plan coverage based on current employment ends.

If a Covered Person does not enroll in Medicare and elects COBRA continuation coverage instead, they may have to pay a Part B late enrollment penalty and they may have a gap in coverage if they decide they want Part B later. If they elect COBRA continuation coverage and later enroll in Medicare Part A or B before the COBRA continuation coverage ends, the Plan may terminate the continuation coverage. However, if Medicare Part A or B is effective on or before the date of the COBRA election, COBRA coverage may not be discontinued on account of Medicare entitlement, even if they enroll in the other part of Medicare after the date of the election of COBRA coverage.

If an individual is enrolled in both COBRA continuation coverage and Medicare, Medicare will generally pay first (primary payer), and COBRA continuation coverage will pay second. Certain plans may pay as if secondary to Medicare, even if not enrolled in Medicare.

For more information visit https://www.medicare.gov/medicare-and-you.

IF THERE ARE ANY QUESTIONS

Questions concerning this Plan, or COBRA continuation coverage rights should be addressed to the contact or contacts identified below. For more information about rights under the Employee Retirement Income Security Act (ERISA), including COBRA, the Patient Protection and 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 www.dol.gov/ebsa. (Addresses and phone numbers of Regional and District EBSA Offices are available through EBSA's website.) For more information about the Marketplace, visit www.HealthCare.gov.

ADDITIONAL INFORMATION

Additional information about the Plan and COBRA continuation coverage is available from the Plan Administrator (whose contact information is outlined in the General Plan Information section of this document) or the COBRA Administrator whose contact information is outlined in the General Plan Information section.

CURRENT ADDRESSES

Let the Plan Administrator know about any changes in the addresses of family members. Covered Persons should also keep a copy, for their records, of any notices sent to the Plan Administrator.

ARTICLE XVI -
RESPONSIBILITIES FOR PLAN ADMINISTRATION

The Plan is administered by the Plan Administrator in accordance with the provisions of the Employee Retirement Income Security Act of 1974, as amended ("ERISA"). 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 may delegate to one or more individuals or entities part or all of its discretionary authority under the Plan, provided that any such delegation must be made in writing.

The Plan Administrator shall establish the policies, practices and procedures of this Plan. The Plan Administrator shall administer this Plan in accordance with its terms. 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 and/or Investigational), to decide disputes which may arise relative to a Covered Person'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, in its discretion, that the Covered Person 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, shall be considered ambiguous and shall be interested by the Plan Administrator in a fashion consistent with its intent, as determined by the Plan Administrator. The Plan may amend retroactively to cure such ambiguity, notwithstanding anything in the Plan to the contrary.

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 Covered Person's rights;

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 Claims 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 or National Medical Support Notice is a QMCSO;

11. To delegate to any person or entity such powers, duties and responsibilities as it deems appropriate; and

12. To approve, in its sole discretion, payment of, or reimbursement for, Covered Expenses rendered by a Provider which has agreed to a charge for its services that are less than, or equal to, the charges that would otherwise be paid by the Plan; provided, reimbursement to a Covered Person for a Provider that accepts only cash payments from the Covered Person, shall be subject to the applicable Deductibles, Copayments or out-of-pocket requirements of the Plan;

13. To negotiate or approve contracts with specific Providers as the Plan Administrator deems is in the best interest of the Plan; including payment of a different amount payable under the Plan, taking into consideration specific circumstances;

14. To adjust, settle, contest, compromise and arbitrate any claims, debts or damages due and owing to or from the Plan, and to sue, commence or defend any legal proceedings in reference thereto. If the Plan Administrator considers it in the best interest of the Plan, they may abstain from enforcing any right, obligation or claim, or abandon any property held by the Plan;

15. To impose limitations of benefits and/or Providers as the Plan Administrator deems necessary or appropriate to ensure the fiscal viability of the Plan; provided, such limitations shall be applied in a uniform and consistent manner to all persons in similar circumstances; and

16. To perform each and every function necessary for or related to the Plan's administration.

Plan Administrator Compensation. The Plan Administrator serves without compensation; however, all expenses for plan administration, including compensation for hired services, will be paid by the Plan.

Fiduciary. A fiduciary exercises discretionary authority or control over management of the Plan or the disposition of its assets, renders investment advice to the Plan or has discretionary authority or responsibility in the administration of the Plan.

Fiduciary Duties. A fiduciary must carry out their duties and responsibilities for the purpose of providing benefits to the Employees and their Dependent(s), and defraying reasonable expenses of administering the Plan. These are duties which must be carried out:

1. With care, skill, prudence and diligence under the given circumstances that a prudent person, acting in a like capacity and familiar with such matters, would use in a similar situation;

2. By diversifying the investments of the Plan so as to minimize the risk of large losses, unless under the circumstances it is clearly prudent not to do so; and

3. In accordance with the Plan Documents to the extent that they agree with ERISA.

The Named Fiduciary. A "named fiduciary" is the one named in the Plan. A named fiduciary can appoint others to carry out fiduciary responsibilities (other than as a trustee) under the Plan. These other persons become fiduciaries themselves and are responsible for their acts under the Plan. To the extent that the named fiduciary allocates its responsibility to other persons, the named fiduciary shall not be liable for any act or omission of such person unless either:

1. The named fiduciary has violated its stated duties under ERISA in appointing the fiduciary, establishing the procedures to appoint the fiduciary or continuing either the appointment or the procedures; or

2. The named fiduciary breached its fiduciary responsibility under Section 405(a) of ERISA.

Claims Administrator is not a fiduciary. A Claims Administrator is not a fiduciary under the Plan by virtue of paying claims in accordance with the Plan's rules as established by the Plan Administrator.

ARTICLE XVII -
FUNDING THE PLAN AND PAYMENT OF BENEFITS

The cost of the Plan is funded as follows:

For Employee Coverage: Funding is derived from contributions made to the Plan by the covered Employees and Employer contributions.

For Dependent Coverage: Funding is derived from contributions made by the covered Employees.

The level of any Employee contributions will be set by the Employer. These Employee contributions will be used in funding the cost of the Plan as soon as practicable after they have been received from the Employee or withheld from the Employee's pay through payroll deduction.

Benefits are paid directly from the Plan through the Claims Administrator.

PLAN IS NOT AN EMPLOYMENT CONTRACT

The Plan is not to be construed as a contract for or of employment.

CLERICAL ERROR

Any clerical error by the Plan Administrator or an agent of the Plan Administrator in keeping pertinent records or a delay in making any changes will not invalidate coverage otherwise validly in force or continue coverage validly terminated. An equitable adjustment of contributions will be made when the error or delay is discovered.

If an overpayment occurs in a Plan reimbursement amount, the Plan retains a contractual right to the overpayment. The person or Institution receiving the overpayment will be required to return the incorrect amount of money. In the case of a Covered Person, the amount of overpayment may be deducted from future benefits payable.

AMENDING AND TERMINATING THE PLAN

If the Plan is terminated, the rights of the Covered Persons are limited to expenses Incurred before termination.

The Plan Sponsor or Plan Administrator reserves the right, at any time, to 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).

DISTRIBUTION OF ASSETS

Subject to the requirements of ERISA §402, in the event of a termination or partial termination of the Plan or Trust (if applicable), the Plan Administrator shall direct the disposition of Plan assets pursuant to applicable law and governing documents, including assets held in a Trust, if any, which may include transfer of such assets to another employee benefit plan or trust maintained by an Employer.

ARTICLE XVIII -
HIPAA PRIVACY AND SECURITY

STANDARDS FOR PRIVACY OF INDIVIDUALLY IDENTIFIABLE HEALTH INFORMATION (THE "PRIVACY STANDARDS") ISSUED PURSUANT TO THE HEALTH INSURANCE PORTABILITY AND ACCOUNTABILITY ACT OF 1996, AS AMENDED (HIPAA)

DISCLOSURE OF SUMMARY HEALTH INFORMATION TO THE PLAN SPONSOR

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

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

DISCLOSURE OF PROTECTED HEALTH INFORMATION (PHI) TO THE PLAN SPONSOR FOR PLAN ADMINISTRATION PURPOSES

Protected Health Information (PHI) means individually identifiable health information, created or received by a health care Provider, health plan, Employer, or health care clearinghouse; and relates to the past, present, or future physical or mental health 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 is transmitted or maintained in any form or medium.

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 Documents or as Required by Law (as defined in the PrivacyStandards);

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. 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;

4. 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;

5. Make available PHI in accordance with Section 164.524 of the Privacy Standards (45 CFR164.524);

6. 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);

7. Make available the information required to provide an accounting of disclosures in accordance with Section 164.528 of the Privacy Standards (45 CFR164.528);

8. 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*);

9. If feasible, return or destroy all PHI received from the Plan that the Plan Sponsor still maintains in any form and retain no copies of such PHI when no longer needed for the purpose for which disclosure was made, except that, if such return or destruction is not feasible, limit further uses and disclosures to those purposes that make the return or destruction of the PHI infeasible; and

10. 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. Those Employees, or classes of Employees, or other persons under control of the Plan Sponsor, that shall be given access to the PHI to be disclosed are available by contacting the Plan Administrator.

    b. The access to and use of PHI by the individuals described in subsection (a) above shall be restricted to the Plan Administration functions that the Plan Sponsor performs for the Plan.

    c. In the event any of the individuals described in subsection (a) above do not comply with the provisions of the Plan Documents relating to use and disclosure of PHI, the Plan Administrator shall impose reasonable sanctions as necessary, in its discretion, to ensure that no further non- compliance occurs. Such sanctions shall be imposed progressively (for example, an oral warning, a written warning, time off without pay and termination), if appropriate, and shall be imposed so that they are commensurate with the severity of the violation.

    "Plan Administration" activities are limited to activities that would meet the definition of payment or health care operations, but do not include functions to modify, amend or terminate the Plan or solicit bids from prospective issuers. "Plan Administration" functions include quality assurance, claims processing, auditing, monitoring, and management of carve-out plans, such as vision and dental. It does not include any employment-related functions or functions in connection with any other benefit or benefit plans.

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

DISCLOSURE OF CERTAIN ENROLLMENT INFORMATION TO THE PLAN SPONSOR

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

DISCLOSURE OF PHI TO OBTAIN STOP-LOSS OR EXCESS LOSS COVERAGE

The Plan Sponsor hereby authorizes and directs the Plan, through the Plan Administrator or the Claims 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 and any applicable Business Associate Agreement(s).

OTHER DISCLOSURES AND USES OF PHI

With respect to all other uses and disclosures of PHI, the Plan shall comply with the Privacy Standards. Covered Persons can contact the designated Privacy Officer as outlined in the General Plan Information section of this document.

STANDARDS FOR SECURITY OF ELECTRONIC PROTECTED HEALTH INFORMATION (THE "SECURITY STANDARDS") ISSUED PURSUANT TO THE HEALTH INSURANCE PORTABILITY AND ACCOUNTABILITY ACT OF 1996, AS AMENDED (HIPAA)

Disclosure of Electronic Protected Health Information ("Electronic PHI") to the Plan Sponsor for Plan Administration Functions

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 security measures to protect the Electronic PHI; and

4. Report to the Plan any security incident of which it becomes aware.

ARTICLE XIX -
NO SURPRISES ACT (NSA)

EMERGENCY SERVICES AND SURPRISE BILLS

Generally, the NSA limits the amount a Covered Person will pay for (1) Emergency Services furnished by a Non-Network Provider, and (2) for certain non-emergency services furnished by a Non-Network Provider at a Network facility.

For non-network claims subject to the NSA, the Covered Person's cost-sharing will be calculated at the Recognized Amount, as defined by the NSA, regardless of the Plan's actual Reasonable and Allowed 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 all-payer model agreement or state law applies 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. The NSA prohibits Providers from pursuing Covered Persons for the difference between the Recognized Amount 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 Network Deductibles and maximum out of pocket amounts.

The Plan's payment or denial of claims subject to the NSA will be completed within thirty (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, including certain post-stabilization care, rendered at a non-network hospital emergency department, a freestanding emergency department which provides emergency services, is geographically separate and distinct, and licensed separately from, a hospital or an urgent care center licensed by the state consistent with the definition of a freestanding emergency department;
- Non-emergency services rendered by a Non-Network Provider at a Network Facility, provided the Covered Person has consented after a valid notification by the Non-Network Provider. This notice and consent process is never available for certain ancillary services related to emergency medicine: radiology, anesthesiology, pathology and lab, neonatology, assistant surgeons, and specialty services needed to respond to unexpected complications and hospitalist services. The NSA also prevents balance billing by Non-Network Providers if there is not a Network Provider available.
- Covered non-network air ambulance services.
- A Non-Network Provider may balance bill a Covered Person for Covered Expenses provided after the Covered Person is stabilized, provided the following conditions for informed consent are met:
    - The Provider must determine that the Covered Person can travel using non-medical transportation or non-emergency medical transportation;
    - The Provider must provide notice to Covered Person that further treatment is not in-network;
    - The Covered Person must be in a condition to acknowledge, and acknowledge, receipt of the notice.

If the Plan and the Provider disagree about the amount due for services that are covered by the NSA, the disagreement will be addressed pursuant to the remedies set forth in the NSA. The Provider cannot balance bill Covered Persons for services covered under the NSA even if the Provider does not agree with the amount of reimbursement.

If a Covered Person believes the Plan incorrectly denied or applied non-network cost sharing to surprise medical bills, the Covered Person may appeal the decision, first to the Plan and then to an independent external reviewer. Please see the Claims Procedures section of this Plan for more information.

CONTINUITY OF CARE

In the event a Covered Person is a continuing care patient receiving a course of treatment from a Network Provider or a Provider that otherwise has a contractual relationship governing such care and that contractual relationship is terminated, not renewed, or otherwise ends for any reason other than the Network Provider's/Provider's failure to meet applicable quality standards or for fraud, the Covered Person shall have rights to continuation of care under this Plan and in compliance with the NSA and/or other applicable state law.

In a timely manner after the Network Provider's/Provider's contractual relationship has terminated, the Plan shall notify the Covered Person that the Covered Person has rights to elect continued transitional care from the Network Provider/Provider. If the Covered Person elects in writing to receive continued transitional care, and unless otherwise specified in an applicable law, the Covered Person shall receive the same benefits under this Plan as if the Network Provider/Provider was still in-network, beginning on the date the Plan's notice of termination is provided and ending ninety (90) days later or when the Covered Person ceases to be a continuing care patient, whichever is sooner.

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

- Is undergoing a course of treatment for a serious and complex condition from a specific Provider;
- Is undergoing a course of institutional or inpatient care from a specific Provider;
- Is scheduled to undergo non-elective surgery from a specific Provider, including receipt of postoperative care with respect to the surgery;
- Is pregnant and undergoing a course of treatment for the Pregnancy from a specific Provider; or
- Is or was determined to be terminally ill and is receiving treatment for such Illness from a specific Provider.

Note that during continuation of care, Plan benefits will be processed as if the Provider was still considered a Network Provider, however, the Provider may be free to pursue the Covered Person for any amounts above the Plan's benefit amount.

ARTICLE XX -
CERTAIN COVERED PERSONS RIGHTS UNDER ERISA

Covered Persons in this Plan are entitled to certain rights and protections under the Employee Retirement Income Security Act of 1974 (ERISA). ERISA specifies that all Covered Persons shall be entitled to:

- Examine, without charge, at the Plan Administrator's office, all Plan Documents and copies of all documents governing the Plan, including a copy of the latest annual report (form 5500 series) filed by the Plan with the U.S. Department of Labor and available at the Public Disclosure Room of the Employee Benefits Security Administration.

- Obtain copies of all Plan Documents and other Plan information upon written request to the Plan Administrator. The Plan Administrator may make a reasonable charge for the copies.

- Continue health care coverage for a Covered Person, spouse, or other Dependents if there is a loss of coverage under the Plan as a result of a Qualifying Event. Employees or Dependents may have to pay for such coverage.

- Review this summary plan description and the documents governing the Plan or the rules governing COBRA Continuation Coverage rights.

If a Covered Person's claim for a benefit is denied or ignored, in whole or in part, the Covered Person 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 a Covered Person can take to enforce the above rights. For instance, if a Covered Person requests a copy of Plan Documents or the latest annual report from the Plan and does not receive them within thirty (30) days, they may file suit in a federal court. In such a case, the court may require the Plan Administrator to provide the materials and to pay the Covered Person up to $110 a day until they receive the materials, unless the materials were not sent because of reasons beyond the control of the Plan Administrator. If the Covered Person has a claim for benefits which is denied or ignored, in whole or in part, the Covered Person may file suit in state or federal court.

In addition, if a Covered Person disagrees with the Plan's decision or lack thereof concerning the qualified status of a Medical Child Support Order, they may file suit in federal court.

In addition to creating rights for Covered Persons, ERISA imposes obligations upon the individuals who are responsible for the operation of the Plan. The individuals who operate the Plan, called "fiduciaries" of the Plan, have a duty to do so prudently and in the interest of the Covered Persons and their beneficiaries. No one, including the Employer or any other person, may fire a Covered Person or otherwise discriminate against a Covered Person in any way to prevent the Covered Person from obtaining benefits under the Plan or from exercising their rights under ERISA.

If it should happen that the Plan fiduciaries misuse the Plan's money, or if a Covered Person is discriminated against for asserting their rights, they may seek assistance from the U.S. Department of Labor, or may file suit in a federal court. The court will decide who should pay court costs and legal fees. If the Covered Person is successful, the court may order the person sued to pay these costs and fees. If the Covered Person loses, the court may order them to pay these costs and fees, for example, if it finds the claim or suit to be frivolous.

If the Covered Person has any questions about the Plan, they should contact the Plan Administrator. If the Covered Person has any questions about this statement or their rights under ERISA, including COBRA or the Health Insurance Portability and Accountability Act (HIPAA), and other laws affecting group health plans, that Covered Person should contact either the nearest Regional or District Office of the U.S. Department of Labor's Employee Benefits Security Administration (EBSA) or visit the EBSA website at www.dol.gov/agencies/ebsa/. (Addresses and phone numbers of Regional and District EBSA Offices are available through EBSA's website.)