

Krapf Group

Employee Benefit Plan

Plan Document

Table of Contents

Plan Specifications.....	1
How to File a Claim.....	2
Schedule of Benefits – MEC Plan Products.....	3
Eligibility	9
Benefits of Coverage	16
General Exclusions	17
Definitions	18
General Claim Information.....	23

Plan Specifications

Company	Krapf Group
Plan Administrator, Plan Fiduciary, and Agent for Process of Legal Service	Krapf Group 1030 Andrew Drive West Chester, PA 19380
Plan Name	Krapf Group Employee Benefit Plan
Plan Supervisor	Key Benefit Administrators, Inc. P.O. Box 2217 Ft. Mill, SC 29716-2217 (800) 331-4757
Type of Administration	Contract Administration
Participant	Employees of Krapf Group as defined herein
Original Plan Effective Date	December 1, 2014
Current Plan Effective Date	January 1, 2027
Annual Plan Renewal Date	January 1
Group Number	MVP01644
Employer Identification Number	46-3426293

How to File a Claim

How to File a Claim

Instructions for filing a claim for yourself and/or your dependents are as follows if your healthcare provider is unwilling to do so for you:

The initial report of a claim should be done on the Benefit Request claim form that you can get from your employer. You should complete the Patient Information section. If you wish your medical benefits paid directly to your benefit providers, sign the form in the designated area. A separate form should be submitted for each family member.

Have your healthcare provider give you a complete itemized bill that you can attach to the Benefit Request claim form. An itemized bill is one that shows a patient's name, relationship to the plan participant, date of service, the type of service rendered and the nature of the accident or illness being treated. If this information is missing, please write it on the bill yourself and sign your name.

Send the completed Benefit Request claim form and the itemized bill directly to the plan supervisor at the address shown on the plan specifications of this document. Please note that if additional information is needed for payment of a claim, the plan supervisor will need to request this information before your claim can be processed.

Claims will be processed based upon the billing codes and other billing information of your healthcare provider.

Provider Balance Billing

If a healthcare provider bills you for amounts that exceed the patient responsibility amount on the Explanation of Benefits for a claim, assistance is available from the Plan to help resolve the charges. If you negotiate with the provider yourself, you may be responsible for paying the provider more than patient responsibility amount on the Explanation of Benefits for a claim. You do not have the authority to negotiate with the provider about how much the Plan will pay the provider, and you may be responsible to the provider if you agree that the provider will be paid more than the Plan agrees to pay. If you experience "balance billing" or "surprise billing" please call 855-264-1797 or the phone number listed on your Explanation of Benefits and the Plan will make patient advocacy services available to resolve the balance bill with the provider.

Time Limit for Filing a Claim

You must submit claims for benefits under this plan within six months from the date that you received the service or supply. If through no fault of your own, you are not able to meet the deadline for filing the claim, your claim will still be accepted if it is received by us within 4 months after the end of the annual plan year in which the claim was incurred. Such notice must be received by us in writing with information sufficient to process the claim. When we receive sufficient written notice of a claim, we may require additional information. We will not cover charges if the required information or authorization for the release of the claim is not furnished to us within this filing time limit.

Schedule of Benefits – MEC Plan Products

The benefits listed below are for the MEC portion of your Plan benefits.

Patient Protection and Affordable Care Act (“PPACA”) Compliance:

The Plan will at all times be in compliance with PPACA rules and regulations.

Notes regarding the Plan

This Plan provides coverage for preventive services. **Claims will be processed based upon the billing codes and other billing information of your healthcare provider. Services that are not Preventive Services as defined by the Patient Protection and Affordable Care Act (“PPACA”) will not be covered by the MEC Plan.**

Effective Date of Coverage

The first of the month following the Employer’s eligibility waiting period.

Child Maximum Age

To the end of the month when the child attains age 26.

Deductibles

Individual	None
Family	None

Individual Coinsurance

Plan pays 100%

The plan pays the above percentages of eligible charges, unless otherwise stated.

Out-of-pocket Maximums

Individual Maximum	None
Family Maximum	None

Preventive/Wellness

	Limitations
100%	This benefit is limited to the following list of services.

The following are considered “Preventive Services” and are covered by the Plan and payable at 100% of eligible charges which are subject to reasonable and customary fee limitations. If a listed service does not specify the frequency, method, treatment or setting for the provision of the service, the Plan will use reasonable medical management techniques to determine any coverage limitations.

Office exams billed with the below services or with a covered preventive diagnosis are covered under the Plan.

Schedule of Benefits – MEC Plan Products

Covered Preventive Services for Adults (ages 18 and older)

1. **Abdominal Aortic Aneurysm** one time screening for age 65-75
2. **Unhealthy Alcohol or Drug use** screening and counseling
3. **Anxiety screening** in adults
4. **Aspirin** use for adults ages 50-59 to prevent Cardiovascular Disease and Colorectal Cancer when prescribed by a physician
5. **Blood Pressure** screening for all adults
6. **Cholesterol** screening for adults
7. **Colorectal Cancer** screening for adults starting at age 45 and continuing until age 75. This does not include Cologuard or FIT-DNA testing. Cologuard or FIT-DNA testing is not covered under the Plan.
8. **Depression** screening for adults
9. **Type 2 Diabetes** screening for adults
10. **Diet** counseling for adults
11. **Fall Prevention** to include physical therapy to prevent fall in community dwellings age 65 and older
12. **Hepatitis B** screening for adults
13. **Hepatitis C** screening for adults at high risk and one time for everyone between the ages of 18 and 79 years old.
14. **HIV** screening for all adults
15. **Immunization** vaccines for adults:
 - Covid 19
 - Hepatitis A
 - Hepatitis B
 - Herpes Zoster
 - Human Papillomavirus
 - Influenza (Flu Shot)
 - Measles, Mumps, Rubella
 - Meningococcal
 - Mpox
 - Pneumococcal
 - RSV
 - Tetanus, Diphtheria, Pertussis
 - Varicella
16. **Lung Cancer Screening** for adults age 50-80 who are at high risk because they smoke 20 packs a year (or have quit in the past 15 years)
17. **Obesity** screening and counseling for all adults
18. **Sexually Transmitted Infection (STI)** prevention counseling and screening for adults
19. **Skin Cancer** behavioral counseling for adults to age 24 with fair skin

Schedule of Benefits – MEC Plan Products

20. **Tobacco Use** screening, counseling and cessation interventions for all adults
21. **Syphilis** screening for adults
22. **Latent tuberculosis infection** screening for adults.
23. **Statin preventive medication** for adults ages 40-75 years with no history of cardiovascular disease, 1 or more cardiovascular disease risk factors and a calculated 10 year cardiovascular disease event risk of 10% or greater.
24. **Prevention of Human Immunodeficiency Virus (HIV) Infection: Preexposure Prophylaxis (PrEP)** for person considered at high risk of HIV acquisition per USPSTF guidelines on identification of persons at high risk. The USPSTF recommends that the following persons be considered for PrEP: 1) Men who have sex with men, are sexually active, and have one of the following characteristics: (a) A serodiscordant sex partner (i.e. in a sexual relationship with a partner living with HIV), (b) Inconsistent use of condoms during receptive or insertive anal sex, or (c) A sexually transmitted infection (STI) with syphilis, gonorrhea, or chlamydia within the past 6 months; 2) Heterosexually active women and men who have 1 of the following characteristics: (a) A serodiscordant sex partner (i.e. in a sexual relationship with a partner living with HIV), (b) Inconsistent use of condoms during sex with a partner whose HIV status is unknown and who is at high risk (i.e. a person who injects drugs or a man who has sex with men and women), or (c) An STI with syphilis or gonorrhea within the past 6 months; and 3) Persons who inject drugs and have 1 of the following characteristics: (a) Shared use of drug injection equipment or (b) risk of sexual acquisition of HIV (see above). It is important to note that men who have sex with men and heterosexually active persons are not considered to be at high risk if they are in a mutually monogamous relationship with a partner who has recently tested negative for HIV. In addition, all persons being considered for PrEP must have a recently documented negative HIV test result. Prior authorization is required. If you have questions about the prior authorization process, please contact the Plan Supervisor. The following additional services are covered when provided to assess whether to start/re-start PrEP or keep a person on PrEP medications:
 - HIV testing – Prior to or at the start of PrEP and every 3 months while taking PrEP
 - Hep B Testing – Prior to or at start of PrEP
 - Hep C Testing – Prior to or at the start of PrEP and thereafter
 - Creatinine testing – At the start of PrEP and while on PrEP
 - eCrCl or eGFR calculations - At the start of PrEP and while on PrEP
 - Pregnancy Testing – Persons with childbearing potential - At the start of PrEP and while on PrEP
 - STI Screening and Counseling - At the start of PrEP and while on PrEP. Includes testing for syphilis. Includes multiple anatomic site testing for gonorrhea and chlamydia
 - Adherence Counseling – On a “Regular” basis
 - Office visits associated each of the above services if the service (a) is not billed separately from the office visit, and (b) the primary purpose of the visit is the delivery of the recommended service.

The Plan covers PrEP related services at frequencies that are consistent with CDC guidelines.

Schedule of Benefits – MEC Plan Products

Covered Preventive Services for Women, Including Pregnant Women

1. **Anemia** screening on a routine basis for pregnant women
2. **Aspirin** for pregnant women at high risk for preeclampsia.
3. **Bacteriuria** urinary tract or other infection screening for pregnant women
4. **BRCA** counseling and genetic testing for women at higher risk
5. **Breast Cancer Mammography** screenings every 1 to 2 years for women age 40 and over, including additional screenings (e.g., another mammogram, an MRI or an ultrasound) and diagnostic pathology screening evaluations as needed to complete the screening process
6. **Breast Cancer Chemoprevention** counseling as well as breast cancer testing and medications for women with increased risk for breast cancer
7. **Breastfeeding** comprehensive support and counseling from trained providers, as well as access to breastfeeding supplies, for pregnant and nursing women.
8. **Cervical Cancer** screening, including primary hrHPV testing and patient-collected hrHPV testing, and additional testing (e.g., cytology, biopsy, colposcopy, extended genotyping, dual stain) and pathologic evaluation as needed to complete the screening process
9. **Chlamydia Infection** screening
10. **Contraception:** For adolescent and adult women Food and Drug Administration-approved, granted, or cleared contraceptive methods (including during the post-partem period), sterilization procedures, and patient screening, education and counseling and follow-up care (including management, evaluation, and changes) and the removal, continuation and discontinuation of contraceptive), not including abortifacient drugs
11. **Diabetes screening** for women with a history of gestational diabetes who are not currently pregnant and who have not previously been diagnosed with type 2 diabetes.
12. **Domestic and interpersonal violence** screening and counseling for all women
13. **Folic Acid** supplements for women who may become pregnant when prescribed by a physician
14. **Gestational diabetes** screening
15. **Gonorrhea** screening for all women
16. **Hepatitis B** screening for pregnant women
17. **Human Immunodeficiency Virus (HIV)** screening and counseling
18. **Human Papillomavirus (HPV) DNA Test:** HPV DNA testing every three years for women with normal cytology results who are 30 or older
19. **Osteoporosis** screening age 65 and older and postmenopausal women at increased risk
20. **Hypertension screening** in pregnant women with blood pressure measurements throughout pregnancy.
21. **Routine prenatal visits** for pregnant women
22. **Rh Incompatibility** screening for all pregnant women and follow-up testing
23. **Tobacco Use** screening and interventions for all women, and expanded counseling for pregnant tobacco users
24. **Sexually Transmitted Infections (STI)** counseling

Schedule of Benefits – MEC Plan Products

25. **Syphilis** screening
26. **Urinary Incontinence** screening
27. **Well-woman visits** to obtain recommended preventive services
28. **Perinatal Depression** counseling interventions for pregnant and postpartum persons at risk.
29. **Anxiety screening** in adolescent women and adult women, including but not limited to, those who are pregnant or postpartum.
30. **Healthy weight and weight gain in pregnancy** behavioral counseling interventions for pregnant persons.

Covered Preventive Services for Children

1. **Alcohol and Drug Use** assessments
2. **Anxiety** screening in children and adolescents age 8 to 18.
3. **Autism** screening for children limited to two screenings up to 24 months
4. **Behavioral** assessments for children limited to 5 assessments up to age 17.
5. **Bilirubin concentration screening** for newborns.
6. **Blood screening** for newborns.
7. **Blood Pressure** screening
8. **Cervical Dysplasia** screening
9. **Congenital Hypothyroidism** screening for newborns
10. **Depression** screening for adolescents age 12 and older
11. **Developmental** screening for children under age 3, and surveillance throughout childhood
12. **Dyslipidemia** screening for children.
13. **Fluoride Chemoprevention to include** supplements for children without fluoride in their water source when prescribed by a physician and fluoride varnish to primary teeth through age 5.
14. **Gonorrhea** preventive medication for the eyes of all newborns
15. **Hearing** screening for all newborns and 3 additional screenings at periodic ages up to age 21.
16. **Height, Weight and Body Mass Index** measurements for children.
17. **Anemia screening** for children
18. **Hemoglobinopathies** or sickle cell screening for newborns
19. **Hepatitis B** screening for adolescents
20. **HIV** screening for adolescents
21. **Immunization** vaccines for children from birth to age 18 —doses, recommended ages, and recommended populations vary:
 - Covid 19
 - Diphtheria, Tetanus, Pertussis
 - Hemophilus influenza type b
 - Hepatitis A

Schedule of Benefits – MEC Plan Products

- Hepatitis B
 - Human Papillomavirus
 - Inactivated Poliovirus
 - Influenza (Flu Shot)
 - Measles, Mumps, Rubella
 - Meningococcal
 - Pneumococcal
 - Rotavirus
 - RSV
 - Varicella
22. **Iron** supplements for children ages 6 to 12 months when prescribed by a physician
 23. **Lead** screening for children
 24. **Maternal depression** screening for mothers of infants at 1, 2, 4, and 6 month visits.
 25. **Medical History** for all children throughout development
Ages: 0 to 11 months, 1 to 4 years, 5 to 10 years, 11 to 14 years, 15 to 17 years.
 26. **Obesity** screening and counseling
 27. **Oral Health** risk assessment for young children up to age 10.
 28. **Phenylketonuria (PKU)** screening in newborns
 29. **Sexually Transmitted Infection (STI)** prevention counseling and screening for adolescents
 30. **Skin Cancer** behavioral counseling for children age six months and up who have fair skin
 31. **Syphilis** screening for adolescents.
 32. **Tobacco Use** screening, counseling, and interventions to prevent initiation of tobacco use
 33. **Tuberculin** testing for children
 34. **Vision** screening for children.

For more information regarding preventive care recommendations and immunizations, visit the websites for the Centers for Disease Control and Preventions or the United States Department of Human Services:

<https://www.healthcare.gov/coverage/preventive-care-benefits/>

Eligibility

Classes Eligible for Coverage

All classes of participants of the plan and their dependents are eligible except the following:

- Part-time employees as defined by the Employer; however any employee working less than 20 hours will not be eligible.
- Temporary employees
- Seasonal employees
- Any class of employees which has been specifically excluded from this plan.

For the purpose of this plan, a participant's dependent is any person as defined in the definitions section of this plan. Any person who is covered as a participant cannot also be covered as a dependent under this plan. No person shall be considered to be a dependent of more than one participant. Dependents must be enrolled in the same coverage as the participant.

Date Coverage Is Effective

Coverage under the plan shall become effective with respect to an eligible employee and eligible dependents at the end of any applicable waiting period or, if none, on the enrollment date, provided written application for such coverage is made on or before such date and the employee is actively-at-work as of the effective date. If the employee is not actively-at-work on the effective date other than due to injury or illness, coverage for the employee and dependent(s) shall become effective on the date the employee returns to work.

The participant must be regularly working the Employer's normal work week, as defined by the Employer, at any of the Employer's business establishments, or at some other location to which he or she is required to travel for business reasons by the Employer, to be considered a full-time employee, unless the participant is not at work due to medical reasons and the absence has been approved pursuant to the employer's employment policies.

Actively-at-Work

Actively-at-work means performance of the employee of all regular duties of his/her occupation at an established business location of the employer or any other location he/she may travel to perform duties of the employer. An employee will be deemed actively at work if the employee is absent from work due to a health factor. In no event will an employee be considered actively at work if employment has been terminated for any reason.

Enrollment: Open Enrollment

An open enrollment period shall be held each year, closing 15 days prior to the Plan's renewal date. Any eligible employee of the company who was not previously covered under a health plan offered by the company may choose to be covered under any one of the health plans offered by the company, including himself and any eligible dependents.

Enrollment: Special Enrollees

The Health Insurance Portability and Accountability Act of 1996 requires that group health programs allow certain individuals be covered by the plan as **special enrollees** as follows:

If an otherwise eligible employee or dependent declined coverage under the plan at the time of initial eligibility, and stated in writing at that time that coverage was declined because of other group health coverage, and that other group health coverage is subsequently lost, and that person makes application for coverage hereunder within 30 days of the loss of the other health coverage, such individual shall be a **special enrollee** provided:

- Such person lost the other health coverage as a result of loss of eligibility for the coverage (including as the result of legal separation, divorce, death, termination of employment, or reduction in the number of hours of employment, but not including an increase in cost of the other coverage or reduction in benefits of the other coverage); or,
- Employer contributions toward such other coverage were terminated; or,
- The eligible employee or dependent was covered under a COBRA continuation provision and the COBRA continuation period has been exhausted.

Individuals who lose other health coverage due to non-payment of premium or for cause (e.g., filing fraudulent claims) shall not be a **special enrollee** hereunder.

Eligibility

An otherwise eligible employee who is not covered by the plan, an otherwise eligible employee and dependent who are not covered by the plan, or a participant's dependent who is not otherwise covered by the plan may apply for coverage under the plan as a result of the acquisition of a new dependent by the participant through marriage and shall be a *special enrollee* provided such person is properly enrolled as a participant or dependent of the participant within 30 days of the acquisition of the new dependent. A newborn child, a child placed for adoption, or a newly-adopted child of a covered participant will be covered from the moment of birth, placement for adoption, or adoption, including coverage for the necessary care or treatment of medically diagnosed congenital defects, birth abnormalities, or prematurity, provided the child is properly enrolled as a dependent of the participant within 30 days of the child's date of birth, adoption, or placement for adoption.

Coverage for a *special enrollee*, other than for a newborn, a child placed for adoption, or a newly-adopted child, shall begin the day following loss of other coverage.

HIPAA requires that the plan allow those individuals who enroll as *special enrollees* to be offered the opportunity to enroll in a different plan option, if another option exists.

Change of Election Under Cafeteria Plan.

If a situation occurs that would allow an election change under the plan sponsor's cafeteria plan, then this plan will allow mid-year election changes attributable to and consistent with that authorized change of election, provided all requirements of the cafeteria plan and this plan are met. Election changes under this plan must be timely requested within 31 days of the authorized cafeteria plan election change event by submitting a written request to the Plan Administrator.

Special Enrollment Rights under state Medicaid or state sponsored children health insurance programs ("CHIP") where available.

The Plan will allow employees and their dependents who are eligible for coverage but not enrolled for coverage to enroll in two additional circumstances:

1. The employee's or dependent's Medicaid or CHIP coverage is terminated as a result of loss of eligibility and the employee requests coverage under the plan within 60 days after the termination, or
2. The employee or dependent becomes eligible for a premium assistance subsidy under Medicaid or CHIP, and the employee requests coverage under the Plan within 60 days after eligibility is determined.

Coverage will become effective as of the date that a complete application for coverage is submitted.

Family and Medical Leave Act Continued Coverage

All participants and their dependents covered under the plan who are eligible for a leave of absence under the Family and Medical Leave Act of 1993 (i.e., FMLA) shall have the right to continue coverage under the plan for the term of the leave of absence under the same terms, conditions, and coverage as enjoyed by all other participants.

If the plan requires a contribution from the participant for normal coverage, those contributions must be paid by the participant during the term of the leave of absence in order for coverage under the plan to continue.

If the leave of absence is a paid leave, normal contributions will be deducted from those payments. If the leave of absence is not a paid leave, the participant must pay the contribution to the plan, through the company as the Plan Administrator, at the same time that contributions are normally taken from the company payroll. If a contribution is not made within 15 days of such date, coverage under the plan for the participant and all covered dependents will end after a 15-day non-payment notice is given and payment is not received during the 15-day period. All eligible claims which are incurred during the 15 days will still be considered as eligible by the plan. The company may withhold a delinquent contribution from any amount due the participant or may bring a legal action to recover the contribution if not paid by the participant.

Eligibility

If a participant returns to employment during or at the end of the FMLA leave of absence and during the leave the participant's coverage under the plan has ended for any reason, the participant will be allowed to re-enter the plan as of the date that the participant returns to work. The participant and those dependents who were previously covered by the plan will not be subject to a new waiting period. Coverage for new entrants at the time that the participant returns to work will be governed by the terms of the plan.

The company may recover its contribution to the plan for a participant who is on an unpaid FMLA leave of absence if the participant fails to return to work for at least 30 days after the FMLA leave has been exhausted or expires, unless the reason the participant does not return to work is due to one of the following:

The continuation, recurrence, or onset of a serious health condition which would entitle the participant to leave under the FMLA; or other circumstances beyond the participant's control.

The company may recover its contribution from any sums due the participant provided such deductions do not violate applicable federal or state wage payment or other laws. The company may also bring legal action against the participant to recover its share of the contribution.

If the participant elects or is required to substitute normal company paid leave (vacation, sick days, personal days, etc.) for part or all of a FMLA leave, the company may not recover its contribution for the period of the leave that is covered by the normal company paid leave.

Service Member and Family Leave under the FMLA

The Plan recognizes two additional periods of continued coverage under the FMLA in relation to a family caregiver for certain military service individuals. They are as follows:

(1) An employee caregiver who is the spouse, child, parent, or next-of-kin of a covered servicemember is entitled to up to 26 weeks of continued coverage under the Plan during any single 12-month period if granted protected leave under the FMLA to provide care to the covered servicemember. Covered servicemember is defined by federal regulation and generally includes (a) a current member of the Armed Forces who is undergoing medical treatment, recuperation, or therapy, who is otherwise in outpatient status, or who is otherwise on the temporary disability retired list, for a serious injury or illness or (b) a veteran of the Armed Forces discharged within the five-year period before the family member first takes military care taker leave to assist the veteran and who is undergoing medical treatment, recuperation or therapy for a qualifying serious injury or illness. Serious injury or illness is defined by federal regulation.

(2) An employee is entitled to up to 12 weeks of continued coverage under the Plan during any single 12 month period if granted protected leave under the FMLA as a result of any "qualifying exigency" as defined by federal regulation when the employee's spouse, son, daughter or parent is on covered active duty as defined by federal regulation (or has been notified of an impending call to covered active duty) in the Armed Forces involving deployment to a foreign country. The employee must provide acceptable proof of the event prior to the start of the leave or as soon after the absence begins as is reasonable under the circumstances.

All other terms of the Plan's Family and Medical Leave Act provisions are effective as to these two provisions that are related to military service members.

The Genetic Information Nondiscrimination Act of 2008 (GINA)

The Genetic Information Nondiscrimination Act of 2008 (GINA) prohibits discrimination in group health plan coverage based on genetic information. The Plan will not discriminate in individual eligibility, benefits or premiums based on any genetic information. The Plan will not require genetic testing of participants or intentionally gather genetic information (including family medical history) prior to or in connection with enrollment, or for underwriting purposes.

Eligibility

What is “genetic information”?

Genetic information means information about an individual’s genetic tests, the genetic tests of family members of the individual, family medical history or any request for and receipt of genetic services by an individual or a family member. The term also includes, with respect to a pregnant woman (or a family member of a pregnant woman) genetic information about the fetus and with respect to an individual using assisted reproductive technology, genetic information about the embryo.

HIPAA: Compliance with Health Insurance Portability and Accountability Act of 1996

All provisions of the plan are intended to bring the plan into compliance with the requirements of the Health Insurance Portability and Accountability Act of 1996 (HIPAA). Any provisions of the plan that differ with the requirements of HIPAA are hereby amended so that the plan shall at all times be in compliance with HIPAA and the Plan Administrator shall administer the plan accordingly.

The plan is a self-funded welfare benefit plan that provides medical benefits to covered persons. No benefits are payable by any insurance company. The company will provide all payments for the benefit plan. Employees may be required to pay a contribution that will partially reimburse the employer for the cost of operating the plan and for benefit payments.

All plan participants will be given written notice of any material reduction in benefits provided by the plan within 60 days of the adoption of such material reduction.

Leave of Absence

The company may provide an approved sick leave or leave of absence for the participant for a period of up to 90 days. Coverage may be continued during this time if the participant makes the required contribution.

Medicaid Eligibility

An individual who is otherwise eligible for coverage under this plan shall remain eligible even though such individual is eligible for coverage under a state plan for medical assistance approved under Title XIX of the Social Security Act (i.e., Medicaid), unless the state providing Medicaid as a rule that having any other coverage will disqualify the individual from Medicaid coverage.

The plan will make payment of all benefits under the plan for an individual covered by Medicaid coverage in accordance with the assignment of rights requirements of that individual’s Medicaid coverage. Coverage provided by the plan shall be considered primary coverage and shall pay for covered services before Medicaid.

Qualified Medical Child Support Orders

A medical child support order is a child support order of a court which requires that an employee benefit plan provide coverage for a dependent child of a participant if the plan normally provides coverage for dependent children. Typically these types of orders are generated as a part of a divorce proceeding or a paternity action.

When the plan receives a medical child support order, it will notify the participant and each child specified in the order that it has been received and that the plan will review the order to determine if it is a qualified medical child support order (i.e., **qualified order**). If it is determined the dependent child is to be covered, they must be enrolled in the same coverage as the employee.

Reinstatement of Coverage

If coverage for a participant or dependent terminates under the plan due to layoff, reduction in hours, or termination of employment, he/she will be considered as a new hire and subject to the waiting period, except when a person is rehired within 13 weeks of termination date, the waiting period will only apply to the extent that the waiting period was not satisfied prior to the layoff, reduction in hours or termination.

Eligibility

Section 125 (a.k.a. Cafeteria Plan) Premium Provision

Eligibility is dependent upon the employee's participation in the employer's cafeteria plan to the extent that the employee contributions to this plan will be paid through the cafeteria plan. All of the rules and regulations associated with Section 125 of the Internal Revenue Code shall apply.

Termination of Coverage

Termination of coverage of a participant will occur on the earliest of the following:

- The provisions of the plan for the coverage terminate;
- His or her class is no longer included in the eligible coverage classes;
- If the coverage is contributory, any contribution required of him or her for any coverage under the plan is not made when due;
- The last day of an approved leave of absence; or
- The member's date of Plan termination, as determined by Employer

The Plan Administrator will signify a participant's termination of employment by notifying the plan supervisor. No contributory coverage may be continued beyond the end of the period for which the participant has made the required contributions to the Plan Administrator.

Any dependent coverage of a participant covered for dependent coverage will cease, regardless of continuation of other dependent coverage when one or more of the following apply:

- The individual ceases to be a dependent as defined herein,
- The participant is no longer covered under this plan, and/or
- The dependent becomes eligible for participant coverage hereunder.

If a child who is a dependent as defined herein is incapable of self-sustaining employment by reason of mental retardation or physical handicap and is chiefly dependent upon the participant for support and maintenance beginning prior to the end of the calendar year in which he or she turns the age specified in the schedule of benefits, coverage will continue for the dependent until the earliest of the following:

- The participant discontinues his or her coverage hereunder,
- The participant is no longer considered an eligible participant,
- The plan is cancelled, or
- The disability no longer exists as determined by the plan.

Satisfactory evidence of such disability and dependency is required by the plan. Such evidence must be received within 120 days after the end of the calendar year in which the maximum age is attained. The plan may require that the evidence of disability or dependency be updated annually.

Termination and Available Coverage after Termination – COBRA

For employers who are required to offer COBRA continuation of coverage, the following benefits and procedures apply. Please see your employer's benefit administrator to find out if COBRA benefits are available to you.

All eligible participants and dependents covered under the plan on the date before a qualifying event who would otherwise have lost coverage herein as a result of any of the events listed below shall have the right to elect continuation coverage. Newborns and children placed for adoption with a person covered by COBRA continuation coverage may be added to their parent's coverage while the parent has coverage under COBRA if the plan would otherwise allow such a child to be covered by the plan. If a newborn child or child placed for adoption is added to the COBRA continuation coverage of the participant, such child shall be considered a qualified beneficiary under the plan.

The company will notify the Plan Administrator of the participant's death, termination of employment, layoff or reduction of working hours, or when he or she becomes entitled to benefits under Title XVIII of the Social Security Act within 30 days of the occurrence of any of these events. The participant or covered dependent must notify the Plan Administrator within 60 days of his or her divorce or legal separation, or when a dependent child is no longer eligible for coverage as defined in the plan, in order for continuation coverage to be offered to the dependent.

Eligibility

The Plan Administrator will notify the participant or covered dependent of his or her right to elect to continue coverage within 14 days from the date the Plan Administrator is first notified of any of the events described above. The election period shall begin no later than the date on which coverage terminates under the plan due to any of the events listed below, shall be of at least 60 days duration, and shall end 60 days after the later of:

- The date coverage terminates under the plan due to any qualifying event listed below, or
- The date the Plan Administrator sends notification to the participant or covered dependent of his or her rights under this provision as described above.

Benefits will be identical to those available under the plan to all active participants and covered dependents that are similarly situated beneficiaries.

The plan may require the participant and/or covered dependent pay for all or part of the cost for continuing his or her coverage, not to exceed 102% of the premium. If the participant or covered dependent is required by the plan to pay the cost of continuing coverage, payment for the initial premium must be made within 45 days from the date of election. Payments must be made in monthly installments. Payments are due by the first day of the month for which coverage is being provided.

Covered dependent spouses and children are eligible for continuation of coverage for up to 36 months upon the occurrence of any of the following qualifying events, which results in the loss of coverage under the plan:

- The death of the participant,
- The divorce or legal separation of the participant from the covered dependent spouse,
- The participant becoming entitled to Medicare benefits under Title XVIII of the Social Security Act, or
- With respect to a dependent child, the dependent child is no longer eligible for coverage as a dependent child as defined in the plan.

The participant and covered dependents shall be eligible for continuation of coverage for up to 18 months upon the occurrence of any of the following qualifying events, which results in the loss of coverage under the plan:

- The participant's employment with the company terminates (except if due to the participant's gross misconduct), or
- The participant is laid off or his or her working hours are reduced so as to render him or her ineligible for coverage as defined in the plan.

If the participant or covered dependent is disabled on or within 60 days of the initial qualifying event for continuation coverage due to termination of employment or reduction in hours, continuation coverage may be extended for all qualified beneficiaries within that family for up to 29 months from the qualifying event date rather than for only 18 months. The disabled person is subject to all of the following:

- The Social Security Administration must make a determination that the person was disabled under Title II or XVI of the Social Security Act and that the disability began before or within 60 days after the qualifying event date;
- The disability determination must be made by the Social Security Administration before the end of the original 18-month continuation of coverage period;
- The person must notify the Plan Administrator within the latter of either 60 days after the disability determination has been made or the date of the qualifying event which results in a loss of coverage and before the end of the original 18-month continuation of coverage period;
- The person must notify the Plan Administrator within 30 days after the final determination is made that the person is no longer totally disabled; and
- The cost for coverage for months one through 18 will be at the rate of up to 102% of the cost of the coverage, and the cost for months 19 through 29 will be at the rate of up to 150% of the cost of the coverage.

The continuation period will end when any of the following occur:

- When the participant or dependent fails to make the required contribution (if any) to the plan before the due date or within a grace period of 30 days;
- When the participant or covered dependent first becomes covered by any other group health plan, except as described below, or first becomes entitled to Medicare benefits under Title XVIII of the Social Security Act;
- When the company ceases to maintain any group health plan; or
- In the case of a disabled participant and/or dependent who has been on continuation coverage for more than 18 months due to a disability, the month that begins more than 30 days after the date of the final determination under Title II or XVI of the Social Security Act that the person is no longer disabled.

Eligibility

A retired participant and his or her spouse who would otherwise lose health coverage under the plan after the employer files a Chapter 11 bankruptcy proceeding may continue coverage under the plan until the death of the participant. Upon the death of the retired covered participant, his or her covered dependents shall be entitled to continuation coverage for a period of 36 months from the retiree's death.

Any other group health plan will be considered the primary coverage and must always pay benefits before this plan will consider a claim for benefits. The only exception is that the plan will remain primary if the COBRA covered person is covered by Medicare by reason of end stage renal disease, and then only until the end of the first 30 months of Medicare coverage for that disease.

In no event shall coverage as provided in this provision be continued for more than 36 months. For example, if a dependent is receiving continuation of coverage benefits due to an 18-month qualifying event, and during the 18-month period another qualifying event occurs which would entitle the person to 36 months of continuation coverage, that dependent shall be eligible for continuation of coverage for not more than a total of 36 months.

USERRA: Continuation of Coverage under the Uniformed Services Employment and Re-employment Rights Act

In any case in which a participant (or the participant's dependents) has coverage under the plan, and such participant is absent from such position of employment by reason of service in the uniformed services, the participant may elect to continue coverage under the plan as provided in this section. The maximum period of coverage of a participant and the participant's dependents under such an election shall be the lesser of the following:

- The 24-month period beginning on the date on which the participant's or dependent's absence begins; or
- The day after the date on which the participant fails to apply for or return to a position of employment, as determined under USERRA.

Any continuation coverage provided under this section will run concurrently with any other continuation coverage available, including COBRA continuation coverage.

A participant who elects to continue plan coverage under this section must pay 102% of his or her normal premium under the plan. Except that, in the case of a participant who performs service in the uniformed services for less than 31 days, such participant will pay his or her normal contribution for coverage for the 31 days.

A participant who is qualified for re-employment under the provisions of USERRA will be eligible for reinstatement of coverage under the plan upon re-employment. Except as provided in the following paragraph, upon re-employment and reinstatement of coverage, no new waiting period will be imposed in connection with the reinstatement of such coverage if a waiting period would normally have been imposed.

The paragraph directly above shall not apply to the coverage of any illness or injury determined by the Secretary of Veteran's Affairs to have been incurred in, or aggravated during, performance of service in the uniformed services.

Benefits of Coverage

Eligible Expenses

Eligible expenses for covered services of participants and dependents are covered as described in this plan subject to the plan design the participant and dependents are enrolled in. Eligible expenses are subject to the deductible, copayments and coinsurance percentage as shown in the schedule of benefits. The plan agrees to provide for eligible expenses provided by healthcare providers as defined in the Plan, subject to the plan design the participant and dependents are enrolled in. Eligible expenses may be limited by certain provisions listed in the general exclusions section of this plan.

Wellness Benefit

Preventive Services described in the Schedule of Benefits are covered without imposing any co-pays, co-insurance, deductibles, or other cost-sharing requirements. Wellness Benefits for prescription drugs are limited to participating pharmacies. For the MVP Plan, preventive services are covered under the Wellness Benefit and payable at 100% of eligible charges when services are rendered by a participating provider.

- Evidence based items or services with an A or B rating recommended by the United States Preventive Services Task Force;
- Immunizations for routine use in children, adolescents, or adults recommended by the Advisory Committee on Immunizations Practices of the Centers for Disease Control and Prevention.
- Evidence-informed preventive care and screening provided for in the comprehensive guidelines supported by the Health Resources and Services Administration (HRSA) for infants, children, and adolescents; and
- Other evidence informed preventive care and screenings provided for in comprehensive guidelines supported by HRSA for women.
- Listed preventive services that are a part of a qualified clinical trial and not reimbursed or reimbursable as a part of the clinical trial.

For more information regarding preventive care recommendations and immunizations, visit the websites for the Centers for Disease Control and Preventions or the United States Department of Human Services.

General Exclusions

General Exclusions:

Covered expenses do not include and no benefits are payable for the following:

1. Charges that the participant is not legally required to pay for or charges which would not have been made if this coverage had not existed.
2. Charges that are in excess of the reasonable and customary rates for the services as determined by the plan:
3. Charges for a covered person that are reimbursed, that could be reimbursed, or that could have been reimbursed as part of a clinical trial, by any public program, such as Medicare or Medicaid, even if the person could have, but does not, elect to be covered by that public program.
4. Charges Treatment or services provided by anyone other than a healthcare provider as defined herein unless specifically stated in the plan.
5. Services that are not preventive services will not be covered by the Plan.
6. Charges for investigatory and experimental treatment, services, and supplies, unless provided for herein.
7. Services for the treatment of an illness or injury shall not be covered by the Plan.

Definitions

Actively-at-Work

Actively-at-work means performance of the employee of all regular duties of his/her occupation at an established business location of the employer or any other location he/she may travel to perform duties of the employer. An employee will be deemed actively at work if the employee is absent from work due to a health factor. In no event will an employee be considered actively at work if employment has been terminated for any reason.

Ancillary Provider

Ancillary providers are state licensed healthcare professionals such as, but not limited to a physician's assistant, nurse practitioner, nurse assistant, licensed clinical social worker, health service provider in psychology, registered physical therapists, registered speech therapists, certified registered nurses of anesthesia or state licensed healthcare providers who are licensed and acting within the scope of their license.

Biotech/Specialty Drug

A **specialty/biotech drug** is a drug that meets more than a majority of the following criteria:

- 1) It is prescribed for a person with a complex or chronic medical condition, which is defined as a physical, behavioral, or developmental condition that may have no known cure, is progressive, and/or is debilitating or fatal if left untreated or under-treated.
- 2) It treats rare or orphan disease indicators.
- 3) It requires additional patient education, product support services, support beyond traditional dispensing activities such as side effect management and clinical management, as well as possibly in-person, patient centered care for side effect management and patient compliance with dosage instructions.
- 4) It may be difficult to administer. For example, it is administered by an injection or infusion, as opposed to being an oral medication.
- 5) It has a high monthly or annual cost.
- 6) It may require unique storage or shipping requirements, such as constant refrigeration.
- 7) A majority of retail pharmacies in the United States do not maintain it in stock or as part of their inventory.

Copayment or Copay

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

Dependent

The term **dependent** means the spouse of a participant and the following children:

- Natural children,
- Stepchildren, and/or
- Legally adopted children under the age of 26 who have been placed for adoption or who have been adopted by the participant.
 - a. Such a child shall be eligible for coverage as of the date of placement for adoption, or as of the date of actual adoption, whichever occurs first.
 - b. Coverage under the plan for such a child shall be the same coverage which is available to all other dependent children under the plan except that all pre-existing condition exclusions or waiting periods are hereby waived for such a child for any illness or injury of the child which exists as of the date of adoption or placement for adoption.
- Children for whom the person or the person's spouse is legal guardian.

Definitions

A dependent child shall remain a dependent hereunder until attaining the age specified in the schedule of benefits.

A child who has lost eligibility hereunder may resume coverage if the child's reason for loss of eligibility no longer exists and the child otherwise meets the eligibility criteria of the plan.

Diagnosis

Diagnosis shall mean the act or process of identifying or determining the nature and cause of an illness or injury through evaluation of patient history, examination of symptoms, and review of laboratory data. Diagnosis shall also mean the findings resulting from such act or process.

Diagnostic Service

Diagnostic Service shall mean an examination, test, or procedure performed for specified symptoms to obtain information to aid in the assessment of the nature and severity of a medical condition or the identification of an illness or injury. The diagnostic service must be ordered by a physician or other professional provider.

Effective Date

The **effective date** shall mean the first day this plan was in effect as shown in the plan specifications. As to the individual, it is the first day that benefits under this plan would be in effect after satisfaction of the waiting period and any other provisions or limitations contained herein.

Eligible Charges

Eligible charges mean charges for services covered under this plan to the extent that such charges are not excessive, based upon professional medical opinion, or upon the reasonable and customary charge for similar providers who perform like covered services. Rates contracted by the Plan, network or other designee of the Plan will not be considered excessive. For the Essential MEC Plans, amounts that the Plan or its designee decides to pay in connection with attempts to resolve amounts balance billed to participants or dependents by providers for covered services will not be considered excessive. Amounts attempted to be negotiated by participants or their dependents in connection with amounts balance billed to participants and dependents may be considered excessive, depending on professional medical opinion or reasonable and customary charges. Participants and/or their dependents do not have authority to negotiate on behalf of the Plan.

Emergency

Emergency means an unexpected acute illness or injury which, in the judgment of the attending physician and/or a prudent layperson who possesses an average knowledge of health and medicine, could risk permanent damage to the patient's health unless immediate medical or surgical treatment is provided.

Enrollment Date

The term **enrollment date** is defined as the first day of coverage or, if there is a waiting period for coverage to begin under the plan, the first day of any applicable waiting period. For a person who is a late enrollee or who enrolls as a special enrollee, the enrollment date will be the first date of actual coverage.

Experimental

The term **experimental** is if one or more of the following is true of a treatment, procedure, device, drug, or medicine:

- It cannot be lawfully marketed without U.S. Food and Drug Administration approval and approval for marketing for the condition treated has not been given at the time the device, drug, or medicine is furnished.
- Reliable evidence shows that to determine its maximum tolerated dose, toxicity, safety, efficacy (or efficacy as compared with the standard means of treatment or diagnosis):
 - a. It is undergoing phase I, II, or III clinical trials or is under study; or
 - b. Further clinical trials or studies are needed, according to the experts' consensus of opinion.

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

Definitions

Experimental or *investigational* shall also mean:

- Any treatments, services, supplies or related expenses that are educational or provided primarily for research; or
- Treatments, procedures, devices, drugs or medicines, or other expenses relating to the transplant of non-human organs.

Gender

Whenever a personal pronoun in the masculine *gender* is used, it shall include the feminine also, unless the context clearly indicates the contrary.

Hospital

A *hospital* is a legally licensed or Joint Commission on Accreditation of Healthcare Organizations (JCAHO) approved institution which, for compensation from its patients and on an inpatient basis, is primarily engaged in providing diagnostic and therapeutic facilities for the surgical and medical diagnosis, treatment, and care of injured and ill persons by or under the supervision of a staff of physicians who are duly licensed to practice medicine, and which continuously provides 24 hour a day nursing services by registered graduate nurses. It is not, other than incidentally, a place for rest or for the aged.

Illness

The term *illness* means a physical condition causing loss while this Plan is in force for the covered person whose illness is the basis of the claim. Illness shall also be deemed to include disability caused or contributed by pregnancy, miscarriage, childbirth, and recovery there from. It shall only mean illness or disease which requires treatment by a physician.

Incurred Charges

Incurred charges are the charges for a service or supply and are considered to be incurred on the date furnished. In the absence of due proof to the contrary when a single charge is made for a series of services, the date of service shall be considered the last date of service shown on the claim.

Injury

The term *injury* shall mean only bodily injury caused by an accident while the Plan is in force for the covered person whose injury is the basis of the claim. Injury shall mean only those injuries that require treatment by a physician. A hernia shall be considered an illness, not an injury.

Medically Necessary

The term *medically necessary* refers to medical services and/or supplies which are absolutely necessary and essential, as determined by the plan, to treat an illness or injury of a covered participant or dependent while covered by this plan. Such items are as follows:

- Consistent with the patient's diagnosis or symptoms; and
- Appropriate treatment according to generally accepted standards of medical practice; and
- Not provided only as a convenience to the patient or provider; and
- Not experimental or unproven; and
- Not educational, vocational, or provided primarily for medical or other research; and
- Not excessive in scope, duration, or intensity to provide safe, adequate, and appropriate treatment to the covered person.

Any service or supply provided at a provider facility will not be considered medically necessary if the covered person's symptoms or condition indicate that it would be safe to provide the service or supply in a less comprehensive setting.

Medicare

Medicare is the United States government's health insurance program for people 65 years of age or older, certain younger people with specific disabilities, people with end-stage renal disease.

Definitions

Participant

A **participant** is a person directly involved in the regular business of and compensated for services by the company, who is regularly scheduled to work at least 30 hours per week on an active, full-time basis and who is a person who is actually enrolled and covered by the Plan.

Physician

The term **physician** means a Doctor of Medicine or Doctor of Osteopathy who is legally qualified and licensed without limitation to practice medicine, surgery, or obstetrics at the time and place service is rendered. For services covered by this plan and for no other purpose, Doctor of Dental Surgery, Doctor of Dental Medicine, Doctor of Podiatry or Surgical Chiropractic, Optometrists, and Chiropractors will be considered a physician.

Plan Administrator

The **Plan Administrator** is the person, group, or organization responsible for the day-to-day functions and management of the plan. The Plan Administrator may employ persons or firms to process claims and perform other plan-connected services. The Plan Administrator is the company that is the named fiduciary.

Plan Document

The term **plan document** whenever used herein shall mean the document held by the company, which describes the terms and conditions of the benefits of the plan and will prevail over the **summary plan description**.

Plan Supervisor

The **plan supervisor** is the person or group providing administrative services to the company in connection with the operation of the plan and performing such other functions, including processing and payment of claims, as may be delegated to it.

Plan year

The term **plan year** means a n annual period beginning on the effective date of this Plan and ending 12 calendar year months thereafter or upon termination of the Plan, whichever occurs earliest.

PPACA

Patient Protection and Affordable Care Act.

Primary Care Physician

Primary Care Physician includes general practitioner, family practitioner, internist, pediatrician, OB/GYN, or doctor of osteopathy.

Reasonable and Customary

Reasonable and Customary: If a claim is subject to a negotiated/contracted rate, that negotiated rate will be the Reasonable and Customary amount. Absent an applicable negotiated rate, the Plan will determine the Reasonable and Customary rate by taking any combination of the following factors into account, in its discretion:

- 140% of the applicable Medicare rates within the geographical area;
- Rates customarily charged, paid, or accepted by the provider of services;
- Rates customarily charged, paid, or accepted by other providers in the same or similar specialty;
- Claims pricing data as reflected by objective pricing tools, such as FAIR Health or similar database, generally at the 90th percentile.

Rates contracted by the Plan, network or other designee of the Plan will be considered reasonable and customary. For the Essential MEC Plans, amounts that the Plan or its designee decides to pay in connection with attempts to resolve amounts balance billed to participants or dependents by providers for covered services will be considered reasonable and customary. The criteria above will apply when assessing whether amounts negotiated by participants or their dependents in connection

Definitions

with amounts balance billed to participants and dependents are reasonable and customary. Participants and/or their dependents do not have authority to negotiate on behalf of the Plan.

Special Enrollee

The term *special enrollee* means an employee or dependent who is entitled to, is qualified for, and who requests special enrollment under the plan within 30 days of losing other health coverage or who is added to the plan as a result of marriage, birth, placement for adoption, or is a newly adopted child under the age of 26.

Spouse

The term *spouse* means a person that is considered to be a lawful spouse under the law of the state of the employer.

Summary Plan Description

Each participant covered under the plan will be issued a *summary plan description*, which is a document which tell participants what the plan provides and how it operates, including information on various provisions of the plan affecting the participant.

The document is designed to be a summary of the participant's benefits and, in the event of any question, the master plan document shall be the prevailing document.

Surgical Procedure

The term surgical procedure means any procedure performed by a physician which has a CPT surgical code. Claims will be processed based upon the CPT code submitted by your healthcare provider.

Treatment

The term *treatment* refers to any service or supply used to evaluate, diagnose, or remedy a condition of a participant or his covered dependents.

Waiting Period

The term *waiting period* means the term that must pass under this plan before an employee or dependent is eligible to be actually covered by the plan. Notwithstanding the foregoing, the time between the date a late enrollee or special enrollee first becomes eligible for enrollment under the plan and the first day of coverage shall not be treated as a waiting period.

General Claim Information

Medical Claim Payment and Appeals

Pre-Service Urgent Care Claims

When a request to review an “urgent” pre-service claim is submitted, the participant will be notified of the plan’s decision as soon as possible, but no more than 72 hours after the plan receives the claim (unless the participant fails to provide sufficient information to determine whether or what benefits are covered or payable under the Plan). If the treating physician classifies a claim as “urgent,” the plan will do so as well.

If information to review of an “urgent” claim is incomplete, the following will occur:

- The plan will notify the participant of the deficiency and specify what information is missing. This will be done within 24 hours after receipt of the claim.
- The participant has 72 hours to provide the missing information.
- The plan will make its decision within 48 hours after the earlier of (1) when it receives all necessary information or (2) the end of the period provided for the participant to submit the information (usually 72 hours)..

If a participant appeals the denial of a pre-service “urgent” claim, the plan must render a review decision as soon as possible, but no more than 24 hours after receiving the appeal.

Concurrent Care Claims

Reduction or Termination of Coverage by the Plan:

If a plan has approved an on-going course of treatment and then determines that such treatment should be reduced or terminated, the plan must notify the participant of this decision far enough in advance of the reduction or termination date to allow for an appeal and review of the decision. However, this does not apply if the plan has been amended to reduce or end coverage for the treatment, or when the plan itself terminates.

Extensions of Treatment:

When a participant requests an extension of an on-going course of treatment beyond that which the plan has approved, the plan must do the following:

- Make a decision about the extension as soon as possible; and
- Notify the participant of the decision within 72 hours after receipt of the request, if the request was made at least 24 hours before the end of the treatment that had already been approved.

Pre-Service Benefit Claim Review for Coverage

If the plan requires that benefits for a service be predetermined prior to the service being provided, the participant or the healthcare provider must submit a request for that pre-service benefit claim review to the plan supervisor. A decision for a pre-service benefit determination will be made within 15 days after receipt of the request.

Extensions:

- The 15-day period may be extended for another 15 days if it is necessary because of matters beyond the plan’s control, and if the plan notifies the participant of those circumstances and the expected date of the decision before the end of the first 15-day period.
- If the extension is necessary because insufficient information was submitted, the extension notice will describe the missing information and give the participant 45 days to submit such information.

Normal Post-Service Health Claims

A participant or healthcare provider must file a claim with the plan supervisor within the time frames set out in the plan. A claim will be considered to have been filed upon receipt by the plan supervisor. The participant will be notified within 30 days of receipt of a claim by the plan as to the benefits to be paid for that claim.

Extensions:

- The 30-day period may be extended for 15 days if it is necessary due to matters beyond the control of the plan, but the plan will notify the participant before the end of the 30-day period of those circumstances and the expected date of the decision.
- If more information is necessary to properly process the claim, a notice will be given within the 30-day period that the plan cannot meet the 30-day time frame. The notice will describe the missing information and give the participant at

General Claim Information

least 45 days to provide the missing information. Upon receipt of the missing information, the claim will be processed within the later of 45 days after the original receipt of the claim or within 15 days of receipt of the missing information. If more information is necessary to properly process the claim and it is not received within the 45-day time frame, the claim will be denied. The claim may thereafter be re-submitted with the missing information as long as the re-filing is completed within the claim filing time limits set out in the plan.

General Conditions

The period of time within which a benefit determination is required to be made shall begin at the time the claim is filed with the plan, without regard to whether all the information necessary to make the benefit determination accompanies the filing. In the case of any extension of time to make a benefit determination which is based on a lack of submitted information necessary to determine a claim, the period for making the benefit determination shall stop running until the claimant responds to the request for additional information.

Any adverse determination shall set forth the following:

- The specific reason or reasons for the adverse determination;
- A reference to any specific plan provisions on which the determination is based;
- A description of any additional material or information necessary for the participant to make the claim payable and an explanation of why such material or information is necessary;
- A description of the plan's review procedures and the time limits which are applicable to such procedures, including a statement of the participant's right to bring a civil action under Section 502(a) of ERISA;
- If an internal rule, guideline, protocol, or other similar criterion was relied upon in making the adverse determination, the plan will provide that criterion free of charge upon request; and
- If the adverse determination is based on a medical necessity or experimental treatment or similar exclusion or limit, the plan will provide an explanation of how it made that determination free of charge upon request.

Appealing an Adverse Decision

In order to appeal an adverse decision, the plan will do the following:

- Allow a participant 180 days following receipt of a notification of an adverse benefit determination within which to file a written appeal to the Plan Administrator at the address found in the summary plan description;
- Allow a participant the opportunity to submit written comments, documents, records, and other information relating to the claim for benefits;
- Provide a participant, upon request and free of charge, reasonable access to, and copies of, all documents, records, and other information which is relevant to the participant's claim for benefits;
- Provide a participant any new or additional evidence or rationale that is relied upon, considered or generated by or at the direction of the plan. The new evidence or rationale shall be provided free of charge as soon as possible, and sufficiently in advance of the time within which a final determination or appeal is required to allow the participant to respond.
- Provide for a review that takes into account all comments, documents, records, and other information submitted by the participant relating to the claim, without regard to whether such information was submitted or considered in the initial benefit determination;
- Provide a review that does not afford deference to the initial adverse benefit determination and that is conducted by an appropriate fiduciary of the plan who is neither the individual who made the original adverse benefit determination, nor the subordinate of such individual;
- In deciding an appeal from an adverse benefit determination that is based in whole or in part on a medical judgment, provide that the appropriate plan fiduciary shall consult with a healthcare professional who has appropriate training and experience in the field of medicine involved in the medical judgment;
- Identify medical or vocational experts whose advice was obtained on behalf of the plan in connection with a claimant's adverse benefit determination, without regard to whether the advice was relied upon in making the benefit determination;
- Provide that the healthcare professional engaged for purposes of a consultation as a part of the appeal of the benefit determination shall be an individual who is neither an individual who was consulted in connection with the adverse benefit determination that is the subject of the appeal, nor the subordinate of any such individual; and

General Claim Information

- Notify the participant of the plan's benefit determination on review within a reasonable time, but not later than 60 days after receipt of the participant's appeal, unless the Plan Administrator determines that special circumstances require an extension of time for processing the appeal.

Standard External Review

The Plan shall allow an external review of a benefit denial when a request for a standard external review is submitted within four months after the date of receipt of a notice of an adverse benefit determination.

The Plan will complete a preliminary review of the request within five business days following receipt of the external review request to: 1) determine if the claimant was covered by the plan at the time the claim was incurred, 2) determine if the claimant has exhausted the Plan's internal review process, if required, and 3) determine that the claimant has provided all information and forms required to process an external review. Within one business day after completion of the preliminary review, the Plan will notify the covered person in writing if the request is complete. If the request is incomplete the Plan will allow the covered person to provide complete information within the later of the end of the four month period after the date of receipt of the notice of adverse benefit determination or within a 48-hour period after receipt of notification to complete the request. If the plan determines that the claim is ineligible for external review the claimant will be notified and will be given the telephone number of the Employee Benefits Security Administration (866-444-3272).

If accepted for external review the file will be assigned to an accredited independent review organization (IRO).

Upon receipt of a final external review decision the claimant will be notified of the decision. If the decision reverses in whole or in part the adverse benefit determination, the Plan will provide coverage or payment for the claim to the extent that the claim is found payable.

Expedited External Review.

The Plan shall allow an "expedited external review" when he/she receives:

- (a) An adverse benefits determination, if (i) the adverse benefit determination involves a medical condition of the covered person for which the time frame for completion of an expedited internal appeal under the final regulations would seriously jeopardize the covered person's (I) life or health, or (II) ability to regain maximum function, and (ii) the covered person has filed a request for an expedited internal appeal; or
- (b) A final internal adverse benefit determination, if (i) the covered person has a medical condition where the time frame completion of a standard external review would seriously jeopardize the covered person's (I) life or health, or (II) ability to regain maximum function; or (ii) the final internal adverse benefit determination concerns an admission, availability or care, continued stay, or healthcare item or service for which the covered person received emergency services, but has not been discharged from a facility.

Upon receipt of the request, the Plan will determine whether the request meets the reviewability requirements for standard external review. The Plan will immediately send a notice of the eligibility determination to the claimant.

Upon receipt of a final external review decision the Plan and the claimant will be notified of the decision. If the decision reverses in whole or in part the adverse benefit determination, the Plan will provide coverage or payment for the claim to the extent that the claim is found payable.

Administration of the Group Medical Plan

The plan is administered through the Plan Administrator. The services of an independent plan supervisor experienced in claims processing have been retained to process claims for the plan. The plan is a legal entity. Legal notices may be filed with, and legal process served upon the Plan Administrator. The Plan Administrator is given the specific discretionary authority to determine eligibility for benefits or to construe terms of the plan. Benefits under this plan will be paid only if the Plan Administrator decides in its sole discretion that the applicant is entitled to them. Amounts paid out under this plan shall be based solely upon the benefits in effect as of the date the services are rendered. No payment will be made for services incurred before coverage is in effect or after coverage terminates for the patient receiving the services.

Amendment of Plan Document

The company reserves the power at any time and from time to time (and retroactively, if necessary or appropriate to meet the requirements of the Internal Revenue Code or other applicable law) to modify, amend, or terminate in whole or in part, any or all provisions of the plan, provided, however, that no modification, amendment, or termination shall deny a participant or

General Claim Information

covered dependent of a right to those benefits to which he or she has become entitled under the plan. Any amendment to the plan may be affected by the Plan Administrator in writing at the direction of the company.

Application and Identification Card

To obtain coverage, an eligible participant must complete and deliver to the Plan Administrator an application on a form supplied by the plan supervisor.

All statements contained in the application must be true and correct and no material information may be withheld or omitted. Any misstatements or failure to report information which is material to the covered person's qualification and participation under the plan may be used as a basis for rescission of participation and/or denial of payment of claims.

Acceptance of this application will be evidenced by the delivery of an identification card, showing the participant's name, by the plan supervisor to the Plan Administrator.

Assignment of Payment

Except where otherwise provided in this plan, the plan will pay any benefits accruing under this plan to the participant unless the participant shall assign benefits to a hospital, physician, or other provider of service furnishing the services for which benefits are provided herein. No assignment, however, shall be binding on the plan unless the plan supervisor is notified in writing of such assignment prior to payment hereunder.

Balance Billing

If a healthcare provider bills the covered person for amounts that exceed the patient responsibility amount on the Explanation of Benefits for a claim, assistance is available from the Plan to help resolve the charges. If the covered person negotiates with the provider himself/herself, he/she may be responsible for paying the provider more than patient responsibility amount on the Explanation of Benefits for a claim. The covered person does not have the authority to negotiate with the provider about how much the Plan will pay the provider, and he/she may be responsible to the provider if the covered person agrees that the provider will be paid more than the Plan agrees to pay. If the covered person experiences "balance billing" or "surprise billing" please call 855-264-1797 or the phone number listed on his/her Explanation of Benefits and the Plan will make patient advocacy services available to resolve the balance bill with the provider.

Cancellation

A participant may cancel only if a situation occurs that would allow an election change under the plan sponsor's cafeteria plan, then this plan will allow mid-year election changes (including cancellation) attributable to and consistent with that authorized change of election, provided all requirements of the cafeteria plan and this plan are met. Election changes under this plan must be timely requested within 31 days of the authorized cafeteria plan election change event by submitting a written request to the Plan Administrator.

Conditions Precedent to the Payment of Benefits

The participant or dependent shall present the plan identification card upon admission to a hospital or upon receiving service from a physician.

Claim forms are available through the plan supervisor and are required along with an itemized statement with a diagnosis, the participant's name, Social Security number, and the name of the Plan Administrator.

The participant and all dependents agree that in order to receive benefits hereunder, any physician, nurse, hospital, or other providers of service, having rendered service or being in possession of information or records relating thereto, is authorized and directed to furnish the plan supervisor, at any time, upon request, any and all such information and records, or copies thereof.

The Plan Administrator has the right to have a physician examine a participant or dependent as often as reasonably required during the pendency of a claim or to aid in the determination of whether services are medically necessary. The Plan Administrator will notify the participant or dependent in advance of the time and place for such examination and shall pay for the cost of the examination.

General Claim Information

Contributions and Funding

The plan is a self-funded welfare benefit plan that provides medical benefits to covered persons. No benefits are payable by any insurance company. The company will provide all payments for the benefit plan. Employees may be required to pay a contribution that will partially reimburse the employer for the cost of operating the plan and for benefit payments.

- **Employer Contributions:** The employer shall pay such amounts needed to provide plan benefits.
- **Participant Contributions:** Upon election to participate, each participant must contribute such amounts as may be required by the employer toward the cost of benefits.
- **Authorization:** An employee shall authorize the deduction from earnings for required contributions in writing at the time of application to participate.
- **Funding:** Benefits provided under the plan are paid out of the general assets of the employer and authorized earnings deductions withheld from employee from an account maintained by the employer.

All funds are applied to benefit payments, insurance costs, and reasonable expenses for administration or plan maintenance. The order of priority for payment is as follows:

- First from authorized earnings deductions withheld from employees;
- Second from employer contributions.

Should there be a claim surplus generated by any of the benefit designs contained in the Plan that surplus may be used to offset any claim deficit generated by another benefit design.

Coordination of Benefits

Definitions

The term *allowable expense* shall mean the amount of expenses, at least a portion of which is paid under at least one of any multiple plans covering the person for whom the claim is made. The term *order of benefits determination* shall mean the method for ascertaining the order in which the plan renders payment hereunder. The principle applies when another plan has a coordination of benefits provision.

Application

Under the order of benefits determination method, the plan that is obligated to pay its benefits first is known as the primary plan. The plan that is obligated to pay additional benefits for allowable expenses not paid by the primary plan is known as the secondary plan. Where another plan contains a coordination of benefits provision, the following order of benefits determination will establish the responsibility for payment hereunder:

- If the patient has individual insurance coverage that covers medical expenses, that plan will be deemed the primary plan. If the patient does not have such individual insurance coverage, the health coverage which covers the patient as an employee shall be deemed the primary plan and is obligated to pay benefits before the health coverage covering the patient as a dependent.
- The plan covering the patient as a dependent of a person whose birthday anniversary occurs earlier in the calendar year will be deemed to be the primary plan and is obligated to pay before the plan covering the patient as a dependent of a person whose birthday anniversary occurs later in the calendar year. If the birthday anniversaries are identical, the plan that has been in force the longer period of time shall be deemed to be primary.

If either plan is lawfully issued in another state and does not have the coordination of benefits procedure regarding dependents based on birthday anniversaries as provided herein, and as a result each plan determines its benefits after the other, the coordination of benefits procedure set forth in the plan which does not have the coordination of benefits procedure based on birthday anniversaries shall be deemed to be primary.

In the event of divorce or legal separation, the following order will establish responsibility for payment. If this order of benefit determination is not recognized by the plan being coordinated with, order will be determined at the option of the plan supervisor on a case-by-case basis.

- If a court decree has determined financial responsibility for a child's healthcare expenses, the plan of the parent having that responsibility pays first.
- The plan of the parent with custody of the child pays before the plan of the other parent or the plan of any step-parent.

General Claim Information

- The plan of the step-parent married to the parent with custody of the child pays before the plan of the parent not having custody.
- Where the order of payment cannot be determined in accordance with the provisions above, the primary plan shall be deemed to be the plan which has covered the patient for the longer period of time.

In the case of an inactive employee, the benefits of a plan which covers a person as an employee who is neither laid off nor retired (or as that employee's dependent) are determined before those of a plan which covers that person as a laid off or retired employee (or as that employee's dependent). If the other plan does not have this rule, and if, as a result, the plans do not agree on the order of benefits, this rule is ignored.

If a person, whose coverage is provided under a right of continuation pursuant to federal or state law, is also covered under another plan, the benefits of the plan covering the person as an employee (or as the employee's dependent) will be determined first and the benefits under the continuation coverage will be determined second.

As the primary plan, the plan will provide payment in accordance with the provisions of this plan.

As a secondary plan, the plan will provide payment for allowable expenses and services of hospitals and physicians, but only to the extent that payment for such hospital services and services of physicians are not provided by the primary plan or other secondary plans. In no event will total payment by the plan exceed the amount which would have been paid as primary plan.

The plan shall be considered to be the secondary plan when the other plan does not contain a coordination of benefits provision. The total payment by the plan for hospital services and physician services shall not exceed the amount that would have been paid as a secondary plan.

Dependents: Privileges Regarding

The participant shall have the privilege of adding or withdrawing the name or names of any dependents to or from this coverage, as permitted by the plan, by submitting to the Plan Administrator an application for reclassification, furnished by the plan supervisor. Each dependent added to the coverage shall be subject to all conditions and limitations contained in this plan.

Facility of Payment

If, in the opinion of the plan supervisor, a valid release cannot be rendered for the payment of any benefit payable under this plan, the plan supervisor may, at its option, make such payment to the individuals as have, in the plan supervisor's opinion, assumed the care and principal support of the covered person and are therefore equitably entitled thereto. In the event of the death of the covered person prior to such time as all benefit payments due him or her have been made, the plan supervisor may, at its sole discretion and option, honor benefit assignments, if any, prior to the death of such covered person.

Any payment made by the plan supervisor in accordance with the above provisions shall fully discharge the plan to the extent of such payment.

Fiduciary Operation

Except as may be otherwise specifically provided in the plan or in any benefit contract or policy, the Plan Administrator or its designee shall have full discretionary authority to enable it to carry out its duties under the plan, including, but not limited to, the authority to determine eligibility under the plan and to construe and interpret the terms of the plan and to determine all questions of fact or law arising hereunder and to authorize coverage in a manner which is cost effective under the plan. All such determinations and interpretations shall be final, conclusive, and binding on all persons affected thereby.

The Plan Administrator or its designee shall have full discretionary authority to correct any defect, supply any omission or reconcile any inconsistency, and resolve ambiguities in the plan in such manner and to such extent as it may deem expedient, and subject to the above, the Plan Administrator or its designee shall be the sole and final judge of such expediency. Each fiduciary shall discharge his or her duties with respect to the plan solely in the interest of the participants and beneficiaries:

- For the exclusive purposes of providing benefits to participants and their beneficiaries and defraying reasonable expenses of administering the plan;

General Claim Information

- With care, skill, prudence, and diligence under the circumstances then prevailing that a prudent person acting in a like capacity and familiar with such matters would use in the conduct of an enterprise of a like character and with like aims; and
- In accordance with the documents and instruments governing the plan to the extent that they are consistent with the provisions of the Employee Retirement Income Security Act of 1974.

Inadvertent Error

Inadvertent error by the Plan Administrator or plan supervisor in the keeping of records or the transmission of participants' applications shall not deprive any participant or dependent of benefits otherwise due.

Medicare

To the extent allowable under applicable law, if the participant or his or her dependents are eligible to be covered under Medicare, coverage under the plan will be secondary to coverage provided by Medicare. If the plan is primary to Medicare and if the participant or his or her dependents are eligible to be covered by Medicare and incur a claim, coverage under the plan will be paid as usual for eligible charges, subject to any applicable deductible and any applicable copay, exclusion, and any other limitations as set forth in the plan.

The following rules apply:

- When the employer has less than 20 employees, Medicare is the primary coverage. In that situation participants and covered dependents must inform their healthcare providers that Medicare is the primary coverage.
- When the employer has 20 or more employees, the benefit plan is primary and Medicare is the secondary coverage for active employees and their dependents regardless of age.
- Medicare is the primary coverage for retirees over age 65 and for over age 65 dependents of retirees, unless the spouse is an active employee of another group health plan of more than 20 employees.
- The benefit plan is primary and Medicare is the secondary coverage for the first 30 months of Medicare eligibility due to End Stage Renal Disease. After the first 30 months, Medicare is the primary coverage. This applies if the person is covered due to active employment, being the dependent of an active employee, or covered due to COBRA continuation coverage.
- COBRA always pays secondary to Medicare except in the case of the first 30 months of Medicare eligibility due to End Stage Renal Disease.
- When the employer has 100 or less employees and Medicare coverage for an active employee or dependent is due to disability, Medicare is the primary coverage. When the employer has more than 100 employees, the benefit plan is primary. When the employee is no longer an active employee, Medicare is primary.

If the participant or his or her dependents choose not to be covered by the plan and choose to be covered primarily by Medicare, Medicare will provide coverage and coverage under this plan will terminate. The participant or his or her dependents are considered eligible for Medicare for the purposes of the plan during any period the participant or his or her dependents have coverage under Medicare or, while otherwise qualifying for coverage under Medicare, do not have such coverage solely because the participant or his or her dependents refused, discontinued, or failed to make any necessary application for Medicare coverage.

Misrepresentation

Any fraudulent or material misrepresentation on the part of a participant or dependent in making application for benefits, or any application for reclassification thereof, or for any claim for benefits hereunder may result in rescission of coverage back to the original effective date or termination of ongoing coverage after a 30 day notice is given to the covered individual.

Notice

Any notice given under this plan shall be sufficient if given to the Plan Administrator when addressed to it at its office; if given to the plan supervisor, when addressed to it at its home office; or if given to a participant, when addressed to the participant at his address as it appears on the records of the plan supervisor in the care of the Plan Administrator.

General Claim Information

Not Liable for Acts of Hospitals or Physicians

Nothing contained herein shall confer upon a participant or dependent any claim, right, or cause of action, either at law or at equity, against the plan for the acts of any hospital in which he receives care, or for the acts of any physician from whom he receives service under this plan.

Plan Administration

The Plan Administrator shall be responsible for compliance by the plan with all requirements of Part 1, Subtitle B or Title 1 of the Employee Retirement Income Security Act of 1974 (ERISA).

Plan Is Not a Contract

The plan shall not be deemed to constitute a contract between the Plan Administrator and any participant or to be a consideration for, or an inducement or condition of, the employment of any participant. Nothing in the plan shall be deemed to give any participant the right to be retained in the service of the Plan Administrator or to interfere with the right of the Plan Administrator to discharge any employee at any time, provided that the foregoing shall not be deemed to modify the provisions of any collective bargaining agreements which may be made by the Plan Administrator with the bargaining representative of any participants.

Protected Health Information: Use and Disclosure

Use and Disclosures of Protected Health Information (PHI)

The Plan will use protected health information (PHI) to the extent of and in accordance with the uses and disclosures permitted by the Health Insurance Portability and Accountability Act of 1996 (HIPAA). For a copy of the Plan's Notice of Privacy Practices, contact your employer. Specifically, the plan will use and disclose PHI for purposes related to health care treatment, payment for health care and health care operations.

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

- Determination of eligibility, coverage, and cost sharing amounts (for example, cost of a benefit, plan maximums, and copays as determined for an individual's claim);
- Coordination of benefits;
- Adjudication of health benefit claims (including appeals and other payment disputes);
- Subrogation of health benefit claims;
- Establishing employee contributions;
- Risk adjusting amounts due based on enrollee health status and demographic characteristics;
- Billing, collection activities, and related health care data processing;
- Claims management and related health care data processing, including auditing payments, investigating and resolving payment disputes, and responding to participant inquiries about payments;
- Obtaining payment under a contract for reinsurance (including stop-loss and excess of loss insurance);
- Medical necessity reviews or reviews of appropriateness of care or justification of charges;
- Utilization review, including pre-certification, and pre-authorization;
- Disclosure to consumer reporting agencies related to the collection of premiums or reimbursement (the following PHI may be disclosed for payment purposes: name and address, date of birth, Social Security number, payment history, account number, and name and address of the provider and/or health plan); and
- Reimbursement to the plan.

General Claim Information

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

- Quality assessment;
- Population-based activities relating to improving health or reducing health care costs, protocol development, case management and care coordination, disease management, contacting health care providers and patients with information about treatment alternatives and related functions;
- Rating provider and plan performance, including accreditation, certification, licensing, or credentialing activities;
- Underwriting, premium rating, and other activities relating to the creation, renewal, or replacement of a contract of health insurance or health benefits, and ceding, securing, or placing a contract for reinsurance of risk relating to health care claims (including stop-loss insurance and excess of loss insurance);
- Conducting or arranging for medical review, legal services, and auditing functions, including fraud and abuse detection and compliance programs;
- Business planning and development, such as conducting cost-management and planning-related analyses related to managing and operating the plan, including formulary development and administration, development or improvement of payment methods or coverage policies;
- Business management and general administrative activities of the plan, including, but not limited to the following:
 - a. Management activities relating to the implementation of and compliance with HIPAA's administrative simplification requirements; or
 - b. Customer service, including the provision of data analyses for policyholders, plan sponsors, or other customers;
 - c. Resolution of internal grievances; and
 - d. Due diligence in connection with the sale or transfer of assets to a potential successor in interest, if the potential successor in interest is a "covered entity" under HIPAA or, following completion of the sale or transfer, will become a covered entity.

The plan is not allowed to use genetic information that is PHI for underwriting purposes, such as to decide whether to give an individual coverage, or the price of that coverage. This limitation does not apply to long term care plans.

Treatment includes, but is not limited to, activities undertaken by the Plan to help support health care treatments provided by hospitals, physicians and other health care providers.

The Plan Will Use and Disclose PHI as Required by Law and as Permitted by Authorization of the Participant or Beneficiary

With an authorization, the plan will disclose PHI to the pension plan, disability plan, EAP plan, Section 125 cafeteria plan, Workers' Compensation plan, and other benefit plans established by the plan sponsor for the purposes related to administration of these plans.

For Purposes of this Section company name Is the Plan Sponsor

The plan will disclose PHI to the plan sponsor only upon receipt of a certification from the plan sponsor that the plan documents have been amended to incorporate the following provisions.

The Plan hereby includes the following provisions, and all of the other provisions of this Protected Health Information: Use and Disclosure section.

With Respect to PHI, the Plan Sponsor Agrees to Certain Conditions

The plan sponsor agrees to:

- Not use or further disclose PHI other than as permitted or required by the plan document or as required by law;
- Ensure that any agents, including a subcontractor, to whom the plan sponsor provides PHI received from the plan agree to the same restrictions and conditions that apply to the plan sponsor with respect to such PHI;

General Claim Information

- Not use or disclose PHI for employment-related actions and decisions unless authorized by an individual;
- Not use or disclose PHI in connection with any other benefit or employee benefit plan of the plan sponsor unless authorized by an individual;
- Report to the plan any PHI use or disclosure that is inconsistent with the uses or disclosures provided for of which it becomes aware;
- Make PHI available to an individual in accordance with HIPAA's access requirements;
- Make PHI available for amendment and incorporate any amendments to PHI in accordance with HIPAA;
- Make available the information required to provide an accounting of disclosures;
- Make internal practices, books, and records relating to the use and disclosure of PHI received from plan available to the HHS Secretary for the purposes of determining the plan's compliance with HIPAA; and
- If feasible, return or destroy all PHI received from the plan that the plan sponsor still maintains in any form, and retain no copies of such PHI when no longer needed for the purpose for which disclosure was made (or if return or destruction is not feasible, limit further uses and disclosures to those purposes that make the return or destruction infeasible); and
- Ensure that adequate separation is established in accordance with HIPAA and this Plan.

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

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

- The benefits manager; and
- Staff designated by the benefits manager.

Limitations of PHI Access and Disclosure

The persons described in the ***Adequate Separation*** section above may only have access to and use the disclosed PHI for plan administration functions that the plan sponsor performs for the plan.

Non-compliance Issues

If the persons described in the ***Adequate Separation*** section above do not comply with this plan document, the plan sponsor shall provide a mechanism for resolving issues of noncompliance, including disciplinary sanctions.

Electronic Protected Health Information

Electronic Protected Health Information – The term “Electronic Protected Health Information” has the meaning set forth in 45 C.F.R. § 160.103, as amended from time to time, and generally means protected health information that is transmitted or maintained in any electronic media.

Security Incidents – The term “Security Incidents” has the meaning set forth in 45 C.F.R. § 164.304, as amended from time to time, 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.

Where Electronic Protected Health Information 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 Electronic Protected Health Information as follows:

- Plan sponsor shall implement administrative, physical, and technical safeguards that reasonably and appropriately protect the confidentiality, integrity, and availability of the Electronic Protected Health Information that Plan sponsor creates, receives, maintains, or transmits on behalf of the Plan;
- Plan sponsor shall ensure that the adequate separation that is required by 45 C.F.R. § 164.504(f)(2)(iii) of the HIPAA Privacy Rule is supported by reasonable and appropriate security measures;

General Claim Information

- Plan sponsor shall ensure that any agent, including a subcontractor, to whom it provides Electronic Protected Health Information agrees to implement reasonable and appropriate security measures to protect such Information; and
- Plan sponsor shall report to the Plan any Security Incidents of which it becomes aware as described below:
 - a. Plan sponsor shall report to the Plan within a reasonable time after Plan sponsor becomes aware, any Security Incident that results in unauthorized access, use, disclosure, modification, or destruction of the Plan's Electronic Protected Health Information; and
 - b. Plan sponsor shall report to the Plan any other Security Incident on an aggregate basis annually, or more frequently upon the Plan's request.

Right of Recovery

Whenever payments have been made by the plan in excess of the maximum amount of payment necessary at that time to satisfy the intent of this plan, the plan shall have the right to recover such payments, to the extent of such excess, from among one or more of the following as the plan supervisor shall determine: any persons to or for, or with respect to whom such payments were made, and/or any insurance companies or other organizations.

Rights of Participants

As a participant in the plan you are entitled to certain rights and protections under the Employee Retirement Income Security Act of 1974 (ERISA). ERISA provides that all plan participants shall be entitled to do the following:

- Examine, without charge, at the Plan Administrator's office and at other specified locations, such as work sites and union halls, all plan documents, including insurance contracts, collective bargaining agreements, and copies of all documents filed by the plan with the U.S. Department of Labor, such as detailed reports and plan descriptions.
- Obtain copies of all plan documents and other plan information upon written request to the Plan Administrator. The administrator may make a reasonable charge for the copies.
- Receive a summary of the plan's annual financial report. The Plan Administrator is required by law to furnish each participant with a copy of this summary annual report.

In addition to creating rights for plan participants, ERISA imposes duties upon the people who are responsible for the operation of the employee benefit plan. The people who operate your plan, called fiduciaries of the plan, have a duty to do so prudently and in the interest of you and other plan participants and beneficiaries. No one, including your employer, your union, or any other person, may fire you or otherwise discriminate against you in any way to prevent you from obtaining a welfare benefit or exercising your rights under ERISA.

If your claim for a welfare benefit is denied in whole or in part, you must receive a written explanation of the reason for the denial. You have the right to have the Plan Administrator review and reconsider your claim. Under ERISA, there are steps you can take to enforce the above rights.

For instance, if you request materials from the Plan Administrator and do not receive them within 30 days, you may file suit in a federal court. In such a case, the court may require the Plan Administrator to provide the materials and pay up to \$120 fine a day until you receive the materials, unless the materials were not sent because of reasons beyond the control of the administrator. If you have a claim for benefits which is denied or ignored, in whole or in part, you may file suit in a state or federal court.

If it should happen the plan fiduciaries misuse the plan's money, or if you are discriminated against for asserting your rights, you may seek assistance from the U.S. Department of Labor, or you may file suit in a federal court. The court will decide who should pay court costs and legal fees. If you are successful, the court may order the person you have sued to pay these costs and fees. If you lose, the court may order you to pay these costs and fees, for example, if it finds your claim is frivolous. If you have any questions about your plan, you should contact the Plan Administrator. If you have any questions about this statement or about your rights under ERISA, you should contact the nearest office of the EBSA, U.S. Department of Labor, listed in your telephone directory or the Division of Technical Assistance and Inquiries, Pension and Welfare Benefits Administration, U.S. Department of Labor, 200 Constitution Avenue, N.W., Washington, D.C. 20210.

General Claim Information

Subrogation

When the plan provides benefits for accidental injury or illness or other loss (hereinafter referred to as injury) to or for the benefit of a covered person, the plan shall be subrogated to all rights of recovery that the person, his heirs, guardians, executors, agents, or other representatives (hereafter individually and collectively referred to as injured person) may have as a result of the loss. The rights of recovery to which the plan shall be subrogated includes, without limitation, the injured person's rights to recovery:

- Against any person or entity that caused, contributed to, or is in any way responsible for the injury;
- Against any person, insurance company, healthcare provider, or other entity that is in any way responsible for providing indemnification, coverage, compensation, or other payment as a result of the injury;
- Under no-fault, personal injury protection, financial responsibility, uninsured motorist, and underinsured motorist insurance;
- Under motor vehicle and wage loss reimbursement insurance;
- Under homeowners, renters, premises and owners, landlords and tenants insurance including medical reimbursement coverages; and
- Under group accident and health insurance, and athletic team, sporting event, school, club, and other specific risk insurance coverages or accident benefit plans.

The injured person and persons acting on his or her behalf shall do nothing to prejudice the plan's subrogation rights and shall, when requested, provide the plan with accident-related information and cooperate with the plan in the enforcement of its subrogation rights. If the plan receives notice that it has or may be required to provide injury-related benefits to any person, it shall be entitled to assert a subrogation lien against responsible entities, persons, insurers, and attorneys when, and as necessary, to protect the rights of the plan and its members and beneficiaries. Even though the plan may request that a subrogation form be signed by the injured person, the subrogation right of the plan shall not be dependent upon the receipt by the plan of such a form. However, the plan has the right to hold all benefit payments until a signed subrogation form is received by the plan.

The amount of the plan's subrogation interest shall be deducted first from any recovery received by or on behalf of the injured person without regard to whether the recovery has been apportioned between medical or other damages and without regard to whether full and complete recovery of damages has occurred. The plan reserves the right to reduce the amount of its recoverable interest where, in the discretion of its fiduciaries, a reduction is in the best interest of the plan and its participants and is warranted by the circumstances. The plan is also entitled to recover any attorney's fees incurred in enforcing its subrogation rights. The plan shall not be responsible for expenses or attorney fees that are charged in connection with any recovery unless the plan agrees in writing to pay those expenses or fees. The plan also reserves the right to initiate an action in the name of the plan or in the name of the injured person to recover its subrogation interest.