OHIO HEALTHCARE PLAN

2080 Citygate Drive
Columbus, Ohio 43219
Phone: (614) 445-3750

PPO PLAN (ESC & COG LOCATION)

This book describes the Medical benefits for Eligible Employees of the participating public employers of Ohio Healthcare Plan.

Information Applicable to Plan 501

Employer Identification Number
45-4109527

The Benefits In This Book Are Effective
January 1, 2026

TABLE OF CONTENTS

KEY INFORMATION 1
PERSONAL OR MEDICAL LEAVE OF ABSENCE EXTENSION 4
PRE-CERTIFICATION PROGRAM 8
SERVICES REQUIRING PRECERTIFICATION 9
PPO SCHEDULE OF COVERED EXPENSES AND PROVISIONS 13
PRESCRIPTION DRUG BENEFIT 28
TRAVEL AND LODGING EXPENSES 32
TRANSPLANTS 33
GENE THERAPY 36
EXCLUSIONS 38
DEFINITIONS 43
ELIGIBILITY 54
INDIVIDUALS PARTICIPATING IN APPROVED CLINICAL TRIALS 57
NETWORK BENEFITS 59
OUT-OF-NETWORK BENEFITS 60
PROCEDURES FOR FILING CLAIMS 61
THIS PLAN AND MEDICARE 63
GENERAL PROVISIONS 64
COORDINATION OF BENEFITS (COB) 79
COMPLIANCE REGULATIONS 81
NOTICE OF CONTINUATION COVERAGE RIGHTS UNDER COBRA 83
PLAN ADMINISTRATION 88
STANDARDS FOR PRIVACY OF INDIVIDUALLY IDENTIFIABLE HEALTH INFORMATION (THE “PRIVACY STANDARDS”) 91
NOTICE OF PRIVACY PRACTICES 93
STANDARDS FOR SECURITY OF INDIVIDUALLY IDENTIFIABLE HEALTH INFORMATION (THE “SECURITY STANDARDS”) 104

KEY INFORMATION

EMPLOYER/COMPANY/PLAN ADMINISTRATOR/PLAN SPONSOR CONTACT INFORMATION:
Ohio Healthcare Plan
2080 Citygate Drive
Columbus, Ohio 43219
Phone: (614) 445-3750

EMPLOYER/COMPANY IDENTIFICATION NUMBER (EIN) AS ASSIGNED BY THE INTERNAL REVENUE SERVICE (IRS):
45-4109527

PLAN NAME:
Ohio Healthcare Plan Medical Plan

PLAN CONTACT INFORMATION:
Insurance Department
Ohio Healthcare Plan
2080 Citygate Drive
Columbus, Ohio 43219
Phone: (614) 445-3750

PLAN NUMBER:
501

STOP LOSS COVERAGE:
The Company has purchased specific and aggregate stop-loss reinsurance coverage.

GROUP NUMBER:
A18103

BENEFIT BOOK EFFECTIVE DATE:
January 1, 2026

PLAN YEAR:
The financial records of the Plan are kept on a Plan Year basis. The Plan Year ends each December 31st.

TYPE OF PLAN:
Medical and Prescription Drugs

NAME, ADDRESS AND TELEPHONE NUMBER OF THE CLAIMS PROCESSOR:
Allied Benefit Systems, LLC
P.O. Box 211651
Eagan, MN 55121
Phone: (312) 906-8080 or (800) 288-2078 (outside IL)

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

Access to PHI information may be given only to the Plan Sponsor and staff of the Plan Sponsor who receive protected health information relating to payment under, health care operations of, or other matters pertaining to the Plan in the ordinary course of business in carrying out Plan administration functions that the Plan Sponsor performs for the Plan. The access and use of PHI by the Plan Sponsor and staff described above is limited to purposes of the administration functions that the Plan Sponsor performs for the Plan. If the Plan Sponsor and said staff do not comply with this Benefit Book, the Plan Sponsor shall provide a mechanism for resolving issues of noncompliance, including disciplinary sanctions.

ELIGIBILITY:

- Full-Time Employees: A regularly assigned, full-time Employee of a participating Employer scheduled to work 20 or more hours per week. However, this definition also includes Board Members or other individuals who are required to be covered by State or Federal law, regardless of hours worked. Provided you satisfy the foregoing "full-time" requirements, you are eligible to enroll in the Plan if 1) you work for a Participating Employer and you are a member of a group of Employees designated by your Participating Employer as eligible to participate, 2) if you are a full-time Employee of the Ohio Healthcare Plan, or 3) your employer is contracted by the Trust to provide Chief Administrator Support and/or Services.

- Retirees: This Plan does not cover Retirees or their Dependents.

- Dependents Including:

  - Dependent Children: Child(ren) through the end of the month in which the child turns age 26, consisting of natural children, stepchildren, foster children, adopted children, children placed for adoption, children in a legal guardianship status or children for whom the Employee is required to provide health care coverage under a Qualified Medical Child Support Order.

  - Spouse: This Plan defines "marriage" as both 1) a legal union between one man and one woman as husband and wife, legally married in a jurisdiction (domestic or foreign) that recognizes their marriage, and 2) a legal union between two persons of the same sex, legally married in a jurisdiction (domestic or foreign) that recognizes their marriage. Marriage does not include a civil union, domestic partnership or any other similar arrangement, nor does it include a legally separated spouse.

    Note: If your spouse is currently enrolled in other coverage and contributing to a Health Savings Account (HSA), and you enroll them in your PPO Plan as secondary, IRS rules may preclude them from making or receiving additional HSA contributions. In order to make or receive HSA contributions, an individual must only be covered by an HSA-qualified health plan. For questions regarding spousal secondary coverage when receiving HSA contributions, please reach out to the Administrative Support Team (AST) at 1-855-664-0012 or email AST@planmanagementservice.com

  - Domestic Partners: This Plan does not cover Domestic Partners.

WORKING SPOUSE COVERAGE PROVISION:

A spouse of an Employee who is eligible/entitled to other coverage through an employer-sponsored group medical plan must enroll in that coverage on an individual basis as "primary" coverage in order to be eligible for the OHP Plan as "secondary" coverage. The spouse must enroll in at least single coverage where such availability exists, provided his/her contribution is less than 50% of the total premium for single coverage of the lowest cost plan option available to the spouse. For those entitled to employment-related funds or stipends, the cost of individual/exchange coverage is reduced by the value of the funds/stipend. Premium does NOT include spousal waiver incentives or other such additional compensation forfeited upon enrollment in their plan. This provision only applies to the group medical plan options and includes both employed and retired spouses who are eligible for group health plans. A spouse receiving funds or stipends by a former or current employer must use those funds to enroll in that coverage or purchase coverage through the Exchange or Open Market on an individual basis as primary insurance, in which case this Plan may be secondary.

You may be required to supply on an annual basis sufficient documentation of the conditions that may allow coverage under this Plan. Such information may include, but is not limited to, employment verification, employer health plan offerings and documentation, retirement status and related materials.

Failure of the spouse to enroll in his employer-sponsored coverage will result in the Plan's recovery of all benefits which were paid during the period of coverage availability under the spouse's employer's plan.

For purposes of this provision, employer sponsored coverage includes employer provided incentive programs for choosing not to elect coverage under the employer's plan.

Eligible Employees and spouses who are employed by the same participating Employer are not subject to the provisions of this section. Eligible Employees and spouses who are Covered Persons under the Ohio Healthcare Plan coverage but who work at different participating Employers will be subject to these provisions.

This provision will only apply to those spouses that are considered full-time employees and eligible for benefits. This provision does not apply to retired/impaired spouses.

ENROLLMENT:

- **Enrollment Waiting Period:**
  All Employees shall be eligible on the date specified by their Employer. Please see the business office of your Employer for specific details on your Waiting Period.

- **Open Enrollment Period:**
  Each year an annual period, specified by the Plan Administrator, is designated an "Open Enrollment" period. During this time, an Employee or Dependent who did not enroll at initial eligibility may enroll and coverage will begin on the first day of the following year. Also, an Employee who wishes to change coverage from one plan to the other may do so at this time and any limitations that would apply under the old plan will continue to apply under the new plan. It is only during this period or during a designated "Open Enrollment" that you can make a change without a qualifying event.

- **Late Enrollment Period:**
  This Plan does not have a Late Enrollment provision.

Total Disability Extension
If a Covered Employee becomes totally disabled, coverage for the Employee and any covered Eligible Dependents may be continued until terminated by the Employer (to run concurrently with the Family Medical Leave Act of 1993 extension of coverage). The Employee will be responsible for making any required contributions to the Plan.

PERSONAL OR MEDICAL LEAVE OF ABSENCE EXTENSION
Unpaid Leave - Continuation of Coverage Policy:

After the Employee has exhausted all paid leave with benefits, and/or is no longer paid by the Employer, the Employee is now on "unpaid leave with benefits." The Plan will provide "unpaid leave with benefits coverage for a maximum of 12 weeks annually. The annual 12-month period is measured forward from the start date of the unpaid leave period. When coverage ends under the Plan following the 12-week period of unpaid leave with benefits, the Employee is eligible for COBRA continuation of coverage.

Notwithstanding the foregoing, the Plan Administrator may, in its sole discretion and on a nondiscriminatory basis, elect to extend coverage during an unpaid leave period beyond the annual 12-week unpaid leave with benefits coverage continuation period in extraordinary circumstances (e.g., including but not limited to pandemics, when necessary or appropriate for administrative purposes, etc.). The Plan does not require unpaid leave to qualify as FMLA leave or military leave in order to be considered an eligible unpaid leave with benefits period. However, if such unpaid leave does qualify as FMLA leave or military leave, such leave period will be subject to any additional requirements set forth in the book that apply to FMLA/military leave periods. Further, any period of unpaid leave with benefits described above will run concurrently with any unpaid FMLA or military extension of coverage.

Grandfathering:

Employees currently on unpaid leave or leave of absence (LOA) with continuation of benefits prior to January 1, 2021, shall maintain coverage on the Plan through the unpaid leave/LOA period as approved by the Employer. If the pre-existing unpaid leave/LOA that is grandfathered is greater than 12 weeks past January 1, 2021, there is no opportunity to extend the unpaid leave/LOA period.

TERMINATION OF COVERAGE:

- **Employee:** The coverage of any Employee covered under this Plan shall terminate at the end of the month on the earliest of the following**:**
  - The last day of the month in which the Employee ceases to meet the definition of Employee, as listed in the Key Information section; or
  - The date of termination of the Plan.

- **Dependent children (attaining age 26):** The coverage of Dependent children attaining age 26 covered under this Plan shall terminate at the end of the month on the earliest of the following:
  - The last day of the month such individual ceases to meet the definition of Dependent, as listed in the Key Information section; or
  - The date the Employee's coverage terminates under the Plan.

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

FRAUD

Fraud is a crime for which an individual may be prosecuted. Any Covered Person who willfully and knowingly engages in an activity intended to defraud the Plan is guilty of fraud. The Plan will utilize all means necessary to support fraud detection and investigation. It is a crime for a Covered Person to file a claim containing any false, incomplete or misleading information with intent to injure, defraud or deceive the Plan. In addition, it is a fraudulent act when a Covered Person willfully and knowingly fails to notify the Plan regarding an event that affects eligibility for a Covered Person. Notification requirements are outlined in this Benefit Book and other Plan materials. Please read them carefully and refer to all Plan materials that You receive (i.e., COBRA notices). A few examples of events that require Plan notification are divorce, a Dependent aging out of the Plan, and enrollment in other group health coverage while on COBRA. (Please note that the examples listed are not all-inclusive).

These actions will result in denial of the Covered Person's claim or in termination of the Covered Person's coverage under the Plan and are subject to prosecution and punishment to the full extent under state and/or federal law.

Each Covered Person must:

- **File accurate claims**. If someone else - such as Your spouse or another family member – files claims on the Covered Person's behalf, the Covered Person should review the claim form before signing it. Similarly, if a provider submits a claim on Your behalf that You know may contain false or inaccurate information (e.g., diagnoses, services provided, etc.), You have an obligation to immediately notify the Plan;

- **Review the Explanation of Benefits (EOB) form**. The Covered Person should make certain that benefits have been paid correctly based on his or her knowledge of the expenses Incurred and the services rendered;

- **Never allow another person to seek medical treatment under his or her identity**. If the Covered Person's Plan identification card is lost, the Covered Person should report the loss to the Plan immediately;

- **Provide complete and accurate information on claim forms and any other forms**. He or she should answer all questions to the best of his or her knowledge; and

- **Notify the Plan when an event occurs that affects a Covered Person's eligibility**.

In order to maintain the integrity of this Plan, each Covered Person is encouraged to notify the Plan whenever a provider:

- Bills for services or treatment that have never been received; or

- Asks a Covered Person to sign a blank claim form; or

- Asks a Covered Person to undergo tests that the Covered Person feels are not needed.

If, for the purpose of obtaining or continuing to obtain benefits under the Plan, a Covered Person or anyone acting on behalf of such person makes, or causes to be made, a false statement or misrepresentation, conceals or withholds information, commits fraud against the Plan, or otherwise misleads the Plan, Employer, Administrator or Plan Administrator, the Plan shall be entitled to recover its damages, including benefits paid and legal fees, from the Covered Person or from any other person responsible for misleading or committing fraud against the Plan, and from the person for whom the benefits were provided.

Covered Persons concerned about any of the charges that appear on a bill or EOB form, or who know of or suspect any illegal activity, should please reach out to the Administrative Support Team (AST) at 1-855-664-0012 or email AST@planmanagementservice.com.

RESCISSION

The Plan will not rescind a Participant's or Dependent's coverage under a group health plan component of the Plan except in the case of fraud or intentional misrepresentation of a material fact. For purposes of this provision, a rescission is a cancellation or discontinuance of coverage that has a retroactive effect. However, a cancellation or discontinuance of coverage that is effective retroactively to the extent it is attributable to a failure to timely pay required premiums or Contributions towards the cost of coverage is not a rescission. In the event of fraud or an intentional misrepresentation of a material fact, the Plan will provide at least 30 days' notice to a Participant or Dependent before coverage is rescinded.

IMPORTANT NETWORK CONTACT INFORMATION:

Function	Network Name	Claims Filing Information	Phone Number	URL
PPO Network	Aetna Signature Administrators	Electronic Emdeon Payer: #37308 Paper: Allied Benefit Systems, LLC P.O. Box 211651 Eagan, MN 55121	(866) 455-8727	www.alliedbenefit.com

PRE-CERTIFICATION PROGRAM

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

If your Physician recommends any of the services listed on the following page, please follow these steps:

1. Notify your Physician that you participate in a Pre-Certification Program. Please note that this applies even if this Plan is the secondary payer under Coordination of Benefits.
2. You or your Physician must call the number shown on your member ID card 2 weeks before or, if less than 2 weeks, as soon as scheduled for an elective Hospital admission or any of the services listed above.
3. If You are not able to call in advance, pre-certification is required following admission.

The following information will be needed to pre-certify:

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

4. A nurse may call your Physician to review a proposed Inpatient admission or other listed service. If admission is necessary, an assigned length of stay will be determined. If additional days are later thought to be necessary, these additional days must also be pre-certified.
5. When you or your Physician call to pre-certify an Inpatient admission or other listed service, the call will be logged so that:
   a. The facility can verify that pre-certification has been done and can track expected length of stay.
   b. The Claims Processor can verify that the pre-certification requirements have been met when the claim is received for processing.

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

SERVICES REQUIRING PRECERTIFICATION		
BENEFIT	**REQUIREMENTS**	**COMMENTS/PENALTY**
Inpatient Hospitalization (includes Inpatient hospitalization for Mental Health Disorders, Substance Abuse and Chemical Dependency). Also applies to "partial hospitalization" services which are prescribed in place of Inpatient hospitalization for Mental Health Disorders/Substance Abuse treatment.	The Utilization Review firm must be notified at least 10 days in advance of a non-emergency admission. If the admission is on an Emergency basis, the Utilization Review Firm must be notified within 48 hours or as soon as reasonably possible, given the circumstances, following admission.	If pre-certified and approved, but additional days are later thought to be necessary, these additional days must also be pre-certified and approved. When pre-certification and approval is not obtained as required, normal benefits will be subject to a 50% penalty up to a maximum penalty of $500 per occurrence.
Organ Transplant Services (separate network provisions apply).	All coverage for specified covered transplants (see "Organ Transplant Coverage" in "Additional Coverage Details" section) require an approved transplant program and must be performed at an approved Network Transplant center.	No coverage is available unless course of treatment has been pre-certified and services are performed in an approved Network Transplant Center. Additional restrictions apply (see details in "Organ Transplant Coverage" in "Additional Coverage Details" section).
Outpatient Physical Therapy Outpatient Electroconvulsive Therapy (electrical shock therapy)	Pre-certification must be done between the 3rd and 4th visit, per condition. Procedure must be pre-certified at least 7 days in advance	When pre-certification is not obtained as required, normal benefits will be subject to a 50% penalty up to a maximum penalty of $500 per occurrence.
Other Required* Outpatient services (including the following diagnostic imaging services in these categories: PET/SPECT scans, and the following outpatient (including office) surgeries: • Sclerotherapy • Septoplasty • Rhinoplasty, • Abdominoplasty, • Panniculectomy, • Uvulopalatopharyngoplasty, • Blepharoplasty, • Non-Cancer Breast Surgery of any kind, • artificial intervertebral disk surgery, • lumber spinal fusion surgery, • orthognathic surgery procedures, bone grafts, osteotomies, surgical management of the temporomadibular joint	*Listed services are not voluntary All procedures must be pre-certified at least 7 days in advance.	When pre-certification is not obtained as required, normal benefits will be subject to a 50% penalty up to a maximum penalty of $500 per occurrence.
All home health care services, including home uterine monitoring	All procedures must be pre-certified at least 7 days in advance.	When pre-certification is not obtained as required, normal benefits will be subject to a 50% penalty up to a maximum penalty of $500 per occurrence.

BENEFIT	REQUIREMENTS	COMMENTS/PENALTY
Elective (non-emergent) transportation by ambulance or medical van, and all transfers via air ambulance	All procedures must be pre-certified at least 7 days in advance.	When pre-certification is not obtained as required, normal benefits will be subject to a 50% penalty up to a maximum penalty of $500 per occurrence
Gene-based, cellular and other innovative therapies	All procedures must be pre-certified at least 7 days in advance.	No coverage is available unless treatment has been pre-certified
Reconstructive procedures that may be considered cosmetic: • Blepharoplasty/canthopexy/ canthoplasty. • Excision of excessive skin due to weight loss. • Rhinoplasty/rhytidectomy. • Gastroplasty/gastric bypass. • Pectus excavatum repair. • Breast reconstruction/breast enlargement. • Breast reduction /mammoplasty. • Surgical treatment of gynecomastia. • Lipectomy or excess fat removal. • Sclerotherapy or surgery for varicose veins	All procedures must be pre-certified at least 7 days in advance.	When pre-certification is not obtained as required, normal benefits will be subject to a 50% penalty up to a maximum penalty of $500 per occurrence
Oncology Treatment • Chemotherapy (Including oral) • Radiation Therapy • Oncology and transplant related injections, infusions and treatment (e.g., CAR-T, endocrine and immunotherapy), excluding supportive drugs (e.g., antiemetic and antihistamine)	All procedures must be pre-certified at least 7 days in advance.	When pre-certification is not obtained as required, normal benefits will be subject to a 50% penalty up to a maximum penalty of $500 per occurrence
Selected durable medical equipment: • Electric or motorized wheelchairs and scooters. • Clinitron and electric beds. • Limb prosthetics. • Customized braces.	All procedures must be pre-certified at least 7 days in advance.	When pre-certification is not obtained as required, normal benefits will be subject to a 50% penalty up to a maximum penalty of $500 per occurrence

BENEFIT	REQUIREMENTS	COMMENTS/PENALTY
The following conditionally eligible services: • Stereotactic radiosurgery. • Somatosensory evoked potential studies. • Hyperbaric oxygen therapy. • Osteochondral allograft/knee. • Cochlear device and/or implantation. • Osseointegrated implant • Percutaneous implant of neuroelectrode array, epidural • GI tract imaging through capsule endoscopy • Botox injections -- botulinum toxin type A • Alpha 1-proteinase inhibitor – human • Negative pressure wound therapy pump • High-frequency chest wall oscillation generator system	All procedures must be pre-certified at least 7 days in advance.	When pre-certification is not obtained as required, normal benefits will be subject to a 50% penalty up to a maximum penalty of $500 per occurrence.
Dental implants and oral appliances	All procedures must be pre-certified at least 7 days in advance.	When pre-certification is not obtained as required, normal benefits will be subject to a 50% penalty up to a maximum penalty of $500 per occurrence.

PENALTY FOR NON-COMPLIANCE:

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

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

MANAGED MATERNITY PROGRAM

The Managed Maternity Program provides for a series of interviews with the expectant mother at various stages throughout the pregnancy. A registered nurse will screen the expectant mother for risk factors related to the pregnancy and provide the expectant mother with educational material to help prevent potential complications from developing. Refer to the Plan identification card for the telephone number to call for this program.

In order to enroll in the Managed Maternity Program and receive valuable prenatal information, the expectant mother is strongly encouraged to call the precertification vendor (see ID card) within 30 days after the pregnancy is confirmed. Information will be obtained over the telephone about health, medical history and lifestyle during each of the three trimesters. If at any time, based on the answers to the questions and criteria developed for the program, there is an indication that the expectant mother may have specific prenatal health needs, a nurse will work closely with the attending Physician to minimize complications and encourage the highest quality prenatal care. In addition, a nurse will be available throughout the pregnancy to answer any questions or concerns that arise.

PRE-NOTIFICATION

The following procedures are generally not covered by the Plan unless medically appropriate. Therefore, it is strongly recommended that a pre-notification of the following procedures be obtained before treatment. The toll-free number You should use for pre-notification is 800-892-1893.

Procedures for which pre-notification is recommended are:

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

PPO SCHEDULE OF COVERED EXPENSES AND PROVISIONS

I. MEDICAL CARE BENEFITS:

COVERED EXPENSES and PROVISIONS		
	In-Network	**Out-of-Network**
Calendar Year Deductible *(taken before benefits are payable unless waived).* *This is an embedded Deductible, meaning each covered family member only needs to satisfy his or her individual Deductible, not the entire Family Deductible, prior to receiving plan benefits. The balance of the Family Deductible can be satisfied by one member or a combination of remaining family members.*	$750/person $2,000/family	$1,500/person $4,000/family
Deductible Carry-Over	N/A	
Out-of-Pocket Maximum per Calendar Year *(*medical and Rx co-pays, co-insurance and deductibles count towards the Out-of-Pocket Maximum) *After amount is reached, 100% level of benefits applies for that Calendar Year.* The following expenses do not apply to and are not affected by the Out-of-Pocket Maximum: • "Non-compliance penalty" (for failure to abide by pre-certification requirements). • Any out-of-pocket expenses that are for non-covered services or for services that are in excess of any Plan maximum or limit. *This is an embedded Out-of-Pocket Maximum, meaning each covered family member only needs to satisfy his or her individual Out-of-Pocket Maximum, not the entire family Out-of-Pocket maximum, prior to receiving Plan benefits paid at 100%. The balance of the family Out-of-Pocket Maximum can be satisfied by one member or a combination of remaining family members.*	$3,500/person $7,000/family	$7,000/person $14,000/family
ANNUAL BENEFIT MAXIMUM (see listing in "Definitions" for clarifying details)	**Unlimited**	
LIFETIME BENENFIT MAXIMUM	**Unlimited**	
Benefits subject to the penalty as stated per occurrence ***(in addition to Deductible)*** when pre-certification procedures stated in the Pre-Certification section are not followed. Note, penalty does not apply to Outpatient oncology services.	**Allied Care** **1-800-892-1893**	
Claims Filing Limit	All charges, and corresponding requested documentation, must be submitted within 12 months of the date incurred.	
Coordination of Benefits	If it is determined that this Plan is the Secondary Payer, Benefits will be adjusted and reduced (carve out). This Plan will only pay the difference of what the Plan would have paid if it was the Primary Payer.	
In-Network and Out-of-Network Deductibles and Out of Pocket Maximums are "separately tracked," such that covered expenses applied to one does not apply to the other.		

II. PRESCRIPTION DRUG BENEFIT:

COVERED EXPENSES and PROVISIONS	
	In-Network Out-of-Network
Prescription Drug Card Benefit *(up to 34-day supply through participating pharmacies)* Deductible does not apply - see pages 24-25 for covered drugs and special considerations. **Note**: ***Maintenance drugs must be filled through Mail Order/Smart 90 Drug Benefit after 3 pharmacy fills***	• Generic Drugs - $10 co-pay per prescription or refill; then 100% • Formulary Brand Name Drugs - $35 co-pay per prescription or refill; then 100% • Non- Formulary Brand Name Drugs - $60 co-pay per prescription or refill; then 100% • Specialty medication drugs- $75 co-pay per prescription or refill; then 100%.
Mail Order/Smart 90 Drug Benefit *(up to 90-day supply through Home Delivery/Mail Order or a Smart 90 vendor) except where prohibited by state or federal law.* Deductible does not apply – see page 25	• Generic Drugs - $25 co-pay per prescription or refill; then 100% • Formulary Brand Name Drugs - $87.50 co-pay per prescription or refill; then 100% • Non-Formulary Brand Name Drugs- $150 co-pay per prescription or refill; then 100% • Specialty medication drugs- $150 co-pay per prescription or refill; then 100%.
Penalty for purchasing non-Generic when Generic Drug is Available	For both the Drug Card and Mail Order Drug benefit, if a Covered Person purchases a brand name medication when a generic is available, then, in addition to the brand co-pay, he must also pay the difference in price between the generic and brand medication.

Contraception- The Ohio Healthcare Plan includes coverage for several types of contraceptives. Generic hormonal and emergency oral contraceptives, diaphragms and the Mirena IUD will be covered at no cost to you as the Covered Person. Brand and Non-Formulary contraceptives will remain not covered. For additional information about your contraceptive benefits, including the applicable copay for a medication, please contact Express Scripts toll free at 1-866-275-0044 or online at www.express-scripts.com.

III. PREVENTIVE CARE SERVICES:

COVERED EXPENSES and PROVISIONS		
	In-Network	**Out-of-Network**
Preventive Care Services - (*must be billed with a routine diagnosis).* This plan includes coverage for physical exams, immunizations, tests, labs, x-rays, pap smears and analysis, mammograms (including 3D, age 35 and older, 1 per Covered Person per Calendar Year), PSA test, bone density tests (for women age 60 and older, every 5 Calendar Years) and every 5 Calendar Years, a choice between a sigmoidoscopy or a colonoscopy (age 45 and older), counseling for smoking cessation, and eye exams (birth through age 5). *This benefit also covers all services referenced within the Recommendations of the United States Preventive Service Task Force, Recommendations of the Advisory Committee On Immunization Practices (ACIP) that have been adopted by the Director of the Centers for Disease Control and Prevention and appear on the Immunization Schedules of the Centers for Disease Control and Prevention, and the Comprehensive Guidelines Supported by the Health Resources and Services Administration (HRSA), as well as referenced in the Guidelines for Women's Preventative Services adopted by the United States Department of Health and Human Services, based on recommendations by the Institute of Medicine.* This benefit specifically does not cover executive physicals, heart scans, full body scans, CAT scans, MRIs, PET or other similar tests.	100% Deductible Waived	60%
Family Planning - Permanent Procedures for Women *Includes:* • *Sterilization.*	100% Deductible waived	60%
Family Planning – Temporary Procedures *Including but not limited to injections, implants, and intrauterine contraceptives including administration, insertion, and removal.*	100% Deductible waived	60%
Breast Pumps and Supplies (Includes one breast pump per pregnancy and certain covered supplies purchased through a retail supplier).	100% Deductible waived	100% Deductible waived

IV. URGENT CARE FACILITY & PHYSICIAN EXPENSES:

COVERED EXPENSES and PROVISIONS		
Note: Generally, for out-of-network charges billed on a Form CMS-1500 exceeding $10,000, payment will be limited to the Medicare fee schedule. *Note: Generally, for out-of-network Outpatient Hospital charges exceeding $10,000, payment will be limited to the Medicare APC Reimbursement Rate.* *Some exceptions may apply. See the Out-of-Network Benefits section of this Benefit Book for more information*	**In-Network**	**Out-of-Network**
Urgent Care - Includes all services done during or in connection with the urgent care visit.	$60 co-pay per visit, then 100%. Deductible waived	60%

V. PHYSICIAN SERVICES:

COVERED EXPENSES and PROVISIONS *Note: Generally, for out-of-network charges billed on a Form CMS-1500 exceeding $10,000, payment will be limited to the Medicare fee schedule. Some exceptions may apply. See the Out-of-Network Benefits section of this Benefit Book for more information.*	**In-Network**	**Out-of-Network**
 Teladoc Health Teladoc provides access to a national network of U.S. board-certified doctors and pediatricians who are available on-demand 24 hours a day, 7 days a week, 365 days a year to diagnose, treat and prescribe medication (when necessary) for many medical issues via phone, by calling 1-800-Teladoc (835-2362), or online video consultations by accessing www.teladoc.com. Teladoc does not replace the existing primary care physician relationship, but enhances it as a convenient, affordable alternative for medical care.	100% Deductible Waived	
Virtual Physician charges	Paid same as any other service according to type of service and provider.	

IV. URGENT CARE FACILITY & PHYSICIAN EXPENSES:

COVERED EXPENSES and PROVISIONS		
Note: Generally, for out-of-network charges billed on a Form CMS-1500 exceeding $10,000, payment will be limited to the Medicare fee schedule. *Note: Generally, for out-of-network Outpatient Hospital charges exceeding $10,000, payment will be limited to the Medicare APC Reimbursement Rate.* *Some exceptions may apply. See the Out-of-Network Benefits section of this Benefit Book for more information*	**In-Network**	**Out-of-Network**
Office Visit Charge ***Primary Care Physician** is an M.D., D.O., or a Nurse Practitioner who is a general or family practitioner, obstetrician/gynecologist, internist, pediatrician, or covered mental health provider who has contracted with the PPO organization.	***PCP** - $30 co-pay per visit, then 100%. Deductible waived **Specialist** - $60 co-pay per visit, then 100%. Deductible waived	60%
All Other Expenses in Office *(except as stated above or under "Other Professional Services")*	80%	60%

VI. OUTPATIENT/INDEPENDENT LABORATORY (non-office) X-RAY/LAB AND DIAGNOSTIC TESTING EXPENSES:

COVERED EXPENSES and PROVISIONS		
Note: Generally, for out-of-network charges billed on a Form CMS-1500 exceeding $10,000, payment will be limited to the Medicare fee schedule. Some exceptions may apply. See the Out-of-Network Benefits section of this Benefit Book for more information.	**In-Network**	**Out-of-Network**
Facility Expenses	80%	60%
Professional Expenses *(excludes Urgent Care labs and x-rays, see Urgent Care benefit)*	80%	60%

VII. OTHER PROFESSIONAL SERVICES:

COVERED EXPENSES and PROVISIONS		
Note: Generally, for out-of-network charges billed on a Form CMS-1500 exceeding $10,000, payment will be limited to the Medicare fee schedule. Some exceptions may apply. See the Out-of-Network Benefits section of this Benefit Book for more information.	**In-Network**	**Out-of-Network**
Second Surgical Opinions	100% (Deductible waived)	100% (Deductible waived)

VII. OTHER PROFESSIONAL SERVICES:

COVERED EXPENSES and PROVISIONS *Note: Generally, for out-of-network charges billed on a Form CMS-1500 exceeding $10,000, payment will be limited to the Medicare fee schedule. Some exceptions may apply. See the Out-of-Network Benefits section of this Benefit Book for more information.*	In-Network	Out-of-Network
Therapy and Chiropractic Services *(including, but not limited to, physical, occupational, speech therapy and all care rendered by a Chiropractor). Limited to a combined maximum of 62 Visits for office and Outpatient facility services, per Covered Person per Calendar Year. Does not include labs or x-rays, see Additional Coverage Details on following pages). However, this Calendar Year visit maximum does not apply to covered therapy services for mental health and substance use disorder services.*	$30 co-pay per visit, then 100% (Deductible waived)	60%
Inpatient Physician Visits *(limited to one visit per Physician per day)*	80%	60%
All Other Covered Professional Expenses *(except as previously stated or as listed under "Emergency Room Services", or as clarified under "Additional Coverage Details."*	80%	60%

VIII. HOSPITAL SERVICES AND SPECIALIZED TREATMENT FACILITIES:

COVERED EXPENSES and PROVISIONS	In-Network	Out-of-Network
Inpatient Hospital Facility Services *limited to facility's semi-private room rate (unless private room is medically required for isolation) and all Medically Necessary services including, but not limited to, intensive care and cardiac care. Notice and consent rules may apply to certain post-stabilization items and services. See Emergency Room Services in the "Definitions" section.* *Note: for out-of-network Inpatient Hospital charges exceeding $25,000, payment will be limited to the Medicare DRG Reimbursement Rate.*	80%	60%
Outpatient Hospital Facility Services *Note: for out-of-network Outpatient Hospital charges exceeding $10,000, payment will be limited to the Medicare APC Reimbursement Rate.*	80%	60%
Ambulatory Surgical Facility Charges for Outpatient Surgical Procedures *Note: for out-of-network Ambulatory Surgical Center charges exceeding $5,000, payment will be limited to the Medicare ASC Reimbursement Rate.*	80%	60%
Emergency Room Services *including all related expenses performed during the same visit.* **Co-pay waived if admitted.* Note: See the "Out-of-Network Benefits" section for more information regarding out of network Emergency Room Services.	$250 co-pay*, then 100% (Deductible waived)	$250 co-pay*, then 100% (Deductible waived)
Renal Dialysis (All dialysis providers are out-of-network. This Plan does not access or use the Aetna network for dialysis providers.) *Note: For charges due to renal dialysis, payment by this Plan will not exceed 100% of the Medicare allowance for such incurred expenses*	100% Deductible Waived	
Birthing Center Facility Services	80%	60%
Rehabilitation Facility	80%	60%

VIII. HOSPITAL SERVICES AND SPECIALIZED TREATMENT FACILITIES:

COVERED EXPENSES and PROVISIONS		
	In-Network	**Out-of-Network**
Skilled Nursing Facility Services *(Limited to a Maximum of 60 visits per Calendar Year)*	80%	60%

IX. MISCELLANEOUS SERVICES:

COVERED EXPENSES and PROVISIONS		
Note: Generally, for out-of-network charges billed on a Form CMS-1500 exceeding $10,000, payment will be limited to the Medicare fee schedule. *Note: Generally, for out-of-network Outpatient Hospital charges exceeding $10,000, payment will be limited to the Medicare APC Reimbursement Rate.* *Note: Generally, for out-of-network Inpatient Hospital charges exceeding $25,000, payment will be limited to the Medicare DRG Reimbursement Rate.* *Some exceptions may apply. See the Out-of-Network Benefits section of this Benefit Book for more information*	**In-Network**	**Out-of-Network**
Home Health Care (Facility Expenses) **Home Health Care (Professional Expenses)** **Home Health Aide Services**	80% 80% 50%	60% 60% 50%
Hospice Care *(Inpatient and/or Home services).*	80%	60%
Inpatient/Outpatient Private Duty Nursing	80%	60%
Professional Ambulance Service ***subject to the In-Network Deductible and Out of Pocket Maximum*** *Transportation from the city or town in which the Covered Person becomes impaired, to and from the nearest Hospital qualified to provide treatment for the accidental bodily Injury or disease.* *Note: Ambulance Charges: For out-of-network ambulance (ground and air) charges exceeding $5,000, payment by this Plan will not exceed 100% of the Medicare allowance for such incurred expenses. Charges include those which relate to 1) transportation and 2) medical supplies used during transport, including those for BLS (basic life support) only services and ALS (advanced life support) services/supplies.*	80%	*80%
Prosthetic Medical Appliances *Limited to charges for the purchase, maintenance, or repair of internal and external permanent or temporary aids and supports for defective body parts.*	80%	Not Covered
Durable Medical Equipment	80%	60%
Morbid Obesity *(surgery or any other treatment for) See also "Additional Coverage Details."*	80%	60%

IX. MISCELLANEOUS SERVICES:

COVERED EXPENSES and PROVISIONS		
Note: Generally, for out-of-network charges billed on a Form CMS-1500 exceeding $10,000, payment will be limited to the Medicare fee schedule. *Note: Generally, for out-of-network Outpatient Hospital charges exceeding $10,000, payment will be limited to the Medicare APC Reimbursement Rate.* *Note: Generally, for out-of-network Inpatient Hospital charges exceeding $25,000, payment will be limited to the Medicare DRG Reimbursement Rate.* *Some exceptions may apply. See the Out-of-Network Benefits section of this Benefit Book for more information*	**In-Network**	**Out-of-Network**
Infusion therapy and Injections *The first dose of infusion therapy may be given at the Physician's facility of choice, including Outpatient Hospitals, free-standing facilities and home care. Any subsequent dose may also be given at the Physician's facility of choice, but only when clinically appropriate and at a lower cost than other sites of administration.* *For infusion therapy charges exceeding $1,500 (including, but not limited to, chemotherapy), payment by this Plan will not exceed 100% of the Medicare allowance for such incurred expenses. (Infusion therapy encompasses intravenous and/or intramuscular injections, as well as drugs administered through other non-oral routes, such as epidural routes).*	80%	60%
Other Covered Services/Items *(see "Additional Coverage Details" and "General Limitations" for possible impact or clarifications to coverage as shown at right).*	80%	60%- Professional 60%- Facility

X. EXCEPTIONS TO NETWORK PROVIDER COVERAGE:

COVERED EXPENSES and PROVISIONS *Note: Generally, for out-of-network charges billed on a Form CMS-1500 exceeding $10,000, payment will be limited to the Medicare fee schedule. Some exceptions may apply. See the Out-of-Network Benefits section of this Benefit Book for more information.*	**In-Network**	**Out-of-Network**
If professional services are received from non-network Physician/specialist in a network facility. *Note that this will normally only be paid on appeal as it may not be possible to determine that this situation applied when claims are initially received.*	N/A	Paid at In-Network level (subject to R&C provisions)
If non-network providers render services in a Medical Emergency. *Note that this may require an appeal as it may not be possible to determine that this situation applied when claims are initially received.*	N/A	Paid at In-Network level (subject to R&C provisions)
If services are received from non-network providers by Covered Persons residing outside network service area.	N/A	Paid at In-Network level (subject to R&C provisions)

X. EXCEPTIONS TO NETWORK PROVIDER COVERAGE:

COVERED EXPENSES and PROVISIONS *Note: Generally, for out-of-network charges billed on a Form CMS-1500 exceeding $10,000, payment will be limited to the Medicare fee schedule. Some exceptions may apply. See the Out-of-Network Benefits section of this Benefit Book for more information.*	In-Network	Out-of-Network
If Medically Necessary services are provided by a non-network provider because they are unavailable within the network *(only with approved network waiver).*	N/A	Paid at In-Network level (subject to R&C provisions)
If services are received from non-network independent lab services when lab samples are referred by a network provider. *Note that this will normally only be paid on appeal as it may not be possible to determine that this situation applied when claims are initially received.*	N/A	Paid at In-Network level (subject to R&C provisions)

XI. MENTAL/NERVOUS AND SUBSTANCE USE DISORDERS:

COVERED EXPENSES and PROVISIONS *Note: Generally, for out-of-network charges billed on a Form CMS-1500 exceeding $10,000, payment will be limited to the Medicare fee schedule.* *Some exceptions may apply. See the Out-of-Network Benefits section of this Benefit Book for more information*	In-Network	Out-of-Network
Inpatient Facility Services (includes "partial hospitalization" – see definition of "Inpatient") Also see the definitions of Physician and Hospital for further detail. *Note: for out-of-network Inpatient Hospital charges exceeding $25,000, payment will be limited to the Medicare DRG Reimbursement Rate.*	80%	60%
Outpatient Facility Services *Note: for out-of-network Outpatient Hospital charges exceeding $10,000, payment will be limited to the Medicare APC Reimbursement Rate.*	80%	60%
Outpatient Psychotherapy	$30 co-pay per visit, then 100%. Deductible waived	60%

ADDITIONAL COVERAGE DETAILS-

See provider status and place of service in previous pages to determine level of coverage for the following services:

Abortion. Induced termination of a pregnancy for all covered females by any acceptable means.

Allergy Injections and Surveys

Anesthetic services when performed by a licensed anesthesiologist or certified registered nurse anesthetist in connection with a covered surgical procedure

Autism Spectrum Disorders

For those diagnosed with this disorder, the following treatments are covered:

- Psychiatric and Psychological care, meaning direct, consultative, or diagnostic services provided by a licensed psychiatrist or psychologist;
- Habilitative or rehabilitative care, meaning professional, counseling, and guidance services and treatment programs, including applied behavior analysis, that are intended to develop, maintain, and restore the functioning of an individual.

Autism spectrum disorders means pervasive developmental disorders as defined in the most recent edition of the Diagnostic and Statistical Manual of Mental Disorders, including autism, Asperger's disorder, and pervasive developmental disorder not otherwise specified.

Birthing Center Services (either freestanding or part of a Hospital)

Blood and blood derivatives that are not donated or replaced. Administration of these services is also considered an eligible expense.

Cardiac Rehabilitation as deemed Medically Necessary provided services are rendered under the supervision of a Medical Doctor and in a medical care facility.

Chemotherapy and radiation treatment. The materials and services of technicians are included.

Dental Care for Accidental Injury. Treatment of accidental Injuries to the jaw, mouth, or sound natural tooth, provided treatment is received within one year following the date of the Injury.

Diabetes Self-Management Training, Educational Services and Supplies. Covered if such expenses are certified by the Covered Person's Physician as necessary for the treatment of diabetes.

Diagnostic Services and Supplies Charges for diagnostic testing such as, but not limited to: laboratory testing, basal metabolism tests, electrocardiograms, electroencephalograms, magnetic imaging, nuclear medicines, pneumo-encephalograms, ultrasounds and x-rays or similar well-established diagnostic tests generally approved by Physicians throughout the United States for the Participant's condition.

Durable Medical Equipment – Purchase or rental (up to purchase price) of such equipment which is Medically Necessary and prescribed by the attending Physician for therapeutic use of treatment of an Injury or Illness, suitable for use in the home, and exclusively for the participant. Repair/replacement which is Medically Necessary due to normal use, or growth of a child will be considered a covered expense. Routine maintenance of the equipment is **not** an eligible expense.

Foot treatment if deemed Medically Necessary for conditions, including removal of nail roots, surgical procedures or treatment of a metabolic or peripheral vascular disease. Routine foot care such as non-surgical treatment of weak, strained, flat, unstable, or unbalanced feet; metatarsalgia or bunions; corns; callouses; and toe nails is excluded.

Gender Affirming Surgery (including any associated labs and x-rays).

ADDITIONAL COVERAGE DETAILS-

See provider status and place of service in previous pages to determine level of coverage for the following services:

Home Health Care

Charges for home health care will be an eligible expense when certified by a Physician to be in lieu of confinement in a Hospital or skilled nursing facility. Services include: part-time or intermittent nursing care and/or home health aide services; physical, occupational, speech or respiratory therapy, nutrition counseling under the supervision of a registered dietician; medical supplies, laboratory services, drugs, and medications prescribed by a Physician.

Hospital

Charges by a Hospital are covered as stated in the "Schedule of Covered Medical Expenses" for:

Room, board and general nursing care, except that charges for a private room when not prescribed as medically necessary by a Physician will be eligible up to the most common semi-private room charge of the Hospital. If the Hospital has private rooms only, the private room charge will be considered the semi-private room charge.

- Intensive care unit, cardiac care unit, neo-natal, nursery and burn unit;
- Operating, recovery and delivery rooms;
- Pre-operative and post-operative care;

Other services and supplies, on an Inpatient or Outpatient basis, including but not limited to:

- Ancillary services
- Services of an anesthesiologist, radiologist and pathologist;
- Services of a licensed registered nurse or licensed practical nurse under the direct supervision of a registered nurse;
- Diagnostic tests.

Mammoplasty is covered under the following circumstances:

1. Medically Necessary reduction mammoplasties;
2. removal of a breast implant to the extent that such removal is Medically Necessary and not due to cosmetic reasons such as appearance, size, shape or comfort.
3. replacement of a breast implant to the extent that:
   a) the charge for the removal of the breast implant is covered; and
   b) the insertion of the initial breast implant would have been a covered expense under this Plan.

Charges for a reconstructive mammoplasty will be eligible after a medically necessary mastectomy as follows:
for reconstruction of the breast on which the mastectomy was performed;

- for surgery and reconstruction of the other breast to produce a symmetrical appearance; and
- for prostheses and physical complications at all stages of the mastectomy, including lymphedemas

Medical and Special Supplies including but not limited to: surgical supplies, surgical bras, casts, splints and trusses, ostomy supplies, catheters, oxygen and other gas therapy, and its administration, allergy tests and serum, electronic heart pacemakers, mechanical medical devices implanted in a body cavity to aid the function of an internal body organ, first pair of glasses or contact lenses, but not both, needed as a result of cataract surgery, soft lenses or sclera shell intended for use in the treatment of an Illness or Injury to the eye; dressings as well as swabs and bandages (but not for home use).

ADDITIONAL COVERAGE DETAILS- **See provider status and place of service in previous pages to determine level of coverage for the following services:**
Morbid Obesity (*surgery)* only if the Covered Person is at least twice his/her ideal weight and suffers from documented separate conditions which are aggravated by morbid obesity. This must be documented by objective evidence provided by the physician who is treating the Covered Person for the condition that is aggravated by morbid obesity. **Also, it should be approved by, and coordinated through, the Case Management process**. To be considered for a surgical procedure, there must be objective evidence to indicate that physician-dietician monitored alternative methods of weight reduction have been recently undertaken but did not produce successful outcomes.
Newborn Nursery Care (routine) while the mother is confined for delivery (including circumcision)
Nutritional Counseling rendered by a licensed nutritionist (if licensing is required by the state) or registered dietician. Benefits will be limited to the following conditions: • Diabetes • Mental health and substance use disorders • Pre and post covered weight loss surgery • Post cardiac surgery
Oral Surgery. Benefits are limited to the following procedures: • Excision of tumors or cysts from the mouth • Treatment of fractures of facial bones • External incision and drainage of cellulitis • Incision of accessory sinuses, salivary glands or ducts

ADDITIONAL COVERAGE DETAILS-

See provider status and place of service in previous pages to determine level of coverage for the following services:

Organ or **Tissue Transplants** (human organs only)

Covered Expenses include the following types of transplants under the following conditions:

- Transplantation of solid human organs (or bone marrow/stem cell transplants) and related Covered Expenses for initial and follow-up treatment provided that the condition is life threatening, the treatment follows a written protocol approved by the Plan, the patient is a suitable candidate for the transplant approved by the Plan, and that the following conditions are also met.
- Transplant services are provided at a Network Transplant Facility approved by the Plan, and all transplant related services are done by network providers.
- Organ transplant related benefits are payable only during a transplant benefit period. A transplant period is a period of time which begins five days prior to the day the Covered Person receives the covered transplant and ends twelve months after the claim for the covered transplant was incurred. A new transplant benefit period starts only when the next covered transplant occurs at least twelve months after the last covered transplant was performed. If coverage terminates, benefits will be provided for the following transplant related benefits received during a transplant benefit period which began while covered under this Plan: a) whole blood, blood processing and administration; b) private duty nursing in the Covered Person's home (must be certified at thirty day intervals as to medical necessity); c) medically necessary ambulance services; d) Outpatient prescription drugs pursuant to the approved transplant program; e) durable medical equipment prescribed by a Physician and utilized in conjunction with the approved transplant program.

Benefits are also provided for:

- Compatibility matching, preparation, acquisition, transportation and storage of human organs, bone marrow, or human tissue in conformance to the written and approved protocol.
- The transportation of the covered person, if the organ recipient, to and from the site of the transplant procedure.

Donor Expenses. Eligible medical expenses incurred by a donor who is not covered under this Plan will be considered, up to a maximum payment of $10,000 per transplant, to the extent that such benefits are not provided under any other health plan covering the donor. Any benefits payable for a donor who is not a Participant under this Plan will apply towards the covered recipient's maximum lifetime benefit under this Plan, but if both the donor and the recipient are covered under this Plan, eligible medical expenses incurred by each person will be treated separately for each person. When the transplant recipient is not covered under this Plan, no donor coverage is available

Transplant procedures considered to be Experimental or Investigational shall not be eligible.

ADDITIONAL COVERAGE DETAILS-

See provider status and place of service in previous pages to determine level of coverage for the following services:

Orthopedic appliances that are the original fitting, adjustment and placement of appliances such as braces, casts, splints, crutches, cervical collars, head halters, or other appliances to aid in their function when impaired. Replacement of such devices is only covered if the replacement is necessary due to a change in the physical condition of the Covered Person.

Orthotics that are the initial purchase, fitting and repair of orthotics, orthopedic or corrective shoes, and supportive appliances for the feet when determined to be Medically Necessary by the attending Physician.

Physician's Services
Charges made by a Physician for home, facility or office visits (including consultations), surgery or medical care.

Multiple Surgical Procedures/Multiple Surgeons are covered based on the following**:**

- For related operations or procedures performed through the same incision or in the same operative field, covered expenses shall include the surgical allowance for the highest paying procedure, plus 50% of the surgical allowance for each additional procedure (however, no benefit is payable for incidental procedures (such as an appendectomy during abdominal surgery);
- If two or more surgeons perform multiple unrelated surgical procedures, each procedure will be treated separately. If two or more surgeons perform a procedure that is normally performed by one surgeon, benefits for all surgeons will not exceed the Reasonable and Customary allowance allowed for that procedure;

For surgical assistance provided by an assistant surgeon (when Medically Necessary), Covered Expenses of the assistant surgeon are limited to 20% of the surgical allowance.

Pre-admission and pre-surgical testing in connection with a scheduled Inpatient Hospital admission or Outpatient surgical procedure.

Pregnancy – Coverage applies for all Covered Persons. Charges for pre-natal care, delivery, post-natal care and complications of pregnancy are eligible as any other medical condition.

The initial purchase, fitting and repair of fitted **Prosthetic Devices,** artificial limbs and artificial eyes, which replace body parts. Replacement of such devices is only covered if the replacement is necessary due to a change in the physical condition of the Covered Person, or, replacement is less expensive than repair of the existing device.

Skilled Nursing Facility (a.k.a. Extended Care Facility)

Room, board and floor nursing care (up to the facility's semi-private room rate for each day for room and board charges). Covered services include therapy, drugs, biologicals, supplies, appliances and equipment for use in the facility ordinarily furnished by the facility for the care and treatment of in-patients.

Sleep Studies (*home)*

ADDITIONAL COVERAGE DETAILS-

See provider status and place of service in previous pages to determine level of coverage for the following services:

Sleep Studies *(In-lab, facility) ages 18 and over*

*In order to be eligible, the member must have **one of the following**:*

- *Excessive daytime sleepiness*
- *Epworth Sleepiness Scale (ESS) score of 10 or greater*
- *Witnessed apneas, choking, or gasping*

AND one of the following comorbid conditions:

- *moderate to severe pulmonary disease*
- *neuromuscular disease*
- *stroke*
- *epilepsy*
- *congestive heart failure (NYHA class III or IV)*
- *pulmonary hypertension*
- *chronic opioid medication use*
- *super obesity (BMI > 45)*
- *periodic limb movement disorder*
- *parasomnias*
- *severe insomnia*
- *narcolepsy*
- *central sleep apnea or complex sleep apnea*
- *negative or technically inadequate home sleep study results*
- *Inability to use portable monitoring equipment safely at home.*

Sleep Studies *(In-lab, facility) ages 17 and under*

In order to be eligible, the member must be under 18 years of age and have one of the following indications:

- *Snoring*
- *Hypersomnia*
- *Suspected obstructive sleep apnea*
- *Suspected narcolepsy*
- *Suspected parasomnia*
- *Suspected restless leg syndrome*
- *Suspected periodic limb movement disorder*
- *Suspected congenital central alveolar hypoventilation syndrome*
- *Suspected sleep-related hypoventilation due to neuromuscular disorders or chest wall deformities*
- *After adenotonsillectomy or pharyngeal surgery for OSA*

Sterilization procedures. (but not the reversal of such procedures)

Therapy Services including, but not limited to, radiation, chemical, physical, occupational or orthopedic therapy and cardiac rehabilitation, if prescribed by a Physician. For physical and occupational therapy, services must be designed to restore the loss or impairment of motor functions resulting from Illness or Injury. Speech therapy is covered to restore already established speech loss due to an Illness or Injury, or to correct an impairment due to congenital defect for which corrective surgery has been performed. For all therapies other than those provided to treat mental health and substance use disorders, coverage ends once maximum medical recovery has been achieved and further treatment is primarily for maintenance purposes.

See "Exclusions From Coverage" & "General Provisions" For Additional Coverage Details, Exclusions and Limitations

PRESCRIPTION DRUG BENEFIT

Prescription drug benefits are provided through the Pharmacy Benefit Manager (PBM), Express Scripts. All general provisions in this Plan regarding eligibility and general administration also apply to the prescription drug benefits provided by the Plan. All Benefits will be paid as stated in the Schedule of Benefits for charges made by a participating pharmacy for treatment of you or your eligible Dependents. A covered charge is considered made on the date the prescription is dispensed by the pharmacist.

In the event of a direct conflict between the general provisions of this Plan and the provisions in this prescription drug section, the provisions of this prescription drug section shall prevail.

This Plan does not cover any secondary claims on Prescription Drugs. Prescription Drugs will only be paid on claims incurred by members with primary Prescription Drug coverage through this Plan, meaning there is no Coordination of Benefits for Prescription Drug claims, even when another plan has paid primary.

Note: Misrepresentation of a medical condition to obtain coverage of medications may constitute fraud.

Covered Prescription Drugs:
The Plan's prescription drug benefit covers a wide variety of prescription drugs. Prescription drugs are generally drugs that, by law, may be dispensed only by prescription. Covered Prescription Drugs generally include generic drugs and brand-name drugs. The Plan also maintains a Prescription Drug Formulary, which is a list of preferred drugs that members can obtain for lower co-pays and to help save them money. An expert panel of Physicians and pharmacists carefully reviews the drugs on the Prescription Drug Formulary for safety, quality, effectiveness and cost. The Prescription Drug Formulary and conditions of drug coverage under the Plan is subject to change.

To find out whether a particular drug is included on the Prescription Drug Formulary and covered under the Plan, and what conditions of coverage (if any) may apply, go to express-scripts.com or call Express Scripts Member Services. A pharmacist can also check whether a medication is on the Prescription Drug Formulary or covered at any time.

Covered Pharmaceutical Products:
The Plan also covers insulin, diabetic testing devices, test strips, syringes, and needles.

Prescriptions Not Covered Under Prescription Drug Benefit:

1. Federal Legend non-drugs and Non-Federal Legend drugs or non-drugs
2. Investigational drugs
3. Diagnostic medications
4. Experimental drugs
5. Fertility Agents

6. Medications furnished on an in-patient basis covered under any other carrier providing group coverage for prescription legend drugs or insulin
7. Pharmaceutical Products used for Cosmetic purposes – All Hypopigmentation, Renova, Vaniqa except Topical Tretinoin with Prior Authorization for member > 25 years of age)
8. Prescription vitamins, except pre-natal
9. Biological, Allergy Sera, and Toxoids
10. Nutritional Supplements
11. Drugs to treat Impotency
12. Anti-Obesity Preparations
13. Abortifacients
14. Yohimbine
15. Insulin Pump supplies (available as Durable Medical Equipment with Medical Necessity)
16. Medical Supplies (e.g. Ostomy Supplies)
17. Over-the Counter products
18. Therapeutic devices or appliances, including needles, syringes, support garments and other non-medicinal substances, regardless of intended use, except those listed above.
19. Dental Fluoride Products

LONG-TERM MAINTENANCE MEDICATION

You have two ways to get up to a 90-day supply of your long-term maintenance medication (those drugs you take regularly for ongoing conditions). You can conveniently fill those prescriptions either through mail order home delivery from the Express Scripts Pharmacy or at a Retail pharmacy in the Smart90 network.

HOME DELIVERY/MAIL ORDER DRUG BENEFIT

This benefit offers a Home Delivery/Mail Order service which delivers required prescription drugs directly to your home after a prescription co-pay has been made (see Schedule of Covered Expenses and Provisions for co-pay amount). The mail order drug benefit permits up to a 90-day supply of medication and up to one year of refills upon authorization.

You should receive a packet providing complete details on how to use your mail order drug benefit. If you have any questions regarding this aspect of your coverage, please contact your Business Office.

SMART90 RETAIL PHARMACY BENEFIT

This benefit provides 90-days of medication to be filled for pick-up at a Smart90 participating Retail Pharmacy. To locate one, login to express-scripts.com and click "Locate a pharmacy" from the menu under "Manage Prescriptions." Smart90 network pharmacies will be noted in your search results. Or, call Express Scripts (see your member ID card). You can also use the Express Scripts mobile app on your digital device to locate a participating pharmacy.

SPECIALTY DRUG PHARMACY BENEFIT

Certain specialty medications may be required to be purchased through your pharmacy vendor's, Accredo or Allied's specialty pharmacy program. Typically, these medications are very costly, require special storage or handling, are for long term use, or require careful monitoring and management. You will be notified by the pharmacy at the time of purchase if a particular drug is in this specialty pharmacy program, or you may contact the Accredo Customer Service number (see your member ID card) as soon as a drug has been prescribed to determine how it must be dispensed. The specialty pharmacy unit will coordinate fast shipment to the location a member chooses, such as your home or your Physician's office. Alternatively, if Accredo indicates the drug cannot be dispensed, please contact the Accredo customer service team (see your member ID card) to determine how the specialty drug that has been prescribed must be dispensed.

PRESCRIPTION COVERAGE MANAGEMENT PROGRAM

- Express Scripts will identify quality and cost opportunities based on medical criteria recognized by the medical and pharmacy communities at the point a prescription is placed to be filled.
- They look for possible conflicts with the diagnosis and standard drug use; possible multi-drug interactions; untried first or second line medication options, etc.
- Express Scripts will contact your Physician on your behalf to discuss the opportunity. The Physician has the final determination for prescription use, NOT Express Scripts.
    - The determination (whether the Physician re-issues the prescription or supports the first order) is maintained in the Express Scripts database for one year. Prior to the year expiration, a letter will be mailed to you indicating the review process needs to be updated if continued use of the medication is needed.

QUANTITY LEVEL LIMITS

Note that certain medications may have specific quantity limitations that are not the standard supply limit. You will be notified if this is the case either by the pharmacist or through the mail order process.

PRESCRIPTION DRUG FORMULARY

The "Prescription Drug Formulary" is a list of Federal Drug Administration (FDA) approved Prescription Drugs and supplies developed by a Pharmacy and Therapeutics Committee. This list reflects the current clinical judgment of practicing health care practitioners—based on a review of current data, medical journals, and research information. The Plan's Formulary Drug list is used as a guide for determining your costs for each prescription. Drugs not listed on the Formulary Drug List are not covered by the Plan.

PRIOR AUTHORIZATION REQUIREMENTS

Certain medications may need to have additional clarifications or authorizations made prior to being dispensed. You will be provided with details through the mail order process if this situation should occur when using the program. If this should occur during your purchase of a retail drug or Smart90 Retail Pharmacy, the pharmacist will provide you with a number to contact the pharmacy vendor and initiate the process.

STEP THERAPY

Certain Prescription Drugs are subject to Step Therapy review. Step Therapy is the practice of beginning drug therapy for a medical condition with the most cost-effective and safest drug and stepping up through a sequence of alternative drug therapies as a preceding treatment option fails. If Step Therapy criteria are not met, Prior Authorization will be required. Your doctor may initiate the Prior Authorization process by calling Express Scripts. If you pay out-of-pocket while waiting for a prior authorization to be approved, please be aware that reimbursement will only be for 90 days from the approval date. If approved, your prescription will be filled within any stated plan limits. If the medication is not approved for coverage, you will be responsible for paying the full cost of the drug. However, rejection of coverage may be appealed. To appeal, you or your doctor must follow the procedure outlined in the Appeals section.

VACCINES

Many diseases are preventable through the use of vaccinations. To help you stay healthy, Your Plan covers vaccines for the flu and other illnesses administered through your local retail pharmacy, at no cost to you. These vaccines administered at your retail pharmacy typically do not require an appointment and are the same effective medications as in your physician's office.

TRAVEL AND LODGING EXPENSES

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

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

Reimbursement of expenses incurred by the patient for lodging is limited to a maximum rate of $50 per night, payable at 100% Deductible waived. If a traveling companion is necessary to enable the patient to receive medical care, the companion's reasonable travel and lodging expenses will also be covered, with lodging expenses also reimbursed at a maximum rate of $50 per night, payable at 100% Deductible waived. Travel & lodging reimbursement is limited to a total cap of $10,000 per Calendar Year, payable at 100% Deductible waived, which is the combined maximum for both the patient and companion and applies collectively to all trips taken in a Calendar Year.

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

TRANSPLANTS

Institute of Excellence (IOE):

This is a facility that is contracted with Aetna to furnish particular services and supplies to You in connection with one or more highly specialized medical procedures. The maximum charge made by the IOE for such services and supplies will be the amount agreed to between Aetna and the IOE.

Transplant Expenses:

Once it has been determined that You or one of Your Dependents may require an organ transplant, You, or Your physician should call the pre-certification department to discuss coordination of Your transplant care. Aetna will coordinate all transplant services. In addition, You must follow any pre-certification requirements. Organ means solid organ; stem cell; bone marrow; and tissue.

While all organ/tissue transplants (other than cornea or skin transplants) are covered only under these provisions, benefits may vary if an Institute of Excellence (IOE) facility or non-IOE is used. The IOE facility must be specifically approved and designated by Aetna to perform the procedure You require. A transplant will be covered as network care only if performed in a facility that has been designated as an IOE facility for the type of transplant in question. Any treatment or service related to transplants that is provided by a facility that is not specified as an IOE network facility, even if the facility is considered as a network facility for other types of services, will not be considered network care. Please read each section carefully.

Covered Transplant Expenses:

Covered transplant expenses include the following:

- Charges for activating the donor search process with national registries.
- Compatibility testing of prospective organ donors who are immediate family members. For the purpose of this coverage, an "immediate" family member is defined as a first-degree biological relative. These are Your: biological parent, sibling or child.
- Inpatient and outpatient expenses directly related to a transplant**.**
- Charges made by a Physician or transplant team.
- Charges made by a Hospital**,** outpatient facility or Physician for the medical and surgical expenses of a live donor, but only to the extent not covered by another plan or program.
- Related supplies and services provided by the IOE facility during the transplant process. These services and supplies may include: physical, speech and occupational therapy; bio-medicals and immunosuppressants; home health care expenses and home infusion services.

Covered transplant expenses are typically incurred during the four phases of transplant care described below. Expenses incurred for one transplant during these four phases of care will be considered one Transplant Occurrence.

A Transplant Occurrence is considered to begin at the point of evaluation for a transplant and end either: (1) 180 days from the date of the transplant; or (2) upon the date You are discharged from the Hospital or outpatient facility for the admission or visit(s) related to the transplant, whichever is later.

The four phases of one Transplant Occurrence and a summary of covered transplant expenses during each phase are:

1. Pre-transplant Evaluation/Screening: Includes all transplant-related professional and technical components required for assessment, evaluation and acceptance into a transplant facility's transplant program.
2. Pre-transplant/Candidacy Screening: Includes HLA typing/compatibility testing of prospective organ donors who are immediate family members.
3. Transplant Event: Includes inpatient and outpatient services for all covered transplant-related health services and supplies provided to You and a donor during the one or more surgical procedures or medical therapies for a transplant; prescription drugs provided during Your inpatient stay or outpatient visit(s), including bio-medical and immunosuppressant drugs; physical, speech or occupational therapy provided during Your inpatient stay or outpatient visit(s); cadaveric and live donor organ procurement.
4. Follow-up Care: Includes all covered transplant expenses; home health care services; home infusion services; and transplant-related outpatient services rendered within 180 days from the date of the transplant event.

For the purposes of this section, the following will be considered to be one Transplant Occurrence:

- Heart.
- Lung.
- Heart/Lung.
- Simultaneous Pancreas Kidney (SPK).
- Pancreas.
- Kidney.
- Liver.
- Intestine.
- Bone marrow/stem cell transplant.
- Multiple organs replaced during one transplant surgery.
- Tandem transplants (stem cell).
- Sequential transplants.
- Re-transplant of same organ type within 180 days of the first transplant.
- Any other single organ transplant, unless otherwise excluded under the Plan.

The following will be considered to be more than one Transplant Occurrence:

- Autologous blood/bone marrow transplant followed by allogenic blood/bone marrow transplant (when not part of a tandem transplant).
- Allogenic blood/bone marrow transplant followed by an autologous blood/bone marrow transplant (when not part of a tandem transplant).
- Re-transplant after 180 days of the first transplant.
- Pancreas transplant following a kidney transplant.
- A transplant necessitated by an additional organ failure during the original transplant surgery/process.
- More than one transplant when not performed as part of a planned tandem or sequential transplant (e.g., a liver transplant with subsequent heart transplant).

Limitations:

The transplant coverage does not include charges for:

- Outpatient drugs including bio-medicals and immunosuppressants not expressly related to an outpatient Transplant Occurrence.
- Services and supplies furnished to a donor when recipient is not a covered person.
- Home infusion therapy after the Transplant Occurrence.
- Harvesting or storage of organs, without the expectation of immediate transplantation for an existing illness.
- Harvesting and/or storage of bone marrow, tissue or stem cells without the expectation of transplantation within 12 months for an existing illness.
- Cornea (corneal graft with amniotic membrane) or cartilage (autologous chondrocyte or autologous osteochondral mosaicplasty) transplants, unless otherwise authorized by the Plan.

GENE THERAPY

Gene-based, cellular and other innovative therapies (GCIT)

Covered services include GCIT provided by a Physician, Hospital or other provider.

Key Terms

Gene
A gene is a unit of heredity which is transferred from a parent to child and is thought to determine some feature of the child.

Molecular
Molecular means relating to or consisting of molecules. A molecule is a group of atoms bonded together, making the smallest vital unit of a chemical compound that can take part in a chemical reaction.

Therapeutic
Therapeutic means a treatment, therapy, or drug meant to have a good effect on the body or mind; adding to a sense of well-being.

GCIT are defined as any services that are:

- Gene-based
- Cellular and innovative therapeutics

The services have a basis in genetic/molecular medicine and are not covered under the Institutes of Excellence™ (IOE) programs "GCIT services."

GCIT covered services include:

- Cellular immunotherapies.
- Genetically modified oncolytic viral therapy.
- Other types of cells and tissues from and for use by the same person (autologous) and cells and tissues from one person for use by another person (allogenic) for certain therapeutic conditions.
- All human gene-based therapy that seeks to change the usual function of a gene or alter the biologic properties of living cells for therapeutic use. Examples include therapies using:
  - Luxturna® (Voretigene neparvovec)
  - Zolgensma® (Onasemnogene abeparvovec-xioi)
  - Spinraza® (Nusinersen)
- Products derived from gene editing technologies, including CRISPR-Cas9.

- Oligonucleotide-based therapies. Examples include:
  - Antisense. An example is Spinraza.
  - siRNA.
  - mRNA.
  - microRNA therapies.

Facilities/provider for gene-based, cellular and other innovative therapies
GCIT Physicians, Hospitals and other providers are GCIT-designated facilities/providers for Aetna and CVS Health.

Important note: GCIT services require Pre-Certification
You must get GCIT covered services from the GCIT-designated facility/provider. If there are no GCIT-designated facilities/providers assigned in Your network, it's important that You contact the Pre-Certification number shown on Your ID card. If You do not get Your GCIT services at the facility/provider Aetna designates, they will not be covered services.

EXCLUSIONS

The following exclusions apply to this Plan except that if any exclusion is contrary to any law to which this Plan is subject, the provision is hereby automatically changed to meet the law's minimum requirement.

Acupuncture.

Ambulatory Surgical Center- For out-of-network charges exceeding $5,000 (except as specifically stated in the Schedule of Covered Services and "Out-of-Network Benefits section), payment will be limited to the Medicare ASC reimbursement fee schedule.

Ambulance (ground and air)- For out-of-network charges exceeding $5,000 (except as specifically stated in the Schedule of Covered Services and "Out-of-Network Benefits section), payment by this Plan will not exceed 100% of the Medicare allowance for such incurred expenses. Charges include those which relate to 1) transportation and 2) medical supplies used during transport, including those for BLS (basic life support) only services and ALS (advanced life support) services/supplies.

Charges billed on a Form CMS-1500- For out-of-network charges exceeding $10,000 (except as specifically stated in the Schedule of Covered Services and "Out-of-Network Benefits section), payment will be limited to the Medicare fee schedule.

Charges which are not Medically Necessary.

Charges incurred outside the United States. Charges incurred outside the United States if travel to such a location was for the primary purpose of obtaining medical services, drugs or supplies;

Contraceptives. Contraceptives or medications used for contraceptive purposes, except as provided under the Prescription Drug Card Program or as specifically listed in the Schedule of Covered Expenses.

Cosmetic or Reconstructive Surgery. Cosmetic or reconstructive surgery unless the surgery is necessary for (a) repair or alleviation of damage resulting from an Accident; (b) because of infection or Sickness; or (c) because of congenital disease, developmental condition or anomaly of a covered Dependent child which has resulted in a functional defect. A treatment will be considered cosmetic for either of the following reasons: (a) its primary purpose is to beautify or (b) there is no documentation of a clinically significant impairment, meaning decrease in function or change in physiology due to illness, Injury or congenital abnormality. The term "cosmetic services" includes those services which are described in IRS Code Section 213(d)(9).

Custodial Care. Charges for custodial care, domiciliary care, rest cures, services that are primarily educational in nature (except as specified), or any maintenance-type care which is not reasonably expected to improve the patient's condition (except Hospice Care as specified).

Dental Treatment. The Plan does not pay for dental treatment unless provided in connection with accidental Injuries to sound natural teeth and begun within one year following the date of the Injury.

Drugs requiring a written prescription (except those taken or administered in whole or in part during confinement in a licensed facility or those administered in a Physician's office) are not covered by this Plan. They are provided under a separate plan provided by the Employer through Express Scripts.

Educational or Vocational Testing. Services for educational or vocational testing or training, except as specified.

Excess Charges. For any expense in excess of any maximum or limit as stated elsewhere in this document.

Exercise Programs. Exercise programs for treatment of any condition, except for Physician-supervised cardiac rehabilitation, occupational or physical therapy covered by this Plan.

Experimental or Investigative. For experimental or investigational services; or, for treatment not deemed clinically acceptable by (1) the National Institute of Health; or (2) the FDA; or (3) the Centers for Medicare and Medicaid Services (CMS); or (4) the AMA; or a similar national medical organization of the United States;

Eye Care. Glasses, contact lenses, or eye examinations and/or treatment (surgical or nonsurgical) of refractive error for the correction of vision or fitting of glasses, except as specified.

Failure to Provide. For failure to provide any additional documentation or information as may be requested pursuant to the "Procedures For Filing Claims" section of this Plan;

Felony Participation. Charges for a Sickness or Injury sustained during the commission, or attempted commission, of an assault or felony; or Injuries sustained while engaging in an illegal occupation.

Foot Care. Treatment of weak, strained, flat, unstable or unbalanced feet, metatarsalgia or bunions (except open cutting operations), and treatment of corns, calluses or toenails (unless needed in treatment of a metabolic or peripheral-vascular disease).

Government Coverage. Charges for services or supplies provided by the Veterans Administration or in any Hospital or institution owned, operated, or maintained by the United States Government for a service-related Sickness or Injury.

Hair Loss. Care and treatment for hair loss including wigs, cranial prostheses, hair transplants or any drug that promises hair growth, whether or not prescribed by a Physician, except for wigs after chemotherapy.

Hearing Aids and Exams. Charges for services or supplies in connection with hearing aids or exams for their fitting.

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

Hypnosis.

Infertility Treatment. Any infertility treatment, testing or any procedure for which the purpose is to enhance the possibility of reproduction.

Infusion Therapy- For charges exceeding $1,500 (except as specifically stated in the Schedule of Covered Services and "Out-of-Network Benefits section), including, but not limited to, chemotherapy, payment by this Plan will not exceed 100% of the Medicare allowance for such incurred expenses. (Infusion therapy encompasses intravenous and/or intramuscular injections, as well as drugs administered through other non-oral routes, such as epidural routes).

Inpatient Hospital- For out-of-network charges exceeding $25,000 (except as specifically stated in the Schedule of Covered Services and "Out-of-Network Benefits section), payment will be limited to the Medicare DRG Reimbursement Rate. If a Medicare DRG Reimbursement Rate is not available, then reimbursement will be limited to the Rate of the next closest Hospital.

Marriage Counseling.

No Charge. Care or treatment for which there would not have been a charge if no coverage had been in force.

Non-emergency Hospital Admissions. Care and treatment billed by a Hospital for non-Medical Emergency admissions on a Friday or a Saturday. This does not apply if surgery is performed within 24 hours of admission.

Non-Medical Expenses. For non-medical expenses such as preparing medical reports, itemized bills or charges for mailing; for training, educational instructions or materials, even if they are performed or prescribed by a Physician; for legal fees and expenses incurred in obtaining medical treatment;

No Obligation to Pay. Charges incurred for which the Plan has no legal obligation to pay or for which no charge would have been made in the absence of this coverage.

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

Obesity. Care and treatment relating to weight loss or dietary control, including the care and treatment of obesity whether or not it is, in any case a part of the treatment plan for another Sickness. Medically Necessary charges for Morbid Obesity, including Physician office visits, behavior modification and required X-ray and laboratory examinations will be covered. All benefits are covered only as stated in the "Schedule of Covered Expenses."

Occupational. Any treatment or service resulting from Sickness or Injury which is covered by a Workers' Compensation Act or similar legislation.

Oral Nutrition, including infant formula.

Orthoptics/Vision Therapy.

Outpatient Hospital- For out-of-network charges exceeding $10,000 (except as specifically stated in the Schedule of Covered Services and "Out-of-Network Benefits section), payment will be limited to the Medicare APC Reimbursement Rate. If a Medicare APC Reimbursement Rate is not available, then reimbursement will be limited to the Rate of the next closest Hospital.

Personal Comfort Items. Personal comfort items or other equipment, such as, but not limited to, air conditioners, air-purification units, humidifiers, electric heating units, orthopedic mattresses, blood pressure instruments, scales, elastic bandages or stockings, nonprescription drugs and medicines, and first-aid supplies and nonhospital adjustable beds.

Physician Visits. Charges made by a doctor for phone calls or interviews when the Physician does not see the patient for treatment. This also includes charges for failure to keep a scheduled visit or charges for completion of a claim form.

Purported Lost Discounts. For provider charges claimed due to purported lost discounts.

Reasonable and/or Usual and Customary. The part of an expense for care and treatment of an Injury or Sickness which is not Reasonable and/or in excess of Usual and Customary Charges. This limitation will not apply to charges from contracted network providers, unless otherwise set forth in the "Out-of-Network Benefits" section.

Relationships. Professional services performed by a person who ordinarily resides in the Covered Person's home or is related to the Covered Person as a spouse, parent, child, brother or sister, whether the relationship is by blood or exists in law.

Renal Dialysis- for charges due to renal dialysis, payment by this Plan will not exceed 100% (except as specifically stated in the Schedule of Covered Services and "Out-of-Network Benefits section) of the Medicare allowance for such incurred expenses. All dialysis providers are out-of-network. This Plan does not access or use the Aetna network for dialysis providers.

Replacement Braces. Replacement of braces of the leg, arm, back, neck or artificial arms or legs, unless there is sufficient change in the Covered Person's physical condition to make the original device no longer functional or the age of the brace makes it no longer functional.

Routine Care. Charges for routine or periodic examinations, screening examinations, evaluation procedures, preventive medical care, or treatment or services not directly related to the diagnosis or treatment of a specific Injury, Sickness or pregnancy-related condition which is known or reasonably suspected, except as specified.

Services Before or After Coverage. Care, treatment or supplies for which a charge was incurred before a person was covered under this Plan or after coverage ceased under this Plan.

Sexual Dysfunction. Care or treatment for sexual dysfunction or inadequacy (except as may be indicated under the "Prescription Drug Benefit"), including implants and related hormone treatment.

Smoking Cessation. Care and treatment for smoking cessation programs, including smoking deterrent patches, unless Medically Necessary due to a severe active lung Illness such as emphysema or asthma (except as covered under the Prescription Drug Card section).

Special Education Services

Sterilization Reversal.

Temporomandibular Joint Dysfunction Syndrome. Treatment of Temporomandibular Joint Dysfunction Syndrome (including all myofacial pain syndromes and other associated disorders).

Vitamins. Charges for vitamins, minerals, non-prescription food and/or food supplements and non-prescription dietary drugs.

War. Any loss that is due to a declared or undeclared act of war.

DEFINITIONS

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

AIR AMBULANCE

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

AMBULATORY SURGICAL CENTER

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

ANCILLARY SERVICES

Items and services provided by an out-of-network provider at an in-network facility that are related to emergency medicine, anesthesiology, pathology, radiology, and neonatology, whether provided by a Physician or non-Physician practitioner; items and services provided by assistant surgeons, hospitalists, and intensivists; diagnostic services, including radiology and laboratory services; and items and services provided by an out-of-network provider if there is no in-network provider who can furnish such item or service at the in-network facility.

ASC REIMBURSEMENT FEE SCHEDULE

The ambulatory surgical center reimbursement rate set by Centers for Medicare and Medicaid Services (CMS).

CALENDAR YEAR

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

CASE MANAGEMENT PROGRAM

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

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

CHIEF ADMINISTRATOR SUPPORT AND/OR SERVICES
Services specifically contracted by the Trust for administration of the Plan.

CLAIMS PROCESSOR

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

COMPANY

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

COSMETIC SURGERY/TREATMENT

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

COVERED EXPENSES

These are expenses for certain Hospital and other medical services and supplies for the treatment of Injury or Illness. A detailed list of Covered Expenses is set forth in this book in the section entitled "Schedule of Covered Expenses and Provisions."

COVERED PERSON

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

CREDITABLE COVERAGE

Coverage of an individual under a qualified medical plan, including but not limited to the following: group health plans, other health insurance coverage, Part A or Part B of Medicare, Medicaid, state health benefit risk pools, state children's health insurance program and public health plans of various sorts (including from other countries).

DEDUCTIBLE/CO-INSURANCE

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

DEPENDENTS

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

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

A child who is physically or mentally incapable of self-support upon attaining age 26 may be continued under the health care benefits, while remaining incapacitated and unmarried, subject to the covered Employee's own coverage continuing in effect. To continue a child under this provision, the Company must receive proof of incapacity within 60 days after coverage would otherwise terminate. Additional proof will be required from time to time.

DOMESTIC PARTNER

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

ELECTIVE SURGICAL PROCEDURE

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

EMERGENCY ROOM SERVICES

"Emergency Room Services**"** are services provided with respect to a Medical Emergency in an emergency department of a Hospital or an independent freestanding emergency department, to evaluate, stabilize, and treat the patient. Covered Services provided by an out of network provider or facility after a patient has stabilized and as part of Outpatient observation or a required Inpatient or Outpatient stay immediately following and related to the illness or injury for which the Emergency Room Services were needed will also be considered Emergency Room Services unless the following conditions are satisfied:

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

judgment, and to provide informed consent under such section, in accordance with applicable state law.

- The provider or facility satisfies any additional requirements or prohibitions as may be imposed under state law.

A nonparticipating provider or nonparticipating facility described above will always be considered providing Emergency Room Services with respect to items or services furnished as a result of unforeseen, urgent medical needs that arise at the time an item or service is furnished, regardless of whether the nonparticipating provider or nonparticipating emergency facility satisfied the notice and consent requirement described above.

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

EMPLOYEE

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

EMPLOYER

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

ENROLLMENT DATE

The first day of coverage or, if there is a Waiting Period, the first day of the Waiting Period. The Enrollment Date is the point in time where the Look Back Period or Look Forward Period begins.

ESSENTIAL HEALTH BENEFITS

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

EXTENDED CARE FACILITY

An institution (or a distinct part of an institution) which: (a) provides for Inpatients (1) 24-hour nursing care and related services for patients who require medical or nursing care, or (2) service for the rehabilitation of injured or sick persons; (b) has policies developed with the advice of (and subject to review by) professional personnel to cover nursing care and related services; (c) has a Physician, a registered professional nurse or a medical staff responsible for the execution of such policies; (d) requires that every patient be under the care of a Physician and makes a Physician available to furnish medical care in case of emergency; (e) maintains clinical records on all patients and has appropriate methods for dispensing drugs and biologicals; (f) has at least one registered professional nurse employed full time; (g) provides for periodic review by a group of Physicians to examine the need for admissions, adequacy of care, duration of stay and medical necessity of continuing confinement of patients; (h) is licensed pursuant to law, or is approved

by appropriate authority as qualifying for licensing and is also approved by Medicare; (i) is not primarily a place for the elderly, a place for rest, or a place for custodial or educational care.

FAMILY DEDUCTIBLE

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

GENDER NEUTRAL WORDING

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

GENETIC INFORMATION

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

HOME HEALTH CARE AGENCY

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

HOSPICE

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

HOSPITAL

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

jurisdiction in which it operates; and (b) is accredited by the Joint Commission on the Accreditation of Healthcare Organizations.

HOSPITAL INTENSIVE CARE/CARDIAC CARE UNIT

Only a section, ward or wing within the Hospital which is distinguishable from other Hospital facilities because it (a) is operated solely for the purpose of providing room and board and professional care and treatment for critically ill patients, including constant observation and care by a Registered Nurse (R.N.) or other highly trained Hospital personnel, and (b) has special supplies and equipment necessary for such care and treatment, available on a standby basis for immediate use.

HOSPITAL SEMI-PRIVATE

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

ILLNESS

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

INJURY

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

INPATIENT

A Covered Person shall be considered to be an "Inpatient" if he is treated at a Hospital and is confined for more than 18 consecutive hours. The term "Inpatient" shall also apply to those situations where "partial hospitalization" (defined as an on-going period of treatment involving full use of Hospital facilities excepting only room and board service) is recommended by the patient's Physician as an alternative to Hospital confinement.

LATE ENROLLMENT

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

LIFETIME

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

MEDICAL EMERGENCY

A **"**Medical Emergency**"** is defined as a medical condition, including a Mental/Nervous or Substance Use Disorder, manifesting itself by acute symptoms of sufficient severity (including severe pain) so that a prudent layperson, who possesses an average knowledge of health and

medicine, could reasonably expect the absence of immediate medical attention to result in 1) a condition placing the health of the individual (or, with respect to a pregnant woman, the health of the woman or her unborn child) in serious jeopardy; 2) serious impairment to bodily functions; or 3) serious dysfunction of any bodily organ or part.

MEDICALLY NECESSARY

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

MEDICARE DRG OR APC REIMBURSEMENT RATE

The inpatient and outpatient reimbursement rates set by Centers for Medicare and Medicaid Services (CMS).

MENTAL/NERVOUS AND SUBSTANCE USE DISORDER SERVICES

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

NAMED FIDUCIARY

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

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

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

OPEN ENROLLMENT

Each year an annual period, specified by the Plan Administrator, is designated an "Open Enrollment" period. During this time, an Employee or Dependent who did not enroll at initial eligibility may enroll and coverage will begin on the first day of the following year. Also, an Employee who wishes to change coverage from one plan to the other may do so at this time and any limitations that would apply under the old plan will continue to apply under the new plan. It is only during this period or during a designated "Open Enrollment" that you can make a change without a qualifying event.

OUT-OF-NETWORK RATE

With regard to services that are subject to balance billing protections (see the "Out-of-Network Benefits" section for more detail), the Out-of-Network Rate is the amount used to calculate the benefit payable to the out of network provider for Covered Services. The Out-of-Network Rate will equal (i) the Recognized Amount, (ii) an amount agreed to by the Plan and the provider, (iii) or the amount determined payable in accordance with the independent dispute resolution process set forth in PHS Act sections 2799A-1(c) and 2799A-2.

OUT-OF-POCKET MAXIMUM

The "Out-of-Pocket Maximum" is the total amount of Co-Insurance for which the Covered Person or covered family is responsible during the course of a Calendar Year. These amounts are shown in the "Schedule of Covered Expenses and Provisions".

OUTPATIENT

A Covered Person shall be considered to be an "Outpatient" if he is treated at a Hospital and is confined less than 18 consecutive hours.

PHYSICIAN

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

PLACEMENT FOR ADOPTION

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

PLAN

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

PLAN ADMINISTRATOR

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

PLAN YEAR

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

QUALIFIED MEDICAL CHILD SUPPORT ORDER

A legal order requiring the coverage of specified child(ren) under an individual's medical plan benefits. If your employer determines that a separated or divorced spouse or any state child

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

REASONABLE/REASONABLENESS

"Reasonable" and/or "Reasonableness" shall mean in the Plan Administrator's discretion, services or supplies, or charges for services or supplies, which are necessary for the care and treatment of Illness or Injury. Determination that charges or services/supplies are Reasonable will be made by the Plan Administrator, taking into consideration unusual circumstances or complications requiring additional time, skill and experience in connection with a particular service or supply; industry standards and practices as they relate to similar scenarios; and/or the cause of Injury or Illness necessitating the service(s) and/or charge(s).

This determination may consider, but not be limited to, the findings and assessments of the following entities: (a) national medical associations, societies, and organizations; and (b) The Food and Drug Administration. To be Reasonable, services, supplies and/or charges must be in compliance with the Plan Administrator's policies and procedures relating to billing practices for unbundling or multiple procedures. The Plan Administrator retains discretionary authority to determine whether services, supplies and/or charges are Reasonable based upon information presented to the Plan Administrator.

The Plan reserves for itself and parties acting on its behalf the right to review charges processed and/or paid by the Plan, and to identify charges and/or services that are not Reasonable, and therefore not eligible for payment by the Plan.

RECOGNIZED AMOUNT

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

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

RECONSTRUCTIVE BREAST SURGERY COVERAGE

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

RETIREE

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

SECOND SURGICAL OPINION

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

SPECIAL ENROLLMENT

An enrollment which takes place during the 60-day period following the date of the event which triggers the Special Enrollment period. See "Eligibility" section for details.

USUAL AND CUSTOMARY

"Usual and Customary" (U&C) shall mean Covered Expenses which are identified by the Plan Administrator, taking into consideration the charge(s) which the provider most frequently bills the majority of patients for the service or supply, the cost to the provider for providing the service or supply, the prevailing range of charges billed in the same "area" by providers of similar training and experience for the service or supply, and/or the Medicare reimbursement rates. The term(s) "same geographic locale" and/or "area" shall be defined as a metropolitan area, county, or such greater area as is necessary to obtain a representative cross-section of providers, persons or organizations rendering such treatment, service, or supply for which a specific charge is made. To be Usual and Customary, the charge must be in compliance with the Plan Administrator's policies and procedures relating to billing practices for unbundling or multiple procedures.

The term "Usual" refers to the amount of a charge made for medical services, care, or supplies, to the extent that the charge does not exceed the common level of charges made by other medical professionals with similar credentials, or health care facilities, pharmacies, or equipment suppliers of similar standing, which are located in the same geographic locale in which the charge is incurred.

The term “Customary” refers to the form and substance of a service, supply, or treatment provided in accordance with generally accepted standards of medical practice to one individual, which is appropriate for the care or treatment of the same sex, comparable age and who receive such services or supplies within the same geographic locale.

The term “Usual and Customary” does not necessarily mean the actual charge made nor the specific service or supply furnished to a Covered Person by a provider of services or supplies. The Plan Administrator will determine what the Usual and Customary charge is, for any procedure, service, or supply, and whether a specific procedure, service or supply is Usual and Customary.

Usual and Customary charges may, at the Plan Administrator’s discretion, alternatively be determined and established by the Plan using normative data such as, but not limited to, average wholesale price (AWP) for prescriptions and/or manufacturer’s retail pricing (MRP) for supplies and devices.

WAITING PERIOD

The period of time before an individual is eligible to be covered under the terms of a group health plan. Any period before a Late Enrollment, Open Enrollment or Special Enrollment is not a Waiting Period. A Waiting Period does not count for Creditable Coverage or for a Significant Break in Coverage.

ELIGIBILITY

WHO IS ELIGIBLE

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

NON-DISCRIMINATION

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

EMPLOYEE COVERAGE

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

DEPENDENT COVERAGE

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

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

INDIVIDUAL EFFECTIVE DATE

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

1. All Employees, who are eligible Employees, shall be covered on the day they become eligible, as discussed in the Key Information section at the beginning of this document.
2. Dependents shall be covered simultaneously with Employees covering them as Dependents.
3. Coverage for a spouse will begin from the date of marriage. A spouse can also be added to the plan as a result of the birth of a dependent child, coverage for the spouse will begin from the date of birth of the child. Coverage for a newborn birth child will begin from the date of birth. Coverage for a child placed under legal guardianship, an adopted child or a child placed for adoption with the Employee will begin from the date of Placement for Adoption. Coverage for a stepchild or foster child will begin from the date the child meets the definition of "Dependent." With respect to family coverage, if you have family coverage, your newly-eligible dependent child becomes eligible for coverage from the moment the child qualifies, provided you actually enroll

the newly-eligible dependent child in your coverage within 60 days of the qualifying event. A newly-eligible dependent child is permitted to obtain coverage retroactively from the moment of birth or adoption, even after the 60-day enrollment period. However, no claims will be processed for the newly-eligible dependent child until the individual's enrollment record is received and all verification documents are provided and approved.

OPEN ENROLLMENT

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

LATE ENROLLMENT

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

SPECIAL ENROLLMENT

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

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

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

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

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

Under Special Enrollment, the Employee must request enrollment, in writing within 60 days after the exhaustion of COBRA, or termination of the other coverage (other than Medicaid or Children's Health Insurance, see below), or the date of the marriage, birth, adoption or placement for adoption. If eligible, enrollment in the Plan, in cases of marriage, birth or adoption/Placement for Adoption, will be effective as of the date of the event; otherwise, coverage will be available no later than the first day of the first month beginning after the completed request for enrollment is received.

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

TERMINATION OF COVERAGE

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

INDIVIDUALS PARTICIPATING IN APPROVED CLINICAL TRIALS

The Plan may not 1) deny a Qualified Individual participation in an Approved Clinical Trial, 2) deny (or limit or impose additional conditions on) coverage of Routine Patient Costs for items and services furnished in connection with the Approved Clinical Trial, or 3) discriminate against the Qualified Individual based on his/her participation in the Approved Clinical Trial. However, if the Plan has a network of providers and one or more network providers is participating in an Approved Clinical Trial, the Qualified Individual must participate in the Approved Clinical Trial through such network provider if the provider will accept the Qualified Individual as a Covered Person in the trial. This requirement to use network providers will not apply to a Qualified Individual participating in an Approved Clinical Trial that is conducted outside the state in which the Qualified Individual resides (unless the Plan does not otherwise provide out-of-network coverage generally).

The following definitions are applicable under this provision:

Qualified Individual

A Covered Person who meets the following conditions:

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

B. Either:

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

Approved Clinical Trial

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

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

7. Any of the following entities in clauses 7a. through 7c. below if the following conditions are met: the study or investigation has been reviewed and approved through a system of peer review that the Secretary of Health and Human Services determines to be comparable to the system of peer review of studies and investigations used by the National Institutes of Health, and assures unbiased review of the highest scientific standards by qualified individuals who have no interest in the outcome of the review.
    a. The Department of Veterans Affairs.
    b. The Department of Defense.
    c. The Department of Energy.

- The study or investigation is conducted under an investigational new drug application reviewed by the Food and Drug Administration.
- The study or investigation is a drug trial that is exempt from having such an investigational new drug application.

Routine Patient Costs

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

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

Life-Threatening Disease or Condition

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

NETWORK BENEFITS

Your Plan contains enhanced benefits through network providers. The name of the organization associated with these network providers is indicated on the front of Your ID card, along with instructions regarding where to file medical claims. Benefits are generally paid at a higher level when using network Hospitals and network Physicians than when using non-network providers. Please refer to the Schedule of Covered Services and Provisions for benefits payable according to type of provider used.

A Physician or Hospital's status within Your network can change. In order to access the most up-to-date list of in-network providers, visit alliedbenefit.com or call the customer service number on Your ID card.

When Your Provider Leaves the Network
If Your provider or facility is leaving/has left the Plan's network due to nonrenewal or expiration of the contract, the Plan will notify You. You, in turn, will need to notify the Plan if You require continuing transitional care with that provider or facility for certain serious or complex conditions, pregnancy, terminal illness, scheduled non-elective surgical care, or if You are undergoing Inpatient or institutional care. You may have a right to elect to continue transitional treatment and still be covered by the Plan under the same terms and conditions that existed when the provider or facility was part of the Plan's network. Such coverage would be temporary, up to a maximum of 90 days (or until treatment is complete, if earlier).

A Covered Person has a free choice of any provider for medical care. At any time, the Covered Person may choose any qualified provider with the understanding that different benefits may apply according to the provisions of the Plan. Please see the "Out-of-Network Benefits" section for an explanation of notice and consent requirements for non-network providers.

OUT-OF-NETWORK BENEFITS

This Plan is designed for You to receive maximum benefits through its network Hospitals and network Physicians. As set forth in the Schedule of Covered Services and Provisions, benefits are payable at a different level for non-network providers, and the Plan Administrator, in its sole discretion, uses various methodologies for determining the Plan's reimbursable amount for Covered Services from non-network providers. When You choose a non-network provider, You are responsible for paying, directly to the non-network provider, any difference between the reimbursable amount and the amount the provider bills You. This is called "balance billing."

BALANCE BILLING PROTECTIONS

For Covered Services received on or after January 1, 2022, new federal rules apply to the following services provided by an out of network provider or facility to prevent You from being balanced billed:

- Emergency Room Services.
- Air Ambulance.
- *Non-Emergency Care* when provided by a non-network provider at certain in-network facilities (i.e., a Hospital, a Hospital Outpatient department, a critical access Hospital, an Ambulatory Surgical Center, and any other facility specified by the Secretary of HHS) for the categories of service listed below:
- Ancillary Services (see the Definitions section);
- Non-Ancillary Services, if the non-network provider has not given proper notice and You've not given proper consent;

For the services above, the most a provider may bill You is Your Plan's in-network cost-sharing amount (co-pay, Coinsurance and/or Deductible) that is based on the Recognized Amount for such services.

Your out-of-pocket amounts for the above mentioned services will be applied to Your in-network limits (e.g. deduction and/or Out-of-Pocket Maximum).

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

If You believe You have been wrongly billed, You may contact the No Surprises Help Desk at 1-800-985-3059 from 8 am to 8 pm EST, 7 days a week, to submit Your question or a complaint. You can also submit a complaint online at:
https://www.cms.gov/nosurprises/consumers/complaints-about-medical-billing.

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

PROCEDURES FOR FILING CLAIMS

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

KEY POINTS TO REMEMBER

The claims filing address you must use for filing all medical claims is shown on your ID card.

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

FILING A HOSPITAL CLAIM

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

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

MISCELLANEOUS CLAIMS FILING CONSIDERATIONS

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

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

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

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

Always retain a copy of the bill for your records.

THIS PLAN AND MEDICARE

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

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

GENERAL PROVISIONS

ADMINISTRATION OF THE PLAN

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

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

APPEALING A MEDICAL BENEFITS CLAIM

When appealing a medical benefits claim, as discussed in detail below, please submit a written appeal directly to Allied Benefit Systems, LLC, the medical Claims Processor, at:

VIA U.S. Mail: Allied Benefit Systems, LLC
P.O. Box 211651
Eagan, MN 55121
Attention: Appeals Department

VIA FAX: (312) 906-8359
Re: Appeals

CLAIMS PROCEDURES

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

The Claims Processor will notify you of an Adverse Benefit Determination within 30 days after receipt of the claim. However, in certain cases an extension of up to 15 days may be utilized if the Claims Processor determines that the extension is necessary due to matters beyond the control of the Plan and you are notified prior to the expiration of the initial 30 day period of the circumstances requiring the extension of time and the date by which the Claims Processor expects to render a decision. If such an extension is necessary due to your failure to submit the information necessary to decide the claim, the notice of extension shall specifically describe the

required information, and you shall be given at least 45 days within which to provide the specified information. A notice of Adverse Benefit Determination will include the following:

- Sufficient information to identify the claim involved, including the date(s) of service, health care provider, and claim amount.
- The specific reason or reasons for the Adverse Benefit Determination, as well as the Plan's standard that was used in denying the claim, if applicable, and including identifying denial codes and providing their meaning.
- Reference to specific Plan provisions on which the Adverse Benefit Determination is based.
- A statement that if you think a coding error may have caused this claim to be denied, you have the right to have billing and diagnosis codes sent to you.
- A description of any additional material or information necessary for you to perfect the claim and an explanation of why such material or information is necessary.
- A description of the Plan's first level appeal procedures and the time limits applicable to such procedures, including information on how to initiate an appeal.
- If an internal rule, guideline, protocol, or other similar criterion was relied upon in making the adverse determination, either the specific rule, guideline, protocol, or other similar criterion will be set forth in the notice of Adverse Benefit Determination; or the notice will contain a statement that such rule, guideline, protocol, or other similar criterion was relied upon in making the Adverse Benefit Determination and that a copy of such rule, guideline, protocol, or other criterion will be provided free of charge to you upon written request.
- If the Adverse Benefit Determination is based on a medical necessity or experimental treatment or similar exclusion or limit, either an explanation of the scientific or clinical judgment for the determination, applying the terms of the Plan to your medical circumstances, will be set forth in the notice of Adverse Benefit Determination, or the notice will contain a statement that such explanation will be provided free of charge upon written request.
- A description of the availability of assistance from the Ohio Superintendent of Insurance ("**Superintendent**"), including the mailing address, telephone number and web site of the Superintendent's office of Consumer Affairs. The mailing address is 50 West Town Street, Suite 300, Columbus, OH 43215. The telephone number is 800-686-1526 / 614-644-2673, and the website is:
  https://secured.insurance.ohio.gov/ConsumServ/ConServComments.asp.

FIRST LEVEL APPEALS PROCEDURE

If you receive an Adverse Benefit Determination, you or your authorized representative may appeal the determination by filing a written application with the Plan Administrator, through Allied Benefit Systems, LLC, the medical Claims Processor. Be sure to say why you think the decision is not correct—in other words, why you think your claim should be paid. In appealing an Adverse Benefit Determination, the Claims Processor will provide you or your authorized representative:

- The opportunity to submit written comments, documents, records, and other information relating to the claim for benefits.
- Upon written request and free of charge, reasonable access to, and copies of, all documents, records, the claim file, and other information relevant to the claim.
- A full and fair review that takes into account all comments, documents, records, and other information submitted by you relating to the claim, without regard to whether such information was submitted or considered in the initial benefit determination. You must also be provided, free of charge, with any new or additional evidence considered, relied upon, or generated by the Claims Processor, as well as any new or additional rationale relied upon by the Claims Processor in reaching its determination on appeal, that differs from that which the Claims Processor relied on in its Adverse Benefit Determination. Such evidence and/or rationale must be provided as soon as possible and sufficiently in advance of the date on which the Claims Processor's determination is required to be provided to give you a reasonable opportunity to respond prior to that date.
- A full and fair review that does not afford deference to the initial benefit determination and is conducted by an appropriate individual who is neither the individual who made the initial Adverse Benefit Determination that is the subject of the appeal, nor the subordinate of such individual.
- In deciding an appeal of an Adverse Benefit Determination that is based in whole or in part on a medical judgment, including determinations with regard to whether a particular treatment, drug, or other item is experimental, investigational, or not medically necessary or appropriate, that the appropriate individual shall consult with a health care professional who has appropriate training and experience in the field of medicine involved in the medical judgment and that the health care professional consulted shall neither be an individual who was consulted in connection with the initial Adverse Benefit Determination that is the subject of the appeal, nor the subordinate of any such individual.
- Upon written request, the identification of medical or vocational experts whose advice was obtained on behalf of the Plan in connection with your Adverse Benefit Determination, without regard to whether the advice was relied upon in making the benefit determination.

A first level appeal must be filed, in writing, within 180 days after the Adverse Benefit Determination is received. An appeal will be considered filed on the date it is received. An appeal for claims filed beyond the timely filing date will not be considered. The Claims Processor will notify you or your authorized representative of its determination within 30 days after receipt of an appeal. The determination notice:

- Will contain sufficient information to identify the claim involved, including the date(s) of service, health care provider, claim amount, denial codes and their meaning, as well as the Plan's standard used in denying the claim.

- Will be in writing, setting forth specific reasons for the decision and reference to the specific Plan provisions upon which the determination is based.
- Will contain a statement that you are entitled to receive, upon written request and free of charge, reasonable access to, and copies of, all documents, records, and other information relevant to the claim for benefits.
- Will contain a description of the Plan's second and third level (external) review processes, including information on how to initiate a second and third level appeal (if applicable).
- If an internal rule, guideline, protocol, or other similar criterion was relied upon in making the Adverse Benefit Determination, either the specific rule, guideline, protocol, or other similar criterion will be set forth in the determination; or the determination will contain a statement that such rule, guideline, protocol, or other similar criterion was relied upon in making the Adverse Benefit Determination and that a copy of the rule, guideline, protocol, or other similar criterion will be provided free of charge to you upon written request.
- If the Adverse Benefit Determination is based on a medical necessity or experimental treatment or similar exclusion or limit, either an explanation of the scientific or clinical judgment for the determination, applying the terms of the Plan to your medical circumstances, will be set forth in the determination or the determination will contain a statement that such explanation will be provided free of charge upon written request.
- Will contain a description of the availability of assistance from the Superintendent, including the mailing address, telephone number and web site of the Superintendent's office of Consumer Affairs. The mailing address is 50 West Town Street, Suite 300, Columbus, OH 43215. The telephone number is 800-686-1526 / 614-644-2673, and the website is:
  https://secured.insurance.ohio.gov/ConsumServ/ConServComments.asp.

SECOND LEVEL APPEALS PROCEDURE (MEDICAL CLAIMS ONLY)

If you are not satisfied with the benefit determination on review of your first appeal, write to the Claims Processor asking to have the Plan Administrator review your claim. Again, be sure to say why you think the decision is not correct—in other words, why you think your claim should be paid. You must send this written request to the Claims Processor within 180 calendar days after you receive your Explanation of Benefits, or within 30 days after you receive the benefit determination on review of your first appeal from the Claims Processor, whichever is later. In connection with your appeal, you have the right to:

- Submit written comments, documents, records and other information relating to the claim for benefits; and
- Review and obtain, without charge, copies of documents, records and other information relevant to the claim being appealed.

The Claims Processor will send the request to the Plan Administrator, and the Plan Administrator will then make a full and fair review of the claim, taking into account everything you have submitted. The Plan Administrator may require you to submit additional information to complete the review.

In making a decision, the Plan Administrator will:

- Not give deference to the initial claim determination.
- Not allow the same person who made the initial decision (or any subordinate of that person) to decide the appeal.
- Consult with a health care professional on any appeal that involves the exercise of medical judgment. The health care professional will have training or experience in a field of medicine appropriate to the questions raised on appeal. The professional will not be the same person consulted in connection with the original denial or any subordinate of that person. The Plan Administrator will identify the professionals consulted upon written request.

The Plan Administrator will make a final decision in writing. That decision will be given within 30 days after the date the Claims Processor receives the request for review.

Your appeal will be determined on its own merits at each stage of review, and the decision on your appeal will not be considered as setting any precedent or creating any future liability with respect to you or any other Covered Person. If for any reason the Plan Administrator fails to act within these time frames, the appeal will be deemed to be denied.

You must exhaust the first and second level appeals processes (outlined above) prior to initiating a request for a third level (external) appeal (if applicable), except where the Plan does not respond to the first and second level appeals within the required time frame or otherwise does not strictly adhere to all the requirements of the first and second level appeals processes (unless the Plan's failure to strictly adhere to these procedural requirements is 1) *de minimis*, 2) non-prejudicial, 3) attributable to good cause or matters beyond the Plan's control, 4) in the context of an ongoing good faith exchange of information, and 5) not reflective of a pattern or practice of non-compliance).

To the extent the Plan Administrator or its delegate denies a request for external review (see below) because the first and second level appeals processes have not been exhausted, you will be entitled, upon written request, to an explanation of the Plan Administrator's or its delegate's decision (to be provided within ten days), so that you can make an informed judgment about whether to seek review by the Superintendent. If the Superintendent upholds the Plan Administrator's or its delegate's explanation, you have the right to resubmit and pursue the first level claims and appeals process within ten days.

If the Plan denies Your second level appeal, in whole or in part, and You choose to bring a civil action, such action must be filed within 365 days of the date of the Plan's denial of Your second level appeal. This 365 day time period, however, will be temporarily suspended to the extent

You are entitled to file a third level (external) appeal (see below) and do in fact file such an appeal. Under such circumstances, this 365 day time period will be suspended from the date You submit a request for a third level (external) appeal that is both complete and eligible until the date of the decision of the Independent Review Organization or Superintendent, as applicable (see below).

THIRD LEVEL (EXTERNAL) APPEALS PROCEDURE

Circumstances Triggering the Opportunity for External Review: If your second level appeal is denied, in whole or in part, such denial is called a "**Final Internal Adverse Benefit Determination**." You or your authorized representative may submit a third level (external) appeal of the Final Internal Adverse Benefit Determination (known as a "**request for external review**") by filing a written application with the Plan Administrator, through the Claims Processor, under four distinct circumstances. First, a request for external review may be sought where the underlying determination involves medical necessity, appropriateness, health care setting and/or level of care or effectiveness. Such a request will be reviewed by an Independent Review Organization ("**IRO**") (see below).

Second, you may request an external review for treatment the Plan Administrator or its delegate has determined to be experimental or investigational (except when the requested treatment is explicitly excluded under the terms of the Plan) if your treating physician certifies that 1) standard health care services have not been effective in improving your condition, 2) standard health care services are not medically appropriate for you, or 3) there is no available standard health care service covered by the Plan that is more beneficial than the requested treatment. This request, if allowed, will similarly be reviewed by an IRO.

Third, a request for external review may be sought based on a contractual issue that does not involve medical judgment or any medical information. Such a request will be reviewed by the Superintendent. The Superintendent will determine whether the health care service at issue is a service covered under the terms of the Plan. If the determination requires a medical judgment or is based on medical information, however, the Superintendent will inform the Claims Processor, and the Claims Processor, on behalf of the Plan Administrator, will initiate an external review with an IRO.

Finally, for an adverse benefit determination where emergency medical services have been determined to be not medically necessary or appropriate *after an external review*, you will have the opportunity to request a further external review by the Superintendent.

How to File a Request for External Review: To file a request for external review, you must request such an appeal in writing with the Plan Administrator. When filing a request for an external review, you will be required to authorize the release of your medical records as necessary to conduct the external review.

A third level external appeal must be filed within 180 days after the Final Internal Adverse Benefit Determination is received. The Plan will pay the cost of the external review, including the cost of any external review that is required at the direction of the Superintendent.

Following receipt of a request for external review, the Claims Processor, on behalf of the Plan Administrator, must review the request to determine whether it is complete, including whether you have exhausted the Plan's first and second level appeal processes. If complete, and reviewable by an IRO, the Superintendent shall assign an IRO from the list of organizations maintained by the Superintendent to conduct the external review. The Superintendent shall notify the Claims Processor of the name of the assigned IRO. The Claims Processor shall then notify you in writing of the acceptance of the third level review. Depending on the type of request for external review, this notice will include the name and contact information for either the assigned IRO or Superintendent (whichever is applicable) for the purpose of submitting additional documentation. The notice will also include a statement that you may submit in writing to either the IRO or Superintendent (whichever is applicable) within ten business days following the date of receipt of the notice, any additional information that should be considered when conducting the third level review. (If the request for an external review is not complete, the Claims Processor shall inform you in writing, and include what information is needed to make the request complete. If the Plan Administrator denies a request for an external review on the basis that the Final Internal Adverse Benefit Determination is not eligible for an external review, the Claims Processor shall notify you in writing the reason for the denial, and that the denial may be appealed to the Superintendent.)

Within five days after the receipt of a request for an external review, the Plan Administrator or Claims Processor must provide to the assigned IRO or Superintendent (whichever is applicable) the documents and any information considered in making the Final Internal Adverse Benefit Determination. If the Plan Administrator or Claims Processor fails to timely provide the documents and information, the IRO may terminate the third level review and make a decision to reverse the Final Internal Adverse Benefit Determination. Within one business day after making that decision, the IRO must notify you, the Plan Administrator and the Superintendent. The IRO may also grant a request from the Plan Administrator or Claims Processor for more time to provide the required information.

Upon receipt of any information submitted by you to the IRO, the IRO shall forward the information to the Plan Administrator or Claims Processor. Upon receipt of any such information, the Plan Administrator may reconsider its Final Internal Adverse Benefit Determination that is the subject of the third level review. Within one business day after making such a decision, the Plan Administrator or Claims Processor must provide written notice of the Plan Administrator's decision to you, the IRO and the Superintendent. The IRO must terminate the third level review upon receipt of the notice from the Plan Administrator or Claims Processor of the Plan Administrator's reconsideration.

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

- Your medical records;
- The attending health care professional's recommendation;

- Reports from appropriate health care professionals and other documents submitted by the Plan Administrator or Claims Processor, you or your treating provider;
- The terms of the Plan to ensure that the IRO's decision is not contrary to these terms;
- Appropriate practice guidelines, including evidence-based standards and other guidelines developed by the Federal government, national or professional medical societies, boards and associations;
- Any applicable clinical review criteria developed and used by the Claims Processor or Plan Administrator; and
- The opinion of the IRO's clinical reviewer(s) after considering the other sources referenced above.

The IRO must provide written notice of its decision within 30 days after it receives the request for the external review. The notice must be provided to you, the Plan Administrator or Claims Processor, and the Superintendent, and must include the following:

- A general description of the reason for the request for the review with enough information to identify the claim;
- The date the IRO was assigned by the Superintendent to conduct the external review;
- The dates over which the external review was conducted;
- The date of the IRO's decision;
- References to the evidence or documentation, including evidence-based standards, considered in reaching its decision; and
- The rationale for the decision.

External Reviews Involving Experimental and Investigational Treatment. With respect to external reviews involving experimental and investigational treatment, the IRO that is assigned by the Superintendent must select at least one clinical reviewer to conduct the external review and make a decision to uphold or reverse the Final Internal Adverse Benefit Determination based on the clinical reviewer(s) opinion. The IRO will select physicians or other health care professionals who meet the follow minimum qualifications to conduct the clinical review:

- The clinical reviewer(s) assigned by the IRO to conduct the external review shall have the same license as the health care provider of the service in question;
- The clinical reviewer(s) must be an expert in the treatment of the medical condition that is the subject of the external review through clinical experience, within the last three years, in the treatment of the covered person's condition and have knowledge of the requested health care service;
- The clinical reviewer(s) must hold a non-restricted license in the United States, and for physicians, hold a current certification by a recognized American medical specialty board in the area(s) appropriate to the subject of the external review; and

- The clinical reviewer(s) must have no history of disciplinary actions or sanctions that would raise a question as to the clinical reviewer's physical, mental, or professional competence or moral character.

The clinical reviewer(s) shall review all the information the Plan Administrator considered in making the Final Internal Adverse Benefit Determination, as well as any additional information previously provided by you within ten business days of receipt of notice by the Plan Administrator or Claims Processor, that the request for external review was complete.

The clinical reviewer(s) is not bound by the conclusions reached by the Plan Administrator or Claims Processor. The clinical reviewer will provide a written opinion to the IRO which shall include:

- A description of your condition;
- A description of the indicators relevant to determining whether there is sufficient evidence to demonstrate that the recommended or requested therapy is more likely than not to be more beneficial to you than standard therapies, and that the adverse risks of the requested therapy would not be substantially greater than those of available standard health care services;
- A description and analysis of any medical or scientific evidence considered in reaching the opinion;
- A description and analysis of any evidence-based standard considered; and
- Information on whether the reviewer's rationale for the opinion is based on whether the requested health care service has been approved by the federal Food and Drug Administration, if applicable for the condition, and whether medical or scientific evidence, or evidence-based standards, demonstrate that the expected benefits of the requested services are more likely than not to be beneficial to you than any available standard services, and that the adverse risks of the services would not be substantially greater than those of available standard services.

If there are multiple clinical reviewers, and the majority of the reviewers recommend the service should not be covered, the IRO will uphold the Final Internal Adverse Benefit Determination. If the majority of clinical reviewers recommend the service should be covered, the IRO will reverse the Final Internal Adverse Benefit Determination. If the reviewers are evenly split as to whether the Final Internal Adverse Benefit Determination should be reversed or upheld, the IRO shall obtain the opinion of an additional clinical reviewer in order for the IRO to make a decision based on the opinions of a majority of the clinical reviewers. The additional clinical reviewer selected shall use the same information to reach an opinion as the clinical reviewers who have already submitted their opinions. The selection of the additional clinical reviewer shall not extend the time within which the assigned IRO is required to make a decision.

Reversal of the Plan's decision. Upon receipt of a notice of an external review decision reversing the Final Internal Adverse Benefit Determination, the Plan must immediately pay the claim. For questions about your appeal rights or for assistance, you can contact:

Ohio Department of Insurance
ATTN: Consumer Affairs
50 West Town Street, Suite 300, Columbus, OH 43215
800-686-1526 / 614-644-2673
614-644-3744 (fax)
614-644-3745 (TDD)
Contact ODI Consumer Affairs:
https://secured.insurance.ohio.gov/ConsumServ/ConServComments.asp
File a Consumer Complaint:
http://insurance.ohio.gov/Consumer/OCS/Pages/ConsCompl.aspx

APPEALING A PHARMACY BENEFITS CLAIM

When appealing a pharmacy benefits claim, please submit a written appeal directly to Express Scripts, the pharmacy benefits manager, at:

For a clinical review* appeal:

VIA U.S. MAIL:	Express Scripts Attn: Clinical Appeals Department P.O. Box 66588 St. Louis, MO 63166-6588
VIA FAX:	(877) 852-4070

For an administrative review* appeal:

VIA U.S. MAIL:	Express Scripts Attn: Administrative Appeals Department P.O. Box 66587 St. Louis, MO 63166-6587
VIA FAX:	(877) 328-9660

* Please review your initial benefits denial letter for additional information on whether your appeal is clinical or administrative.

An urgent appeal may be submitted if in the opinion of the attending provider, the application of the time periods for making a non-urgent care determination could seriously jeopardize the life or health of the patient or the patient's ability to regain maximum function or would subject the

patient to severe pain that cannot be adequately managed without the care or treatment that is the subject of the claim.

NOTE: Urgent pharmacy appeals must be submitted by phone at (800) 753-2851 or fax at (877) 852-4070. Claims and appeals submitted by mail will not be considered for urgent processing unless a subsequent phone call or fax identifies the appeal as urgent.

Express Scripts will comply with both the First Level Appeals Procedure and Third Level (External) Appeals Procedure (if applicable) discussed above. Accordingly, if you are not satisfied with Express Scripts' review of your First Level Appeal, the Second Level Appeals Procedure discussed above is not applicable for pharmacy claims. Rather, please review the Third Level (External) Appeals Procedure to determine whether you have the opportunity to initiate a request for external review with Express Scripts.

When appealing a pharmacy benefits claim, please do not submit any appeals or requests for external review to the medical Claims Processor.

ASSIGNMENT OF BENEFITS

An arrangement whereby the Plan Participant assigns their right to seek and receive payment of eligible Plan benefits. Plan Participants cannot assign, pledge, borrow against or otherwise promise any benefits payable under the Plan before receipt of the benefit. However, benefits will be provided to a Participant's qualified dependent if required by a Qualified Medical Child Support Order or National Medical Support Notice. In addition, subject to the written direction of a Participant, all or a portion of benefits provided by the Plan may, at the option of the Plan and unless a Participant requests otherwise in writing, be paid directly to the person rendering such service. The payment of benefits directly to a provider of services, if any, is done as a convenience to the Plan Participant and does not constitute an assignment of rights or benefits under the Plan. Providers of services are not, and shall not be construed as, either "Participants" or "beneficiaries" under this Plan and have no rights to receive benefits from the Plan or to pursue legal causes of action on behalf of (or in place of) Participants and beneficiaries under any circumstances. Any payment made by the Plan in good faith pursuant to this provision shall fully discharge the Plan and the Employer to the extent of such payment.

BENEFIT BOOK

The Company will issue to each Employee under the Plan, a document that shall summarize the benefits to which the person is entitled, to whom the benefits are payable, and the provisions of the Plan principally affecting the Employee. This document serves as the Benefit Book for the Company.

CLAIM AUDIT

Once a written claim for benefits is received, the Plan Administrator, at its discretion, may elect to have such claim reviewed or audited for accuracy, Reasonableness and/or the Usual and Customary nature of charges as part of the adjudication process. This process may include, but not be limited to, identifying charges for items/services that may not be covered or may not have

been delivered, duplicate charges and charges beyond the Reasonable and/or Usual and Customary guidelines as determined by the Plan Administrator.

COMPLIANCE

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

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

Same as Employer.

CONTRIBUTIONS

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

FUNDING

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

LIENS

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

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

NO WAIVER

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

PLAN IS NOT A CONTRACT

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

PLAN AMENDMENT, MODIFICATION OR TERMINATION

The Company reserves the right to amend, modify, revoke or terminate the Plan, in whole or in part, at any time and such amendment, modification, revocation or termination of the Plan shall be made by a written Plan endorsement signed by an authorized representative of the Company.

Any such changes to the Plan, which affect Covered Persons, will be communicated to such Covered Persons by the Plan Administrator. Upon termination of the Plan, the rights of Covered Persons to benefits are limited to claims incurred and due up to the date of termination.

REIMBURSEMENT AND SUBROGATION PROVISION

By enrolling for coverage under the Plan, Covered Persons understand and agree that if Sickness, Injury or other condition to a Covered Person is caused by an act or omission of a third party, the Plan may, if the requirements of this Section (F.) are satisfied, advance benefits for medical expenses incurred as a consequence of the act or omission. In addition, Covered Persons agree that if any payments are made now or in the future, to or on behalf of a Covered Person, and such payments have arisen as a result of an Injury, Illness or other condition for which the Covered Person has, or may have, or asserts any claim or right of recovery (including, without limitation) any claims for medical expenses, pain and suffering, loss of consortium, consequential, punitive, exemplary, and/or other damages) against any first and/or third party or parties, then any benefits advanced by this Plan for such medical expenses shall be made on the condition, and with the agreement and understanding, that the Covered Person shall reimburse the Plan to the extent of (but not 58 exceeding) any amount or amounts recovered by or on behalf of the Covered Person (including the Covered Person's estate) from any first and/or third party by way of settlement, or in satisfaction of any judgment relating to said claim. For example, should the Plan advance benefits totaling $90,000 on behalf of a Covered Person involved in a subrogation or right of recovery matter, and that Covered Person receives a settlement in the amount of $60,000, the Plan would be entitled to recover the $60,000 amount which, assuming no other source of recovery is available now or in the future, would serve to fully satisfy the Plan's subrogation interest in that matter. The Plan shall maintain a lien on any such recovery and be entitled to reimbursement in full in accordance with this Section, irrespective of whether the Covered Person has been fully compensated or made whole for all or any of said claims. The Plan shall be entitled to such reimbursement from first dollar recovery amounts received by the Covered Person, and as such, shall specifically have priority over any other interests including without limitation attorney fees and supersede the Covered Person's right to be made whole. As security for the Plan's rights to such reimbursements, the Plan shall be subrogated to all claims, demands, actions or rights of recovery of the Covered Person against any first and/or third party or parties (or their insurers) to the extent of any and all benefits advanced by the Plan. The Covered Person agrees to cooperate with and assist the Plan in obtaining or providing any information or document production necessary to support the subrogation rights of the Plan. Any Covered Person that takes any action prejudicing or otherwise impairing the subrogation rights of the Plan shall be liable to the Plan for any losses, including out of pocket expenses, to the Plan caused by such action. Any action prejudicing or otherwise impairing the subrogation rights of the Plan made by the Covered Person shall also terminate the Plan's obligation to advance benefits to or on behalf of the Covered Person. The Claims Administrator shall withhold payments of claims made under this Plan to the extent that the Claims Administrator has reason to believe that said claims arise as a result of any act of a third party.

The subrogation rights of the Plan, as set forth in this Section, shall also apply to payments made by the Covered Person's own insurance or his own or any auto insurance, including, but not limited to, medical payments coverage, any excess, umbrella, uninsured/underinsured motorists

coverage, personal protection policies issued under "no-fault" coverage provisions, and any other applicable insurance coverage (with the exception of payment for property damage).

The Plan shall have no obligation to share the cost of, or pay any part of, the Covered Person's attorney fees and costs incurred in obtaining any recovery against the third party. The Plan retains the right, at its sole discretion, to commence litigation against third parties, file claims or take any other action on behalf of the Covered Person, respective to the Plan's advanced benefits, should the Covered Person not commence litigation, file claims or take appropriate action within a reasonable period of time. The Covered Person must notify the Plan of the Covered Person's claim at the time the Covered Person files a lawsuit to recover damages or 90 days prior to the expiration of the statute of limitations, whichever is sooner. Should the Covered Person fail to comply with the requirements of this Section, the 59 Covered Person shall pay the Plan's reasonable collection costs and attorney fees incurred in collecting amounts due under the Plan. For purposes of this Section and any Agreement executed pursuant hereto, the term Covered Person shall include the heirs, guardians, executors or other representatives of the Covered Person. For purposes of this Section and any Agreement executed pursuant hereto, the spouses, children and other Dependents as Covered Persons under the Plan are third party beneficiaries under the Plan and therefore subject to the same duties and obligations as Employees who are Covered Persons under the Plan.

RIGHT TO RECEIVE AND RELEASE NECESSARY INFORMATION

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

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

RIGHTS OF RECOVERY

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

SEVERABILITY

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

SUBMISSION OF CLAIM

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

SYSTEM FOR PROCESSING CLAIMS

Claims will be processed on the following basis: 1) first, any non-covered services or services in excess of Plan provisions will be subtracted from billed charges; 2) then, Reasonable and/or Usual and Customary limitations will be applied (if applicable); 3) then, any reduction authorized by agreements with provider networks will be applied to charges from network providers; and 4) then, any Deductible/Co-Insurance or uncollected co-pays will be deducted from the remaining eligible amount prior to payment.

TYPE OF ADMINISTRATION

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

COORDINATION OF BENEFITS (COB)

The Coordination of Benefits provision is intended to prevent payments of benefits that exceed expenses. It applies when any other plan or plans also cover the person covered by this Plan. When more than one coverage exists, one plan normally pays its benefits in full and the other plans pay a reduced benefit. This Plan will always pay either its benefits in full or a reduced amount which, when added to the benefits payable by the other plan or plans, will not exceed 100% of allowable expenses. Only the amount paid by the Plan will be charged against the Plan maximums. See Schedule of Covered Expenses and Provisions to determine the type of Coordination of Benefits this Plan provides.

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

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

   If the parent with custody has not remarried:

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

   If the parent with custody has remarried:

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

   There may be a court decree that makes one parent financially responsible for the health care expenses incurred by the child. When such coverage is engaged and a plan covers the child as a Dependent of that parent, its benefits are payable before those of a plan that covers the child as a Dependent of the parent without financial responsibility.
5. If a plan covers an individual who is also allowed to be covered by this Plan pursuant to COBRA continuation coverage, its benefits are payable before this Plan.
6. If items 1, 2, 3, 4 or 5 do not apply, the benefits of a plan that has covered the person for the longest period of time will be payable before those of the other plan.

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

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

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

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

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

COMPLIANCE REGULATIONS

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

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

Also, under federal law, plans and issuers may not set the level of benefits or out-of-pocket costs so that any later portion of the 48-hour (or 96 hour) stay is treated in a manner less favorable to the mother or newborn than any earlier portion of the stay.
In addition, a plan or issuer may not, under federal law, require that a Physician or other health care provider obtain authorization for prescribing a length of stay of up to 48 hours (or 96 hours). However, to use certain providers or facilities, or to reduce your out-of-pocket costs, you may be required to obtain pre-certification. For information on pre-certification, contact your Plan Administrator.

SOURCE OF INJURY RESTRICTIONS

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

WELLNESS VS. RISK FACTORS

The Plan will not charge Covered Persons who have adverse health factors, or who participate in certain adverse lifestyle activities, more than those similarly situated Covered Persons who do not have such factors or participate in such activities.* Further, the Plan will not provide rewards to Covered Persons who participate in, or meet the requirements of, positive lifestyle activities in excess of what is offered to those similarly situated Covered Persons who do not participate in, or meet the requirements of, such activities.*
* Except as such differential treatment is allowed through the incorporation of wellness program(s) meeting federally approved guidelines.

FAMILY MEDICAL LEAVE ACT (FMLA)

The following applies to companies with 50 or more employees

If the Covered Person is entitled to, and elects to take, a family or medical leave solely under the terms of the Family and Medical Leave Act of 1993 (FMLA), the Covered Person and his covered Dependents shall continue to be covered under this Plan while the Covered Person is absent from work on an FMLA leave as if there were no interruption of active employment. Provided the applicable premium is paid, such coverage will continue until the earlier of the expiration of such leave or the date notice is given to the Company that the Covered Person does not intend to return to work at the end of the FMLA leave.

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

Military Leaves

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

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

GENETIC INFORMATION

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

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

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

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

NOTICE OF CONTINUATION COVERAGE RIGHTS UNDER COBRA

INTRODUCTION

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

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

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

WHAT IS COBRA CONTINUATION COVERAGE?

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

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

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

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

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

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

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

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

WHEN IS COBRA COVERAGE AVAILABLE?

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

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

HOW IS COBRA COVERAGE PROVIDED?

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

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

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

DISABILITY EXTENSION OF 18-MONTH PERIOD OF CONTINUATION COVERAGE

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

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

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

ARE THERE OTHER COVERAGE OPTIONS BESIDES COBRA CONTINUATION COVERAGE?

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

You should compare your other coverage options with COBRA continuation coverage and choose the coverage that is best for you. For example, if you move to other coverage you may pay more out of pocket than you would under COBRA because the new coverage may impose a new deductible.

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

WHAT IS THE HEALTH INSURANCE MARKETPLACE?

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

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

WHEN CAN I ENROLL IN MARKETPLACE COVERAGE?

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

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

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

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

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

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

WHAT FACTORS SHOULD I CONSIDER WHEN CHOOSING COVERAGE OPTIONS?

When considering your options for health coverage, you may want to think about:

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

IF YOU HAVE QUESTIONS

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

KEEP YOUR PLAN INFORMED OF ADDRESS CHANGES

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

PLAN CONTACT INFORMATION

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

PLAN ADMINISTRATION

Plan Administrator

Any duly authorized officer of the Plan Administrator may exercise any authority or responsibility allocated or reserved to the Plan Administrator under this Plan.

The Plan Administrator shall have the right to hire all persons providing services to the Plan and to appoint a Claims Administrator to receive, initially review, and process claims for benefits.

The Plan Administrator shall have the authority and responsibility to call and attend the meetings at which this Plan's funding policy and method are reestablished and reviewed.

The Plan Administrator shall have the discretionary authority and responsibility to construe and interpret terms of this Plan; to make factual determinations, including all questions of eligibility; to establish the policies, interpretations, practices, and procedures of this Plan; to adopt and implement procedures, including care management, in its sole discretion; to decide whether care or treatment is Medically Necessary and whether a charge meets Reasonable and Customary criteria; and to render final decisions on review of claims as described in this Benefit Book. All interpretations under the Plan, and all determinations of fact made in good faith by the Plan Administrator will be final and binding on the Covered Persons and beneficiaries and all other interested parties.

All of the terms of this Plan may be amended at any time by the Plan Sponsor. Not by way of limitation, terms of the Plan that may be amended shall include (i) the definitions of Eligible Employees and Dependents, (ii) Plan terms defining the types and amounts of benefits and conditions under which benefits will be payable (e.g. clarifications of medical necessity or experimental care), and (iii) the terms of the care management Program.

All amendments to this Plan shall be approved by the Board of Trustees of the Plan Sponsor; and shall be committed to writing and signed by a member of the Board of Trustees, the Executive Director of the Plan Sponsor, or another office or employee of the Plan Sponsor who is authorized by the Board of Trustees to execute amendments to this Plan.
The Plan Sponsor shall promptly notify the Claims Administrator, Utilization Review Manager and all Employers of any amendment to this Plan. Employers shall be responsible for advising Eligible Employees of any Plan amendments unless the Plan Sponsor and the Employer agree otherwise. The Plan Sponsor shall provide notice of all Plan amendments to any individuals who have elected, or are eligible to elect, to continue coverage under this Plan pursuant to applicable law.

The Plan Administrator has a duty to maintain records and to file reports required by law. This duty shall include complying with applicable reporting or disclosure requirements.

The Plan Administrator shall forward applications to the Claims Administrator and notify the Claims Administrator in writing of changes with respect to Covered Persons and other facts necessary for determining Plan coverages and for processing claims for Plan benefits.

The Plan Administrator or any duly authorized representative of the Plan Administrator will have the right to examine any claim for benefits under this Plan, whether assigned or unassigned. The Plan Administrator will, at the Plan's expense, have the right to have the person whose Sickness or Injury is the basis for a claim examined as often as reasonably required during the time a claim is pending under the Plan. The Plan Administrator will not discriminate in treatment of individuals in similar situations, and the Claims Administrator is not obligated to inquire into the circumstances.

For purposes of determining the applicability of the coordination of benefits and subrogation provisions of this Plan or any provision with a similar purpose that is in another plan and for purposes of implementing those provisions, the Plan Administrator or Claims Administrator may release necessary information to, or obtain necessary information from, any other organization or individual.

The Plan Administrator shall have the unlimited right to amend this Plan in any and all respects at any time, and from time to time, without prior notice to any Covered Person or Eligible Dependent. Any such amendment shall be by a written resolution of the majority of the Board of Trustees and shall become effective as of the date specified in the enabling resolution. Any such amendment shall be binding upon all Covered Persons (including those Covered Persons on continuation coverage). However, the responsibilities of the named fiduciaries and their delegates shall not be increased or changed by amendment without their written consent.

An amendment to the Plan may be retroactively effective but shall not adversely affect the rights of a Covered Person under this Plan for covered medical expenses provided after the effective date of the amendment but before the amendment is adopted.

The Plan shall furnish a summary of a material reduction in covered services or benefits to Covered Persons within 60 days after the change has been adopted by the Plan.

Notwithstanding that the Plan is established with the intention that it be maintained indefinitely, the Plan Administrator reserves the unlimited right to terminate or merge the Plan at any time without prior written notice to any Covered Person. Such termination shall be evidenced by a resolution of the majority of the Board of Trustees. The date of the merger or termination will be the date specified in the enabling resolution. Termination of the Plan shall apply to all Covered Persons (including those on continuation coverage).

The Plan Administrator shall perform all other responsibilities allocated to the Plan Administrator in the instrument appointing the Plan Administrator.

Claims Administrator

The Claims Administrator shall have the authority and responsibility to administer the Plan's claims procedures, to process claims for benefits in accordance with Plan provisions, and to file claims with the insurance companies, if any, who issue stop loss insurance policies to the Plan.

The Plan Administrator must furnish the Claims Administrator all information the Claims Administrator reasonably requires as to matters pertaining to this Plan. All material which may have a bearing on coverage or contributions will be open for inspection by the Claims Administrator at all reasonable times during the continuance of this Plan and until the final determination of all rights and obligations under this Plan.

Covered Person

As a Covered Person in this Plan, the Employee is entitled to certain rights. All Covered Persons shall be entitled to:

1. Examine, without charge, at the Plan Administrator's office, all Benefit Books, including insurance contracts, collective bargaining agreements, and copies of documents, such as detailed annual reports and Plan descriptions.

2. Obtain copies of all Benefit Books and other Plan information upon written request to the Plan Administrator. (The Plan Administrator may make a reasonable charge for the copies.)

STANDARDS FOR PRIVACY OF INDIVIDUALLY IDENTIFIABLE HEALTH INFORMATION (THE "PRIVACY STANDARDS")

ISSUED PURSUANT TO

The Health Insurance Portability and Accountability Act of 1996, as amended ("HIPAA")

1. **Disclosure of Summary Health Information to the Plan Sponsor**

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

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

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

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

   a. Not use or further disclose PHI other than as permitted or required by the Benefit Books or as required by law (as defined in the Privacy Standards);

   b. Ensure that any agents, including a subcontractor, to whom the Plan Sponsor provides PHI received from the Plan agree to the same restrictions and conditions that apply to the Plan Sponsor with respect to such PHI;

   c. Not use or disclose PHI for employment-related actions and decisions or in connection with any other benefit or employee benefit plan of the Plan Sponsor, except pursuant to an authorization which meets the requirements of the Privacy Standards;

   d. Report to the Plan any PHI use or disclosure that is inconsistent with the uses or disclosures provided for of which the Plan Sponsor becomes aware;

   e. Make available PHI in accordance with Section 164.524 of the Privacy Standards (45 CFR 164.524);

   f. Make available PHI for amendment and incorporate any amendments to PHI in accordance with Section 164.526 of the Privacy Standards (45 CFR 164.526);

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

   h. Make its internal practices, books and records relating to the use and disclosure of PHI received from the Plan available to the Secretary of the U.S. Department of Health and Human Services ("HHS"), or any other officer or employee of HHS to whom the authority involved has been delegated, for purposes of determining compliance by the Plan with Part 164, Subpart E, of the Privacy Standards (45 CFR 164.500 *et seq*);

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

j. Ensure that adequate separation between the Plan and the Plan Sponsor, as required in Section 164.504(f)(2)(iii) of the Privacy Standards (45 CFR 164.504(f)(2)(iii)), is established as follows:

   i. The access to and use of PHI by the individuals described in the Key Information section at the beginning of this document shall be restricted to the Plan Administration functions that the Plan Sponsor performs for the Plan.

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

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

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

3. Disclosure of Certain Enrollment Information to the Plan Sponsor

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

4. Other Disclosures and Uses of PHI

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

NOTICE OF PRIVACY PRACTICES

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

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

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

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

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

THE PLAN'S RESPONSIBILITIES

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

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

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

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

- disclosures to or requests by a health care provider for treatment;
- uses or disclosures made to the individual;

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

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

Permissible USES AND DISCLOSURES OF PHI

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

TREATMENT, PAYMENT AND HEALTH CARE OPERATIONS

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

TREATMENT

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

PAYMENT

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

HEALTH CARE OPERATIONS

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

POTENTIAL IMPACT OF STATE LAW

The HIPAA Privacy Regulations generally do not "preempt" (or take precedence over) state privacy or other applicable laws that provide individuals greater privacy protections. As a result, to the extent state law applies, the privacy laws of a particular state, or other federal laws, rather than the HIPAA Privacy Regulations, might impose a privacy standard under

which the Plan will be required to operate. For example, where such laws have been enacted, the Plan will follow more stringent state privacy laws that relate to uses and disclosures of PHI concerning HIV or AIDS, mental health, substance abuse/chemical dependency, genetic testing, reproductive rights, etc.

OTHER Permissible USES AND DISCLOSURES OF PHI

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

REQUIRED BY LAW

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

PUBLIC HEALTH ACTIVITIES

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

HEALTH OVERSIGHT ACTIVITIES

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

ABUSE OR NEGLECT

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

LEGAL PROCEEDINGS

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

LAW ENFORCEMENT

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

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

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

RESEARCH

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

TO PREVENT A SERIOUS THREAT TO HEALTH OR SAFETY

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

MILITARY ACTIVITY AND NATIONAL SECURITY, PROTECTIVE SERVICES

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

INMATES

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

WORKERS' COMPENSATION

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

EMERGENCY SITUATIONS

The Plan may disclose PHI of a Covered Person in an emergency situation, or if the Covered Person is incapacitated or not present, to a family member, close personal

friend, authorized disaster relief agency, or any other person previously identified by the Covered Person. The Plan will use professional judgment and experience to determine if the disclosure is in the best interests of the Covered Person. If the disclosure is in the best interest of the Covered Person, the Plan will disclose only the PHI that is directly relevant to the person's involvement in the care of the Covered Person.

FUNDRAISING ACTIVITIES

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

GROUP HEALTH PLAN DISCLOSURES

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

UNDERWRITING PURPOSES

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

OTHERS INVOLVED IN YOUR HEALTH CARE

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

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

REQUIRED DISCLOSURES OF PHI

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

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

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

DISCLOSURES TO COVERED PERSONS

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

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

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

BUSINESS ASSOCIATES

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

OTHER COVERED ENTITIES

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

PLAN SPONSOR

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

USES AND DISCLOSURES OF PHI THAT REQUIRE A COVERED PERSON'S AUTHORIZATION

SALE OF PHI

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

MARKETING

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

PSYCHOTHERAPY NOTES

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

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

A COVERED PERSON'S RIGHTS

The following is a description of a Covered Person's rights with respect to PHI:

RIGHT TO REQUEST A RESTRICTION

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

A Covered Person may request a restriction by contacting the person(s) or office identified under Plan Contact Information in the Key Information section at the beginning of this document. It is important that the Covered Person directs his

request for restriction to this individual or office so that the Plan can begin to process Your request. Requests sent to individuals or offices other than the one indicated might delay processing the request.

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

RIGHT TO REQUEST CONFIDENTIAL COMMUNICATIONS

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

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

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

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

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

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

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

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

RIGHT TO INSPECT AND COPY

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

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

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

RIGHT TO AMEND

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

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

RIGHT OF AN ACCOUNTING

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

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

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

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

RIGHT TO A COPY OF THIS NOTICE

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

COMPLAINTS

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

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

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

STANDARDS FOR SECURITY OF INDIVIDUALLY IDENTIFIABLE HEALTH INFORMATION (THE "SECURITY STANDARDS")

1. DEFINITIONS

a. The term "Electronic Protected Health Information" ("EPHI") has the meaning set forth in Section 160.103 of the Security Standards (45 C.F.R. 160.103) and generally means individually identifiable health information that is transmitted or maintained in any electronic media.

b. The term "Security Incidents" has the meaning set forth in Section 164.304 of the Security Standards (45 C.F.R. 164.304) and generally means the attempted or successful unauthorized access, use, disclosure, modification, or destruction of information or interference with systems operations in an information system.

2. PLAN SPONSOR OBLIGATIONS

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

a. Plan Sponsor shall implement administrative, physical, and technical safeguards that reasonably and appropriately protect the confidentiality, integrity, and availability of EPHI that Plan Sponsor creates, receives, maintains, or transmits on behalf of the Plan;

b. Plan Sponsor shall ensure that the adequate separation that is required by Section 164.504 (f) (2) (iii) of the Security Standards (45 C.F.R. 164.504 (f) (2) (iii)) is supported by reasonable and appropriate security measures;

c. Plan Sponsor shall ensure that any agents, including a subcontractor, to whom it provides EPHI agrees to implement reasonable and appropriate security measures to protect such EPHI; and

d. Plan Sponsor shall report to the Plan any Security Incidents of which it becomes aware as described below:

   i.) Plan Sponsor shall report to the Plan within a reasonable time after the Plan Sponsor becomes aware of any Security Incident that results in unauthorized access, use, disclosure, modification, or destruction of the Plan's EPHI; and

   ii.) Plan Sponsor shall report to the Plan any other Security Incident on an aggregate basis every quarter, or more frequently upon the Plan's request.

e. Plan Sponsor shall make its internal practices, books, and records relating to its compliance with the Security Standards to the Secretary of the U.S. Department of Health and Human Services ("HHS"), or any other officer or employee of HHS to whom the authority involved has been delegated, for purposes of determining compliance by the Plan with the Security Standards.