# TEAM Risk Management Strategies, LLC

# Medical/Dental/Vision

**Plan Document and Summary Plan Description**

Effective:  January 1, 2020

# THE VALUE OF YOUR GROUP HEALTH PLAN

This is the Plan Document and Summary Plan Description ("Plan Document"), made by **TEAM Risk Management Strategies, LLC** (the "Company" or the "Plan Sponsor"). No oral interpretations can change this Plan. The Plan Sponsor is required under ERISA to provide to Covered Persons a Plan Document and a Summary Plan Description; a combined Plan Document and Summary Plan Description, such as this document, is an acceptable structure for ERISA compliance. The Plan Sponsor has adopted this Plan Document as the written description of the Plan to set forth the terms and provisions of the Plan that provide for the payment or reimbursement of all or a portion of certain expenses for eligible benefits. The Plan Document is maintained by **TEAM Risk Management Strategies, LLC** and may be reviewed at any time during normal working hours by any Covered Person.

This Group Health Plan provides Covered Persons with important protection against financial hardship that often accompanies Illness or Injury. It has been carefully designed to provide excellent benefits and offers financial incentives if individuals seek the most efficient quality health care services available. The Company provides the Group Health Plan for Employees and Dependents.

Coverage under the Plan will take effect for the Employee and his or her eligible Dependents when the Employee and such Dependents satisfy the Waiting Period and all eligibility requirements of the Plan.

The Company 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.

Changes in the Plan may occur in any or all parts of the Plan including, but not limited to applicable benefit coverage, Deductibles, maximums, Co-payments, exclusions, limitations, definitions, and eligibility.

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, even if the expenses were incurred as a result of an Accident, Injury or Illness that occurred, began, or existed while coverage was in force. An expense for a service or supply is Incurred on the date the service or supply is furnished.

If the Plan is terminated, the rights of Covered Persons are limited to Covered Expenses Incurred before termination. This document summarizes the Plan rights and benefits for Covered Persons, explaining:

- How to become eligible to participate,
- What benefits are available, and
- How the Plan is administered.

We hope Employees will take the time to review this benefit coverage from **TEAM Risk Management Strategies, LLC** and share with eligible Dependents ways to contribute to making the health care system work cost effectively and efficiently.

Please contact Human Resources Department and/or Claims Administrator with any questions regarding the Plan.

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# SCHEDULE OF BENEFITS - GOLD PLAN

## GENERAL LIMITS

Payment for any of the expenses listed below is subject to all Plan exclusions, limitations and provisions.

| DEDUCTIBLE/OUT-OF-POCKET/PENALTIES | |
|---|---|
| **SUMMARY OF SERVICES** | **MEDICAL BENEFITS** |
| | |
| **Hospital Pre-Admission And Pre-Surgical Review** *Refer To The Section Entitled "Utilization Review Program"* | |
| Non-Compliance Penalty | |
| Inpatient Admissions | |
| *Acute Care* | Benefits may be reduced by 50%. |
| *Extended Care Facility* | Benefits may be reduced by 50%. |
| *Rehabilitation Care Facility* | Benefits may be reduced by 50%. |
| *Substance Abuse Facility* | Benefits may be reduced by 50%. |
| Hospice | Benefits may be reduced by 50%. |
| Outpatient Surgical Procedures | Benefits may be reduced by 50%. |
| Reconstructive Surgery | Benefits may be reduced by 50%. |
| Durable Medical Equipment | Benefits may be reduced by 50%. |
| Transplants | Benefits may be reduced by 50%. |
| Home Infusion Therapy | Benefits may be reduced by 50%. |
| Hemophilia Home Infusion | Benefits may be reduced by 50%. |
| Select Injectable Drugs in Office | Benefits may be reduced by 50%. |
| | |
| **Lifetime Maximum Benefit** | Unlimited |
| | |
| **Calendar Year Deductible** | |
| Individual | $2,000 |
| Family | $5,000 |
| | |
| **Note:** ***The Family Deductible Maximum includes covered expenses which are used to satisfy Deductibles for all family members combined. No one person must satisfy more than the Individual Deductible amount.*** | |
| | |
| **Out-of-Pocket Maximum** ***(including Deductible, Co-insurance, Medical Co-payments and Prescription Co-payments)*** | |
| Individual | $8,150 |
| Family | $16,300 |
| | |
| **Note:** ***The Family Out-of-Pocket Maximum includes Out-of-Pocket expenses for all family members combined. No one person must satisfy more than the Individual Out-of-Pocket amount.*** | |
| | |

## SPECIAL COVERAGES

| SUMMARY OF SERVICES | MEDICAL BENEFITS |
|---|---|
| | |
| Second Surgical Opinion | 100% No Deductible After a $40 Co-Pay or $80 Co-Pay |
| | |
| Expanded Women's Preventive Care Services as required under the Patient Protection and Affordable Care Act (PPACA) | 100% No Deductible |
| Preventive Care Services as required under the Patient Protection and Affordable Care Act (PPACA) include the following: | 100% No Deductible |
| | |
| *Evidence-based items or services with an A or B rating recommended by the United States Preventive Services Task Force;* | |
| *Immunizations for routine use in children, adolescents, or adults recommended by the Advisory Committee on Immunization Practices of the Centers for Disease Control and Prevention;* | |
| *Evidence-informed preventive care and screenings provided for in comprehensive guidelines supported by the Health Resources and Services Administration (HRSA) for infants, children and adolescents; and* | |
| *Evidence-informed preventive care and screenings provided for in comprehensive guidelines supported by HRSA for women.* | |
| The complete list of recommendations and guidelines can be found at: https://www.healthcare.gov/preventive-care-benefits/ | |
| | |
| Cardiac Rehabilitation | 100% No Deductible After a $40 Co-Pay |
| | |
| Dialysis Treatment and Services including End Stage Renal Disease (ESRD) | 80% Deductible Applies |
| | |
| Enteral Formula and Modified Food Product for PKU | 80% Deductible Applies |
| | ***Calendar Year Maximum - $2,000 that also includes Medical Supplies.*** |
| | |
| Lab Card | 100% No Deductible |
| | |
| Rehabilitation Facility | 80% Deductible Applies |
| | ***Calendar Year Maximum - 100 Days Combined with Skilled Nursing Facility*** |
| | |
| Respiratory / Pulmonary Therapy | 100% No Deductible After a $40 Co-Pay |
| | ***Calendar Year Maximum - 24 Visits*** |
| | |
| US Imaging Advanced Radiology Program | 100% No Deductible |
| | |

## PHYSICIAN AND OFFICE SERVICES

| SUMMARY OF SERVICES | MEDICAL BENEFITS |
|---|---|
| | |
| PCP Office Visits | 100% No Deductible After a $40 Co-Pay |
| | |
| Specialist Office Visit | 100% No Deductible After a $80 Co-Pay |
| | |
| Surgery | 80% Deductible Applies |
| | |
| Diagnostic X-Ray & Lab | 80% Deductible Applies |
| | |
| Independent Lab, Radiologist & Pathologist | 80% Deductible Applies |
| | |
| Allergy Injections | 80% Deductible Applies |
| | |
| Allergy Testing | 80% Deductible Applies |
| | |
| Chemotherapy | 80% Deductible Applies |
| | |
| Physical Therapy | 100% No Deductible After a $40 Co-Pay |
| | ***Calendar Year Maximum -24 visits*** |
| | |
| Occupational Therapy | 100% No Deductible After a $40 Co-Pay |
| | ***Calendar Year Maximum -24 visits*** |
| | |
| Speech Therapy | 100% No Deductible After a $40 Co-Pay |
| | ***Calendar Year Maximum -24 visits*** |
| Chiropractic Services | |
| Office Visits | Not Covered |
| Manipulations | Not Covered |
| X-Rays | Not Covered |
| | |
| Podiatric Services | |
| Office Visits | 100% No Deductible After $40 Co-Pay or $80 Co-Pay |
| Surgery | 80% Deductible Applies |
| X-Ray & Lab | 80% Deductible Applies |
| Orthotics | Not Covered |
| | |
| Infertility Services | |
| Initial Diagnostic Testing | 80% Deductible Applies |
| Infertility Treatment | Not Covered |
| | |
| TMJ Services | |
| Office Visits | Not Covered |
| Surgery & Related Services | Not Covered |
| | |
| Mental Health | Benefit payable the same as any other Illness. |
| | |
| Substance Abuse | Benefit payable the same as any other Illness. |
| | |
| Other Covered Services | 80% Deductible Applies |
| | |

## OUTPATIENT HOSPITAL & AMBULATORY SURGICAL CENTER

| SUMMARY OF SERVICES | MEDICAL BENEFITS |
|---|---|
| | |
| Facility | 80% Deductible Applies |
| | |
| Emergency Room | 80% Deductible Applies |
| | |
| Urgent Care | 100% No Deductible After a $50 Co-Pay. |
| | |
| Diagnostic X-Ray & Lab | 80% Deductible Applies |
| | |
| Pre-Admission Testing | 80% Deductible Applies |
| | |
| Surgeon | 80% Deductible Applies |
| | |
| Physical Therapy | 100% No Deductible After a $40 Co-Pay |
| | ***Calendar Year Maximum -24 visits*** |
| | |
| Occupational Therapy | 100% No Deductible After a $40 Co-Pay |
| | ***Calendar Year Maximum -24 visits*** |
| | |
| Speech Therapy | 100% No Deductible After a $40 Co-Pay |
| | ***Calendar Year Maximum -24 visits*** |
| | |
| Chemotherapy & Radiation Therapy | 80% Deductible Applies |
| | |
| Assistant Surgeon, Anesthesiologist, Pathologist, Radiologist & Consulting Physician | 80% Deductible Applies |
| | |
| Mental Health | Benefit payable the same as any other Illness. |
| | |
| Substance Abuse | Benefit payable the same as any other Illness. |
| | |
| Other Covered Services | 80% Deductible Applies |
| | |

## INPATIENT HOSPITAL

| SUMMARY OF SERVICES | MEDICAL BENEFITS |
|---|---|
| | |
| Facility | 80% Deductible Applies |
| | |
| Room, Board & Miscellaneous | 80% Deductible Applies |
| | |
| Nursery | 80% Deductible Applies |
| | ***Baby & Mother's Charges Will Be Combined*** |
| | |
| Diagnostic X-Ray & Lab | 80% Deductible Applies |
| | |
| Surgeon | 80% Deductible Applies |
| | |
| Physician Visits | 80% Deductible Applies |
| | |
| Private Duty Nursing | Not Covered |
| | |
| Assistant Surgeon, Anesthesiologist, Radiologist, Pathologist & Consulting Physician | 80% Deductible Applies |
| | |
| Mental Health | 80% Deductible Applies |
| | |
| Substance Abuse | 80% Deductible Applies |
| | |
| Other Covered Services | 80% Deductible Applies |
| | |

## OTHER COVERED SERVICES

| SUMMARY OF SERVICES | MEDICAL BENEFITS |
|---|---|
| | |
| Extended Care Facility / Skilled Nursing Facility | 80% Deductible Applies |
| | ***Calendar Year Maximum - 100 Days*** |
| | |
| Home Health Care / ***Note: 1 visit = 4 hours*** | 80% Deductible Applies |
| | ***Calendar Year Maximum - 40 Visits*** |
| | |
| Hospice Care | 80% Deductible Applies |
| | |
| Bereavement Counseling | 80% Deductible Applies |
| | ***Limited to services within six months of the patient's death.*** |
| | |
| Private Duty Nursing | Not Covered |
| | |
| Ambulance | 80% Deductible Applies After a $100 Co-Pay |
| | |
| Durable Medical Equipment | 80% Deductible Applies |
| | ***Limited to the lesser of the purchase price or the total anticipated rental charges.*** |
| | |
| Prosthetic Appliances | 80% Deductible Applies |
| | ***Includes replacements which are Medically Necessary or required by pathological change or normal growth.*** |
| | |

## PRESCRIPTION DRUG PLAN

| | |
|---|---|
| **RETAIL PRESCRIPTION PLAN** | |
| If obtained through the Prescription Drug Plan - 100% after satisfaction of applicable Co-payment: **Per 31 day supply** | |
| Generic | $20 Co-payment |
| Preferred Brand | $40 Co-payment |
| Non-Preferred Brand | $100 Co-payment |
| Brand if no Generic available | $40 Co-payment |
| Brand if Physician mandates | $40 Co-payment |
| Specialty | 50% after Medical Deductible. |
| | |
| **90 DAY AT RETAIL PRESCRIPTION PLAN** | |
| If obtained through the Prescription Drug Plan - 100% after satisfaction of applicable Co-payment: **Per 90 day supply** | |
| Generic | $60 Co-payment |
| Preferred Brand | $120 Co-payment |
| Non-Preferred Brand | $300 Co-payment |
| Brand if no Generic available | $120 Co-payment |
| Brand if Physician mandates | $120 Co-payment |
| | |
| **MAIL ORDER PRESCRIPTION PLAN** | |
| If obtained through the Mail Order Prescription Drug Plan - 100% after satisfaction of applicable Co-payment: **Per 90 day supply** | |
| Generic | $40 Co-payment |
| Preferred Brand | $80 Co-payment |
| Non-Preferred Brand | $200 Co-payment |
| Brand if no Generic available | $80 Co-payment |
| Brand if Physician mandates | $80 Co-payment |
| | |
| **PURCHASED OUTSIDE OF THE RETAIL OR MAIL ORDER PRESCRIPTION PLANS** | **Applicable Co-payment Applies** |

| **COVERAGE INCLUDES** | **COVERAGE EXCLUDES** |
|---|---|
| ♦ Federal Legend Drugs | ♦ Diagnostic Agents |
| ♦ AIDS Medications | ♦ Sexual Dysfunction Drugs |
| ♦ Insulin | ♦ Rogaine & Other Hair Loss Products |
| ♦ Diabetic Supplies (lancets, needles, test strips, alcohol swabs) | ♦ Medical Devices |
| ♦ ADHD Drugs | ♦ Blood Products (RhoGAM) |
| ♦ Migraine Medication | ♦ Anorexiants, Diet Drugs |
| ♦ Acne Medication | ♦ OTC Counterparts |
| ♦ Prenatal Vitamins | ♦ Cosmetic Drugs |
| ♦ Self Injectables | ♦ Growth Hormone Drugs |
| ♦ Narcolepsy Drugs | ♦ Fertility Drugs |
| ♦ FDA approved forms of Contraceptives for Women | ♦ Vitamins |
| ♦ Smoking Cessation Products | ♦ Fluoride |
| ♦ Vaccinations/Immunizations | ♦ Investigational Drugs |
| ♦ Compounds | ♦ Anabolic Steroids |

**Charges In Excess Of Benefit Maximums, Charges In Excess Of Reasonable And Customary Fees, Allowable Claim Limits, Maximum Allowable Amounts And Non-Compliance Penalties Do Not Accumulate Toward The Out-of-Pocket Maximum.**

# SCHEDULE OF BENEFITS - SILVER PLAN

## GENERAL LIMITS

Payment for any of the expenses listed below is subject to all Plan exclusions, limitations and provisions.

| DEDUCTIBLE/OUT-OF-POCKET/PENALTIES | |
|---|---|
| **SUMMARY OF SERVICES** | **MEDICAL BENEFITS** |
| | |
| **Hospital Pre-Admission And Pre-Surgical Review** *Refer To The Section Entitled "Utilization Review Program"* | |
| Non-Compliance Penalty | |
| Inpatient Admissions | |
| *Acute Care* | Benefits may be reduced by 50%. |
| *Extended Care Facility* | Benefits may be reduced by 50%. |
| *Rehabilitation Care Facility* | Benefits may be reduced by 50%. |
| *Substance Abuse Facility* | Benefits may be reduced by 50%. |
| Hospice | Benefits may be reduced by 50%. |
| Outpatient Surgical Procedures | Benefits may be reduced by 50%. |
| Reconstructive Surgery | Benefits may be reduced by 50%. |
| Durable Medical Equipment | Benefits may be reduced by 50%. |
| Transplants | Benefits may be reduced by 50%. |
| Home Infusion Therapy | Benefits may be reduced by 50%. |
| Hemophilia Home Infusion | Benefits may be reduced by 50%. |
| Select Injectable Drugs in Office | Benefits may be reduced by 50%. |
| | |
| **Lifetime Maximum Benefit** | Unlimited |
| | |
| **Calendar Year Deductible** | |
| Individual | $3,500 |
| Family | $7,000 |
| | |
| **Note:** ***The Family Deductible Maximum includes covered expenses which are used to satisfy Deductibles for all family members combined. No one person must satisfy more than the Individual Deductible amount.*** | |
| | |
| **Out-of-Pocket Maximum** ***(including Deductible, Co-insurance, Medical Co-payments and Prescription Co-payments)*** | |
| Individual | $8,150 |
| Family | $16,300 |
| | |
| **Note:** ***The Family Out-of-Pocket Maximum includes Out-of-Pocket expenses for all family members combined. No one person must satisfy more than the Individual Out-of-Pocket amount.*** | |

## SPECIAL COVERAGES

| SUMMARY OF SERVICES | MEDICAL BENEFITS |
|---|---|
| | |
| Second Surgical Opinion | 70% Deductible Applies |
| | |
| Expanded Women's Preventive Care Services as required under the Patient Protection and Affordable Care Act (PPACA) | 100% No Deductible |
| Preventive Care Services as required under the Patient Protection and Affordable Care Act (PPACA) include the following: | 100% No Deductible |
| | |
| *Evidence-based items or services with an A or B rating recommended by the United States Preventive Services Task Force;* | |
| *Immunizations for routine use in children, adolescents, or adults recommended by the Advisory Committee on Immunization Practices of the Centers for Disease Control and Prevention;* | |
| *Evidence-informed preventive care and screenings provided for in comprehensive guidelines supported by the Health Resources and Services Administration (HRSA) for infants, children and adolescents; and* | |
| *Evidence-informed preventive care and screenings provided for in comprehensive guidelines supported by HRSA for women.* | |
| The complete list of recommendations and guidelines can be found at: https://www.healthcare.gov/preventive-care-benefits/ | |
| | |
| Cardiac Rehabilitation | 70% Deductible Applies |
| | |
| Dialysis Treatment and Services including End Stage Renal Disease (ESRD) | 70% Deductible Applies |
| | |
| Enteral Formula and Modified Food Product for PKU | 70% Deductible Applies |
| | ***Calendar Year Maximum - $2,000 that also includes Medical Supplies.*** |
| | |
| Lab Card | 100% No Deductible |
| | |
| Rehabilitation Facility | 70% Deductible Applies |
| | ***Calendar Year Maximum - 100 Days Combined with Skilled Nursing Facility*** |
| | |
| Respiratory / Pulmonary Therapy | 70% Deductible Applies |
| | ***Calendar Year Maximum - 24 Visits*** |
| | |
| US Imaging Advanced Radiology Program | 100% No Deductible |
| | |

## PHYSICIAN AND OFFICE SERVICES

| SUMMARY OF SERVICES | MEDICAL BENEFITS |
|---|---|
| | |
| PCP Office Visits | 70% Deductible Applies |
| | |
| Specialist Office Visit | 70% Deductible Applies |
| | |
| Surgery | 70% Deductible Applies |
| | |
| Diagnostic X-Ray & Lab | 70% Deductible Applies |
| | |
| Independent Lab, Radiologist & Pathologist | 70% Deductible Applies |
| | |
| Allergy Injections | 70% Deductible Applies |
| | |
| Allergy Testing | 70% Deductible Applies |
| | |
| Chemotherapy | 70% Deductible Applies |
| | |
| Physical Therapy | 70% Deductible Applies |
| | ***Calendar Year Maximum -24 visits*** |
| | |
| Occupational Therapy | 70% Deductible Applies |
| | ***Calendar Year Maximum -24 visits*** |
| | |
| Speech Therapy | 70% Deductible Applies |
| | ***Calendar Year Maximum -24 visits*** |
| Chiropractic Services | |
| Office Visits | Not Covered |
| Manipulations | Not Covered |
| X-Rays | Not Covered |
| | |
| Podiatric Services | |
| Office Visits | 70% Deductible Applies |
| Surgery | 70% Deductible Applies |
| X-Ray & Lab | 70% Deductible Applies |
| Orthotics | Not Covered |
| | |
| Infertility Services | |
| Initial Diagnostic Testing | 70% Deductible Applies |
| Infertility Treatment | Not Covered |
| | |
| TMJ Services | |
| Office Visits | Not Covered |
| Surgery & Related Services | Not Covered |
| | |
| Mental Health | Benefit payable the same as any other Illness. |
| | |
| Substance Abuse | Benefit payable the same as any other Illness. |
| | |
| Other Covered Services | 70% Deductible Applies |
| | |

## OUTPATIENT HOSPITAL & AMBULATORY SURGICAL CENTER

| SUMMARY OF SERVICES | MEDICAL BENEFITS |
|---|---|
| | |
| Facility | 70% Deductible Applies |
| | |
| Emergency Room | 70% Deductible Applies |
| | |
| Urgent Care | 70% Deductible Applies |
| | |
| Diagnostic X-Ray & Lab | 70% Deductible Applies |
| | |
| Pre-Admission Testing | 70% Deductible Applies |
| | |
| Surgeon | 70% Deductible Applies |
| | |
| Physical Therapy | 70% Deductible Applies |
| | ***Calendar Year Maximum -24 visits*** |
| | |
| Occupational Therapy | 70% Deductible Applies |
| | ***Calendar Year Maximum -24 visits*** |
| | |
| Speech Therapy | 70% Deductible Applies |
| | ***Calendar Year Maximum -24 visits*** |
| | |
| Chemotherapy & Radiation Therapy | 70% Deductible Applies |
| | |
| Assistant Surgeon, Anesthesiologist, Pathologist, Radiologist & Consulting Physician | 70% Deductible Applies |
| | |
| Mental Health | Benefit payable the same as any other Illness. |
| | |
| Substance Abuse | Benefit payable the same as any other Illness. |
| | |
| Other Covered Services | 70% Deductible Applies |
| | |

## INPATIENT HOSPITAL

| SUMMARY OF SERVICES | MEDICAL BENEFITS |
|---|---|
| | |
| Facility | 70% Deductible Applies |
| | |
| Room, Board & Miscellaneous | 70% Deductible Applies |
| | |
| Nursery | 70% Deductible Applies |
| | ***Baby & Mother's Charges Will Be Combined*** |
| | |
| Diagnostic X-Ray & Lab | 70% Deductible Applies |
| | |
| Surgeon | 70% Deductible Applies |
| | |
| Physician Visits | 70% Deductible Applies |
| | |
| Private Duty Nursing | Not Covered |
| | |
| Assistant Surgeon, Anesthesiologist, Radiologist, Pathologist & Consulting Physician | 70% Deductible Applies |
| | |
| Mental Health | 70% Deductible Applies |
| | |
| Substance Abuse | 70% Deductible Applies |
| | |
| Other Covered Services | 70% Deductible Applies |
| | |

## OTHER COVERED SERVICES

| SUMMARY OF SERVICES | MEDICAL BENEFITS |
|---|---|
| | |
| Extended Care Facility / Skilled Nursing Facility | 70% Deductible Applies |
| | ***Calendar Year Maximum - 100 Days*** |
| | |
| Home Health Care / ***Note: 1 visit = 4 hours*** | 70% Deductible Applies |
| | ***Calendar Year Maximum - 40 Visits*** |
| | |
| Hospice Care | 70% Deductible Applies |
| | |
| Bereavement Counseling | 70% Deductible Applies |
| | ***Limited to services within six months of the patient's death.*** |
| | |
| Private Duty Nursing | Not Covered |
| | |
| Ambulance | 70% Deductible Applies |
| | |
| Durable Medical Equipment | 70% Deductible Applies |
| | ***Limited to the lesser of the purchase price or the total anticipated rental charges.*** |
| | |
| Prosthetic Appliances | 70% Deductible Applies |
| | ***Includes replacements which are Medically Necessary or required by pathological change or normal growth.*** |
| | |

## PRESCRIPTION DRUG PLAN

| | |
|---|---|
| **RETAIL PRESCRIPTION PLAN** | |
| If obtained through the Prescription Drug Plan - Subject to Medical Deductible and Out of Pocket: **Per 31 day supply** | |
| Generic | 30% after Medical Deductible. |
| Preferred Brand | 30% after Medical Deductible. |
| Non-Preferred Brand | 30% after Medical Deductible. |
| Brand if no Generic available | 30% after Medical Deductible. |
| Brand if Physician mandates | 30% after Medical Deductible. |
| Specialty | 50% after Medical Deductible. |
| | |
| **90 DAY AT RETAIL PRESCRIPTION PLAN** | |
| If obtained through the Prescription Drug Plan - Subject to Medical Deductible and Out of Pocket: **Per 90 day supply** | |
| Generic | 30% after Medical Deductible. |
| Preferred Brand | 30% after Medical Deductible. |
| Non-Preferred Brand | 30% after Medical Deductible. |
| Brand if no Generic available | 30% after Medical Deductible. |
| Brand if Physician mandates | 30% after Medical Deductible. |
| | |
| **MAIL ORDER PRESCRIPTION PLAN** | |
| If obtained through the Mail Order Prescription Drug Plan - Subject to Medical Deductible and Out of Pocket: **Per 90 day supply** | |
| Generic | 30% after Medical Deductible. |
| Preferred Brand | 30% after Medical Deductible. |
| Non-Preferred Brand | 30% after Medical Deductible. |
| Brand if no Generic available | 30% after Medical Deductible. |
| Brand if Physician mandates | 30% after Medical Deductible. |
| | |
| **PURCHASED OUTSIDE OF THE RETAIL OR MAIL ORDER PRESCRIPTION PLANS** | **30% after Medical Deductible.** |
| | |
| **COVERAGE INCLUDES** | **COVERAGE EXCLUDES** |
| ♦ Federal Legend Drugs | ♦ Diagnostic Agents |
| ♦ AIDS Medications | ♦ Sexual Dysfunction Drugs |
| ♦ Insulin | ♦ Rogaine & Other Hair Loss Products |
| ♦ Diabetic Supplies (lancets, needles, test strips, alcohol swabs) | ♦ Medical Devices |
| ♦ ADHD Drugs | ♦ Blood Products (RhoGAM) |
| ♦ Migraine Medication | ♦ Anorexiants, Diet Drugs |
| ♦ Acne Medication | ♦ OTC Counterparts |
| ♦ Prenatal Vitamins | ♦ Cosmetic Drugs |
| ♦ Self Injectables | ♦ Growth Hormone Drugs |
| ♦ Narcolepsy Drugs | ♦ Fertility Drugs |
| ♦ FDA approved forms of Contraceptives for Women | ♦ Vitamins |
| ♦ Smoking Cessation Products | ♦ Fluoride |
| ♦ Vaccinations/Immunizations | ♦ Investigational Drugs |
| ♦ Compounds | ♦ Anabolic Steroids |

**Charges In Excess Of Benefit Maximums, Charges In Excess Of Reasonable And Customary Fees, Allowable Claim Limits, Maximum Allowable Amounts And Non-Compliance Penalties Do Not Accumulate Toward The Out-of-Pocket Maximum.**

# SCHEDULE OF BENEFITS - BRONZE PLAN

## GENERAL LIMITS

Payment for any of the expenses listed below is subject to all Plan exclusions, limitations and provisions.

| DEDUCTIBLE/OUT-OF-POCKET/PENALTIES | |
|---|---|
| **SUMMARY OF SERVICES** | **MEDICAL BENEFITS** |
| | |
| **Hospital Pre-Admission And Pre-Surgical Review** *Refer To The Section Entitled "Utilization Review Program"* | |
| Non-Compliance Penalty | |
| Inpatient Admissions | |
| *Acute Care* | Benefits may be reduced by 50%. |
| *Extended Care Facility* | Benefits may be reduced by 50%. |
| *Rehabilitation Care Facility* | Benefits may be reduced by 50%. |
| *Substance Abuse Facility* | Benefits may be reduced by 50%. |
| Hospice | Benefits may be reduced by 50%. |
| Outpatient Surgical Procedures | Benefits may be reduced by 50%. |
| Reconstructive Surgery | Benefits may be reduced by 50%. |
| Durable Medical Equipment | Benefits may be reduced by 50%. |
| Transplants | Benefits may be reduced by 50%. |
| Home Infusion Therapy | Benefits may be reduced by 50%. |
| Hemophilia Home Infusion | Benefits may be reduced by 50%. |
| Select Injectable Drugs in Office | Benefits may be reduced by 50%. |
| | |
| **Lifetime Maximum Benefit** | Unlimited |
| | |
| **Calendar Year Deductible** | |
| Individual | $7,000 |
| Family | $14,000 |
| | |
| **Note:** ***The Family Deductible Maximum includes covered expenses which are used to satisfy Deductibles for all family members combined. No one person must satisfy more than the Individual Deductible amount.*** | |
| | |
| **Out-of-Pocket Maximum** ***(including Deductible, Co-insurance, Medical Co-payments and Prescription Co-payments)*** | |
| Individual | $8,150 |
| Family | $16,300 |
| | |
| **Note:** ***The Family Out-of-Pocket Maximum includes Out-of-Pocket expenses for all family members combined. No one person must satisfy more than the Individual Out-of-Pocket amount.*** | |

## SPECIAL COVERAGES

| SUMMARY OF SERVICES | MEDICAL BENEFITS |
|---|---|
| | |
| Second Surgical Opinion | 60% Deductible Applies |
| | |
| Expanded Women's Preventive Care Services as required under the Patient Protection and Affordable Care Act (PPACA) | 100% No Deductible |
| Preventive Care Services as required under the Patient Protection and Affordable Care Act (PPACA) include the following: | 100% No Deductible |
| | |
| *Evidence-based items or services with an A or B rating recommended by the United States Preventive Services Task Force;* | |
| *Immunizations for routine use in children, adolescents, or adults recommended by the Advisory Committee on Immunization Practices of the Centers for Disease Control and Prevention;* | |
| *Evidence-informed preventive care and screenings provided for in comprehensive guidelines supported by the Health Resources and Services Administration (HRSA) for infants, children and adolescents; and* | |
| *Evidence-informed preventive care and screenings provided for in comprehensive guidelines supported by HRSA for women.* | |
| The complete list of recommendations and guidelines can be found at: https://www.healthcare.gov/preventive-care-benefits/ | |
| | |
| Cardiac Rehabilitation | 60% Deductible Applies |
| | |
| Dialysis Treatment and Services including End Stage Renal Disease (ESRD) | 60% Deductible Applies |
| | |
| Enteral Formula and Modified Food Product for PKU | 60% Deductible Applies |
| | ***Calendar Year Maximum - $2,000 that also includes Medical Supplies.*** |
| | |
| Lab Card | 100% No Deductible |
| | |
| Rehabilitation Facility | 60% Deductible Applies |
| | ***Calendar Year Maximum - 100 Days Combined with Skilled Nursing Facility*** |
| | |
| Respiratory / Pulmonary Therapy | 60% Deductible Applies |
| | ***Calendar Year Maximum - 24 Visits*** |
| | |
| US Imaging Advanced Radiology Program | 100% No Deductible |
| | |

## PHYSICIAN AND OFFICE SERVICES

| SUMMARY OF SERVICES | MEDICAL BENEFITS |
|---|---|
| | |
| PCP Office Visits | 100% No Deductible After a $40 Co-Pay for the first 2 visits, then 60% Deductible Applies. |
| | |
| Specialist Office Visit | 60% Deductible Applies |
| | |
| Surgery | 60% Deductible Applies |
| | |
| Diagnostic X-Ray & Lab | 60% Deductible Applies |
| | |
| Independent Lab, Radiologist & Pathologist | 60% Deductible Applies |
| | |
| Allergy Injections | 60% Deductible Applies |
| | |
| Allergy Testing | 60% Deductible Applies |
| | |
| Chemotherapy | 60% Deductible Applies |
| | |
| Physical Therapy | 60% Deductible Applies |
| | ***Calendar Year Maximum -24 visits*** |
| | |
| Occupational Therapy | 60% Deductible Applies |
| | ***Calendar Year Maximum -24 visits*** |
| | |
| Speech Therapy | 60% Deductible Applies |
| | ***Calendar Year Maximum -24 visits*** |
| Chiropractic Services | |
| Office Visits | Not Covered |
| Manipulations | Not Covered |
| X-Rays | Not Covered |
| | |
| Podiatric Services | |
| Office Visits | Benefit payable the same as any other Illness. |
| Surgery | 60% Deductible Applies |
| X-Ray & Lab | 60% Deductible Applies |
| Orthotics | Not Covered |
| | |
| Infertility Services | |
| Initial Diagnostic Testing | 60% Deductible Applies |
| Infertility Treatment | Not Covered |
| | |
| TMJ Services | |
| Office Visits | Not Covered |
| Surgery & Related Services | Not Covered |
| | |
| Mental Health | Benefit payable the same as any other Illness. |
| | |
| Substance Abuse | Benefit payable the same as any other Illness. |
| | |
| Other Covered Services | 60% Deductible Applies |
| | |

## OUTPATIENT HOSPITAL & AMBULATORY SURGICAL CENTER

| SUMMARY OF SERVICES | MEDICAL BENEFITS |
|---|---|
| | |
| Facility | 60% Deductible Applies |
| | |
| Emergency Room | 60% Deductible Applies |
| | |
| Urgent Care | 60% Deductible Applies |
| | |
| Diagnostic X-Ray & Lab | 60% Deductible Applies |
| | |
| Pre-Admission Testing | 60% Deductible Applies |
| | |
| Surgeon | 60% Deductible Applies |
| | |
| Physical Therapy | 60% Deductible Applies |
| | ***Calendar Year Maximum -24 visits*** |
| | |
| Occupational Therapy | 60% Deductible Applies |
| | ***Calendar Year Maximum -24 visits*** |
| | |
| Speech Therapy | 60% Deductible Applies |
| | ***Calendar Year Maximum -24 visits*** |
| | |
| Chemotherapy & Radiation Therapy | 60% Deductible Applies |
| | |
| Assistant Surgeon, Anesthesiologist, Pathologist, Radiologist & Consulting Physician | 60% Deductible Applies |
| | |
| Mental Health | Benefit payable the same as any other Illness. |
| | |
| Substance Abuse | Benefit payable the same as any other Illness. |
| | |
| Other Covered Services | 60% Deductible Applies |
| | |

## INPATIENT HOSPITAL

| SUMMARY OF SERVICES | MEDICAL BENEFITS |
|---|---|
| | |
| Facility | 60% Deductible Applies |
| | |
| Room, Board & Miscellaneous | 60% Deductible Applies |
| | |
| Nursery | 60% Deductible Applies |
| | ***Baby & Mother's Charges Will Be Combined*** |
| | |
| Diagnostic X-Ray & Lab | 60% Deductible Applies |
| | |
| Surgeon | 60% Deductible Applies |
| | |
| Physician Visits | 60% Deductible Applies |
| | |
| Private Duty Nursing | Not Covered |
| | |
| Assistant Surgeon, Anesthesiologist, Radiologist, Pathologist & Consulting Physician | 60% Deductible Applies |
| | |
| Mental Health | 60% Deductible Applies |
| | |
| Substance Abuse | 60% Deductible Applies |
| | |
| Other Covered Services | 60% Deductible Applies |
| | |

## OTHER COVERED SERVICES

| SUMMARY OF SERVICES | MEDICAL BENEFITS |
|---|---|
| | |
| Extended Care Facility / Skilled Nursing Facility | 60% Deductible Applies |
| | ***Calendar Year Maximum - 100 Days*** |
| | |
| Home Health Care / ***Note: 1 visit = 4 hours*** | 60% Deductible Applies |
| | ***Calendar Year Maximum - 40 Visits*** |
| | |
| Hospice Care | 60% Deductible Applies |
| | |
| Bereavement Counseling | 60% Deductible Applies |
| | ***Limited to services within six months of the patient's death.*** |
| | |
| Private Duty Nursing | Not Covered |
| | |
| Ambulance | 60% Deductible Applies |
| | |
| Durable Medical Equipment | 60% Deductible Applies |
| | ***Limited to the lesser of the purchase price or the total anticipated rental charges.*** |
| | |
| Prosthetic Appliances | 60% Deductible Applies |
| | ***Includes replacements which are Medically Necessary or required by pathological change or normal growth.*** |
| | |

## PRESCRIPTION DRUG PLAN

| | |
|---|---|
| **RETAIL PRESCRIPTION PLAN** | |
| If obtained through the Prescription Drug Plan - Subject to Medical Deductible and Out of Pocket: **Per 31 day supply** | |
| Generic | 40% after Medical Deductible. |
| Preferred Brand | 40% after Medical Deductible. |
| Non-Preferred Brand | 40% after Medical Deductible. |
| Brand if no Generic available | 40% after Medical Deductible. |
| Brand if Physician mandates | 40% after Medical Deductible. |
| Specialty | 50% after Medical Deductible. |
| | |
| **90 DAY AT RETAIL PRESCRIPTION PLAN** | |
| If obtained through the Prescription Drug Plan - Subject to Medical Deductible and Out of Pocket: **Per 90 day supply** | |
| Generic | 40% after Medical Deductible. |
| Preferred Brand | 40% after Medical Deductible. |
| Non-Preferred Brand | 40% after Medical Deductible. |
| Brand if no Generic available | 40% after Medical Deductible. |
| Brand if Physician mandates | 40% after Medical Deductible. |
| | |
| **MAIL ORDER PRESCRIPTION PLAN** | |
| If obtained through the Mail Order Prescription Drug Plan - Subject to Medical Deductible and Out of Pocket: **Per 90 day supply** | |
| Generic | 40% after Medical Deductible. |
| Preferred Brand | 40% after Medical Deductible. |
| Non-Preferred Brand | 40% after Medical Deductible. |
| Brand if no Generic available | 40% after Medical Deductible. |
| Brand if Physician mandates | 40% after Medical Deductible. |
| | |
| **PURCHASED OUTSIDE OF THE RETAIL OR MAIL ORDER PRESCRIPTION PLANS** | **40% after Medical Deductible.** |
| | |
| **COVERAGE INCLUDES** | **COVERAGE EXCLUDES** |
| ♦ Federal Legend Drugs | ♦ Diagnostic Agents |
| ♦ AIDS Medications | ♦ Sexual Dysfunction Drugs |
| ♦ Insulin | ♦ Rogaine & Other Hair Loss Products |
| ♦ Diabetic Supplies (lancets, needles, test strips, alcohol swabs) | ♦ Medical Devices |
| ♦ ADHD Drugs | ♦ Blood Products (RhoGAM) |
| ♦ Migraine Medication | ♦ Anorexiants, Diet Drugs |
| ♦ Acne Medication | ♦ OTC Counterparts |
| ♦ Prenatal Vitamins | ♦ Cosmetic Drugs |
| ♦ Self Injectables | ♦ Growth Hormone Drugs |
| ♦ Narcolepsy Drugs | ♦ Fertility Drugs |
| ♦ FDA approved forms of Contraceptives for Women | ♦ Vitamins |
| ♦ Smoking Cessation Products | ♦ Fluoride |
| ♦ Vaccinations/Immunizations | ♦ Investigational Drugs |
| ♦ Compounds | ♦ Anabolic Steroids |

**Charges In Excess Of Benefit Maximums, Charges In Excess Of Reasonable And Customary Fees, Allowable Claim Limits, Maximum Allowable Amounts And Non-Compliance Penalties Do Not Accumulate Toward The Out-of-Pocket Maximum.**

## SCHEDULE OF BENEFITS - DENTAL PLAN

| DENTAL SCHEDULE OF BENEFITS | |
|---|---|
| **Calendar Year Maximum Benefit**<br>For Preventive, Basic and Major Services | $1,500 |
| | |
| **Calendar Year Deductible** | |
| Individual | $50 |
| Family | $150 |
| For Basic and Major Services. The Deductible does not apply to Preventive and Orthodontic Services. | |
| | |
| **Note:** ***The Family Maximum includes covered expenses which are used to satisfy Deductibles for all family members combined.*** | |
| | |
| **Co-insurance Factor** | |
| Preventive Services | 100% |
| Basic Services | 80% |
| Major Services | 50% |
| | |
| **Orthodontia*** | |
| Co-insurance | 50% |
| Lifetime Maximum | $1,500 |
| | |
| *Lifetime Maximum per Covered Person | |
| | |

## SCHEDULE OF BENEFITS - VISION PLAN

| VISION SCHEDULE OF BENEFITS | |
|---|---|
| **VISION EXAMINATION** | $50 |
| *Maximum per twelve month period – one exam* | |
| | |
| **LENSES** | $100 |
| *Maximum per twenty-four (24) month period – one pair* | |
| | |
| Contact lenses (in lieu of glasses) in a twenty-four (24) month period. | $100 |
| | |
| **Note: The limit for one lens is one-half the per pair limit.** | |
| | |
| **FRAMES** | $100 |
| *Maximum per twenty-four (24) month period is per frame* | |
| | |
| Frames are not available in conjunction with contact lenses. | |

# PLAN PARTICIPATION

## ELIGIBILITY FOR EMPLOYEES

An Employee is a person who is an active, full-time Employee of the Company. In order to be considered "full-time," an Employee must be regularly scheduled to work at least thirty (30) hours per week.

Each Employee will become eligible for coverage under this Plan on the first of the month after the Employee completes the employment Waiting Period of two consecutive months as an Active Employee. 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. Employees who reside in Puerto Rico, Alaska and Hawaii are not eligible for coverage.

An Employee's status as a Full-Time Employee will be determined on the basis of the average number of hours worked during an initial or standard measurement period, as applicable, as established by the Plan in accordance with applicable law. The Employee's eligibility (or lack of eligibility) for Plan coverage on the basis of his or her Full-Time or Part-Time status will extend through the stability period established by the Plan in accordance with applicable law. In calculating the average hours worked, the Plan will count hours paid and hours for which the Employee is entitled to payment (such as paid holidays, vacation, pay, etc.). An Employee's status as a Full-Time or Part-Time Employee will be determined on the basis of the Employer's standard employment practices.

Contact the Human Resources Department for additional information.

## REINSTATEMENT FOR COVERAGE

If an Employee is terminated and then re-hired within thirteen (13) weeks, the Employee’s coverage will begin immediately after rehire, as long as all other eligibility requirements are also satisfied; or

If an Employee has a break in employment that lasts between four (4) and thirteen (13) weeks, but the Employee’s length of employment is less than the length of the break in employment, the Employee will have to satisfy the new hire Waiting Period; or

If an Employee is terminated and then re-hired after thirteen (13) weeks, the Employee’s coverage will begin as soon as the Employee satisfies the new hire Waiting Period, as long as all other eligibility requirements are also satisfied.

## ELIGIBILITY FOR DEPENDENT COVERAGE

A Dependent is a person who fits one (1) or more of the following categories:

1. A covered Employee's Spouse. The term Spouse shall mean a person who is legally married to the eligible employee in their state of primary residency, and shall not include common law marriages. The Plan Administrator may require documentation proving a legal marital relationship. The term "Spouse" shall also mean the person who is currently registered with the Employer as the Domestic Partner of the Employee, this includes opposite sex and same sex couples. An individual is a Domestic Partner of an Employee if that individual and the Employee meet each of the following requirements:

    a. The Employee and individual are eighteen (18) years of age or older and are mentally competent to enter into a legally binding contract.
    b. The Employee and the individual are not married to anyone.
    c. The Employee and the individual are not related by blood to a degree of closeness that would prohibit legal marriage between individuals of the opposite sex in the state in which they reside.

d. The Employee and the individual share the same principal residence(s), the common necessities of life, the responsibility for each other's welfare, are financially interdependent with each other and have a long-term committed personal relationship in which each partner is the other's sole domestic partner. Each of the foregoing characteristics of the domestic partner relationship must have been in existence for a period of at least twelve (12) consecutive months and be continuing during the period that the applicable benefit is provided. The Employee and the individual must have the intention that their relationship will be indefinite.
e. The Employee and the individual have common or joint ownership of a residence (home, condominium, or mobile home), motor vehicle, checking account, credit account, mutual fund, joint obligation under a lease for their residence or similar type ownership.

In the event the domestic partnership is terminated, either partner is required to inform TEAM, Risk Management Strategies of the termination of the partnership.

The Plan Administrator may require documentation proving a legal marital and/or Domestic Partner relationship.

2. An Employee's "Child" includes his natural child, stepchild, foster child, adopted child, or a child placed with the Employee for adoption. An Employee's child will also include children, adopted children and children placed for adoption with the Employee's Domestic Partner. An Employee's Child will be an eligible Dependent until reaching the limiting age of 26, without regard to student status, marital status, financial dependency or residency status with the Employee or any other person. When the child reaches the applicable limiting age, coverage will end on the last day of the child's birthday month.

   The phrase "placed for adoption" refers to a child whom a person intends to adopt, whether or not the adoption has become final, who has not attained the age of 18 as of the date of such placement for adoption. The term "placed" means the assumption and retention by such person 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 Plan Participant who is an alternate recipient under a qualified medical child support order shall be considered as having a right to Dependent coverage under this Plan. A participant of this Plan may obtain, without charge, a copy of the procedures governing qualified medical child support order (QMCSO) determinations from the Plan Administrator. The Plan Administrator may require documentation proving eligibility for Dependent coverage, including birth certificates, tax records or initiation of legal proceedings severing parental rights.

These persons are excluded as Dependents: other individuals living in the covered Employee's home, but who are not eligible as defined; the legally separated or divorced former Spouse of the Employee; any person who is on active duty in any military service of any country; totally disabled dependent children over age 26; any former Domestic Partner of the Employee; or any person who is covered under the Plan as an Employee.

## EFFECTIVE DATE OF DEPENDENT COVERAGE

An Employee's Dependents will become eligible for coverage under this Plan on the latest of the following dates:

1. The date the Employee becomes eligible for the Employee's own coverage under the Plan.
2. The date coverage for the Employee's Dependents first becomes available under any amendment to the Plan, if such coverage was not provided under the Plan on the Effective Date of the Plan.
3. The first date upon which the Employee acquires a Dependent.

A Dependent Child cannot be covered as a Dependent of more than one Employee who is covered under the Plan.

## EFFECTIVE DATES OF COVERAGE; CONDITIONS

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

1. Enrollment Form (paper or electronic as applicable). Employees can obtain coverage for themselves and/or their Dependents by submitting an enrollment form (paper or electronic as applicable) provided by the Plan Administrator. This enrollment form must be submitted within thirty (30) days following the applicable date of eligibility. After the enrollment form is reviewed, and if it is determined that coverage is available and appropriate, coverage will then become effective upon the subsequent date that the Employee or Dependents are eligible.

2. Coverage as Both Employee and Dependent. A Covered Person that is qualified to enroll in this Plan as an Employee or a Dependent may enroll as either an Employee or Dependent, but not both.

3. Birth of Dependent Child. A newborn Child will be covered at birth if the Employee submits a written application within thirty (30) days of the date of birth and authorizes any required contributions.

   A newborn Child of a Dependent Child is not eligible for this Plan unless the newborn Child meets the definition of an eligible Dependent.

4. Newly Acquired Dependents. If an Employee acquires a new Dependent while already enrolled for coverage, coverage for the newly acquired Dependent will become effective on the date the Dependent becomes eligible if the Employee's existing coverage extends to Dependents. If coverage for Dependents has not already been obtained by the Employee, the Employee must submit a written application to the Plan within thirty (30) days of the date that the newly acquired Dependent became eligible. If enrollment is approved by the Plan Administrator, the Employee must also make any required contributions.

5. Requirement for Employee Coverage. Coverage will only be available for Dependents of Employees who are themselves eligible for coverage.

6. Dependents of Multiple Employees. If a Dependent is capable of qualifying as a Dependent of more than one Covered Employee, that Dependent will be considered a Dependent of only one such Employee.

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

8. FMLA Leave. Regardless of any requirements set forth in the Plan, the Plan shall at all times comply with FMLA (if applicable).

NOTE: It is the responsibility of the enrolled Employee to notify the Company of any changes in the Dependent's status.

## SPECIAL AND ANNUAL ENROLLMENT

Federal law requires that the Plan provide "Special Enrollment Periods" during which Employees may enroll in the Plan, even if the Employee declined to enroll during an initial or subsequent eligibility period. The Special Enrollment rules are described in more detail within this section.

## LOSS OF OTHER COVERAGE

This Plan will permit an eligible Employee or Dependent (including his or her Spouse or Domestic Partner) who is eligible for coverage, but not yet enrolled, to enroll for coverage under the terms of the Plan if each of the following conditions is met:

1. The eligible Employee or Dependent was covered under another Group Health Plan or had other health insurance coverage at the time coverage under this Plan was offered.
2. The eligible Employee stated in writing at the time this Plan was offered, that the reason for declining enrollment was due to the eligible Employee having coverage under another Group Health Plan or due to the Employee already having other health insurance coverage.
3. The eligible Employee or Dependent lost other coverage due to one of the following events:
    a. The eligible Employee or Dependent was under COBRA coverage and the COBRA coverage was exhausted.
    b. The eligible Employee or Dependent was not under COBRA coverage and the other coverage was terminated as a result of loss of eligibility (including as a result of Legal Separation, divorce, loss of Dependent status, death, termination of employment, or reduction in the number of hours worked).
    c. The eligible Employee or Dependent moved out of an HMO service area with no other option available.
    d. The other coverage is no longer offering benefits to a class of similarly situated individuals.
    e. The benefit package option is no longer being offered by the other coverage and no substitute is available.
    f. The Employer contributions to the other coverage were terminated.

If an Employee is currently enrolled in a benefit package, the Employee may elect to enroll in another benefit package under the Plan if:

1. Multiple benefit packages are available, and
2. A Dependent of the enrolled Employee has a special enrollment right in the Plan because the Dependent has lost eligibility for other coverage.

Any benefits which were paid or are payable for Covered Expenses incurred by or on behalf of the Covered Person while covered under the current plan, will be charged against the corresponding benefit limits of the newly elected plan and vice versa.

Special enrollment rights will not be available to an Employee or Dependent if:

1. The other coverage is/was available through COBRA Continuation Coverage and the Employee or Dependent failed to exhaust the maximum time available for such COBRA coverage.
2. The Employee or Dependent lost the other coverage failing 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 other health coverage).

For those eligible Employees or Dependents who meet the conditions specified above, this Plan will be effective following enrollment, and provided that the request is made within thirty (30) days from the loss of the other health coverage.

## NEW DEPENDENT SPECIAL ENROLLMENT

An Employee or Dependent who is eligible for coverage under this Plan but is not yet enrolled may be eligible to enroll during a “special enrollment period” if the Employee acquires a new Dependent as a result of marriage, birth, domestic partnership, adoption, or placement for adoption. To be eligible for this special enrollment, the Employee must apply in writing, or electronically, as applicable, no later than thirty (30) days after the Employee acquires the new Dependent. The following conditions apply to any eligible Employees and Dependents:

An Employee or Dependent who is eligible for coverage under this Plan but is not yet enrolled may enroll during a special enrollment period if both of the following conditions are met:

1. The eligible Employee is a covered Employee under the terms of this Plan but elected not to enroll during a previous enrollment period.

2. An individual has become a Dependent of the eligible Employee through marriage, birth, adoption, or placement for adoption or domestic partnership.

If the conditions for special enrollment are satisfied, the coverage of the Dependent and/or Employee enrolled during the Special Enrollment Period will be effective at 12:01 A.M.:

1. In the case of marriage, on the date of the marriage.
2. In the case of a Dependent's birth, on the date of birth.
3. In the case of a Dependent's adoption or placement for adoption, on the date of the adoption or placement for adoption.
4. In the case of domestic partnership, on the date of the domestic partnership agreement.

## ADDITIONAL SPECIAL ENROLLMENT RIGHTS

Employees and Dependents who are eligible for coverage under this Plan but are not yet enrolled are entitled to enroll under the following circumstances:

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

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

## ANNUAL ENROLLMENT PERIOD

This Plan has an Annual Enrollment Period before the start of every Plan Year. Eligible Covered Persons who are not yet covered under this Plan may enroll for coverage during the Annual Enrollment Period. Employees who are already enrolled in the Plan will be given an opportunity to change their coverage during the Annual Enrollment Period. Such a change in coverage will be effective on the first day of the upcoming Plan Year. A Covered Person who fails to make an election during the Annual Enrollment Period will automatically retain their present coverage(s). Coverage for Covered Persons who enroll during an Annual Enrollment Period will become effective on January 1, as long as all other eligibility requirements have been met. If the other eligibility requirements have not been met, coverage for Covered Persons enrolling during an Open Enrollment Period will become effective as stated in the provision, "Eligibility for Individual Coverage."

The terms of the Annual Enrollment Period, including the duration of the election period, will be determined by the Plan Administrator and communicated to all Covered Persons before the start of the Annual Enrollment Period.

## QUALIFIED MEDICAL CHILD SUPPORT ORDERS

This Plan will provide for immediate enrollment and benefits to the Child(ren) of a Covered Person who are the subject of a Qualified Medical Child Support Order (QMCSO), not including an ex-stepchild or ex-stepchildren, regardless of whether the Child(ren) reside with the Covered Person, provided that the Child or Child(ren) are not already enrolled as an eligible Dependent as described in this Plan. If a QMCSO is issued, then the Child(ren) shall become Alternate Recipient(s) of the benefits under this Plan, subject to the same limitations, restrictions, provisions and procedures as any other Covered Person. The Plan Administrator will determine if the QMCSO properly meets the standards described in this section. A properly completed National Medical Support Notice (NMSN) will also be treated as a QMCSO and will have the same effect.

"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.

"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:

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.

"National Medical Support Notice" or "NMSN" means a notice that contains the following information:

1. The name of the State child support enforcement agency issuing the notice.
2. The name and mailing address (if any) of the Employee who is a Covered Person under this Plan or is otherwise eligible for enrollment under this Plan.
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 who may be substituted for the mailing address of the Alternate Recipients(s)).
4. The identification of an underlying child support order.

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

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

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

A National Medical Support Notice shall be deemed a QMCSO if it:

1. Contains the information set forth above in the definition of "National Medical Support Notice."
2. Identifies either the specific type of coverage or all available group health coverage. If the Employer receives an NMSN that does not designate either specific type(s) of coverage or all available coverage, the Employer and the Plan Administrator will assume that all are designated.
3. Informs the Plan Administrator that, if a Group Health Plan has multiple options and the Covered Person is not enrolled, the issuing agency will make a selection after the NMSN is qualified, and, if the agency does not respond within twenty (20) days, the Child will be enrolled under the Plan's default option (if any).
4. Specifies that the period of coverage may end for the Alternate Recipient(s) only when similarly situated dependents are no longer eligible for coverage under the terms of the Plan, or upon the occurrence of certain specified events.

A NMSN does not need to be recognized as a QMSCO if it requires the Plan to provide any type or form of benefit, or any option, not otherwise provided to the Covered Persons and eligible Covered Persons without regard to the provisions herein, except to the extent necessary to meet the requirements of a State law relating to Medical Child Support Orders, as described in Social Security Act §1908 (as added by the Omnibus Budget Reconciliation Act of 1993 §13822).

When a Medical Child Support Order is received by this Plan, the Plan Administrator shall, as soon as administratively possible:

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

In the instance of any National Medical Support Notice received by this Plan, the Plan Administrator shall:

1. Notify the State agency issuing the notice with respect to the Child whether coverage of the Child is available under the terms of the Plan and, if so:
    a. Whether the Child is covered under the Plan,
    b. Either the effective date of the coverage or, if necessary, any steps to be taken by the custodial parent or by the official of a State or political subdivision to effectuate the coverage.
2. Provide to the custodial parent (or any State official serving in a substitute capacity) a description of the coverage that is available and any forms or documents necessary to begin such coverage.

As required by Federal law, the Plan Administrator shall:

1. Establish reasonable procedures to determine whether Medical Child Support Orders or National Medical Support Notices are Qualified Medical Child Support Orders.
2. Administer benefits in accordance with such orders.
3. Such procedures shall
    a. Be in writing.
    b. Provide for the prompt notification of each person specified in a Medical Child Support Order as eligible to receive benefits under the plan (at the address included in the Medical Child Support Order) of such procedures upon the receipt by the Plan of the Medical Child Support Order.
    c. Permit an Alternate Recipient to designate a representative for receipt of copies of notices that are sent to the Alternate Recipient with respect to a Medical Child Support Order.

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

# TERMINATION OF COVERAGE

## TERMINATION DATES OF INDIVIDUAL COVERAGE

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

1. The date upon which the Plan is terminated.
2. The day of the month in, or with respect to which, he or she requests that such coverage be terminated, on the condition that such request is made on or before such date.
3. The date of the expiration of the last period for which the Employee has made a contribution, in the event of his or her failure to make, when due, any contribution for coverage to which he or she has agreed in writing.
4. The last day of the month in which he or she no longer eligible for such coverage under the Plan.
5. The day of the month in which he or she enters the armed forces of any country on a full-time active duty basis.
6. If absent from work due to an Employer-Certified Leave of Absence or Layoff, other than a Family and Medical Leave Act leave, coverage will end on the earliest of the following dates:
    a. On the last day of the approved leave of absence, not to exceed six months, or in accordance with state or federal laws if such laws require a continuation period longer than six months;
    b. the date the person becomes covered under any other group plan for benefits of a type similar to that provided by this Plan;
    c. the end of the period for which the last contribution was paid, if such contribution is required;
    d. the date of termination of this Plan.

    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 continued person.
7. If absent from work due to a disability, coverage terminates at the end of the month following the date of disability.
8. The end of the month in which the termination of employment occurs.
9. Immediately upon submission of a fraudulent claim or any fraudulent information to the Plan (including enrollment information), by and/or on behalf of an Employee or his or her Dependent, or upon the Employee or his or her Dependent gaining knowledge of the submission, as determined by the Plan Administrator in its discretion, consistent with applicable laws and/or rules regarding such rescission.

This Plan intends to comply with the provisions of the Family and Medical Leave Act (FMLA). A Leave of Absence runs consecutively with the Family and Medical Leave Act (FMLA).

Refer to the section entitled COBRA for information regarding continued coverage after ceasing to be eligible under the Plan.

## TERMINATION DATES OF DEPENDENT COVERAGE

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

1. The date upon which the Plan is terminated.
2. Upon the discontinuance of coverage for Dependents under the Plan.
3. The date of termination of the Employee's coverage for himself or herself under the Plan.
4. The date of the expiration of the last period for which the Employee has made a contribution, in the event of his or her failure to make, when due, any contribution for coverage for Dependents to which he or she has agreed in writing.
5. The date such person is no longer a Dependent Spouse (including, but not limited to, the case where the Spouse is Legally Separated or divorced), except as may be provided for in other areas of this section.

6. The last day of the month in which such person ceases to be a Dependent Child, as defined herein, except as may be provided for in other areas of this section or within this document.
7. The last day of the month in which the Dependent enters the armed forces of any country on a full-time active duty basis.
8. For a Dependent Child whose coverage is required pursuant to a QMCSO, the last day of the calendar month as of which coverage is no longer required under the terms of the order or this Plan.
9. Immediately upon submission of a fraudulent claim or any fraudulent information to the Plan (including enrollment information), by and/or on behalf of an Employee or his or her Dependent, or upon the Employee or his or her Dependent gaining knowledge of the submission, as determined by the Plan Administrator in its discretion, consistent with applicable laws and/or rules regarding such rescission.

Refer to the section entitled COBRA for information regarding continued coverage after ceasing to be eligible under the Plan.

# CLAIM REVIEW AND AUDIT PROGRAM

***Assignment of Benefits***

"Assignment of Benefits" means an arrangement whereby a Plan Participant assigns his or her right to seek and receive payment of eligible Plan benefits to a healthcare provider. The Plan Administrator may revoke an Assignment of Benefits at its discretion. If the provider accepts the arrangement, the provider's right to receive Plan benefits are equal to those of the Plan Participant, and limited by the terms of the Plan. A provider that accepts this arrangement indicates acceptance of the Assignment of Benefits as consideration in full for treatment, supplies and other services rendered, and is bound by the terms of the Plan Document.

Benefits that are payable by the Plan to Direct Providers are automatically assigned to the provider of services or supplies unless evidence of previous payment is submitted. All other benefits payable by the Plan may be assigned to the provider of services or supplies at the Plan Participant's option and at the Plan's discretion. Payments made in accordance with an assignment are made in good faith and release the Plan's obligation to the extent of the payment. Reimbursement to Medicaid will be made in accordance with applicable law.

No Plan Participant shall at any time, either during the time in which he or she is a Participant in the Plan, or following his or her termination as a Plan Participant, in any manner have any right to assign his or her right to sue to recover benefits under the Plan, to enforce rights due under the Plan or to any other causes of action which he or she may have against the Plan or its fiduciaries.

***Allowable Charge***

"Allowable Charge" for a treatment, supply or other services rendered is determined by the Plan, at the Plan's discretion, by determining the amount established by a negotiated arrangement if one exists, or the lesser of:

- Specified Benefit Amount;
- Gross billed charge made by the provider;
- Usual, Customary and Reasonable payment for the same treatment, service, or supply;
- Prevailing fee charged in an area large enough to obtain a representative cross-section of providers rendering such treatment, supply or services for which the charge is made by Providers of similar skill and experience.
- For Covered Charges rendered by a Physician or other professional provider in a geographic area where applicable law dictates the maximum amount that can be billed by the rendering provider, the Allowable Charge shall mean the amount established by applicable law for that Covered Charge.

The Allowable Charges shall not include:

- Charges for any items billed separately that are customarily included in a global billing procedure code in accordance with American Medical Association's CPT® (Current Procedural Terminology) and/or the Healthcare Common Procedure Coding System (HCPCS) codes used by CMS;
- Charges for billing errors including, but not limited to, upcoding, duplicate charges, and charges for services not performed;
- Charges relating to clearly identifiable errors in medical care;
- Charges the Plan cannot identify or understand the item(s) being billed; or,
- Charges identified based upon a medical record review and audit, which determines that a different treatment or different quantity of a drug or supply was provided.

Nothing in this section shall be construed to limit the Plan's discretion to deem a greater amount payable than the lesser of any of the above-referenced amounts. Furthermore, the Plan is not obligated to consider all factors. In the event that the Plan determines that insufficient information is available to identify the Allowable Charge for a specific service or supply using the listed guidelines above, the Plan reserves the right, in its sole discretion, to determine any Allowable Charge amount for certain conditions, services and supplies using accepted industry-standard documentation, applied without discrimination to any Covered Person.

***Specified Benefit Amount***
"Specified Benefit Amount" means the charges for services and supplies, listed and included as Covered Charges under the Plan, which are Medically Necessary for the care and treatment of Illness or Injury, but only to the extent that such fees do not exceed the Specified Benefit Amount. The determination that a charge does not exceed the Specified Benefit Amount include, but are not limited to, the following guidelines:

- 150% of the Medicare allowed amount for a Hospital facility, facility which is owned and operate by a Hospital, or an Ambulatory Surgery Centers;
- 115% of the Medicare allowed Average Sale Price (ASP) for pharmacy charges;
- 120% of the Medicare allowed amount for Physician and other eligible providers;
- 100% of the Organ Procurement Organization's invoice cost; and,
- 100% of the National Marrow Donor Program's invoice cost.

***Usual, Customary and Reasonable***
"Usual, Customary and Reasonable" means the common paid amount for the same or comparable service in the geographic area in which the service or supply is furnished. Usual, Customary and Reasonable payment is based upon:

- Amount of resources expended to deliver the treatment;
- Complexity of the treatment rendered;
- Generally accepted billing practices for unbundling or multiple procedures;
- Medicare reimbursement rates for comparable services or supplies;
- Costs of provider for providing the service or supply;
- Charging protocols and billing practices generally accepted by the medical community; and
- Amounts paid after discounts under government and private plans.

Nothing in this section shall be construed to limit the discretion of the Plan. The Plan is not obligated to consider all factors listed above.

***Transplants***
Medically Necessary charges incurred for the care and treatment due to an organ or tissue transplant that is not considered Experimental or Investigational, subject to the following criteria:

- Charges do not exceed the Allowable Charge;
- Transplant must be performed to replace an organ or tissue;
- Charges for obtaining donor organs or tissues are Covered Charges under the Plan only when the recipient is a Plan Participant. When the donor has medical coverage, his or her Plan will pay first. The donor benefits under this Plan will be reduced by those payable under the donor's Plan.

Donor charges include those for:

- Evaluating the organ or tissue;
- Removing the organ or tissue from the donor;
- Transportation of the organ or tissue from within the United States or Canada to the facility where the transplant is to be performed; and,
- Charges listed above that are not in violation of any federal or state law.

If a transplant is performed pursuant to a negotiated arrangement and the Plan Participant resides 50 miles or more from the transplant facility, the Plan will pay for the following services incurred during the transplant benefit period subject to the maximum benefit as specifically stated in the Schedule of Benefits:

- Transportation expenses to and from the Center of Excellence facility for the following individuals:
    - The Plan Participant; and
    - One or both parents of the Plan Participant (only if the Plan Participant is a Dependent minor child); or

- One adult to accompany the Plan Participant; and,
- Living donor (if applicable under the Plan).

Transportation expenses include commercial transportation (coach class only).

Reasonable lodging and meal expenses incurred for the living donor, Plan Participant, and one or both parents of the Plan Participant (only if the Plan Participant is a Dependent minor child), or one adult companion who is accompanying the Plan Participant, only while the Plan Participant is receiving transplant-related services at the Directly Contracted Provider.

Lodging, for purposes of this Plan, will not include private residences.

***PROVIDER OF SERVICE APPEAL RIGHTS - CLAIM REVIEW AND AUDIT PROGRAM***

A Plan Participant may appoint the provider of service as the Authorized Representative with full authority to act on his or her behalf in the appeal of a denied claim. An assignment of benefits by a Plan Participant to a provider of service will not constitute appointment of that provider as an Authorized Representative. However, in an effort to ensure a full and fair review of the denied claim, and as a courtesy to a provider of service that is not an Authorized Representative, the Plan will consider an appeal received from the provider in the same manner as a Plan Participant's appeal, and will respond to the provider with the results of the review accordingly. Any such appeal from a provider of service must be made within the time limits and under the conditions for filing an appeal specified under the section, "Appeals of Adverse Benefit Determinations" above. **Providers requesting such appeal rights under the Plan must agree to pursue reimbursement for Covered Charges directly from the Plan, waiving any right to recover such expenses from the Plan Participant, and comply with the conditions for appeal above.**

For purposes of this section, the provider's waiver to pursue covered medical expenses does not include the following amounts, which are the responsibility of the Plan Participant:

- Deductibles;
- Copayments;
- Coinsurance;
- Penalties for failure to comply with the terms of the Plan;
- Charges for services and supplies which are not included for coverage under the Plan; and
- Amounts which are in excess of any stated Plan maximums or limits. **Note: This does not apply to amounts found to be in excess of Allowable Claim Limits, as defined in the section, "Claim Review and Audit Program."** The provider must agree to waive billing the Plan Participant for these amounts.

Also, for purposes of this section, if a provider indicates on a Form UB or on a Form HCFA (or similar claim form) that the provider has an assignment of benefits, then the **Plan** will require no further evidence that benefits are legally assigned to that provider.

Contact the Claims Administrator or the **Plan Administrator** for additional information regarding provider of service appeals.

# UTILIZATION REVIEW PROGRAM

This Plan has implemented a program of Utilization Review so that Covered Persons understand the Medical Necessity of a proposed inpatient admission or outpatient surgery recommended by the Covered Person's Physician. The Utilization Review Service is staffed by medical professionals who consult with the Covered Person and his or her Physician to determine the type of care required, the appropriate setting for such care, and quality, yet cost effective care for his or her condition.

The Plan conforms to the procedures, protocols and methodologies of the contracted Utilization Review Service.

**ALL BENEFITS PROVIDED BY THIS PLAN FOR CHARGES FOR HOSPITAL CONFINEMENTS ARE SUBJECT TO THE FOLLOWING REQUIREMENTS:**

**Inpatient Admissions**

- Acute Care
- Extended Care
- Rehabilitation Care Facility
- Substance Abuse Facility

**Other Required Procedures**

- Outpatient Surgical Procedures
- Reconstructive Surgery
- Transplants
- Hospice
- Durable Medical Equipment
- Select Injectable Drugs in a Physician's Office Setting
- Hemophilia Home Infusion

## PRE-ADMISSION REVIEW

**For Non-Emergency Hospital Admissions:**

A pre-admission authorization is required at least three (3) business days prior to admission to a Hospital as a bed patient. Covered Persons, Physicians or the Hospital must call the Utilization Review Service whenever a Hospital admission is recommended.

The Utilization Review Service will evaluate the Covered Person's planned treatment based upon the diagnosis provided by the Covered Person's Physician and established standards for medical care. After consultation with the Covered Person's Physician the Utilization Review Service will provide written authorization to the Covered Person, the Hospital, and the Claims Administrator.

The Utilization Review Service's authorization does not verify eligibility or benefits. Questions regarding eligibility or benefits must be directed to the Claims Administrator.

**For Emergency Hospital Admissions:**

"Emergency Hospital Admission" means an admission for Hospital confinement which, if delayed, would result in disability or death.

In case of an Emergency Hospital Admission, a Covered Person, their Physician, the Hospital or a member of the Covered Person's immediate family must inform the Utilization Review Service of the admission, by telephone, within one (1) working day after such admission.

**For Maternity Hospital Admissions:**

Maternity admissions are not considered emergencies. A pre-admission authorization is recommended at least two (2) months prior to the estimated date of delivery. Covered Persons or their Physician must call the Utilization Review Service.

Although the Plan ***does*** require a Covered Person to notify the Utilization Review Service of their Pregnancy in advance of an admission, the first forty-eight (48) hours following a vaginal delivery, or ninety-six (96) hours following a cesarean section are automatically authorized. Stays in excess of the forty-eight (48) or ninety-six (96) hours will require authorization through the Utilization Review Service. Under Federal law, Group Health Plans may not restrict benefits for any Hospital length of stay in connection with Childbirth for the mother (if a Covered Person) or newborn Child (if a Covered Person) 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).

**The pre-certification requirement shall be waived for all admissions outside of the United States; however, all other provisions apply.**

**The Utilization Review Service must be informed of:**

- **The name and birth date of the patient**
- **The name and identification number of the Employee**
- **The date of Hospital admission or surgery**
- **The name of the Employer**
- **The admitting diagnosis**
- **The name of the hospital**
- **The name and telephone number of the attending Physician**

## CONTINUED STAY REVIEW

Before the Covered Person's scheduled discharge, the Utilization Review Service will call the Hospital and the Covered Person's Physician to confirm the discharge. If additional days of confinement are required because of complications or other medical reasons, the Utilization Review Service will again evaluate the treatment and diagnosis in consultation with the Covered Person's Physician. This process will continue until the Covered Person is discharged from the Hospital.

If Hospital charges are incurred by a Covered Person for a period of Hospital confinement which has NOT been authorized under the Continued Stay Review provisions, the eligible Hospital charges for such confinement will be limited to the charges incurred during the period of Hospital confinement initially authorized.

**IF UTILIZATION REVIEW IS NOT USED**

If charges are incurred by a Covered Person for the services listed herein have NOT been authorized by the Utilization Review Service as set out under the Utilization Review program provisions, the penalty, as shown on the Schedule of Benefits, will apply.

**THE NON-COMPLIANCE PENALTIES WILL NOT ACCUMULATE TOWARD THE REQUIRED DEDUCTIBLE(S) OR TO THE OUT-OF-POCKET MAXIMUMS.**

## RETROSPECTIVE REVIEW

The Utilization Review Service will review and evaluate the medical records and other pertinent data of an individual whose Hospital stay, or a portion of his stay, was not authorized under the Pre-Admission and/or Continued Stay Review provisions of the Plan.

Requests for such review must be made, in writing, by the attending Physician or Hospital and must define the medical basis for the review.

Benefits will be limited to only those expenses incurred during the period of hospitalization which **would have been** authorized. Benefits are not payable for expenses related to any period of Hospital confinement which is deemed not Medically Necessary.

## VOLUNTARY SECOND SURGICAL OPINION BENEFIT

If the Covered Person's Physician recommends non-emergency surgery, meaning surgery that can be postponed without causing undue risk, the Plan will pay for any necessary Physician, x-ray or laboratory expense incurred for a second surgical opinion (and a third opinion, if the second opinion does not agree with the first opinion), if:

- **The Physician providing the second or third opinion is not associated with the Physician who first recommended surgery.**
- **The Physician providing the second or third opinion does not perform the surgery.**
- **The second or third opinion is obtained before the recommended surgery.**
- **The Physician providing the second or third opinion is a Board Certified specialist in the appropriate specialty.**
- **The Physician places the second or third opinion in writing.**

An opinion confirming the advisability of surgery may provide greater peace of mind, and a non-confirming opinion may provide an alternative non-surgical method of treatment for the medical condition. If the patient does not use the Benefit, he will be passing up the chance to get additional medical advice.

The Second Surgical Opinion Benefit DOES NOT apply to expenses incurred for or in connection with:

- **Surgical procedures which are not covered under the Plan.**
- **Minor surgical procedures that are routinely performed in a Physician's office, such as incision and drainage of an abscess or excision of benign lesions.**
- **An opinion obtained more than three (3) months after a surgeon first recommended the elective surgical procedure.**

# CASE MANAGEMENT

Case Management is an added service which is used to assist seriously ill or injured Covered Persons requiring long term care. Case Management nurses can provide intensive planning and management for these special situations by recommending alternate Treatment Plans, arranging Home Health Care services and equipment rental and coordinating the services of the many Providers that may be involved in these designated situations.

Examples of Illnesses or Injuries which may benefit from Case Management services are stroke, premature birth, some forms of cancer, severe burns and head Injury.

The Covered Person must cooperate with the Case Manager and provide all relevant medical information regarding his condition; however, the choice of the course of treatment is the patient's.

Certain circumstances may cause the Plan Administrator to allow charges that would not otherwise be covered if the proposed alternative is shown to be cost effective. Prior to any final determination, the severity of the condition and the prognosis are taken into consideration. The Plan Administrator shall have the right to waive the normal provisions of the Plan when it is reasonable to expect a cost effective result without sacrifice to the quality of patient care.

# MEDICAL EXPENSE BENEFIT

## THE DEDUCTIBLE AMOUNT

The Individual Deductible amount is shown on the Schedule of Benefits and is the total amount of Covered Expenses that the Covered Person and his or her Dependents must satisfy in a Calendar Year before the Covered Person or his or her Dependents are eligible to receive the Medical Expense Benefit.

**INDIVIDUAL DEDUCTIBLE**
The Individual Deductible amount is shown on the Schedule of Benefits and is the total amount of Covered Expenses that the Covered Person must satisfy in a Calendar Year before the Covered Person is eligible to receive the Medical Expense Benefits.

**FAMILY DEDUCTIBLE**
When covered family members have satisfied the Family Deductible amount as shown on the Schedule of Benefits in a Calendar Year (no person can contribute more than the Individual Deductible amount), the Plan will not apply Medical Expense Deductibles to the remaining Covered Expenses for all covered family members combined.

**CO-INSURANCE FACTOR**
After the Deductible is satisfied, the Plan will pay the applicable percentages of eligible medical expenses as shown on the Schedule of Benefits.

## OUT-OF-POCKET MAXIMUM

If, in a Calendar Year, a Covered Person accumulates an Out-of-Pocket Maximum which equals the amount shown on the Schedule of Benefits, the Plan will pay one hundred percent (100%) of any further Covered Expenses incurred during the remainder of that Calendar Year.

**FAMILY OUT-OF-POCKET MAXIMUM**
When covered family members have satisfied the Family Out-of-Pocket Maximum amount shown on the Schedule of Benefits in a Calendar Year, the Plan will not apply the Co-insurance Factor to and will pay one hundred percent (100%), from that date forward, of any further Covered Expenses for all covered family members for the remainder of that Calendar Year.

# COVERED MEDICAL EXPENSES

Reasonable and Customary charges Incurred by, or on behalf of, a Covered Person for the following Medically Necessary items, if performed or prescribed by a Physician for an Injury or Illness, subject to the applicable exclusions and limitations of the Plan, are covered by the Medical Expense Benefit:

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

**Ambulatory Surgical Center.** Services and supplies furnished by an Ambulatory Surgical Center.

**Birthing Center.** Charges incurred in connection with a Birthing Center (in lieu of Hospital confinement) and Medically Necessary supplies furnished to the mother and necessary supplies furnished to the covered newborn Child, including charges incurred by State certified and/or licensed Midwives at a Birthing Center.

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

**Breast Reconstruction.** Charges for the following expenses related to breast reconstruction in connection with a mastectomy in a manner determined in consultation with the attending Physician and the patient:

a. Reconstruction of the breast on which the mastectomy has been performed.
b. Surgery and reconstruction of the other breast to produce a symmetrical appearance.
c. Prostheses and physical complications in all stages of mastectomy, including lymphedemas.

**Cardiac Rehabilitation.** Charges for cardiac rehabilitation that are rendered under the supervision of a Physician, in connection with a myocardial infarction, coronary occlusion or coronary bypass surgery and in a medical care facility as defined by this Plan.

**Certified Registered Nurse Anesthetist.** Anesthesia and its administration when rendered by a Physician other than the operating surgeon or by a Certified Registered Nurse Anesthetist. However, benefits will be provided for anesthesia services administered by oral and maxillofacial surgeons when such services are rendered in the surgeon's office or an ambulatory surgical facility.

**Chemotherapy or Radiation Therapy.** Chemotherapy or radiation therapy by x-ray, radium, radon or radioactive isotopes, or other such treatment or care recommended or prescribed by a Physician.

**Cosmetic Surgery.** Charges for reconstructive or Cosmetic Surgery provided the following conditions are met:

a. The surgery must be required to correct a condition that results from an Illness or Injury.
b. The surgery is required to correct the congenital anomaly of a Dependent Child.

**Dental.** Expenses for the following dental related services and supplies:

a. Treatment for the repair or alleviation of damage to sound natural teeth due to an accidental Injury, other than from eating or chewing, or treatment of an Injury to the jaw due to an Injury.
b. Excision of a tumor, cyst, or foreign body of the oral cavity and related anesthesia.
c. Biopsies of the oral cavity and related anesthesia.
d. Expenses billed by a Hospital for Inpatient and Outpatient dental services will be covered if the Covered Person has a serious medical condition that requires hospitalization. Expenses billed by a Hospital for

Inpatient and Outpatient dental services will be covered for any Covered Person when the dental services cannot be safely provided due to the Covered Person's physical, mental or medical condition.

**Diabetic Supplies.** Charges for diabetic supplies.

**Drugs.** Drugs and medications requiring a Physician's written prescription. Drugs and medications purchased through the retail prescription drug plan will be covered as shown on the Schedule of Benefits. Maintenance drugs and medications purchased through the mail order prescription drug plan will be covered as shown on the Schedule of Benefits.

**Durable Medical Equipment.** Durable Medical Equipment limited to the lesser of the purchase price or the total anticipated rental charges.

**Extended Care Facility / Skilled Nursing Facility.** Extended Care Facility / Skilled Nursing Facility services (refer to the specific section for coverage details).

**Emergency Medical Care and Emergency Accident Care.** The initial Outpatient treatment of a medical emergency or an accidental Injury rendered in a Hospital or by a Physician. The term "Medical Emergency" means the sudden and unexpected onset of a medical condition manifesting itself by symptoms severe enough that the absence of medical attention could reasonably result in serious and permanent dysfunction of any bodily organ or part, or other serious and permanent medical consequences. Examples of medical emergencies include, but are not limited to, chest pain, suspected poisoning, severe and persistent abdominal pain, convulsions and emergencies by broadly accepted medical standards.

**FDA Approved Medications.** FDA approved medications used for conditions other than those for which they received FDA approval, when considered the standard of care and not part of a clinical study or in conjunction with any experimental treatment. For the purposes of this Plan, Standard of Care is defined as, charges for any care, treatment, services or supplies that are approved or accepted as essential to the treatment of any Illness or Injury by the American Medical Association, U.S. Surgeon General, U.S. Department of Public Health, or the National Institute of Health, and recognized by the medical community as potentially safe and efficacious for the care and treatment of the Injury or Illness. ***(Unless otherwise stated under the Approved Clinical Trial section)*.**

**Genetic Counseling or Testing.** In addition to coverage specified under Preventive Care, charges for prenatal genetic testing for inherited susceptibility to a medical condition and counseling related to family history or test results to determine the physical characteristics of an unborn child. Refer to the Genetic Information Nondiscrimination Act of 2008 (GINA) subsection for information regarding the prohibition of discriminating on the basis of genetic information.

**Glasses or Contact Lenses.** The first pair of glasses or contact lenses, but not both, prescribed to treat glaucoma or keratoconus or resulting from cataract surgery.

**Home Health Care.** Home health care services (refer to the specific section for coverage details).

**Hospice Care.** Hospice Care services (refer to the specific section for coverage details).

**Hospital Room and Board** including bed and board, general nursing care, meals and dietary services provided by the Hospital. All semi-private or ward accommodations are covered.

a. For private rooms, an allowance will be paid equal to the Hospital's semi-private room charge.
b. If the Hospital only has private room facilities, private room charges will be considered as semi-private charges.
c. If a private room is Medically Necessary for isolation purposes, the private room charge will be considered as semi-private.
d. If intensive care, coronary and intermediate care accommodations are Medically Necessary, the Hospitals actual charges are covered.

**Infertility (initial diagnosis).** Covered services related to the initial diagnosis of infertility. Treatment to enhance fertility is not covered.

**Infusion Therapy / Home Infusion Services.** Charges for infusion therapy/ home infusion services.

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

**Licensed Psychologist / Social Worker.** Licensed Psychologist's and licensed clinical Social Worker's professional medical services for the treatment of psychiatric disorders and Substance Abuse that would be covered if provided by a doctor of medicine (M.D.) and only when the psychologist or social worker is acting within the scope of his license.

**Medical and Surgical Supplies.** Medical and surgical supplies including bandages, dressings, casts, splints, crutches, cervical collars, head halters, traction apparatus and orthopedic braces.

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

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

**Miscellaneous Hospital**. Miscellaneous Hospital services and supplies including equipment and medications and general nursing care provided to registered Inpatients.

**Obstetrical Care.** Charges for obstetrical care are paid on the same basis as any other Illness, including pre-natal care, Pregnancy, and miscarriages. Benefits are provided for the Pregnancy of a Dependent Child. Benefits for Pregnancy expenses are paid the same as any other Sickness. ***NOTE:*** *Preventive care charges for Pregnancy are covered under the Preventive Care benefit in the Medical Benefits section.*

Benefits are not payable for the newborn unless and until the Employee (the grandparent) becomes the legal guardian for that Child.

Although the Plan ***does*** require a Covered Person to notify the Utilization Review Service of their Pregnancy in advance of an admission, the first forty-eight (48) hours following a vaginal delivery, or ninety-six (96) hours following a cesarean section are automatically authorized. Stays in excess of the forty-eight (48) or ninety-six (96) hours will require authorization through the Utilization Review Service. Under Federal law, Group Health Plans may not restrict benefits for any Hospital length of stay in connection with Childbirth for the mother (if a Covered Person) or newborn Child (if a Covered Person) 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).

**Orthotic Appliances.** The initial purchase, fitting and repair of orthotic appliances such as braces, splints or other appliances which are required for support for an injured or deformed part of the body as a result of a disabling congenital condition or an Injury or Sickness.

**Outpatient.** Hospital charges for Medically Necessary Outpatient services.

**Oxygen.** Oxygen and rental of equipment for its administration.

**Physical and/or Occupational Therapy.** Charges for Physical and/or Occupational Therapy rendered by a licensed physical or occupational therapist for improvement of physical functions impaired due to Injury, Illness or congenital defect and in accordance with a Physician's orders. The type, frequency and duration of Physical and/or

Occupational Therapy must be under reasonable expectations that significant improvement within a reasonable period of time and accepted standards of medical practice is obtained.

**Physician's Services.** Physician's services for surgery or other necessary medical care, including second surgical opinions, whether rendered in the office, Hospital, home, Extended Care Facility / Skilled Nursing Facility or Hospice Care.

**Pre-Admission Testing.** Pre-Admission Testing for Medically Necessary diagnostic x-ray and laboratory examinations performed under a Pre-Admission Testing program in the Outpatient department of a Hospital, an ambulatory surgical facility or other facility recognized by the Hospital or Physician provided they are made in contemplation of hospitalization and are made within ten (10) days of a scheduled Hospital confinement. If a confinement is canceled or postponed this benefit will not be payable unless the cancellation or postponement is due to Medical Necessity or the admission is canceled by the Hospital or attending Physician.

**Preventive Care Services.** Preventive care services. Refer to the Schedule of Benefits for additional information.

This benefit does not include any expenses Incurred in connection with a diagnosed Illness, school physicals or physicals required by a third party.

Benefits mandated through the ACA legislation include Preventive Care such as immunizations, screenings, and other services that are listed as recommended by the United States Preventive Services Task Force (USPSTF), the Health Resources and Services Administration (HRSA), and the Federal Centers for Disease Control (CDC). Benefits include gender-specific Preventive Care services, regardless of the sex the Participant was assigned at birth, his or her gender identity, or his or her recorded gender.

**Prosthetic Devices.** Charges for artificial limbs, eyes and other prosthetic devices to replace physical organs and body parts, including replacements which are Medically Necessary or required by pathological change or normal growth. Covered Expenses do not include expenses for the repair or replacement of damaged, lost or stolen devices.

**Pulmonary Rehabilitation.** Charges for pulmonary rehabilitation.

**Renal Dialysis.** Renal dialysis treatment, including equipment and supplies when such services are provided in a Hospital, Dialysis Facility or in the home under the supervision of a Hospital or Dialysis Facility.

**Registered Nurse or Licensed Practical Nurse.** Charges made by a Registered Nurse (R.N.) or Licensed Practical Nurse (L.P.N.) when the attending Physician certifies that such nursing care is Medically Necessary.

**Residential Treatment Facility.** Services or supplies received at a Residential Treatment Facility.

**Respiratory Care.** Charges for respiratory care.

**Routine Newborn Care.** Routine newborn care while Hospital confined, including Hospital nursery care and other Hospital services and supplies and Physicians charges for pediatric care and circumcision.

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

1. The clinical trial is approved by any of the following:
    a. The Centers for Disease Control and Prevention of the U.S. Department of Health and Human Services.
    b. The National Institute of Health.
    c. The United States Food and Drug Administration.
    d. The United States Department of Defense.
    e. The United States Department of Veterans Affairs.

f. An institutional review board of an institution that has an agreement with the Office for Human Research Protections of the U.S. Department of Health and Human Services.

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

Coverage will not be provided for:

1. The cost of an Investigational new drug or device that is not approved for any indication by the United States Food and Drug Administration, including a drug or device that is the subject of the Approved Clinical Trial.
2. The cost of a service that is not a health care service, regardless of whether the service is required in connection with participation in an Approved Clinical Trial.
3. The cost of a service that is clearly inconsistent with widely accepted and established standards of care for a particular Diagnosis.
4. A cost associated with managing an Approved Clinical Trial.
5. The cost of a health care service that is specifically excluded by the Plan.
6. Services that are part of the subject matter of the Approved Clinical Trial and that are customarily paid for by the research institution conducting the Approved Clinical Trial.

**Speech Therapy.** Charges for Speech Therapy rendered by a qualified speech therapist in accordance with a Physician's orders when such therapy is administered to restore or rehabilitate speech impairment due to a congenital defect or due to an Injury or due to an Illness that is other than a Non-Organic/Functional disorder (i.e. lisping, stuttering, and stammering), a non-curable developmental disorder (i.e. mentally challenged, down's syndrome, delayed speech or other learning development disorder).

**Voluntary Sterilizations.** Voluntary sterilizations, but not the reversal of such procedures.

# HUMAN ORGAN TRANSPLANT BENEFIT

Coverage includes benefits for Medically Necessary expenses related to human organ, bone marrow/stem cell and tissue transplants at only designated facilities. Expenses incurred by a live organ donor, who is without insurance coverage and is not covered under this Plan, will be covered for each organ transplant procurement.

Expenses incurred for organs obtained through an organ bank or from a cadaver and expenses for storage and transportation that are Reasonable and Customary, are covered under this Plan. If both the recipient and the donor are covered under this Plan, the expenses will be treated separately.

This coverage is subject to the following conditions and limitations:

Transplant services include the recipient's medical, surgical and hospital services; inpatient immunosuppressive medications; and cost for organ or bone marrow/stem cell procurement. Transplant services are covered only if they are required to perform any of the following human to human organ or tissue transplants: allogeneic, autologous and syngeneic bone marrow/stem cell, cornea, heart, heart/lung, kidney, kidney/pancreas, liver, lung, pancreas or intestinal which includes small bowel, small bowel/liver or multivisceral. All other types of organ and tissue transplants will be considered experimental and will be excluded.

**Second Opinion**
The Plan will notify the Covered Person if a second opinion is required at any time during the determination of benefits period. If a Covered Person is denied a transplant procedure by the designated transplant facility, the Plan will allow them to go to a second designated transplant facility for evaluation. If the second facility determines, for any reason, that the Covered Person is an unacceptable candidate for the transplant procedure, benefits will not be paid for further transplant related services and supplies, even if a third designated transplant facility accepts the Covered Person for the procedure.

**Pre-Certification Requirement:**
In order to obtain the Network Benefits, Covered Persons must contact the Transplant Coordinator as soon as they are informed that they may be a candidate for one of the covered transplant procedures. Please call the Transplant Coordinator at: Inside Illinois: 1-800-843-3831. Outside Illinois: 1-800-523-0582.

## EXTENDED CARE FACILITY / SKILLED NURSING FACILITY

The Plan will provide benefits to the maximum shown on the Schedule of Benefits for charges made by an Extended Care Facility for convalescing from an Illness or Injury. Covered Expenses include:

- Room and Board including charges for services such as general nursing care made in connection with room occupancy. The charge for daily Room and Board is limited to the semi-private room rate,
- Use of special treatment rooms, x-ray and laboratory examination, physical, occupational, or Speech Therapy and other medical services customarily provided by an Extended Care Facility except private duty or special nursing services or Physician's services,
- Drugs, biological solutions, dressings, casts and other Medically Necessary supplies.

Benefits are provided when an individual is confined in an Extended Care Facility if:

- The attending Physician certified that twenty-four (24) hour nursing care is necessary for the recuperation from an Injury or Illness which required the Hospital confinement, and
- He is confined in the Extended Care Facility to receive skilled nursing and physical restorative services for convalescence from the Illness or Injury that caused that Hospital confinement.

# HOME HEALTH CARE

The Plan will provide benefits to the maximum shown on the Schedule of Benefits, for charges made by a licensed Home Health Care Agency for the following services and supplies furnished to a Covered Person in his home, or the place of residence used as such person's home for the duration of his Illness or Injury, for care in accordance with a Home Health Care Plan.

The care must be administered in lieu of a Hospital or Extended Care Facility confinement. Expenses for, but not limited to, the following are covered under this benefit:

- Part-time or intermittent nursing care by a Registered Nurse (R.N.) or a Licensed Practical Nurse (L.P.N.).
- Part-time or intermittent Home Health Aide services.
- Physical, occupational, respiratory and Speech Therapy.
- Medical supplies, drugs and medicines prescribed by a Physician, and x-ray and laboratory services.
- Medical social services.
- Nutritional counseling.
- Renal Dialysis.

**The following Home Health Care Expenses are not covered under the Plan:**

- Meals, personal comfort items and housekeeping services.
- Services or supplies not prescribed in the Home Health Care Plan.
- Services of a person who ordinarily resides in the Covered Person’s home, or who is a member of the Covered Person’s or the Covered Person’s spouse's family.
- Transportation services.
- Treatment of Psychiatric Disorders of any type, including Substance Abuse.

# HOSPICE CARE

The Plan will provide benefits for care received through a home or Inpatient Hospice Care program to which a Terminally Ill Patient (not expected to live more than six (6) months) was referred by his attending Physician. Expenses for, but not limited to, the following are covered under this benefit:

- Inpatient Hospice, limited to the semi-private room rate.
- Part-time or intermittent nursing care by a Registered Nurse (R.N.) or by a Licensed Practical Nurse (L.P.N.).
- Physical, occupational, respiratory and Speech Therapy.
- Medical social services.
- Part-time or intermittent Home Health Aide services.
- Medical supplies, drugs, and medicines prescribed by a Physician, and x-ray and laboratory services.
- Physician's services.
- Dietary counseling.
- Bereavement counseling for immediate family members. Services must be furnished within six months after the patient's death.

**The following Hospice Care expenses are not covered under the Plan:**

- Transportation services.
- Financial or legal counseling for estate planning or drafting a will.

# US IMAGING NETWORK

US Imaging is a national diagnostic program for advanced radiology procedures including MRI, CT and PET scans. This radiology solution offers both the Plan and Covered Person the ability to lower advanced radiology costs while providing access to high-quality facilities.

US Imaging also includes an enhanced VIP concierge scheduling service. The US Imaging radiology program begins as soon as a Covered Person is prescribed an advanced radiology test. First, a Covered Person or prescribing Physician contacts US Imaging. Program representatives take care of the entire process, from scheduling an appointment on behalf of the Covered Person, to claims processing and Provider payment. Through the exclusive VIP appointment scheduling service, Covered Persons have access to appointment times and locations that meet their unique needs. Many appointments are available within twenty-four (24) - forty-eight (48) hours of request.

US Imaging appointment scheduling program schedules Covered Persons into our high-quality, cost effective facilities. The program works in the following manner:

1. US Imaging receives a call to schedule a test from the Covered Person, referring Provider or the Utilization Review Service used by the Covered Person's plan.
2. US Imaging will find the most convenient radiology facility that meets the Covered Person's needs (near office or home).
3. US Imaging educates the Covered Person about the test they are going to receive, what to expect during the test and how to prepare.
4. US Imaging obtains a copy of the prescription from the referring Provider and will fax the copy to the facility.
5. US Imaging provides an appointment confirmation and directions via email to the Covered Person.
6. US Imaging calls the Covered Person to remind them a day before their scheduled exam.

Refer to ID Card for Contact Information. Refer to the Schedule of Benefits for the US Imaging benefit level.

# MEDICAL EXPENSE EXCLUSIONS AND LIMITATIONS

In addition to the General Limitations and Exclusions stated elsewhere in this Plan, the Medical Provisions of this Plan do not cover any loss caused by, incurred for or resulting from:

**Abortions.** Abortion unless the mother's life is endangered, when Medically Necessary or as a result of rape or incest.

**Acupuncture**. Charges for acupuncture, including acupuncture provided in lieu of anesthetic.

**Alternative or Complementary Medicine**. Charges for services or supplies related to alternative or complimentary medicine. Excluded services include, but are not limited to:

- Acupuncture
- Biofeedback
- Holistic medicine
- Homeopathy
- Hypnosis
- Aromatherapy
- Massage therapy
- Reiki therapy
- Herbal, vitamin or dietary products or therapies
- Naturopathy
- Thermograph
- Orthomolecular therapy
- Contact reflex analysis
- Bioenergial synchronization technique (BEST)
- Iridology study of the iris

**Assistant Surgeons and Co-Surgeons related to podiatry surgery**.

**Autism**. Charges for autism spectrum disorder or pervasive developmental conditions, developmental delays or sensory integration disorders, unless otherwise required by law or when specifically identified elsewhere as a Covered Expense.

**Behavioral Problems**. Services or supplies received during an Inpatient stay when the stay is primarily for behavioral problems or social maladjustment or other anti-social actions which are not specifically the result of mental Illness.

**Chelation Therapy.** Charges for chelation (metallic ion) therapy.

**Cosmetic Surgery**. 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, except to the extent where it is needed for: (a) repair or alleviation of damage resulting from an Accident; (b) because of infection or Illness; (c) because of congenital Disease, developmental condition or anomaly of a covered Dependent Child which has resulted in a functional defect. 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. The term "cosmetic services" includes those services which are described in IRS Code Section 213(d)(9).

**Custodial Care**. Charges for care that does not restore health, unless specifically mentioned otherwise. Refer to definition of Custodial Care.

**Educational or Developmental Training.** Charges for testing, training or rehabilitation for educational, developmental or vocational purposes.

**Fertility**. Charges for services to restore or enhance fertility, including, but not limited to, artificial insemination, in vitro fertilization, embryo transfer procedures and sterilization reversal.

**Foot Care.** Foot care resulting from:

a. Weak, strained, unstable, unbalanced or flat feet.
b. Metatarsalgia or bunions, unless an open cutting operation is performed.
c. Treatment of corns, calluses or toenails, unless at least part of the nail root is removed or care is necessary for metabolic or peripheral vascular disease.

In addition, supportive devices (orthotics) for such conditions are not covered.

**Genetic Treatment or Engineering**. Charges for genetic treatment and engineering, except to the extent required by the Affordable Care Act (ACA).

**Impotence.** Care, treatment, services, supplies or medication in connection with treatment for impotence that are not related to organic disease.

**Learning Disability**. Charges for treatment of a learning disability which are not specifically the result of mental Illness.

**Marriage Counseling or Sexual Therapy**. Charges for marriage counseling and/or sexual therapy.

**Milieu therapy**. Milieu therapy or any confinement in an institution primarily to change or control one's environment.

**Miscellaneous Charges**. Charges for any of the following items, including their prescription or fitting, except as shown as a Covered Expense:

a. Hearing aids.
b. Optical or visual aids, including contact lenses and eyeglasses; visual analysis testing, vision therapy, training related to muscular imbalance of the eye or eye exercises.
c. Wigs.
d. Hair Transplants.
e. Orthopedic shoes.
f. Any examination to determine the need for, or the proper adjustments of any item listed above.
g. Any procedure or surgical procedure to correct refractive error.

**Morbid Obesity**. Charges for care, treatment, surgery, services or supplies that are primarily for morbid obesity, unless otherwise stated.

**Not Approved or Recognized.** Charges for care:

1. Not approved or accepted as essential to the treatment of any Illness or Injury by any of the following: the American Medical Association, the United States Surgeon General, the United States Department of Public Health, or the National Institute of Health.
2. Not recognized by the medical community as potentially safe and efficacious for the care and treatment of the Injury or Illness.

**Nutritional Supplements**. Charges for nutritional supplements, vitamins, or minerals. Charges for nutritional formulas and dietary supplements, except as shown as a Covered Expense, including but not limited to, nutritional formulas and dietary supplements that can be purchased over the counter; vitamins and food replacements, such as infant formulas and nutritional formulas.

**Obesity**. Charges for care, treatment, surgery, services or supplies that are primarily for obesity, weight reduction or dietary control, including but not limited to vitamins, diet supplements or enrollment in health, athletic or similar clubs or exercise programs, whether formal or informal and whether or not recommended by a Physician, or complications thereof. Specifically excluded are charges for bariatric surgery, including but not limited to, gastric bypass, stapling and intestinal bypass, and lap band surgery, including reversals. Medically Necessary surgical and non-surgical charges for Morbid Obesity are not covered. This exclusion does not apply to obesity screening and counseling that are covered under the Preventive Care benefit.

**Oral Care**. The care and treatment of the teeth, gums or alveolar process, and dentures, appliances or supplies used in such care and treatment, extraction, restoration and replacement of teeth; medical or surgical treatments of dental conditions and services to improve dental clinical outcomes; except as shown as Covered Expenses.

**Orthognathic Surgery.** Surgery to correct a receding or protruding jaw.

**Personal Hygiene or Comfort Items**. Personal hygiene, comfort or convenience items that do not qualify as Durable Medical Equipment and are generally useful to the Covered Person's household, including but not limited to:

a. All types of beds, other than Hospital type beds that qualify as a Covered Expense.
b. Air conditioners, humidifiers ***(unless attached to covered equipment)***, air cleaners, filtration units and related apparatus.
c. Whirlpools, saunas, swimming pools and related apparatus.
d. Medical equipment generally used only by Physicians in their work.
e. Vans and van lifts, stair lifts and similar other ambulatory apparatus.
f. Exercise bicycles and other types of physical fitness equipment.

**Physical or Occupational Therapy**. Physical or Occupational Therapy when it is not a constructive therapeutic activity designed and adapted to promote the improvement of physical function and expenses for supportive (maintenance/palliative) care treatment when maximum therapeutic benefit has been reached.

**Private duty nursing**. Charges in connection with care, treatment or services of a private duty nurse.

**Radial Keratotomy.** Charges for radial keratotomy.

**Recreational or Educational Therapy**. Recreational or educational therapy or forms of non-medical self-care or self-help training and any diagnostic testing.

**School Physicals.** Expenses in connection with school physicals required by a third party.

**Sex Assignment/Reassignment.** Related to a sex change operation.

**Sexual Dysfunction Therapy or Surgery.** For sexual dysfunctions or inadequacies that do not have psychological or organic basis.

**Special Braces and Related Equipment**. Special braces, splints, equipment, appliances, battery or anatomically controlled implants unless Medically Necessary.

**Surrogate Mother**. Services or supplies for surrogate mothers (unless the surrogate is a Covered Person, in which case the Preventive Care and/or Pregnancy expenses will be covered in accordance with the Plan provisions).

**Temporomandibular Joint (TMJ) Dysfunction.** Treatment of temporomandibular joint (TMJ) dysfunction with intraoral prosthetic devices, or any other method to alter vertical dimension.

**Travel**. Travel for health.

**Weekend Admissions**. Hospital charges that are incurred prior to the first Monday of a confinement that begins on a Friday, Saturday or Sunday, unless:

a. Such confinement is due to a Medical Emergency.
b. Surgery is performed within twenty-four (24) hours after such confinement begins.

**Any Other Excluded Items**. Any item shown in General Limitations and Exclusions.

# COVERED DENTAL SERVICES

The Dental Expense Benefit has been designed to help Covered Persons pay for their family's dental expenses and orthodontic treatment.

This benefit covers only those dental expenses which are performed by a licensed Dentist or by a licensed Dental Hygienist if rendered under the supervision and guidance of a Dentist.

Covered Dental Expenses are further limited to those services and supplies customarily employed for treatment of dental conditions only if rendered in accordance with accepted standards of dental practice.

This benefit covers the services included in the Covered Dental Services, appearing on later pages. The list is divided into Preventive, Basic, Major and Orthodontic services.

If a dental service is performed that is not on the list and the service is not excluded by this Plan, but the list contains a similar service that is suitable for the condition being treated, then benefits will be payable as if the listed service was the one actually performed.

**A charge will be considered to be incurred:**

- For dentures or partials - on the date the impression is taken.
- For fixed bridgework, crowns, inlays or onlays - on the date the tooth or teeth are prepared and the final impressions are made.
- For root canal therapy - on the date the pulp chamber is opened and explored.
- For all other services - on the date the service is performed.

## DEDUCTIBLE AMOUNT

The Dental Deductible, if applicable, is the amount of Covered Dental Expenses which Covered Persons must pay before benefits are payable by the Plan. The Dental Deductible is shown on the Schedule of Benefits and must be satisfied each Calendar Year.

**FAMILY DEDUCTIBLE**
When covered family members have satisfied the Family Deductible amount as shown on the Schedule of Benefits in a Calendar Year (no person can contribute more than the Individual Deductible amount), the Plan will not apply Dental Deductibles to the remaining Covered Dental Expenses for all covered family members for that Calendar Year.

**CO-INSURANCE FACTOR**

After the Calendar Year Deductible is satisfied, the Plan will pay benefits at the applicable Co-insurance percentage shown on the Schedule of Benefits for all eligible dental expenses incurred by that individual during the remainder of that Calendar Year.

## CALENDAR YEAR MAXIMUM BENEFIT

The Maximum Benefit shown on the Schedule of Benefits applies separately to each Covered Person for all dental services, not including orthodontic services, received in any one (1) Calendar Year.

## ALTERNATE TREATMENT

Many dental conditions can be treated in more than one way. This Plan has an "alternate treatment" clause which governs the amount of benefits the Plan will pay for treatments covered under the Plan. If a patient chooses a more

expensive treatment than is needed to correct a dental problem according to accepted standards of dental practice, the benefit payment will be based on the cost of the treatment which provides professionally satisfactory results at the most cost-effective level. Excess charges for a veneer or facing (i.e., a "tooth-colored" exterior) on a crown or pontic or a tooth-colored restoration is not covered on a tooth posterior to the second bicuspid but will be considered "cosmetic". The maximum allowance will be the allowance for the least costly restoration which will provide a functional result.

## ORTHODONTIC EXPENSE BENEFIT

When all Covered Persons incur(s) expenses on the accompanying Covered Dental Services and such expense is incurred while this coverage is in force for all Covered Persons and treatment is rendered by a Dentist as defined herein, the Plan will pay the benefits as determined for the reasonable charges actually incurred.

**ORTHODONTIC PROCEDURE**
Orthodontic procedures means movement of teeth by means of active appliances to correct the position of maloccluded or malpositioned teeth.

**COVERED EXPENSES**
The total Covered Expenses scheduled to be made in accordance with an Orthodontic Treatment Plan shall be payable in equal quarterly installments over a period of time equal to the estimated duration of the Orthodontic Treatment Plan; however, the number of quarterly installments shall not exceed eight. The first installment shall become payable on the date on which the orthodontic appliances were first installed, and subsequent installments shall become payable at the end of each three (3) month period thereafter.

Charges are covered only to the extent that they are made in connection with an orthodontic procedure which is required by one (1) or more of the following conditions:

1. Overbite or overjet of at least four (4) millimeters.
2. Maxillary (upper) and mandibular (lower) arches in either protrusive or retrusive relation of at least one (1) cusp.
3. Cross-bite.
4. An arch length discrepancy of more than four (4) millimeters in either the upper or lower arch.

**ORTHODONTIC MAXIMUM BENEFIT**
The Maximum Benefit shown on the Schedule of Benefits applies separately to each covered Dependent for all Orthodontic benefits received in a lifetime.

## COVERED DENTAL SERVICES

### PREVENTIVE AND DIAGNOSTIC DENTAL PROCEDURES

Routine oral exams. This includes the cleaning and scaling of teeth. Limit of two (2) per Covered Person each Calendar Year.

One (1) bitewing x-ray series every Calendar Year.

One (1) full mouth x-ray every twenty-four (24) months.

One (1) fluoride treatment for covered Dependent children under age sixteen (16) each Calendar Year.

Space maintainers for covered Dependent children under age sixteen (16) to replace primary teeth.

Sealants on the occlusal surface of a permanent posterior tooth for Dependent children under age sixteen (16), once per tooth in any three (3) years.

### BASIC SERVICES

Dental x-rays not included in Preventative and Diagnostic Dental Procedures section.

Oral surgery. Extraction of teeth, including simple extractions and surgical extraction of bone or tissue-impacted teeth. Other surgical and adjunctive treatment of disease, injury and defects of the oral cavity and associated structures.

Periodontics (gum treatments).

Extractions. This service includes local anesthesia and routine post-operative care.

Recementing bridges, crowns or inlays.

Fillings, other than gold.

General anesthetics, upon demonstration of Medical Necessity.

Antibiotic drugs.

Emergency palliative treatment for pain.

Repair of crowns, bridgework and removable dentures.

Rebasing or relining of removable dentures.

Endodontics (root canals).

### MAJOR DENTAL PROCEDURES

Gold restorations, including inlays, onlays and foil fillings. The cost of gold restorations in excess of the cost for amalgam, synthetic porcelain or plastic materials will be included only when the teeth must be restored with gold.

Installation of crowns

Installing precision attachments for removable dentures.

## MAJOR DENTAL PROCEDURES - CONTINUED

Installing partial, full or removable dentures to replace one or more natural teeth. This service also includes all adjustments made during six months following the installation.

Addition of clasp or rest to existing partial removable dentures.

Initial installation of fixed bridgework to replace one or more natural teeth.

Replacing an existing removable partial or full denture or fixed bridgework; adding teeth to an existing removable partial denture; or adding teeth to existing bridgework to replace newly extracted natural teeth. However, this item will apply only if:

- The existing denture or bridgework was installed at least five years prior to its replacement and cannot currently be made serviceable.
- The existing denture is of an immediate temporary nature. Further, replacement by permanent dentures is required and must take place within 12 months from the date the temporary denture was installed.

## ORTHODONTIC TREATMENT AND APPLIANCES

This is treatment to move teeth by means of appliances to correct a handicapping malocclusion of the mouth.

Payments for comprehensive full-banded orthodontic treatments are made in installments.

## DENTAL EXPENSE EXCLUSIONS AND LIMITATIONS

The Dental Expense Benefit provisions of this Plan do not cover any loss caused by, incurred for, or resulting from:

**Any item shown in the General Limitations and Exclusions section.**

**Administrative Costs.** Administrative costs of completing claim forms or reports or for providing dental records.

**Broken Appointments.** Charges for broken or missed dental appointments.

**Certain Appliances, Restorations, or Procedures.** Appliances, restorations, or procedures for the purpose of altering vertical dimension, restoring or maintaining occlusion, splinting, replacing tooth structure lost as a result of abrasion or attrition or treatment of disturbances of the temporomandibular joint.

**Cosmetic and/or Congenital or Developmental Malformation.** A service furnished a Covered Person for:

a. Cosmetic purposes, unless necessitated as a result of accidental injuries sustained while such person was covered under this Plan and for the repair of which the service is furnished while the individual remains a Covered Person. For purposes of this limitation, facings on crowns or pontics posterior to the second bicuspid and the personalization and characterization of dentures shall always be considered cosmetic.

b. Dental care of a congenital or developmental malformation (unless an Orthodontic Benefit provision is specifically included and made a part of this Plan).

**Crowns.** Crowns for teeth that are restorable by other means or for the purpose of Periodontal Splinting.

**Dental Services Which Are Covered Expenses Under Any Other Provision In This Plan.** Any dental services or supplies which are included as Covered Expenses under any other provision in this Plan, or under any other group plan carried or sponsored by the Company.

**Duplicate X-Rays.**

**Implants.** Implants, including any appliances and/or crowns and the surgical insertion or removal of implants.

**Initial Placement of Denture or Fixed Bridgework.** The initial placement of a partial or full removable denture or fixed bridgework, including crowns and inlays forming the abutments, if involving the replacement of one (1) or more natural teeth extracted prior to the Covered Person becoming covered under this Plan, unless the denture or fixed bridgework also includes the replacement of a natural tooth which is extracted while the Covered Person is covered under this Plan.

**Lost, Missing or Stolen Prosthetic Device.** Replacement of lost, missing or stolen Prosthetic Device or any other device or appliance.

**Lost, Missing or Stolen Orthodontic Appliances.** Replacement of lost, missing or stolen orthodontic appliances.

**Missing Tooth.** Charges for partials, bridges, or implants needed due a missing tooth if the tooth was extracted prior to enrolling in this Plan. This Exclusion does not apply for congenitally missing natural teeth.

**Myofunctional Therapy.** Muscle training therapy or training to correct or control harmful habits.

**Not Furnished by a Dentist.** A service not furnished by a Dentist, unless the service is performed by a licensed Dental Hygienist under the supervision of a Dentist or an x-ray ordered by a Dentist.

**No listing.** Services which are not included in the list of covered dental services.

**Not Necessary.** A service not reasonably necessary or not customarily performed for the dental care of the Covered Person.

**Occlusal Restoration**. Procedures, appliances, or restorations that are performed to alter, restore or maintain occlusion (i.e., the way the teeth mesh), including:

a. increasing the vertical dimension;
b. replacing or stabilizing tooth structure lost by attrition;
c. realignment of teeth;
d. gnathological recording or bite registration or bite analysis;
e. occlusal equilibration.

**Orthodontic Service.** An orthodontic service, unless specifically provided by an Orthodontic Benefit provision included in and made a part of this Plan.

**Oral hygiene instruction, a plaque control program or dietary instructions.**

**Orthognathic Surgery.** Surgery to correct malposition's in the bones of the jaw.

**Personalization.** Personalization of dentures.

**Replacement of a Removable Partial or Denture or Fixed Bridgework.** The replacement of a removable partial or denture or fixed bridgework by a new denture or new bridgework, or the addition of teeth to an existing partial removable denture to replace extracted natural teeth, is covered only due to one (1) of the following:

a. The replacement or addition of teeth is required to replace one (1) or more natural teeth extracted while covered under this Plan.
b. The existing denture or bridgework was installed at least five (5) years prior to its replacement and the existing denture or bridgework cannot be made serviceable.
c. An accidental bodily Injury sustained while the Covered Person is covered under this Plan.

**Services or Supplies That Do Not Meet Accepted Standards**. Services or supplies that do not meet accepted standards of dental practice including, but not limited to, services which are Investigational or Experimental in nature.

**Splinting.** Crowns, fillings or appliances that are used to connect (splint) teeth, or change or alter the way the teeth meet, including altering the vertical dimension, restoring the bite (occlusion) or are cosmetic.

**Sport.** Services or supplies of the type normally intended for sport or home use such as athletic mouth guards, toothpaste, toothbrushes, etc.

**Temporary Restorations and Appliances.** Excess charges for temporary restorations and appliances. The eligible expenses for the permanent restoration or appliance will be the maximum covered charge.

**TMJ.** Treatment, by any means, of jaw joint problems including temporomandibular joint (TMJ) dysfunction and other craniomandibular disorders, or other conditions of the joint linking the jawbone and skull, and the muscles, nerves, and other tissues related to that joint, and appliances.

# VISION CARE EXPENSE BENEFIT

The Vision Expense Benefit has been designed to provide reimbursement for the expenses incurred for the cost of vision examinations, lenses, and frames prescribed by a legally qualified Ophthalmologist or Optometrist.

## COVERED EXPENSES

Covered Expenses include the following services or supplies and are payable up to the maximum amounts shown on the Schedule of Benefits:

## VISION EXAMINATION

- The examination may include an ocular case history, external examination, ophthalmoscopic examination, refraction, binocular measure, tonometry, or any other Medically Necessary vision test, prescription for corrective lenses when indicated, summary and findings, and inspection of any corrective lenses prescribed.
- Vision examination charges are considered a Covered Expense once in any 12 month period.

## LENSES

- The charge for one (1) pair of the following lenses once in any 24 month period:
- Single Vision Lenses
- Bifocal or equivalent progressive lenses
- Trifocal or equivalent progressive lenses
- Lenticular lenses
- Contact lenses, if required after cataract surgery, or when required to correct visual acuity to 20/40 in the better eye when such a correction is not possible with other lenses.
- Contact lenses for any other purpose.

***The limit for one (1) lens is one-half the per pair limit.***

## FRAME

- The charge for one (1) frame in any 24 month period.

***Frames are not available in conjunction with contact lenses.***

When lenses and frames are purchased at the same time, the combined limit is the total of the lens and frame limits, and separate lens and frame limits will not be applied.

## VISION CARE EXCLUSIONS AND LIMITATIONS

The Vision Expense Benefit provisions of this Plan do not cover any loss caused by, incurred for or resulting from:

**Any item shown in General Exclusions and Limitations.**

**Before covered.** Care, treatment or supplies for which a charge was incurred before a person was covered under this Plan.

**Duplicate or spare-eyeglasses or lenses or frames.**

**Excluded.** Charges excluded or limited by the Plan design as stated in this document.

**Health plan.** Any charges that are covered under a health plan that reimburses a greater amount than this Plan.

**Medical or Surgical Treatment or Supplies.** Any medical or surgical treatment or supplies (including prosthetic devices) furnished for surgical or medical care for the treatment of an eye disease and/or Injury.

**Non-prescription lenses of any kind.**

**Not Recommended and Approved.** Vision care expenses incurred which were not recommended and approved by a licensed Optometrist or Ophthalmologist.

**Orthoptics.** Charges for orthoptics (eye muscle exercises).

**Replacement.** Replacement, at other than the normal policy period, of lenses or frames which were furnished under this Plan and which have been lost, stolen, or broken.

**Sunglasses.** Sunglasses, with or without a prescription, and charges for tinting and anti-reflective coatings.

**Training.** Charges for vision training or subnormal vision aids.

**Visual Aids.** Subnormal vision aids, such as ocular microscopes, ocular telescopes or hand-held magnifiers.

# GENERAL EXCLUSIONS AND LIMITATIONS

Some health care services are not covered by the Plan. Coverage is not available from the Plan for charges arising from care, supplies, treatment, and/or services:

**Administrative Costs.** That are solely for and/or applicable to administrative costs of completing claim forms or reports or for providing records wherever allowed by applicable law and/or regulation.

**After the Termination Date.** That are Incurred by the Covered Person on or after the date coverage terminates, even if payments have been predetermined for a course of treatment submitted before the termination date, unless otherwise deemed to be covered in accordance with the terms of the Plan or applicable law and/or regulation.

**Alcohol.** Services, supplies, care or treatment to a Covered Person for an Injury or Sickness which occurred as a result of that Covered Person's illegal use of alcohol. The responding officer's determination of inebriation will be sufficient for this exclusion, but is not required. The Plan may rely on any information contained in the medical records, traffic collision report, toxicology report, or other documentary evidence. Expenses will be covered for Injured Covered Persons other than the person illegally using alcohol and expenses will be covered for Substance Abuse treatment as specified in this Plan. This exclusion does not apply if the Injury resulted from an act of domestic violence or a medical (including both physical and mental health) condition.

**Broken Appointments.** That are charged solely due to the Covered Person's having failed to honor an appointment.

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

**Condition of Employment.** That are required by any employer as a condition of employment, or rendered through a medical department, clinic or other similar facility provided by an employer or by a union Employee benefit association or similar group of which the person is a member, unless otherwise covered under this Plan.

**Confined Persons.** That are for services, supplies, and/or treatment of any Covered Person that Incurred while confined and/or arising from confinement in a prison, jail or other penal institution with said confinement exceeding twenty-four (24) consecutive hours.

**Custodial Care.** That do not restore health, unless specifically mentioned otherwise.

**Deductible.** That are amounts applied toward satisfaction of Deductibles and expenses that are defined as the Covered Person's responsibility in accordance with the terms of the Plan.

**Excess.** That exceed Plan limits, set forth herein and including (but not limited to) the Maximum Allowable Charge in the Plan Administrator's discretion and as determined by the Plan Administrator, in accordance with the Plan terms as set forth by and within this document.

**Experimental and/or Investigational.** That are for charges that are Experimental and/or Investigational.

**Family Member.** That are performed by a person who is related to the Covered Person as a Spouse, parent, Child, brother or sister, whether the relationship exists by virtue of "blood" or "in law".

**Government.** That the Covered Person obtains, but which is paid, may be paid, is provided or could be provided for at no cost to the Covered Person through any program or agency, in accordance with the laws or regulations of any government, or where care is provided at government expense, unless there is a legal obligation for the Covered Person to pay for such treatment or service in the absence of coverage. This exclusion does not apply when otherwise prohibited by law, including laws applicable to Medicaid and Medicare.

**Government-Operated Facilities.**

a. That are furnished to the Covered Person in any veteran's Hospital, military Hospital, institution or facility operated by the United States government or by any State government or any agency or instrumentality of such governments.
b. That can be paid for by any government agency, even if the patient waives his rights to those services or supplies.

NOTE: This exclusion does not apply to treatment of non-service related disabilities or for Inpatient care provided in a military or other Federal government Hospital to Dependents of active duty armed service personnel or armed service retirees and their Dependents. This exclusion does not apply where otherwise prohibited by law.

**Health Examinations.** That are required for the use of a third party, unless otherwise covered under this Plan.

**Hospital Employees**. Professional services billed by a Physician or nurse who is an employee of a Hospital or Skilled Nursing Facility and paid by the Hospital or facility for the service.

**Illegal Acts.** That are for any Injury or sickness which is Incurred while taking part or attempting to take part in an illegal activity, including but not limited to misdemeanors and felonies, even if the cause of the Illness or Injury is not related to the commission of the illegal act. It is not necessary that an arrest occur, criminal charges be filed, or, if filed, that a conviction result. Proof beyond a reasonable doubt is not required to be deemed an illegal act. This exclusion does not apply if the Injury (a) resulted from being the victim of an act of domestic violence, or (b) resulted from a documented medical condition (including both physical and mental health conditions).

**Illegal Drugs or Medications**. That are services, supplies, care or treatment to a Covered Person for Injury or sickness Incurred while the Covered Person was voluntarily taking or was under the influence of any controlled substance, Drug, hallucinogen or narcotic not administered on the advice of a Physician, even if the cause of the Illness or Injury is not related to the use of the controlled substance, drug, hallucinogen or narcotic. Expenses will be covered for Injured Covered Persons other than the person using controlled substances and expenses will be covered for Substance Abuse treatment as specified in this Plan. This exclusion does not apply if the Injury (a) resulted from being the victim of an act of domestic violence, or (b) resulted from a documented medical condition (including both physical and mental health conditions).

**Incurred by Other Persons.** That are expenses actually Incurred by other persons.

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

**Medical Necessity.** That are not Medically Necessary and/or arise from services and/or supplies that are not Medically Necessary.

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

**Negligence.** That are for Injuries resulting from negligence, misfeasance, malfeasance, nonfeasance or malpractice on the part of any caregiver, institution, or Provider, as determined by the Plan Administrator, in its discretion, in light of applicable laws and evidence available to the Plan Administrator.

**No Coverage.** That are Incurred at a time when no coverage is in force for the applicable Covered Person and/or Dependent.

**No Legal Obligation.** That are for services provided to a Covered Person for which the Provider of a service does not and/or would not customarily render a direct charge, or charges Incurred for which the Covered Person or Plan has no legal obligation to pay, or for which no charges would be made in the absence of this coverage, including but not limited to charges for services not actually rendered, fees, care, supplies, or services for which a person, company or any other entity except the Covered Person or the Plan, may be liable for necessitating the fees, care, supplies, or services.

**No Physician Recommendation.** Care, treatment, services or supplies not recommended and approved by a Physician; or treatment, services or supplies when the Covered Person is not under the regular care of a Physician. Regular care means ongoing medical supervision or treatment which is appropriate care for the Injury or Sickness.

**Non-Prescription Drugs.** That are for drugs for use outside of a Hospital or other Inpatient facility that can be purchased over-the-counter and without a Physician's written prescription. Drugs for which there is a non-prescription equivalent available. This does not apply to the extent the non-prescription drug must be covered under Preventive Care, subject to the Affordable Care Act.

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

**Not Caused By Illness or Resulting From Bodily Injury.** That are not caused by Illness or not resulting from bodily Injury, except as shown as a Covered Expense.

**Not Covered Provider.** That are performed by Providers that do not satisfy all the requirements per the Provider definition as defined within this Plan.

**Not specified as Covered.** Non-traditional medical services, treatments and supplies which are not specified as covered under this Plan.

**Occupational.** That are for any condition, Illness, Injury or complication thereof arising out of or in the course of employment, including self-employment, or an activity for wage or profit where workers' compensation or another form of occupational Injury medical coverage is available.

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

**Postage, Shipping, Handling Charges, Etc.** That are for any postage, shipping or handling charges which may occur in the transmittal of information to the Claims Administrator; including interest or financing charges.

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

**Prohibited by Law.** That are to the extent that payment under this Plan is prohibited by law.

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

**Self-Inflicted.** That are Incurred due to an intentionally self-inflicted Injury or Illness, not definitively arising from (a) being the victim of an act of domestic violence, or (b) resulting from a documented medical condition (including both physical and mental health conditions).

**Standards of Medical or Dental Practice.** That do not meet accepted standards of medical or dental practice including, but not limited to, services which are Experimental or Investigational in nature.

**Subrogation, Reimbursement, and/or Third Party Responsibility.** That are for an Illness, Injury or sickness not payable by virtue of the Plan's subrogation, reimbursement, and/or third party responsibility provisions.

**Telecommunications.** Advise or consultation given by or through any form of telecommunication.

**Timely Filing.** That are submitted more than twelve (12) months after the date Incurred, except that failure to submit within the stated time shall not invalidate or reduce any claim if it shall be shown not to have been reasonably possible to submit such claim in a timely manner and that the claim was submitted as soon as was reasonably possible.

**Travel.** That are Incurred outside the United States if:

a. The Covered Person traveled to such location to obtain medical services, drugs or supplies.
b. Such services, drugs or supplies are unavailable or illegal in the United States.

**Unbundling.** That are made separately for services and/or procedures, supplies and materials when they are considered to be included within the charge for a total service payable, or if the charge is payable to another provider.

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

**War/Riot.** That Incurred as a result of war or any act of war, whether declared or undeclared, or any act of aggression by any country, including rebellion or riot, 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, or voluntary participation in a riot. This exclusion does not apply to any Covered Person who is not a member of the armed forces, and does not apply to victims of any act of war or aggression.

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

# COORDINATION OF BENEFITS

The Coordination of Benefits provision is intended to prevent payments of benefits which exceed expenses. It applies when the Employee or any eligible Dependent who is covered by this Plan is also covered by any other plan or plans. When more than one (1) coverage exists, one (1) plan normally pays its benefits in full and the other plan(s) pay a reduced benefit. This Plan will always pay either its benefits in full or, when this Plan has secondary responsibility, a reduced amount which, when added to the benefits payable by the other plan or plans, will not exceed one hundred percent (100%) of the total allowable expenses. Only the amount paid by this Plan will be charged against the Plan maximums.

The Coordination of Benefits provision applies whether or not a claim is filed under the other plan or plans. If requested, authorization must be given to this Plan to obtain information as to benefits or services available from the other plan or plans, or to recover overpayment. All benefits contained in this Plan are subject to this provision.

**Benefits Subject to This Provision**
This following shall apply to the entirety of the Plan and all benefits described therein. There is no Coordination of Benefits within this Plan. Coordination is applicable only with other plans.

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

The Plan's benefits will be excess to, whenever possible:

1. Any primary payer besides the Plan.
2. Any first party insurance through medical payment coverage, personal injury protection (PIP), 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.

**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.

This Plan does not permit Covered Persons to opt out of no-fault auto insurance as the primary plan. If the Covered Person should opt out, be aware that this Plan will reimburse the Covered Person as the secondary plan only under the assumption that the Covered Person has received primary reimbursement from the Covered Peron's auto insurance to the maximum limit available. Therefore, in order to be eligible for secondary reimbursement for automobile-accident related medical costs, a Covered Person: (1) must have maximum PIP coverage, and (2) must have exceeded that coverage limit.

**Allowable Expenses**
"Allowable Expenses" shall mean the Reasonable and Customary charge for any Medically Necessary, and eligible item of expense, at least a portion of which is covered under a plan. When some Other Plan pays first in accordance with the Application to Benefit Determinations 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 instead of cash payments, the reasonable cash value of each service rendered, in the amount that would be payable in accordance with the terms of the Plan, 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.

**"Claim Determination Period"**
"Claim Determination Period" shall mean each Calendar Year.

**Effect on Benefits**

**Application to Benefit Determinations**
The plan that pays first according to the rules in the section entitled "Order of Benefit Determination" will pay as if there were no Other Plan involved. The secondary and subsequent plans will pay the balance due up to each one's plan formula minus the amount the primary plan paid. 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:

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

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

1. A plan without a coordinating provision will always be the primary plan.
2. The benefits of a plan which covers the person on whose expenses 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. The Plan that covers the person (and his or her dependents) as an active Employee, pays before the plan that covers the person as a retired or laid-off Employee or COBRA continuant.
4. If the person for whom claim is made is a dependent child covered under both parents' plans, the plan covering the parent whose birthday (month and day of birth, not year) falls earlier in the year will be primary, except:
    a. When the parents were never married, are separated or are divorced, and the parent with the custody of the child has not remarried, the benefits of a plan which covers the child as a dependent of the parent with custody will be determined before the benefits of a plan which covers the child as a dependent of the parent without custody.
    b. When the parents are divorced and the parent with custody of the child has remarried, the benefits of a plan which covers the child as a dependent of the parent with custody shall be determined before the benefits of a plan which covers that child as a dependent of the stepparent, and the benefits of a plan which covers that child as a dependent of the stepparent will be determined before the benefits of a plan which covers that child as a dependent of the parent without custody.

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

5. 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.
6. 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 provisions 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 an amount 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**
In accordance with the Recovery of Payments section, 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 section, the Plan shall have the right to recover such payments, to the extent of such excess, from any one (1) 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 his or her Dependents. Please see the Recovery of Payments section.

# THIRD PARTY RECOVERY, SUBROGATION AND REIMBURSEMENT

## PAYMENT CONDITION

1. The Plan, in its sole discretion, may elect to conditionally advance payment of benefits in those situations where an Injury, sickness, Illness or disability is caused in whole or in part by, or results from the acts or omissions of Covered Persons, 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").

2. Covered Person(s), his or her attorney, and/or legal guardian of a minor or incapacitated individual agrees that acceptance of the Plan's conditional payment of medical benefits is constructive notice of these provisions in their entirety and agrees to maintain one hundred percent (100%) of the Plan's conditional payment of benefits or the full extent of payment from any one (1) 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.

3. 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.

4. If there is more than one (1) 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

1. 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.

2. If a Covered Person(s) receives or becomes entitled to receive benefits, an automatic equitable lien attaches in favor of the Plan to any claim, which any Covered Person(s) may have against any Coverage and/or party causing the sickness 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.

3. 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.

4. If the Covered Person(s) fails to file a claim or pursue damages against:

    a. The responsible party, its insurer, or any other source on behalf of that party.
    b. Any first party insurance through medical payment coverage, personal injury protection, no-fault coverage, uninsured or underinsured motorist coverage.
    c. Any policy of insurance from any insurance company or guarantor of a third party.
    d. Workers' compensation or other liability insurance company.

the Covered Person(s) authorizes the Plan to pursue, sue, compromise and/or settle any such claims in the Covered Person(s)' 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

1. The Plan shall be entitled to recover one hundred percent (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 his or her recovery from all sources. The Plan shall have an equitable lien which supersedes all common law or statutory rules, doctrines, and laws of any State prohibiting assignment of rights which interferes with or compromises in any way the Plan's equitable lien and right to reimbursement. The obligation to reimburse the Plan in full exists regardless of how the judgment or settlement is classified and whether or not the judgment or settlement specifically designates the recovery or a portion of it as including medical, disability, or other expenses and extends until the date upon which the liable party is released from liability. If the 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.

2. 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.

3. 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.

4. 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).

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

## COVERED PERSON IS A TRUSTEE OVER PLAN ASSETS

1. 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 he or she is required to:

    a. Notify the Plan or its authorized representative of any settlement prior to finalization of the settlement, execution of a release, or receipt of applicable funds.
    b. Instruct his or her attorney to ensure that the Plan and/or its authorized representative is included as a payee on all settlement drafts.
    c. In circumstances where the 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.
    d. Hold any and all funds so received in trust, on the Plan's behalf, and function as a trustee as it applies to those funds, until the Plan's rights described herein are honored and the Plan is reimbursed.

2. 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 he or she exercises control, in an account segregated from their general accounts or general assets until such time as the dispute is resolved.

3. 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.

## EXCESS INSURANCE

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

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

1. The responsible party, its insurer, or any other source on behalf of that party.

2. Any first party insurance through medical payment coverage, personal injury protection, no-fault coverage, uninsured or underinsured motorist coverage.
3. Any policy of insurance from any insurance company or guarantor of a third party.
4. Workers' compensation or other liability insurance company.

## 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.

## WRONGFUL DEATH

In the event that the Covered Person(s) dies as a result of his or her Injuries and a wrongful death or survivor claim is asserted against a third party or any Coverage, the Plan's subrogation and reimbursement rights shall still apply, and the entity pursuing said claim shall honor and enforce these Plan rights and terms by which benefits are paid on behalf of the Covered Person(s) and all others that benefit from such payment.

## OBLIGATIONS

1. It is the Covered Person's/ Covered Persons' obligation at all times, both prior to and after payment of medical benefits by the Plan:

    a. To cooperate with the Plan, or any representatives of the Plan, in protecting its rights, including discovery, attending depositions, and/or cooperating in trial to preserve the Plan's rights.
    b. To provide the Plan with pertinent information regarding the sickness, Illness, disability, or Injury, including accident reports, settlement information and any other requested additional information.
    c. To take such action and execute such documents as the Plan may require to facilitate enforcement of its subrogation and reimbursement rights.
    d. To do nothing to prejudice the Plan's rights of subrogation and reimbursement.
    e. To promptly reimburse the Plan when a recovery through settlement, judgment, award or other payment is received.
    f. 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.
    g. To notify the Plan or its authorized representative of any settlement prior to finalization of the settlement.
    h. 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.
    i. To instruct his or her attorney to ensure that the Plan and/or its authorized representative is included as a payee on any settlement draft.
    j. 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.
    k. 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.
    l. If the Covered Person(s) and/or his or her attorney fails to reimburse the Plan for all benefits paid to be paid, Incurred, or that will be Incurred, prior to the date of the release of liability from the relevant entity, 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).
    m. 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 his or her attorney fails to comply with any of the requirements of the Plan, the Plan has the right, in addition to any other lawful means of recovery, to deduct the value of the 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

1. 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 his or her estate insofar as these subrogation and reimbursement provisions are concerned.

2. 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.

This Plan's Third Party Recovery, Subrogation, and Reimbursement right is subject to ERISA, which preempts individual state law.

# MEDICARE

Medicare means Title XVIII (Health Insurance for the Aged) of the United States Social Security Act, as added by the Social Security Amendments of 1965 or as later amended.

Full Medicare coverage means coverage for all the benefits provided under Medicare (including Medicare Part A and Part B) established by Medicare.

Medical charges as used in this provision with respect to any services, treatments or supplies, means the charges actually made for such services, treatments or supplies to the extent usual and customary.

## ACTIVE EMPLOYEES AGE SIXTY-FIVE (65) OR OVER

For active Employees age sixty-five (65) or over who continue to participate in this Plan, this Plan will provide its full regular benefits first and Medicare coverage would provide supplemental benefits for those expenses not paid by this Plan.

If the active Employee's Spouse is also enrolled in this Plan, this provision would apply to the Spouse during the period of time the Spouse is sixty-five (65) or over, regardless of the age of the Employee.

This provision does not apply to individuals entitled to Medicare because of end stage renal disease (ESRD) and/or disability.

## CERTAIN DISABLED INDIVIDUALS

(Employers with one hundred (100) or more Employees)

This Plan will be the primary payor and Medicare will be the secondary payor for the payment of benefits for Disabled individuals who are "currently working" (as defined by Medicare) covered Employees or covered Dependents of such Employees.

Effective August 10, 1993, Medicare will be the primary payor and this Plan will be the secondary payor for the payment of benefits for Disabled individuals who are not "currently working" (as defined by Medicare) covered Employees or covered Dependents of such Employees. The benefits of Medicare and this Plan are fully coordinated to provide benefits totaling not more than the actual expenses incurred.

This provision does not apply to "currently working" Disabled individuals entitled to Medicare because of end stage renal disease (ESRD) during the period of time which Medicare is the primary payor and the Plan is the secondary payor as prescribed by law.

## CERTAIN DISABLED INDIVIDUALS

(Employers with less than one hundred (100) Employees)

For covered individuals who are totally Disabled who are eligible for Medicare benefits, both Medicare Part A (Hospital portion) and Medicare Part B (doctor’s portion) will be considered the primary payor in computing benefits under this Plan. The benefits of Medicare and this Plan are fully coordinated to provide benefits totaling not more than the actual expenses incurred.

## APPLICABLE TO ALL OTHER COVERED PERSONS ELIGIBLE FOR MEDICARE

To the extent required by Federal regulations, this Plan will pay before any Medicare benefits. There are some circumstances under which Medicare would be required to pay its benefits first. In these cases, benefits under this Plan would be calculated as secondary payor (as described under the section entitled “Coordination of Benefits”). If the Provider accepts assignment with Medicare, Covered Expenses will not exceed the Medicare approved expenses.

For a Covered Person who is eligible for Medicare benefits, both Medicare Part A (Hospital portion) and Medicare Part B (doctor's portion) will be considered in computing benefits under this Plan.

## INDIVIDUALS WITH END STAGE RENAL DISEASE

For a Covered Person with end stage renal disease (ESRD) who is eligible for Medicare benefits, this Plan will be the primary payor and Medicare will be the secondary payor for the payment of benefits for the period of time specified by law, after which time Medicare will become the primary payor and this Plan will be the secondary payor. Both Medicare Part A (Hospital portion) and Medicare Part B (doctor's portion) will be considered in computing benefits under this Plan. The benefits of Medicare and this Plan are fully coordinated to provide benefits totaling not more than the actual expenses incurred.

This provision intends to comply with the TEFRA Act of 1982, the DEFRA Act of 1985, the COBRA Act of 1985 and the OMBRA Act of 1986 and all similar Federal acts.

# CONTINUATION OF COVERAGE

## EMPLOYER SPONSORED CONTINUATION COVERAGE

## CONTINUATION COVERAGE RIGHTS UNDER COBRA

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

The right to COBRA continuation coverage was created by a federal law, the Consolidated Omnibus Budget Reconciliation Act of 1985 (COBRA). COBRA continuation coverage can become available to you when you would otherwise lose your group health coverage. It can also become available to other members of your family who are covered under the Plan when they would otherwise lose their group health coverage. Under the Plan, certain Covered Persons and their eligible family members (called Qualified Beneficiaries) that elect COBRA Continuation Coverage must pay the entire cost of the coverage, including a reasonable administration fee. There are several ways coverage will terminate, including the failure of the Covered Person or their covered Dependents to make timely payment of contributions or premiums. For additional information, Covered Persons should contact the Participating Employer to determine if COBRA applies to him or her and/or his or her covered Dependents.

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

**What Is COBRA Continuation Coverage?**
COBRA continuation coverage is a continuation of Plan coverage when coverage would otherwise end because of a life event known as a "Qualifying Event". A qualifying event is any of those listed below if the Plan provided that the Participant would lose coverage (i.e., cease to be covered under the same terms and conditions as in effect immediately before the qualifying event) in the absence of COBRA continuation coverage. After a Qualifying Event, COBRA continuation coverage must be offered to each person who is a "Qualified Beneficiary". You, your Spouse and your Dependent Children could become Qualified Beneficiaries if coverage under the Plan is lost because of the Qualifying Event. Under the Plan, Qualified Beneficiaries who elect COBRA continuation coverage must pay the full cost of COBRA continuation coverage (the full cost means the Employee and Employer cost of coverage) before the group health coverage is continued **and** monthly payments must be made in order to continue the coverage.

If you are an Employee, you will become a Qualified Beneficiary if you lose your coverage under the Plan because either one (1) of the following Qualifying Events happens:

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

If you are the Spouse of an Employee, you will become a Qualified Beneficiary if you lose coverage under the Plan because any of the following Qualifying Events happens:

- Your Spouse dies.
- Your spouse's hours of employment are reduced.
- Your spouse's employment end for any reason other than gross misconduct.
- Your Spouse becomes entitled to Medicare benefits (Part A, Part B or both).

- You become divorced or Legally Separated from your Spouse.

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

- The parent-Employee dies.
- The parent-Employee's hours of employment are reduced.
- The parent-Employee's employment ends for any reason other than gross misconduct.
- The parent-Employee becomes entitled to Medicare benefits (Part A, Part B or both).
- The parents become divorced or Legally Separated.
- The Child stops being eligible for coverage under the Plan as a "Dependent Child".

Sometimes, filing a proceeding in bankruptcy under title eleven (11) of the United States Code can be a Qualifying Event, but only if the Plan offers retiree coverage. 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 with respect to the bankruptcy. The retired Employee's Spouse, surviving Spouse and Dependent Children will also become Qualified Beneficiaries if bankruptcy results in the loss of their coverage under the Plan.

**When Is COBRA Coverage Available?**
The Plan will offer COBRA continuation coverage to Qualified Beneficiaries only after the Plan Administrator has been notified that a Qualifying Event has occurred. When the Qualifying Event is the end of employment or the reduction of hours of employment, death of Employee, commencement of a proceeding in bankruptcy with respect to the Employer, or the Employee becoming entitled to Medicare benefits (Part A, Part B or both), the Employer must notify the Plan Administrator within thirty (30) days of any of these events.

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

**Employee Notice of Qualifying Events**
In certain circumstances, the covered Employee or Qualified Beneficiary, in order to protect his or her rights under COBRA, is required to provide notification to the COBRA Administrator in writing, either by U.S. First Class Mail or hand delivery. These circumstances are any of the following:

1. **Notice of Divorce or Separation:** Notice of the occurrence of a Qualifying Event that is a divorce or Legal Separation of a covered Employee (or former Employee) from his or her Spouse.
2. **Notice of Child's Loss of Dependent Status:** Notice of the occurrence of a Qualifying Event that is an individual's ceasing to be eligible as a Dependent Child under the terms of the Plan.
3. **Notice of a Second Qualifying Event:** Notice of the occurrence of a second Qualifying Event after a Qualified Beneficiary has become entitled to COBRA Continuation Coverage with a maximum duration of eighteen (18) (or twenty-nine (29) months.
4. **Notice Regarding Disability:** Notice that a Qualified Beneficiary entitled to receive COBRA Continuation Coverage with a maximum duration of eighteen (18) months has been determined by the Social Security Administration ("SSA") to be disabled at any time during the first sixty (60) days of COBRA Continuation Coverage.
5. **Notice Regarding End of Disability:** Notice that a Qualified Beneficiary, with respect to whom a notice described above in #4 has been provided, has subsequently been determined by the SSA to no longer be disabled.

As indicated above, Notification of a Qualifying Event must be made in writing. Notice must be made by submitting the "Notice of Qualifying Event" form and mailing it by U.S. First Class Mail or hand delivery to the COBRA Administrator. This form is available, without charge, from the COBRA Administrator.

Notification must include an adequate description of the Qualifying Event or disability determination. Please see the remainder of this section for additional information.

Notification must be received by the COBRA Administrator, who is:

TEAM Risk Management Strategies, LLC
3131 Camino Del Rio North, Suite 650
San Diego, CA 92108
Phone: 1-619-281-1100
Fax: 1-619-281-1926
Email/Website: https://team-risk.com

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

**Deadline for providing the notice**
For Qualifying Events described above, notice must be furnished within sixty (60) days of the latest occurring event set forth below:

1. The date upon which the Qualifying Event occurs.
2. The date upon which the Qualified Beneficiary loses (or would lose) Plan coverage due to a Qualifying Event.
3. The date upon which the Qualified Beneficiary is notified via the Plan's SPD or general notice, and/or becomes aware of their status as a Qualified Beneficiary and/or the occurrence of a Qualifying Event; as well as their subsequent responsibility to comply with the Plan's procedure(s) for providing notice to the COBRA Administrator regarding said status.

As described above, if an Employee or Qualified Beneficiary is determined to be disabled under the Social Security Act, the notice must be delivered no more than sixty (60) days after the latest of:

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

In any event, this notice must be provided within the first eighteen (18) months of COBRA Continuation Coverage.

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

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

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

**Who Can Provide the Notice**
Any individual who is the covered Employee (or former Employee) with respect to a Qualifying Event, or any representative acting on behalf of the covered Employee (or former Employee) or Qualified Beneficiary, may provide the notice. Notice by one individual shall satisfy any responsibility to provide notice on behalf of all related Qualified Beneficiaries with respect to the Qualifying Event.

**Required Contents of the Notice**
After receiving a notice of a Qualifying Event, the Plan must provide the Qualified Beneficiary with an election notice, which describes their rights to COBRA Continuation Coverage and how to make such an election. The notice must contain the following information:

1. Name and address of the covered Employee or former Employee.
2. Name of the Plan and the name, address, and telephone number of the Plan's COBRA administrator.
3. Identification of the Qualifying Event and its date (the initial Qualifying Event and its date if the Qualifying Participant is already receiving COBRA Continuation Coverage and wishes to extend the maximum coverage period).
4. A description of the Qualifying Event (for example, divorce, Legal Separation, cessation of Dependent status, entitlement to Medicare by the covered Employee or former Employee, death of the covered Employee or former Employee, disability of a Qualified Beneficiary or loss of disability status).
    a. In the case of a Qualifying Event that is divorce or Legal Separation, name(s) and address(es) of Spouse and Dependent Child(ren) covered under the Plan, date of divorce or Legal Separation, and a copy of the decree of divorce or Legal Separation.
    b. In the case of a Qualifying Event that is Medicare entitlement of the covered Employee or former Employee, date of entitlement, and name(s) and address(es) of Spouse and Dependent Child(ren) covered under the Plan.
    c. In the case of a Qualifying Event that is a Dependent Child's cessation of Dependent status under the Plan, name and address of the Child, reason the Child ceased to be an eligible Dependent (for example, attained limiting age).
    d. In the case of a Qualifying Event that is the death of the covered Employee or former Employee, the date of death, and name(s) and address(es) of Spouse and Dependent Child(ren) covered under the Plan.
    e. In the case of a Qualifying Event that is disability of a Qualified Beneficiary, name and address of the disabled Qualified Beneficiary, name(s) and address(es) of other family members covered under the Plan, the date the disability began, the date of the SSA's determination, and a copy of the SSA's determination.
    f. In the case of a Qualifying Event that is loss of disability status, name and address of the Qualified Beneficiary who is no longer disabled, name(s) and address(es) of other family members covered under the Plan, the date the disability ended and the date of the SSA's determination.
5. Identification of the Qualified Beneficiaries (by name or by status).
6. An explanation of the Qualified Beneficiaries' right to elect continuation coverage.
7. The date coverage will terminate (or has terminated) if continuation coverage is not elected.
8. How to elect continuation coverage.
9. What will happen if continuation coverage isn't elected or is waived.
10. What continuation coverage is available, for how long, and (if it is for less than thirty-six (36) months), how it can be extended for disability or second qualifying events.
11. How continuation coverage might terminate early.
12. Premium payment requirements, including due dates and grace periods.
13. A statement of the importance of keeping the Plan Administrator informed of the addresses of Qualified Beneficiaries.
14. A statement that the election notice does not fully describe COBRA or the plan and that more information is available from the Plan Administrator and in the SPD.
15. A certification that the information is true and correct, a signature and date.

If a copy of the decree of divorce or Legal Separation or the SSA's determination cannot be provided by the deadline for providing the notice, complete and provide the notice, as instructed, by the deadline and submit the copy of the decree of divorce or Legal Separation or the SSA's determination within thirty (30) days after the

deadline. The notice will be timely if done so. However, no COBRA Continuation Coverage, or extension of such Coverage, will be available until the copy of the decree of divorce or Legal Separation or the SSA's determination is provided.

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

**How Is COBRA Coverage Provided?**
Once the Plan Administrator receives notice that a Qualifying Event has occurred, COBRA continuation coverage will be offered to each of the Qualified Beneficiaries. Each Qualified Beneficiary has 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. When the Qualifying Event is the death of the Employee, your divorce or legal separation, a Dependent Child's losing eligibility as a Dependent or loss of coverage due to Medicare Entitlement (under Part A, Part B or both), COBRA continuation lasts for up to a total of thirty-six (36) months.

When the Qualifying Event is the end of employment or reduction of the Employee's hours of employment, and the Employee became entitled to Medicare benefits less than eighteen (18) months before the Qualifying Event, COBRA continuation coverage for Qualified Beneficiaries other than the Employee lasts until thirty-six (36) months after the date of Medicare entitlement. For example, if a Covered Employee becomes entitled to Medicare eight (8) months before the date on which his employment terminates, COBRA continuation coverage for his Spouse and children can last up to thirty-six (36) months after the date of Medicare entitlement, which is equal to twenty-eight (28) months after the date of the Qualifying Event (thirty-six (36) months minus eight (8) months).

Otherwise, when the Qualifying Event is the end of employment or reduction of the Employee's hours of employment, COBRA continuation coverage generally lasts for only up to a total of eighteen (18) months. There are two ways in which this eighteen (18) month period of COBRA continuation coverage can be extended.

**Disability Extension of the Eighteen (18) Month Period**
If you or anyone in your family covered under the Plan is determined by the Social Security Administration to be Disabled and you notify the Plan Administrator in writing in a timely fashion, you and your entire family may be entitled to receive up to an additional eleven (11) months of COBRA continuation coverage, for a total maximum of twenty-nine (29) months. The disability would have to have started some time before the sixtieth (60th) day of COBRA continuation coverage and last at least until the end of the eighteen (18) month period of COBRA continuation coverage. A copy of the Notice of Award from the Social Security Administration must be submitted to the Plan Administrator and the COBRA Administrator within sixty (60) days of receipt of Notice of Award and before the end of the eighteen (18) month period of COBRA continuation coverage.

**Second Qualifying Event Extension of Eighteen (18) Month Period**
If your COBRA covered family members experience another COBRA Qualifying Event within the first eighteen (18) months of COBRA continuation coverage, the Spouse and Dependent children in your family may be eligible to receive up to eighteen (18) additional months of COBRA continuation coverage, for a maximum of thirty-six (36) months, if notice of the secondary event is properly given to the Plan. This extension may be available to the Spouse and any Dependent Children receiving COBRA continuation coverage if the Employee or former Employee dies, or is divorced or Legally Separated, or if the Dependent Child stops being eligible under the Plan as a Dependent Child. In all cases, the eighteen (18) month extension is available only 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.

The following example shows how the second Qualifying Event rule works. Former Employee A elects eighteen (18) months of COBRA continuation coverage for the entire family. After the first six (6) months of COBRA

continuation coverage, former Employee A becomes entitled to Medicare (Part A, Part B or both). If former Employee A were still actively employed, entitlement to Medicare **would not** result in a loss of coverage under the Employer's Group Health Plan. The additional eighteen (18) month extension is not available for the former Employee's Spouse and Dependents because if Medicare entitlement had occurred during active employment there would have been no loss of Employer Group Health Plan coverage.

In all of these cases, you must notify the Plan Administrator within sixty (60) days of the second Qualifying Event.

**Early Termination of COBRA Continuation Coverage**
COBRA continuation coverage will terminate before the end of the maximum period if:

- The Qualified Beneficiary fails to make the required contributions when due.
- The Qualified Beneficiary becomes covered under another Group Health Plan after the date of the COBRA election.
- The Qualified Beneficiary becomes entitled to Medicare benefits (Part A, Part B or both) after electing COBRA continuation coverage.
- The Employer ceases to provide any Group Health Plan for its Employees.

**How Can You Elect COBRA Continuation Coverage?**
To elect COBRA continuation coverage, you must complete the Election Form and furnish it according to the directions on the form. Each Qualified Beneficiary has a separate right to elect COBRA continuation coverage. For example, the Employee's Spouse may elect COBRA continuation coverage even if the Employee does not. COBRA continuation coverage may be elected for only one, several or for all Dependent Children who are Qualified Beneficiaries. A parent may elect to continue COBRA continuation coverage on behalf of any Dependent Children. The Employee or the Employee's Spouse can elect COBRA continuation coverage on behalf of all of the Qualified Beneficiaries.

You should take into account that you have special enrollment rights under federal law. You have the right to request special enrollment in another Group Health Plan for which you are otherwise eligible (such as a plan sponsored by your spouse's employer) within thirty (30) days after your group health coverage ends because of the Qualifying Event listed above. You will also have the same special enrollment right at the end of COBRA continuation coverage if you elect COBRA continuation coverage for the maximum time available to you.

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

**How Much Does COBRA Continuation Coverage COST?**
Generally, each Qualified Beneficiary may be required to pay the entire cost of COBRA continuation coverage. The amount a Qualified Beneficiary may be required to pay may not exceed one hundred two percent (102%) (or, in the case of an extension of COBRA continuation coverage due to a disability, one hundred fifty percent (150%) of the cost to the Group Health Plan (including both Employer and Employee contributions) for coverage of a similarly situated Covered Person or Beneficiary who is not receiving COBRA continuation coverage.

**You may be able to get coverage through the Health Insurance Marketplace that costs less than COBRA continuation coverage.** You can learn more about the Marketplace below.

**What is the Health Insurance Marketplace?**
The Marketplace offers "one-stop shopping" to find and compare private health insurance options. In the Marketplace, you could be eligible for a new kind of tax credit that lowers your monthly premiums and cost-sharing reductions (amounts that lower your out-of-pocket costs for deductibles, Co-insurance, and Co-payments) right away, and you can see what your premium, deductibles, and out-of-pocket costs will be before you make a decision to enroll. Through the Marketplace you'll also learn if you qualify for free or low-cost coverage from Medicaid or

the Children's Health Insurance Program (CHIP). You can access the Marketplace for your State at www.HealthCare.gov.

Coverage through the Health Insurance Marketplace may cost less than COBRA continuation coverage. Being offered COBRA continuation coverage won't limit your eligibility for coverage or for a tax credit through the Marketplace.

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

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

**If I sign up for COBRA continuation coverage, can I switch to coverage in the Marketplace? What about if I choose Marketplace coverage and want to switch back to COBRA continuation coverage?**
If you sign up for COBRA continuation coverage, you can switch to a Marketplace plan during a Marketplace annual enrollment period. You can also end your COBRA continuation coverage early and switch to a Marketplace plan if you have another Qualifying Event such as marriage or birth of a child through something called a "special enrollment period." But be careful though - if you terminate your COBRA continuation coverage early without another qualifying event, you'll have to wait to enroll in Marketplace coverage until the next annual enrollment period, and could end up without any health coverage in the interim.

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

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

**Can I enroll in another Group Health Plan?**
You may be eligible to enroll in coverage under another Group Health Plan (like a spouse's plan), if you request enrollment within thirty (30) days of the loss of coverage.

If you or your dependent chooses to elect COBRA continuation coverage instead of enrolling in another Group Health Plan for which you're eligible, you'll have another opportunity to enroll in the other Group Health Plan within thirty (30) days of losing your COBRA continuation coverage.

**What factors should I consider when choosing coverage options?**
When considering your options for health coverage, you may want to think about:

- Premiums: Your previous plan can charge up to one hundred two percent (102%) of total plan premiums for COBRA coverage. Other options, like coverage on a spouse's plan or through the Marketplace, may be less expensive.
- Provider Networks: If you're currently getting care or treatment for a condition, a change in your health coverage may affect your access to a particular health care provider. You may want to check to see if your current health care providers participate in a network as you consider options for health coverage.
- Drug Formularies: If you're currently taking medication, a change in your health coverage may affect your costs for medication – and in some cases, your medication may not be covered by another plan. You may want to check to see if your current medications are listed in drug formularies for other health coverage.
- Severance Payments: If you lost your job and got a severance package from your former Employer, your former Employer may have offered to pay some or all of your COBRA payments for a period of time. In this scenario, you may want to contact the Department of Labor at 1-866-444-3272 to discuss your options.

- Service Areas: Some plans limit their benefits to specific service or coverage areas – so if you move to another area of the country, you may not be able to use your benefits. You may want to see if your plan has a service or coverage area, or other similar limitations.
- Other Cost-Sharing: In addition to premiums or contributions for health coverage, you probably pay Co-payments, deductibles, Co-insurance, or other amounts as you use your benefits. You may want to check to see what the cost-sharing requirements are for other health coverage options. For example, one option may have much lower monthly premiums, but a much higher deductible and higher Co-payments.

**When and How Must Payment for COBRA Continuation Coverage be Made?**

**First Payment For COBRA Continuation Coverage**
If you elect COBRA continuation coverage, you do not have to send any payment with the Election Form. However, you must make your first payment for COBRA continuation coverage not later than forty-five (45) days after the date of your election. (This is the date the Election Notice is post-marked, if mailed.) If you do not make your first payment for COBRA continuation coverage in full within forty-five (45) days after the date of your election, you will lose all COBRA continuation coverage rights under the Plan. You are responsible for making sure that the amount of your first payment is correct. You may contact the COBRA Administrator or Plan Administrator to confirm the correct amount of your first payment.

**Periodic Payments For COBRA Continuation Coverage**
After you make your first payment for COBRA continuation coverage, you will be required to make periodic payments for each subsequent coverage period. The amount due for each coverage period for each Qualified Beneficiary is shown on the Election Notice. The periodic payments can be made on a monthly basis. Under the Plan, each of these periodic payments for COBRA continuation coverage is due on the first day of each month for that coverage period. If you make a periodic payment on or before the first day of the coverage period to which it applies, your coverage under the Plan will continue for that coverage period without any break. The Plan will send periodic notices of payments due for these coverage periods.

**Grace Periods For Periodic Payments**
Although periodic payments are due on the dates shown above, you will be given a grace period of thirty (30) days after the first day of the coverage period to make each periodic payment. Your COBRA continuation coverage will be provided for each coverage period as long as payment for that coverage period is made before the end of the grace period for that payment. However, if you pay a periodic payment later than the first day of the coverage period to which it applies, but before the end of the grace period for the coverage period, your coverage under the Plan will be suspended as of the first day of the coverage period and then retroactively reinstated (going back to the first day of the coverage period) when the periodic payment is received. This means that any claim you submit for benefits while your coverage is suspended may be denied and may have to be resubmitted once your coverage is reinstated.

If you fail to make a periodic payment before the end of the grace period for that coverage period, you will lose all rights to COBRA continuation coverage under the Plan.

Your first payment and all periodic payments for COBRA continuation coverage should be sent to the Plan Administrator or COBRA Administrator.

**If You Have Questions**
Questions concerning your Plan or your COBRA continuation rights should be addressed to the contact identified below. For more information about your rights under ERISA, including COBRA, the Health Insurance Portability and Accountability Act (HIPAA), and other laws affecting Group Health Plans, contact the nearest Regional or District Office of the United States Department of Labor's Employee Benefit Security Administration (EBSA) in your area or visit the EBSA website at https://www.dol.gov/agencies/ebsa.

**Keep Your Plan Informed**
In order to protect your family's rights, you should keep the Plan Administrator informed of any change in marital status, Dependent status or address change. You should also keep a copy, for your records, of any notices you send to the Plan Administrator.

**Plan Contact Information**

TEAM Risk Management Strategies, LLC
3131 Camino Del Rio North, Suite 650
San Diego, CA 92108
1-619-281-1100

**Trade Reform Act of 2002 and Trade Preferences Extension Act of 2015**
The Trade Preferences Extension Act of 2015 has extended certain provisions of the Trade Reform Act of 2002, which created a special COBRA right applicable to certain employees who have been terminated or experienced a reduction of hours and who qualify for a "trade readjustment allowance" or "alternative trade adjustment assistance." These individuals can either take a Health Coverage Tax Credit (HCTC) or get advance payment of the applicable percentage of premiums paid for qualified health insurance coverage, including COBRA continuation coverage. These individuals are also entitled to a second opportunity to elect COBRA coverage for themselves and certain family members (if they did not already elect COBRA coverage). This election must be made within the sixty (60)-day period that begins on the first day of the month in which the individual becomes eligible for assistance under the Trade Reform Act of 2002. However, this election may not be made more than six months after the date the individual's group health plan coverage ends.

A Covered Person's eligibility for subsidies under the Trade Preferences Extension Act of 2015 affects his or her eligibility for subsidies that provide premium assistance for coverage purchased through the Health Insurance Marketplace. For each coverage month, a Covered Person must choose one or the other, and if he or she receives both during a tax year, the IRS will reconcile his or her eligibility for each subsidy through his or her individual tax return. Covered Persons may wish to consult their individual tax advisors concerning the benefits of using one subsidy or the other.

Covered Persons may contact the Plan Administrator for additional information or they have any questions they may call the Health Coverage Tax Credit Customer Contact Center toll-free at 1-866-628-4282. TTD/TTY callers may call toll-free at 1-866-626-4282. More information about the Trade Reform Act is available at www.doleta.gov/tradeact; for information about the Health Coverage Tax Credit (HCTC), please see: https://www.irs.gov/Credits-&-Deductions/Individuals/HCTC.

## CONTINUATION DURING FAMILY AND MEDICAL LEAVE ACT (FMLA) LEAVE

The Plan shall at all times comply with FMLA (if applicable). It is the intention of the Plan Administrator to provide these benefits only to the extent required by applicable law and not to grant greater rights than those so required. During a FMLA Leave, coverage will be maintained in accordance with the same Plan conditions as coverage would otherwise be provided if the covered Employee had been a continuously active employee during the entire leave period. If Plan coverage lapses during the FMLA Leave, coverage will be reinstated for the person(s) who had coverage under the Plan when the FMLA Leave began, upon the Employee's return to work at the conclusion of the FMLA Leave.

**Family and Medical Leave Act of 1993 (FMLA)**
This applies to employers with fifty (50) or more Employees within seventy-five (75) miles for at least twenty (20) workweeks in the current or preceding Calendar Year. The following are some definitions identified by the FMLA:

**Covered Service Member**
"Covered Service Member" shall mean current service members and covered veterans who are undergoing medical treatment, recuperation, or therapy due to a serious Injury or Illness, rather than just current service members. A covered veteran is an individual who was discharged or released under conditions other than dishonorable at any time during the five-year period prior to when the eligible Employee takes FMLA Leave to care for the covered veteran.

**Eligible Employee**
"Eligible Employee" shall mean an individual who has been employed by the Company for at least twelve (12) months, has performed at least one thousand two hundred fifty (1,250) hours of service during the previous twelve

(12) month period, and has worked at a location where at least fifty (50) Employees are employed by the Employer within seventy-five (75) miles.

**Family Member**
"Family Member" shall mean the (a) Employee's biological, step, or foster parent or (b) a natural, adopted, foster, or stepchild, or a legal ward under eighteen (18) years of age, or eighteen (18) years and older and incapable of self-care because of a mental or physical disability or (c) spouse.

**Serious Illness or Injury (of a service member or covered veteran)**
"Serious Illness or Injury" shall mean an Illness or Injury Incurred in the line of duty that may render the service member medically unfit to perform his or her military duties. A serious Injury or Illness for a current service member includes an Injury or Illness that existed before the beginning of the service member's active duty and was aggravated by service in the line of duty on active duty in the armed forces. A serious Injury or Illness for a covered veteran means an Injury or Illness that was Incurred or aggravated by the service member in the line of duty on active duty in the armed forces and manifested itself before or after the service member became a veteran.

These definitions are listed as a guide and the actual wording of the FMLA, as amended, shall supersede these definitions.

**Basic Leave Entitlement**
FMLA requires covered employers to provide up to twelve (12) weeks of unpaid, job-protected leave to eligible Employees for the following reasons:

1. for incapacity due to Pregnancy, prenatal medical care or Childbirth;
2. to care for the Employee's Child after birth, or placement for adoption or foster care;
3. to care for the Employee's spouse, son, daughter or parent, who has a serious health condition; or
4. for a serious health condition that makes the Employee unable to perform the Employee's job.

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

**Military Family Leave Entitlements**
Eligible Employees whose spouse, son, daughter or parent is on covered active duty or call to covered active duty status may use their twelve (12) week leave entitlement to address certain qualifying exigencies. Qualifying exigencies may include attending certain military events, arranging for alternative childcare, addressing certain financial and legal arrangements, attending certain counseling sessions, and attending post-deployment reintegration briefings.

FMLA also includes a special leave entitlement that permits eligible Employees to take up to twenty-six (26) weeks of leave to care for a covered service member during a single twelve (12) month period. A covered service member is: (1) a current member of the Armed Forces, including a member of the National Guard or Reserves, who is undergoing medical treatment, recuperation or therapy, is otherwise in outpatient status, or is otherwise on the temporary disability retired list, for a serious Injury or Illness*; or (2) a veteran who was discharged or released under conditions other than dishonorable at any time during the five (5)-year period prior to the first date the eligible Employee takes FMLA Leave to care for the covered veteran, and who is undergoing medical treatment, recuperation, or therapy for a serious Injury or Illness.*

***The FMLA definitions of "serious Injury or Illness" for current service members and veterans are distinct from the FMLA definition of "serious health condition".**

**Benefits and Protections**
During FMLA Leave, the Employer must maintain the Employee's health coverage under any "Group Health Plan" on the same terms as if the Employee had continued to work. Upon return from FMLA Leave, most Employees must be restored to their original or equivalent positions with equivalent pay, benefits, and other employment terms.

Use of FMLA Leave cannot result in the loss of any employment benefit that accrued prior to the start of an Employee's leave.

**Eligibility Requirements**
Employees are eligible if they have worked for a covered employer for at least twelve (12) months, have one thousand two hundred fifty (1,250) hours of service in the previous twelve (12) months*, and if at least fifty (50) Employees are employed by the Employer within seventy-five (75) miles.

***Special hours of service eligibility requirements apply to airline flight crew Employees.**

**Definition of Serious Health Condition**
A serious health condition is an Illness, Injury, impairment, or physical or mental condition that involves either an overnight stay in a medical care facility, or continuing treatment by a health care Provider for a condition that either prevents the Employee from performing the functions of the Employee's job, or prevents the qualified family member from participating in school or other daily activities.

Subject to certain conditions, the continuing treatment requirement may be met by a period of incapacity of more than three consecutive calendar days combined with at least two visits to a health care Provider or one visit and a regimen of continuing treatment, or incapacity due to Pregnancy, or incapacity due to a chronic condition. Other conditions may meet the definition of continuing treatment.

**Use of Leave**
An Employee does not need to use this leave entitlement in one block. Leave can be taken intermittently or on a reduced leave schedule when Medically Necessary. Employees must make reasonable efforts to schedule leave for planned medical treatment so as not to unduly disrupt the Employer's operations. Leave due to qualifying exigencies may also be taken on an intermittent basis.

**Substitution of Paid Leave for Unpaid Leave**
Employees may choose or employers may require use of accrued paid leave while taking FMLA Leave. In order to use paid leave for FMLA Leave, Employees must comply with the Employer's normal paid leave policies.

**Employee Responsibilities**
Employees must provide thirty (30) days' advance notice of the need to take FMLA Leave when the need is foreseeable. When thirty (30) days notice is not possible, the Employee must provide notice as soon as practicable and generally must comply with an Employer's normal call-in procedures.

Employees must provide sufficient information for the Employer to determine if the leave may qualify for FMLA protection and the anticipated timing and duration of the leave. Sufficient information may include that the Employee is unable to perform job functions, the family member is unable to perform daily activities, the need for hospitalization or continuing treatment by a health care Provider, or circumstances supporting the need for military family leave. Employees also must inform the Employer if the requested leave is for a reason for which FMLA Leave was previously taken or certified. Employees also may be required to provide a certification and periodic recertification supporting the need for leave.

**Employer Responsibilities**
Covered Employers must inform Employees requesting leave whether they are eligible under FMLA. If they are, the notice must specify any additional information required as well as the Employees' rights and responsibilities. If they are not eligible, the Employer must provide a reason for the ineligibility.

Covered Employers must inform Employees if leave will be designated as FMLA-protected and the amount of leave counted against the Employee's leave entitlement. If the Employer determines that the leave is not FMLA-protected, the Employer must notify the Employee.

**Unlawful Acts by Employers**
FMLA makes it unlawful for any employer to:

1. Interfere with, restrain, or deny the exercise of any right provided under FMLA.
2. Discharge or discriminate against any person for opposing any practice made unlawful by FMLA or for involvement in any proceeding under or relating to FMLA.

**Enforcement**
An Employee may file a complaint with the United States Department of Labor or may bring a private lawsuit against an employer.

FMLA does not affect any Federal or State law prohibiting discrimination, or supersede any State or local law or collective bargaining agreement which provides greater family or medical leave rights.

**FMLA section 109 (29 U.S.C. § 2619) requires FMLA covered employers to post the text of this notice. Regulation 29 C.F.R. § 825.300(a) may require additional disclosures.**
**For additional information:**
1-866-4US-WAGE (1-866-487-9243) TTY: 1-877-889-5627
https://www.dol.gov/whd/
United States Department of Labor Wage and Hour Division
WHD Publication 1420 · Revised February 2013

## UNIFORMED SERVICES EMPLOYMENT AND REEMPLOYMENT RIGHTS ACT OF 1994 (USERRA)

The Uniformed Services Employment and Reemployment Rights Act of 1994 (USERRA) established requirements that employers must meet for certain Employees who are involved in the uniformed services (defined below). In addition to the rights that Employees have under COBRA, Employees are entitled under USERRA to continue the coverage that they (and their covered Dependents, if any) had under the Medical and/or Dental Plan.

**Employees Have Rights Under Both COBRA and USERRA**
Employees' rights under COBRA and USERRA are similar but not identical. Any election that an Employee makes pursuant to COBRA will also be an election under USERRA, and COBRA and USERRA will both apply with respect to the continuation coverage elected. If COBRA and USERRA give an Employee (or their covered Spouse or Dependent Children) different rights or protections, the law that provides the greater benefit will apply.

**Definitions**

***"Uniformed Services"*** means the Armed Forces, The Army National Guard, and the Air National Guard when engaged in active duty for training, inactive duty training, or full-time National Guard duty (i.e., pursuant to orders issued under federal law), the commissioned corps of the Public Health Service, and any other category of persons designated by the President in time of war or national emergency.

***"Service in the uniformed services" or "service"*** means the performance of duty on a voluntary or involuntary basis in the uniformed services under competent authority, including active duty, active duty for training, initial active duty for training, inactive duty training, full-time National Guard duty, a period for which a person is absent from employment for an examination to determine his or her fitness to perform any of these duties, and a period for which a person is absent from employment to perform certain funeral honors duty. It also includes certain service by intermittent disaster-response personnel of the National Disaster Medical System.

**Duration of USERRA Coverage**
*General Rule:* Twenty-four (24) month maximum. When a Covered Employee takes a leave for service in the uniformed services, USERRA coverage for the Employee (and covered Dependents for whom coverage is elected) begins the day after the Employee (and covered Dependents) lose coverage under the Plan, and it can continue for up to twenty-four (24) months. However, USERRA coverage will end earlier if one of the following events takes place:

1. A premium payment is not made within the required time;

2. The Employee fails to return to work within the time required under USERRA (see below) following the completion of the Employee's service in the uniformed services; or

3. The Employee loses his or her rights under USERRA as a result of a dishonorable discharge or other conduct specified in USERRA.

*Returning to Work:* An Employee's right to continue coverage under USERRA will end if the Employee does not notify the Company of their intent to return to work within the time required under USERRA following the completion of their service in the uniformed services by either reporting to work (if the Employee's uniformed services was for less than thirty-one (31) days) or applying for reemployment (if the Employee's uniformed services was for more than thirty (30) days). The time for returning to work depends on the period of uniformed services, as follows:

| **Period of Service** | **Return-to Work Requirement** |
|---|---|
| | |
| Less than thirty-one (31) days | The beginning of the first regularly scheduled work period on the day following the completion of the Employee's service, after allowing for safe travel home and an eight (8)-hour rest period, or if that is unreasonable or impossible through no fault of the Employee, as soon as is possible. |
| More than thirty (30) days but less than one hundred eighty-one (181) days | Within fourteen (14) days after completion of the Employee's service or, if that is unreasonable or impossible through no fault of the Employee, the first day on which it is possible to do so. |
| More than one hundred eighty (180) days | Within ninety (90) days after completion of the Employee's service. |
| Any period if for purposes of an examination for fitness to perform uniformed service. | The beginning of the first regularly scheduled work period on the day following the completion of the Employee's service, after allowing for safe travel home and an eight-hour rest period, or if that is unreasonable or impossible through no fault of the Employee, as soon as is possible. |
| Any period if the Employee was Hospitalized for or is convalescing from an Injury or Illness incurred or aggravated as a result of the Employee's service. | Same as above (depending on length of service period) except that time periods begin when the Employee has recovered from their injuries or Illness rather than upon completion of the Employee's service. Maximum period for recovering is limited to two (2) years, but the two (2)-year period may be extended if circumstances beyond the Employee's control make it impossible or unreasonable for the Employee to report to work within the above time periods. |

*COBRA and USERRA coverage are concurrent.* This means that COBRA coverage and USERRA coverage begin at the same time. However, COBRA coverage can continue for up to eighteen (18) months (it may continue for a longer period and is subject to early termination, as described in the COBRA section. In contrast, USERRA coverage can continue for up to twenty-four (24) months, as described above.

**Premium Payments for USERRA Continuation Coverage**
If the Employee elects to continue their health coverage (or their Spouse's or Dependent Children's coverage) pursuant to USERRA, the Employee will be required to pay one hundred two percent (102%) of the full premium for the coverage elected (the same rate as COBRA). However, if the Employee's uniformed service period is less than thirty-one (31) days, the Employee is not required to pay more than the amount that they pay as an active Employee for that coverage.

**Questions**
If Employees have any questions regarding this information or their rights to coverage, they should contact their Human Resources Department.

**Reinstatement of Coverage**

When coverage under this Plan is reinstated, all provisions and limitations of this Plan will apply to the extent that they would have applied if the Employee had not taken military leave and their coverage had been continuous under this Plan. The eligibility Waiting Period will be waived. (This waiver of limitations does not provide coverage for any Illness or Injury caused by or aggravated by the Employee's military service, as determined by the VA. For complete information regarding an Employee's rights under the Uniformed Services Employment and Reemployment Rights Act, Employees should contact their Employer).

# DEFINITIONS

Some of the terms used in this document begin with a capital letter, even though the term normally would not be capitalized. These terms have special meaning under the Plan. Most terms will be listed in this Definitions section, but some terms are defined within the provision the term is used.

Becoming familiar with the terms defined in the Definitions section will help to better understand the provisions of this Plan. The terms are capitalized to highlight their use.

**ACCIDENT** - An Injury which is:

1. Caused by an event which is sudden and unforeseen; and
2. Exact as to time and place of occurrence.

**ADA** - The American Dental Association.

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

**AHA** - The American Hospital Association.

**ALLOWABLE EXPENSES** - The Reasonable and Customary charge for any Medically Necessary, and eligible items of expense, at least a portion of which is covered under a Plan. When some Other Plan pays first in accordance with the Application to Benefit Determinations 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 instead of cash payments, the reasonable cash value of each service rendered, in the amount that would be payable in accordance with the terms of the Plan, 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.

In the case of HMO (Health Maintenance Organization) plans, this Plan will not consider any charges in excess of what an HMO Provider has agreed to accept as payment in full. Also, when an HMO is primary and the Covered Person does not use an HMO Provider, this Plan will not consider as an Allowable Expenses any charge that would have been covered by the HMO had the Covered Person used the services of an HMO Provider.

**AMA** - The American Medical Association.

**AMBULATORY SURGICAL CENTER** - A specialized facility or a facility affiliated with a Hospital which is approved by the Joint Commission on Accreditation of Healthcare Organizations (JCAHO) or licensed in accordance with the applicable laws in the jurisdiction in which it is located and is established, equipped and operated primarily for the purpose of performing surgical procedures on an ambulatory basis.

**APPROVED CLINICAL TRIAL** - 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 doctor 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 patient; and 3) a service that is clearly inconsistent with the widely accepted and established standards of care for a particular Diagnosis. Plans are not required to provide benefits for routine patient care services provided outside of the Plan's Network area unless out-of network benefits are otherwise provided under the Plan.

**BIRTHING CENTER** - A specialized facility or a facility affiliated with a Hospital which:

1. Provides twenty-four (24) hour a day nursing service by or under the supervision of registered graduate nurses (R.N.) and certified nurse midwives.
2. Is staffed, equipped and operated to provide:
    a. Care for patients during uncomplicated Pregnancy, delivery, and the immediate postpartum period.
    b. Care for infants born in the center who are normal or have abnormalities which do not impair function or threaten life.
    c. Care for obstetrical patients and infants born in the center who require emergency and immediate life support measures to sustain life, pending transfer to a Hospital.

**CALENDAR YEAR** - For the purposes of this Plan, a length of time beginning on January 1 and ending on December 31.

**CERTIFIED REGISTERED NURSE ANESTHETIST (CRNA)** - A person who:

1. Is a graduate of an approved school of nursing and is duly licensed as a Registered Nurse.
2. Is a graduate of an approved program of nurse anesthesia accredited by the Council of Certification of Nurse Anesthetists or its predecessors.
3. Has been certified by the Council of Certification of Nurse Anesthetists or its predecessors.
4. Is recertified every two (2) years by the Council on Recertification of Nurse Anesthetists.

**CHILD** - The Employee's natural Child, any stepchild, 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. A "legal guardian" is a person recognized by a court of law as having the duty of taking care of the person and managing the property and rights of a minor child.

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

**CHIPRA** - The Children's Health Insurance Program Reauthorization Act of 2009 or any provision or section thereof, which is herein specifically referred to, as such act.

**CLAIMS ADMINISTRATOR** - Benefit Administrative Systems, L.L.C.

**CLEAN CLAIM** – A claim that can be processed in accordance with the terms of this document without obtaining additional information from the service Provider or a third party. It is a claim which has no defect or impropriety. A defect or impropriety shall include a lack of required sustaining documentation as set forth and in accordance with this document, or a particular circumstance requiring special treatment which prevents timely payment as set forth in this document, and only as permitted by this document, from being made. A Clean Claim does not include claims

under investigation for fraud and abuse or claims under review for Medical Necessity or other coverage criteria, or fees under review for application of the Maximum Allowable Charge, or any other matter that may prevent the charge(s) from being Covered Expenses in accordance with the terms of this document.

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

**CODE** - The Internal Revenue Code of 1986, as amended from time to time, and the regulations thereunder.

**CO-INSURANCE** - That portion of Covered Medical Expenses to be paid by the Plan in accordance with the coverage provisions as stated in the Plan. It is the basis used to determine any out-of-pocket expenses in excess of the Deductible which are to be paid by the Employee.

**COMPANY** - TEAM Risk Management Strategies, LLC.

**CO-PAYMENT** - That portion of Covered Expenses which must be paid by or on behalf of the Covered Person incurring the expense.

**COSMETIC SURGERY** - Surgery that is intended to improve the appearance of a patient or preserve or restore a pleasing appearance. It does not mean surgery that is intended to correct normal functions of the body. This does not include reconstructive surgery resulting from an Illness or Injury.

**COVERED EXPENSE(S)** - A Reasonable and Customary fee for, and/or, a Reasonable, Medically Necessary service, treatment or supply, meant to improve a condition or Covered Person's health, which is eligible for coverage under this Plan. Covered Expenses will be determined based upon all other Plan provisions. When more than one (1) treatment option is available, and one (1) option is no more effective than another, the Covered Expense is the least costly option that is no less effective than any other option.

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

**COVERED PERSON** - Any Employee, Dependent, or individual that is covered under the Plan through COBRA continuation who is eligible for benefits (and enrolled) under the Plan.

**CUSTODIAL CARE** - Custodial Care shall mean care or confinement designated principally for the assistance and maintenance of the Covered Person, in engaging in the activities of daily living, whether or not Disabled. This care or confinement could be rendered at home or by persons without professional skills or training. This care may relieve symptoms or pain but is not reasonably expected to improve the underlying medical condition. Custodial Care includes, but is not limited to, assistance in eating, dressing, bathing and using the toilet, preparation of special diets, supervision of medication which can normally be self-administered, assistance in walking or getting in and out of bed, and all domestic activities.

**DEDUCTIBLE** - The amount of Covered Expenses that a Covered Person must pay before he can receive a benefit payment under the Medical and/or Dental Expense Benefits. However, certain covered benefits may be considered Preventive Care and paid first (1st) dollar.

**DENTIST** - A duly licensed Dentist practicing within the scope of his license and any other Physician furnishing any dental services which he is licensed to perform.

**DENTAL HYGIENIST** - A person who is currently licensed to practice dental hygiene by the governmental authority having jurisdiction over the licensing and practice of Dental Hygiene, and who works under the direct supervision and direction of a Dentist.

**DEPENDENT** - A Dependent is a person who fits one (1) or more of the following categories:

1. A covered Employee's Spouse. The term Spouse shall mean a person who is legally married to the eligible employee in their state of primary residency, and shall not include common law marriages. The Plan Administrator may require documentation proving a legal marital relationship. The term "Spouse" shall also mean the person who is currently registered with the Employer as the Domestic Partner of the Employee, this includes opposite sex and same sex couples. An individual is a Domestic Partner of an Employee if that individual and the Employee meet each of the following requirements:

    a. The Employee and individual are eighteen (18) years of age or older and are mentally competent to enter into a legally binding contract.
    b. The Employee and the individual are not married to anyone.
    c. The Employee and the individual are not related by blood to a degree of closeness that would prohibit legal marriage between individuals of the opposite sex in the state in which they reside.
    d. The Employee and the individual share the same principal residence(s), the common necessities of life, the responsibility for each other's welfare, are financially interdependent with each other and have a long-term committed personal relationship in which each partner is the other's sole domestic partner. Each of the foregoing characteristics of the domestic partner relationship must have been in existence for a period of at least twelve (12) consecutive months and be continuing during the period that the applicable benefit is provided. The Employee and the individual must have the intention that their relationship will be indefinite.
    e. The Employee and the individual have common or joint ownership of a residence (home, condominium, or mobile home), motor vehicle, checking account, credit account, mutual fund, joint obligation under a lease for their residence or similar type ownership.

    In the event the domestic partnership is terminated, either partner is required to inform TEAM, Risk Management Strategies of the termination of the partnership.

    The Plan Administrator may require documentation proving a legal marital and/or Domestic Partner relationship.

2. An Employee's "Child" includes his natural child, stepchild, foster child, adopted child, or a child placed with the Employee for adoption. An Employee’s child will also include children, adopted children and children placed for adoption with the Employee’s Domestic Partner. An Employee's Child will be an eligible Dependent until reaching the limiting age of 26, without regard to student status, marital status, financial dependency or residency status with the Employee or any other person. When the child reaches the applicable limiting age, coverage will end on the last day of the child's birthday month.

    The phrase "placed for adoption" refers to a child whom a person intends to adopt, whether or not the adoption has become final, who has not attained the age of 18 as of the date of such placement for adoption. The term "placed" means the assumption and retention by such person 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 Plan Participant who is an alternate recipient under a qualified medical child support order shall be considered as having a right to Dependent coverage under this Plan. A participant of this Plan may obtain, without charge, a copy of the procedures governing qualified medical child support order (QMCSO) determinations from the Plan Administrator. The Plan Administrator may require documentation proving eligibility for Dependent coverage, including birth certificates, tax records or initiation of legal proceedings severing parental rights.

A Dependent Spouse cannot be divorced from the Employee.

Active duty members of any armed force cannot qualify as "Dependents."

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

**DIALYSIS FACILITY** - A facility (other than a Hospital) whose primary function is the provision of maintenance and/or training dialysis on an ambulatory basis for renal dialysis patients and which is duly licensed by the appropriate governmental authority to provide such services.

**DISABLED** -

1. The Covered Person's complete inability as an active Employee, to perform any and every duty pertaining to his occupation or employment or for any occupation for wage or profit, or
2. The Covered Dependent's complete inability to perform the normal activities of a person of like age and sex, or
3. The Covered Person's complete inability, as a retired Employee, to perform the normal activities of a person of like age and sex.

**DURABLE MEDICAL EQUIPMENT** - Only that equipment and those supplies that:

1. Are primarily and customarily used to serve a medical purpose.
2. Would not be generally useful to a person in the absence of an Illness or Injury.
3. Are designed for repeated use.
4. Either:
    a. Are Medically Necessary to:
        i. Treat an Illness or Injury.
        ii. Effect improvement of a Covered Person's medical condition.
        iii. Arrest or retard deterioration of a Covered Person's medical condition.
    b. Are alternatives to chair or bed confinement.

**ELECTIVE SURGERY** - Surgery that is not emergency in nature or is not performed to correct a life-threatening situation.

**EMERGENCY DENTAL CARE** - An urgent, unplanned diagnostic visit and/or alleviation of acute or unexpected Dental condition.

**EMERGENCY MEDICAL CARE** - The initial treatment, including necessary related diagnostic services, of the unexpected and sudden onset of a medical condition manifesting itself by symptoms severe enough that the absence of immediate treatment could result in serious and/or permanent medical consequences.

**EMPLOYEE** - The word "Employee" as used herein shall mean any person employed and compensated for services by the Company on a regular full-time permanent basis.

**ERISA** - The Employee Retirement Income Security Act of 1974, as amended. As a participant of the Plan, the Covered Person has a number of rights under ERISA as outlined.

**EXPERIMENTAL AND/OR INVESTIGATIONAL** - Services or treatments that are not widely used or accepted by most practitioners or lack credible evidence to support positive short or long-term outcomes from those services or treatments, and that are not the subject of, or in some manner related to, the conduct of an Approved Clinical Trial, as such term is defined herein; these services are not included under or as Medicare reimbursable procedures, and include services, supplies, care, procedures, treatments or courses of treatment which:

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

A drug, device, or medical treatment or procedure is Experimental:

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

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

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

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

Reliable evidence shall mean:

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

FDA approved medications used for conditions other than those for which they received Food and Drug Administration (FDA) approval, when considered the standard of care and ***not*** part of a clinical study or in conjunction with any experimental treatment. For the purposes of this Plan, Standard of Care is defined as, charges for any care, treatment, services or supplies that are approved or accepted as essential to the treatment of any Illness or Injury by the American Medical Association, United States Surgeon General, United States Department of Public Health, or the National Institute of Health (NIH), and recognized by the medical community as potentially safe and efficacious for the care and treatment of the Injury or Illness. ***(Unless otherwise stated under the Approved Clinical Trial section or Covered Medical Expenses section)***

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

**EXTENDED CARE FACILITY / SKILLED NURSING FACILITY** -

1. A Skilled Nursing Facility, as the term is defined in Medicare, which is qualified to participate and eligible to receive payments under and in accordance with the provisions of Medicare, except for a Skilled Nursing Facility which is part of a Hospital, as defined,
2. An institution which fully meets all of the following tests:
    a. It is operated in accordance with the applicable laws of the appropriate governmental authority where it is located.
    b. It is under the supervision of a licensed Physician, or Registered Nurse (R.N.), who is devoting full-time to such supervision.

c. It is regularly engaged in providing Room and Board and continuously provides twenty-four (24) hour-a-day skilled nursing care of ill and injured persons at the patient's expense during the convalescent stage of an Injury or Illness.
d. It maintains a daily medical record of each patient who is under the care of a duly licensed Physician.
e. It is authorized to administer medication on the order of a duly licensed Physician.
f. It is not, other than incidentally, a home for the aged, the blind or the deaf, a hotel, a domiciliary care home, a maternity home, or a home for Alcoholics or drug addicts or the mentally ill.

**GENERIC DRUGS** - Prescription drugs and prescription medicines which are not protected by a trademark.

**GINA** - The Genetic Information Nondiscrimination Act of 2008 (Public Law No. 110-233), which prohibits Group Health Plans, issuers of individual health care policies, and employers from discriminating on the basis of genetic information.

**GROUP HEALTH PLAN** - Any plan or arrangement constituting a Group Health Plan under Section 607(l) of ERISA.

**HOME HEALTH AIDE** - A person who provides care of a medical or therapeutic nature and reports to and is under the direct supervision of a Home Health Care Agency.

**HOME HEALTH CARE AGENCY** - Is either:

1. An Agency that is certified to participate as a Home Health Care Agency under Medicare.
2. A Hospital that has a valid operating certificate and is certified by the appropriate authority to provide home health services.
3. An agency licensed as such, if such licensing is required, in the State in which such Home Health Care is delivered.
4. A public agency or private organization or subdivision of such that meets the following requirements:

    a. It is primarily engaged in providing nursing and other therapeutic services.
    b. It is duly licensed, if such licensing is required, by the appropriate licensing authority, to provide such services.
    c. It is federally certified as a Home Health Care Agency.

**HOME HEALTH CARE PLAN** - A Home Health Care program, prescribed in writing by a person's Physician, for the care and treatment of the person's Illness or Injury in the person's home. In the Plan, the Physician must certify that an Inpatient stay in a Hospital, a Convalescent Nursing Home, or an Extended Care Facility would be required in the absence of the services and supplies provided as part of the Home Health Care Plan. The Home Health Care Plan must be established in writing no later than fourteen (14) days after the start of the Home Health Care. An Inpatient stay is one for which a Room and Board charge is made.

**HOSPICE CARE** -

1. A coordinated, interdisciplinary Hospice-provided program meeting the physical, psychological, spiritual and social needs of dying individuals, and
2. Consists of palliative and supportive medical, nursing and other health services provided through home or Inpatient care during the Illness to a Covered Person who has no reasonable prospect of cure and as estimated by a Physician, has a life expectancy of fewer than six (6) months; and consists of bereavement counseling for members of such Covered Person's immediate family.

**HOSPICE CARE FACILITY** - Is either:

1. A free-standing facility which is fully staffed and equipped to provide for the needs of the terminally ill (and their families).

2. An Inpatient facility which is part of a Hospital but designated as a Hospice unit or is an adjacent facility, administered by a Hospital and designated as a Hospice unit.

   A Hospice Care Facility must be approved by the Joint Commission on Accreditation of Healthcare Organizations (JCAHO) or must meet the standards of the National Hospice Organization (NHO) and the appropriate licensing authority, if such licensing is required.

**HOSPITAL** - A legally operated institution which meets either of these tests:

1. Is accredited as a Hospital under the Hospital accreditation program of the Joint Commission on Accreditation of Healthcare Organizations (JCAHO), or is accredited by the proper authority in the country in which the hospital is located.
2. Is a Hospital, as defined, by Medicare, which is qualified to participate and eligible to receive payments under an in accordance with the provisions of Medicare.
3. Is supervised by a staff of Physicians, has twenty-four (24) hour-a-day nursing services, and is primarily engaged in providing either:
    a. General Inpatient medical care and treatment through medical, diagnostic and major surgical facilities on its premises or under its control.
    b. Specialized Inpatient medical care and treatment through medical and diagnostic facilities (including x-ray and laboratory) on its premises, or under its control, or through a written agreement with a Hospital (which itself qualifies under this definition) or with a specialized provider of these facilities.
    c. A psychiatric Hospital primarily engaged in diagnosing and treating mental Illness, if it meets all of the requirements set forth in clause (a) other than the major surgery requirement.
    d. A free standing treatment facility, other than a Hospital, whose primary function is the treatment of Alcoholism or drug abuse provided the facility is duly licensed by the appropriate governmental authority to provide such service.
    e. A rehabilitative Hospital which is an institution operated primarily for the purpose of providing the specialized care and treatment for which it is duly licensed, and which meets all of the requirements of an accredited Hospital.

***In no event will the term "Hospital" include a nursing home or an institution or part of one which:***

a. Is primarily a facility for convalescence, nursing, rest, or the aged, or
b. Furnishes primarily domiciliary or Custodial Care, including training in daily living routines, or
c. Is operated primarily as a school.

**ILLNESS** - A bodily disorder, disease, Pregnancy, or mental infirmity. All bodily injuries sustained by an individual in a single Accident or all Illnesses which are due to the same or related cause or causes will be deemed one Illness.

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

**INDEPENDENT LABORATORY** – A freestanding facility offering radiology and pathology services which is not part of a Hospital and is licensed by the proper authority in the State in which it is located.

**INJURY** - An unforeseen happening to the body, requiring medical attention, including all related symptoms and recurrent conditions resulting from the Accident.

**INPATIENT** - A person receiving Room and Board while undergoing treatment in a Hospital, Hospice or other covered facility.

**INTENSIVE CARE UNIT** - A section, ward or wing within a Hospital which is operated exclusively for critically ill patients and provides special supplies, equipment and constant observation and care by professional nurses or other highly trained personnel, excluding any Hospital facility maintained for the purposes of providing normal post-operative recovery treatment or services.

**LEAVE OF ABSENCE** - A period of time during which the Employee does not work but which is of stated duration and after which time the Employee is expected to return to active full-time work. A Leave of Absence is generally requested by an Employee and approved by his or her Participating Employer, and as provided for in the Participating Employer's rules, policies, procedures and practices where applicable.

**LEGAL SEPARATION or LEGALLY SEPARATED** - An arrangement under the applicable state laws to remain married but maintain separate lives, pursuant to a valid court order.

**LICENSED PRACTICAL NURSE/LICENSED VOCATIONAL NURSE** - An individual who has received specialized nursing training and practical nursing experience and who is licensed to perform such service, other than one who ordinarily resides in the patient's home or who is a member of the patient's immediate family.

**LIFETIME** - When used in reference to benefit maximums and limitations, "Lifetime" is understood to mean while covered under this Plan. Under no circumstances does "Lifetime" mean during the lifetime of the Covered Person.

**MAXIMUM ALLOWABLE CHARGE** - The benefit payable for a specific coverage item or benefit under the Plan. Maximum Allowable Charge(s) will be calculated by the Plan Administrator taking into account any or all of the following:

1. The Reasonable and Customary amount.
2. The allowable charge specified under the terms of the Plan.
3. The negotiated rate established in a contractual arrangement with a Provider.
4. The actual billed charges for the covered services.

The Plan will reimburse the actual charge billed if it is less than the Reasonable and Customary amount. The Plan has the discretionary authority to decide if a charge is Reasonable and Customary and for a Medically Necessary service.

The Maximum Allowable Charge will not include any identifiable billing mistakes including, but not limited to, up-coding, duplicate charges, and charges for services not performed.

**MEDICAL EXPENSE BENEFIT** - After satisfaction of the applicable Deductible, benefits will be provided for Covered Expenses for an Illness or Injury in a Calendar Year.

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

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

1. Its purpose must be to restore health.

2. It must not be primarily custodial in nature.
3. It is ordered by a Physician for the Diagnosis or treatment of a sickness or Injury.
4. The Plan reserves the right to incorporate CMS guidelines in effect on the date of treatment as additional criteria for determination of Medical Necessity and/or an Allowable Expense.

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

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

**MEDICARE** - Title XVIII of the Social Security Act of 1965, as amended from time to time, and the regulations thereunder.

**MENTAL HEALTH PARITY ACT OF 1996 (MHPA) AND MENTAL HEALTH PARITY AND ADDICTION EQUITY ACT OF 2008 (MHPAEA), COLLECTIVELY, THE MENTAL HEALTH PARITY PROVISIONS IN PART 7 OF ERISA** - In the case of a Group Health Plan (or health insurance coverage offered in connection with such a plan) that provides both medical and surgical benefits and mental health or Substance Use Disorder benefits, such plan or coverage shall ensure that:

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

**NETWORK PROVIDER or PREFERRED PROVIDER** - A health care provider who agrees to provide Medically Necessary care and treatment at a negotiated rate.
**NO-FAULT AUTO INSURANCE** - The basic reparations provision of a law providing for payments without determining fault in connection with automobile Accidents.

**NOTICE OR NOTIFICATION** - The ability to reasonably ensure actual receipt of the materials and specifically includes the normal mailing through the U. S. Mail.

**OCCUPATIONAL THERAPY** - Treatment rendered as a part of a physical medicine and rehabilitation program to improve functional impairments where the expectation exists that the therapy will result in practical improvement in the level of functioning within a reasonable period of time. Benefits are not provided for diversion, recreational and vocational therapies (such as hobbies, arts & crafts).

**ORTHOTIC APPLIANCE** - An external device intended to correct any defect in form or function of the human body.

**OTHER PLAN** - Shall include, but is not limited to:

1. Any primary payer besides the Plan.
2. Any other Group Health Plan.
3. Any other coverage or policy covering the 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.

**OUT-OF-POCKET MAXIMUM** - The maximum covered expense that a Covered Person or family must pay before the Plan pays a hundred percent (100%) of the balance of eligible medical expenses for such person or family for the remainder of the Calendar Year.

**OUTPATIENT** - When a Covered Person receives diagnosis, treatment or twenty-three (23) hour observation in a Hospital or treatment facility but is not admitted as an Inpatient.

**PARTICIPANT -** An Employee of the Plan Administrator who participates in the Plan.

**PHARMACY** - Any licensed establishment in which the profession of Pharmacy is practiced.

**PHYSICAL THERAPY** - Treatment by physical means including modalities such as whirlpool and diathermy; procedures such as massage, ultrasound, manipulation and subluxation; as well as tests of measurement requirements to determine the need and progress of treatment. Such treatment must be given to relieve pain, restore maximum function, and to prevent disability following Illness, Injury or loss of body parts. Treatment must be for acute conditions where rehabilitation potential exists and the skills of a Physician or other professional are required.

**PHYSICIAN** - A medical doctor (M.D.), an osteopath (D.O.), a Dentist or dental surgeon (D.D.S., D.M.D.), a podiatrist (D.P.M.), a chiropractor (D.C.), a psychologist (Ph.D., Psy.D.) or an optometrist (D.O.) or other medical professional who is duly licensed under the laws of the appropriate governmental authority to practice medicine, to the extent they, within the scope of their license are permitted to perform the services provided by this Plan. (The term shall also include a Social Worker for the treatment of psychiatric disorders and Substance Abuse). A Physician shall not include the Covered Person or any close relative of the Covered Person.

**PLAN** - TEAM Risk Management Strategies, LLC.

**PLAN ADMINISTRATOR** - The entity responsible for the day to day functions and management of the Plan. The Plan Administrator may employ persons or firms to process claims and perform other services related to the Plan.

**PLAN DOCUMENT -** The legal document according to which the Plan is administered and governed.

**PLAN YEAR** - For purposes of this Plan, a length of time beginning on November 1st and ending on October 31st.

**POST-SERVICE CLAIM** - Any claim that involves only the payment or reimbursement of the cost for medical care that has already been provided.

**PRE-ADMISSION TESTING** - X-rays, laboratory examinations or other tests performed in the Outpatient department of a Hospital or other facility prior to Outpatient treatment or to confinement as an Inpatient provided:

1. Such tests are related to the scheduled Hospital confinement.
2. Such tests have been ordered by a duly qualified Physician after a condition requiring such confinement has been diagnosed.
3. The Covered Person is subsequently admitted to the Hospital, or the confinement is canceled or postponed because a Hospital bed is unavailable, or under the directions of the attending Physician, or because there is a change in the patient's condition which precludes the confinement.

**PREFERRED PROVIDER** - A health care provider who agrees to provide Medically Necessary care and treatment at a negotiated rate under this Plan.

**PREGNANCY** - A physical state whereby a woman presently bears a child or children in the womb, prior to but likely to result in childbirth, miscarriage and/or non-elective abortion. Pregnancy is considered an Illness for the purpose of determining benefits under this Plan.

**PRE-SERVICE CLAIM** - A claim that must be decided before a claimant will be afforded access to health care.

**PROSTHETIC DEVICE** - A device which:

1. Replaces all or part of a missing body organ and its adjoining tissue.
2. Replaces all or part of the function of a permanently useless or malfunctioning organ.

**PROVIDER -** An entity whose primary responsibility is related to the supply of medical care. Each Provider must be licensed, registered, or certified by the appropriate State agency where the medical care is performed, as required by that State's law where applicable. Where there is no applicable State agency, licensure, or regulation, the Provider must be registered or certified by the appropriate professional body. The Plan Administrator may determine that an entity is not a "Provider" as defined herein if that entity is not deemed to be a "Provider" by the Centers for Medicare and Medicaid (CMS) for purposes arising from payment and/or enrollment with Medicare; however, the Plan Administrator is not so bound by CMS' determination of an entity's status as a Provider. All facilities must meet the standards as set forth within the applicable definitions of the Plan as it relates to the relevant provider type.

**PSYCHIATRIC DISORDER** - Neuroses, psychoneurosis, psychosis, or mental or emotional disease or disorder of any kind.

**PSYCHIATRIC TREATMENT** - Treatment or care for:

1. A mental or emotional disease or disorder.
2. A functional nervous disorder.
3. Psychological effects of Substance Abuse.

**QUALIFIED BENEFICIARY** - Any Beneficiary who is a Qualified Beneficiary as defined under Section 607(3) of ERISA.

**REASONABLE AND CUSTOMARY** - Fees limited to Covered Expenses which are identified as eligible for payment by the Plan Administrator in accordance with the terms of this Plan. "Reasonable and Customary" amounts may be determined and established by the Plan, at the Plan Administrator's discretion, using normative data such as, but not limited to, the fee(s) which the Provider most frequently charges the majority of patients for the service or supply, amounts the Provider most often agrees to accept as payment in full either through direct negotiation or through a preferred provider organization ("PPO") network, the cost to the Provider for providing the services, average wholesale price (AWP) and/or manufacturer's retail pricing (MRP), the prevailing range of fees charged in the same "area" by Providers of similar training and experience for the service or supply, rates negotiated with the Plan, and/or Medicare reimbursement rates. The Plan Administrator may, in its discretion, take into consideration specific circumstances and negotiated terms when defining the payable amount.

The term(s) "same geographic locale" and/or "area" shall be defined as a metropolitan area, county, or such greater area as is necessary to obtain a representative cross-section of Providers, persons or organizations rendering such treatment, services, or supplies for which a specific charge is made.

Furthermore, Reasonable and Customary shall be limited to those claims that, in the Plan Administrator's discretion, are services or supplies or fees for services or supplies that are necessary for the care and treatment of Illness or Injury not unreasonably caused by the treating Provider. Determination that fee(s) or services are therefore Reasonable and Customary will be made by the Plan Administrator, taking into consideration, but not limited to, the findings and assessments of the following entities: (a) The National Medical Associations, Societies, and organizations; and (b) The Food and Drug Administration. To be Reasonable and Customary, service(s) and/or

fee(s) must be in compliance with generally accepted billing practices for unbundling or multiple procedures. Services, supplies, care and/or treatment that results from errors in medical care that are clearly identifiable, preventable, and serious in their consequence for patients, are not Reasonable and Customary. The Plan Administrator retains discretionary authority to determine whether service(s) and/or fee(s) are Reasonable and Customary based upon information presented to the Plan Administrator. A finding of Provider negligence and/or malpractice is not required for service(s) and/or fee(s) to be considered not Reasonable and Customary.

The Plan Administrator reserves for itself and parties acting on its behalf the right to review charges processed and/or paid by the Plan, to identify charge(s) and/or service(s) that are not Reasonable and Customary and therefore not eligible for payment by the Plan.

**REGISTERED NURSE** - A professional nurse who has the right to use the title Registered Nurse (R.N.) other than one who ordinarily resides in the patient's home or who is a member of the patient's immediate family.

**RESIDENTIAL TREATMENT FACILITY** - A facility (other than a hospital) whose primary function is the treatment of a mental or emotional disease or disorder, functional nervous disorder, the treatment of alcoholism, chemical dependency or drug addiction and which is approved by the Joint Commission on Accreditation of Healthcare Organization (JCAHO) or is duly licensed by the appropriate governmental authority to provide such services.

**ROOM AND BOARD** - A Hospital's charge for any of the following:

1. Room and complete linen service.
2. Dietary service including all meals, special diets, therapeutic diets, required nourishment's, dietary supplements and dietary consultation.
3. All general nursing services including but not limited to coordinating the delivery of care, supervising the performance of other staff members who have delegated patient care and patient education.
4. Other conditions of occupancy which are Medically Necessary.

**SOUND NATURAL TOOTH** - A tooth which:

1. Is free of decay, but may be restored by fillings.
2. Has a live root.
3. Does not have a cap or a crown.

**SPECIALTY DRUG(S)** - High-cost prescription medications used to treat complex, chronic conditions like cancer, rheumatoid arthritis and multiple sclerosis. Specialty Drugs often require special handling (like refrigeration during shipping) and administration (such as injection or infusion). Please contact the Prescription Drug Plan Administrator to determine specific drug coverage.

**SPEECH THERAPY** - Active treatment for improvement of an organic medical condition causing a speech impairment. Treatment must be either post-operative or for the convalescent stage of an Illness or Injury.

**SPINAL MANIPULATION / CHIROPRACTIC CARE** - Means skeletal adjustments, manipulation or other treatment in connection with the detection and correction by manual or mechanical means of structural imbalance or subluxation in the human body. Such treatment is done by a Physician to remove nerve interference resulting from, or related to, distortion, misalignment or subluxation of, or in, the vertebral column.

**SPOUSE** - The person who is married to the Employee while the Employee is covered under this Plan. Refer to the Plan Participation section for more specific details.

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

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

**TEMPOROMANDIBULAR JOINT DYSFUNCTION (TMJ)** - Pain, swelling, clicking, grinding, popping, dislocation, locking, malposition, bite discrepancies or other pathological conditions which create a loss or decrease of function in or around one or both of the jaw joints.

**TREATMENT PLAN** - A Physician's or Dentist's report, on a form satisfactory to the Company, which:

1. Itemizes the medical or dental services recommended by him or her for the necessary and customary care of a Covered Person.
2. Shows his or her charge for each service.
3. Is accompanied by supporting pre-operative X-rays or other appropriate diagnostic materials as required by the Company.

**URGENT CARE CLAIM** - A claim for care that is needed if making a non-urgent care decision could seriously jeopardize the life or health of the claimant or the ability of the claimant to regain maximum function or would subject the claimant to severe pain that cannot be adequately managed without treatment.

**WAITING PERIOD -** An interval of time that must pass before an Employee or Dependent is eligible to enroll under the terms of the Plan.

**WORKERS' COMPENSATION** - A fund administered under any Workers' Compensation, Occupational Diseases Act or Law or any other act or law of similar purpose to which the Company contributes, which provides the Employee with coverage for job-related accidental injuries and Illnesses.

# HOW TO SUBMIT A CLAIM

## MEDICAL CLAIMS

Every medical claim must include a Physician's statement specifying the nature of the Illness or Injury for which reimbursement is requested. The Claims Administrator will accept such a diagnostic statement on any form which the Covered Person's doctor prefers to use. ***WITHOUT A DIAGNOSIS, A COVERED PERSON'S CLAIM CANNOT BE PROCESSED***.

All bills, except those for drugs, must indicate the patient's full name, the nature of the Illness or Injury, the date(s) of service, the type(s) of service and the charge for each service and the name, address and tax identification number of the provider.

For reimbursement of prescription drug expenses under the Medical Expense Benefit Plan, Covered Persons should submit bills indicating the patient's full name, the name of the prescribing Physician, the prescription number and the name of the medication, the charge for each prescription and the date of each purchase.

When prescription drugs are purchased through the Prescription Drug Plan, a claim submission is not necessary. The Covered Person's only responsibility is to pay the applicable Co-payment / Coinsurance (as applicable) at the time he or she purchases the prescription.

Should there be a primary insurance carrier for a member of the Covered Person's family, it is important to submit a copy of the itemized claim with a copy of the primary carrier's Explanation of Benefits statement indicating payment or denial of the charges.

## MEDICARE CLAIMS

A Medicare claim is submitted as previously explained; however, when a Covered Person submits the claim, they need to be sure to also submit the Explanation of Benefits (EOB) that they receive from Medicare. The Claims Administrator may be unable to accurately determine benefits payable under the Plan without the Medicare EOB.

## DENTAL CLAIMS

Covered Persons should discuss the Treatment Plan with their Dentist. If the services will exceed $500, Covered Persons should ask their Dentist to submit a "Pre-Treatment Estimate". The Claims Administrator will advise the Dentist of the amount the Plan can pay toward the Covered Person's treatment.

If the services are for emergency treatment or less than $500, a Treatment Plan is not required.

## WHERE TO SUBMIT A CLAIM

Itemized bills must be submitted to the address indicated on the Covered Person's health benefit ID Card.

# CLAIMS REVIEW PROCEDURES

## DEFINITIONS

**ADVERSE BENEFIT DETERMINATION -** Any of the following:

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

**CLAIMANT** - Any Covered Person or entity acting on his or her behalf, authorized to submit claims to the Plan for processing and/or to appeal an Adverse Benefit Determination.

**FINAL INTERNAL ADVERSE BENEFIT DETERMINATION** - 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.

## INTRODUCTION

In accordance with applicable law, the Plan will allow an authorized representative to act on a Claimant's behalf in pursuing or appealing a benefit claim.

The availability of health benefit payments is dependent upon Claimants complying with the following:

## HEALTH CLAIMS

Full and final authority to adjudicate claims and make determinations as to their payability by and under the Plan belongs to and resides solely with the Plan Administrator. The Plan Administrator shall make claims adjudication determinations after full and fair review and in accordance with the terms of this Plan, applicable law, and with ERISA. To receive due consideration, claims for benefits and questions regarding said claims should be directed to the Claims Administrator. The Plan Administrator may delegate to the Claims Administrator responsibility to process claims in accordance with the terms of the Plan and the Plan Administrator's directive(s). The Claims Administrator is not a fiduciary of the Plan and does not have discretionary authority to make claims payment decisions or interpret the meaning of the Plan terms.

Written proof that expenses eligible for Plan reimbursement and/or payment were Incurred, as well as proof of their eligibility for payment by the Plan, must be provided to the Plan Administrator via the Claims Administrator. Although a provider of medical services and/or supplies may submit such claims directly to the Plan by virtue of an assignment of benefits, ultimate responsibility for supplying such written proof remains with the Claimant. The Plan Administrator may determine the time and fashion by which such proof must be submitted. No benefits shall be payable under the Plan if the Plan Administrator so determines that the claims are not eligible for Plan payment, or, if inadequate proof is provided by the Claimant or entities submitting claims to the Plan on the Claimant's behalf.

A call from a Provider who wants to know if an individual is covered under the Plan, or if a certain procedure is covered by the Plan, prior to providing treatment is not a "claim," since an actual claim for benefits is not being filed

with the Plan. These are simply requests for information, and any response is not a guarantee of benefits, since payment of benefits is subject to all Plan provisions, limitations and exclusions. Once treatment is rendered, a Clean Claim must be filed with the Plan (which will be a "Post-service Claim"). At that time, a determination will be made as to what benefits are payable under the Plan.

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

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

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

According to Federal regulations which apply to the Plan, there are four (4) types of claims: Pre-service (Urgent and Non-urgent), Concurrent Care and Post-service.

1. Pre-service Claims. A "Pre-service Claim" occurs when issuance of payment by the Plan is dependent upon determination of payability prior to the receipt of the applicable medical care; however, if the Plan does not require the Claimant to obtain approval of a medical service prior to getting treatment, then there is no "Pre-service Claim."

   Urgent care or Emergency medical services or admissions will not require notice to the Plan prior to the receipt of care. Furthermore, if in the opinion of a Physician with knowledge of the Claimant's medical condition, pre-determination of payability by the Plan prior to the receipt of medical care (a Pre-service Claim) would result in a delay adequate to jeopardize the life or health of the Claimant, hinder the Claimant's ability to regain maximum function (compared to treatment without delay), or subject the Claimant to severe pain that cannot be adequately managed without the care or treatment that is the subject of the claim, said claim may be deemed to be a "Pre-service Urgent Care Claim." In such circumstances, the Claimant is urged to obtain the applicable care without delay, and communicate with the Plan regarding their claim(s) as soon as reasonably possible.

   If, due to Emergency or urgency as defined above, a Pre-service claim is not possible, the Claimant must comply with the Plan's requirements with respect to notice required after receipt of treatment, and must file the claim as a Post-service Claim, as herein described.

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

2. Concurrent Claims. If a Claimant requires an on-going course of treatment over a period of time or via a number of treatments, the Plan may approve of a "Concurrent Claim." In such circumstances, the Claimant must notify the Plan of such necessary ongoing or routine medical care, and the Plan will assess the Concurrent Claim as well as determine whether the course of treatment should be reduced or terminated. The Claimant, in turn, may request an extension of the course of treatment beyond that which the Plan has approved. If the Plan does not require the Claimant to obtain approval of a medical service prior to getting treatment, then there is no need to contact the Plan Administrator to request an extension of a course of treatment, and the Claimant must simply comply with the Plan's requirements with respect to notice required after receipt of treatment, as herein described.

3. Post-service Claims. A "Post-service Claim" is a claim for benefits from the Plan after the medical services and/or supplies have already been provided.

## WHEN CLAIMS MUST BE FILED

Post-service health claims (which must be Clean Claims) must be filed with the Claims Administrator within twelve (12) months of the date charges for the service(s) and/or supplies were Incurred. Benefits are based upon the Plan's provisions at the time the charges were Incurred. Claims filed later than that date shall be denied.

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

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

1. The date of service.
2. The name, address, telephone number and tax identification number of the Provider of the services or supplies.
3. The place where the services were rendered.
4. The Diagnosis and procedure codes.
5. Any applicable pre-negotiated rate;
6. The name of the Plan.
7. The name of the covered Employee.
8. The name of the patient.

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

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

## TIMING OF CLAIM DECISIONS

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

1. Pre-service Urgent Care Claims:

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

facsimile, or other similarly expeditious method. Alternatively, the Claimant may request an expedited review under the external review process.

2. Pre-service Non-urgent Care Claims:
   a. If the Claimant has provided all of the information needed to process the claim, in a reasonable period of time appropriate to the medical circumstances, but not later than fifteen (15) days after receipt of the claim, unless an extension has been requested, then prior to the end of the fifteen (15) day extension period.
   b. If the Claimant has not provided all of the information needed to process the claim, then the Claimant will be notified as to what specific information is needed as soon as possible. The Claimant will be notified of a determination of benefits in a reasonable period of time appropriate to the medical circumstances, either prior to the end of the extension period (if additional information was requested during the initial processing period), or by the date agreed to by the Plan Administrator and the Claimant (if additional information was requested during the extension period).
3. Concurrent Claims:
   a. Plan Notice of Reduction or Termination. If the Plan Administrator is notifying the Claimant of a reduction or termination of a course of treatment (other than by Plan amendment or termination), notification will occur before the end of such period of time or number of treatments. The Claimant will be notified sufficiently in advance of the reduction or termination to allow the Claimant to appeal and obtain a determination on review of that Adverse Benefit Determination before the benefit is reduced or terminated. This rule does not apply if benefits are reduced or eliminated due to plan amendment or termination. A similar process applies for claims based on a rescission of coverage for fraud or misrepresentation.
   b. Request by Claimant Involving Urgent Care. If the Plan Administrator receives a request from a Claimant to extend the course of treatment beyond the period of time or number of treatments involving urgent care, notification will occur as soon as possible, taking into account the medical exigencies, but not later than twenty-four (24) hours after receipt of the claim, as long as the Claimant makes the request at least twenty-four (24) hours prior to the expiration of the prescribed period of time or number of treatments. If the Claimant submits the request with less than twenty-four (24) hours prior to the expiration of the prescribed period of time or number of treatments, the request will be treated as a claim involving urgent care and decided within the urgent care timeframe.
   c. Request by Claimant Involving Non-urgent Care. If the Plan Administrator receives a request from the Claimant for a claim not involving urgent care, the request will be treated as a new benefit claim and decided within the timeframe appropriate to the type of claim (either as a Pre-service non-urgent claim or a Post-service claim).
   d. Request by Claimant Involving Rescission. With respect to rescissions, the following timetable applies:

| | | |
|---|---|---|
| i. | Notification to Claimant | thirty (30) days |
| ii. | Notification of Adverse Benefit Determination on appeal | thirty (30) days |

4. Post-service Claims:
   a. If the Claimant has provided all of the information needed to process the claim, in a reasonable period of time, but not later than thirty (30) days after receipt of the claim, unless an extension has been requested, then prior to the end of the fifteen (15) day extension period.
   b. If such an extension is necessary due to a failure of the Claimant to submit the information necessary to decide the claim, the notice of extension shall specifically describe the required information, and the Claimant shall be afforded at least forty-five (45) days from receipt of the notice within which to provide the specified information.
   c. If the Claimant has not provided all of the information needed to process the claim and additional information is requested during the initial processing period, then the Claimant will be notified of a determination of benefits prior to the end of the extension period, unless additional information is requested during the extension period, then the Claimant will be notified of the determination by a date agreed to by the Plan Administrator and the Claimant.

5. Extensions:
    a. Pre-service Urgent Care Claims. No extensions are available in connection with Pre-service urgent care claims.
    b. Pre-service Non-urgent Care Claims. This period may be extended by the Plan for up to fifteen (15) days, provided that the Plan Administrator both determines that such an extension is necessary due to matters beyond the control of the Plan and notifies the Claimant, prior to the expiration of the initial fifteen (15) day processing period, of the circumstances requiring the extension of time and the date by which the Plan expects to render a decision.
    c. Post service Claims. This period may be extended by the Plan for up to fifteen (15) days, provided that the Plan Administrator both determines that such an extension is necessary due to matters beyond the control of the Plan and notifies the Claimant, prior to the expiration of the initial thirty (30) day processing period, of the circumstances requiring the extension of time and the date by which the Plan expects to render a decision.
6. Calculating Time Periods. The period of time within which a benefit determination is required to be made shall begin at the time a claim is deemed to be filed in accordance with the procedures of the Plan.

## NOTIFICATION OF AN ADVERSE BENEFIT DETERMINATION

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

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

## APPEAL OF ADVERSE BENEFIT DETERMINATIONS

**Full and Fair Review of All Claims**

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

1. A one hundred eighty (180) day timeframe following receipt of a notification of an initial Adverse Benefit Determination within which to appeal the determination. The Plan will not accept appeals filed after a one hundred eighty (180) day timeframe.
2. The opportunity to submit written comments, documents, records, and other information relating to the claim for benefits.
3. The opportunity to review the Claim file and to present evidence and testimony as part of the internal claims and appeals process.
4. A review that does not afford deference to the previous Adverse Benefit Determination and that is conducted by an appropriate named fiduciary of the Plan, who shall be neither the individual who made the Adverse Benefit Determination that is the subject of the appeal, nor the subordinate of such individual.
5. A review that takes into account all comments, documents, records, and other information submitted by the Claimant relating to the claim, without regard to whether such information was submitted or considered in the prior benefit determination.
6. That, in deciding an appeal of any Adverse Benefit Determination that is based in whole or in part upon a medical judgment, the Plan fiduciary shall consult with a health care professional who has appropriate training and experience in the field of medicine involved in the medical judgment, who is neither an individual who was consulted in connection with the Adverse Benefit Determination that is the subject of the appeal, nor the subordinate of any such individual.
7. Upon request, the identity of medical or vocational experts whose advice was obtained on behalf of the Plan in connection with a claim, even if the Plan did not rely upon their advice.
8. If applicable, a discussion of the basis for disagreeing with the disability determination made by either (a) the Social Security Administration; or (b) an independent medical expert that has conducted a full medical review of the Claimant if presented by the Claimant in support of the claim;
9. That a Claimant will be provided, free of charge: (a) reasonable access to, and copies of, all documents, records, and other information relevant to the Claimant's claim in possession of the Plan Administrator or Claims Administrator; (b) information regarding any voluntary appeals procedures offered by the Plan; (c) information regarding the Claimant's right to an external review process; (d) any internal rule, guideline, protocol or other similar criterion relied upon, considered or generated in making the adverse determination; and (e) an explanation of the scientific or clinical judgment for the determination, applying the terms of the Plan to the Claimant's medical circumstances.
10. That a Claimant will be provided, free of charge, and sufficiently in advance of the date that the notice of Final Internal Adverse Benefit Determination is required, with new or additional evidence considered, relied upon, or generated by the Plan in connection with the Claim, as well as any new or additional rationale for a denial at the internal appeals stage, and a reasonable opportunity for the Claimant to respond to such new evidence or rationale.

**Requirements for First Level Appeal**
The Claimant must file an appeal regarding a Post-service claim and applicable Adverse Benefit Determination, in writing within at least one hundred eighty (180) days following receipt of the notice of an Adverse Benefit Determination.

Pre-service Claims.

Claims appeals received by the Claims Administrator listed on the ID Card shall be deemed filed.

Oral appeals should be submitted in writing as soon as possible after it has been initiated.

To file any appeal in writing, the Claimant's appeal must be addressed as follows:

1. For Pre-service Claims:
   Claimants should refer to their identification card for the name and address of the utilization review administrator. All pre service claims must be sent to the utilization review administrator.

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

Benefit Administrative Systems, LLC
17475 Jovanna Dr.
Homewood, IL 60430
1-800-523-0582

Claims appeals received by the Claims Administrator listed on the ID Card shall be deemed filed.

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

1. The name of the Employee/Claimant.
2. The Employee/Claimant's identification number.
3. The group name or identification number.
4. All facts and theories supporting the claim for benefits. Failure to include any theories or facts in the appeal will result in their being deemed waived. In other words, the Claimant will lose the right to raise factual arguments and theories which support this claim if the Claimant fails to include them in the appeal.
5. A statement in clear and concise terms of the reason or reasons for disagreement with the handling of the claim.
6. Any material or information that the Claimant has which indicates that the Claimant is entitled to benefits under the Plan.

If the Claimant provides all of the required information, it may be that the expenses will be eligible for payment under the Plan.

## TIMING OF NOTIFICATION OF BENEFIT DETERMINATION ON REVIEW

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

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

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

## MANNER AND CONTENT OF NOTIFICATION OF ADVERSE BENEFIT DETERMINATION ON REVIEW

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

1. Information sufficient to allow the Claimant to identify the claim involved (including date of service, the healthcare Provider, the claim amount, if applicable, and a statement describing the availability, upon request, of the Diagnosis code and its corresponding meaning, and the treatment code and its corresponding meaning).
2. Specific reason(s) for a denial, including the denial code and its corresponding meaning, and a description of the Plan's standard, if any, that was used in denying the claim, and a discussion of the decision.

3. A reference to the specific portion(s) of the plan provisions upon which a denial is based.
4. Upon request, the identity of any medical or vocational experts consulted in connection with a claim, even if the Plan did not rely upon their advice (or a statement that the identity of the expert will be provided, upon request).
5. A 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 Claimant's claim for benefits.
6. Any rule, guideline, protocol or similar criterion that was relied upon, considered, or generated in making the determination will be provided free of charge. If this is not practical, a statement will be included that such a rule, guideline, protocol or similar criterion was relied upon in making the determination and a copy will be provided to the Claimant, free of charge, upon request.
7. A description of any additional information necessary for the Claimant to perfect the claim and an explanation of why such information is necessary.
8. A description of available internal appeals and external review processes, including information regarding how to initiate an appeal.
9. A description of the Plan's review procedures and the time limits applicable to the procedures. This description will include information on how to initiate the appeal and a statement of the Claimant's right to bring a civil action under section 502(a) of ERISA following an Adverse Benefit Determination on final review;
10. In the case of denials based upon a medical judgment (such as whether the treatment is Medically Necessary or Experimental), either an explanation of the scientific or clinical judgment for the determination, applying the terms of the Plan to the Claimant's medical circumstances, will be provided. If this is not practical, a statement will be included that such explanation will be provided to the Claimant, free of charge, upon request.
11. Information about the availability of, and contact information for, an applicable office of health insurance consumer assistance or ombudsman established under applicable federal law to assist Participants with the internal claims and appeals and external review processes.
12. The following statement: "You and your Plan may have other voluntary alternative dispute resolution options, such as mediation. One way to find out what may be available is to contact your local United States Department of Labor Office and your State insurance regulatory agency."

## FURNISHING DOCUMENTS IN THE EVENT OF AN ADVERSE DETERMINATION

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

## DECISION ON REVIEW

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

### REQUIREMENTS FOR SECOND LEVEL APPEAL

The Claimant must file an appeal regarding a Post-service claim and applicable Adverse Benefit Determination, in writing within sixty (60) days following receipt of the notice of the first level Adverse Benefit Determination.

## TWO (2) LEVELS OF APPEAL

This Plan requires two (2) levels of appeal by a Claimant before the Plan's internal appeals are exhausted. For each level of appeal, the Claimant and the Plan are subject to the same procedures, rights, and responsibilities as stated within this Plan. Each level of appeal is subject to the same submission and response guidelines.

Once a Claimant receives an Adverse Benefit Determination in response to an initial claim for benefits, the Claimant may appeal that Adverse Benefit Determination, which will constitute the initial appeal. If the Claimant receives an Adverse Benefit Determination in response to that initial appeal, the Claimant may appeal that Adverse Benefit Determination as well, which will constitute the final internal appeal. If the Claimant receives an Adverse Benefit

Determination in response to the Claimant's second appeal, such Adverse Benefit Determination will constitute the Final Internal Adverse Benefit Determination, and the Plan's internal appeals procedures will have been exhausted.

## EXTERNAL REVIEW PROCESS

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

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

1. Any eligible Adverse Benefit Determination (including a Final Internal Adverse Benefit Determination) by a plan or issuer that involves medical judgment (including, but not limited to, those based on the plan's or issuer's requirements for Medical Necessity, appropriateness, health care setting, level of care, or effectiveness of a covered benefit; or its determination that a treatment is Experimental or Investigational), as determined by the external reviewer; and
2. A rescission of coverage (whether or not the rescission has any effect on any particular benefit at that time).

Standard external review

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

1. Request for external review. The Plan will allow a Claimant to file a request for an external review with the Plan if the request is filed within four (4) months after the date of receipt of a notice of an Adverse Benefit Determination or Final Internal Adverse Benefit Determination. If there is no corresponding date four (4) months after the date of receipt of such a notice, then the request must be filed by the first day of the fifth (5th) month following the receipt of the notice. For example, if the date of receipt of the notice is October 30, because there is no February 30, the request must be filed by March 1. If the last filing date would fall on a Saturday, Sunday, or Federal holiday, the last filing date is extended to the next day that is not a Saturday, Sunday, or Federal holiday.

2. Preliminary review. Within five (5) business days following the date of receipt of the external review request, the Plan will complete a preliminary review of the request to determine whether:
    a. The Claimant is or was covered under the Plan at the time the health care item or service was requested or, in the case of a retrospective review, was covered under the Plan at the time the health care item or service was provided;
    b. The Adverse Benefit Determination or the Final Adverse Benefit Determination does not relate to the Claimant's failure to meet the requirements for eligibility under the terms of the Plan (e.g., worker classification or similar determination);
    c. The Claimant has exhausted the Plan's internal appeal process unless the Claimant is not required to exhaust the internal appeals process under the interim final regulations;
    d. The Claimant has provided all the information and forms required to process an external review. Within one (1) business day after completion of the preliminary review, the Plan will issue a notification in writing to the Claimant. If the request is complete but not eligible for external review, such notification will include the reasons for its ineligibility and contact information for the Employee Benefits Security Administration (toll-free number 866-444-EBSA (3272)). If the request is not complete, such notification will describe the information or materials needed to make the request complete and the Plan will allow a Claimant to perfect the request for external review within the four (4) month filing period or within the forty-eight (48) hour period following the receipt of the notification, whichever is later.

3. Referral to Independent Review Organization. The Plan will assign an independent review organization (IRO) that is accredited by URAC or by a similar nationally-recognized accrediting organization to conduct the external review. Moreover, the Plan will take action against bias and to ensure independence.

Accordingly, the Plan will contract with (or direct the Claims Administrator to contract with, on its behalf) at least three IROs for assignments under the Plan and rotate claims assignments among them (or incorporate other independent unbiased method for selection of IROs, such as random selection). In addition, the IRO may not be eligible for any financial incentives based on the likelihood that the IRO will support the denial of benefits.

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

Expedited external review

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

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

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

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

## DEEMED EXHAUSTION OF INTERNAL CLAIMS PROCEDURES AND DE MINIMIS

Exception to the Deemed Exhaustion Rule

A Claimant will not be required to exhaust the internal claims and appeals procedures described above if the Plan fails to adhere to the claims procedures requirements. In such an instance, a Claimant may proceed immediately

to the External Review Program or make a claim in court. However, the internal claim and appeals procedures will not be deemed exhausted (meaning the Claimant must adhere to them before participating in the External Review Program or bringing a claim in court) in the event of a de minimis violation that does not cause, and is not likely to cause, prejudice or harm to the Claimant as long as the Plan Administrator demonstrates that the violation was for good cause or due to matters beyond the control of the Plan, the violation occurred in the context of an ongoing, good faith exchange of information between the Plan and the Claimant, and the violation is not reflective of a pattern or practice of non-compliance.

If a Claimant believes the Plan Administrator has engaged in a violation of the claims procedures and would like to pursue an immediate review, the Claimant may request that the Plan provide a written explanation of the violation, including a description of the Plan's basis for asserting that the violation should not result in a "deemed exhaustion" of the claims procedures. The Plan will respond to this request within ten days. If the External Reviewer or a court rejects a request for immediate review because the Plan has met the requirements for the "de minimis" exception described above, the Plan will provide the Claimant with notice of an opportunity to resubmit and pursue an internal appeal of the claim.

## APPOINTMENT OF AUTHORIZED REPRESENTATIVE

A Claimant may designate another individual to be an authorized representative and act on his or her 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 Claimant, 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 will permit, in a medically urgent situation, such as a claim involving Urgent Care, a Claimant's treating health care practitioner to act as the Claimant's authorized representative without completion of the authorized representative form.

Should a Claimant designate an authorized representative, all future communications from the Plan will be conducted with the authorized representative instead of the Claimant, unless the Plan Administrator is otherwise notified in writing by the Claimant. A Claimant can revoke the authorized representative at any time. A Claimant 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 a similar form. An assignment of benefits by a Claimant shall not be recognized as a designation of the Provider as an authorized representative. Assignment and its limitations under this Plan are described below.

## CLAIM AUDIT

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

The analysis will be employed to identify charges billed in error and/or charges that are not Reasonable and Customary and/or Medically Necessary, if any, and may include a patient medical billing records review and/or audit of the patient's medical charts and records.

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

Despite the existence of any agreement to the contrary, the Plan Administrator has the discretionary authority to reduce any charge to a Reasonable and Customary charge, in accord with the terms of this Plan Document.

Please refer to the section entitled "Claim Review and Audit Program" for information regarding Plan provisions related to the audit and adjudication of certain claims under the Claim Review and Audit Program.

## AUTOPSY

Upon receipt of a claim for a deceased Claimant for any condition, sickness, or Injury is the basis of such claim, the Plan maintains the right to request an autopsy be performed upon said Claimant. The request for an autopsy may be exercised only where not prohibited by any applicable law.

## PAYMENT OF BENEFITS

Where benefit payments are allowable in accordance with the terms of this Plan, payment shall be made in United States Dollars (unless otherwise agreed upon by the Plan Administrator). Payment shall be made, in the Plan Administrator's discretion, to an assignee of an assignment of benefits, but in any instance may alternatively be made to the Claimant, on whose behalf payment is made and who is the recipient of the services for which payment is being made. Should the Claimant be deceased, payment shall be made to the Claimant's heir, assign, agent or estate (in accordance with written instructions), or, if there is no such arrangement and in the Plan Administrator's discretion, the Institute and/or Provider who provided the care and/or supplies for which payment is to be made – regardless of whether an assignment of benefits occurred.

## ASSIGNMENTS

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

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

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

## NON UNITED STATES PROVIDERS

A Provider of medical care, supplies, or services, whose primary facility, principal place of business or address for payment is located outside the United States shall be deemed to be a "Non United States Provider." Claims for medical care, supplies, or services provided by a Non United States Provider and/or that are rendered outside the United States of America, may be deemed to be payable under the Plan by the Plan Administrator, subject to all Plan exclusions, limitations, maximums and other provisions. Assignment of benefits to a Non United States Provider is prohibited absent an explicit written waiver executed by the Plan Administrator. If assignment of benefits is not authorized, the Claimant is responsible for making all payments to Non United States Providers, and is solely responsible for subsequent submission of proof of payment to the Plan. Only upon receipt of such proof of payment, and any other documentation needed by the Plan Administrator to process the claims in accordance with the terms of the Plan, shall reimbursement by the Plan to the Claimant be made. If payment was made by the Claimant in United

States currency (American dollars), the maximum reimbursable amount by the Plan to the Claimant shall be that amount. If payment was made by the Claimant using any currency other than United States currency (American dollars), the Plan shall utilize an exchange rate in effect on the Incurred date as established by a recognized and licensed entity authorized to so establish said exchange rates. The Non United States Provider shall be subject to, and shall act in compliance with, all United States and other applicable licensing requirements; and claims for benefits must be submitted to the Plan in English.

## RECOVERY OF PAYMENTS

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

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

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

Providers and any other person or entity accepting payment from the Plan or to whom a right to benefits has been assigned, in consideration of services rendered, payments and/or rights, agrees to be bound by the terms of this Plan and agree to submit claims for reimbursement in strict accordance with their State's health care practice acts, ICD-9 or CPT standards, Medicare guidelines, HCPCS standards, or other standards approved by the Plan Administrator or insurer. Any payments made on claims for reimbursement not in accordance with the above provisions shall be repaid to the Plan within thirty (30) days of discovery or demand or incur prejudgment interest of one and a half percent (1.5%) per month. If the Plan must bring an action against a Claimant, Provider or other person or entity to enforce the provisions of this section, then that Claimant, Provider or other person or entity agrees to pay the Plan's attorneys' fees and costs, regardless of the action's outcome.

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

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

1. In error.
2. Pursuant to a misstatement contained in a proof of loss or a fraudulent act.

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

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

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

## MEDICAID COVERAGE

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

## LIMITATION OF ACTION

A Claimant cannot bring any legal action against the Plan for a claim of benefits until ninety (90) days after all appeal processes have been exhausted. After ninety (90) days, if the Claimant wants to bring a legal action against the Plan, he or she must do so within three (3) years of the date he or she is notified of the final decision on the final appeal or he or she will lose any rights to bring such an action against the Plan.

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

## BALANCE BILLING

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

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

The Covered Person is responsible for payment of applicable Co-insurances, Deductibles, and out-of-pocket maximums and may be billed for any or all of these.

## 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 healthcare Providers are not agents or delegates of the Plan Sponsor, Company, Plan Administrator, Employer or Claims Administrator. The delivery of medical and other healthcare services on behalf of any Covered Person remains the sole prerogative and responsibility of the attending Physician or other healthcare Provider. The Covered Person, together with his or her Physician, is ultimately responsible for determining the appropriate course of medical treatment, regardless of whether the Plan will pay for all or a portion of the cost of such care.

# PLAN ADMINISTRATION

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

## PLAN ADMINISTRATOR

The Plan is administered by the Plan Administrator in accordance with ERISA and in accordance with these provisions. An individual, committee, or entity may be appointed by the Plan Sponsor to be Plan Administrator and serve at the convenience of the Plan Sponsor. If the appointed Plan Administrator or a committee member 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 shall be administered by the Plan Administrator, in accordance with its terms. Policies, interpretations, practices, and procedures are established and maintained by the Plan Administrator. 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 all interpretive and factual determinations as to whether any individual is eligible and entitled to receive any benefit under the terms of this Plan, to decide disputes which may arise with respect 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 will be final and binding on all interested parties. Benefits will be paid under this Plan only if the Plan Administrator, in its discretion, determines 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, the provision shall be considered ambiguous and shall be interpreted by the Plan Administrator in a fashion consistent with its intent, as determined by the Plan Administrator. The Plan may be amended retroactively to cure any such ambiguity, notwithstanding anything in the Plan to the contrary.

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

**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 and/or availability of benefits.
6. To prescribe procedures for filing a claim for benefits, to review claim denials and appeals relating to them and to uphold or reverse such denials.
7. To keep and maintain the Plan documents and all other records pertaining to the Plan.

8. To appoint and supervise a 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 is a QMCSO.
11. To delegate to any person or entity such powers, duties and responsibilities as it deems appropriate.
12. To perform each and every function necessary for or related to the Plan's administration.

## AMENDING AND TERMINATING THE PLAN

This Plan was established for the exclusive benefit of the Employees with the intention it will continue indefinitely; however, as the settlor of the Plan, the Plan Sponsor, through its directors and officers, may, in its sole discretion, at any time, amend, suspend or terminate the Plan in whole or in part. This includes amending the benefits under the Plan or the trust agreement (if any). All amendments to this Plan shall become effective as of a date established by the Plan Sponsor.

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

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

## SUMMARY OF MATERIAL MODIFICATION (SMM)

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

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

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

## SUMMARY OF MATERIAL REDUCTION (SMR)

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

The Plan Administrator shall notify all eligible Employees of any plan amendment considered a Material Reduction in covered services or benefits provided by the Plan as soon as administratively feasible after its adoption, but no later than 60 days after the date of adoption of the reduction. Eligible Employees and beneficiaries must be furnished

a summary of such reductions, and any changes so made shall be binding on each Participant. The 60 day period for furnishing a summary of Material Reduction does not apply to any Employee covered by the Plan who would reasonably expect to receive a summary through other means within the next 90 days.

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

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

# MISCELLANEOUS PROVISIONS

## NOT A CONTRACT

This Plan Document and any amendments constitute the terms and provisions of coverage under this Plan. The Plan Document is not to be construed as a contract of any type between the Company and any Covered Person or to be consideration for, or an inducement or condition of, the employment of any Employee. Nothing in this Plan Document shall be deemed to give any Employee the right to be retained in the service of the Company or to interfere with the right of the Company to discharge any Employee at any time; provided, however, that the foregoing shall not be deemed to modify the provisions of any collective bargaining agreements which may be entered into by the Company with the bargaining representatives of any Employees.

## MENTAL HEALTH PARITY

Pursuant to the Mental Health Parity Act (MHPA) of 1996 and the Mental Health Parity and Addiction Equity Act of 2008 (MHPAEA), collectively, the mental health parity provisions in Part 7 of ERISA, this Plan applies its terms uniformly and enforces parity between covered health care benefits and covered mental health and substance disorder benefits relating to financial cost sharing restrictions and treatment duration limitations. For further details, please contact the Plan Administrator.

### NON-DISCRIMINATION

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

## APPLICABLE LAW

Any provision of this Plan that is contrary to any applicable law, regulation or court order (if such a court is of competent jurisdiction) will be interpreted to comply with said law, or, if it cannot be so interpreted, shall be automatically amended to satisfy the law's minimum requirement. It is intended that the Plan will conform to the requirements of ERISA, as it applies to Employee welfare plans, as well as any other applicable law.

## DISCRETIONARY AUTHORITY

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

## CLERICAL ERROR/DELAY

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 to such records will not invalidate coverage otherwise validly in force or continue coverage validly terminated. Contributions made in error by Covered Persons due to such clerical error will be returned to the Covered Person; coverage will not be inappropriately extended. Contributions that were due but not made, in error and due to such clerical error will be owed immediately upon identification of said clerical error. Failure to so remedy amounts owed may result in termination of coverage. Effective Dates, waiting periods,

deadlines, rules, and other matters will be established based upon the terms of the Plan, as if no clerical error had occurred. 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 Plan Covered Person, the amount of overpayment may be deducted from future benefits payable.

## CONFORMITY WITH APPLICABLE LAWS

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

## FRAUD

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

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

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

## HEADINGS

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

## WORD USAGE

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

## NO WAIVER OR ESTOPPEL

All parts, portions, provisions, conditions, and/or other items addressed by this Plan shall be deemed to be in full force and effect, and not waived, absent an explicit written instrument expressing otherwise; executed by the Plan Administrator. Absent such explicit waiver, there shall be no estoppel against the enforcement of any provision of this Plan. Failure by any applicable entity to enforce any part of the Plan shall not constitute a waiver, either as it

specifically applies to a particular circumstance, or as it applies to the Plan's general administration. If an explicit written waiver is executed, that waiver shall only apply to the matter addressed therein, and shall be interpreted in the narrowest fashion possible.

## PLAN CONTRIBUTIONS

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

The Plan Sponsor shall fund the Plan in a manner consistent with the provisions of the Internal Revenue Code, ERISA, and such other laws and regulations as shall be applicable to the end that the Plan shall be funded on a lawful and sound basis The manner and means by which the Plan is funded shall be solely determined by the Plan Sponsor, to the extend allowed by applicable law.

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

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

## RIGHT TO RECEIVE AND RELEASE 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 person any information regarding coverage, expenses, and benefits which the Plan Administrator, at its sole discretion, considers necessary to determine and apply the provisions and benefits of this Plan. In so acting, the Plan Administrator shall be free from any liability that may arise with regard to such action. 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.

## WRITTEN NOTICE

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

## RIGHT OF RECOVERY

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

## STATEMENTS

All statements made by the Company or by a Covered Person will, in the absence of fraud, be considered representations and not warranties, and no statements made for the purpose of obtaining benefits under this document will be used in any contest to avoid or reduce the benefits provided by the document unless contained in a written application for benefits and a copy of the instrument containing such representation is or has been furnished to the Covered Person.

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

## PROTECTION AGAINST CREDITORS

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

# HIPAA PRIVACY

## Commitment to Protecting Health Information

The Plan will comply with the Standards for Privacy of Individually Identifiable Health Information (i.e., the "Privacy Rule") set forth by the U.S. Department of Health and Human Services ("HHS") pursuant to the Health Insurance Portability and Accountability Act of 1996 ("HIPAA"). Such standards control the dissemination of "protected health information" ("PHI") of Participants. Privacy Standards will be implemented and enforced in the offices of the Employer and Plan Sponsor and any other entity that may assist in the operation of the Plan.

The Plan is required by law to take reasonable steps to ensure the privacy of the Participant's PHI, and inform him/her about:

1. The Plan's disclosures and uses of PHI.
2. The Participant's privacy rights with respect to his or her PHI.
3. The Plan's duties with respect to his or her PHI.
4. The Participant's right to file a complaint with the Plan and with the Secretary of HHS.
5. The person or office to contact for further information about the Plan's privacy practices.

**The Plan provides each Participant with a separate Notice of Privacy Practices. This Notice describes how the Plan uses and discloses a Participant's personal health information. It also describes certain rights the Participant has regarding this information. Additional copies of the Plan's Notice of Privacy Practices are available.**

Within this provision capitalized terms may be used, but not otherwise defined. These terms shall have the same meaning as those terms set forth in 45 CFR Sections 160.103 and 164.501. Any HIPAA regulation modifications altering a defined HIPAA term or regulatory citation shall be deemed incorporated into this provision.

## Definitions

- **Breach** means an unauthorized acquisition, access, use or disclosure of Protected Health Information ("PHI") or Electronic Protected Health Information ("ePHI") that violates the HIPAA Privacy Rule and that compromises the security or privacy of the information.
- **Protected Health Information ("PHI")** means individually identifiable health information, as defined by HIPAA, that is created or received by the Plan and that relates to the past, present, or future physical or mental health or condition of an individual; the provision of health care to an individual; or the past, present, or future payment for the provision of health care to an individual; and that identifies the individual or for which there is a reasonable basis to believe the information can be used to identify the individual. PHI includes information of persons living or deceased.

## HOW HEALTH INFORMATION MAY BE USED AND DISCLOSED

In general, the Privacy Rules permit the Plan to use and disclose, the minimum necessary amount, an individual's PHI, without obtaining authorization, only if the use or disclosure is for any of the following:

1. To carry out Payment of benefits; or
2. If the use or disclosure falls within one of the limited circumstances described in the rules (e.g., the disclosure is required by law or for public health activities).

## Primary Uses and Disclosures of PHI

1. Treatment, Payment and Health Care Operations: The Plan has the right to use and disclose a Participant's PHI for all activities as included within the definitions of Treatment, Payment, and Health Care Operations and pursuant to the HIPAA Privacy Rule.

2. Business Associates: The Plan contracts with individuals and entities (Business Associates) to perform various functions on its behalf. In performance of these functions or to provide services, Business Associates will receive, create, maintain, use, or disclose PHI, but only after the Plan and the Business Associate agree in writing to contract terms requiring the Business Associate to appropriately safeguard the Participant's information.
3. Other Covered Entities: The Plan may also disclose or share PHI with other insurance carriers (such as Medicare, etc.) in order to coordinate benefits, if a Participant has coverage through another carrier.

**Disclosure of PHI to the Plan Sponsor for Plan Administration Purposes**

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

1. Not use or further disclose PHI other than as permitted or required by the Plan documents or as required by law (as defined in the Privacy Standards).
2. Ensure that any agents, including a subcontractor, to whom the Plan Sponsor provides PHI received from the Plan, agree to the same restrictions and conditions that apply to the Plan Sponsor with respect to such PHI.
3. Maintain the confidentiality of all PHI, unless an individual gives specific consent or authorization to disclose such data or unless the data is used for health care payment or Plan operations.
4. Receive PHI, in the absence of an individual's express authorization, only to carry out Plan administration functions.
5. 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.
6. Make available PHI in accordance with section 164.524 of the Privacy Standards (45 CFR 164.524).
7. 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).
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 United States 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.

**Required Disclosures of PHI**

1. Disclosures to Covered Persons: The Plan is required to disclose to a Covered Person most of the PHI in a Designated Record Set when the Covered Person requests access to this information. The Plan will disclose a Covered Person's PHI to an individual who has been assigned as his or her representative and who has qualified for such designation in accordance with the relevant State law. Before disclosure to an individual qualified as a personal representative, the Plan must be given written supporting documentation establishing the basis of the personal representation.

   The Plan may elect not to treat the person as the Covered Person's personal representative if it has a reasonable belief that the Covered Person has been, or may be, subjected to domestic violence, abuse, or neglect by such person, it is not in the Covered Person's best interest to treat the person as his or her personal representative, or treating such person as his or her personal representative could endanger the Covered Person.

2. Disclosures to the Secretary of the United States Department of Health and Human Services: The Plan is required to disclose the Covered Person's PHI to the Secretary of the United States Department of Health and Human Resources when the Secretary is investigating or determining the Plan's compliance with the HIPAA Privacy Rule.

**Covered Person's Rights**

The Covered Person has the following rights regarding PHI about him/her:

1. Request Restrictions: The Covered Person has the right to request additional restrictions on the use or disclosure of PHI for treatment, payment, or health care operations. The Covered Person may request that the Plan restrict disclosures to family members, relatives, friends or other persons identified by him/her who are involved in his or her care or payment for his or her care. The Plan is not required to agree to these requested restrictions.
2. Right to Receive Confidential Communication: The Covered Person has the right to request that he or she receive communications regarding PHI in a certain manner or at a certain location. The request must be made in writing and how the Covered Person would like to be contacted. The Plan will accommodate all reasonable requests.
3. Right to Receive Notice of Privacy Practices: The Covered Person is entitled to receive a paper copy of the plan's Notice of Privacy Practices at any time. To obtain a paper copy, contact the Privacy Officer Coordinator.
4. Accounting of Disclosures: The Covered Person has the right to request an accounting of disclosures the Plan has made of his or her PHI. The request must be made in writing and does not apply to disclosures for treatment, payment, health care operations, and certain other purposes. The Covered Person is entitled to such an accounting for the six years prior to his or her request. Except as provided below, for each disclosure, the accounting will include: (a) the date of the disclosure, (b) the name of the entity or person who received the PHI and, if known, the address of such entity or person; (c) a description of the PHI disclosed, (d) a statement of the purpose of the disclosure that reasonably informs the Covered Person of the basis of the disclosure, and certain other information. If the Covered Person wishes to make a request, please contact the Privacy Officer Coordinator.
5. Access: The Covered Person has the right to request the opportunity to look at or get copies of PHI maintained by the Plan about him/her in certain records maintained by the Plan. If the Covered Person requests copies, he or she may be charged a fee to cover the costs of copying, mailing, and other supplies. To inspect or copy PHI, or to have a copy of your PHI transmitted directly to another designated person, contact the Privacy Officer Coordinator. A request to transmit PHI directly to another designated person must be in writing, signed by the Covered Person and the recipient must be clearly identified. The Plan must respond to the Covered Person's request within thirty (30) days (in some cases, the Plan can request a thirty (30) day extension). In very limited circumstances, the Plan may deny the Covered Person's request. If the Plan denies the request, the Covered Person may be entitled to a review of that denial.
6. Amendment: The Covered Person has the right to request that the Plan change or amend his or her PHI. The Plan reserves the right to require this request be in writing. Submit the request to the Privacy Officer Coordinator. The Plan may deny the Covered Person's request in certain cases, including if it is not in writing or if he or she does not provide a reason for the request.
7. Other uses and disclosures not described in this section can only be made with authorization from the Participant. The Participant may revoke this authorization at any time.

**Questions or Complaints**

If the Covered Person wants more information about the Plan's privacy practices, has questions or concerns, or believes that the Plan may have violated his or her privacy rights, please contact the Plan using the following information. The Covered Person may submit a written complaint to the United States Department of Health and Human Services or with the Plan. The Plan will provide the Covered Person with the address to file his or her complaint with the United States Department of Health and Human Services upon request.

The Plan will not retaliate against the Covered Person for filing a complaint with the Plan or the United States Department of Health and Human Services.

**Plan Contact Information**

Contact Information:
TEAM Risk Management Strategies, LLC
3131 Camino Del Rio North, Suite 650
San Diego, CA 92108
Phone: 1-619-281-1100
Fax: Please contact Plan Administrator for a secure fax number
Email/Website: https://team-risk.com

# HIPAA SECURITY

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

**STANDARDS FOR SECURITY OF INDIVIDUALLY IDENTIFIABLE HEALTH INFORMATION ("SECURITY RULE")**

The Health Insurance Portability and Accountability Act (HIPAA) and other applicable law shall override the following wherever there is a conflict, or a term or terms is/are not hereby defined.

The Security Rule imposes regulations for maintaining the integrity, confidentiality and availability of protected health information that it creates, receives, maintains, or maintains electronically that is kept in electronic format (ePHI) as required under HIPAA.

## DEFINITIONS

- **Electronic Protected Health Information (ePHI)**, as defined in Section 160.103 of the Security Standards (45 C.F.R. 160.103), means individually identifiable health information transmitted or maintained in any electronic media.
- **Security Incidents**, as defined within Section 164.304 of the Security Standards (45 C.F.R. 164.304), means the attempted or successful unauthorized access, use, disclosure, modification, or destruction of information or interference with systems operation in an information system.

## PLAN SPONSOR OBLIGATIONS

To enable the Plan Sponsor to receive and use Electronic PHI for Plan Administration Functions (as defined in 45 CFR §164.504(a)), the Plan Sponsor agrees to:

1. Implement administrative, physical, and technical safeguards that reasonably and appropriately protect the confidentiality, integrity and availability of the Electronic PHI that it creates, receives, maintains, or transmits on behalf of the Plan.
2. Ensure that adequate separation between the Plan and the Plan Sponsor, as required in 45 CFR § 164.504(f)(2)(iii), is supported by reasonable and appropriate Security Measures.
3. Ensure that any agent, including a subcontractor, to whom the Plan Sponsor provides Electronic PHI created, received, maintained, or transmitted on behalf of the Plan, agrees to implement reasonable and appropriate administrative, physical, and technical safeguards to protect the confidentiality, integrity, and availability of the Electronic PHI and report to the Plan any security incident of which it becomes aware.
4. Report to the Plan any security incident of which it becomes aware.
5. Establish safeguards for information, including security systems for data processing and storage.
6. Not use or disclose PHI for employment-related actions and decisions or in connection with any other benefit or Employee benefit plan of the Plan Sponsor, except pursuant to an authorization which meets the requirements of the Privacy Standards.
7. Ensure that adequate separation between the Plan and the Plan Sponsor, as required in section 164.504(f)(2)(iii) of the Privacy Standards (45 CFR 164.504(f)(2)(iii)), is established as follows:
    a. The following Employees, or classes of Employees, or other persons under control of the Plan Sponsor, shall be given access to the PHI to be disclosed:
        i. Privacy Officer.
        ii. Director of Employee Benefits.
        iii. Employee Benefits Department employees.
        iv. Information Technology Department.
    b. The access to and use of PHI by the individuals identified above shall be restricted to the plan administration functions that the Plan Sponsor performs for the Plan.

## Disclosure of Summary Health Information to the Plan Sponsor

The Plan may disclose PHI to the Plan Sponsor of the group health plan for purposes of plan administration or pursuant to an authorization request signed by the Covered Person. The Plan may use or disclose "summary health information" to the Plan Sponsor for obtaining premium bids or modifying, amending, or terminating the group health plan. "Summary health information" may be individually identifiable health information and it summarizes the claims history, claims expenses or the type of claims experienced by individuals in the plan, but it excludes all identifiers that must be removed for the information to be de-identified, except that it may contain geographic information to the extent that it is aggregated by five-digit zip code.

## Disclosure of Certain Enrollment Information to the Plan Sponsor

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

## Disclosure of PHI to Obtain Stop-loss or Excess Loss Coverage

The Plan Sponsor may hereby authorize and direct the Plan, through the Plan Administrator or the Third Party Administrator, to disclose PHI to stop-loss carriers, excess loss carriers or managing general underwriters ("MGUs") for underwriting and other purposes in order to obtain and maintain stop-loss or excess loss coverage related to benefit claims under the Plan. Such disclosures shall be made in accordance with the Privacy Standards.

## Resolution of Noncompliance

In the event that any authorized individual of the Employer's workforce uses or discloses Protected Health Information other than as permitted by the Privacy Standards, the incident shall be reported to the Privacy Officer. The Privacy Officer shall take appropriate action, including:

1. Investigation of the incident to determine whether the breach occurred inadvertently, through negligence, or deliberately; whether there is a pattern of breaches; and the degree of harm caused by the breach.
2. Applying appropriate sanctions against the persons causing the breach, which, depending upon the nature of the breach, may include oral or written reprimand, additional training, or termination of employment.
3. Mitigating any harm caused by the breach, to the extent practicable.
4. Documentation of the incident and all actions taken to resolve the issue and mitigate any damages.
5. Training Employees in privacy protection requirements and appoint a Privacy Officer responsible for such protections.
6. Disclosing the Covered Person's PHI to the Secretary of the U.S. Department of Health and Health and Human Resources when the Secretary is investigating or determining the Plan's compliance with the HIPAA Privacy Rule.

# PARTICIPANT'S RIGHTS

As a Covered Person in the Plan, he or she is entitled to certain rights and protections under ERISA as follows:

## RECEIVE INFORMATION ABOUT YOUR PLAN AND BENEFITS

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

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

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

## CONTINUE GROUP HEALTH PLAN COVERAGE

Continue health care coverage for yourself, spouse or Dependents if there is a loss of coverage under the Plan as a result of a Qualifying Event. You or your Dependents may have to pay for such coverage. Review this Plan Document and the documents governing the Plan on the rules governing your COBRA Continuation Coverage rights.

You should be provided a Certificate of Coverage, free of charge, from your Group Health Plan or health insurance issuer when you lose coverage under the plan, when you become entitled to elect COBRA Continuation Coverage, when your COBRA Continuation Coverage ceases, if you request it before losing coverage, or if you request it up to 24 months after losing coverage.

## PRUDENT ACTIONS BY PLAN FIDUCIARIES

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

## ENFORCE YOUR RIGHTS

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

Under ERISA, there are steps you can take to enforce the above rights. For instance, if you request a copy of Plan documents or the latest annual report from the Plan and do not receive them within thirty (30) days, you may file suit in a Federal court. In such a case, the court may require the Plan Administrator to provide the materials and pay you up to one hundred and ten ($110) dollars per day until you receive the materials, unless the materials were not sent because of reasons beyond the control of the Plan Administrator. If you have a claim for benefits which is denied or ignored, in whole or in part, you may file suit in a State or Federal court. In addition, if you disagree with the Plan's decision or lack thereof concerning the qualified status of a domestic relations order or a Medical Child Support Order, you may file suit in Federal court. If it should happen that Plan fiduciaries misuse the Plan's money,

or if you are discriminated against for asserting your rights, you may seek assistance from the United States Department of Labor, or you may file suit in a Federal court. The court will decide who would pay court costs and legal fees. If you are successful, the court may order the person you have sued to pay these costs and fees. If you lose, the court may order you to pay these costs and fees, for example, if it finds your claim is frivolous.

## ASSISTANCE WITH YOUR QUESTIONS

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

# GENERAL PLAN INFORMATION

## TYPE OF ADMINISTRATION

The Plan Sponsor has established the Plan for the benefit of eligible Employees and their eligible Dependents, in accordance with the terms and conditions described herein. Plan benefits are self-funded through a benefit fund or a trust established by the Plan Sponsor and self-funded with contributions from Covered Persons and/or the Plan Sponsor, or are funded solely from the general assets of the Plan Sponsor. The Plan's benefits and administration expenses are paid directly from the Employer's general assets. Covered Persons in the Plan may be required to contribute toward their benefits. Contributions received from Covered Persons are used to cover Plan costs and are expended immediately.

The Plan Sponsor's purpose in establishing the Plan is to protect eligible Employees and their Dependents against certain health expenses and to help defray the financial effects arising from Injury or sickness. To accomplish this purpose, the Plan Sponsor must be mindful of the need to control and minimize health care costs through innovative and efficient plan design and cost containment provisions, and of abiding by the terms of the Plan Document, to allow the Plan Sponsor to effectively assign the resources available to help Covered Persons in the Plan to the maximum feasible extent.

**PLAN NAME**
TEAM Risk Management Strategies, LLC

**PLAN NUMBER**
501

**TAX ID NUMBER**
68-0535627

**PLAN AMENDED AND RESTATED**
January 1, 2020

**PLAN YEAR ENDS**
October 31

**EMPLOYER INFORMATION**
TEAM Risk Management Strategies, LLC
3131 Camino Del Rio North, Suite 650
San Diego, CA 92108
Phone: 1-619-281-1100
Fax: 1-619-281-1926

**PLAN ADMINISTRATOR**
TEAM Risk Management Strategies, LLC
3131 Camino Del Rio North, Suite 650
San Diego, CA 92108
Phone: 1-619-281-1100
Fax: 1-619-281-1926

**AGENT FOR SERVICE OF LEGAL PROCESS**
TEAM Risk Management Strategies, LLC
3131 Camino Del Rio North, Suite 650 San Diego, CA 92108
Phone: 1-619-281-1100
Fax: 1-619-281-1926

**CLAIMS ADMINISTRATOR**
Benefit Administrative Services, L.L.C.
17475 Jovanna Drive, 1D
Homewood, IL 60430
(708) 799-7400

**SOURCE OF FUNDING**
Self-Funded

**PLAN STATUS**
Non-Grandfathered

**APPLICABLE LAW**
ERISA

**PLAN YEAR**
November - October

**PLAN TYPE**
Medical
Prescription Drugs
Dental
Vision

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

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