CBA Blue

An Independent Licensee of the Blue Cross and Blue Shield Association

ROARING FORK EMPLOYEE MINIMUM ESSENTIAL COVERAGE PLAN

Summary Plan Description

Effective: May 1, 2014
Last Revision: May 1, 2021

ROARING FORK EMPLOYEE
MINIMUM ESSENTIAL COVERAGE PLAN

INTRODUCTION

This is a summary of the **ROARING FORK** Employee Minimum Essential Coverage Plan (the "Plan").

In accordance with the Plan's status as a self-funded ERISA welfare plan, the Contract Administrator shall administer the Plan to comply with any introduced Code of Federal Regulations (CFR) or related amendments, from the executive departments and agencies of the federal government, that pertain to a participant's access to the ERISA-governed benefits described herein, including covered and/or excluded expenses, filing procedures, and review procedures.

This booklet is provided to help you understand how the Plan works. It highlights what types of expenses are covered under the Plan, definitions you need to know, how to file claims and what your legal rights are under the Plan.

Your employer, as a member of the National Franchisee Association, is sponsoring this self-funded ERISA employee health plan which provides medical benefits for all covered employees and their covered dependent(s). Stop loss reinsurance is being purchased to protect the Plan Sponsor from unpredictable claims experience.

Each covered person is entitled to the benefits outlined in this Plan Document. To obtain benefits from the Plan, the covered person must ultimately submit a diagnostic bill to the Contract Administrator, Comprehensive Benefits Administrator, LLC dba CBA Blue, for processing. This claim submission is required for reimbursement to the employee or direct payment to the service provider by the National Franchisee Association Health + Medical Plan.

In any event where a question may arise as to a claim for benefits or denial of a claim for benefits, the Employer, the Contract Administrator (the third-party administrator) and any other persons that may be associated with the Plan's operation will be guided solely by this Plan document, which is also the Summary Plan Description within the meaning of the Employee Retirement Income Security Act of 1974, as amended ("ERISA").

A clerical error will neither invalidate the employee's coverage if otherwise validly in force nor continue coverage otherwise validly terminated.

Comprehensive Benefits Administrator, LLC dba CBA Blue, an independent licensee of the Blue Cross and Blue Shield Association, provides administrative claims payment services only and does not assume any financial risk or obligation with respect to claims.

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GENERAL INFORMATION

Plan Sponsor: ROARING FORK
- Grate Concepts LLC
- MR CHICKEN

Federal Tax Identification Number: 39-1917008

Name of the Plan: Employee Health Plan of **ROARING FORK**

Plan Number: 502

Plan Administrator: Plan Sponsor, acting through its exclusive agent, Steven E. Schindler, Trustee of the NFA Member Plan Master Trust and exclusive agent of the Sponsor:
337 Pennock Lane
Rutland, VT 05701

Group Number: 50704

Benefits Covered: Medical benefits under the **ROARING FORK** Minimum Essential Coverage Plan

Plan Effective Date: May 1, 2022

Plan Anniversary Date: May 1st

Plan Year Ends: April 30th

Contract Administrator/Pre-Certification Administrator:
Comprehensive Benefits Administrator, LLC dba CBA Blue
P.O. Box 2365
South Burlington, VT 05407-2365
Customer Service & Pre-Certification: (888) 222-9206

Agency for Service of Legal Process: Steven E. Schindler, Trustee of the NFA Member Plan Master Trust and exclusive agent of the Sponsor
337 Pennock Lane
Rutland, VT 05701

Contributions: The Plan is contributory.

Eligibility Requirements: All employees working an average of twenty (20) hours or more per week.

The Plan Sponsor will identify those employees who have performed sufficient hours of service to be considered "full-time" employees eligible to participate in the Plan. To do so, the Plan Sponsor may use any method permitted by the final "Employer Shared Responsibility" regulations issued by the IRS and the Department of Treasury (the Employer Shared Responsibility Regulations) under the Patient Protection and Affordable Care Act of 2010 (the Affordable Care Act). Depending on the Plan Sponsor's application of the Employer Shared Responsibility Regulations, in certain circumstances, an employee may be eligible for coverage under the Plan during periods in which the employee performed fewer than thirty (30) hours of service per week. Contact the Plan Sponsor if you have questions about your eligibility to receive coverage under the Plan.

Dependent Children's Coverage: Married or unmarried dependent children up to twenty-six (26) years of age.

Eligibility Date: First day of the month following sixty (60) days of continuous employment unless the waiting period is waived as a condition of employment.

Termination Date: See "Termination of Benefits" section.

ROARING FORK
Employee Minimum Essential Coverage
Basic Plan

Benefit	
INPATIENT CARE (PER DIEM BENEFIT)	
Daily Hospital Confinement	Plan pays $450 per day $900 per day for ICU
Inpatient Mental Health/Substance Abuse	Plan pays $100 per day
Convalescent Hospital/Extended Care Facility/Skilled Nursing Facility	Plan pays $100 per day
Anesthesia Services	Plan pays $100 per day
SURGERY (PER SURGERY BENEFIT)	
Inpatient	Plan pays $1,000 per surgery
Outpatient	Plan pays $500 per surgery
Office Visit	Plan pays $100 per surgery
PHYSICIAN'S SERVICES (PER VISIT BENEFIT)	
Preventive Care (only covered when received from an in-network provider)	Plan pays 100% See Schedule on page 8
Physician's Office Visits (Non-Wellness)	Plan pays $40 per visit
Specialist Office Visits (Non-Wellness)	Plan pays $60 per visit
Chiropractic Care	Plan pays $25 per visit
Outpatient Physical Therapy	Plan pays $25 per visit
EMERGENCY CARE	
Ambulance Services	Plan pays $100 (Ground) $500 (Air)
Emergency Room Services	Plan pays $75 per visit
Urgent Care Services	Plan pays $40 per visit

ROARING FORK
Employee Minimum Essential Coverage
Basic Plan

OUTPATIENT DIAGNOSTIC IMAGING (PER SERVICE BENEFIT)	
Labs	Plan pays $10 per service
X-Ray/Ultrasound	Plan pays $50 per service
PET	Plan pays $150 per service
CT Scan	Plan pays $200 per service
MRI	Plan pays $350 per service
PRESCRIPTION DRUGS – 30 DAY SUPPLY RETAIL; 90 DAY SUPPLY MAIL ORDER (PER SCRIPT BENEFIT)	
Prescription Drug Benefits	**1–30 day supply retail & 90 day supply mail order:** Generic – Plan pays up to $10 per script Preferred Brand – Plan pays up to $25 per script Non-Preferred Brand – Plan pays up to $40 per script **31 – 90 day supply retail:** Generic – Plan pays up to $30 per script Preferred Brand – Plan pays up to $75 per script Non-Preferred Brand – Plan pays up to $120 per script

NOTES:

1. This Plan is participating with Blue Cross Blue Shield of Vermont preferred provider network as well as the BlueCard Program. These preferred providers will bill the Contract Administrator directly and write off charges that exceed their contractual allowances.
3. All covered charges billed by non-participating providers will be subject to a maximum allowable benefit. Preventive care benefits are only covered when received from an in-network provider.
4. All other benefits not listed above will not be covered.
5. The Plan pays up to the dollar amount listed on the Schedule of Benefits. With the exception of prescription drug benefits, if reimbursement to the provider totals less than the dollar amounts listed, the covered person will be reimbursed the difference.
6. Except as outlined in "No Surprises Act – Emergency Services and Surprise Bills" below, if the charge billed by an Out-of-Network Provider for any covered service is higher than the Maximum Allowable Benefit determined by the Plan, Covered Persons are responsible for the excess unless the Provider accepts assignment of payment as consideration in full for services rendered. Since In-Network Providers have agreed to accept a negotiated discounted fee as full payment for their services, Covered Persons are not responsible for any billed amount that exceeds that fee. The Plan Administrator reserves the right to revoke any previously-given assignment of payment or to proactively prohibit assignment of payment to anyone, including any Provider, at its discretion

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

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

No Surprises Act – Emergency Services and Surprise Bills

For Out-of-Network claims subject to the No Surprises Act, Covered Person Cost-Sharing will be the same amount as would be applied if the claim was provided by an In-Network Provider and will be calculated as if the Plan's allowable expense was the Recognized Amount,
regardless of the Plan's actual Maximum Allowable Benefit. The No Surprises Act prohibits Providers from pursuing Covered Persons for the difference between the Maximum Allowable Benefit and the Provider's billed charge for applicable services, with the exception of valid Plan-appointed Cost-Sharing as outlined above. Any such Cost-Sharing amounts will accrue toward In-Network Deductibles and the Out-of-Pocket Maximum Limit.

Benefits for claims subject to the No Surprises Act will be denied or paid within 30 days of receipt of an initial claim, and if approved will be paid directly to the Provider.

Claims subject to the No Surprises Act are those which are submitted for:

- Emergency Services;
- Non-emergency services rendered by an Out-of-Network Provider at a Participating Health Care Facility, provided the Covered Person has not validly waived the applicability of the No Surprises Act; and
- Covered Out-of-Network air ambulance service

ROARING FORK
Employee Minimum Essential Coverage
Choice Plan

Benefit	
INPATIENT CARE (PER DIEM BENEFIT)	
Daily Hospital Confinement Requires pre-certification.	Plan pays $2,000 per day $4,000 per day for ICU
Inpatient Mental Health/Substance Abuse Requires pre-certification.	Plan pays $200 per day
Convalescent Hospital/Extended Care Facility/Skilled Nursing Facility Requires pre-certification.	Plan pays $200 per day
Anesthesia Services	Plan pays $300 per day
SURGERY (PER SURGERY BENEFIT)	
Inpatient	Plan pays $3,000 per surgery
Outpatient	Plan pays $2,000 per surgery
Office Visit	Plan pays $175 per surgery
PHYSICIAN'S SERVICES (PER VISIT BENEFIT)	
Preventive Care (only covered when received from an in-network provider)	Plan pays 100% See Schedule of Covered Services on page 8
Physician's Office Visits (Non-Wellness)	Plan pays $60 per visit
Specialist Office Visits (Non-Wellness)	Plan pays $80 per visit
Chiropractic Care	Plan pays $35 per visit
Outpatient Physical Therapy	Plan pays $35 per visit
EMERGENCY CARE	
Ambulance Services	Plan pays $150 (Ground) $750 (Air)
Emergency Room Services	Plan pays $200 per visit

ROARING FORK
Employee Minimum Essential Coverage Choice Plan

EMERGENCY CARE (continued)	
Urgent Care Services	Plan pays $60 per visit
OUTPATIENT DIAGNOSTIC IMAGING (PER SERVICE BENEFIT)	
Labs	Plan pays $15 per service
X-Ray/Ultrasound	Plan pays $75 per service
PET	Plan pays $225 per service
CT Scan	Plan pays $300 per service
MRI	Plan pays $500 per service
PRESCRIPTION DRUGS – 30 DAY SUPPLY RETAIL; 90 DAY SUPPLY MAIL ORDER (PER SCRIPT BENEFIT)	
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2. All covered charges billed by non-participating providers will be subject to a maximum allowable benefit. Preventive care benefits are only covered when received from an in-network provider.
3. All other benefits not listed above will not be covered.
4. The Plan pays up to the dollar amount listed on the Schedule of Benefits. With the exception of prescription drug benefits, if reimbursement to the provider totals less than the dollar amounts listed, the covered person will be reimbursed the difference.
5. Except as outlined in "No Surprises Act – Emergency Services and Surprise Bills" below, if the charge billed by an Out-of-Network Provider for any covered service is higher than the Maximum Allowable Benefit determined by the Plan, Covered Persons are responsible for the excess unless the Provider accepts assignment of payment as consideration in full for services rendered. Since In-Network Providers have agreed to accept a negotiated discounted fee as full payment for their services, Covered Persons are

not responsible for any billed amount that exceeds that fee. The Plan Administrator reserves the right to revoke any previously-given assignment of payment or to proactively prohibit assignment of payment to anyone, including any Provider, at its discretion

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

No Surprises Act – Emergency Services and Surprise Bills

For Out-of-Network claims subject to the No Surprises Act, Covered Person Cost-Sharing will be the same amount as would be applied if the claim was provided by an In-Network Provider and will be calculated as if the Plan's allowable expense was the Recognized Amount,
regardless of the Plan's actual Maximum Allowable Benefit. The No Surprises Act prohibits Providers from pursuing Covered Persons for the difference between the Maximum Allowable Benefit and the Provider's billed charge for applicable services, with the exception of valid Plan-appointed Cost-Sharing as outlined above. Any such Cost-Sharing amounts will accrue toward In-Network Deductibles and the Out-of-Pocket Maximum Limit.

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Claims subject to the No Surprises Act are those which are submitted for:

- Emergency Services;
- Non-emergency services rendered by an Out-of-Network Provider at a Participating Health Care Facility, provided the Covered Person has not validly waived the applicability of the No Surprises Act; and
- Covered Out-of-Network air ambulance service

PREVENTIVE CARE SCHEDULE

The list of preventive care services covered may change periodically based upon the recommendation of the United States Preventive Services Task Force, the Advisory Committee on Immunization Practices of the Centers for Disease Control and Prevention, and the Health Resources and Services Administration. Information on the recommendations of these agencies can be found at: http://www.uspreventiveservicestaskforce.org/uspstf/uspsabrecs.htm or at https://www.healthcare.gov/prevention.

Adults and Children

- Routine physical examinations
- Alcohol misuse screening and counseling (primary care visits only, beginning at age 11)
- Cervical Dysplasia screening (for sexually active females)
- Depression screening (adults, children ages 12-18, primary care visits only)
- HIV screening and counseling
- Immunizations, including flu shots (flu shots at age 19 and above at a doctor's office or pharmacy; under age 19 at a doctor's office)
- Obesity screening and counseling (adults and children, in primary care settings)
- Sexually transmitted diseases (STDs) – screenings and counseling (adolescents, adults and pregnant women)
- Skin cancer behavioral counseling

Adults Only

- Anemia screening for pregnant women
- Aspirin for the prevention of heart disease (no coverage for over-the-counter aspirin)
- Blood pressure screening (adults without known hypertension)
- Cholesterol screening
- Colorectal cancer screening, including colonoscopy, sigmoidoscopy and fecal occult blood test for adults over age 50
- Diabetes screenings
- Diet behavioral counseling (included as part of annual visit and intensive counseling by primary care clinicians or by nutritionists and dieticians)
- Vitamin D supplement for adults age 65 and older to decrease the risk of falls and fractures
- Lung cancer screening
- Hepatitis C screening
- Tobacco use screening and counseling (primary care visits only)

Women Only

- Breast cancer chemoprevention (counseling only for women at high risk for breast cancer and low risk for adverse effects of chemoprevention)
- Breast cancer genetic test counseling (BRCA) for women at higher risk for breast cancer
- Breast cancer mammography screening – every 1 to 2 years for women over age 40 (screening by ultrasound for covered persons whose screening mammograms were inconclusive or who have dense breast tissue, or both).
- Breastfeeding primary care interventions (applicable to pregnant women and new mothers) includes lactation classes and support at prenatal and post-partum visits, and newborn visits; supplies
- Cervical cancer screening, including pap smears

- Comprehensive lactation support, counseling, and costs of renting breastfeeding equipment
- Contraceptive methods approved by the FDA [2], sterilization procedures and contraceptive patient education and counseling (contraceptives covered with no member cost sharing include generics and brand name drugs with no generic alternative, including emergency contraceptives.)
- Folic acid supplements (women planning or capable of pregnancy only)
- Gestational diabetes screening
- HPV (human papillomavirus) testing
- Interpersonal and domestic violence counseling and screenings
- Iron deficiency anemia (pregnant women at prenatal visits)
- Osteoporosis screening (screening to begin at age 50 for women at increased risk)
- Rh (D) incompatibility, screening (pregnant women)
- Routine OB/GYN examinations
- Routine outpatient prenatal and postpartum visits
- Urinary tract or other infection screening

Men Only

- Abdominal aortic aneurysm screening (for males 65-75 one time only, if ever smoked)

Children Only

- Autism screening (for children at 18 and 24 months of age; primary care settings)
- Behavioral assessments (children of all ages; developmental surveillance, in primary care settings)
- Blood pressure screenings for children 0 to 11 months
- Congenital hypothyroidism (screening for newborns only)
- Dental caries prevention – oral fluoride (for children to age 5 only) Note: Coverage for fluoride is only provided if your plan includes outpatient pharmacy coverage
- Developmental screening for children under age 3
- Dyslipidemia screening (for children at high risk for higher lipid levels)
- Gonorrhea preventive medication (newborn eye drops) for all newborn between 0-7 days of age for the prevention of gonococcal ophthalmia neonatorum
- Hearing screening (screening for newborn only, primary care settings)
- Height, weight and body mass index measurements
- Hematocrit or hemoglobin screenings for children
- Iron deficiency prevention (primary care counseling for children ages 6 to 12 months only)
- Lead screening (children at risk)
- Phenylketonuria screening (newborns before 7 days old)
- Sickle cell disease, screening (screening at birth and first newborn visit)
- Vision screening (children to age 5 only)
- Tuberculosis skin testing
- Tobacco use intervention for children and adolescents

GENERAL PROVISIONS

PLAN ENROLLMENT

Eligibility: Only employees who satisfy the eligibility requirements set forth in the "General Information" section are eligible for coverage under this Plan. The dependent(s) of a covered employee will become eligible for coverage on the date of the employee's eligibility for coverage or on the date which the employee acquires the dependent.

If an employee and spouse are both eligible for coverage as employees under the Plan, only one (1) will be eligible to enroll dependent(s). Also, an employee cannot be covered as an employee and a dependent.

Plan Enrollment: To become covered under the Plan, an employee must enroll themselves and/or their dependents for coverage within thirty-one (31) days of the eligibility date. The employee and dependents will be enrolled when a benefit enrollment form is completed, signed, and delivered to the employer within the time limit. Should the enrollment occur more than thirty-one (31) days following the eligibility date, the employee and/or dependents will only be eligible to enroll during the annual open enrollment period described below or, in certain circumstances, during a special enrollment period. Should multiple plan options exist, an employee may switch plan options during an annual open enrollment period or special enrollment period.

Annual Open Enrollment Period: There will be an annual open enrollment period during the one (1) month period preceding the Plan's anniversary date. The effective date of coverage will be the Plan's anniversary date.

Special Enrollment Periods: Individuals are eligible for special enrollment for the following reasons:

1. If an employee acquires a dependent through marriage, birth, adoption, or placement for adoption, the dependent (and if not otherwise enrolled, the employee and eligible dependents) may be enrolled under this Plan. The request to enroll must be within thirty-one (31) days of the event. If enrollment is not requested within thirty-one (31) days following the event, the dependents will only be eligible to enroll during the annual open enrollment period. The effective date of coverage will be the date of the event.
2. If an employee declines enrollment in the Plan for themselves or their dependents because the employee or dependents have other health coverage, the employee may in the future be able to enroll themselves and/or their dependents in the Plan, provided they are otherwise eligible for coverage under the terms of the Plan, they meet certain conditions including any one of those set forth below and they request enrollment within thirty-one (31) days of that condition being satisfied:
    - when enrollment was declined under this Plan for employee and/or dependent coverage, the employee and/or dependent had COBRA continuation coverage under another health plan, and COBRA continuation coverage under that other plan has since been exhausted; or
    - if the other coverage that applied to the employee and/or dependent when coverage was declined was not COBRA continuation coverage, employer contributions toward the other coverage have ceased, regardless of whether coverage under the other employer's plan has terminated; or

- if the other coverage that applied to the employee and/or dependent when coverage was declined was not COBRA continuation coverage, the other coverage has been terminated as a result of:
    a. loss of eligibility as a result of legal separation, divorce, death, termination of employment, or reduction in the number of hours of employment, and any loss of eligibility after a period that is measured by reference to any of the foregoing; or
    b. the employee and/or dependent moving out of an HMO service area if HMO coverage terminates for that reason and, no other plan options are available to the employee/dependent; or
    c. the other plan ceasing to offer coverage to the group of similarly situated individuals that include the employee and/or dependent; or
    d. the dependent losing dependent status per plan terms; or
    e. the other plan terminating a benefit package option and no substitution is offered.

The effective date of coverage will be the date following the date of the loss of the other coverage. The Plan's waiting period will not be applied.

3. If an employee's or dependent's Medicaid or Children's Health Insurance Program (CHIP) coverage is terminated as a result of loss of eligibility, or if the employee or dependent becomes eligible for a state-granted premium subsidy towards employer health coverage under either Medicaid or CHIP, the employee may request to be enrolled in this Plan. The employee's request to enroll must be made within sixty (60) days of the date on which the employee or dependent either (a) loses eligibility under Medicaid or CHIP or (b) becomes eligible for a state-granted premium subsidy towards employer health coverage under either Medicaid or CHIP. The effective date of coverage will be the first day of the month following the employee's request to enroll in this Plan.

Qualified Medical Child Support Orders: If an employee is required to provide benefits for his dependent child under the direction of a court order and the employee is not enrolled in the Plan, the employee may enroll himself and his dependent child provided enrollment is requested within thirty (30) days of issuance of the court order. The Plan's open enrollment provision will not apply. The effective date of coverage will be the date of the court order. However, if the employee has not yet satisfied the Plan's waiting period, coverage will become effective after satisfaction of such waiting period.

If an employee is required to provide benefits for their ex-spouse under the direction of a court order, the employee may continue to cover their ex-spouse under the Plan or enroll their ex-spouse in the Plan provided enrollment occurs within thirty-one (31) days of the receipt of the court order. The effective date of coverage will be the date of the court order.

COORDINATION OF BENEFITS (COB)

This Plan contains a Non-Duplication of Benefits provision as part of coordination of benefits. This means that when this Plan is the secondary plan, the benefits paid from all the plans combined may not total more than the amount this Plan would have paid on its own.

This Plan will always pay benefits secondary to any other coverage, except for government-sponsored health coverage.

When this plan is the secondary payer, the plan will coordinate payment with the primary plan in such a way that when this plan's payment is combined with the primary plan's payment, the total does not exceed the amount this plan would have paid if it were primary.

If a plan does not have its own COB rules, it will be primary to this Plan (that is, it will pay benefits before this Plan does).

Even if a plan does have its own COB rules, the first of this Plan's following COB rules to apply will determine which of the plans is primary:

1. Non-Dependent/Dependent - Any plan under which the covered person is covered as an employee, member or subscriber (that is, other than as a dependent) will pay first. Any plan under which the covered person is covered as a dependent of the employee will pay second.

2. Dependent Child/Parents Not Separated or Divorced - If a dependent child is covered under the plans of both the child's parents, and the parents are not separated or divorced (regardless of whether they were ever married), the plan of the parent whose birth date occurs earlier in the calendar year will pay first, and the plan of the parent whose birth date occurs later in the calendar year will pay second. If the birth dates of the parents are the same, the plan which has covered a parent for the longest period of time will pay benefits before the plan of the other parent.

3. Dependent Child/Separated or Divorced Parents - Where a dependent child is covered under the plans of both parents, the parents are separated or divorced from one another, and there is otherwise no court decree setting forth the responsibility for the child's health care costs:

    a) the plan under which the child is covered as a dependent of the custodial parent will pay first;
    b) the plan under which the child is covered as a dependent of the custodial parent's spouse will pay second; and
    c) the plan under which the child is covered as a dependent of the non-custodial parent will pay third.

4. Active/Inactive Employee - Any plan under which the covered person is covered as an active employee (or as that employee's dependent) will pay first. Any plan under which the covered person is covered as a laid off or retired employee (or as that employee's dependent) will pay second. If the other plan does not have this rule, and if, as a result, the plans do not agree on the order of benefits, this rule is ignored.

5. Continuation Coverage - Any plan under which the covered person is covered as an employee (or as that employee's dependent) will pay first. Any plan under which the

covered person is covered under a right of continuation as provided under federal or state law (for example, under the Consolidated Omnibus Budget Reconciliation Act of 1985), will pay second. If the other plan does not have this rule, and if, as a result, the plans do not agree on the order of benefits, this rule is ignored.

If none of the above rules determine the order of benefits, the plan which has covered the eligible person for the longest period of time will pay first; the plan which has covered the eligible person for the shortest period of time will pay last.

Right to Receive and Release Needed Information: The Plan may release or receive any information needed to enforce this provision. Any person claiming benefits under this Plan must furnish the Plan with any information requested by the Plan to enforce the COB provisions in accordance with the HIPAA Privacy Requirements.

Right to Make Payments: Should another plan provide benefits which should have been paid by this Plan, the Plan has the right to make payment to the other plan directly. That payment will satisfy the obligation of this Plan.

Right to Recovery: The Plan has the right to recover from the covered person any overpayment made if the Plan was not made aware of the other available benefits.

Coordination with Other Liability: This Plan will pay benefits secondary to the covered person's personal automobile insurance (including, but not limited to, no-fault insurance and uninsured motorist coverage) or other liability insurance policies through which medical payments may be made for expenses resulting from or in connection with an accidental injury.

Coordination with Prescription Claims: There is no coordination of benefits with prescription drugs.

TERMINATION OF BENEFITS

An employee's and/or a dependent's coverage under the Plan will terminate:

1. on the date the Plan terminates; or
2. on the date an employee withdraws from the Plan; or
3. on the date an employee is no longer eligible; or
4. on the date which an employee is terminated, unless continuation coverage, as provided herein, is elected; or
5. on the date a dependent withdraws from the Plan or a dependent ceases to meet the definition of a dependent as defined herein or dependent coverage is discontinued under the Plan for any reason, unless continuation of coverage, as provided herein, is elected; or
6. at the end of the month in which a dependent child turns age twenty-six (26); or
7. on the date when an employee or dependent enters the military, naval, or air force of any country or international organization on a full-time, active-duty basis other than scheduled drills or other training not exceeding one (1) month in any calendar year (see Military Leave section below); or
8. on the last date of the period for which contribution has been made if the employee fails to make any required contribution.

The Plan Sponsor, in its sole discretion, may cause a covered person's coverage under the Plan to terminate if the covered person provides false information or makes misrepresentations in connection with a claim for benefits; permits a non-participant to use a membership or other identification card for the purpose of wrongfully obtaining benefits; obtains or attempts to obtain benefits by means of false, misleading or fraudulent information, acts or omissions; fails to make any copayment, supplemental charge, or other amount due with respect to a benefit; behaves in a manner disruptive, unruly, abusive, or uncooperative to the extent that the Plan is unable to provide benefits to him or her; or threatens the life or well-being of personnel administering the Plan or of providers of services or benefits.

MILITARY LEAVE

The Uniformed Services Employment and Reemployment Rights Act of 1994 ("USERRA") provides special continuation coverage to covered employees who otherwise lose health insurance coverage under the Plan because they leave employment to serve in the uniformed services. Under USERRA, affected covered employees and their dependents must be offered the right to continue coverage for up to twenty-four (24) months. The employer may charge 102% of the applicable premium, provided the length of the military leave is longer than thirty (30) days. However, on the date that the employee completes his active duty and returns to full-time employment, the employee and his eligible dependents will be re-enrolled in the Plan and coverage will be provided immediately. However, any limitations on the employee's or dependent's coverage which were in affect before the active military duty leave will continue to apply.

REINSTATEMENT OF COVERAGE

If coverage terminates due to termination of employment and the employee returns to work within 91 days after the date of termination, the employee may (depending on the method by which the

Plan Sponsor determines employee eligibility for Plan benefits under the Employer Shared Responsibility Regulations) be eligible for reinstatement of coverage as soon as administratively practicable following the date on which the employee returns to work. If the Plan Sponsor is an educational institution, if coverage terminates due to termination of employment, and the employee returns to work within 182 days of the date of termination, the employee may (depending on the method by which the Plan Sponsor determines employee eligibility for Plan benefits under the Employer Shared Responsibility Regulations) be eligible for reinstatement of coverage as soon as administratively practicable following the date on which the employee returns to work. In each case, when the employee returns to work, the employee's coverage (if any) will be on the same basis as that being provided on the date of the employee's termination. However, any limitations on the employee's coverage which were in effect before the employee's termination will continue to apply. If the employee does not return to work within the periods set forth above, or if coverage terminates for any reason except termination of employment, the employee will be treated as a new employee.

EXTENSION OF BENEFITS (COBRA)

Qualified beneficiaries may elect to continue coverage under the Plan when their coverage terminates due to a "qualifying event." Depending on the type of qualifying event, "qualified beneficiaries" can include the employee covered under the Plan and the employee's covered dependents. These rights are protected under the Consolidated Omnibus Budget Reconciliation Act (COBRA) of 1986.

A child who is born to or placed for adoption with the covered employee during a period of COBRA coverage will be eligible to become a qualified beneficiary. In accordance with the terms of the Plan and the requirements of federal law, these qualified beneficiaries can be added to COBRA coverage upon proper notification to the Plan Administrator of the birth or adoption.

Continuation coverage is the same coverage that the Plan gives to other participants or beneficiaries under the Plan who are not receiving continuation coverage. Each qualified beneficiary who elects continuation coverage will have the same rights under the Plan as other participants or beneficiaries covered under the Plan.

The employee has the right to choose COBRA continuation of coverage under the Plan if coverage terminates for any of the following qualifying events:

1. The employee's termination of employment for reasons other than gross misconduct.
2. The employee's retirement or reduction in hours of employment.

The employee's spouse has the right to choose COBRA continuation of coverage under the Plan if coverage terminates for any of the following qualifying events:

1. The employee's termination of employment for reasons other than gross misconduct.
2. The employee's retirement or reduction in hours of employment.
3. The employee's death.
4. The employee's divorce or legal separation.
5. The employee becomes enrolled in Medicare benefits (Part A, Part B or both).

The employee's dependent children have the right to choose COBRA continuation of coverage under the Plan if coverage terminates for any of the following qualifying events:

1. The employee's termination of employment for reasons other than gross misconduct.
2. The employee's retirement or reduction in hours of employment.
3. The employee's death.
4. The employee's divorce or legal separation.
5. The employee becomes enrolled in Medicare benefits (Part A, Part B or both).
6. The employee's dependent child ceases to be an eligible dependent as such term is defined in the Plan.

Similar rights may apply to certain retirees, spouses, and dependent children if the employer commences a bankruptcy proceeding and these individuals lose coverage.

The Plan will offer COBRA continuation coverage to qualified beneficiaries only after the Plan Administrator has been notified that a qualifying event has occurred. When the qualifying event is the end of employment or reduction of hours of employment, death of the employee, or enrollment of the employee in Medicare (Part A, Part B, or both), the employer must notify the Contract Administrator of the qualifying event within thirty (30) days of any of these events on the form provided by the Contract Administrator to the employer.

For the other qualifying events (divorce or legal separation of the employee and spouse or a dependent child's losing eligibility for coverage as a dependent child), the qualified beneficiary must notify the Plan Administrator. The Plan Administrator must be notified in writing within sixty (60) days after the qualifying event occurs.

Once the Plan Administrator receives notice that a qualifying event has occurred, COBRA continuation coverage will be offered to each of the qualified beneficiaries. The Plan Administrator must notify the qualified beneficiary in writing of their right to COBRA continuation of coverage within fourteen (14) days from the date the Plan Administrator is notified of a qualifying event.

The qualified beneficiary has sixty (60) days from the date of the written notice or qualifying event, whichever is later, to notify the Plan Administrator of their decision to elect COBRA continuation of coverage. To receive COBRA continuation of coverage, no evidence of insurability will be required, but a monthly premium will be charged. If continuation of coverage is not elected on a timely basis, group health insurance coverage will end.

If Medicare entitlement occurs prior to a qualifying event, then COBRA begins on the date of Medicare entitlement.

For each qualified beneficiary who elects COBRA continuation coverage, COBRA continuation coverage will begin on the day following the date of the qualifying event.

COBRA continuation coverage is a temporary continuation of coverage. When the qualifying event is the death of the employee, the employee's divorce or legal separation, or a dependent child losing eligibility as a dependent child, COBRA continuation coverage lasts for up to thirty-six (36) months.

If a qualifying event that is a termination of employment or reduction of hours occurs within eighteen (18) months after the covered employee becomes enrolled in Medicare, then the maximum coverage period for the spouse and dependent children who are qualified beneficiaries receiving COBRA coverage will end thirty-six (36) months from the date the employee became enrolled in Medicare (but the covered employees' maximum coverage period will be eighteen (18) months). This extension is available only if the covered employee becomes enrolled in Medicare within eighteen (18) months before the termination of employment or reduction of hours occurs.

When the qualifying event is the end of employment or reduction of the employee's hours of employment, COBRA continuation coverage lasts for up to eighteen (18) months. There are two ways in which this eighteen (18) month period of COBRA continuation coverage can be extended.

Disability extension of 18-month period of continuation coverage

If a qualified beneficiary is determined by the Social Security Administration to be disabled at any time during the first sixty (60) days of COBRA continuation coverage and the Plan Administrator is notified in a timely fashion, the employee and his covered dependents can receive up to an additional eleven (11) months of COBRA continuation coverage, for a total maximum of twenty-nine (29) months. The qualified beneficiary must make sure that the Plan Administrator is notified in writing of the Social Security Administration's determination within sixty (60) days of the date of the determination and before the end of the eighteen (18) month period of COBRA continuation coverage. If a qualified beneficiary is determined by the Social Security Administration to no longer be disabled, then the beneficiary must notify the Plan within thirty (30) days of determination by the Social Security Administration.

Second qualifying event extension of 18-month period of continuation coverage

If the employee's family experiences another qualifying event while receiving COBRA continuation coverage, the spouse and dependent children can get additional months of COBRA continuation coverage, up to a maximum of thirty-six (36) months. This extension is available to the spouse and dependent children if the former employee dies, gets divorced or legally separated. This extension may be available to a spouse or dependents if the former employee enrolls in Medicare. The extension is also available to a dependent child when that child stops being eligible under the Plan as a dependent child. **In all of these cases, the qualified beneficiary must make sure that the Plan Administrator is notified in writing of the second qualifying event within sixty (60) days of the second qualifying event.**

In no event will COBRA coverage continue beyond thirty-six (36) months from the date of the original qualifying event.

Monthly Premium

1. The monthly premium will be 102% or, if applicable, 150% of the applicable premium (which for self-funded plans, is based on reasonable actuarial estimates or on past costs). All premium payments are due in advance and include the cost of the next month of COBRA continuation of coverage.

2. The initial premium payment is due within forty-five (45) days of electing COBRA continuation of coverage. The payment must cover all premiums due from the date of the qualifying event.

3. The maximum grace period for payment of monthly COBRA coverage premiums will not exceed thirty (30) days from the due date established by the Plan Administrator or their authorized agent.

Termination of COBRA continuation coverage

COBRA continuation of coverage may be terminated prior to the expiration of the applicable time period as follows:

1. The Plan Administrator no longer provides group health and/or dental coverage to any of its employees. The applicable monthly premium for COBRA coverage is not paid within thirty (30) days of the established due date.

2. The person who has elected COBRA coverage becomes enrolled in Medicare benefits (Part A, Part B or both). COBRA coverage will terminate on the first day of the person's birthday month. Should the person's birthday be on the first day of

the month, then COBRA coverage will terminate on the first day of the month prior to the person's birthday.

3. The qualified beneficiary who has elected COBRA coverage becomes covered under another group health and/or dental plan which does not contain any exclusion or limitation with respect to any preexisting condition of such covered person.

   (**NOTE:** Should COBRA continuation provide coverage for such "preexisting" conditions, COBRA continuation of coverage will be primary for the applicable preexisting conditions only and will provide secondary coverage to all other covered expenses.)

4. The unique disability continuation period will end as of the first day of month that begins more than thirty (30) days after the date of final determination under the Social Security Act that the qualified beneficiary is no longer disabled.

The Health Insurance Portability and Accountability Act of 1996 (HIPAA) restricts the extent to which group health plans may impose pre-existing condition limitations. HIPAA coordinates COBRA's other coverage cut-off rule with these new limits as follows.

If the covered employee becomes covered by another group health plan and that plan contains a pre-existing condition limitation that affects the covered employee, the covered employee's COBRA coverage cannot be terminated. However, if the other plan's pre-existing condition rule does not apply to the covered employee by reason of HIPAA's restrictions on pre-existing condition clauses, the Plan may terminate the covered employee's COBRA coverage.

The covered employee does not have to show that he or she is insurable to choose continuation coverage. However, continuation coverage under COBRA is provided subject to the covered employee's eligibility for coverage; the Plan Administrator reserves the right to terminate the covered employee's coverage retroactively if he or she is determined to be ineligible.

Note: Some of the changes under the Affordable Care Act (described below) may be relevant to a covered employee's decision to elect COBRA:

First, there may be other coverage options for a covered employee and the employee's family. Beginning January 1, 2014, individuals will be able to buy coverage through the Health Insurance Marketplace. In the Marketplace, the individual could be eligible for a new kind of tax credit that lowers his or her monthly premiums right away. Covered employees will be able to see what the premiums, deductibles, and out-of-pocket costs will be before making a decision to enroll in the Marketplace. Being eligible for COBRA does not limit a covered employee's eligibility for coverage for a tax credit through the Marketplace.

Second, health plans will be prohibited from imposing preexisting condition exclusions beginning in plan years which commence on or after January 1, 2014. Because this requirement applies on a plan year basis, the exclusion may not apply immediately to all plans.

Keep Plan Informed of Address Changes

In order to protect the participant's family's rights, the participant should keep the Plan Administrator informed of any changes in the addresses of family members. The participant should also keep a copy, for his or her records, of any notices sent to the Plan Administrator.

PLAN DETAILS

Preferred Provider Network Program
The Plan includes access to Blue Cross Blue Shield of Vermont's preferred provider network and the BlueCard Program in order to obtain discounts from participating providers for covered medical care. The plan identification card identifies the selected preferred provider network and a current list of the participating providers will be furnished to covered persons automatically by the Plan Sponsor. Use of the network is voluntary and the benefits of utilizing participating providers include provider fee discounts, direct billing to the Plan for covered services, and network provider write-offs of any charges in excess of the discounted fee schedule.

If a covered person is referred by an in-network provider to a specialist and no provider exists for that area of specialty within the preferred provider network, then the covered person may seek services of an out-of-network specialist and benefits for covered services will be paid as though they were furnished by an in-network provider.

Explanation of Preferred Provider Network, BlueCard®, and Out-of-Network Benefits:
To receive Preferred Provider Network / BlueCard® benefits as indicated on the Schedule of Benefits, you must choose providers in the Blue Cross Blue Shield of Vermont's preferred provider network or the BlueCard® Program for all care (with specific, limited exceptions as noted in this Plan Document, such as those explained in the No Surprises Act – Emergency Services and Surprise Bills language herein). If you, instead, choose to obtain services from an Out-of-Network Provider or facility, then the Plan will pay for any covered services at the out-of- network benefit level indicated on the Schedule of Benefits, and you will be responsible for paying any additional amount to the Provider.

As explained in the No Surprises Act – Emergency Services and Surprise Bills language herein, please note that Out-of-Network Providers and facilities are generally permitted to "balance bill" covered persons. This means that a Covered Person may be required to pay the difference between what the provider charges for a service and what the Plan agreed to pay for that service (including amounts paid from the Plan and from Coinsurance and Copayments). In many situations, this difference could be significant.

You should not receive balance bills from Out-of-Network Providers and facilities (including Independent Freestanding Emergency Departments) for the provision of Emergency Services, air ambulance Providers, or certain Out-of-Network Providers rendering services in in-network facilities. **In certain situations, an Out-of-Network Provider may ask for your consent to balance bill. You are never required to consent to balance billing in those situations. If you consent, you may receive a balance bill.**

The Preferred Provider Network Program provisions explain the Plan's Preferred Provider network, including how to find a Preferred Provider and what happens if you use an Out-of- Network Provider instead. Note that the Plan's Preferred Provider network benefits and out-of- network benefits refer to the "Maximum Allowable Benefit" under the Plan. The maximum Allowable Benefit is important to understanding how much you and the Plan will pay for a covered service. Please refer to the definition of this term later in this Plan Document for more information.

Out-of-Area Services
We have a variety of relationships with other Blue Cross and/or Blue Shield Licensees referred to generally as "Inter-Plan Programs". Whenever you obtain health care services outside of the Vermont service area, the claims for these services may be processed through one of these Inter-Plan Programs, which include the BlueCard® Program and may include negotiated National Account arrangements available between us and other Blue Cross and Blue Shield Licensees.

Typically, when accessing care outside of the Vermont service area, you will obtain care from health care providers that have a contractual agreement (i.e. are "preferred providers") with the local Blue Cross and/or Blue Shield Licensee in that other geographic area ("Host Blue"). In some instances, you may obtain care from non-preferred health care providers. Our payment practices in both instances are described below.

The BlueCard® Program
Under the BlueCard® Program, when you access covered health care services within the geographic area served by a local Blue Cross Blue Shield Plan ("Host Blue"), we will remain responsible for fulfilling our contractual obligations. However, the Host Blue is responsible for contracting with and generally handling all interactions with its preferred health care providers.

Whenever you access covered health care services outside our service area and the claim is processed through the BlueCard® Program, the amount you pay for covered health care services is calculated based on the lower of:

- The billed covered charges for your covered services; or
- The negotiated price that the Host Blue makes available to us.

Often, this "negotiated price" will be a simple discount that reflects an actual price that the Host Blue pays to your health care provider. Sometimes, it is an estimated price that takes into account special arrangements with your health care provider or provider group that may include types of settlements, incentive payments, and/or other credits or charges. Occasionally, it may be an average price, based on a discount that results in expected average savings for similar types of health care providers after taking into account the same types of transactions as with an estimated price.

Estimated pricing and average pricing, going forward, also take into account adjustments to correct for over- or under estimation of modifications of past pricing for the types of transaction modifications noted above. However, such adjustments will not affect the price we use for your claim because they will not be applied retroactively to claims already paid.

Laws in a small number of states may require the Host Blue to add a surcharge to your calculation. If any state laws mandate other liability calculation methods, including a surcharge, we would then calculate your liability for any covered health care services according to applicable law.

When covered health care services are provided outside of our service area by non-preferred health care providers, the amount you pay for such services will generally be based on either the Host Blue's non-preferred health care provider local payment or the pricing arrangements required by applicable state law. In these situations, you may be liable for the difference between the amount that the non-preferred health care provider bills and the payment we will make for the covered services as set forth in this paragraph.

In certain situations, we may use other payment bases, such as billed covered charges, the payment we would make if the health care services had been obtained within our service area, or a special negotiated payment, as permitted under Inter-Plan Programs Policies, to determine the amount we will pay for services rendered by non-preferred health care providers. In these situations, you may be liable for the difference between the amount that the non-preferred health care provider bills and the payment we will make for the covered services as set forth in this paragraph.

Inpatient Hospital Confinement: Charges for inpatient hospital services may include room and board, operating room, x-rays, physical therapy, radiation therapy, chemotherapy, prescription drugs, laboratory expenses, intensive care unit, physician charges, and other necessary services

and supplies, unless otherwise specified herein, incurred during any period of hospital confinement are covered expenses. Please see the applicable "Schedule of Benefits" to determine payment level.

Inpatient Mental Health/Substance Abuse: Charges for inpatient mental health care and alcohol and/or drug addiction in a hospital, public or licensed mental hospital, drug/alcohol abuse treatment facility, day treatment facility are covered expenses. Please see the applicable "Schedule of Benefits" to determine payment level.

Inpatient Pre-Admission Certification Penalty (only applies to Choose Plan option): The Plan requires that all non-emergency hospital admissions be pre-certified and authorized by the Contract Administrator. This does not include hospital stays in connection with childbirth for the mother or newborn child which are forty-eight (48) hours or less for vaginal deliveries, or ninety-six (96) hours or less for cesarean section deliveries. When a doctor recommends that the employee or dependent be admitted to a hospital, **it is the employee's responsibility** to notify the Plan and to obtain pre- certification and authorization of the hospital admission. **It is the employee's responsibility** to be sure that in the event of an **emergency admission**, the Contract Administrator is notified within **forty-eight (48)** hours. In the event that an employee or dependent incur expenses for services which have not been pre-certified and authorized, a thorough review will be conducted of the services to determine medical necessity at the point of claim. If the review process identifies care which is not medically necessary, services will not be covered under the Plan. In order for the Plan to approve the inpatient stay, the attending physician must certify to the Contract Administrator that, in the physician's professional opinion, the stay is necessary for the condition. The Plan reserves the right to request an independent medical opinion by a physician of the Plan's choice.

Convalescent Hospital/Extended Care Facility/Skilled Nursing Facility: Charges for confinement in a convalescent hospital/extended care facility/skilled nursing facility are covered expenses. Please see the applicable "Schedule of Benefits" to determine payment level.

Surgery (Inpatient, Outpatient, and Office Visits): Charges for surgery provided on an inpatient or outpatient basis or office visit setting including charges for x-ray and laboratory expenses, surgeon, assistant surgeon, and any other necessary services and supplies, unless otherwise specified herein, are covered expenses. Please see the applicable "Schedule of Benefits" to determine payment level.

Preventive Services: Charges for preventive care services are covered expenses. Please see page 8 and 9 for a list of services. The list of preventive care services covered under this benefit may change periodically based upon the recommendation of the United States Preventive Services Task Force, the Advisory Committee on Immunization Practices of the Centers for Disease Control and Prevention, and the Health Resources and Services Administration. Information on the recommendations of these agencies can be found at: https://www.healthcare.gov/preventive-care-benefits/. Please see the applicable "Schedule of Benefits" to determine payment level.

Physician's Office Visits: Charges for physician's office visits when the employee or their dependent(s) incur expenses as a result of an illness or accidental injury are covered expenses. The copayment does not apply to any additional services provided at the time of the visit. Please see the applicable "Schedule of Benefits" to determine payment level.

Chiropractic Care: Charges for home, office, and nursing home visits, as well as examinations, x-rays, consultations, spinal manipulations, electrical stimulation, and interpretation are covered expenses. Please see the applicable "Schedule of Benefits" to determine payment level.

Outpatient Physical Therapy: Charges for outpatient physical therapy are covered expenses. Please see the applicable "Schedule of Benefits" to determine payment level.

Anesthesia Services: Charges for anesthesia services are covered expenses. Please see the applicable "Schedule of Benefits" to determine payment level.

Ambulance Services: Charges for medically necessary ground ambulance service for inpatients or for outpatients receiving accident or illness care to and from the hospital or medical facility where treatment is given are covered expenses. Air ambulance is considered a covered expense if it is medically necessary, and the ground ambulance is not advisable. Please see the applicable "Schedule of Benefits" to determine payment level.

Emergency Room Services: Charges for emergency room services are covered expenses. Charges may include facility fees, physician fees, x-rays, laboratory tests, and other necessary services and supplies, unless otherwise specified herein. Please see the applicable "Schedule of Benefits" to determine payment level.

Urgent Care Services: Charges for urgent care services are covered expenses. Please see the applicable "Schedule of Benefits" to determine payment level.

Outpatient Diagnostic Imaging Services: Charges for outpatient diagnostic laboratory exams, x-rays, ultrasounds, PET scans, CT scans, MRI's rendered in a physician's office, outpatient laboratory, independent lab, or radiology facility are covered expenses. Please see the applicable "Schedule of Benefits" to determine payment level.

Retail Prescription Drug Program: The Plan includes a prescription drug program. Prescriptions filled at participating pharmacies are limited to a maximum thirty (30) day supply. The Plan pays up to the amounts listed below.

Basic Plan:

1-30 day supply:

Generic	Preferred Brand	Non-Preferred Brand
Plan pays $10/script	Plan pays $25/script	Plan pays $40/script

31-90 day supply:

Generic	Preferred Brand	Non-Preferred Brand
Plan pays $30/script	Plan pays $75/script	Plan pays $120/script

Choice Plan:

1-30 day supply:

Generic	Preferred Brand	Non-Preferred Brand
Plan pays $15/script	Plan pays $75/script	Plan pays $100/script

31-90 day supply:

Generic	Preferred Brand	Non-Preferred Brand
Plan pays $45/script	Plan pays $225/script	Plan pays $300/script

A list of participating pharmacies can be obtained by visiting www.magellanrx.com .
Prescriptions purchased at non-participating pharmacies are not covered expenses.

Compound drugs that are not available from a participating pharmacy will be considered a covered expense subject to the applicable benefit listed above.

When filling a prescription for which a generic drug is available, and the covered person chooses the brand name drug, the covered person will be responsible for the difference in cost between the generic and the brand name drug.

All prescribed FDA approved generic oral contraceptives for women are covered at 100% when received from a participating pharmacy or in-network provider. The brand version will be covered at 100% when received from a participating pharmacy or in-network provider only if medically necessary or a generic equivalent is not available.

Some prescription drugs may be subject to quantity limits, based on criteria developed by the Prescription Benefit Manager or upon Food and Drug Administration (FDA) approved dosing and usage guidelines. The same quantity limit requirements apply to both mail order and retail pharmacies.

Mail Order Maintenance Prescription Drug Program: Maintenance drugs to treat illnesses should be purchased through the mail order program. These illnesses usually include diabetes, epilepsy, anemia, chronic constipation, arthritis, high blood pressure, tuberculosis, various gastric disease, emphysema, menopause, mental and nervous disorders, thyroid disease, adrenal disease, ulcers, and any other condition that requires continuous medication. Mail order prescriptions are limited to a maximum ninety (90) day supply. The Plan pays up to the amounts listed below.

Basic Plan:

Generic	Preferred Brand	Non-Preferred Brand
Plan pays $10/script	Plan pays $25/script	Plan pays $40/script

Choice Plan:

Generic	Preferred Brand	Non-Preferred Brand
Plan pays $15/script	Plan pays $75/script	Plan pays $100/script

Select Drugs and Products ProgramSM: The Select Drugs and Products ProgramSM offered through MagellanRx is administered by Paydhealth and is designed to improve access to specialty drugs. This program will assist covered persons in reducing the cost of their medication by seeking sources of alternate funding for specialty drugs on the Select Drugs and Products List.

In order to take advantage of these benefits, the Plan requires covered persons to specifically enroll in the Select Drugs and Products ProgramSM when individuals are prescribed prescription drugs listed on the Select Drugs and Products List. This Program is paid for by the Plan and provides matching of alternate funding programs to covered persons. All covered persons using listed specialty drugs are required to meet prior authorization, step-therapy, and administrative review criteria, which includes enrollment in the Program and adjudication of their specialty drug cost by an alternate funding program prior to meeting Plan coverage criteria. Failure to prior authorize and complete the requirements of the Select Drugs and Products ProgramSM will result in a penalty equal to a 100% reduction in benefits payable.

If covered persons are taking a specialty drug, they will be contacted by a Program Case Coordinator. The Case Coordinator will provide covered persons with further information regarding the Select Drugs and Products ProgramSM and walk them through the enrollment process and requirements. If you have any questions regarding the Select Drugs and Products Program, please call the Specialty Contact Center at 877.869.7772 (8:00 a.m. – 8:00 p.m. EST).

Select Drugs and Products List means a list of specialty drugs that are subject to prior authorization, step-therapy, and administrative review and must be acquired after enrollment in the Plan's Select Drugs and Products ProgramSM for coverage limits to apply.

Specialty drugs under this Program means a drug or biologic product that have ANY of the following features associated with their use or acquisition: 1) difficult or unusual process of administration to the patient when self-administered, 2) require enrollment in a FDA mandated Risk Evaluation and Mitigation Strategy ("REMS"), 3) require enhanced data collection efforts, 4) require patient management service that are enhanced to the normal practice of pharmacy, 5) are products used in the treatment of rare disease, 6) require patient training or side effect management, and 7) cost greater than $670 per 30-day supply.

The Select Drugs and Products ProgramSM offered by Paydhealth does not apply to healthcare practitioner administered specialty drugs that are covered under the medical benefit.

Step Therapy Program: The Plan has implemented a Step Therapy program in order to control overall plan costs and to assure members access to clinically appropriate medications to treat all conditions.

The Step Therapy program establishes an order of drug therapy options within select categories for covered persons to follow that may affect their access to, and out-of-pocket costs for, medications covered under the Step Therapy program.

The Step Therapy program ensures that the covered person receives clinically appropriate, cost-effective medication based on their prescription history. Step Therapy guidelines maintain open access for covered persons and encourages the utilization of lower cost medications.

The order of medication usage will include generic and selected over-the-counter drugs first at the lowest copayments for the covered person to preferred brand name drugs at the middle copayment, and finally non-preferred brand name drugs at the highest copayment. The goal of the Plan is to achieve successful treatment outcomes at the most efficient cost to the plan.

The covered person will receive communication from Magellan or their pharmacist if a prescription is written for them in one of the covered categories listed above.

MEDICAL COVERED EXPENSES

Expenses incurred for the following medical, health care services, and supplies will be considered a covered expense, provided the expenses are (i) medically necessary to treat an illness or injury or furnished in connection with participation of a covered person in a "Clinical Trial," as such term is defined here, (ii) prescribed or approved by an attending physician, and (iii) incurred during a period that coverage was in effect in accordance with the applicable provisions of the Plan. Payment of such expenses will be subject to all applicable deductibles, coinsurance limits, the maximum individual limit, and all other limitations described herein.

1. Inpatient hospital charges for room and board, operating room, x-rays, physical therapy, radiation therapy, chemotherapy, prescription drugs, anesthesia, laboratory expenses, intensive care unit, and other necessary services and supplies during any one (1) period of hospital confinement, as shown below. Should the facility have no semi-private rooms or less expensive accommodations available, or the patient's condition requires the employee or the employee's covered dependent to be isolated for their own health or the health of others, the private room rate will be allowed.

   Room and Board:

   semi-private room allowance.....semi-private room rate
   private room allowance.....semi-private room rate
   intensive care allowance.....actual charge (not to exceed the maximum allowable benefit)

2. Outpatient hospital charges for necessary services and supplies incurred as a result of an illness, accident, or as a result of outpatient surgery performed (if performed on the same day), including charges for x-ray and laboratory expenses, physical therapy.

3. Charges for inpatient physician visits while the employee or their dependents are hospital confined as a result of an illness or an accidental injury. No benefits will be paid for more than one (1) visit per day by any one (1) physician or for the treatment received in connection with, on, or after the date of an operation for which a surgical expense benefit is payable under the Plan if such treatment is given by the physician who performed the operation.

4. All charges of a professional anesthesiologist, radiologist, or pathologist.

5. Charges for pre-admission testing, exams, x-ray and laboratory examinations on an outpatient basis made before a scheduled hospital admission and related to a condition previously diagnosed.

6. Charges for medically necessary ground ambulance service for inpatients or for outpatients receiving accident or illness care to and from the hospital or medical facility where treatment is given. Air ambulance is considered a covered expense if it is medically necessary and the ground ambulance is not advisable.

7. Emergency room charges for treatment of an Emergency Medical Condition.

8. Diagnostic x-rays and laboratory charges for expenses incurred as a result of an illness or injury. No benefits are payable for dental care except as provided for in this Plan.

9. Charges for physical therapy by a qualified practitioner.

10. Charges for oral surgery, limited to: excision of tumors and cysts of the jaws, cheeks, lips, tongue, roof and floor of mouth; treatment of an accidental injury to the jaws, cheeks, lips, tongue, roof and floor of mouth; excision of exostoses of jaws and hard palate; treatment of cleft lip and palate; external incision and drainage of cellulitis; incision of accessory sinuses, salivary glands or ducts; frenectomies; and removal of fully or partially impacted teeth. If the covered person has elected both medical and dental coverage, expenses for frenectomies will be considered under the medical portion of this Plan.

11. Charges for the surgical and non-surgical treatment of temporomandibular joint syndrome (TMJ) will be covered.

12. Charges for orthognathic surgery.

13. Charges for physician's surgical services for treatment of an injury or illness, if performed in an inpatient or outpatient unit of a hospital, a free-standing facility, a physician's office, or a dentist or an oral surgeon's services for the treatment of an accidental injury to sound natural teeth will be considered a covered expense. Injuries caused by biting or chewing are not considered accidental injuries.

14. Charges for x-ray, laboratory, and radium expenses excluding dental x-rays, unless rendered for the treatment of a fractured jaw, cysts, tumors or injury to sound natural teeth as a result of an accident will be considered covered expenses.

15. Charges for the professional services of a legally qualified physician for the care of a covered illness or accidental injury.

16. Charges for physician's home and office visits when the employee or his dependent incur expenses as a result of an illness or accidental injury.

17. Charges for services of a surgeon and an assistant surgeon if two (2) or more procedures are performed during the course of a single operation through the same incision or in the same operative field. The fees will be limited to the sum of the maximum allowable benefit for the largest amount billed for one procedure plus fifty (50%) of the sum of the maximum allowable benefit billed for all other procedures performed. Benefits are payable for the professional services of a legally qualified physician in rendering technical assistance to the operating surgeon when required in connection with a surgical procedure performed on an inpatient basis (benefits will not exceed twenty (20%) of the maximum allowable benefit for the procedure performed when the assistant is a physician and ten (10%) when the assistant is a PA). However, no benefits are payable for surgical assistance rendered in a hospital where it is routinely available as a service provided by a hospital intern, resident, or house officer.

18. Charges for medically necessary dressings and medicines for which a physician's prescription is required and dispensed by a licensed pharmacy.

19. Charges for birth control methods. All prescribed Food and Drug Administration (FDA) approved contraceptive methods for women, and patient education and counseling for all women with reproductive capacity are covered at 100% at the in-network benefit level or when received from a participating pharmacy. All prescribed brand oral contraceptives will be covered at 100% when received from a participating pharmacy or in-network provider only if medically necessary or a generic equivalent is not available.

20. Charges for diabetic supplies such as insulin, accustrips, lancets, syringes necessary for the administration of prescription drugs and professional instructions, not including printed material for their use.

21. Charges for sterilizations.

22. Charges for abortions are covered expenses when the physical or mental health of the mother would be in danger if the fetus were carried to term. The attending physician will determine when the health of the mother is in danger.

23. Charges for selective or non-selective reduction of multiple pregnancy provided every effort is taken to ensure the health of the remaining fetus(es) when one (or more) fetus is abnormal, when the mother's health is in danger, or there are three (3) or more fetuses and they are all likely to be spontaneously aborted or delivered prematurely with a high risk of either dying or being harmed. This is not a covered benefit if the fetus(es) are a result of infertility services that are not covered.

24. Charges for maternity care including prenatal, delivery, and postpartum care as well as charges arising from complications that may occur during maternity and delivery. Comprehensive lactation support and counseling, by a trained provider during pregnancy and/or in the postpartum period, and costs for renting breastfeeding equipment are payable at 100% at the in-network benefit level.

25. Convalescent Hospital/Extended Care Facility/Skilled Nursing Facility not in excess of a daily charge for room and board, services, and supplies equal to one-half (1/2) of the discharging hospital's semi-private room rate; provided however, the confinement in such a hospital or facility begins not more than fourteen (14) days after a period of confinement in a general hospital of at least five (5) consecutive days. The covered person must be under the care of an attending physician who determines the continuing need for the hospital or facility stay.

26. Newborn care charges are a covered expense for an employee's newborn dependents. Charges for care of newborn children to include hospital charges for nursery room and board and miscellaneous expenses, charges by a pediatrician for attendance at a cesarean section, charges for physician examination for a newborn while hospital confined and charges for circumcisions.

27. **Chiropractic Care:** Charges for home, office, and nursing home visits as well as examinations, x-rays, consultations, spinal manipulations, electrical stimulation, and interpretation are covered expenses.

28. **Preventive Care:** Charges for routine physical examinations, well-baby care, and well-adult care are covered expenses. Charges can include examinations (including breast and pelvic), gynecological exams, immunizations, vaccinations, inoculations, consultations, routine x-ray and laboratory services (e.g. cholesterol screenings, TSH, resting EKG's, fecal occult blood tests and double contrast barium enemas), pap smears (including laboratory fees), routine vision exams and screening including refractions for children to age 5 only, x-rays, mammograms (coverage includes screening by ultrasound for covered persons whose screening mammograms were inconclusive or who have dense breast tissue, or both), prostate cancer screenings (including PSA tests and digital rectal exams), sterilization procedures for women, and EKG's. The list of preventive care services covered under this benefit may change periodically based upon the recommendation of the United States Preventive Services Task Force, the Advisory Committee on Immunization Practices of the Centers for Disease Control and Prevention, and the Health Resources and Services

Administration. Information on the recommendations of these agencies can be found at: https://www.healthcare.gov/preventive-care-benefits/.

29. **Mental Health Care and Substance Abuse:** Charges resulting from inpatient mental health care and alcohol and/or drug addiction in a hospital, public or licensed mental hospital, drug/alcohol abuse treatment facility, day treatment facility will be considered covered expenses. Outpatient mental health and substance abuse services will not be covered.

30. Any taxes and/or surcharges applied to a covered expense are considered eligible expenses when the tax or surcharge is mandated by state or federal government until such time that ERISA preemption is clearly established by law prohibiting the applicable tax and/or surcharge.

31. Any of the following services in connection with a mastectomy:

    a) all stages of reconstruction of the breast on which the mastectomy is performed;
    b) surgery and reconstruction of the other breast to produce a symmetrical appearance; and
    c) prostheses and treatment of physical complications of the mastectomy, including lymphedema.

    The Women's Health and Cancer Rights Act of 1998 requires the Plan Sponsor to notify you, as a covered participant or dependent under this Plan, of your rights related to benefits provided through the Plan in connection with a mastectomy. You as a covered participant or dependent under this Plan have rights for coverage to be provided in a manner determined in consultation with your attending physician for the above referenced services.

32. Charges for smoking cessation treatment to include counseling, office visits, prescription and over-the-counter medication will be covered at 100% when received from an In-Network provider or participating pharmacy. Prescription and over-the-counter smoking cessation aids will be covered under the prescription drug plan.

33. Charges for second and third surgical opinions.

34. Charges for allergy testing and allergy injections (including serum).

35. Charges for non-naroctic analgesics for the treatment of migraines (e.g., Amerge, Frova, Imitrex, Maxalt, Relpax, and Zomig.

36. Charges for female libido enhancement drugs and male impotence medications, including Viagra.

37. Charges for Stadol Nasal Spray.

38. Charges for testosterone replacement (e.g., Androderm, Androgel, Testim, Striant).

39. Charges for Prozac Weekly. Prior authorization may apply.

40. Charges for podiatry surgery, limited to open cutting procedures of the foot.

41. Charges for infertility testing, only to establish the initial diagnosis of infertility.

42. The Plan will reimburse otherwise eligible medical covered expenses for "patient care services," as such term is defined herein, furnished in connection with participation of a covered person in a "Clinical Trial," as such term is defined herein, which is intended to treat cancer or other life-threatening condition in a patient who has been so diagnosed. A copy of the "Clinical Trial" protocol may be required in order to determine if benefits are available under this Plan. Nothing herein shall create a presumption that the Employer recommended, directed, endorsed, or required any covered person's participation in a Clinical Trial.

GENERAL MEDICAL EXCLUSIONS AND LIMITATIONS

1. Expenses for confinement, treatment, services, or supplies except to the extent herein provided which are:

    a) not furnished or ordered by a recognized provider and not medically necessary to diagnose or treat a sickness or injury;
    b) experimental or investigational in nature.

2. Expenses for services for disease or injury sustained as a result of war, declared or undeclared. For all purposes of this Plan, terrorism is considered an act of war.

3. Services for any injury or illness which is incurred while taking part or attempting to take part in a riot of civil disobedience, or 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).

4. Expenses incurred in connection with any accidental bodily injury or illness arising out of or in the course of any employment, regardless of whether the employment is for profit or compensation. This exclusion applies to all covered individuals, including but not limited to, self-employed individuals who choose not to provide themselves with insurance coverages such as, but not limited to, workers' compensation and occupational disease, regardless of whether such coverage or coverages are required by law.

5. Expenses incurred while on full-time active duty in the armed forces of any country, combination of countries or international authority.

6. Expenses for treatment or services rendered outside of the United States of America or its territories, except for accidental injuries or a medical emergency.

7. Expenses for dental services, except to the extent herein provided.

8. Expenses for vision therapy or orthoptics, except following surgery to the muscles controlling the eye or in treatment of strabismus.

9. Expenses incurred for or in connection with any corrective treatment or surgery to correct a refractive error (i.e., such as hyperopia, myopia, astigmatism, LASIK, keratomileusis surgery, or radial keratotomy, etc.) or fitting or actual cost of corrective lenses except to the extent herein provided (i.e., intra-ocular implant of lenses in the treatment of cataracts).

10. Expenses for hearing examinations or hearing aids, unless provided herein under the preventive care benefit.

11. Expenses for treatment, services, supplies, and facilities provided by or in a hospital owned or operated by any government or agency thereof where such care is provided at government expense under a plan or program established pursuant to the laws or regulations of any government or under a plan or program under which any government participates other than as an employer. The term "any government" includes the federal,

veteran, state, provincial, municipal, local government, or any political subdivision thereof, of the United States or any other country. The Plan will not exclude benefits for a covered person who receives billable medical care at any of the above facilities.

12. Expenses for treatment, services, or supplies provided by the employee, spouse, parent, son, daughter, brother, or sister of a covered person or by a member of the covered person's household.

13. Expenses for which there is no legal obligation to pay or for which no charges would be made if the person had no medical or dental coverage.

14. Expenses for services for which the covered person recovers the cost by legal action or settlement.

15. Expenses for reverse sterilizations.

16. Expenses for transsexual surgery or related procedures.

17. Expenses for rehabilitative care.

18. Expenses for cosmetic or reconstructive surgery, except for expenses:

    a) to repair or alleviate the damage from an accident; or

    b) incurred for reconstructive surgery following a mastectomy or for surgery and reconstruction of the other breast to produce symmetrical appearance; or

    c) incurred as a result of a birth defect.

19. Expenses solely for sanitarium, rest, or custodial care.

20. Expenses for routine foot care, to include treatment of corns, callouses, bunions (except capsular or bone surgery), flat feet, fallen arches, weak feet, or chronic foot strain.

21. Expenses incurred for weight control by surgical procedures, weight loss programs or a gastric bypass; whether or not it has been determined that the services are medically necessary or the services are under the direction of a physician.

22. Expenses for telephone, radio, television, and beautification services or for the preparation of reports, evaluations and forms, or for missed appointments or for time spent traveling or in connection therewith that may be incurred by the physician or dentist or other health care professional in the course of rendering services.

23. Expenses for procedures which do not correct the condition of infertility but are used to induce pregnancy such as artificial insemination, in-vitro fertilization, embryo transplantation, hormone therapy or gamete intra-fallopian transfer (GIFT).

24. Routine or elective expenses except as set forth herein. [i.e. shoe inserts, ankle pads, printed material, arch supports, foot orthotics, orthopedic or corrective shoes and other supportive appliances for the feet, elastic stockings, fluoride, anabolic steroids, irrigation solutions, vitamins (except prenatal), over-the-counter vitamins, nutritional or dietary counseling (except when related to diabetes), food supplements, and any "over the

counter drug" which can be purchased with or without a prescription or when no injury or illness is involved].

25. Expenses for breast reduction surgery.

26. Expenses incurred prior to the covered person's effective date of coverage or following the termination date of coverage.

27. Expenses in excess of the maximum allowable benefit in the locality where it is rendered.

28. Expenses for rolfing.

29. Expenses for acupuncture.

30. Expenses for massage therapy or rolfing.

31. Expenses for biofeedback training or equipment.

32. Expenses for surrogacy.

33. Expenses for injuries that result from being in any aircraft being used for one or more of the following: test or experimental purposes; speed test; exhibition or stunt flying; and for injuries that result from riding in or on a motorized vehicle of any type designed for or primarily used for racing, speed tests, or hazardous exhibition purposes.

34. Expenses for complications arising from any non-covered surgery or treatment, except as required by law.

35. Expenses for educational, vocational, or training services and supplies, except as specified in the Medical Covered Expenses section.

36. Expenses related to insertion or maintenance of an artificial heart.

37. Expenses for treatment of behavioral or conduct disorders.

38. Expenses for maintenance care.

39. Expenses for education, counseling, job training, or care for learning disorders or behavioral problems, whether or not services are rendered in a facility that also provides medical and/or mental/nervous treatment.

40. Expenses for adoption services.

41. Expenses for hypnosis.

42. Expenses for genetic counseling or genetic testing, except as provided herein.

43. Expenses for marital, family, or sex counseling.

44. Expenses for equipment such as air conditioners, air purifiers, dehumidifiers, heating pads, hot water bottles, water beds, swimming pools, hot tubs and any other clothing or equipment which could be used in the absence of an illness or injury.

45. Expenses for medications which are taken by or administered to a covered person, in whole or in part, while they are a patient in a licensed hospital.

46. Expenses for drugs whose sole purpose is to promote or stimulate hair growth (e.g Rogaine or Propecia) or for cosmetic purposes only (e.g. Renova or Vaniqa).

47. Expenses for anorexiants or weight loss medications.

48. Expenses for extemporaneous or compounded dosage forms of natural estrogen or progesterone, including, but not limited to, oral capsules, suppositories, and troches.

49. Expenses related to "Never Events." These events are procedures performed on the wrong side, wrong body part, wrong procedure, or wrong person. These "Never Events" are not medically necessary as they are not required to diagnose or treat an illness, injury, disease or its symptoms and are not consistent with generally accepted standards of medical practice.

50. Expenses for outpatient mental health or substance abuse.

51. Expenses for speech or occupational therapy.

52. Expenses for hospice care.

53. Expenses for home health care.

54. Expenses for private duty nursing care.

55. Expenses for durable medical equipment.

56. Services involving a covered person who has taken part in any activity made illegal either due to the use of alcohol or a state of intoxication, even if the cause of the illness or injury is not related to the use of alcohol. It is not necessary that an arrest occur, criminal charges be filed, or, if filed, that a conviction result. Proof beyond a reasonable doubt is not required to be deemed an activity made illegal due to the use of alcohol or a state of intoxication. Expenses will be covered for injured covered persons other than the person partaking in an activity made illegal due to the use of alcohol or a state of intoxication, and expenses may be covered for substance abuse treatment as specified in this Plan, if applicable. This exclusion does not apply if the injury (a) resulted from being the victim of an act of domestic violence, or (b) resulted from a documented medical condition (including both physical and mental health conditions).

CLAIM FILING PROCEDURES

Written notice of the Employee or the Employee's Dependent's claim (proof of claim) must be received by the Contract Administrator as soon as is reasonably possible, by the later of:

a. the twelve (12) months after the occurrence or commencement of any loss, benefit, or Expense covered by the Plan.
b. the timely filing provision deadline defined in the Provider's contract with the Host Plan.

For the purposes of this section, a claim is considered "received" once it is both in possession by the Host Plan and capable of being processed by the Contract Administrator. An incomplete or incorrect claim is not considered "received."

Failure to furnish written proof of claim within the time required will invalidate the claim, except in the case of the Covered Person's legal incapacity. Coverage is based on the Plan's provisions at the time the loss is incurred. It is the Employee's responsibility to inform his Provider(s) of this claim submission time limit.

Please note that, as required by applicable law, certain deadlines noted in this Claim Filing Procedures section may be extended due to the public health emergencies. Please contact the Contract Administrator for more information.

Filing an In-Network or Out-of-Network Medical Claim:
To obtain benefits under this Plan, a diagnostic bill must be submitted that provides sufficient information, including the Employee's name, Claimant's name, Claimant's address, and Contract Administrator Group Number to allow the Contract Administrator to properly adjudicate each claim. The Contract Administrator may require additional forms and information to assist them in this process. The Covered Person should instruct their medical care Providers, both in-network and out-of-network, to mail claims to the applicable following address:

Vermont providers send claims to:

CBA Blue
P.O. Box 2365
South Burlington, VT 05407-2365

Provider outside of Vermont: File claims with your local Blue Cross & Blue Shield Plan.

Note that the ***No Surprises Act*** requires the Plan to follow a specific process for paying Providers and facilities for out-of-network claims covered by the No Surprises Act, and that Payment process may include an independent dispute resolution process between the Plan and your out-of-network Provider. That separate Payment process is applicable to the out-of-network Provider -- not to you -- and is different from the claims review procedures explained in this document. You must follow the claims review procedures explained below to request benefits or address any benefit dispute under the Plan.

[Should the Employee have any questions, please feel free to call or write to the Contract Administrator.]

CLAIM REVIEW PROCEDURES

I. Failure to Follow Pre-Service Claim Procedures:

In the case of a failure by a claimant or an authorized representative of a claimant to follow the Plan's procedures for filing a Pre-Service Claim, the claimant or representative will be notified of the failure and the proper procedures to be followed in filing a claim for benefits as soon as possible, but not later than five (5) days (twenty-four (24) hours in the case of a failure to file a Claim involving Urgent Care) following the failure. This notification will be oral unless written certification is requested by the claimant or authorized representative. This section shall only apply in the case of a failure that:

(i) Is a communication by a claimant or an authorized representative of a claimant that is received by the Pre-Certification Administrator; and

(ii) Is a communication that names a specific claimant; a specific medical condition or symptom; and a specific treatment, service or product for which approval is requested.

II. Timing of Notice of Benefit Claim Determinations:

(a) **Provisions Applicable to All Benefits Under the Plan.**

(i) The various time periods set forth in this Section II within which benefit determinations must be made shall begin at the time a claim is filed in accordance with the Plan's procedures without regard to whether all the information necessary to make a benefit determination accompanies the filing.

(ii) If any period of time set forth in this Section II is extended because of a claimant's failure to submit information necessary to decide a claim, the period for making the benefit determination shall be tolled from the date on which the notification of the extension is sent to the claimant until the earlier of (a) the date on which the claimant responds to the request for additional information, or (b) the last day of the period provided to the claimant to respond to the request for additional information.

(b) **Additional Provisions Applicable to Health Benefits.**

(i) *Urgent Care Claims*: In the case of a Claim involving Urgent Care, the Contract Administrator will notify the claimant of the Plan's benefit determination (whether adverse or not) as soon as possible, taking into account the medical urgencies, but not later than seventy-two (72) hours after receipt of the claim by the Contract Administrator, unless the claimant fails to provide sufficient information to determine whether, or to what extent, benefits are covered or payable under the Plan. In the case of such a failure, the Contract Administrator will notify the claimant as soon as possible, but not later than twenty-four (24) hours after receipt of the claim by the Contract Administrator, of the specific information necessary to complete the claim. The claimant will be afforded a reasonable amount of time, taking into account the circumstances, but not less than forty-eight (48) hours, to provide the specified information.

Notification of any Adverse Benefit Determination will be made in accordance with the requirements set forth in Section III, Written Denial Provisions, below. The Contract Administrator will notify the claimant of the Plan's benefit determination as soon as possible, but in no case later than forty-eight (48) hours after the earlier of:

1. The Contract Administrator's receipt of the specified information, or
2. The end of the period afforded the claimant to provide the specified additional information.

(ii) *Concurrent Care Decisions:* If an ongoing course of treatment to be provided over a period of time or number of treatments has been approved by the Plan, any reduction or termination by the Plan of such course of treatment (other than by Plan amendment or termination) before the end of such period of time or number of treatments shall constitute an Adverse Benefit Determination. The Contract Administrator will notify the claimant, in a manner in accordance with the Written Denial provisions set forth below, of the Adverse Benefit Determination at a time 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.

Any request by a claimant to extend the course of treatment beyond the period of time or number of treatments that is a Claim involving Urgent Care shall be decided as soon as possible, taking into account the medical urgencies, and the Contract Administrator shall notify the claimant of the benefit determination, whether adverse or not, within twenty-four (24) hours after receipt of the claim by the Contract Administrator, provided that any such claim is made to the Contract Administrator at least twenty-four (24) hours prior to the expiration of the prescribed period of time or number of treatments. Notification of any adverse determination concerning a request to extend the course of treatment, whether involving Urgent Care or not, shall be made in accordance with the Written Denial provisions set forth below, as appropriate.

(iii) *Pre-Service Claim:* In the case of a Pre-Service Claim, the Contract Administrator shall notify the claimant of the Plan's benefit determination (whether adverse or not) within a reasonable period of time appropriate to the medical circumstances, but not later than fifteen (15) days after receipt of the claim by the Contract Administrator. The period may be extended one time by the Plan for up to fifteen (15) days, provided that the Contract Administrator 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 period of the circumstances requiring the extension of time and the date by which the Plan expects to render a decision. If such an extension is due to a failure of the claimant to submit the information necessary to decide the claim, the notice of extension shall specifically describe the 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. Notification of any Adverse Benefit Determination pursuant to this paragraph shall be made in accordance with the Written Denial provisions set forth below.

(iv) *Post-Service Claim*: In the case of a Post-Service Claim, the Contract Administrator shall notify the claimant, in accordance with the Written Denial provisions set forth below, of the Plan's Adverse Benefit Determination within a reasonable period of time, but not more than thirty (30) days after receipt of the claim. This period may be extended one time by the Contract Administrator for up to fifteen (15) days, provided that the Contract Administrator 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 period of the circumstances requiring the extension of time and the date by which the Plan expects to render a decision. If such an extension is due to a failure of the claimant to submit the information necessary to decide the claim, the notice of extension shall specifically describe the 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) **Additional Provisions Applicable to Disability Benefits.** In the case of a claim for disability benefits, the Contract Administrator shall notify the claimant, in accordance with the Written Denial provisions set forth below, of the Plan's Adverse Benefit Determination within a reasonable period of time, but not later than forty-five (45) days after receipt of the claim by the Contract Administrator. This period may be extended by the Plan for up to thirty (30) days, provided that the Contract 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 forty-five (45) day period of the circumstances requiring the extension of time and the date by which the Plan Administrator expects to render a decision. If, prior to the end of the first thirty (30) day extension period, the Contract Administrator determines that, due to matters beyond the control of the Plan, a decision cannot be rendered within that extension period, the period for making the determination may be extended for up to an additional thirty (30) days, provided that the Contract Administrator notifies the claimant, prior to the expiration of the first thirty (30) day extension period, of the circumstances requiring the extension and the date as of which the Plan expects to render a decision. In the case of any extension under this paragraph, the notice of extension shall specifically explain the standards on which entitlement to a benefit is based, the unresolved issues that prevent a decision on the claim, and the additional information needed to resolve those issues, and the claimant shall be afforded at least forty-five (45) days within which to provide the specified information.

(d) **Additional Provisions Applicable to Benefits other than Health Benefits and Disability Benefits**. If a claim for benefits other than health benefits or disability benefits is wholly or partially denied, the Contract Administrator shall notify the claimant of the Adverse Benefit Determination within a reasonable period of time not to exceed ninety (90) days after receipt of the claim by the Contract Administrator, unless the Contract Administrator determines that special circumstances require an extension of time for processing the claim. If the Contract Administrator determines that such an extension is required, written notice (in accordance with the Written Denial provisions set forth below) of the extension shall be provided to the claimant prior to the termination of the ninety (90) day period. In no event shall such extension exceed a period of ninety (90) days from the end of the initial ninety (90) day period. The notice of the extension provided to the claimant shall indicate the circumstances requiring an extension and the date by which the Contract Administrator expects to render the benefit determination.

III. Written Denial Provisions

(a) **Provisions Applicable to All Benefits under the Plan.** The Contract Administrator shall provide a claimant with written or electronic notification of any determination of a claim. In the case of an Adverse Benefit Determination, the notification shall set forth in a manner calculated to be understood by the claimant:

(i) The specific reason(s) for the denial;

(ii) Specific references to pertinent Plan provisions upon which the denial is based;

(iii) A description of any additional material or information necessary for the claimant to perfect the claim, and an explanation of why such material or information is necessary;

(iv) An explanation of the Plan's claim review procedures and the time limits applicable to such procedures, including a statement of the claimant's right to bring a civil action under Section 502(a) of ERISA following an adverse determination on review.

(b) **Additional Provisions Applicable to Health Benefits and Disability Benefits.**
In the case of an Adverse Benefit Determination concerning health benefits or disability benefits, the notification shall also set forth in a manner calculated to be understood by the claimant:

(i) The specific internal rule, guideline, protocol, or other similar criterion if such rule, guideline, protocol or other similar criterion was relied upon in making the adverse determination, or a statement that a copy of such rule, guideline, protocol or other similar criterion will be provided free of charge to the claimant upon request;

(ii) If the Adverse Benefit Determination is based on a medical necessity or experimental treatment or similar exclusion or limit, either an explanation of the scientific or clinical judgement for the determination, applying the terms of the Plan to the claimant's medical circumstances, or a statement that such explanation will be provided free of charge upon request;

(iii) In the case of an adverse determination concerning a Claim involving Urgent Care, a description of the expedited review process applicable to such claims; and

(iv) In the case of a final internal Adverse Benefit Determination, a discussion of the decision.

In the case of an Adverse Benefit Determination concerning an Urgent Care Claim, the information described above in this Section III may be provided to the claimant orally, provided that a written or electronic notification is furnished to the claimant not later than three (3) days after the oral notification.

IV. Appeal of Adverse Benefit Determinations

(a) **Provisions Applicable to All Benefits under the Plan.**

(i) Each claimant shall be afforded a full and fair review of any Adverse Benefit Determination. In addition to complying with the other requirements described in these Claim Filing Procedures, the Contract Administrator will provide a claimant, free of charge, with any new or additional evidence considered, relied upon, or generated by the Contract Administrator in connection with its review of a claimant's appeal. Such information will be provided as soon as possible and sufficiently in advance of the date on which the notice of final internal Adverse Benefit Determination is to be provided to the claimant so that the claimant will have a reasonable opportunity to respond prior to that date. In addition, if the Contract Administrator intends to issue an Adverse Benefit Determination on a claimant's appeal that is based on a new or additional rationale from the one on which the claim was originally decided, the claimant shall be provided, free of charge, with the new or additional rationale. The rationale will be provided as soon as possible and sufficiently in advance of the date on which the notice of final internal Adverse Benefit Determination is to be provided to the claimant so that the claimant will have a reasonable opportunity to respond prior to that date.

(ii) Each claimant may appeal an Adverse Benefit Determination within one hundred eighty (180) days (sixty (60) days in the case of an Adverse Benefit Determination relating to benefits other than health benefits or disability benefits) following receipt of notification of the Adverse Benefit Determination.

(iii) In connection with such review, the claimant shall have the opportunity to submit any written comments, documents, records or other information the claimant believes is relevant.

(iv) In connection with such review, the claimant shall be provided, upon request and free of charge, reasonable access to, and copies of, all documents, records and other information relevant to the claimant's appeal.

(v) The review of the Adverse Benefit Determination shall take into account all comments, documents, records and other information submitted by the claimant that relate to the claim, without regard to whether such information was submitted or considered in the initial benefit determination.

(b) **Additional Provisions Applicable to Health Benefits and Disability Benefits.**

(i) The review shall not afford deference to the initial Adverse Benefit Determination.

(ii) The review shall be conducted by an appropriate named fiduciary of the Plan who is neither the individual who made the Adverse Benefit Determination that is the subject of the review, nor a subordinate of such individual.

(iii) In deciding an appeal of an Adverse Benefit Determination that is based in whole or in part on a medical judgment, including determinations with regard to whether a particular treatment, drug, or other item is experimental, investigational, or not medically necessary or appropriate, the person conducting the review will consult with a health care professional who has appropriate training and experience in the field of medicine involved in the medical judgment. The health care professional engaged for purposes of consultation in accordance with the previous sentence shall be an individual 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.

(iv) The identity of medical or vocational experts whose advice was obtained on behalf of the Plan in connection with a claimant's Adverse Benefit Determination, without regard to whether the advice was relied upon in making the benefit determination, will be provided to the claimant upon request.

(v) In the case of a Claim involving Urgent Care, an expedited review process will be provided, pursuant to which a request for an expedited appeal to an Adverse Benefit Determination may be submitted orally or in writing by the claimant and all necessary information, including the Plan's benefit determination on review, shall be transmitted between the Plan and the claimant by telephone, facsimile, or other available similarly expeditious method.

V. Timing of Notice of Benefit Determination Following Review

(a) **Provisions Applicable to All Benefits under the Plan.**

(i) The various time periods set forth in this Section V within which the review of an Adverse Benefit Determination must be completed shall begin at the time an appeal is filed in accordance with the procedures of the Plan, without regard to whether all the information necessary to make a determination on review accompanies the filing.

(ii) If the period set forth in this Section V(c) is extended as permitted therein due to a claimant's failure to submit information necessary to decide a claim, the period for making the determination on review shall be tolled from the date on which the notification of the extension is sent to the claimant until the earlier of (a) the date on which the claimant responds to the request for additional information, or (b) the last day of the period provided to the claimant to respond to the request for additional information.

(b) **Additional Provisions Applicable to Health Benefits.**

(i) *Urgent Care Claims:* In the case of a Claim involving Urgent Care, the Contract Administrator shall notify the claimant, in accordance with the Notification of Benefit Determination provisions below, of the Plan's benefit determination on review as soon as possible, taking into account the medical urgencies, but not later than seventy-two (72) hours after receipt of the claimant's request for review of an Adverse Benefit Determination by the Plan.

(ii) *Pre-Service Claims:* In the case of a Pre-Service Claim, the Contract Administrator shall notify the claimant, in accordance with the Notification of Benefit Determination provisions below, of the Plan's benefit determination on review within a reasonable period of time appropriate to the medical circumstances. Such notification shall be provided not later than thirty (30) days after receipt by the Plan of the claimant's request for review of an Adverse Benefit Determination.

(iii) *Post-Service Claims:* In the case of a Post-Service Claim, the Contract Administrator shall notify the claimant, in accordance with the Notification of Benefit Determination, of the Plan's benefit determination on review within a reasonable period of time. Such notification shall be provided not later than

sixty (60) days after receipt by the Plan of the claimant's request for review of an Adverse Benefit Determination.

(c) **Additional Provisions Applicable to Benefits other than Health Benefits.** In the case of an appeal of an Adverse Benefit Determination other than one relating to health benefits, the Contract Administrator shall notify the claimant of the benefit determination on review within a reasonable period of time, but not later than sixty (60) days (forty-five (45) days in the case of a disability benefit) after receipt of the claimant's request for review, unless the Contract Administrator determines that special circumstances such as the need to hold a hearing require an extension of time for processing the claim. If the Contract Administrator determines that an extension of time for processing is required, written notice of the extension shall be furnished to the claimant prior to the termination of the initial period. In no event shall such extension exceed a period of sixty (60) days (forty-five (45) days in the case of disability benefits) from the end of the initial period. The extension notice shall indicate the special circumstances requiring an extension of time and the date by which the Plan expects to render the determination on review.

VI. Notification of Benefit Determination

(a) **Provisions Applicable to All Benefits under the Plan.** The Contract Administrator shall provide a claimant with a written or electronic notification of a Plan's benefit determination on review. In the case of an Adverse Benefit Determination, the notification shall set forth, in a manner calculated to be understood by the claimant:

(i) The specific reason(s) for the adverse determination;

(ii) Reference to the specific Plan provisions on which the benefit determination is based;

(iii) 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;

(iv) A statement describing any voluntary appeal procedures offered by the Plan and the claimant's right to obtain the information about such procedures, and a statement of the claimant's right to bring an action under Section 502(a) of ERISA; and

(v) A statement describing the claimant’s right, if any, to request external review of a final internal Adverse Benefit Determination or Adverse Benefit Determination, as provided under the Patient Protection and Affordable Care Act of 2010.

(b) **Provisions Applicable to Health Benefits and Disability Benefits.** In the case of an Adverse Benefit Determination on review concerning health benefits or disability benefits, the notification shall also set forth, in a manner calculated to be understood by the claimant:

(i) The specific internal rule, guideline, protocol, or other similar criterion if such rule, guideline, protocol or other similar criterion was relied upon in making the adverse determination (a copy of such rule, guideline, protocol or other similar criterion will be provided free of charge to the claimant upon request);

(ii) If the Adverse Benefit Determination is based on a medical necessity or experimental treatment or similar exclusion or limit, either an explanation of the scientific or clinical judgment for the determination, applying the terms of

the Plan to the claimant's medical circumstances, or a statement that such explanation will be provided free of charge upon request; and

(iii) The following statement: "You and your plan may have other voluntary alternative dispute resolution options, such as mediation. One way to find out what may be available is to contact your local U.S. Department of Labor Office and your State insurance regulatory agency."

VII. External Review Process

(a) 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.

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

(i) Any eligible Adverse Benefit Determination (including a Final Internal Adverse Benefit Determination) by a plan or issuer that involves medical judgment (including, but not limited to, those based on the plan's or issuer's requirements for Medical Necessity, appropriateness, health care setting, level of care, or effectiveness of a covered benefit; its determination that a treatment is Experimental or Investigative; its determination whether a Claimant or beneficiary is entitled to a reasonable alternative standard for a reward under a wellness program; its determination whether a plan or issuer is complying with the nonquantitative treatment limitation provisions of Code section 9812 and § 54.9812-1, which generally require, among other things, parity in the application of medical management techniques), as determined by the external reviewer.

(ii) An Adverse Benefit Determination that involves consideration of whether the Plan is complying with the surprise billing and Cost-Sharing protections set forth in the No Surprises Act.

(iii) A recission of coverage (whether or not the recission 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).

(a) Request for external review. The Plan will allow a Claimant to file a request for an external review with the Contract Administrator if the request is filed **within four 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 months after the date of receipt of such a notice, then the request must be filed by the first day of the fifth month following the receipt of the notice. For example, if the date of receipt of the notice is October 30, because there is no February 30, the request must be filed by March 1. If the last filing date would fall on a Saturday, Sunday, or Federal holiday, the last filing date is extended to the next day that is not a Saturday, Sunday, or Federal holiday.

(b) Preliminary review. Within five business days following the date of receipt of the external review request, the Plan will complete a preliminary review of the request to determine whether:

(i) 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.

(ii) The Adverse Benefit Determination or the Final Internal Adverse Benefit Determination does not relate to the Claimant's failure to meet the requirements for eligibility under the terms of the Plan (e.g., worker classification or similar determination).

(iii) The Claimant has exhausted the Plan's internal appeal process unless the Claimant is not required to exhaust the internal appeals process under applicable law.

(iv) The Claimant has provided all the information and forms required to process an external review.

(c) Within one business day after completion of the preliminary review, the Plan will issue a notification in writing to the Claimant. If the request is complete but not eligible for external review, such notification will include the reasons for its ineligibility and contact information for the Employee Benefits Security Administration (toll-free number 866-444-EBSA (3272)). If the request is not complete, such notification will describe the information or materials needed to make the request complete and the Plan will allow a Claimant to perfect the request for external review within the four-month filing period or within the 48-hour period following the receipt of the notification, whichever is later.

(d) Referral to Independent Review Organization. If the claim is eligible for external review, 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 Contract 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 methods for selection of IROs, such as random selection). In addition, the IRO may not be eligible for any financial incentives based on the likelihood that the IRO will support the denial of benefits.

(e) 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

(a) 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:

(i) An Adverse Benefit Determination if the Adverse Benefit Determination involves a medical condition of the Claimant for which the timeframe for completion of a standard internal appeal

under the final regulations would seriously jeopardize the life or health of the Claimant or would jeopardize the Claimant's ability to regain maximum function and the Claimant has filed a request for an expedited internal appeal; or

(ii) 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.

(b) 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.

(c) 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.

(d) Notice of final external review decision. The Plan's (or Contract 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 72 hours after the IRO receives the request for an expedited external review. If the notice is not in writing, within 48 hours after the date of providing that notice, the assigned IRO will provide written confirmation of the decision to the Claimant and the Plan.

VIII. Legal Action

You must exhaust the mandatory levels of appeal in this Plan before you request external review or seek other legal recourse. No legal action may be brought until the Plan's claims and appeals procedures have been exhausted. After completing the claims and appeals procedures, should you wish to bring any legal action against the Plan, the Employer, and/or the Contract Administrator, you must bring any such lawsuit within twelve (12) months after the date of notification of the final decision upon appeal. If you fail to bring any such lawsuit within that timeframe, or if you fail to exhaust the Plan's claims and appeals procedures (including failure to timely file any request for review), you will lose any right you have to

further review/appeal or to file a lawsuit (as applicable), and the Plan Administrator's (or its delegate's) decision will be final and binding.

IX. Recovery of Payments

(a) 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 Benefit. 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.

(b) 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 as Payment was made, shall return or refund the amount of such erroneous Payment to the Plan within 30 days of discovery or demand. The Plan Administrator shall have no obligation to secure Payment for the Expense for which the erroneous Payment was made to which it was applied.

(c) 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 Plan Sponsor. The reductions will equal the amount of the required reimbursement.

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

(e) 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.

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

(i) In error.

(ii) Pursuant to a misstatement contained in a proof of loss or a fraudulent act.

(iii) Pursuant to a misstatement made to obtain coverage under this Plan within two years after the date such coverage commences.

(iv) With respect to an ineligible person.

(v) In anticipation of obtaining a recovery if a Claimant fails to comply with the Plan's Subrogation, Reimbursement & Third-Party Recovery provisions.

(vi) Pursuant to a claim for which benefits are recoverable under any policy or act of law providing for coverage for occupational injury or disease to the extent that such benefits are recovered. This provision (vi) shall not be deemed to require the Plan to pay benefits under this Plan in any such instance.

(g) 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.

(h) 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).

CONTINUITY OF CARE

You may be eligible to continue care with a facility or provider that leaves the Preferred Provider Network (or if there is a change in the contract with that facility or provider that would terminate or result in a loss of your benefits with respect to the facility or provider) if you are a "continuing care patient" of that facility or provider at the time the facility or provider leaves the network (or at the time the contract change is effective). This provision does not apply if the contract for the facility or provider is terminated for failure to meet applicable quality standards or for fraud.

A "continuing care patient" is someone who, with respect to a specific facility or Provider, is: (i) undergoing a course of Treatment from that facility or Provider for a "serious and complex condition," (ii) undergoing a course of institutional or inpatient care from that facility or Provider, (iii) scheduled to undergo nonelective surgery from that facility or provider (including the receipt of postoperative care with respect to such surgery), (iv) pregnant and undergoing a course of treatment for the pregnancy from that facility or provider, or (v) terminally ill (or was terminally ill) as determined under Section 1861(dd)(3)(A) of the Social Security Act, and is receiving treatment for such illness from that facility or Provider. A "serious and complex condition" is: (i) in the case of an acute illness, a condition that is serious enough to require specialized medical Treatment to avoid the reasonable possibility of death or permanent harm, or (ii) in the case of a chronic illness or condition, a condition that is life-threatening, degenerative, potentially disabling, or congenital, and that requires specialized medical care over a prolonged period of time.

If the Contract Administrator determines that you may be eligible for continued care pursuant to this section, then the Contract Administrator will notify you and provide you with an opportunity to elect to continue care. If you make such election, then you may be able to continue care for up to 90 days from the date you receive the notice. Such continued transitional care would be provided under the same terms and conditions that would have applied and with respect to the items and services as would have been covered under the Plan if the termination or contract change had not occurred, with respect to the course of Treatment relating to your status as a continuing care patient.

Please contact the Contract Administrator at (888) 222-9206 if you do not receive a notice, but you think you may be eligible for continued care under this section.

MISCELLANEOUS PROVISIONS

Discharge: All plan benefits made in accordance with the terms and provisions contained herein will discharge the Plan Sponsor from all future liability to the extent of the payments so made.

Discretionary Authority: The Plan Administrator has the authority to interpret the Plan and to determine all questions that arise under it. This will include, but is not limited to: satisfaction of eligibility requirements, determination of medical necessity, and interpretation of terms contained in this document. The Plan Administrator's decisions will be binding on all employees, dependents, and beneficiaries.

Except for functions reserved by the Plan to the Employer or Board of Directors, the Plan Administrator will control and manage the operation and administration of the Plan. In accordance with Sec. 503 of Title I of ERISA, the Plan Administrator will designate one or more named fiduciaries under the Plan, each with complete authority to review all denied claims for benefits under the Plan with respect to which it has been designated named fiduciary (including, but not limited to, the denial of certification of medical necessity of hospital or medical treatment). In exercising its fiduciary responsibilities, the named fiduciary will have discretionary authority to determine whether and to what extent participants and beneficiaries are entitled to benefits and to construe disputed or doubtful Plan terms. The named fiduciary will be deemed to have properly exercised such authority unless it has abused its discretion hereunder by acting arbitrarily and capriciously.

Federal Guidelines for a Plan Subject to the Employee Retirement Income Security Act of 1974 (ERISA): This Plan will comply with all federal law and guidelines relative to welfare benefit plans under ERISA. These federal laws and guidelines will supersede any provisions and terminology contained herein which may be to the contrary.

Family and Medical Leave Policy: All eligible employees have the right to take family and medical leave according to the provisions of the federal and state laws as amended from time to time.

Increases/Decreases in Coverage: Any amendments to the Plan providing an increase in the amount of a covered employee's and/or dependent's coverage will become effective as of the date of such amendment, provided coverage is in effect on the date of such amendment. Any amendment to the Plan providing a decrease in the amount of a covered employee's and/or dependent's coverage will begin on the effective date of such amendment.

Invalidity of Certain Provisions: If any provisions of the Plan will be held invalid or unenforceable, such invalidity or enforceability will not affect any other provision herein and this Plan will be construed and enforced as if such provisions had not been included.

Medicare Program: When you are eligible for Medicare and Medicare is allowed by federal law to be the primary payor, the coverage provided by this health plan will be reduced by the amount of benefits allowed under Medicare for the same covered services. This reduction will be made whether or not you actually receive the benefits from Medicare.

Under Age 65 with End Stage Renal Disease (ESRD)
If you are under age 65 and are eligible for Medicare only because of ESRD (permanent kidney failure), the benefits of this health plan will be provided before Medicare benefits. This is the case only during the first 30 months of your ESRD Medicare coverage. After 30 months, the benefits that are provided by this health plan will be reduced by the amount that Medicare allows for the same covered services.

Under Age 65 with Other Disability
If your employer group employs 100 or more employees and if you are under age 65 and you are eligible for Medicare only because of a disability other than ESRD, this health plan will provide benefits before Medicare benefits. This is the case only if you are the actively employed employee or the enrolled spouse or dependent of the actively employed employee. If you are an inactive employee or a retiree or the enrolled spouse or dependent of the inactive employee or retiree, the benefits that are provided by this health plan will be reduced by the amount that Medicare allows for the same covered services. (In some cases, this provision also applies to certain smaller employer groups. Your plan sponsor can tell you if it applies to your group.)

Age 65 or Older
If you are age 65 or older and are eligible for Medicare only because of age, this health plan will provide benefits before Medicare benefits as long as you have chosen this health plan as your primary payor. This can be the case only if you are an actively employed employee or the enrolled spouse of the actively employed employee. (If you are actively employed at the time you reach age 65 and become eligible for Medicare, you must choose between Medicare and this health plan as the primary payor of your health care benefits).

Dual Medicare Eligibility
If you are eligible for Medicare because of ESRD and a disability or because of ESRD and you are age 65 or older, this health plan will provide benefits before Medicare benefits. This is the case during the first 30 months of your ESRD Medicare coverage only if the coverage under this health plan was primary when you became eligible for ESRD Medicare benefits. Then, for as long as you maintain dual Medicare eligibility, the benefits that are provided by this health plan will be reduced by the amount that Medicare allows for the same covered services. (This provision may not apply to you. To find out if it does, contact your plan sponsor.)

Qualified Medical Child Support Orders: Participants and beneficiaries may obtain upon request from the Contract Administrator, without charge, a copy of the Plan's procedures relating to qualified medical child support orders.

Right to Make Payments: The Plan Administrator has the right to pay any other organization as needed to properly deliver plan benefits. These payments that are made in good faith are considered benefits paid under this Plan. Also, they discharge the Plan Administrator from further liability to the extent that payments are made.

Right to Receive and Release Necessary Information: For the purpose of determining the applicability of and implementing the terms of this provision of this Plan, or any provision of similar purpose of another plan, the Plan Administrator may release to or obtain from any other insurance company or other organization or person any information with respect to any person which the Contract Administrator deems to be necessary for such purposes. Any person claiming benefits under this Plan will furnish to the Contract Administrator such information as may be required to implement this provision in accordance with the HIPAA Privacy Requirements.

Right to Recovery: Whenever the Plan has allowed benefits to be paid which have been paid or should have been paid by any other plan, or which were erroneously paid, the Plan will have the right to recover any such excess payments from the appropriate party.

Right to Amend the Plan: The Plan Sponsor has the authority to amend the Plan Document, modifying any of the provisions herein, or terminating the Plan at any time without the consent of or notice to any covered person hereunder. The Plan may be amended, modified, or terminated as required by plan utilization, costs, market forces, federal legislation, or other general business

concerns of the Plan Sponsor. When a Plan amendment, modification, or termination is executed, the Plan Sponsor will provide notice of such action, in writing, to all covered persons.

Should the Plan be amended and, thereby, terminated, the Plan Administrator will provide for:

First: Payment of benefits to each covered person of all covered expenses for services which were incurred while the Plan was in effect.

Second: Payment of expenses incurred in the liquidation and distribution of the Plan and any payments due to the Plan Administrator.

Third: Direct disposition of all assets, if applicable, held in the Plan to covered persons as determined by the Plan Administrator, subject to the limitations contained herein and any applicable requirements of law or regulation.

Subrogation, Reimbursement & Third-Party Recovery Provision:

Payment Condition

1. The Plan, in its sole discretion, may elect to conditionally advance payment of benefits in those situations where an Injury, Sickness, Disease or disability is caused in whole or in part by, or results from the ads or omissions of Participants, and/or their Dependents, beneficiaries , estate, heirs, guardian, personal representative, or assigns (collectively referred to hereinafter in this section as "Participant(s)") or a third party, where any party besides the Plan may be responsible for expenses arising from an incident , and/or other funds are available, including but not limited to 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. Participant(s), his or her attorney, and/or legal guardian of a minor or incapacitated individual agrees that acceptance of the Plan's conditional payment of medical benefits is constructive notice of these provisions in their entirety and agrees to maintain 100% of the Plan's conditional payment of benefits or the full extent of payment from any one or combination of first and third party sources in trust, without disruption except for reimbursement to the Plan or the Plan's assignee. The Plan shall have an equitable lien on any funds received by the Participant(s) and/or their attorney from any source and said funds shall be held in trust until such time as the obligations under this provision are fully satisfied. The Participant(s) agrees to include the Plan's name as a co-payee on any and all settlement drafts. Further, by accepting benefits the Participant(s) understands that any recovery obtained pursuant to this section is an asset of the Plan to the extent of the amount of benefits paid by the Plan and that the Participant shall be a trustee over those Plan assets.
3. In the event a Plan Participant(s) settles, recovers, or is reimbursed by any Coverage, the Participant(s) agrees to reimburse the Plan for all benefits paid or that will be paid by the Plan on behalf of the Participant(s). If the Participant(s) fails to reimburse the Plan out of any judgment or settlement received, the Participant(s) will be responsible for any and all expenses (fees and costs) associated with the Plan's attempt to recover such money.
4. If there is more than one party responsible for charges paid by the Plan, or may be responsible for charges paid by the Plan, the Plan will not be required to select a particular party from whom reimbursement is due. Furthermore, unallocated settlement

funds meant to compensate multiple injured parties of which the Participant(s) is/are only one or a few, that unallocated settlement fund is considered designated as an "identifiable" fund from which the plan may seek reimbursement.

Subrogation

1. As a condition to participating in and receiving benefits under this Plan, the Participant(s) agrees to assign to the Plan the right to subrogate and pursue any and all claims, causes of action or rights that may arise against any person, corporation and/or entity and to any Coverage to which the Participant(s) is entitled, regardless of how classified or characterized, at the Plan's discretion, if the Participant(s) fails to so pursue said rights and/or action.
2. If a Participant(s) receives or becomes entitled to receive benefits, an automatic equitable lien attaches in favor of the Plan to any claim, which any Participant(s) may have against any Coverage and/or party causing the Sickness or Injury to the extent of such conditional payment by the Plan plus reasonable costs of collection. The Participant is obligated to notify the Plan or it authorized representative of any settlement prior to finalization of the settlement, execution of a release, or receipt of applicable funds. The Participant is also obligated to hold any and all funds so received in trust on the Plan's behalf and function as a trustee as it applies to those funds until the Plan's rights described herein are honored and the Plan is reimbursed.
3. The Plan may, at its discretion, in its own name or in the name of the Participant(s) commence a proceeding or pursue a claim against any party or Coverage for the recovery of all damages to the full extent of the value of any such benefits or conditional payments advanced by the Plan.
4. If the Plan Participant(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) Worker's compensation or other liability insurance company; or
   e) Any other source, including but not limited to crime victim restitution funds, any medical, disability or other benefit payments, and school insurance coverage. The Plan Participant(s) authorizes the Plan to pursue, sue, compromise and/or settle any such claims in the Plan Participant(s)' and/or the Plan's name and agrees to fully cooperate with the Plan in the prosecution of any such claims. The Plan Participant(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 100% of the benefits paid, without deduction for attorneys' fees and costs or application of the common fund doctrine, make whole doctrine, or any other similar legal theory, without regard to whether the Participant(s) is fully compensated by his or her recovery from all sources. The Plan shall have an equitable lien which supersedes all common law or statutory rules, doctrines, and laws of any State prohibiting assignment of rights which interferes with or compromises in any way the Plan's equitable lien and right to reimbursement. The obligation to reimburse the Plan in full exists regardless of how the judgment or settlement is

classified and whether or not the judgment or settlement specifically designates the recovery or a portion of it as including medical, disability, or other expenses. If the Participant(s)' recovery is less than the benefits paid, then the Plan is entitled to be paid all of the recovery achieved. Any funds received by the Participant are deemed held in constructive trust and should not be dissipated or disbursed until such time as the Participant's obligation to reimburse the Plan has been satisfied in accordance with these provisions. The Participant is also obligated to hold any and all funds so received in trust on the Plan's behalf and function as a trustee as it applies to those funds until the Plan's rights described herein are honored and the Plan is reimbursed.

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 Participant(s), whether under the doctrines of causation, comparative fault or contributory negligence, or other similar doctrine in law. Accordingly, any lien reduction statutes, which attempt to apply such laws and reduce a subrogating Plan's recovery will not be applicable to the Plan and will not reduce the Plan's reimbursement rights.
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 Plan Participant(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, Disease or disability.

Participant is a Trustee Over Plan Assets

1. Any Participant who receives benefits and is therefore subject to the terms of this section is hereby deemed a recipient and holder of Plan assets and is therefore deemed a trustee of the Plan solely as it relates to possession of any funds which may be owed to the Plan as a result of any settlement, judgment or recovery through any other means arising from any injury or accident. By virtue of this status, the Participant understands that he/she is required to:
    a. notify the Plan or it authorized representative of any settlement prior to finalization of the settlement, execution of a release, or receipt of applicable funds;
    b. instruct his/her attorney to ensure that the Plan and/or its authorized representative is included as a payee on all settlement drafts;
    c. in circumstances where the Participant is not represented by an attorney, instruct the insurance company or any third party from whom the Participant obtains a settlement, judgment or other source of Coverage to include the Plan or its authorized representative as a payee on the settlement draft; and,
    d. Hold any and all funds so received in trust, on the Plan's behalf, and function as a trustee as it applies to those funds, until the Plan's rights described herein are honored and the Plan is reimbursed.
2. To the extent the Participant disputes this obligation to the Plan under this section, the Participant or any of its agents or representatives is also required to hold any/all settlement funds, including the entire settlement if the settlement is less than the

Plan's interests, and without reduction in consideration of attorney's fees, for which he/she exercises control, in an account segregated from their general accounts or general assets until such time as the dispute is resolved.

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

Excess Insurance

If at the time of Injury, Sickness, Disease 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.
5. Any other source, including but not limited to crime victim restitution funds, any medical, disability or other benefit payments, and school insurance coverage.

Separation of Funds

Benefits paid by the Plan, funds recovered by the Plan Participant(s), and funds held in trust over which the Plan has an equitable lien exist separately from the property and estate of the Plan Participant(s), such that the death of the Plan Participant(s), or filing of bankruptcy by the Plan Participant(s), will not affect the Plan's equitable lien, the funds over which the Plan has a lien, or the Plan's right to subrogation and reimbursement.

Wrongful Death

In the event that the Plan Participant(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 Plan Participant(s) and all others that benefit from such payment.

Obligations

1. It is the Plan Participant(s)' obligation at all times, both prior to and after payment of medical benefits by the Plan:
   a. To cooperate with the Plan, or any representatives of the Plan, in protecting its rights, including discovery, attending depositions, and/or cooperating in trial to preserve the Plan's rights.
   b. To provide the Plan with pertinent information regarding the Sickness, Disease, 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 settlement prior to finalization of the settlement.

g. To not settle or release, without the prior consent of the Plan, any claim to the extent that the Participant may have against any responsible party or Coverage.

h. To instruct his/her attorney to ensure that the Plan and/or its authorized representative is included as a payee on any settlement draft.

i. In circumstances where the Participant is not represented by an attorney, instruct the insurance company or any third party from whom the Participant obtains a settlement to include the Plan or its authorized representative as a payee on the settlement draft.

j. To make good faith efforts to prevent disbursement of settlement funds until such time as any dispute between the Plan and Participant over settlement funds is resolved.

2. If the Plan Participant(s) and/or his or her attorney fails to reimburse the Plan for all benefits paid or to be paid, as a result of said injury or condition, out of any proceeds, judgment or settlement received, the Plan Participant(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 Plan Participant(s).

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

Offset

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

Minor Status

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

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. 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.

The Use and Disclosure of Protected Health Information:

A. Use and Disclterosure of Protected Health Information (PHI)

The Plan will use and/or disclose protected health information (PHI) (as such term is defined in the HIPAA regulations) to the extent of and in accordance with the uses and disclosures permitted or required by the Health Insurance Portability and Accountability Act of 1996 and regulations promulgated pursuant thereto ("HIPAA"). Specifically, to the extent allowed by law, the Plan will use and disclose PHI for purposes related to health care treatment, payment for health care, and health care operations.

B. The Plan Will Use and Disclose PHI in accordance with and as Required by Law and as Permitted by Authorization of the Plan Participant or Beneficiary

The Plan will disclose PHI in accordance with and as permitted or required by law. For example, (i) the Plan may disclose summary health information to the Plan Sponsor if the Plan Sponsor requests the summary information for the purpose of obtaining premium bids for health insurance coverage under the Plan, or for modifying, amending or terminating the Plan; (ii) the Plan may disclose to the Plan Sponsor information on whether an individual is participating in the Plan or is enrolled in or has disenrolled from a health insurance issuer or HMO offered by the Plan; and (iii) to the extent allowed by law, the Plan may use and disclose PHI for purposes related to health care treatment, payment for health care, and health care operations. Except for the uses and disclosures permitted or required by HIPAA, the Plan shall obtain a written authorization from the individual who is the subject of the PHI prior to a disclosure. "Summary health information" means information that may be individually identifiable health information and that summarizes the claims history, claims expenses, or type of claims experienced by individuals for whom the Plan Sponsor has provided health benefits under the Plan; and from which identifying information has been deleted, except that geographic information may be aggregated at the level of a five digit zip code.

C. For Purposes of This Section, the Plan Sponsor is named in the General Information section herein

The Plan has received a certification from the Plan Sponsor that the separate Plan documents (if any) have been amended to incorporate the provisions set forth in D, below.

D. With Respect to PHI, the Plan Sponsor Agrees to the Following Conditions

The Plan Sponsor agrees to:

- not use or further disclose PHI other than as permitted or required by the Plan documents or as required by law;
- 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;
- not use or disclose PHI for employment-related actions and decisions unless authorized by an individual in accordance with HIPAA;
- not use or disclose PHI in connection with any other benefit or employee benefit plan of the Plan Sponsor unless authorized by an individual in accordance with HIPAA;
- report to the Plan any PHI use or disclosure that is inconsistent with the uses or disclosures provided for of which it becomes aware;
- make PHI available to an individual in accordance with HIPAA's access requirements;
- make PHI available for amendment and incorporate any amendments to PHI in accordance with HIPAA;
- make available the information required to provide an accounting of disclosures in accordance with HIPAA;
- make internal practices, books and records relating to the use and disclosure of PHI received from the Plan available to the U.S. Secretary of Health and Human Services for the purposes of determining the Plan's compliance with HIPAA; and
- 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 (or if return or destruction is not feasible, limit further uses and disclosures to those purposes that make the return or destruction infeasible); and
- implement administrative, physical and technical safeguards that reasonably and appropriately protect the confidentiality, integrity and availability of the electronic protected health information.

E. Adequate Separation Between the Plan and the Plan Sponsor Must Be Maintained

In accordance with HIPAA, only the following employees or classes of employees may be given access to PHI:

- the benefits manager; and
- staff designated by the benefits manager.

The following employees, classes of employees or other persons under the Plan Sponsor's control may have access to PHI including PHI relating to payment under, health care operations of, or other matters pertaining to the administration of the Plan in the ordinary course of business:

Benefits Department

F. Limitations of PHI Access and Disclosure

The Plan may disclose PHI to the Plan Sponsor (via the persons described in section E), and the Plan Sponsor may use and further disclose such PHI, only when the Plan Sponsor is either: (i) performing plan administration functions that the Plan Sponsor performs for the Plan or (ii) acting on behalf of the Plan; provided that the Plan Sponsor may only use or disclose PHI to the same extent as would be permitted by the Plan under the HIPAA regulations.

G. Noncompliance Issues

If Plan Sponsor personnel do not comply with this Plan document, the Plan Sponsor shall provide a mechanism for resolving issues of noncompliance, including disciplinary sanctions.

H. Security Requirements

The security rule requires plans to comply with four (4) general requirements. The Plan must:

- ensure the confidentiality, integrity, and availability of all electronic protected health information that it creates, receives, maintains, or transmits;
- protect against any reasonably anticipated threats or hazards to the security or integrity of the electronic protected health information;
- protect against any reasonably anticipated uses or disclosures of electronic protected health information that are not permitted or required under HIPAA; and
- ensure compliance with the security standards by its workforce.

I. Assignments of Benefits

The covered person cannot assign any benefit or monies due from this health plan to any person, corporation, or other organization without the Contract Administrators written consent. Any assignment by the covered person will be void. Assignment means the transfer of the covered person's rights to the benefits provided by this health plan to another person or organization. There is one exception. If Medicaid has already paid the health plan provider, the covered person can assign their benefits to Medicaid.

ERISA STATEMENT OF RIGHTS

As a participant in this Plan, the employee is entitled to certain rights and protection under the Employee Retirement Income Security Act of 1974 (ERISA). ERISA provides that all Plan participants will be entitled to:

1. Examine, without charge, at the Plan Administrator's office all Plan documents including insurance contracts and copies of all documents filed by the Plan with the U.S. Department of Labor, such as detailed annual reports and plan descriptions.

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

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

4. File suit in a federal court if any materials requested are not received within thirty (30) days of the participant's request, unless the materials were not sent because of matters beyond the control of the Plan Administrator. The court may require the Plan Administrator to pay up to $110 per day until the employee receives the materials.

5. File suit in a state or a federal court if the employee is improperly denied a welfare benefit in whole or in part. The employee must receive a written explanation of the reason for the denial. The employee has the right to have the Plan review and reconsider the employee's or their dependent's claim.

6. Seek assistance from the U.S. Department of Labor or file suit in a federal court if:

    a) plan fiduciaries misuse the Plan's money. In addition to creating rights for Plan participants, ERISA imposes duties to the people who are responsible for this operation of the Plan. The people who operate the employee's Plan called "fiduciaries" of the Plan, have a duty to do so prudently and in the interest of the employee and other Plan participants.
    b) the employee is discriminated against for asserting the employee's rights. The employee's employer may not fire the employee or otherwise discriminate against the employee in any way to prevent the employee from obtaining a welfare benefit or exercising the employee's rights under ERISA.

The court will decide who should pay court costs and legal fees. Should the employee be successful, the court may require the other party to pay the employee's legal costs and fees.

Group health plans and health insurance issuers generally may not, under federal law, restrict benefits for any hospital length of stay in connection with childbirth for the mother or newborn child to less than forty-eight (48) hours following a vaginal delivery, or less than ninety-six (96) hours following a cesarean section, However, federal law generally does not prohibit the mother's or newborn's attending provider, after consulting with the mother, from discharging the mother or her newborn earlier than forty-eight (48) or ninety-six (96) hours as applicable. In any case, plans

and issuers may not, under federal law, require that a provider obtain authorization from the plan or the issuer for prescribing a length of stay not in excess of forty-eight (48) hours or ninety-six (96) hours.

Should the employee have any questions about this statement or about the employee's rights under ERISA, the employee should contact the nearest office of the Employee Benefits Security Administration, U.S. Department of Labor, listed in the telephone directory or the Division of Technical Assistance and Inquiries, Employee Benefits Security Administration, U.S. Department of Labor, 200 Constitution Avenue, N.W. Washington D.C. 20210.

DEFINITIONS

The following words and phrases are included here for explanatory purposes only. This list is not intended to include all terms used herein. Any word or phrase not specifically defined below will have its usual and customary meaning. The inclusion of any word or phrase below is not intended to imply that coverage is provided under the Plan with respect to any such condition, service, facility, or person.

Accident: An unforeseen or unexplained sudden injury occurring by chance without intent or volition.

Active Service: An employee will be considered in active service with the employer on a day which is one of the employee's scheduled workdays if he is performing in the customary manner all of the regular duties of their employment with the employer on that day, either at one of the employer's business establishments or at some location to which the employer's business requires him to travel. A regular vacation day properly scheduled in accordance with normal practices and policies of will qualify as a scheduled workday for purposes of this definition.

Adverse Benefit Determination: Any of the following: a denial, reduction, or termination of, or a failure to provide or make payment (in whole or in part) for, a benefit, including any such denial, reduction, termination, or failure to provide or make payment that is based on a determination of a participant's beneficiary's eligibility to participate in the Plan, and including, with respect to group health plans, 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, as well as 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.

Aggregate: The combined total of all family members.

Ambulatory Surgical Center: A facility which is not physically attached to a health care facility, which provides surgical treatment to patients not requiring hospitalization, and does not include the offices of private physicians or dentists whether in an individual or group practice.

Birthing Center: A public or private facility, other than private offices or clinics of physicians, which meets the free-standing birthing center requirements of the State Department of Health in the state where the covered person receives the services.

The birthing center must provide: a facility which has been established, equipped, and operated for the purpose of providing prenatal care, delivery, immediate postpartum care and care of a child born at the center; supervision of at least one (1) specialist in obstetrics and gynecology; a physician or certified nurse midwife at all births and immediate postpartum period; extended staff privileges to physicians who practice obstetrics and gynecology in a area hospital; at least two (2) beds or two (2) birthing rooms; full-time nursing services directed by an R.N. or certified nurse midwife; arrangements for diagnostic x-ray and lab services; and the capacity to administer local anesthetic or to perform minor surgery.

In addition, the facility must only accept patients with low-risk pregnancies, have a written agreement with a hospital for emergency transfers and maintain medical records on each patient and child.

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

Claim for benefits: A request for a Plan benefit or benefits made by a claimant in accordance with the Plan's procedure for filing benefit claims. This includes any Pre-Service Claims and any Post-Service Claims.

Claim involving Urgent Care: Any claim for medical care or treatment with respect to which the application of the time periods for making non-urgent care determination:

(i) Could seriously jeopardize the life or health of the claimant or the ability of the claimant to regain maximum function; or

(ii) In the opinion of a physician with knowledge of the claimant's medical condition, would subject the claimant to severe pain that cannot be adequately managed without the care or treatment that is the subject of the claim;

Except as set forth in the next paragraph, whether a claim is a Claim involving Urgent Care is to be determined by an individual acting on behalf of the Plan applying the judgment of a prudent layperson who possesses an average knowledge of health and medicine.

Any claim that a physician with knowledge of the claimant's medical condition determines is a Claim involving Urgent Care shall be treated as Claim involving Urgent Care.

Clinical Trial: A Phase I, II, III or IV clinical trial that meets the following conditions:

1. The clinical trial is intended to treat cancer or other life-threatening condition in a patient who has been diagnosed; and
2. The clinical trial has been peer reviewed and is approved or funded by at least one of the following:
    a. The National Institutes of Health,
    b. The Centers for Disease Control and Prevention,
    c. The Agency for Health Care Research and Quality,
    d. The Centers for Medicare and Medicaid Services,
    e. A cooperative group or center of the entities described in a.-d. above,
    f. A qualified non-governmental research entity identified in guidelines issued by the National Institutes of Health for center support grants,
    g. The United States Food and Drug Administration pursuant to an investigational new drug exemption,
    h. Under certain conditions, the United States Department of Defense of Veterans Affairs, Department of Defense, or Department of Energy,
    i. Or, with respect to Phase II, III and IV clinical trials, a qualified institutional review board.
3. The facility and personnel conducting the clinical trial are capable of doing so by virtue of their experience and training and treat a sufficient volume of patients to maintain that expertise, and
4. The patient meets the patient selection criteria enunciated in the study protocol for participation in the clinical trial, and
5. The patient has provided informed consent for participation in the clinical trial in a manner that is consistent with current legal and ethical standards, and
6. The available clinical or pre-clinical data provide a reasonable expectation that the patient’s participation in the clinical trial will provide a medical benefit that

is commensurate with the risks of participation in the clinical trial, and

7. The clinical trial must have a preventive, diagnostic, or therapeutic intent and must, to some extent, assess the effect of the intervention on the patient.

Contract Administrator: Third party claims administrator, hired by the Plan Sponsor to handle the day-to-day administration of the Plan, including:

1. reviewing and processing claims for proper benefit payments and providing explanation of benefits to covered employees and/or providers;
2. remitting benefit payments for covered expenses under the Plan to covered employees and/or providers;
3. reviewing all claims appeals.

Contributory Coverage: Plan benefits for which an employee enrolls and agrees to make any required contributions toward the cost of coverage.

Convalescent Hospital/Extended Care Facility/Skilled Nursing Facility: An institution which is licensed pursuant to state and/or local laws and is operated primarily for the purpose of providing treatment for individuals convalescing from injury or illness, including that part or unit of a hospital which is similarly constituted and operated, and:

1. Has organized facilities for medical treatment and provides for twenty-four (24) hour nursing service under the full-time supervision of a physician or a registered nurse. Full-time supervision means a physician or a registered nurse is regularly on the premises at least forty (40) hours per week;
2. Maintains daily clinical records concerning each patient and has a written agreement or arrangement with a physician to provide services and emergency care for its patients;
3. Provides appropriate methods for dispensing and administering drugs and medicines;
4. Has transfer agreements with one (1) or more hospitals, utilization review procedures in effect, and operational policies developed with the advice of and reviewed by a professional group including at least one (1) physician. A convalescent hospital/extended care facility will not include any institution which is a rest home for the aged, or a place for the treatment of mental disease, drug addiction or alcoholism, or a nursing home.
5. Qualifies as an "extended care facility" under the health insurance provided by Title XVIII of the Social Security Act, at the time.

Cost-Sharing: The amount a Covered Person is responsible for paying for a covered Expense under the terms of the Plan. Cost-Sharing generally includes Copayments, Coinsurance, and amounts paid towards Deductibles, but does not include amounts paid towards premiums, balance billing by Out-of-Network Providers, or the cost of items or services that are not covered under the Plan.

Covered Person: A covered employee or a covered dependent as determined under the applicable Plan provision.

Custodial Care: Care which is designed essentially to help a person in the activities of daily living and which does not require the continuous attention of trained medical or paramedical personnel. Custodial care includes services that could be performed by a relative or friend with minimal instruction or supervision.

Custodial Parent: The parent awarded custody by court decree. If there is no court decree, the custodial parent is the one with whom the child resides for more than half the year.

Day of Confinement: Any period of twenty-four (24) hours or any part thereof for which a full charge for room and board is made by a hospital.

Dental Services: Procedures involving the teeth, gums, or supporting structures.

Dentist: A duly licensed doctor of dentistry and a dental professional or practitioner who is duly licensed under appropriate state licensing authorities, provided a benefit is claimed for services which are within the scope of such person's license and for which a reimbursement under the Plan would be made had such services been performed by a doctor of dentistry, and under applicable state laws, such professional or practitioner must be treated under the Plan in the same manner as if such services were provided by a doctor of dentistry.

Dependent:

1. The lawful spouse of an eligible employee; or
2. the married or unmarried child of an eligible employee who has not attained their twenty-sixth (26^{th}) birthday.

The term "lawful spouse," as used above, means an eligible employee's same or opposite-sex spouse, provided that such individual is legally recognized as the eligible employee's spouse in any jurisdiction (such as a State or foreign country), and even if the individual is not recognized as the eligible employee's spouse in the employee's State of residence.

The word "child", as used above, will include an eligible employee's natural child, a legally adopted child (including a child in the custody of the employee under an interim court order of adoption, whether or not a final adoption order is ever issued), a stepchild, a foster child, or a child for whom legal guardianship has been granted, but excludes a child who is eligible for employee coverage under this Plan.

Should an employee have a child covered under the Plan who reaches the age at which the child would otherwise cease to be a covered person and if such child is then mentally or physically handicapped and incapable of earning his own living, the Plan will continue to consider such child as a dependent beyond such age, while such child remains in such condition, subject to all of the terms of the Plan, provided the employee has, within thirty-one (31) days of the date on which the child attained such age, submitted proof of the child's incapacity, as described above.

The Plan Sponsor will have the right to require satisfactory proof of continuance of such mental or physical incapacity and the right to examine such child at any time after receiving proof of the child's incapacity. Upon failure to submit such required proof or to permit such an examination when requested by the Plan Sponsor, or when the child ceases to be so incapacitated, coverage with respect to the child will cease. This continuation of coverage will be subject to all the provisions of the "Termination of Benefits" section of this Plan except as modified herein.

Dependent Coverage: Plan benefits extended to the dependent(s) of a covered employee.

Effective Date: The date the Plan becomes liable to provide coverage under the terms of the Plan.

Eligibility Date: The date an employee and/or their dependent(s) become eligible to enroll in the Plan.

Employee: Any employees who qualify for employee coverage under the eligibility requirements set forth in the "General Information" section contained herein. The definition of an employee does not include independent contractors, contingent workers, or leased employees.

Employee Coverage: Group medical benefits provided under the Plan on behalf of a covered employee.

Employer: The company providing employment to the covered employees.

Emergency Medical Condition: A medical condition, including a mental health condition or substance use disorder, manifesting itself by acute symptoms of sufficient severity (including severe pain) such that a prudent layperson, who possesses an average knowledge of health and medicine, could reasonably expect the absence of immediate medical attention to result in a condition described in clause (i), (ii), or (iii) of Section 1867(e)(1)(A) of the Social Security Act. In that section, such clauses refer to (i) placing the health of the individual (or, with respect to a pregnant woman, the health of the woman or her unborn child) in the serious jeopardy, (ii) serious impairment to body functions, or (iii) serious dysfunction of any body organ or part.

Final determination as to whether services were rendered in connection with an emergency will rest solely with the Plan. The Plan will not limit what constitutes an Emergency Medical Condition solely on the basis of diagnosis codes, as required by the No Surprises Act.

Emergency Services: With respect to an Emergency Medical Condition, (i) an appropriate medical screening examination (as required under Section 1867 of the Social Security Act or as would be required under such section if such section applied to an Independent Freestanding Emergency Department) that is within the capability of the emergency department of a Hospital or of an Independent Freestanding Emergency Department, as applicable, including ancillary services routinely available to the emergency department to evaluate such Emergency Medical Condition, and (ii) within the capabilities of the staff and facilities available at the Hospital or the Independent Freestanding Emergency Department, such further medical examination and Treatment as are required under section 1867 of the Social Security Act, or as would be required under such section if such section applied to an Independent Freestanding Emergency Department, to stabilize the patient (regardless of the department of the Hospital in which such further examination or Treatment is furnished). In addition, Emergency Services include certain items and services (known as "post-stabilization services") (i) for which benefits are provided or covered under the Plan, and (ii) that are furnished by an Out-of-Network Provider or emergency facility (regardless of the department of the Hospital in which such items or services are furnished) after the Covered Person is stabilized and as part of outpatient observation or an inpatient or outpatient stay with respect to the visit in which the Emergency Services described in the preceding sentence are furnished; provided, however, that such items and services are **not** included as Emergency Services if all of the conditions in 45 CFR 149.410(b) are met.

For purposes of this definition, "to stabilize" has the meaning given in section 1867(e)(3) of the Social Security Act; "emergency department of a Hospital" includes a Hospital outpatient department that provides Emergency Services; and "Independent Freestanding Emergency Department" means a health care facility that is geographically separate and distinct and licensed separately from a Hospital under applicable state law and provides Emergency

Enrollment Date: The first day of coverage under the Plan or, if there is a waiting period, the first day of the waiting period. This date is frequently, but not always, the date of hire.

Expense: A charge a covered person is legally obligated to pay. An expense is deemed to be incurred on the date the service or supply is furnished.

Experimental/Investigative: A drug, device, medical treatment or procedure that is not the subject of, or in some manner related to, the conduct of a Clinical Trial, as such term is defined herein, is experimental or investigative:

a) if the drug or device cannot be lawfully marketed without approval of the U.S. Food and Drug Administration and approval for marketing has not been given at the time the drug or device is furnished; or

b) if the drug, device, medical treatment or procedure, or the patient informed consent document utilized with the drug, device, treatment, or procedure, was reviewed and approved by the treating facility's Institutional Review Board or other body serving a similar function, or if federal law requires such review or approval; or

c) if reliable evidence shows that the drug, device, medical treatment, or procedures is the subject of on-going phase I or phase II clinical trials, is the research, experimental, study or investigational arm of on-going phase III clinical trials, or is otherwise under study to determine its maximum tolerated dose, its toxicity, its safety, its efficacy or its efficacy as compared with a standard means of treatment or diagnosis; or

d) if reliable evidence shows that the prevailing opinion among experts regarding the drug, device, medical treatment, or procedure is that further studies or clinical trials are necessary to determine its maximum tolerated dose, its toxicity, its safety, its efficacy or its efficacy as compared with a standard means of treatment or diagnosis.

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

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

Health Care Operations: include, but are not limited to the following activities:

- quality assessment;
- population-based activities relating to improving health or reducing health care costs, protocol development, case management and care coordination, disease management, contacting health care providers and patients with information about treatment alternatives and related functions;
- rating provider and plan performance, including accreditation, certification, licensing or credentialing activities;
- underwriting, premium rating and other activities relating to the creation, renewal or replacement of a contract of health insurance or health benefits, and ceding, securing or placing a contract for reinsurance of risk relating to health care claims (including stop-loss insurance and excess of loss insurance);
- conducting or arranging for medical review, legal services and auditing functions, including fraud and abuse detection and compliance programs;
- business planning and development, such as conducting cost-management and planning-related analyses related to managing and operating the Plan, including formulary development and administration, development or improvement of payment methods or coverage policies;

- business management and general administrative activities of the Plan, including, but not limited to:
  a) management activities relating to the implementation of and compliance with HIPAA's administrative simplification requirements, or
  b) customer service, including the provision of data analyses for policyholders, plan sponsors or other customers;
- resolution of internal grievances;
- the sale, transfer, merger, or consolidation of all or part of the "covered entity" within the meaning of HIPAA with another covered entity, or an entity that following such activity will become a covered entity and due diligence related to such activity; and
- consistent with the applicable requirements of the regulations issued under HIPAA, creating de-identified health information or a limited data set, and fundraising for the benefit of the "covered entity" within the meaning of HIPAA.

Health Care Professional: A physician or other health care professional licensed, accredited, or certified to perform specified health services consistent with State law.

Hospital: A duly licensed, if required, and legally-constituted and operated institution which is primarily engaged in providing diagnostic services, therapeutic services for diagnosis, care and treatment of sick or injured persons on an inpatient and/or outpatient basis, and which provides such care and treatment: (i) under the supervision of one (1) or more physicians, (ii) with twenty-four (24) hour nursing service under the supervision of one (1) or more physicians licensed to practice medicine; and (iii) which has organized facilities for laboratory and diagnostic work and major surgery. The term "Hospital" will not include, other than incidentally, an institution which is primarily a rest home, a nursing home, a convalescent home, a rehabilitation center, an extended care facility, a place (primarily) for the treatment of tuberculosis, mental, emotional, drug or alcoholic disorders, or a home for the aged. Services rendered in the infirmary or clinic of a college, university, or private boarding school will be eligible expenses. In such instances, if a covered person is confined in a school facility that does not meet the definition of a hospital because it has no operating room, benefits may be paid, provided the charges for such confinement do not exceed the maximum allowable benefit for the disability involved.

Hospital Confinement: Being registered as a bed-patient in a hospital upon the recommendation of a physician, or as a result of a surgical operation, or by reason of receiving emergency medical care.

Illness: Sickness or disease which results in expenses for medical care, services, and supplies covered by the Plan. Such expense must be incurred while the covered person, whose illness is the basis of the claim, is covered under the Plan. Medical expenses incurred by a covered person because of pregnancy will be covered to the same extent as any other illness.

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

Injury: Accidental bodily harm resulting from an accident.

Inpatient Basis: Hospital confinement including one (1) or more days of confinement for which a room and board charge is made by a hospital.

Intensive Care Unit: An accommodation in or part of a hospital, other than a post-operative recovery room, which, in addition to providing room and board:

1. Is established by the hospital for the purpose of providing formal intensive care;
2. Is exclusively reserved for critically ill patients requiring constant audio/visual observation prescribed by a physician and performed by a physician or by a specifically trained registered nurse; and
3. Provides all necessary lifesaving equipment, drugs, and supplies in the immediate vicinity on a standby basis.

Maintenance Therapy: Any treatment, service, or therapy that preserves the member's level of function and prevents regression of that function. Maintenance therapy begins when therapeutic goals of a treatment plan have been achieved or when no further functional progress is apparent or expected to occur.

Maximum Allowable Benefit: The Maximum Allowable Benefit shall mean the maximum amount of benefits the Plan will pay for a specific Covered Expense or benefit under this Plan, as determined by the Contract Administrator in its sole and absolute discretion. The Contract Administrator has the sole and absolute discretion to determine the Maximum Allowable Benefit for a Covered Expense or benefit, and expressly disavows use of usual, customary, and reasonable standards.

Blue Card Program for in-network providers
For the Blue Card Program, the maximum allowable benefit will be calculated by the Blue Card Host and the Blue Card Program for in-network providers.

Out-of-Network Provider
For an out-of-network Provider, the Maximum Allowable Benefit for a Covered Expense or benefit will be a negotiated rate, if one exists.

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

If none of the above factors is applicable, the Contract Administrator will exercise its discretion to determine the Maximum Allowable Benefit based on any of the following: Medicare reimbursement rates, Medicare cost data, amounts actually collected by Providers in the area for similar services, or average wholesale price (AWP) or manufacturer's retail pricing (MRP), or Fair Health benchmarking tables, or the "Host Allowed Amount" (when provided by the Blue Cross Plan of the state where a service was rendered). "Host Allowed Amount" is a reimbursement amount that is a proxy for what an in-network Provider would be reimbursed for the same service in the same region of the country in which the out-of-network service was rendered. These ancillary factors will take into account generally-accepted billing standards and practices.

When more than one treatment option is available, and one option is no more effective than another, the least costly option that is no less effective than any other option will be considered within the Maximum Allowable Benefit. The Maximum Allowable Benefit will be limited to an amount which, in the Contract Administrator's discretion, is charged for services or supplies that are not unreasonably caused by the treating Provider, including errors in medical care that are clearly identifiable, preventable, and serious in their consequence for patients. A finding of Provider negligence or malpractice is not required for services or fees to be considered ineligible pursuant to this provision.

Subject to the No Surprises Act rules explained herein, the Contract Administrator will generally calculate the Maximum Allowable Benefit for out-of-network Emergency Services as the greater provision.

With respect to non-network emergency services, the maximum allowable benefit is the greater of:

- The negotiated amount for in-network providers for the Emergency Service furnished, excluding any in-network Copayments or Coinsurance (the median amount if more than one amount applies to in-network Providers).
- The amount for the Emergency Service calculated using the same method the Plan generally uses to determine Payments for out-of-network services, excluding any in- network Copayments and Coinsurance and without reduction for out-of-network Cost- Sharing that generally applies under the Plan for out-of-network services).
- The amount that Medicare parts A and B would pay for the Emergency Service (excluding any Copayments and Coinsurance).

Medical Intervention: Any medical treatment, service procedure, facility, equipment, drug, device, or supply.

Medically Necessary: Health care services, supplies, or treatment will be considered medically necessary if:

a) there is a sickness or injury which requires treatment; or
b) the confinement, service, or supply used to treat the sickness or injury is:
   - required;
   - generally professionally accepted as usual, customary, and effective means of treating the sickness or injury in the United States; and
   - approved by regulatory authorities such as the Food & Drug Administration; and
c) diagnostic x-rays and laboratory tests when they are performed due to definite symptoms of sickness or injury, or they reveal the need for treatment.

Mental Hospital: An institution (other than a hospital as defined) which specializes in the diagnosis and treatment of mental illness or functional nervous disorders and which is operated pursuant to law and meets all of the following requirements:

1. Is licensed to give medical treatment and is operated under the supervision of a physician;

2. Offers nursing services by registered graduate nurses (RN) or licensed practical nurses (LPN) and provides, on the premises, all the necessary facilities for medical treatment;

3. Is not, other than incidentally, a place of rest or a place for the aged, drug addicts, or alcoholics; or a place for convalescent, custodial, or educational care.

Mental Illness: Neuroses, psychoneuroses, psychoses, and other mental and emotional disorders falling within any of the diagnostic categories in the mental disorders section of the international classification of diseases.

Never Events: These events, as defined by The National quality Forum, a private organization whose members include the American Medical Association (AMA), are "errors in medical care that

are clearly identifiable, preventable, and serious in their consequences for patients, and that indicate a real problem in the safety and credibility of a health care facility."

Newborn Care Charges: Charges for care of newborn children as more specifically defined herein.

Non-Contributory Coverage: Plan benefits for which the employee enrolls and for which he is not required to make contribution toward the cost of coverage.

No Surprises Act: The "No Surprises Act", which was enacted in Title I of Division BB of the Consolidated Appropriations Act of 2021, including the regulations and binding guidance issued thereunder, which generally governs patient cost-sharing, balance billing, and payments to providers for Emergency Services rendered in out-of-network facilities, services rendered by Out-of-Network Providers in in-network facilities, and services rendered by air ambulance providers. (For more details, see the No Surprises Act – Emergency Services and Surprise Bills language herein.)

Outpatient Basis: Any hospital expenses incurred for which no room and board charge is made.

Outpatient Mental Health Treatment Facility: A comprehensive, health service organization, a licensed or accredited hospital, or community mental health center or other mental health clinic or day care center which furnished mental health services with the approval of the appropriate governmental authority, any public or private facility or portion thereof providing services especially for the diagnosis, evaluation, service or treatment of mental illness or emotional disorder.

Participating Health Care Facility: A Hospital or Hospital Outpatient Department, critical access Hospital, Ambulatory Surgical Center, or other Provider as required by law, which has a direct or indirect contractual relationship with the Plan with respect to the furnishing of a healthcare item or service. A single direct contract or case agreement between a health care facility and a plan constitutes a contractual relationship for purposes of this definition with respect to the parties to the agreement and particular individual(s) involved.

Patient Care Services: Medical covered services, as described in this Plan, that are furnished to an individual enrolled in a Clinical Trial, as such term is defined here, which are consistent with the usual and customary standard of care for someone with the patient's diagnosis and, are consistent with the study protocol for the Clinical Trial. Notwithstanding the foregoing, patient care services do not include any of the following:

1. The investigational item, device, drug, or service which is the subject of the Clinical Trial;
2. Any other FDA approved drug or device which is used during the course of the Clinical Trial and is paid for by the manufacturer, the distributor or the provider of the drug or device;
3. non-health care services that a patient may be required to receive as a result of being enrolled in the Clinical Trial;
4. costs associated with managing the research related to the Clinical Trial (including items and services that are provided solely to satisfy date collection and analysis needs and are not used in the direct clinical management of the patient;
5. costs that would not be covered under the Plan for non-investigational/experimental treatments;
6. any item, service or cost that is reimbursed or otherwise furnished by the sponsor of the Clinical Trial;

7. the cost of services which are not provided as part of the Clinical Trial's stated protocol or other similar guidelines; or
8. any service that is clearly inconsistent with widely accepted and established standards of care for a particular diagnosis.

Payment: Includes activities undertaken by the Plan to obtain premiums or determine or fulfill its responsibility for the coverage and provision of plan benefits or to obtain or provide reimbursement for the provision of health care that relate to an individual to whom health care is provided. These activities include, but are not limited to, the following:

- determination of eligibility, coverage and cost sharing amounts (for example, cost of a benefit, plan maximums and copayments as determined for an individual's claim);
- coordination of benefits;
- adjudication of health benefit claims (including appeals and other payment disputes);
- subrogation of health benefit claims;
- establishing employee contributions;
- risk adjusting amounts due based on enrollee health status and demographic characteristics;
- billing, collection activities and related health care data processing;
- claims management and related health care data processing, including auditing payments, investigating and resolving payment disputes and responding to participant inquiries about payments;
- obtaining payment under a contract for reinsurance (including stop-loss and excess of loss insurance);
- medical necessity reviews or reviews of appropriateness of care or justification of charges;
- utilization review, including precertification, preauthorization, concurrent review and retrospective review; and
- disclosure to consumer reporting agencies related to the collection of premiums or reimbursement (the following PHI may be disclosed for payment purposes: name and address, date of birth, Social Security number, payment history, account number and name and address of the provider and/or health plan).

Physician: A duly licensed doctor of medicine, a medical professional, or a practitioner who is duly licensed under appropriate state licensing authorities, provided: (i) a benefit is claimed for services which are within the scope of such person's license and for which a reimbursement under the Plan would be made had such services been performed by a doctor of medicine, and (ii) under applicable state laws, such professional or practitioner must be treated under the Plan in the same manner as if such services were provided by a medical doctor.

Plan: The Employee Minimum Essential Coverage Plan, as described herein, and adopted by Plan Sponsor, and named in the General Information section herein.

Plan Administrator: Plan Sponsor, acting through its exclusive agent, Allison Hazen, Trustee of the NFA Member Plan Master Trust.

Plan Anniversary Date: The date occurring in each calendar year which is an anniversary of the effective date of the Plan.

Plan Document: The master contract which describes the terms of coverage and association between the Contract Administrator and the Plan Sponsor.

Plan Sponsor: Your company, named in the General Information section herein.

Post-Service Claim: Any claim for a benefit under the Plan that is not a Pre-Service Claim.

Pre-Service Claim: Any claim for a benefit under the Plan with respect to which the terms of the Plan condition receipt of the benefit, in whole or in part, on approval of the benefit in advance of obtaining medical care.

Preferred Provider Network Program (including BlueCard® Program) for in-network Providers
For the Blue Cross Blue Shield of Vermont's preferred provider network, the Inter-Plan Programs, the BlueCard® Program, and the Blue Cross Blue Shield Global Core Program, the Maximum Allowable Benefit for a Covered Expense or benefit will be calculated by the Blue Card Host, the BlueCard® Program, or Blue Cross Blue Shield Global Core for in-network Providers.

Prior Plan: The prior group medical plan offered by the Plan Sponsor.

Protected Health Information: Health information, including demographic information, which is collected from an individual, and which;

- is created or received by the Plan;
- 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
    a) that identifies the individual; or

    b) with respect to which there is a reasonable basis to believe that the information can be used to identify the individual; and

- is transmitted by electronic media, maintained in any electronic medium, or transmitted or maintained in any other form or medium. Protected Heath Information excludes information in education records covered by the Family Educational Right and Privacy Act, records described at 20 U.S.C. 1232(g)(a)(4)(B)(iv), and employment records held by the Plan Sponsor in its role as employer.

Qualified Beneficiary: Any covered person who loses coverage as a result of a qualifying event described in the "Extension of Benefits" section. These beneficiaries are:

1. covered employees (and their spouses and dependent children) who have been terminated for reasons other than the covered employee's gross misconduct, or have had their hours reduced (resulting in a loss of coverage);

2. widowed spouses and dependent children;

3. divorced or legally separated spouses and their dependent children;

4. Medicare ineligible spouses and their dependent children;

5. a covered dependent child who no longer meets the Plan's definition of a covered dependent child;

6. a child born to, or placed for adoption with the covered employee during the period of COBRA coverage.

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

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

Rehabilitation Hospital: A facility which meets all requirements of a hospital (as defined herein) other than the "surgical facilities" requirements and, in addition, meets the following criteria:

1. It must be accredited by the Joint Commission of Accreditation of Hospitals and be approved for Federal Medicare Benefits as a qualified hospital;
2. It must maintain transfer agreements with acute care facilities to handle surgical and/or medical emergencies;
3. It must maintain a utilization review committee.

Rehabilitative Care: Necessary inpatient medical care (as prescribed by a physician) rendered in a rehabilitation hospital (as defined herein) excluding custodial care or occupational training.

Relevant: In the context of whether a document, record or other information shall be considered "relevant," means the following: a document, record, or other information

(i) relied upon in making the benefit determination;

(ii) submitted, considered, or generated in the course of making the benefit determination, without regard to whether such document, record, or other information was relied upon in making the benefit determination;

(iii) demonstrating compliance with the administrative processes and safeguards designed to ensure and to verify that benefit claim determinations are made in accordance with the governing Plan documents and that, where appropriate, the Plan provisions have been applied consistently with respect to similarly situated claimants in making the benefit determination; or

(iv) constituting a statement of policy of guidance with respect to the Plan concerning the denied treatment option or benefit for the claimant's diagnosis, without regard to whether such advice or statement was relied upon in making the benefit determination.

In no event should the provisions of this Claim Review Procedures section be interpreted to require any claimant to file more than two (2) appeals of an Adverse Benefit determination prior to bringing a civil action under Section 502(a) of ERISA.

Residential Treatment Facility: A childcare institution that provides residential care and treatment for emotionally disturbed children and adolescents. The facility must be accredited as a residential treatment facility by the Council on Accreditation of Hospitals or the American Association of Psychiatric Services for Children.

Substance Abuse: Any use of alcohol or drugs which produces a state of psychological and/or physical dependence.

Substance Abuse Treatment Facility:

1. A public or private facility providing services especially for detoxification or rehabilitation of substance abusers and which is licensed to provide such services;

2. A comprehensive health service organization, community mental health clinic or day care center which furnishes mental health services with the approval of the appropriate governmental authority, any public or private facility or portion thereof providing services especially for the rehabilitation of substance abusers and which is licensed to provide such services.

Totally Disabled: A covered employee shall be considered totally disabled if, as a result of a non-occupational illness or a non-occupational accidental injury, the employee is unable to perform the full duties of his/her occupation or is unable to engage in any gainful occupation.

Treatment: The provision, coordination, or management of health care and related services by one or more health care providers, including the coordination or management of health care by a health care provider with a third party; consultation between health care providers relating to a patient; and the referral of a patient for health care from one health care provider to another.

Waiting Period: The period of time between the employee's enrollment date and the employee's first date of coverage under the Plan.

PLAN DOCUMENT ACCEPTANCE PAGE

APPROVED AND ACCEPTED

This Plan Document, known as the Employee Minimum Essential Coverage Plan, is hereby executed at:

Rutland, VT on 4.5.21

(City) (State) (Date)

BY: Steve Schuda

Trustee

(Title)