PLAN DOCUMENT AND
SUMMARY PLAN DESCRIPTION
FOR

EMPLOYER'S BUSINESS ALLIANCE, INC.

HEALTH PLAN

7350 PLAN

EFFECTIVE JANUARY 1, 2023

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INTRODUCTION

This document is a description of Employer's Business Alliance, Inc. Employee/Member Health Plan (the Plan). No oral interpretations can change this Plan. The Plan described is designed to protect Plan Participants against certain catastrophic health expenses.

Coverage under the Plan will take effect for an eligible Employee/Member and designated Dependents when the Employee/Member and such Dependents satisfy all the eligibility requirements of the Plan.

The Employer fully intends to maintain this Plan indefinitely. However, it reserves the right to terminate, suspend, discontinue or amend the Plan at any time and for any reason.

Changes in the Plan may occur in any or all parts of the Plan including benefit coverage, deductibles, maximums, copayments, exclusions, limitations, definitions, eligibility and the like.

For Plan Years that begin on or after January 1, 2014, to the extent that an item or service is a covered benefit under the Plan, the terms of the Plan shall be applied in a manner that does not discriminate against a health care provider who is acting within the scope of the provider's license or other required credentials under applicable State law. This provision does not preclude the Plan from setting limits on benefits, including cost sharing provisions, frequency limits, or restrictions on the methods or settings in which treatments are provided and does not require the Plan to accept all types of providers as a Network Provider.

Failure to follow the eligibility or enrollment requirements of this Plan may result in delay of coverage or no coverage at all. Reimbursement from the Plan can be reduced or denied because of certain provisions in the Plan, such as coordination of benefits, subrogation, exclusions, timeliness of COBRA elections, utilization review or other cost management requirements, lack of Medical Necessity, lack of timely filing of claims or lack of coverage. These provisions are explained in summary fashion in this document; additional information is available from the Plan Administrator at no extra cost.

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

No action at law or in equity shall be brought to recover under any section of this Plan until the appeal rights provided have been exercised and the Plan benefits requested in such appeals have been denied in whole or in part.

If the Plan is terminated, amended, or benefits are eliminated, the rights of Covered Persons are limited to Covered Charges incurred before termination, amendment or elimination.

This document summarizes the Plan rights and benefits for covered Employee/Members and their Dependents and is divided into the following parts:

Schedule of Benefits. Provides an outline of the Plan reimbursement formulas as well as payment limits on certain services.

Eligibility, Funding, Effective Date and Termination. Explains eligibility for coverage under the Plan, funding of the Plan and when the coverage takes effect and terminates.

Benefit Descriptions. Explains when the benefit applies and the types of charges covered.

Cost Management Services. Explains the methods used to curb unnecessary and excessive charges.

> **This part should be read carefully since each Participant is required to take action to assure that the maximum payment levels under the Plan are paid.**

Defined Terms. Defines those Plan terms that have a specific meaning.

Plan Exclusions. Shows what charges are **not** covered.

Claim Provisions. Explains the rules for filing claims and the claim appeal process.

Coordination of Benefits. Shows the Plan payment order when a person is covered under more than one plan.

Third Party Recovery Provision. Explains the Plan's rights to recover payment of charges when a Covered Person has a claim against another person because of injuries sustained.

Continuation Coverage Rights Under COBRA. Explains when a person's coverage under the Plan ceases and the continuation options which are available.

ERISA Information. Explains the Plan's structure and the Participants' rights under the Plan.

ELIGIBILITY, FUNDING, EFFECTIVE DATE AND TERMINATION PROVISIONS

A Plan Participant should contact the Plan Administrator to obtain additional information, free of charge, about Plan coverage of a specific benefit, particular drug, treatment, test or any other aspect of Plan benefits or requirements.

ELIGIBILITY

Eligible Classes of Employee/Member. All Active Employee/Members of the Employer.

Eligibility Requirements for Employee/Member Coverage. A person is eligible for Employee/Member coverage from the first day that he or she:

1) is a Full-Time, Active Employee/Member/Member of the Employer. An Employee/Member/Member is considered to be Full-Time if he or she normally works at least 30 hours per week and is on the regular payroll of the Employer for that work, as reflected by the wage and tax reports, and the Employer reports the wages paid to that individual on IRS form W-2.

(2) is in a class eligible for coverage.

(3) completes the employment Waiting Period of 30 consecutive days as an Active Employee/Member A "Waiting Period" is the time between the first day of employment as an eligible Employee/Member/Member and the first day of coverage under the Plan.

(4) is a Full-Time, Active Member of the Company. A Member is considered eligible when the company is accepted and participating in Employer's Business Alliance.

(5) is an owner accepted into Employer's Business Alliance.

(6) Coverage begins on the first day of the month following the waiting period

(7) Coverage begins for Members who earn Self-Employment Income as defined under this plan the first of the month following the date they are accepted into Employer's Business Alliance.

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

(1) A covered Employee/Member's Spouse.

The term "Spouse" shall mean the person recognized as the covered Employee/Member's husband or wife under the laws of the state where the covered Employee/Member lives or was married and shall not include common law marriages. The term "Spouse" shall include partners of the same sex who were legally married under the laws of the State in which they were married. The Plan Administrator may require documentation proving a legal marital relationship.

The term "Spouse" shall mean the person with whom the covered Employee/Member has established a valid marriage under applicable State laws of the state where the covered Employee/Member lives or was married and shall not include common law marriages. The term "Spouse" shall include an individual of the same sex as the covered Employee/Member, if they were legally married under the laws of the State or other foreign or domestic jurisdiction. The Plan Administrator may require documentation proving a legal marital relationship.

The term "Spouse" shall also mean the person who is currently registered with the Company as the Domestic Partner of the Employee/Member, this includes opposite sex and same sex couples. An individual is a Domestic Partner of an Employee/Member if that individual and the Employee/Member meet each of the following requirements:

(a) The Employee/Member and individual are 18 years of age or older and are mentally competent to enter into a legally binding contract.

(b) The Employee/Member and the individual are not married to anyone.

(c) The Employee/Member and the individual are not related by blood to a degree of closeness that would prohibit legal marriage between individuals of the opposite sex in the state in which they reside.

(d) The Employee/Member and the individual share the same principal residence(s), the common necessities of life, the responsibility for each other's welfare, are financially interdependent with each other and have a long-term committed personal relationship in which each partner is the other's sole domestic partner. Each of the foregoing characteristics of the domestic partner relationship must have been in existence for a period of at least twelve (12) consecutive months and be continuing during the period that the applicable benefit is provided. The Employee/Member and the individual must have the intention that their relationship will be indefinite.

(e) The Employee/Member and the individual have common or joint ownership of a residence (home, condominium, or mobile home), motor vehicle, checking account, credit account, mutual fund, joint obligation under a lease for their residence or similar type ownership.

To obtain more detailed information or to apply for this benefit, the Employee/Member must contact the Plan Administrator, Employer's Business Alliance, Inc., 33479 Lake Road, Avon Lake, Ohio, 44012.

In the event the domestic partnership is terminated, either partner is required to inform Employer's Business Alliance, Inc. of the termination of the partnership.

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

(1) A covered Employee/Member's Child(ren).

An Employee/Member's "Child" includes his/her natural child, adopted child, or a child placed with the Employee/Member for adoption. An Employee/Member's child will also include children placed for adoption with the Employee/Member's Domestic Partner. The term "Child" also includes a stepchild as long as a natural parent of the step-child remains married to the Employee/Member and resides in the Employee/Member's household. An Employee/Member's Child will be an eligible Child until reaching the limiting age of 26, without regard to student status, marital status, financial dependency or residency status with the Employee/Member or any other person. When the child reaches the applicable limiting age, coverage will end on the final day of the child's birth month unless such Child is Totally Disabled.

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

(2) A Covered Employee/Member's Qualified Dependents

The term "Qualified Dependents" shall include individuals who do not qualify as a Child as defined above, but who are children for whom the Employee/Member is a Legal Guardian including Foster children.
To be eligible for Dependent coverage under the Plan, a qualified dependent must be under the limiting age of 26 years and primarily dependent upon the covered Member for support and maintenance. Coverage will end on the date in which the Qualified Dependent ceases to meet the applicable eligibility requirements, except under circumstance of reaching the limiting age. Coverage will then term end of the month.

Any child of a Plan Participant who is an alternate recipient under a qualified medical child support order shall be considered as having a right to coverage under this Plan.

A participant of this Plan may obtain, without charge, a copy of the procedures governing qualified medical child support order (QMCSO) determinations from the Plan Administrator.

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

(3) A covered Dependent child who reaches the limiting age and is Totally Disabled, incapable of self-sustaining employment by reason of mental or physical handicap, primarily dependent upon the covered Member for support and maintenance and unmarried. The Plan Administrator may require, at reasonable intervals, continuing proof of the Total Disability and dependency.

The Plan Administrator reserves the right to have such Dependent examined by a Physician of the Plan Administrator's choice, at the Plan's expense, to determine the existence of such incapacity.

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

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

If both mother and father are Employee/Members, their children will be covered as Dependents of the mother or father, but not of both.

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

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

FUNDING

Cost of the Plan. Employer's Business Alliance, Inc. may share the cost of Employee/Member and Dependent coverage under this Plan with the covered Employee/Members. The enrollment application for coverage may include a payroll deduction authorization. This authorization must be completed in a manner set forth by the Plan Administrator.

The level of any Employee/Member contributions is set by the Plan Administrator. The Plan Administrator reserves the right to change the level of Employee/Member contributions.

ENROLLMENT

Enrollment Requirements. An Employee/Member must enroll for coverage by filling out and signing an enrollment application along with the appropriate payroll deduction authorization.

Enrollment Requirements for Newborn Children.

A newborn child of a covered Employee/Member or spouse is automatically enrolled for the first 31 days under the covered parent and then is required to be enrolled in this Plan. Charges for covered nursery care will be applied toward the Plan of the covered parent.

If the newborn child of a covered Employee/Member is not formally enrolled in this Plan on a timely basis, as defined in the section "Timey Enrollment" following this section, there will be no payment from the Plan and the parents will be responsible for all costs.

Disclosure Requirements. Any person who, with intent to defraud or knowing that he is facilitating a fraud against the Plan, submits an application containing a false or deceptive statement is guilty of insurance fraud.

TIMELY OR LATE ENROLLMENT

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

If two Employee/Members (husband, wife or domestic partner) are covered under the Plan and the Employee/Member who is covering the Dependent children terminates coverage, the Dependent coverage may be continued by the other covered Employee/Member with no Waiting period as long as coverage has been continuous and the covered Employee/Member enrolls the Dependent children within 30 days of the children's loss of coverage.

(2) **Late Enrollment** - An enrollment is "late" if it is not made on a "timely basis" as described in paragraph (1) above or during a Special Enrollment Period. Late Enrollees and their Dependents who are not eligible to join the Plan during a Special Enrollment Period may join only during open enrollment.

Unless otherwise required by law, if an individual loses eligibility for coverage as a result of terminating employment or a general suspension of coverage under the Plan, then upon becoming eligible again due to resumption of employment or due to resumption of Plan coverage, only the most recent period of eligibility will be considered for purposes of determining whether the individual is a Late Enrollee.

The time between the date a Late Enrollee first becomes eligible for enrollment under the Plan and the first day of coverage is not treated as a Waiting Period. Coverage begins on June 1st of the year following the late enrollment.

SPECIAL ENROLLMENT RIGHTS

Federal law provides Special Enrollment provisions under some circumstances. If an Employee/Member is declining enrollment for himself or herself or his or her dependents (including his or her spouse) because of other health insurance or group health plan coverage, there may be a right to enroll in this Plan if there is a loss of eligibility for that other coverage (or if the employer stops contributing towards the other coverage). However, a request for enrollment must be made within 30 days after the coverage ends (or after the employer stops contributing towards the other coverage).

In addition, in the case of a birth, marriage, adoption or placement for adoption, there may be a right to enroll in this Plan. However, a request for enrollment must be made within 31 days of the birth, marriage, adoption or placement for adoption.

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

SPECIAL ENROLLMENT PERIODS

The events described below may create a right to enroll in the Plan under a Special Enrollment Period. The Enrollment Date for anyone who enrolls under a Special Enrollment Period is the first date of coverage. Thus,

the time between the date a special enrollee first becomes eligible for enrollment under the Plan and the first day of coverage is not treated as a Waiting Period.

(1) Individuals losing other coverage creating a Special Enrollment right. An Employee/Member or Dependent who is eligible, but not enrolled in this Plan, may enroll if loss of eligibility for coverage meets all of the following conditions:

(a) The Employee/Member or Dependent was covered under a group health plan or had health insurance coverage at the time coverage under this Plan was previously offered to the individual.

(b) If required by the Plan Administrator, the Employee/Member stated in writing at the time that coverage was offered that the other health coverage was the reason for declining enrollment.

(c) The coverage of the Employee/Member or Dependent who had lost the coverage was under COBRA and the COBRA coverage was exhausted, or was not under and either (i) the coverage was terminated as a result of loss of eligibility for the coverage (including as a result of legal separation, divorce, cessation of dependent status (such as attaining the maximum age to be eligible as a dependent child under the plan), death, termination of employment or reduction in the number of hours of employment, or the Plan ceasing to provide benefits to a class of similarly-situated individuals), or (ii) company contributions towards the coverage were terminated. The Member or Dependent also has a loss of eligibility when coverage is offered through an HMO, or other arrangement, in the individual or group market that does not provide benefits to individuals who no longer reside, live or work in a service area, (whether or not within the choice of the individual), and, in the case of the group market, no other benefit package is available to the individual.

(d) The Employee/Member or Dependent requests enrollment in this Plan not later than 30 days after the date of exhaustion of COBRA coverage or the termination of non-COBRA coverage due to loss of eligibility or termination of employer contributions, described above.

Coverage obtained due to this Special Enrollment event will be effective on the day after the other coverage ends or first of the month following the date the completed enrollment form is received.

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

(2) **Individuals losing Medicaid coverage or State Child Health Insurance Plan (CHIP) coverage (effective April 1, 2009).**

An Employee/Member or Dependent who is eligible, but not enrolled in this Plan, may enroll if each of the following conditions is met:

(a) The Employee/Member or Dependent is covered under a Medicaid plan under title XIX of the Social Security Act or under a State child health plan under title XXI of such Act and coverage of the Employee/Member or Dependent under such a plan is terminated as a result of loss of eligibility for such coverage.

(b) The Employee/Member or Dependent requests enrollment in this Plan not later than 60 days after the date of termination of the Medicaid or State child health plan coverage. Coverage obtained due to loss of Medicaid or CHIP coverage will be effective on the day after the other coverage ends.

(3) Individuals becoming eligible for employment assistance under Medicaid coverage or CHIP coverage (effective April 1, 2009).

An Employee/Member or Dependent who is eligible, but not enrolled in this Plan, may enroll if each of the following conditions is met:

(a) The Employee/Member or Dependent becomes eligible for assistance, with respect to coverage under this Plan, under a Medicaid plan or State child health plan.

(b) The Member or Dependent requests enrollment in this Plan not later than 60 days after the date the Member or Dependent is determined to be eligible for such assistance. Coverage obtained due to assistance eligibility will be effective on the day the Member or Dependent is eligible for the assistance.

4) Dependent beneficiaries. If:

(a) The Member is a participant under this Plan (or is eligible to be enrolled under this Plan but for a failure to enroll during a previous enrollment period), and

(b) A person becomes a Dependent of the Member through marriage, domestic partnership, birth, adoption, or placement for adoption, then the Dependent (and if not otherwise enrolled, the Member) may be enrolled under this Plan as a covered Dependent of the covered Member. In the case of the birth or adoption of a child, the Spouse of the covered Member may be enrolled as a Dependent of the covered Member if the Spouse is otherwise eligible for coverage.

The Dependent Special Enrollment Period is a period of 30 days and begins on the date of the marriage, birth, adoption or placement for adoption. To be eligible for this Special Enrollment, the Dependent and/or Employee/Member must request enrollment during this 30-day period.

The coverage of the Dependent and/or Employee/Member enrolled in the Special Enrollment Period will be effective:

(a) in the case of marriage, the first day of the first month beginning after the date of the completed request for enrollment is received;

(b) in the case of a Dependent's birth, as of the date of birth; or

(c) in the case of a Dependent's adoption or placement for adoption, the date of the adoption or placement for adoption.

(d) in the case of loss of eligibility for Medicaid or CHIP or eligibility for premium assistance under this Plan under Medicaid or CHIP, on the first day of the month following the change in eligibility.

EFFECTIVE DATE

Effective Date of Employee/Member Coverage. An Employee/Member will be covered under this Plan as of the first day that the Employee/Member satisfies the eligibility and enrollment requirements described previously in this section.

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

Effective Date of Dependent Coverage. A Dependent's coverage will take effect on the day that the Eligibility Requirements are met; the Employee/Member is covered under the Plan; and all Enrollment Requirements are met.

TERMINATION OF COVERAGE

The Company or Plan has the right to rescind any coverage of the Member/Employee and/or Dependents for cause, making a fraudulent claim or an intentional material misrepresentation in applying for or obtaining coverage, or obtaining benefits under the Plan. The Company or Plan may either void coverage for the Member/Employee and/or covered Dependents for the period of time coverage was in effect, may terminate coverage as of a date to be determined at the Plan's discretion, or may immediately terminate coverage. If coverage is to be terminated or voided

retroactively for fraud or misrepresentation, the Plan will provide at least 30 days' advance written notice of such action. The Company will refund all contributions paid for any coverage rescinded; however, claims paid will be offset from this amount. The Company reserves the right to collect additional monies if claims are paid in excess of the Company's and/or Dependent's paid contributions.

When Employee/Member Coverage Terminates. Employee/Member coverage will terminate on the earliest of these dates (except in certain circumstances, a covered Employee/Member may be eligible for COBRA continuation coverage. For a complete explanation of when COBRA continuation coverage is available, what conditions apply and how to select it, see the section entitled Continuation Coverage Rights under COBRA):

(1) The date the Plan is terminated.

(2) The last day of the calendar month in which the covered Employee/Member ceases to be in one of the Eligible Classes. This includes death or termination of Active Employment of the covered Employee/Member. (See the section entitled Continuation Coverage Rights under COBRA.) It also includes an Employee/Member on disability, leave of absence or other leave of absence, unless the Plan specifically provides for continuation during these periods.

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

Continuation During Periods of Employer-Certified Disability, Leave of Absence or Layoff. A person may remain eligible for a limited time if Active, full-time work ceases due to disability, leave of absence or layoff. This continuance will end as follows:

For a leave of absence: Employer approved leave for up to 12 weeks, for non-FMLA eligible members.

For layoff: Follows plan termination guidelines.

For disability: Follows plan termination guidelines.

While continued, coverage will be that which was in force on the last day worked as an Active Employee/Member. However, if benefits reduce for others in the class, they will also reduce for the continued person.

Continuation During Family and Medical Leave. Regardless of the established leave policies mentioned above, this Plan shall at all times comply with the Family and Medical Leave Act of 1993 as promulgated in regulations issued by the Department of Labor. This Plan will only provide benefits mandated by the Family Medical Leave Act of 1993. The Plan will not take any responsibility for an Employer's policy that is more generous and/or contrary to the mandate of FMLA.

During any leave taken under the Family and Medical Leave Act, the Employer will maintain coverage under this Plan on the same conditions as coverage would have been provided if the covered Employee/Member had been continuously employed during the entire leave period.

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

Rehiring a Terminated Employee/Member. An Employee/Member who is rehired will be treated as a new hire and be required to satisfy all Eligibility and Enrollment requirements. If the Employee/Member is returning to

work directly from COBRA coverage this Employee/Member does not have to satisfy any employment waiting period.

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

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

(a) The 24 month period beginning on the date on which the person's absence begins; or

(b) The day after the date on which the person was required to apply for or return to a position of employment and fails to do so.

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

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

If the Employee/Member wishes to elect this coverage or obtain more detailed information, contact the Plan Administrator Employer's Business Alliance, Inc., 33479 Lake Road, Avon Lake, Ohio, 44012. The Employee/Member may also have continuation rights under USERRA. In general, the Employee/Member must meet the same requirements for electing USERRA coverage as are required under COBRA continuation coverage requirements. Coverage elected under these circumstances is concurrent not cumulative. The Employee/Member may elect USERRA continuation coverage for the Employee/Member and their Dependents. Only the Employee/Member has election rights. Dependents do not have any independent right to elect USERRA health plan continuation.

When Dependent Coverage Terminates. (Unless otherwise stated throughout the Summary Plan Description) A Dependent's coverage will terminate on the earliest of these dates (except in certain circumstances, a covered Dependent may be eligible for COBRA continuation coverage. For a complete explanation of when COBRA continuation coverage is available, what conditions apply and how to select it, see the section entitled Continuation Coverage Rights under COBRA):

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

(2) The date that the Employee/Member's coverage under the Plan terminates for any reason including death. (See the section entitled Continuation Coverage Rights under COBRA.)

(3) The date a covered Spouse loses coverage due to loss of eligibility status. (See the section entitled Continuation Coverage Rights under COBRA.)

(4) Coverage will end on the last day of the month in which the Qualified Dependent ceases to meet the applicable eligibility requirements. (See the section entitled Continuation Coverage Rights under COBRA.)

(5) Coverage will end on the last day of the month in which the Child ceases to meet the applicable eligibility requirements. (See the section entitled Continuation Coverage Rights under COBRA.)

(6) If a Dependent commits fraud or makes an intentional misrepresentation of material fact in applying for or obtaining coverage, or obtaining benefits under the Plan, or fails to notify the Plan Administrator that he or she has become ineligible for coverage, then the Employer or Plan may either void coverage for the Dependent for the period of time coverage was in effect, may terminate coverage as of a date to be determined at the Plan's discretion, or may immediately terminate

coverage. If coverage is to be terminated or voided retroactively for fraud or misrepresentation, the Plan will provide at least 30 days' advance written notice of such action.

Telemedicine

As a member, you and your family can receive 24/7/365 access to U.S. board-certified physicians who can consult, diagnose and prescribe medication if deemed appropriate via telephone or video. Regardless of time and location, you can connect with a network physician for common and acute illnesses. The physician will be able to review your telemedicine record and assist you.

COST CONTAINMENT PROGRAMS

The Cost Containment Program is designed to assist participants with finding quality care in a cost-effective manner.

Each Participant (or enrolled family Member/Employee) is strongly encouraged to contact your Care Guide as soon as possible to receive guidance and valuable information for services noted below.

You may qualify for the cost containment program if you contact your Care Guide as soon as you know you need to see a specialist or have an imaging test. If you have already scheduled an appointment, you will not qualify for the cost containment program unless you are willing to change physicians/facilities. There is no penalty for not calling your Care Guide.

Specialty Care Benefits and Preferred Provider Programs

The Plan Administrator has arranged for resources and specialty programs for very specialized care through certain selected facilities, providers and medical management organizations. This specialized care and/or coordination is designed to offer enhanced outcomes for specific Injuries, Illnesses and treatment types. The arrangements will allow Covered Persons to receive the best care available at direct contracted and transparently negotiated rates. Any Covered Person who is about to undergo treatment of the types listed below may be a candidate for this specialized care. In certain cases, Benefits may be paid at 100% by the Plan for charges incurred through these Specialty Care and Preferred Provider program providers.

These services are freestanding and are separate from any PPO or non-PPO contracts or benefits.

Contact Detego Health LLC at (866) 815-6001 in order to find out if you qualify for specialized care for any of the following Illnesses or Injuries or in advance of any major or ongoing course of treatment to see if specialty providers may be available to you:

- Addiction treatment and substance abuse recovery.
- Cancer treatment.
- Cardiac treatment.
- Diagnostics and Radiology (X-rays, MRIs, CT Scans, PET Scans, Laboratory tests).
- Direct primary care and medical clinics.
- Elective surgeries.
- ENT procedures.
- Hemophilia.
- General surgeries.
- Infusions.
- Laboratory tests.
- Orthopedic surgeries.
- Physical therapy.
- Renal disease.
- Severe burns.
- Specialty providers.
- Transplants.

Travel Benefits

When applicable, Plan Administrator may reimburse the Covered Person for any travel expenses for Covered Person when Covered Person is being evaluated for cardiac, joint, replacement, cancer, transplant, spine procedures, or other surgeries. Reimbursement for eligible expenses for Covered Person and one caregiver will be covered when the following conditions apply:

1. **Mileage.** Mileage will be reimbursed based on reimbursement mileage limits set forth on an annual basis by the Internal Revenue Service (IRS). For mileage to apply, the Facility will need to be present at least 200 miles in a single direction. For certain geographic areas, 100 miles in a single direction may be considered based on prior approval from Plan.

2. **Air Travel.** Plan will provide coverage for coach class travel for a Facility that is more than 500 miles in a single direction. Air travel and procedure will need prior approval from Plan and Utilization Review at least two and a half to three weeks (2.5 weeks to 3 weeks) before scheduled procedure date.
3. **Hotel.** Plan will provider and coordinate hotel stay for any Surgical procedure under the Cost Containment and Preferred Provider Programs for pre-operation day, operation day and post-operation day. Any additional days will need prior approval from the Plan.
4. **Meals.** Plan will reimburse meals on a per diem maximum of $70 per day per person to include Covered Person who is the patient and one caregiver.

In addition, if the Plan Administrator identifies additional Conditions for which specialty provider services are available, the Covered Person will be given the opportunity to receive care and treatment through the specialty provider and thereby receive full benefits under the Plan.

Please note that each Covered Person has a free choice of any provider, and the Covered Person, together with his or her provider, is ultimately responsible for determining the appropriate course of medical treatment, regardless of whether the Plan will pay for all or a portion of the cost of such care. The specialty care providers are independent contractors; neither the Plan nor the Plan Administrator makes any warranty as to the quality of care that may be rendered by any provider.

Cost Containment Program Guidelines:
Call 866-815-6001 **before** scheduling services for:

- **Outpatient Surgery** - any scheduled non-emergency outpatient surgery at a hospital-based outpatient surgical center or free-standing surgical center

- **Imaging and Diagnostic Tests -** specific imaging tests: MRI, MRA, CT Scans, PET Scans

- **Diathrive –** a coaching and testing program available to you for diabetic services and testing supplies with access to a Care Guide who can help teach best practices along the way.

- **ConnectDME –** a Durable Medical Equipment program available to you for medical equipment supplies needed post-surgery, diabetic supplies, and Sleep Studies and CPAP/BiPAP equipment.

- **Teladoc Telemedicine -** Teladoc's telehealth services. As a Member/Employee, you and your family can receive 24/7/365 access to U.S. board-certified physicians who can consult, diagnose and prescribe medication if deemed appropriate via telephone or video. Regardless of time and location, you can connect with a network physician for common and acute illnesses. The physician will be able to review your telemedicine record and assist you.

  Telemedicine services available include common and acute illnesses, Behavioral and Mental Health, and Dermatology services.

- **Green Imaging –** a full service virtual Imaging network that provides affordable medical imaging services. As a Member/Employee, use of this program will provide greater patient savings if utilized.

Do not delay seeking medical care for any Covered Person who has a serious Condition that may jeopardize his life or health because of the requirements of this provision. For Urgent Care, emergency admissions, follow your Physician's instructions carefully, and contact Detego Health LLC as soon as possible thereafter.

OPEN ENROLLMENT

During the annual open enrollment period, designated by the Plan Sponsor, covered Employees and their covered Dependents will be able to change some of their benefit decisions based on which benefits and coverages are right for them.

Every annual open enrollment period, Employees and their Dependents who are Late Enrollees will be able to enroll in the Plan.

Benefit elections made during the open enrollment period will remain in effect for a 12-month period.

Mid-year changes to benefit elections are generally not permitted; however, a Member or Dependent who experiences a change in status during the year (such as birth, death, marriage, divorce, adoption, or loss of coverage due to loss of a Spouse's employment) may be eligible to make a corresponding change to his or her benefit elections during the year. See the section on Changes in Plan Enrollment. To the extent previously satisfied, coverage Waiting Periods will be considered satisfied when changing from one coverage to another.

Plan Participants will receive detailed information regarding open enrollment from their Company.

SCHEDULE OF BENEFITS

Verification of Eligibility (866) 815-6001

Call this number to verify eligibility for Plan benefits **before** the charge is incurred.

MEDICAL BENEFITS

All benefits described in this Schedule are subject to the exclusions and limitations described more fully herein including, but not limited to, the Plan Administrator's determination that: care and treatment is Medically Necessary; that charges are within the Plans allowable fee for; that services, supplies and care are not Experimental and/or Investigational. The meanings of these capitalized terms are in the Defined Terms section of this document.

For questions regarding the Medical Necessity of services, the Covered Person should have his or her Physician call the Utilization Management administrator at (866) 815-6001.

The Plan Administrator has the discretionary authority to decide whether a charge is within the Plans allowable fee. Benefits under this Plan shall be paid only if the Plan Administrator decides in its discretion that a Covered Person is entitled to them.

Charges for unidentified or non-specifically identified services must be identified to the Plan Administrator's satisfaction prior to payment. The Plan Administrator reserves the right to adjust charges for services and codes deemed by the Centers for Medicare and Medicaid Services to be "Carrier Priced." For time-related charges, including room and board, when less than 50% of the charged service time is used to the patient's benefit, payment shall be reduced by 50%.

Bundled charges and services include, but are not limited to, services performed under a single order, or reported in a single format, or normally performed or provided as components of a more comprehensive panel or service. Individual charges for individual sub-components of such services shall be considered "Unbundling." Unbundled charges may be rebundled into their more comprehensive service. Rebundled charges may be denied if the more comprehensive service from which they have been unbundled is being paid. At the Plan Administrator's discretion, such charges may be rebundled into the more comprehensive service and paid at the Plans allowable fee or the adjusted provider charge for the comprehensive service.

A provider that accepts the payment from the Plan will be deemed to consent and agree that (i) such payment shall be for the full amount due for the provision of services and supplies to a Covered Person and (ii) it shall not "balance bill" a Covered Person for any amount billed but not paid by the Plan.

Pre-determining Coverage Before Treatment

The Plan may not cover all medical costs incurred by the Covered Person. The patient and doctor can use the pre-determination procedure to know in advance what the Medical Plan will cover. ***The pre-determination procedure is as follows:*** The doctor should submit a letter with specific details and pertinent medical information as to the proposed treatment plan or surgical procedure to the Claims Administrator. The Claims Administrator will review the proposed care and advise the Covered Person and the doctor of the coverage available under the Medical Plan.

Note: The following services must be precertified or reimbursement from the Plan may be reduced.

The attending Physician does not have to obtain precertification from the Plan for prescribing a maternity length of stay that is 48 hours or less for a vaginal delivery or 96 hours or less for a cesarean delivery.

*****Services are precertified based on precertification guidelines established by the Precertification vendor.**

Hospitalizations
Inpatient Substance Abuse/Mental Disorder treatments
Home Health Care
Skilled Nursing Facility stays
Hospice Care
Durable Medical Equipment >$500
Physical, speech and/or occupational therapy
Cardiac rehabilitation therapy
Outpatient surgical procedures (other than the physician's office)
MRI/MRA/CAT/PET scans
Observation > 23 hours
Chemotherapy / Radiation therapy
Organ transplant
Sleep Studies
Dialysis
Prosthetics/Orthotics >$500
Specialty & Select High Costs Prescription Drug Products **

Please see the Cost Management section in this booklet for details.

****NOTE: Specialty and select high-cost medications may require additional review for coverage determination.**
Specialty Prescription Drug Products and select high-cost medications may be limited to up to a 30-day supply per Prescription Order or Refill. Specialty Prescription Drug Products and select high-cost medications must be filled at the MedalistRx Care designated Specialty or Retail Pharmacy.
Some specialty and high-cost medications may only be accessible through programs that are able to access medications at reduced cost including but not limited to drug manufacturer patient assistance programs. You will be contacted if a prescribed medication falls under such a program. MedalistRx Care will assist you in completing any registration needed to access these programs. Some programs may require household income and other documentation or action by you to enroll. For members choosing not to participate in these programs, your medication out-of-pocket cost under the plan could increase by as much as 100% of the medication cost. Any such increase will not accrue to any plan deductible or out-of-pocket maximum.
Any fees charged to facilitate the procurement of a specialty drug from a manufacturer, or another source will be treated as an eligible claim expense payable by the Plan, i.e., as a necessary component of the Plan's costs for obtaining the drug, for all purposes under the Plan (and for purposes of any stop loss coverage obtained by the Plan or the Company).******

Deductibles/Copayments payable by Plan Participants

Deductibles/Copayments are dollar amounts that the Covered Person must pay before the Plan pays.

A deductible is an amount of money that is paid once a Plan Year per Covered Person. Typically, there is one deductible amount per Plan and it must be paid before any money is paid by the Plan for any Covered Charges. Each June 1st, a new deductible amount is required.

A copayment is the amount of money that is paid each time a particular service is used. Typically, there may be copayments on some services and other services will not have any copayments.

Recovery of Incorrect Payment

The Plan tries to be sure that claims are processed correctly and quickly. If the Plan finds a payment that is incorrect, the Covered Person must repay any overpayment or incorrect payment to the Plan. The Plan will advise the Covered Person in writing if a refund is requested. Future benefits could be reduced to recover any overpayment or incorrect payments made.

Information and Records Disclaimer

At times the Plan may need additional information from the participants in order to furnish the Plan with all information and proofs that the Plan may reasonably require regarding any matters pertaining to the Policy. If the Participants do not provide this information when requested, it may delay or deny payment of their Benefits.

By accepting Benefits under this Plan, they authorize and direct any person or institution that has provided

services to them to furnish the Plan with all information or copies of records relating to the services provided. The Plan has the right to request this information at any reasonable time. This applies to all Covered Participants, including Enrolled Dependents whether or not they have signed the Subscriber's enrollment form. The Plan agrees that such information and records will be considered confidential.

MEDICAL BENEFITS SCHEDULE

MAXIMUM ANNUAL BENEFIT AMOUNT	UNLIMITED
ALL BENEFITS PAYABLE UNDER THIS PLAN ARE SUBJECT TO THE APPLICABLE PLAN EXCLUSIONS AND PROCEDURE BASED MAXIMUM EXPENSE	
DEDUCTIBLE, PER PLAN YEAR	
Per Covered Person	$7,350
Per Family Unit	$14,700
COPAYMENTS	
Primary Care Physician office visits (Family and General Practioner, and Internist)	$25 per visit
Specialist office visits	$45 per visit
Physical & Occupational Therapy	$45 per visit
Speech Therapy	$45 per visit
Cardiac Rehabilitation	$45 per visit
Outpatient Mental Health/Substance Abuse/Autism Spectrum Disorders	$25 per visit
Prenatal/Postnatal Office Visits	$25 per visit
Spinal Manipulation Chiropractic	$45 per visit
Routine Vision Exam	$45 per visit
Urgent Care	$60 per visit
MAXIMUM OUT-OF-POCKET AMOUNT, PER PLAN YEAR (INCLUDES DEDUCTIBLE, COINSURANCE & COPAYMENTS)	
Per Covered Person	$7,350
Per Family Unit	$14,700
The Plan will pay the designated percentage of Covered Charges until out-of-pocket amounts are reached, at which time the Plan will pay 100% of the remainder of Covered Charges for the rest of the Plan Year unless stated otherwise.	
The following charges do not apply toward the out-of-pocket maximum and are never paid at 100%. Cost containment penalties Amounts over the Plan allowable fee Charges Ineligible amounts	

COVERED CHARGES	
Hospital Services	
Room and Board	Facility: 100% after deductible, subject to plan allowable Professional Fees: 100% after deductible, subject to plan allowable
	Paid at the facility's semi-private room rate
Intensive Care Unit	Facility: 100% after deductible, subject to plan allowable Professional Fees: 100% after deductible, subject to plan allowable
	Paid at the Hospital's ICU Charge
Emergency Room Visit	
Emergency Room	Facility: 100% after deductible, subject to plan allowable Professional Fees: 100% after deductible, subject to plan allowable
Observation (less than 24 hours)	Facility: 100% after deductible, subject to plan allowable Professional Fees: 100% after deductible, subject to plan allowable
Outpatient Hospital/ Surgery Center	Facility: 100% after deductible, subject to plan allowable Professional Fees: 100% after deductible, subject to plan allowable
Skilled Nursing Facility	Facility: 100% after deductible, subject to plan allowable Professional Fees: 100% after deductible, subject to plan allowable
	Paid at the facility's semi-private room rate Limited to 60 days per benefit period maximum
Urgent Care Services (Includes all charges)	100% after copayment, subject to plan allowable

Physician Services	
Inpatient visits	Facility: 100% after deductible, subject to plan allowable Professional Fees: 100% after deductible, subject to plan allowable
Primary Care Physician Office visits (Includes Family practice, General Practitioner, Internist, Pediatrician, OB/GYN, Physician Assistant, or Nurse Practitioner) (Includes: All services billed and performed by the physician except surgery, anesthesia, MRI/CT/PET/ SPECT/MRA, and allergy testing, serum and injections)	100% after copayment
Specialist Physician Office visits (Includes: All services billed and performed by the physician except surgery, anesthesia, MRI/CT/PET/ SPECT/MRA, and allergy testing, serum and injections)	100% after copayment
Teladoc – Telemedicine	General Med - $5 Copay, Behavioral Health - $25 Copay, Dermatology - $45 Copay
Emergency Room Ancillary	Facility: 100% after deductible, subject to plan allowable Professional Fees: 100% after deductible, subject to plan allowable
Surgery	Facility: 100% after deductible, subject to plan allowable Professional Fees: 100% after deductible, subject to plan allowable
Anesthesia	Facility: 100% after deductible, subject to plan allowable Professional Fees: 100% after deductible, subject to plan allowable
Allergy testing, serum & injections	100% after deductible, subject to plan allowable
Diagnostic Services	Facility: 100% after deductible, subject to plan allowable Professional Fees: 100% after deductible, subject to plan allowable
Laboratory Services at Free Standing Facility	100% of plan allowable
Diagnostic Services at Free Standing Facility (X-ray only)	100% of plan allowable

Radiology **(CT, PET, MRI, MRA, SPECT)**	Facility: 100% after deductible, subject to plan allowable Professional Fees: 100% after deductible, subject to plan allowable
Home Health Care	100% after deductible, subject to plan allowable
	60 visits per benefit period maximum
Hospice Care	100% after deductible, subject to plan allowable
Ambulance Service – ground/air	100% after deductible, subject to plan allowable
Physical & Occupational Therapies	100% after copayment, subject to plan allowable
	Limited to 20 visits combined per benefit period maximum
Speech Therapy	100% after copayment, subject to plan allowable
	Limited to 20 visits per benefit period maximum
Cardiac Rehabilitation Therapy	100% after copayment, subject to plan allowable
	Limited to 36 visits per benefit period maximum
Durable Medical Equipment (Limited to 12 month rental or purchase price, whichever is less)	100% after deductible, subject to plan allowable
Prosthetics and Orthotics	100% after deductible, subject to plan allowable
Spinal Manipulation Chiropractic (Includes x-rays)	100% after copayment, subject to plan allowable
	Limited to 20 visits per benefit period
Mental Disorders/Substance Abuse	
Inpatient/Partial Hospitalization	Facility: 100% after deductible, subject to plan allowable Professional Fees: 100% after deductible, subject to plan allowable
	Paid at the facility's semi-private room rate
Outpatient	100% after copayment, subject to plan allowable
Autism Spectrum Disorders	
Inpatient/Partial Hospitalization	Facility: 100% after deductible, subject to plan allowable Professional Fees: 100% after deductible, subject to plan allowable
	Paid at the facility’s average room rate for treatment

Outpatient Visit	100% after copayment, subject to plan allowable
Preventive Care (Anything coded as wellness)	
Routine Mammogram	100% of plan allowable Limited to 1 per Plan Year
Routine Colonoscopy	100% of plan allowable Limited to 1 per Plan Year
Routine Well Adult Care Includes chest x-ray and EKG	100% of plan allowable
• Abdominal Aortic Aneurysm (Once per lifetime screening for men) • Alcohol Misuse screening/counseling • Aspirin use for men and women of certain ages • Blood Pressure screening • Cholesterol screening for adults of certain ages or at higher risk • Colorectal Cancer screening for adults • Depression screening • Type 2 Diabetes screening for adults with high blood pressure • Diet counseling for adults at higher risk for chronic disease • HIV screening for adults at higher risk • Immunization vaccines: (Doses, ages, and recommended populations vary) Hepatitis A Hepatitis B Herpes Zoster Human Papillomavirus Influenza Measles, Mumps, Rubella Meningococcal Pneumococcal Tetanus, Diphtheria, Pertussis Varicella • Obesity screening and counseling • Sexually Transmitted Infection (STI) prevention counseling for higher risk • Tobacco Use screening • Syphilis screening for higher risk	
Women's Preventive Care Services	100% of plan allowable

• Anemia screening on a routine basis for pregnant women • Bacteriuria urinary tract or other infection screening for pregnant women • BRCA counseling about genetic testing for women with higher risk • Breast cancer Chemoprevention counseling for women at higher risk • Breast Feeding intervention to support and promote breast feeding • Cervical cancer screening for sexually active women • Chlamydia infection screening for younger women and other women at higher risk • Folic Acid supplements for women who may become pregnant • Gonorrhea screening for all women at higher risk • Hepatitis B screening for pregnant women at their first prenatal visit • Osteoporosis screening for women over age 60 depending on risk factors • Rh Incompatibility screening for pregnant women & follow-up testing for women at higher risk • Tobacco Use screening and interventions for all women, and expanded counseling • Syphilis screening for all pregnant women or women at higher risk • Screening for gestational diabetes • Human papillomavirus testing • Counseling for sexually transmitted diseases • Counseling for screening for human immune-deficiency virus • FDA-approved female prescription contraceptive drugs and devices (e.g. diaphragm) • FDA-approved female prescription contraceptive surgical procedures (e.g. IUD's) • FDA-approved emergency contraceptive drugs • Breastfeeding support, supplies and counseling • Screening and counseling for interpersonal and domestic violence	
Routine Well Newborn Care (While hospital confined as a result of birth)	100% of plan allowable

Routine Well Child Care	100% of plan allowable
• Alcohol and Drug Use assessments for adolescents • Autism screening for children at 18 and 24 months • Behavioral assessments for children • Cervical Dysplasia screening for sexually active females • Congenital Hypothyroidism screening for newborns • Developmental screening for children under age 3, and surveillance throughout childhood • Dyslipidemia screening for children at higher risk for lipid disorders • Fluoride Chemoprevention supplements for children without fluoride in their water source • Gonorrhea preventive medication for the eyes of newborns • Hearing screening for newborns • Height, Weight and Body Mass Index measurements • Hematocrit or Hemoglobin screening for children • Hemoglobinopathis or sickle cell screening for newborns • HIV screening for adolescents at higher risk • Immunization vaccines: (Doses, ages, and recommended populations vary) Diphtheria, Tetanus, Pertussis Haemophilus influenzae type b Hepatitis A Hepatitis B Human Papillomavirus Inactivated Poliovirus Influenza Measles, Mumps, Rubella Meningococcal Pneumococcal Rotavirus Varicella • Iron supplements for children ages 6 to 12 months at risk for anemia • Lead screening for children at risk of exposure • Medical History for all children throughout development • Obesity screening and counseling • Oral Health risk assessment for young children • Phenylketonuria (PKU) screening for this genetic disorder in newborns • Sexually Transmitted Infection (STI) prevention counseling for adolescents at higher risk • Tuberculin testing for children at higher risk of tuberculosis • Vision screening for all children	
Organ Transplants	100% after deductible, subject to plan allowable (The Utilization Management Designated Transplant Network must be utilized)
Implantable Devices	100% after deductible, subject to plan allowable
Note: Provider billing must include a manufacturer/wholesaler invoice for the implantable device.	

Prenatal/Postnatal Care	100% after copayment, subject to plan allowable
Maternity Services (Room and Board charges limited to semi-private room rate) (Dependent daughter pregnancy is not covered)	Facility: 100% of plan allowable, deductible does not apply Professional Fees: 100% after deductible, subject to plan allowable
Jaw Joint / TMJ (medical necessity required)	Facility: 100% of plan allowable, deductible does not apply Professional Fees: 100% after deductible, subject to plan allowable
Orthopedic Shoes (Limited to specially molded and Medically Necessary shoes) (Limited to 1 paid per Covered Person per Plan Year)	100% after deductible, subject to plan allowable
Diabetes Self-Management Education Program	100% after deductible, subject to plan allowable
Nutritional Counseling (Limited to 2 visits per Plan Year, unless otherwise eligible under the Preventive Care Services)	100% after deductible, subject to plan allowable
Hearing Aids (benefit is only for under age 18 – medical necessity required)	100% after deductible, subject to plan allowable Limited to $1,500 per hearing aid ($3,000 per pair) including repair/replacement, every 5 Plan Years
Routine Vision Exams (age 21 and over, limited to one exam per covered person per Plan Year)	100% after copayment, subject to plan allowable
All Other Eligible Charges	Facility: 100% of plan allowable, deductible does not apply Professional Fees: 100% after deductible, subject to plan allowable

Covered expenses associated with COVID-19 during the pandemic period include the following:

1. **COVID-19 Testing** (Medically Necessary clinical diagnostic laboratory tests when a doctor or other Provider orders them. Providers must follow the Centers of Disease Control (CDC) guidelines regarding screening/testing for charges to be Covered Expenses. They will be covered at 100%. No deductible, copayment or coinsurance applies. **** For at-home COVID-19 testing coverage, see Prescription Drug Benefit section of this Plan.**

2. **Telehealth and Other Communication-Based Technology Services** will be covered at 100%. No deductible, copayment or coinsurance applies.

3. **Requests for Earl Prescription Refills.** To ensure participants have a least one month of supply of prescription medicines on hand, the Plan and its Prescription Drug Plan Administrator will, on a case-by-case basis, consider each request for an early prescription refill and make decisions based on the circumstances of the patient.

4. **Continuation of Coverage:**

    a. Allow employees not actively at work to be considered covered by the health plan due to the close businesses due to COVID-19 or governmental order related to COVID-19.
    b. Plan members considered Actively-at-Work the day prior to the closure of the business will be considered Actively-at-Work. We will honor employers offering continued eligibility to a plan member who is quarantined and not actively at work. Employees must return to work immediately following a quarantine period in order to continue active at work status. In the event they do not return to work, we would expect the Plan to follow all normal plan language related to continuation of coverage.
    c. Plan members Actively-at-Work the day prior to a furlough will be eligible to extend coverage during the furlough. We will honor employers offering continued eligibility to a plan member who is quarantined and not actively at work or off on a furlough until called back to work. Employees must return to work immediately following a quarantine period and/or furlough period in order to continue active at work status. In the event they do not return to work, we would expect the Plan to follow all normal plan language related to not actively at work status.
    d. If due to COVID-19 Social Distancing guidelines, employees on non-medical leave of absence/unable to work remotely will have continued coverage.
    e. Extended election period and payment for COBRA elections as determined by governmental order.

All above benefits related to COVID-19 will end after the pandemic period has closed, as determined by governmental order and will follow the standard benefit terms.

PRESCRIPTION DRUG BENEFIT SCHEDULE

Pharmacy Option (30 day Supply)

Generic Drugs
Copayment ..... 100% after Deductible

Brand Name
Copayment ..... 100% after Deductible

Non-Preferred Brand
Copayment ..... 100% after Deductible

90-Day Pharmacy and Mail Order Options

Generic Drugs
Copayment ..... 100% after Deductible

Brand Name
Copayment ..... 100% after Deductible

Non-Preferred Brand
Copayment ..... 100% after Deductible

**Non-Participating Pharmacies are not covered.

Refer to the Prescription Drug Section for details on the Prescription Drug benefit.

MEDICAL BENEFITS

Medical Benefits apply when Covered Charges are incurred by a Covered Person for care of an Injury or Sickness and while the person is covered for these benefits under the Plan.

DEDUCTIBLE

Deductible Amount. This is an amount of Covered Charges for which no benefits will be paid. Before benefits can be paid in a benefit period a Covered Person must meet the deductible shown in the Schedule of Benefits.

Family Unit Limit. When the maximum amount shown in the Schedule of Benefits has been incurred by members of a Family Unit toward their benefit period deductibles, the deductibles of all members of that Family Unit will be considered satisfied for that year.

Common Accident Deductible
When two or more individuals covered under the Plan in a family unit are injured in the same accident, those individuals need not meet separate deductibles for treatment of injuries incurred in that accident; instead, only one deductible for the benefit period in which the accident occurred will be required for those individuals for expenses arising from the accident.

BENEFIT PAYMENT

Each Plan Year, benefits will be paid for the Covered Charges of a Covered Person that are in excess of the deductible and any copayments. Payment will be made at the rate shown under reimbursement rate in the Schedule of Benefits. No benefits will be paid in excess of the Maximum Benefit Amount or any listed limit of the Plan. The Plan Administrator maintains the discretion and authority to audit claims, or facilitate the auditing of claims, in order to fulfill its obligations as Plan Fiduciary, and to determine the amounts properly payable under this Plan as to all claims.

OUT-OF-POCKET LIMIT

Covered Charges are payable at the percentages shown each Plan Year until the out-of-pocket limit shown in the Schedule of Benefits is reached. Then, Covered Charges incurred by a Covered Person will be payable at 100% (except for any charges excluded as shown in the Schedule of Benefits) for the rest of the Plan Year.

When a Family Unit (or Member + One) reaches the out-of-pocket limit, Covered Charges for that Family Unit (or Member + One) will be payable at 100% (except for the charges excluded) for the rest of the Plan Year.

COVERED CHARGES

Covered Charges are the allowable charges that are incurred for the following items of service and supply. These charges are subject to the benefit limits, exclusions and other provisions of this Plan. A charge is incurred on the date that the service or supply is performed or furnished.

(1) **Hospital Care.** The medical services and supplies furnished by a Hospital or Outpatient Surgical Center or a Birthing Center. Covered Charges for room and board will be payable as shown in the Schedule of Benefits. After 23 observation hours, a confinement will be considered an inpatient confinement.

Room charges made by a Hospital having only private rooms will be paid at the average private room rate.

Charges for an Intensive Care Unit stay are payable as described in the Schedule of Benefits.

(2) **Coverage of Pregnancy.** The Plans allowable fee for the care and treatment of Pregnancy are covered the same as any other Sickness for a covered Employee/Member or Spouse.

Group health plans generally may not, under Federal law, restrict benefits for any hospital length of stay in connection with childbirth for the mother or newborn child to less than 48 hours following a vaginal delivery, or less than 96 hours following a cesarean section. However, Federal law generally

does not prohibit the mother's or newborn's attending provider, after consulting with the mother, from discharging the mother or her newborn earlier than 48 hours (or 96 hours as applicable). In any case, plans and issuers may not, under Federal law, require that a provider obtain authorization from the plan or the issuer for prescribing a length of stay not in excess of 48 hours (or 96 hours).

(3) **Skilled Nursing Facility Care.** The room and board and nursing care furnished by a Skilled Nursing Facility will be payable if and when:

a) the confinement is in lieu of an inpatient Hospital confinement or the confinement starts immediately after a Hospital confinement of at least three days for the same admitting condition or diagnosis;

(b) the attending Physician certifies that the confinement is needed for further care of the condition that caused the Hospital confinement; and

(c) the attending Physician completes a treatment plan which includes a diagnosis, the proposed course of treatment, and the projected date of discharge from the Skilled Nursing Facility.

Covered Charges for a Covered Person's care in these facilities are payable as described in the Schedule of Benefits.

(4) **Physician Care.** The professional services of a Physician for surgical or medical services.

Charges for **multiple surgical procedures** will be a Covered Charge subject to the following provisions:

(i) If bilateral or multiple surgical procedures are performed by one (1) surgeon, benefits will be determined based on the plan allowable fee Charge for the primary procedures; 50% of the plan allowable fee Charge will be allowed for each additional procedure performed during the same operative session. Any procedure that would not be an integral part of the primary procedure or is unrelated to the diagnosis will be considered "incidental" and no benefits will be provided for such procedures;

(ii) If multiple unrelated surgical procedures are performed by two (2) or more surgeons on separate operative fields, benefits will be based on the plan allowable fee Charge for each surgeon's primary procedure. If two (2) or more surgeons perform a procedure that is normally performed by one (1) surgeon, benefits for all surgeons will not exceed the plan allowable fee Charge for that procedure; and

(iii) If an assistant surgeon is required, the assistant surgeon's covered charge will not exceed 20% of the surgeon's allowable fee allowance.

(iv) If a Certified Registered Nurse Anesthetist (CRNA) is required, the CRNA's covered charge will not exceed 50% of the Anesthesiologist's allowable fee allowance. The total amount payable to the CRNA and Anesthesiologist will not exceed the Anesthesiologist's allowable fee allowance (i.e., the Anesthesiologist's reimbursement shall also be 50% of the Anesthesiologist's allowable fee allowance).

(b) Charges for **multiple office visits** will be a covered expense subject to the following provisions:

(i) If Preventative Medicine Services and Problem Focused Evaluation and Management Services are submitted for the same patient by the same provider on the same date of service, benefits will be determined based on the plan allowable fee for the Preventive service; 50% of the plan allowable fee will be allowed for the Problem Focused Evaluation and Management Service provided the evaluation and management code represents a significant, separately identifiable services and is submitted with a modifier 25. No benefits will be provided for any Problem Focused Evaluation and Management code that does not represent a separately identifiable service, or is not submitted with a modifier 25, or is unrelated to the diagnosis.

Private Duty Nursing Care. The private duty nursing care by a licensed nurse (R.N., L.P.N. or L.V.N.). Covered Charges for this service will be included to this extent:

(a) **Inpatient Nursing Care.** Charges are covered only when care is Medically Necessary or not Custodial in nature and the Hospital's Intensive Care Unit is filled or the Hospital has no Intensive Care Unit.

(b) **Outpatient Nursing Care.** Outpatient private duty nursing care on a 24-hour-shift basis is not covered. The only charges covered for Outpatient nursing care are those shown below, under Home Health Care Services and Supplies.

(6) **Home Health Care Services and Supplies.** Charges for home health care services and supplies are covered only for care and treatment of an Injury or Sickness when Hospital or Skilled Nursing Facility confinement would otherwise be required. The diagnosis, care and treatment must be certified by the attending Physician and be contained in a Home Health Care Plan.

A home health care visit will be considered a periodic visit by either a nurse or therapist, as the case may be. Each visit of four hours or less by a provider of Home Health Care is considered one visit. Benefits for private duty nursing services will not exceed three nurses per day or more than 120 visits per 12-month period. Aides, food or home delivered meals, or dietician, homemaker, and maintenance services are not covered

(7) **Hospice Care Services and Supplies.** Charges for hospice care services and supplies are covered only when the attending Physician has diagnosed the Covered Person's condition as being terminal, determined that the person is not expected to live more than six months and placed the person under a Hospice Care Plan.

Covered Charges for Hospice Care Services and Supplies are payable as described in the Schedule of Benefits.

Covered charges include home health aide services if supervised by a registered nurse. The Plan does not provide hospice care benefits for private duty nursing, chemotherapy and radiation therapy except for relief control, bereavement or spiritual care counseling, or financial, legal, or estate planning.

Charges for Bereavement counseling services by a licensed social worker or a license pastoral counselor for the patient’s immediate family (covered Spouse and/or other covered Dependents). Bereavement services must be furnished within six months after the patient’s death.

Charges for Bereavement counseling are subject to the limits as described in the Schedule of Benefits.

(8) **Other Medical Services and Supplies.** These services and supplies not otherwise included in the items above are covered as follows:

(a) Local Medically Necessary professional land or air **ambulance** service. A charge for this item will be a Covered Charge only if the service is to the nearest Hospital or Skilled Nursing Facility where necessary treatment can be provided unless the Plan Administrator finds a longer trip was Medically Necessary. Air ambulance service is available only when deemed medically necessary.

(b) **Anesthetic**; oxygen; blood and blood derivatives that are not donated or replaced; intravenous injections and solutions. Administration of these items is included.

(c) **Cardiac rehabilitation** as deemed Medically Necessary provided services are rendered (a) under the supervision of a Physician; (b) in connection with a myocardial infarction, coronary occlusion or coronary bypass surgery; (c) initiated within 12 weeks after other treatment for the medical condition ends; and (d) in a Medical Care Facility as defined by this Plan.

(d) Radiation or **chemotherapy** and treatment with radioactive substances. The materials and services of technicians are included.

(e) Routine patient care charges for **Clinical Trials.** Coverage is provided only for routine patient care costs for a Qualified Individual in an approved clinical trial for treatment of cancer or other life-threatening disease or condition. For these purposes, a Qualified Individual is a Covered Person who is eligible to participate in an approved clinical trial according to the trial protocol with respect to the treatment of cancer or another life-threatening disease or condition, and either: (1) the referring health care professional is a Network Provider and has concluded that the individual's participation in such trial would be appropriate; or (2) the Covered Person provides medical and scientific information establishing to the satisfaction of the Plan Administrator that the individual's participation in such trial would be appropriate. Coverage is not provided for charges not otherwise covered under the Plan and does not include charges for the drug or procedure under trial, or charges which the Qualified Individual would not be required to pay in the absence of this coverage.

(f) Initial **contact lenses** or glasses required following cataract surgery.

(g) Outpatient **diabetic self-management training and education** when provided under the supervision of a licensed health care professional with expertise in diabetes.

(h) **Diabetic Shoes.** Limited to one pair per benefit period.

(i) Rental of **durable medical or surgical equipment** if deemed Medically Necessary. These items may be bought rather than rented, with the cost not to exceed the fair market value of the equipment at the time of purchase. Repairs may be considered if deemed Medically Necessary, if repairs do not exceed the fair market replacement value of the equipment at the time of repair. There is no coverage for repairs required due to mistreatment or misuse of equipment.

(j) **Genetic tests** that are Medically Necessary and that meet the following conditions:

- the results will directly impact clinical decision making and/or clinical outcome for the individual;
- the testing method must be considered scientifically valid for identification of a genetically-linked heritable disease; and
- the individual either demonstrates signs/symptoms of a genetically heritable disease or has a direct risk factor (based on family history or pedigree analysis) for the development of a genetically linked heritable disease.

Genetic tests not meeting these criteria are not covered by the Plan, with the exception of items or services provided by Network Providers that are required to be covered by 29 CFR Section 2590.715-2713 pursuant to the Patient Protection and Affordable Care Act (i.e., a preventive health service included in the recommendations and guidelines listed in that section).

(k) Care supplies and services for the diagnosis, and treatment to correct the underlying case of **infertility**.

(l) **Injectables** except as specifically excluded by the Plan or when given as treatment for a condition not covered by the Plan or in relation to services not covered by the Plan.

(m) Medically Necessary services for care and treatment of **jaw joint conditions, including Temporomandibular Joint syndrome (TMJ).** Does not include charges for orthodontic services.

(n) **Laboratory studies.** Covered Charges for diagnostic and preventive lab testing and services.

(o) Treatment of **Mental Disorders and Substance Abuse**. Covered charges for care, supplies and treatment of Mental Disorders and Substance Abuse will be limited as follows:

i. All treated is subject to the benefit payment limits shown in the Schedule of Benefits.
ii. Psychiatrists (M.D.), psychologists (Ph.D.), counselors (Ph.D., LPC), or Master of Social Work (M.S.W.) may bill the Plan directly. Other licensed mental health practitioners must be under the direction of and must be bill the Plan through these professionals.

Regardless of any limitations on benefits for Mental Disorders and Substance Abuse Treatment otherwise specified in the Plan, any aggregate annual limit, financial requirement, out-of-network exclusion or non-quantitative treatment limitation on Mental Disorders and Substance Abuse benefits imposed by the Plan shall comply with federal parity requirements, if applicable.

(p) Injury to or care of **mouth, teeth and gums**. Charges for Injury to or care of the mouth, teeth, gums and alveolar processes will be Covered Charges under Medical Benefits only if that care is for the following oral surgical procedures:

- Excision of tumors and cysts of the jaws, cheeks, lips, tongue, roof and floor of the mouth.
- Care rendered for fractures of facial bones.
- Care rendered for lesions of the mouth, lip, or tongue.
- Dislocations of the jaw due to trauma.
- Reconstruction or repair of traumatic Injuries.
- Emergency repair due to Injury to sound natural teeth. This repair must be made within 12 months from the date of an accident.
- Surgery needed to correct accidental injuries to the jaws, cheeks, lips, tongue, floor and roof of the mouth. An injury caused by chewing or biting, or received in the course of other dental procedures, is not an accidental injury.
- Excision of benign bony growths of the jaw and hard palate.
- Excision of temporomandibular joints (TMJ)
- External incision and drainage of cellulitis.
- Incision of sensory sinuses, salivary glands or ducts.
- Removal of full bony impacted wisdom teeth.

No charge will be covered under Medical Benefits for dental and oral surgical procedures involving orthodontic care of the teeth, periodontal disease and preparing the mouth for the fitting of or continued use of dentures.

(q) **Occupational therapy** by a licensed occupational therapist. Therapy must be ordered by a Physician, result from an Injury or Sickness and improve a body function. Covered Charges do not include recreational programs, maintenance therapy or supplies used in occupational therapy.

(r) **Organ transplant** limits. Charges otherwise covered under the Plan that are incurred for the care and treatment due to an organ or tissue transplant are subject to these limits:

The transplant must be performed to replace an organ or tissue, must be Medically Necessary and not Experimental. Transplantation of non-human organs and tissues and

related services and supplies are not covered. Also, transplantation of the stomach, small intestines, and/or colon as well as services and supplies relating to such transplantations are not covered.

The utilization manager must approve all covered procedures at least 72 hours before the admission of the transplant patient. If the procedure is not approved, benefits may not be paid. See the Utilization Management section for details on obtaining approval.

The Plan will cover donor organ or tissue charges for evaluating the organ or tissue, removing the organ or tissue from the donor, and transportation of the organ from within the United States and Canada to the place where the transplant is to take place. When the donor has medical coverage, his or her plan will pay first. Those payable will reduce the benefits under this Plan under the donor's plan. The Plan will always pay secondary to any other coverage.

The network for transplants may not be the network listed on the I.D. Card. To receive network benefits for a transplant, the transplant network must be utilized.

(s) The initial purchase, fitting and repair of **orthotic appliances** such as braces, splints or other appliances which are required for support for an injured or deformed part of the body as a result of a disabling congenital condition or an Injury or Sickness. This Plan does cover orthotics for the foot, i.e., custom-molded shoe inserts that are used to support and reposition the heel, arch, muscles, ligaments, tendons, and/or bones in the feet. The Plan also covers charges for diabetic shoes (see limits in Schedule of Benefits).

(t) **Pain Management** services performed by either an anesthesiologist or by a provider with the specialty of pain management if Medically Necessary.

(u) **Physical therapy** by a licensed physical therapist. The therapy must be in accord with a Physician's exact orders as to type, frequency and duration and for conditions which are subject to significant improvement through short-term therapy.

(v) **Prescription** Drugs (as defined).

(w) Routine **Preventive Care.** Covered Charges under Medical Benefits are payable for routine Preventive Care as described in the Schedule of Benefits. Additional preventive care shall be provided as required by applicable law if provided by a Panel/Network/Participating Provider. A current listing of required preventive care can be accessed at https://www.healthcare.gov/coverage/preventive-care-benefits/

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

Charges for Routine Well Child Care. Routine well child care is routine care by a Physician that is not for an Injury or Sickness.

(x) The initial purchase, fitting and repair of fitted **prosthetic devices** which replace body parts, and replacement if there is sufficient change in the Covered Person's physical condition to make the original device no longer functional.

(y) **Reconstructive Surgery.** Correction of abnormal congenital conditions and reconstructive mammoplasties will be considered Covered Charges.

This mammoplasty coverage will include reimbursement for:

(i) reconstruction of the breast on which a mastectomy has been performed,

(ii) surgery and reconstruction of the other breast to produce a symmetrical appearance, and

(iii) coverage of prostheses and physical complications during all stages of mastectomy, including lymphedemas,

in a manner determined in consultation with the attending Physician and the patient.

(z) **Speech therapy** by a licensed speech therapist. Therapy must be ordered by a Physician and follow either: (i) surgery for correction of a congenital condition of the oral cavity, throat or nasal complex (other than a frenectomy) of a person; (ii) an Injury; or (iii) a Sickness that is other than a learning or Mental Disorder.

(aa) **Spinal Manipulation services** by a health care provider acting within the scope of his or her license.

(bb) **Sterilization** procedures.

(cc) **Surgical dressings**, splints, casts and other devices used in the reduction of fractures and dislocations.

(dd) Coverage of **Well Newborn Nursery/Physician Care**.

Charges for Routine Nursery Care. Routine well newborn nursery care is care while the newborn is Hospital-confined after birth and includes room, board and other normal care for which a Hospital makes a charge.

This coverage is only provided if the newborn child is an eligible Dependent and a parent (1) is a Covered Person who was covered under the Plan at the time of the birth, or (2) enrolls himself or herself (as well as the newborn child if required) in accordance with the Special Enrollment provisions with coverage effective as of the date of birth.

The benefit is limited to the Plans allowable fee for nursery care for the newborn child while Hospital confined as a result of the child's birth.

Charges for covered routine nursery care will be applied toward the Plan of the covered parent.

Group health plans generally may not, under Federal law, restrict benefits for any hospital length of stay in connection with childbirth for the mother or newborn child to less than 48 hours following a vaginal delivery, or less than 96 hours following a cesarean section. However, Federal law generally does not prohibit the mother's or newborn's attending provider, after consulting with the mother, from discharging the mother or her newborn earlier than 48 hours (or 96 hours as applicable). In any case, plans and issuers may not, under Federal law, require that a provider obtain authorization from the plan or the issuer for prescribing a length of stay not in excess of 48 hours (or 96 hours).

Charges for Routine Physician Care. The benefit is limited to the Plans allowable fee Charges made by a Physician for the newborn child while Hospital confined as a result of the child's birth.

Charges for covered routine Physician care will be applied toward the Plan of the covered parent.

(ee) Charges associated with the initial purchase of a **wig after chemotherapy.**

(ff) Diagnostic **x-rays**.

(gg) A facility or surgical implant provider billing for an **implantable device** shall include with the billing an invoice that represents the actual cost (net amount, exclusive of rebates AND

discounts) for the implantable device. The cost of the implantable device, plus 25% is the documented maximum amount allowable for consideration under the Plan.

In the event the implant invoice is not obtained by the Plan, the Plan will have the discretionary authority to apply the PPO discount and/or audit negotiation in place of the calculation based on the actual implant billing.

(hh) Any charge for **contraceptive** materials, devices injections or any other related services.

(ii) Covered expenses associated with **COVID-19** include the following:

1. **COVID-19 Testing** (Medically Necessary clinical diagnostic laboratory tests when a doctor or other Provider orders them. Providers must follow the Centers for Disease Control (CDC) guidelines regarding screening/testing for charges to be Covered Expenses) will be covered at 100%. No deductible, copayment or coinsurance applies.

2. **Telehealth and Other Communication-Based Technology Services** will be covered at 100%. No deductible, copayment or coinsurance applies.

3. **Requests for Early Prescription Refills.** To ensure participants have at least a one month supply of prescription medicines on-hand, the Plan and its Prescription Drug Plan Administrator will, on a case-by-case, basis, consider each request for an early prescription refill and make decisions based on the circumstances of the patient.

4. **Inpatient Hospital Quarantines through the pandemic period.** There may be times when Participants with the virus need to be quarantined in a Hospital private room to avoid infecting other individuals.

   These patients may not meet the need for acute inpatient care any longer but may remain in the Hospital for public health reasons. Such charges will not be denied solely because otherwise-applicable Medically Necessary requirements would not indicate a need for a private room.

5. **Non-Emergency Ambulance Transportation through the pandemic period**. The Plan will cover limited, Medically Necessary, non-emergency ambulance transportation relating to COVID-19 Diagnosis or treatment.

(jj) NOTE: Specialty and select high-cost medications may require additional review for coverage determination.

Specialty Prescription Drug Products and select high-cost medications may be limited to up to a 30-day supply per Prescription Order or Refill. Specialty Prescription Drug Products and select high-cost medications must be filled at the MedalistRx Care designated Specialty or Retail Pharmacy.

Some specialty and high-cost medications may only be accessible through programs that are able to access medications at reduced cost including but not limited to drug manufacturer patient assistance programs. You will be contacted if a prescribed medication falls under such a program. MedalistRx Care will assist you in completing any registration needed to access these programs. Some programs may require household income and other documentation or action by you to enroll. For members choosing not to participate in these programs, your medication out-of-pocket cost under the plan could increase by as much as 100% of the medication cost. Any such increase will not accrue to any plan deductible or out-of-pocket maximum.
Any fees charged to facilitate the procurement of a specialty drug from a manufacturer, or another source will be treated as an eligible claim expense payable by the Plan, i.e., as a necessary component of the Plan's costs for obtaining the drug, for all purposes under the Plan (and for purposes of any stop loss coverage obtained by the Plan or the Company).

CLAIM REVIEW AND AUDIT PROGRAM – MEDICAL BENEFITS

The Plan has partnered with Claim Control Pro, LLC. ("CCP") for claim review and auditing in order to identify charges billed in error, charges for excessive or unreasonable fees and charges for services which are not medically appropriate. Benefits for claims which are selected for review and auditing may be reduced for any charges that are determined to be in excess of Allowable Claim Limits (as defined below). The determination of Allowable Claim Limits under this Program will supersede any other Plan provisions related to application of a Reasonable and Customary or reasonable fee determination.

Medical care providers will be given a fully detailed explanation of any charges that are found to be in excess of Allowable Claim Limits, and allowed the rights and privileges to file an appeal of the determination which are the same rights and privileges accorded to Covered Persons; and, in return, the provider must agree not to bill the Covered Person for charges which were not covered as a result of the claim review and audit. This will in no way affect the rights of the Covered Person to file an appeal under the Plan. Please refer to the section, "Appeal of Adverse Benefit Determinations" for additional information regarding Covered Person and provider appeals.

Any Covered Person who receives a balance-due billing from a medical care provider for these charges should contact the Plan Administrator right away for assistance.

The Plan Administrator is identified in the Introduction section of the Summary Plan Description. CCP may be contacted at:

Claim Control Pro, LLC
PO BOX 450978
Westlake, OH, 44145
Phone: 877-585-8480
Fax: 440-249-7276

The Covered Person must pay for any normal cost-sharing features of the Plan, such as Deductibles, Coinsurance and Copays, and any amounts otherwise excluded or limited according to the terms of the Plan.

The success of this program will be achieved through a comprehensive review of detailed records including, for example, itemized charges and descriptions of the services and supplies provided. Without this detailed information, the Plan will be unable to make a determination of the amount of Covered Expense that may be eligible for reimbursement. Any additional information required for the audit will be requested directly from the provider of service and the Covered Person. In the event that the Plan Administrator does not receive information adequate for the claim review and audit within the time limits required under the Plan, it will be necessary to deny the claim. Should such a denial be necessary, the Covered Person and/or the provider of service may appeal the denial in accordance with the provisions which may be found in the section, "Benefit Claims Procedure" in this Plan.

In the following provisions of the Claim Review and Audit Program, the term "Plan Administrator" shall be deemed to mean CCP:

"Allowable Claim Limits" means the charges for services and supplies, listed and included as covered expenses under the Plan, which are Medically Necessary for the care and treatment of Illness or Injury, but only to the extent that such fees are within the Allowable Claim Limits. Examples of the determination that a charge is within the Allowable Claim Limit include, but are not limited to, the following guidelines:

1. **Errors, Unbundled and/or Unsubstantiated Charges**. Allowable Claim Limits will not include the following amounts:
    a. Charges identified as improperly coded, duplicated, unbundled and/or for services not performed;
    b. Charges for treating injuries sustained or illnesses contracted, including infections and complications, which, in the opinion of the Plan Administrator can be attributed to medical errors by the provider;
    c. Charges that cannot be identified or understood; and
    d. Charges that cannot be verified from audits of medical records.
2. **Guidelines.** The following guidelines will be used when determining Allowable Claim Limits:

a. **Hospital** - The Allowable Claim Limit for charges incurred under this plan will be based upon 140% of the provider's most recent departmental cost ratio, reported to the Centers for Medicare and Medicaid Services ("CMS") and published in the American Hospital Directory as the "Medicare Cost Report" (the "CMS Cost Ratio"), or may be based upon the Medicare allowed amount for the services in the geographic region plus an additional 20%, not to exceed a maximum of 200% of the Medicare allowable. For providers which do not report cost-to-charge ratios or participate with Medicare such as Children's Hospitals, Independently Owned Cancer Centers, and Physician Owned Hospitals, the Allowable Claim Limits for charges by these types of facilities may be based on 140% of the average of the contracted/discounted rates accepted by nearby providers offering the same or similar services. All hospital billing must follow Medicare guidelines.

b. **Professional Providers** - The Allowable Claim Limit for charges incurred under this plan will be based upon 120% of the provider's most recent departmental cost ratio, reported to the Centers for Medicare and Medicaid Services ("CMS") and published in the American Hospital Directory as the "Medicare Cost Report" (the "CMS Cost Ratio"), or may be based upon the Medicare allowed amount for the services in the geographic region plus an additional 20%, not to exceed a maximum of 200% of the Medicare allowable. The Allowable Claim Limit for charges incurred by a Specialist will be based upon 130% of the Medicare allowable.

3. **DIRECT CONTRACTS WITH A HOSPITAL, OTHER MEDICAL FACILITY OR PROVIDER.** In the event that the Plan Administrator authorizes a direct contract for services with a hospital, other medical facility or provider to provide necessary and appropriate services to Covered Persons, then the terms of those contracts shall be utilized to determine the Allowable Claim limits in lieu of other limits under this Program.

4. **Insufficient Information to Determine Allowable Claim Limit.** In the event that insufficient information is available to determine Allowable Claim Limits for specific services or supplies using the guidelines listed in Section 2 above as may be applicable, ELAP may apply the following guidelines:

   a. **General Medical and/or Surgical Services.** The Allowable Claim Limit for any covered services may be calculated based upon industry-standard resources including, but not limited to, published and publicly available fee and cost lists and comparisons, or any combination of such resources that in the opinion of the Plan Administrator results in the determination of a reasonable expense under the Plan.

   b. **Medical and Surgical Supplies, Implants, Devices.** The Allowable Claim Limit for charges for medical and surgical supplies made by a provider may be based upon the invoice price (cost) to the provider, plus an additional 12%. The documentation used as the resource for this determination will include, but not be limited to, invoices, receipts, cost lists or other documentation as deemed appropriate by the Plan Administrator.

   c. **Physician, Facility-Billed Physician, Medical and Surgical Care, Laboratory, X-ray, and Therapy.** The Allowable Claim Limit for these services may be determined based upon the 60th percentile of Fair Health (FH®) Allowed Benchmarks.

5. **Comparable Services or Supplies.** In the event that insufficient information is available to determine Allowable Claim Limits for specific services or supplies using the guidelines listed in Section 2 above, Allowable Claim Limits will be determined considering the most comparable services or supplies based upon comparative severity and/or geographic area to determine the Allowable Claim Limit. The Plan Administrator reserves the right, in its sole discretion, to determine any Allowable Claim Limit amount for certain conditions, services and supplies using accepted industry-standard documentation, applied without discrimination to any Covered Person.

In the event that a determination of Allowable Claim Limit for a Claim exceeds the actual Charges billed for the services and/or supplies, the actual Charges billed for the Claim shall be the Allowable Claim Limit.

Balance Billing

In the event that a claim submitted by a Network or non-Network Provider is subject to a medical bill review or medical audit under the Claim Review and Audit Program and some or all of the charges in connection with such claim are repriced because of billing errors and/or overcharges or in determining the Allowable Claim Limit, it is the Plan's position that the Participant should not be responsible for payment of any charges denied as a result of the Audit Adjustments and should not be balance billed for the difference between the billed charges and the amount determined to be payable by the Audit Program. However, balance billing is legal in many jurisdictions, and the Plan has no control over non-Network Providers that engage in balance billing practices. The Plan grants Providers a Direct Right of Appeal to object to any such reductions in reimbursements of claims. In return for this right the Provider is required to waive the right to balance bill a member. In the event that a Provider does not appeal, or files and appeal but still balance bills a member for Audit reductions, the Claim Review and Audit Program provides a full legal defense for the Member against the Balance Bill.

In addition, with respect to services rendered by a Network Provider being paid in accordance with a discounted rate, it is the Plan's position that the Participant should not be responsible for the difference between the amount charged by the Network Provider and the amount determined to be payable by the Plan Administrator and should not be balance billed for such difference. Again, the Plan has no control over any Network Provider that engages in balance billing practices, except to the extent that such practices are contrary to the contract governing the relationship between the Plan and the Network Provider.

In either case, in network or out of network or no network, the Participant is responsible for any applicable payment of co-insurances, Deductibles, and out-of-pocket maximums and may be billed for any or all of these claims.

COST MANAGEMENT SERVICES

Cost Management Services Phone Number

(866) 815-6001

The provider, patient or family member must call this number to receive certification of certain Cost Management Services. This call must be made at least 7 days in advance of services being rendered or within 48 hours after a Medical Emergency.

Any costs incurred because of reduced reimbursement due to failure to follow cost management procedures will not accrue toward the 100% maximum out-of-pocket payment.

UTILIZATION REVIEW

Utilization review is a program designed to help insure that all Covered Persons receive necessary and appropriate health care while avoiding unnecessary expenses.

*****Services are precertified based on precertification guidelines established by the Precertification vendor.**

The program consists of:

(a) Precertification of the Medical Necessity for the following non-emergency services before Medical and/or Surgical services are provided:

Hospitalizations
Inpatient Substance Abuse/Mental Disorder treatments
Skilled Nursing Facility stays
Home Health Care
Hospice Care
Durable Medical Equipment >$500
Physical, speech and/or occupational therapy
Cardiac rehabilitation therapy
Outpatient surgical procedures (other than the physician's office)
MRI/MRA/CAT/PET scans
Observation > 23 hours
Chemotherapy / Radiation therapy
Organ transplant
Sleep Studies
Dialysis
Prosthetics/Orthotics >$500
Specialty & Select High Costs Prescription Drug Products **

(b) Retrospective review of the Medical Necessity of the listed services provided on an emergency basis;

(c) Concurrent review, based on the admitting diagnosis, of the listed services requested by the attending Physician; and

(d) Certification of services and planning for discharge from a Medical Care Facility or cessation of medical treatment.

****NOTE: Specialty and select high-cost medications may require additional review for coverage determination.** Specialty Prescription Drug Products and select high-cost medications may be limited to up to a 30-day supply per Prescription Order or Refill. Specialty Prescription Drug Products and select high-cost medications must be filled at the MedalistRx Care designated Specialty or Retail Pharmacy.
Some specialty and high-cost medications may only be accessible through programs that are able to access medications at reduced cost including but not limited to drug manufacturer patient assistance programs. You will be contacted if a prescribed medication falls under such a program. MedalistRx Care will assist you in completing any registration needed to access these programs. Some programs may require household income

and other documentation or action by you to enroll. For members choosing not to participate in these programs, your medication out-of-pocket cost under the plan could increase by as much as 100% of the medication cost. Any such increase will not accrue to any plan deductible or out-of-pocket maximum.
Any fees charged to facilitate the procurement of a specialty drug from a manufacturer, or another source will be treated as an eligible claim expense payable by the Plan, i.e., as a necessary component of the Plan's costs for obtaining the drug, for all purposes under the Plan (and for purposes of any stop loss coverage obtained by the Plan or the Company).**

The purpose of the program is to determine what charges may be eligible for payment by the Plan. This program is not designed to be the practice of medicine or to be a substitute for the medical judgment of the attending Physician or other health care provider.

If a particular course of treatment or medical service is not certified, it means that either the Plan will not pay for the charges or the Plan will not consider that course of treatment as appropriate for the maximum reimbursement under the Plan. The patient is urged to find out why there is a discrepancy between what was requested and what was certified before incurring charges.

The attending Physician does not have to obtain precertification from the Plan for prescribing a maternity length of stay that is 48 hours or less for a vaginal delivery or 96 hours or less for a cesarean delivery.

In order to maximize Plan reimbursements, please read the following provisions carefully.

Here's how the program works.

Precertification. Before a Covered Person enters a Medical Care Facility on a non-emergency basis or receives other listed medical services, the utilization review administrator will, in conjunction with the attending Physician, certify the care as appropriate for Plan reimbursement. A non-emergency stay in a Medical Care Facility is one that can be scheduled in advance.

The utilization review program is set in motion by a telephone call from, or on behalf of, the Covered Person. Contact the utilization review administrator at (866) 815-6001 **at least 7 days before** services are scheduled to be rendered with the following information:

- The name of the patient and relationship to the covered Employee/Member
- The name, Employee/Member identification number and address of the covered Employee/Member
- The name of the Employer
- The name and telephone number of the attending Physician
- The name of the Medical Care Facility, proposed date of admission, and proposed length of stay
- The proposed medical services
- The proposed rendering of listed medical services

If there is an **emergency** admission to the Medical Care Facility, the patient, patient's family member, Medical Care Facility or attending Physician must contact the utilization review administrator **within 48 hours** of the first business day after the admission.

The utilization review administrator will determine the number of days of Medical Care Facility confinement or use of other listed medical services authorized for payment. **Failure to follow this procedure may reduce reimbursement received from the Plan.**

If a Covered Person does not receive authorization as explained in this section, the benefit payment will be reduced by 50% up to a maximum penalty of $2,500. The penalty for failure to pre-certify inpatient Hospital admissions will apply only to the hospital facility charge for the inpatient stay.

Concurrent review, discharge planning. Concurrent review of a course of treatment and discharge planning from a Medical Care Facility are parts of the utilization review program. The utilization review administrator will monitor the Covered Person's Medical Care Facility stay or use of other medical services and coordinate with the attending Physician, Medical Care Facilities and Covered Person either the scheduled release or an extension of the Medical Care Facility stay or extension or cessation of the use of other medical services.

If the attending Physician feels that it is Medically Necessary for a Covered Person to receive additional services or to stay in the Medical Care Facility for a greater length of time than has been precertified, the attending Physician must request the additional services or days.

SECOND AND/OR THIRD OPINION PROGRAM

Certain surgical procedures are performed either inappropriately or unnecessarily. In some cases, surgery is only one of several treatment options. In other cases, surgery will not help the condition.

In order to prevent unnecessary or potentially harmful surgical treatments, the second and/or third opinion program fulfills the dual purpose of protecting the health of the Plan's Covered Persons and protecting the financial integrity of the Plan.

Benefits will be provided for a second (and third, if necessary) opinion consultation to determine the Medical Necessity of an elective surgical procedure. An elective surgical procedure is one that can be scheduled in advance; that is, it is not an emergency or of a life-threatening nature. Benefits for the second (and third, if necessary) opinion will be paid as any other Sickness.

The patient may choose any board-certified specialist who is not an associate of the attending Physician and who is affiliated in the appropriate specialty.

While any surgical treatment is allowed a second opinion, the following procedures are ones for which surgery is often performed when other treatments are available.

Appendectomy	Hernia surgery	Spinal surgery
Cataract surgery	Hysterectomy	Surgery to knee, shoulder, elbow or toe
Cholecystectomy (gall bladder removal)	Mastectomy surgery	Tonsillectomy and adenoidectomy
Deviated septum (nose surgery)	Prostate surgery	Tympanotomy (inner ear)
Hemorrhoidectomy	Salpingo-oophorectomy (removal of tubes/ovaries)	Varicose vein ligation

PREADMISSION TESTING SERVICE

The Medical Benefits percentage payable will be for diagnostic lab tests and x-ray exams when:

(1) performed on an outpatient basis within seven days before a Hospital confinement;

(2) related to the condition which causes the confinement; and

(3) performed in place of tests while Hospital confined.

CASE MANAGEMENT

Case Management. The Plan may elect, in its sole discretion, when acting on a basis that precludes individual selection, to provide alternative benefits that are otherwise excluded under the Plan. The alternative benefits, called "Case Management," shall be determined on a case-by-case basis, and the Plan's determination to provide the benefits in one instance shall not obligate the Plan to provide the same or similar alternative benefits for the same or any other Covered Person, nor shall it be deemed to waive the right of the Plan to strictly enforce the provisions of the Plan.

A case manager consults with the patient, the family and the attending Physician in order to develop a plan of care for approval by the patient's attending Physician and the patient. This plan of care may include some or all of the following:

-- personal support to the patient;

-- contacting the family to offer assistance and support;

-- monitoring Hospital or Skilled Nursing Facility;

-- determining alternative care options; and

-- assisting in obtaining any necessary equipment and services.

Case Management occurs when this alternate benefit will be beneficial to both the patient and the Plan.

The case manager will coordinate and implement the Case Management program by providing guidance and information on available resources and suggesting the most appropriate treatment plan. The Plan Administrator, attending Physician, patient and patient's family must all agree to the alternate treatment plan.

Once agreement has been reached, the Plan Administrator will direct the Plan to cover Medically Necessary expenses as stated in the treatment plan, even if these expenses normally would not be paid by the Plan. Unless specifically provided to the contrary in the Plan Administrator's instructions, reimbursement for expenses incurred in connection with the treatment plan shall be subject to all Plan limits and cost sharing provisions.

Note: Case Management is a voluntary service. There are no reductions of benefits or penalties if the patient and family choose not to participate.

Each treatment plan is individually tailored to a specific patient and should not be seen as appropriate or recommended for any other patient, even one with the same diagnosis.

DEFINED TERMS

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

Active Employee/Member means a person who is a statutory employee of an Employer that is actively involved with the Company.

Allowable Claim Limit means the amount of covered expenses that will be considered by THE PLAN for reimbursement in accordance with the results of the Claim Review and Audit Program and in keeping with the Patient Protection and Affordable Care Act. Please refer to the section entitled "Claim Review and Audit Program" for information regarding Plan provisions related to the audit and adjudication of certain eligible Claims under that Program.

Ambulatory Surgical Center is a licensed facility that is used mainly for performing outpatient surgery, has a staff of Physicians, has continuous Physician and nursing care by registered nurses (R.N.s) and does not provide for overnight stays.

Ancillary services are services incurred while receiving services at an ambulatory surgery center, hospital or other inpatient health program. These may include x-ray interpretation, pathology, assistant surgeon, emergency room physician, anesthesia services, or inpatient physician visits from the network facility's staff.

Autism Spectrum Disorders include any pervasive development disorder as defined by the Diagnostic and Statistical Manual of Mental Disorders (DSM), including but not limited to autism, Asperger's Syndrome, childhood disintegrative disorder and Rett's Syndrome.

Baseline shall mean the initial test results to which the results in future years will be compared in order to detect abnormalities.

Birthing Center means any freestanding health facility, place, professional office or institution which is not a Hospital or in a Hospital, where births occur in a home-like atmosphere. This facility must be licensed and operated in accordance with the laws pertaining to Birthing Centers in the jurisdiction where the facility is located.

The Birthing Center must provide facilities for obstetrical delivery and short-term recovery after delivery; provide care under the full-time supervision of a Physician and either a registered nurse (R.N.) or a licensed nurse-midwife; and have a written agreement with a Hospital in the same locality for immediate acceptance of patients who develop complications or require pre- or post-delivery confinement.

Brand Name means a trade name medication.

Calendar Year means January 1st through December 31st of the same year.

Clean Claim A "Clean Claim" is one that can be processed in accordance with the terms of this document without obtaining additional information from the service Provider or a third party. It is a claim which has no defect or impropriety. A defect or impropriety shall include a lack of required sustaining documentation as set forth and in accordance with this document, or a particular circumstance requiring special treatment which prevents timely payment as set forth in this document, and only as permitted by this document, from being made. A Clean Claim does not include claims under investigation for fraud and abuse or claims under review for Medical Necessity or other coverage criteria, or fees under review for application of the Maximum Allowable Charge, or any other matter that may prevent the charge(s) from being Covered Expenses in accordance with the terms of this document.

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

to the Plan as well.

COBRA means the Consolidated Omnibus Budget Reconciliation Act of 1985, as amended.

Coinsurance is a policy provision under which the insurer and the insured share costs incurred after the deductible is met, according to a specific formula.

Company: Approved member of LLC

Covered Charge(s) means those Medically Necessary services or supplies that are covered under this Plan.

Covered Person is an Employee/Member or Dependent who is covered under this Plan.

Creditable Coverage includes most health coverage, such as coverage under a group health plan (including COBRA continuation coverage), HMO membership, an individual health insurance policy, Medicaid, Medicare or public health plans.

Creditable Coverage does not include coverage consisting solely of dental or vision benefits.

Creditable Coverage does not include coverage that was in place before a significant break of coverage of 63 days or more.

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

Dentist is a person who is properly trained and licensed to practice dentistry and who is practicing within the scope of such license.

Dominant Commercial Payor is the most significant commercial payor by dollar volume at medical provider and/or payor with most favored nation clause in payor/provider agreement.

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

Emergency Services means a medical condition, acute symptoms of sufficient severity that a “prudent layperson, who possesses average knowledge of health and medicine”, could reasonably expect absence of immediate medical attention to result in serious jeopardy, serious impairment to bodily functions or serious dysfunction of bodily organ or part. Services include the Institutional charge for use of the Emergency Room for an Emergency Medical Condition, all other related Institutional charges and Emergency Room Physician’s charges for an Emergency Medical Condition. Services include pre-stabilization services. Care and treatment once you are stabilized are not emergency services. Continuation of care beyond which is needed to evaluate or stabilize your emergency medical condition will be covered according to the Schedule of Benefits. Refer to the Schedule of Benefits for coverage.

Employee/Member means a person who works for the Employer in an Employee/Member/Employer relationship, and who performs the duties of his or her job with the Employer on a full-time basis. Part-time Employee/Members and Retired Employee/Members are not eligible for coverage under this Plan. The following persons are also not eligible for coverage under this Plan: (i) leased Employee/Members as defined in Internal Revenue Code section 414(n); or (ii) individuals classified by the Employer as temporary Employee/Members or seasonal Employee/Members. Employee/Member shall also be construed to include those who earn Self-Employment Income, as defined in Internal Revenue Code section 1402(b).

Enrollment Date is the first day of coverage or, if there is a Waiting Period, the first day of the Waiting Period.

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

ESRD means End Stage Renal (kidney) Disease.

Essential Health Benefits include, to the extent they are covered under the Plan, ambulatory patient services; emergency services; hospitalization; maternity and newborn care; mental health and substance use disorder services, including behavioral health treatment; prescription drugs; rehabilitative and habilitative services and devices; laboratory services; preventive and wellness services and chronic disease management; and pediatric services, including oral and vision care

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

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

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

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

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

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

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

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

Routine Patient Costs include all items and services typically covered by the Plan for Covered Persons but does not include:

(i) the investigational item, device, or service, itself;

(ii) items and services that are provided solely to satisfy data collection and analysis needs and that are not used in the direct clinical management of the patient; or

(**iii)** a service that is inconsistent with established standards of care for the patient’s diagnosis.

Qualified Individual means a Covered Person who meets the following conditions:

(1) The individual is eligible to participate in an Approved Clinical Trial according to the trial protocol with respect to treatment of cancer or other life-threatening disease or condition, and

(2) Either--

(A) the referring health care professional is a Network Provider and has concluded that the individual's participation in such trial would be appropriate based upon the individual meeting the conditions described in paragraph (1); or

(B) the individual provides medical and scientific information establishing that the individual's participation in such trial would be appropriate based upon the individual meeting the conditions described in paragraph (1).

For purposes of this section, the term **`life-threatening condition'** means any disease or condition from which the likelihood of death is probable unless the course of the disease or condition is interrupted.

Approved Clinical Trial means a phase I, phase II, phase III, or phase IV clinical trial that is conducted in relation to the prevention, detection, or treatment of cancer or other life-threatening disease or condition and is described in any of the following subparagraphs:

(A) FEDERALLY FUNDED TRIALS - The study or investigation is approved or funded (which may include funding through in-kind contributions) by one or more of the following:

(i) The National Institutes of Health.

(ii) The Centers for Disease Control and Prevention.

(iii) The Agency for Health Care Research and Quality.

(iv) The Centers for Medicare & Medicaid Services.

(v) Cooperative group or center of any of the entities described in clauses (i) through (iv) or the Department of Defense or the Department of Veterans Affairs.

(vi) A qualified non-governmental research entity identified in the guidelines issued by the National Institutes of Health for center support grants.

(vii) Any of the following if the conditions described in the Conditions for Departments paragraph below are met:

(I) The Department of Veterans Affairs.

(II) The Department of Defense.

(III) The Department of Energy.

(B) The study or investigation is conducted under an investigational new drug application reviewed by the Food and Drug Administration.

(C) The study or investigation is a drug trial that is exempt from having such an investigational new drug application.

CONDITIONS FOR DEPARTMENTS - The conditions described in this paragraph, for a study or investigation conducted by a Department, are that the study or investigation has been reviewed and approved through a system of peer review that the Secretary of the U.S. Department of Health and Human Services determines—

(A) to be comparable to the system of peer review of studies and investigations used by the National Institutes of Health, and

(B) assures unbiased review of the highest scientific standards by qualified individuals who have no interest in the outcome of the review.

Family Unit is the covered Employee/Member and the family members who are covered as Dependents under the Plan.

Formulary means a list of prescription medications compiled by the third party payor of safe, effective therapeutic drugs specifically covered by this Plan.

Full-time Student is an eligible Dependent who is enrolled at an accredited institution of higher learning. It must be certified annually that the student meets the institution's requirements for full-time status.

Generic drug means a Prescription Drug which has the equivalency of the brand name drug with the same use and metabolic disintegration. This Plan will consider as a Generic drug any Food and Drug Administration approved generic pharmaceutical dispensed according to the professional standards of a licensed pharmacist and clearly designated by the pharmacist as being generic.

Genetic Information means information about the genetic tests of an individual or his family members, and information about the manifestations of disease or disorder in family members of the individual. A "genetic test" means an analysis of human DNA, RNA, chromosomes, proteins or metabolites, which detects genotypes, mutations or chromosomal changes. It does not mean an analysis of proteins or metabolites that is directly related to a manifested disease, disorder or pathological condition that could reasonably be detected by a health care professional with appropriate training and expertise in the field of medicine involved. Genetic information does not include information about the age or gender of an individual.

Hearing Aid is defined as any instrument or device, excluding a surgical implant and cochlear devices, designed, intended or offered for the purpose of improving a person's hearing.

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

Home Health Care Plan must meet these tests: it must be a formal written plan made by the patient's attending Physician which is reviewed at least every 30 days; it must state the diagnosis; it must certify that the Home Health Care is in place of Hospital confinement; and it must specify the type and extent of Home Health Care required for the treatment of the patient.

Home Health Care Services and Supplies include: part-time or intermittent nursing care by or under the supervision of a registered nurse (R.N.); part-time or intermittent home health aide services provided through a Home Health Care Agency (this does not include general housekeeping services); physical, occupational and speech therapy; medical supplies; and laboratory services by or on behalf of the Hospital.
Hospice Agency is an organization where its main function is to provide Hospice Care Services and Supplies and it is licensed by the state in which it is located, if licensing is required.

Hospice Care Plan is a plan of terminal patient care that is established and conducted by a Hospice Agency and supervised by a Physician.

Hospice Care Services and Supplies are those provided through a Hospice Agency and under a Hospice Care Plan and include inpatient care in a Hospice Unit or other licensed facility, home care, and family counseling during the bereavement period.

Hospice Unit is a facility or separate Hospital Unit that provides treatment under a Hospice Care Plan and admits at least two unrelated persons who are expected to die within six months.

Hospital is an institution which is engaged primarily in providing medical care and treatment of sick and injured persons on an inpatient basis at the patient's expense and which fully meets these tests: it is accredited as a Hospital by the Joint Commission on Accreditation of Healthcare Organizations or the American Osteopathic Association Healthcare Facilities Accreditation Program; it is approved by Medicare as a Hospital; it maintains diagnostic and therapeutic facilities on the premises for surgical and medical diagnosis and treatment of sick and injured persons by or under the supervision of a staff of Physicians; it continuously provides on the premises 24-hour-a-day nursing services by or under the supervision of registered nurses (R.N.s); and it is operated continuously with organized facilities for operative surgery on the premises.

The definition of "Hospital" shall be expanded to include the following:

- A facility operating legally as a psychiatric Hospital or residential treatment facility for mental health and licensed as such by the state in which the facility operates.

- A facility operating primarily for the treatment of Substance Abuse if it meets these tests: maintains permanent and full-time facilities for bed care and full-time confinement of at least 15 resident patients; has a Physician in regular attendance; continuously provides 24-hour a day nursing service by a registered nurse (R.N.); has a full-time psychiatrist or psychologist on the staff; and is primarily engaged in providing diagnostic and therapeutic services and facilities for treatment of Substance Abuse.

Illness means a bodily disorder, disease, physical sickness or Mental Disorder. Illness includes Pregnancy, childbirth, miscarriage or complications of Pregnancy.

Independent dispute resolution (IDR) is a process whose goal is **to help keep health care costs down.** Out-of network providers can negotiate and resolve disputes with the Plan through this process.

Infertility means incapable of producing offspring.

Injury means an accidental physical Injury to the body caused by unexpected external means.

Impacted tooth means a tooth eruption that is obstructed completely by a bone, tooth, or tissue.

Intensive Care Unit is defined as a separate, clearly designated service area which is maintained within a Hospital solely for the care and treatment of patients who are critically ill. This also includes what is referred to as a "coronary care unit" or an "acute care unit." It has: facilities for special nursing care not available in regular rooms and wards of the Hospital; special lifesaving equipment which is immediately available at all times; at least two beds for the accommodation of the critically ill; and at least one registered nurse (R.N.) in continuous and constant attendance 24 hours a day.

Late Enrollee means a Plan Participant who enrolls under the Plan other than during the first 31-day period in which the individual is eligible to enroll under the Plan or during a Special Enrollment Period.

Legal Guardian means a person recognized by a court of law as having the duty of taking care of the person and managing the property and rights of a minor child.

Maximum Payable Amount and/or Maximum Allowable Charge means the benefit payable for a specific coverage item or benefit under the Plan. Maximum Allowable Charge(s) will be the lesser of:

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

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

Medical Care Facility means a Hospital, a facility that treats one or more specific ailments or any type of Skilled Nursing Facility.

Medical Emergency means a medical condition manifesting itself by acute symptoms of sufficient severity including severe pain such that a prudent layperson with average knowledge of health and medicine could reasonably expect the absence of immediate medical attention to result in (1) serious jeopardy to the health of an individual (or, in the case of a pregnant woman, the health of the woman or her unborn child), (2) serious impairment to body functions, or (3) serious dysfunction of any body organ or part. A Medical Emergency includes such conditions as heart attacks, cardiovascular accidents, poisonings, loss of consciousness or respiration, convulsions or other such acute medical conditions. **In the event non-network provider is utilized**

the plan will negotiation the bill. If the negotiation is not obtained by the Plan, the Plan will have the discretionary authority to pay the services without UCR/R&C.

Medical Non-Emergency Care means care which can safely and adequately be provided other than in a Hospital.

Medical Record Review means, in the event that the Plan, based upon a Medical Record Review and/or audit, determines that a different treatment or different quantity of a drug or supply was provided which is not supported in the billing, then the Plan Administrator may determine the Maximum Allowable Charge according to the Medical Record Review and audit results. Please refer to the section entitled "Claim Review and Audit Program" for the Plan provisions related to the audit and adjudication of certain eligible Claims under that Program.

Medically Necessary care and treatment is recommended or approved by a Physician; is consistent with the patient's condition or accepted standards of good medical practice; is medically proven to be effective treatment of the condition; is not performed mainly for the convenience of the patient or provider of medical services; is not conducted for research purposes; and is the most appropriate level of services which can be safely provided to the patient.

All of these criteria must be met; merely because a Physician recommends or approves certain care does not mean that it is Medically Necessary.

The Plan Administrator has the discretionary authority to decide whether care or treatment is Medically Necessary.

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

Member means a person who is an Active, approved Member of the Company.

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

Morbid Obesity is a diagnosed condition in which the body weight exceeds the medically recommended weight by either 100 pounds or is twice the medically recommended weight for a person of the same height, age and mobility as the Covered Person.

Network Provider. Tertiary care facilities and teaching hospitals are not considered network providers unless necessary patient care is not available at network non-tertiary facilities.
The Plan has the discretionary authority to waive the network provider discount if said discount does not meet the Plan's necessary reimbursement policy of not exceeding the Plans allowable fee arrangement.

Never Event is a serious reportable adverse event that is reasonably preventable through application of evidence based guidelines. These errors include but are not limited to the following: Surgery on wrong body part, foreign object left in patient after surgery, intravascular air embolism, blood incompatibility, stage 3 or 4 pressure ulcers, electric shock, burn, or fall while confined to facility.

No-Fault Auto Insurance is the basic reparations provision of a law providing for payments without determining fault in connection with automobile accidents.

Orthotic is a mechanical device applied externally to limit or assist the motion of any given body part.

Outpatient Care and/or Services is treatment including services, supplies and medicines provided and used at a Hospital under the direction of a Physician to a person not admitted as a registered bed patient; or services rendered in a Physician's office, laboratory or X-ray facility, an Outpatient Surgical Center, or the patient's home.

Permanent Employee/Member is an Employee/Member that is not hired on a Temporary or Seasonal basis.

Pharmacy means a licensed establishment where covered Prescription Drugs are filled and dispensed by a pharmacist licensed under the laws of the state where he or she practices.

Physician means a Doctor of Medicine (M.D.), Doctor of Osteopathy (D.O.), Doctor of Podiatry (D.P.M.), Doctor of Chiropractic (D.C.), Audiologist, Certified Nurse Anesthetist, Licensed Professional Counselor, Licensed Professional Physical Therapist, Master of Social Work (M.S.W.), Midwife, Occupational Therapist, Physiotherapist, Psychiatrist, Psychologist (Ph.D.), Speech Language Pathologist and any other practitioner of the healing arts who is licensed and regulated by a state or federal agency and is acting within the scope of his or her license.

Plan means Employer's Business Alliance, Inc. Employee/Member Health Plan, which is a benefits plan for certain Employee/Members of Employer's Business Alliance, Inc. and is described in this document.

Plan Participant is any Employee/Member or Dependent who is covered under this Plan.

Plan Year is the 12-month period beginning on either the effective date of the Plan or on the day following the end of the first Plan Year which is a short Plan Year.

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

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

Reasonable and/or Reasonableness means in the administrator's discretion, services or supplies, or fees for services or supplies, which are necessary for the care and treatment of illness or injury not caused by the treating Provider. Determination that fee(s) or services are reasonable will be made by the Plan Administrator, taking into consideration unusual circumstances or complications requiring additional time, skill and experience in connection with a particular service or supply; industry standards and practices as they relate to similar scenarios; and the cause of injury or illness necessitating the service(s) and/or charge(s).
This determination will consider, but will not be limited to, the findings and assessments of the following entities: (a) The National Medical Associations, Societies, and organizations; (b) The Food and Drug Administration, and CMS. To be Reasonable, service(s) and/or fee(s) must be in compliance with generally accepted billing practices for unbundling or multiple procedures. Services, supplies, care and/or treatment that results from errors in medical care that are clearly identifiable, preventable, and serious in their consequence for patients, are not Reasonable. The Plan Administrator retains discretionary authority to determine whether service(s) and/or fee(s) are Reasonable based upon information presented to the Plan Administrator. A finding of Provider negligence and/or malpractice is not required for service(s) and/or fee(s) to be considered not Reasonable.
Charge(s) and/or services are not considered to be Reasonable, and as such are not eligible for payment (exceed the Maximum Allowable Charge), when they result from Provider error(s) and/or facility-acquired conditions deemed "reasonably preventable" through the use of evidence-based guidelines, taking into consideration but not limited to CMS guidelines.
The Plan reserves for itself and parties acting on its behalf the right to review charges processed and/or paid by the Plan, to identify charge(s) and/or service(s) that are not Reasonable and therefore not eligible for payment by the Plan. **Reasonable(ness).** The Plan will only pay fee(s) that, in the administrator's discretion, are for services or supplies, which are necessary for the care and treatment of illness or injury not caused by the treating provider. Determination that fee(s) are reasonable will be made by the Plan Administrator, taking into consideration unusual circumstances or complications requiring additional time, skill and experience in connection with a particular service or supply; industry standards and practices as they relate to similar scenarios; and the cause of injury or illness necessitating the charge(s).
This determination will consider, but will not be limited to, the findings and assessments of the following entities: (a) The National Medical Associations, Societies, and organizations; (b) The Food and Drug Administration; and (c) CMS. To be reasonable, fee(s) must be in compliance with generally accepted billing practices for unbundling or multiple procedures. Services, supplies, care and/or treatment that results from errors in medical care that are clearly identifiable, preventable, and serious in their consequence for patients, are not reasonable. The Plan Administrator retains discretionary authority to determine whether fee(s) are reasonable based upon information presented to the Plan Administrator. A finding of provider negligence and/or malpractice is not required for fee(s) to be considered not reasonable.

Qualifying Payment Amount (QPA) – The qualifying payment amount is the median of contracted rates for a specific service in the same geographic region within the same insurance market as of January 31, 2019. The

rate will be adjusted per the Consumer Price Index for All Urban Consumers (CPI-U).

Sickness is:
For a Covered Employee/Member or Spouse: Illness, disease or Pregnancy (including complications).
For a Covered Dependent: Illness or disease

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

(1) It is licensed to provide professional nursing services on an inpatient basis to persons convalescing from Injury or Sickness. The service must be rendered by a registered nurse (R.N.) or by a licensed practical nurse (L.P.N.) under the direction of a registered nurse. Services to help restore patients to self-care in essential daily living activities must be provided.

(2) Its services are provided for compensation and under the full-time supervision of a Physician.

(3) It provides 24 hour per day nursing services by licensed nurses, under the direction of a full-time registered nurse.

(4) It maintains a complete medical record on each patient.

(5) It has an effective utilization review plan.

(6) It is not, other than incidentally, a place for rest, the aged, drug addicts, alcoholics, mentally disabled, Custodial or educational care or care of Mental Disorders.

(7) It is approved and licensed by Medicare.

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

Spinal Manipulation/Chiropractic Care means skeletal adjustments, manipulation or other treatment in connection with the detection and correction by manual or mechanical means of structural imbalance or subluxation in the human body. Such treatment is done by a Physician to remove nerve interference resulting from, or related to, distortion, misalignment or subluxation of, or in, the vertebral column.

Substance Abuse is regular excessive compulsive drinking of alcohol and/or physical habitual dependence on drugs. This does not include dependence on tobacco and ordinary caffeine-containing drinks.

Temporomandibular Joint (TMJ) syndrome is the treatment of jaw joint disorders including conditions of structures linking the jaw bone and skull and the complex of muscles, nerves and other tissues related to the temporomandibular joint.

Temporary or **Seasonal Employee/Member** is an Employee/Member that is hired on a temporary or seasonal basis, regardless of the number of hours worked per week during the duration of their employment.

Total Disability (Totally Disabled) means: In the case of a Dependent, the complete inability as a result of Injury or Sickness to perform the normal activities of a person of like age and sex in good health.

Urgent Care Services means care and treatment for an illness, injury or condition serious enough that a reasonable person would seek care right away, but not so severe as to require emergency room services.

The Plan will reimburse the actual charge billed if it is less than the Plans allowable fee charge, even if the Provider is in Network.

The Plan Reimbursement to a Medical Provider is, regardless of PPO Agreement, limited to the Reasonable Reimbursement for the treating Medical Provider. We define Reasonable Reimbursement to the dominant Commercial Payor Reimbursement at the treating Medical Provider.

The Plan Administrator has the discretionary authority to decide whether a charge is within the Plans allowable fee schedule.

Usual and Customary means covered expenses which are identified by the Plan Administrator, in conjunction with the Claims Audit Decision Maker, taking into consideration the fee(s) which the Provider most frequently charges the majority of patients for the service or supply, the cost to the Provider for providing the services, the prevailing range of fees charged in the same "area" by Providers of similar training and experience for the service or supply, and the Medicare reimbursement rates. The term(s) "same geographic locale" and/or "area" shall be defined as a metropolitan area, county, or such greater area as is necessary to obtain a representative cross-section of Providers, persons or organizations rendering such treatment, services, or supplies for which a specific charge is made. To be Usual and Customary, fee(s) must be in compliance with generally accepted billing practices for unbundling or multiple procedures.

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

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

The term "Usual and Customary" does not necessarily mean the actual charge made nor the specific service or supply furnished to a Covered Person by a Provider of services or supplies, such as a Physician, therapist, nurse, Hospital, or pharmacist. The Plan Administrator, in conjunction with the Claims Audit Decision Maker, will determine what the Usual and Customary charge is, for any procedure, service, or supply, and whether a specific procedure, service or supply is Usual and Customary.

Usual and Customary charges may, at the discretion of the Plan Administrator, in conjunction with the Claims Audit Decision Maker, when necessary, alternatively be determined and established by the Plan using normative data such as, but not limited to, Medicare reimbursement rates and cost to charge ratios, average wholesale price (AWP) for prescriptions and/or manufacturer's retail pricing (MRP) for supplies and devices and the 75th percentile as reflected in the Wasserman Physician's Fee Reference (PFR), Context 4, Healthcare, Inc. Database, or a similar nationally recognized prevailing fee data base as designated by the Plan Administrator.

GENERAL EXCLUSIONS AND LIMITATIONS

Note: Any treatment, charges, and/or medical provider reimbursement not covered by Reinsurance contract.

Note: All exclusions related to Prescription Drugs are shown in the Prescription Drug Plan.

No payment will be eligible under any portion of this Plan for expenses Incurred by a Covered Person for the expenses or circumstances listed below. If an expense is paid that is found to be excluded or limited as shown below, the Plan has the right to collect that amount from the payee, the Covered Person or from future benefits and any such payment does not waive the written exclusions, limitations or other terms of the Plan.

(1) Abortion: Expenses for elective abortions will not be considered eligible

(2) Acupuncture. Services, supplies, care or treatment in connection with acupuncture.

(3) Adoption: Expenses related to adoption will not be considered eligible.

(4) After hours services. Additional charges, billed by the physician, for after hour, extended hour, or holiday services.

(5) Alcohol. Services, supplies, care or treatment to a Covered Person for an Injury or Sickness which occurred as a result of that Covered Person's illegal use of alcohol. Expenses will be covered for Injured Covered Persons other than the person illegally using alcohol and expenses will be covered for Substance Abuse treatment as specified in this Plan. Also excluded for the Employee/Member only are charges for Injuries or Illnesses resulting from an accident where the Employee/Member is the driver and deemed to be under the influence of alcohol or drugs (DUI). This exclusion does not apply if the Injury resulted from an act of domestic violence or a Medical Condition.

(6) Alternative Medicine or Complementary Medicine: services and supplies related to alternative or complementary medicine, including but not limited to acupressure, acupuncture, aroma therapy, bioenergial synchronization technique (BEST), contact reflex analysis, holistic medicine herbal therapy, hypnotism, iridology (study of the iris), naturopathy, Reiki therapy, Rolfing, thermography, or other forms of alternative treatment as defined by the National Center for Complementary and Alternative Medicine of the National Institutes of Health or any similar or successor organization;

(7) Autopsies: Expenses related to autopsies will not be considered eligible

(8) Autotransfusions. Charges for Autotransfusions or cell saver transfusions occurring during or after surgery.

(9) Biofeedback

(10) Blood or Other Body Tissue and Fluids, Including Storage. Blood, and the storage and banking of autologous and cord blood, body tissue and fluids

(11) Breast Surgery. Surgery for male breast reduction is **NOT COVERED**, except when associated with breast reconstructive surgery in connection with a Medically Necessary mastectomy as set forth in Section 3.14 of this Certificate

(12) Close Relative: Expenses for services, care or supplies provided by a person who normally resides in the Covered Person’s home or by a Close Relative will not be considered eligible.

(13) Complications: Expenses for care, services or treatment required as a result of complications from a treatment or procedure not covered under the Plan will not be considered eligible.

(14) Convenience/Comfort Items: Expenses for personal hygiene and convenience items will not be considered eligible.

(15) Corrective Shoes, Shoe Inserts and Supports, Heel Cups, Lifts, or Foot Orthotics of any sort, except for diabetic foot orthotics, except as specified under the Schedule of Benefits and Medical Covered Charges section.

(16) Cosmetic Procedures: Expenses for Cosmetic and reconstructive procedures will not be considered eligible, except as specified under Schedule of Benefits and Medical Covered Charges section of the Plan.

(17) Counseling: Expenses for religious, marital, or relationship counseling will not be considered eligible, except as specified under Schedule of Benefits and Medical Covered Charges section of the Plan.

(18) Custodial Care: Expenses for Custodial Care will not be considered eligible, except as specified under the Home Health Care and Hospice Care benefits.

(19) Dentistry -The plan does not cover general dental services, defined as operations on or treatment of the teeth and immediately supporting tissues. Such general dental services include but are not limited to, restoration, correction of malocclusion and/or orthodontia, repair or extraction of erupted teeth or impacted teeth, dental X-rays, analgesia, other professional or hospital charges for services or supplies in connection with treatment of or operations on the teeth or immediately supporting structures or any ancillary medical procedures required to support a general dental service. However, the plan will cover: a) expenses related to the emergency treatment of sound natural teeth as set forth in the document (excepting implants, bridges, crowns and root canals even if necessitated by or related to trauma to sound natural teeth), b) General Anesthesia and Associated Medical Costs as set forth in this document c) Impacted Wisdom Teeth as set forth in this document

(20) Developmental Delays: Expenses in connection with the treatment of developmental delays, including, but not limited to speech therapy, occupational therapy, physical therapy and any related diagnostic testing will not be considered eligible. This exclusion will not apply to expenses related to the diagnosis, testing and treatment of autism, ADD or ADHD and to expenses covered as a preventive service under the Schedule of Benefits and Medical Covered Charges section of the Plan.

(21) Devises or Computers: Expenses to assist in communication and speech

(22) Educational or vocational testing. Services for educational or vocational testing or training. This does not apply to any diabetic education that may be covered under the Plan.

(23) Employment, Insurance, or License related care. Physical exams or immunizations or any other treatment required for enrollment in any insurance program, as a condition of employment, for licensing, or other similar purposes. However, this exclusion does not apply to the Employer's health plan sponsored screenings.

(24) Exercise Programs: Exercise programs for treatment of any condition will not be considered eligible, except for Physician-supervised cardiac rehabilitation and occupational or physical therapy covered by the Plan.

(25) Experimental or not Medically Necessary. Care and treatment that is either Experimental/Investigational or not Medically Necessary. For Plan Years beginning on or after January 1, 2014, this exclusion shall not apply to the extent that the charge is for a Qualified Individual who is a participant in an approved clinical trial with respect to the treatment of cancer or another life-threatening disease or condition. The Plan shall not deny, limit or impose additional conditions on routine patient costs for items and services furnished in connection with participation in the clinical trial. However, this provision does not require the Plan to pay charges for services or supplies that are not otherwise Covered Charges (including, without limitation, charges which the Qualified Individual would not be required to pay in the absence of this coverage) or prohibit the Plan from imposing all applicable cost sharing and reasonable cost management provisions. For these purposes, a Qualified Individual is a Covered Person who is eligible to participate in an approved clinical trial according to the trial protocol with respect to the treatment of cancer or another life-threatening disease or condition, and either: (1) the referring health care professional is a Network Provider and has concluded that the individual's participation in such trial would be appropriate; or (2) the Covered Person provides medical and scientific information establishing that the individual's participation in such trial would be appropriate.

(26) Eye care. Radial keratotomy, Lasik surgery or other eye surgery to correct vision problems that are alternately correctable by vision lenses. Also, routine eye examinations, including refractions, lenses for the eyes and exams for their fitting (unless specified in the Schedule of Benefits). This exclusion does not apply to

aphakic patients and soft lenses or sclera shells intended for use as corneal bandages or as may be covered under the well adult or well child sections of this Plan.

(27) Foot Care: Expenses for routine foot care, treatment of weak, unstable or flat feet will not be considered eligible. Treatment (including cutting or removal) of toe nails or superficial lesions of the feet including corns, calluses and hyperkeratosis, other than removal of nail matrix or root, except when required to treat diabetes; or shoe orthotics, except when required to treat diabetes; electroshock wave therapy for treatment of plantar fasciitis, except to treat diabetes;

(28) Foot Orthotics, arch supports or other foot support devices, elastic stockings, garter belts or similar devices and orthopedic shoes including any casting or fitting charges except as stated in Schedule of Benefits and Medical Covered Charges section.

(29) Gleevec: Expenses for the prescription drug, Gleevec, will not be considered eligible.

(30) Governmental Agency: Expenses for services and supplies which are provided by any governmental agency for which the Covered Person is not liable for payment will not be considered eligible. In the case of a state sponsored medical assistance program, benefits payable under this Plan will be primary. Benefits payable under this Plan will also be primary for any Covered Person eligible under TRICARE (the government sponsored program for military dependents).

(31) Growth hormone therapy. Charges for growth hormone therapy.

(32) Hair Loss: Expenses for hair loss or hair transplants will not be considered eligible.

(33) Hearing Exams/Aids: Expenses for routine hearing examinations, hearing aids (including the fitting thereof), cochlear implants and supplies will not be considered eligible, except as otherwise covered under the Schedule of Benefits and Medical Covered Charges section of the Plan.

(34) Hazardous Hobby: Expenses for any condition, Illness or Injury, or complication thereof, arising out of engaging in a hazardous hobby or activity will not be considered eligible. For the purposes of this Plan, “hazardous hobby or activity” is defined as an unusual activity characterized by a constant threat of danger, such as skydiving, auto racing, hang gliding, bungee jumping. This does not include common recreational activities, such as water or snow skiing, jet skiing, horseback riding, boating, motorcycling, snowmobiling, all-terrain vehicle riding and team sports.

(35) Holistic Treatment Expenses for holistic treatment including acupressure, acupuncture, aromatherapy, hypnotism, alternative therapy (art, music, dance, horseback) and Rolfing will not be considered eligible.

(36) Homeopathic Treatment: Expenses for naturopathic and homeopathic treatments, services and supplies will not be considered eligible.

(37) Hyperhidrosis: Expenses related to surgical treatment of excess sweating will not be considered eligible

(38) Hypnotherapy: Expenses for hypnotherapy will not be considered eligible.

(39) Illegal acts. Charges for services received as a result of Injury or Sickness occurring directly or indirectly, as a result of an Illegal Act, or a riot, or public disturbance. For purposes of this exclusion, the term Illegal Act shall mean any act or series of acts that, if charged, prosecuted and convicted of a criminal offense, a sentence to a term of imprisonment in excess of one year could be imposed. This exclusion does not apply if the Injury resulted from an act of domestic violence or a Medical Condition.

(40) Illegal Occupation/Felony: Expenses for or in connection with an Injury or Illness arising out of an illegal occupation or commission of a felony will not be considered eligible. This exclusion will not apply to Injuries and/or Illnesses sustained due to a medical condition (physical or mental) or due to an act of domestic violence.

(41) Impotence. Care, treatment, services, supplies or medication in connection with treatment for impotence.

(42) Late submission. Charges for care, treatment, services or supplies which were incurred more than 12 months prior to the date the charges were submitted to the Plan for payments

(43) Learning disabilities. Care, supplies, and services for the treatment of autistic disease of childhood, developmental delay, learning disabilities, hyperkinetic syndromes, behavioral problems or mental retardation, except as specified.

(44) Maintenance Therapy: Expenses for Maintenance Therapy of any type when the individual has reached the maximum level of improvement will not be considered eligible.

(45) Marital or pre-marital counseling. Care and treatment for marital or pre-marital counseling.

(46) Massage Therapy: Expenses for massage therapy will not be considered eligible.

(47) Medically Necessary: Expenses which are determined not to be Medically Necessary will not be considered eligible.

(48) Missed Appointments: Expenses for completion of claim forms, missed appointments, cancelled appointments, or telephone consultations will not be considered eligible, except as shown in the Scheduled of Benefits.

(49) Motor vehicle injury. Charges incurred for the care or treatment of any injury sustained as a result of or related to any motor vehicle accident to the extent that such care or treatment for that injury is covered by any plan, program, policy or other arrangement providing insurance coverage for vehicles. Injury while driving or riding in any organized automobile or motorcycle race or speed contest

(50) Negligence: Expenses for Injuries resulting from negligence, misfeasance, malfeasance, nonfeasance or malpractice on the part of any licensed Physician will not be considered eligible.

(51) Never Events: Expenses for serious preventable adverse events ("Never Events") will not, in any event, be considered eligible. These Never Events include:

(a) Surgery performed on the wrong body part;

(b) Surgery performed on the wrong patient;

(c) Wrong Surgical procedure performed on a patient;

(d) Unintentional retention of a foreign object in a patient after Surgery or other procedure;

(e) Inoperative or immediate postoperative death in an ASA Class I patient;

(f) Patient death or serious disability associated with the use of contaminated Drugs, devices, or biologics provided by the healthcare facility;

(g) Patient death or serious disability associated with the use or function of a device in a patient in which the device is used for functions other than as intended;

(h) Patient death or serious disability associated with intravascular air embolism that occurs while being cared for in a healthcare facility;

(i) Patient death or serious disability associated with patient leaving the facility without permission;

(j) Patient suicide, or attempted suicide resulting in a serious disability, while being cared for in a healthcare facility;

(k) Infant discharged to the wrong person;

(l) Patient death or serious disability associated with a medication error (e.g., error involving the wrong drug, wrong dose, wrong patient, wrong time, wrong rate, wrong preparations, or wrong route of administration);

(m) Patient death or serious disability associated with a hemolytic reaction due to the administration of ABO-incompatible blood or blood products;

(n) Maternal death or serious disability associated with labor and delivery in a low-risk Pregnancy while being cared for in a healthcare facility;

(o) Patient death or serious disability associated with hypoglycemia, the onset of which occurs while the patient is being cared for in a healthcare facility;

(p) Death or serious disability associated with failure to identify and treat hyperbilirubinemia (condition where there is a high amount of bilirubin in the blood) in newborns;

(q) Stage 3 or 4 pressure ulcers acquired after admission to a healthcare facility;

(r) Patient death or serious disability due to spinal manipulative therapy;

(s) Artificial insemination with the wrong donor sperm or wrong egg;

(t) Patient death or serious disability associated with an electric shock while being cared for in a healthcare facility;

(u) Any incident in which a line designated for oxygen or other gas to be delivered to a patient contains the wrong gas or is contaminated by toxic substances;

(v) Patient death or serious disability associated with a burn Incurred from any source while being cared for in a healthcare facility;

(w) Patient death associated with a fall while being cared for in a healthcare facility;

(x) Patient death or serious disability associated with the use of restrains or bedrails while being cared for in a healthcare facility;

(y) Any instance of care ordered by or provided by someone impersonating a Physician, nurse, pharmacist, or other Provider;

(z) Abduction of a patient of any age;

(aa) Sexual assault on a patient within or on the grounds of a healthcare facility; and

(bb) Death or significant Injury of a patient or staff member resulting from a physical assault (i.e. battery) that occurs within or on the grounds of a healthcare facility.

(52) No Legal Obligation: Expenses for services provided for which the Covered Person has no legal obligation to pay will not be considered eligible. This exclusion will not apply to eligible expenses that may be covered by state Medicaid coverage where federal law requires this Employer's plan to be primary.

(53) Non-Covered Procedures: Expenses for services related to a non-covered Surgery or procedure will not be considered eligible regardless of when the Surgery or procedure was performed.

(54) Non-Covered by Medicare or Medicaid: services, supplies or drugs not approved for reimbursement by the Centers for Medicare and Medicaid Services or any successor organization;

(55) Not Performed Under the Direction of a Physician: Expenses for services and supplies which are not prescribed or performed by or under the direction of a Physician will not be considered eligible.

(56) Not Recommended by a Physician: Expenses by a Hospital or covered residential treatment center if hospitalization is not recommended or approved by a legally qualified Physician will not be considered eligible.

(57) Nutritional Supplements: Expenses for nutritional supplements, vitamins, and mega-vitamins or other enteral supplementation will not be considered eligible, except as specified under Schedule of Benefits and Medical Covered Charges of the Plan. Over-the-counter nutritional supplements or infant formulas will not be considered eligible even if prescribed by a Physician.

(58) Obesity. Care and treatment of obesity, weight loss or dietary control whether or not it is, in any case, a part of the treatment plan for another Sickness. Specifically excluded are charges for bariatric surgery, including but not limited to, gastric bypass, stapling and intestinal bypass, and lap band surgery, including reversal unless otherwise stated in the Schedule of Benefits for Morbid Obesity.

(59) Occupational. Care and treatment of an Injury or Sickness that is occupational -- that is, arises from work for wage or profit including self-employment.

(60) Off-label drugs. A charge for FDA-approved drugs that are prescribed for non-FDA-approved uses.

(61) Operated by the Government: Expenses for treatment at a facility owned or operated by the government will not be considered eligible, unless the Covered Person is legally obligated to pay. This does not apply to Covered Expenses rendered by a Hospital owned or operated by the United States Veteran's Administration when services are provided to a Covered Person for a non-service related Illness or Injury.

(62) Oral Nutrition Products or Supplements. Oral nutrition products or supplements used to treat a deficient diet or to provide an alternative source of nutrition in conditions such as, but not limited to, obesity, hypo or hyper-glycemia, gastrointestinal disorders, etc., including, but not limited to, lactose free foods; banked breast milk; and/or standardized or specialized infant formulas.

(63) Orthopedic Therapies: Expenses for acupuncture will not be considered eligible.

(64) Outside the United States (U.S.): Expenses for services or supplies if the Covered Person leaves the U.S. or the U.S. Territories for the express purpose of receiving medical treatment will not be considered eligible.

(65) Over-the-Counter (OTC) Medication: Expenses for any over-the-counter medication will not be considered eligible. Expenses for drugs and medicines not requiring a prescription by a licensed Physician and not dispensed by a licensed pharmacist will not be considered eligible, except as otherwise covered as a preventive services under the Schedule of Benefits and Pharmacy Covered Charges section of the Plan.

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

(67) Personal and Athletic Trainer Services. Services provided by a personal or athletic trainer

(68) Plan design excludes. Charges excluded by the Plan design as mentioned in this document.

(69) Plan Maximums: Charges in excess of Plan maximums will not be considered eligible.

(70) Plan Allowable Fee: Expenses in excess of the Plan allowable fee charge will not be considered eligible.

(71) Podiatric orthotics. Over the counter or custom made shoes, shoe inserts, arch supports and other foot orthotics to control foot function, except as specified under the Schedule of Benefits and Medical Covered Charges section.

(72) Prior to Effective Date: Expenses which are incurred prior to the effective date of your coverage under the Plan will not be considered eligible.

(73) Private Duty Nursing: Expenses for inpatient private duty nursing will not be considered eligible except as otherwise stated in the “Covered Services” section of this document.

(74) Radioactive Contamination: Expenses Incurred as the result of radioactive contamination or the hazardous properties of nuclear material will not be considered eligible.

(75) Radiation Therapy: Expenses for services for dermatitis or similar skin conditions

(76) Recreational and Educational Therapy: Expenses for recreational and educational services; learning disabilities; behavior modification services; any form of non-medical self-care or self-help training, including any related diagnostic testing; music therapy; health club memberships; aquatic or pool therapies; will not be considered eligible. This exclusion will not apply to expenses related to the diagnosis, testing and treatment of autism, ADD or ADHD.

(77) Refractive Errors: Expenses for radial keratotomy, Lasik Surgery or any Surgical Procedure to correct refractive errors of the eye will not be considered eligible, unless otherwise stated in this document.

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

(79) Replacement of Component Parts or Modification of a Prosthetic Device within five (5) years of obtaining a new or other replacement part(s) unless incident to the Member's growth for a Member who is under the age of nineteen (19) years.

(80) Required by Law: In any case where an individual is required by law to maintain insurance coverage (or to maintain any other security or reserve amount in lieu of insurance coverage), expenses of a Covered Person that would be paid by such insurance coverage are not eligible expenses, regardless of whether the individual is in fact covered under such coverage. For purposes of any required automobile, motorcycle or other vehicle coverage, otherwise eligible expenses below the minimum required coverage or the actual coverage elected, whichever is higher, will be excluded from coverage under this Plan.

(81) Reversal of Genital Surgery. Surgical procedures to reverse genital surgery

(82) Riot/Revolt: Expenses resulting from a Covered Person's participation in a riot or revolt will not be considered eligible. This exclusion will not apply to Injuries and/or Illnesses sustained due to a medical condition (physical or mental) or domestic violence.

(83) Routine care. Charges for routine or periodic examinations, screening examinations, evaluation procedures, preventative medical care, or treatment or services not directly related to the diagnosis or treatment of a specific Injury, Sickness or pregnancy-related condition, which is known or reasonably suspected, unless such care is specifically covered in the Schedule of Benefits or required by applicable law.

(84) Safety devices. For drivers and all passengers: charges for the treatment for injuries incurred when not wearing appropriate safety restraints and/or motorcycle helmets, when legally required.

(85) Screening exams. Charges for exams required by an insurance company to obtain insurance, required by a governmental agency, or required by an employer in order to begin or continue working.

(86) Services before or after coverage. Care, treatment or supplies for which a charge was incurred before a person was covered under this Plan or after coverage ceased under this Plan.

(87) Self-Inflicted Injury: Expenses for Injury or Illness arising out of attempted suicide or an intentional self-inflicted Injury will not be considered eligible. This exclusion will not apply if self-inflicted Injuries result from a medical condition (physical or mental) or act of domestic violence and the benefits for such Injuries are normally covered under the Plan.

(88) Sex Transformation: Expenses in connection with sex transformation will not be considered eligible.

(89) Sexual Dysfunction/Impotence: Expenses for services, supplies or drugs related to sexual dysfunction/impotence not related to organic disease will not be considered eligible. Expenses for sex therapy will not be considered eligible.

(90) Speech Therapy except as required for treatment of a speech impediment or speech dysfunction that results from Injury, stroke, cancer, Congenital Anomaly, or Autism Spectrum Disorder.

(91) Stand-by Physician: Expenses for technical medical assistance or stand-by Physician services will not be considered eligible.

(92) Sterilization: Expenses for the reversal of elective sterilization will not be considered eligible.

(93) Surgery for the Jaw: Expenses for orthognathic will not be considered eligible.

(94) Surrogate: Expenses relating to a surrogate pregnancy of any person who is not covered under this Plan, including but not limited to pre-pregnancy, conception, pre-natal, childbirth and post-natal expenses, will not be considered eligible.

(95) Telephone. Charges for telephone or email completion of claim forms, or any charges associated with missed appointments.

(96) Third Party Responsible: expenses related to a Sickness or Injury for which a third party is or may be responsible, unless such expenses are advanced as provided in the provision entitled Subrogation.

(97) Transportation Services. Stretcher van and/or wheelchair van transportation services

(98) Travel: Expenses for travel will not be considered eligible, except as specified under Schedule of Benefits and Medical Covered Charges.

(99) Vivo or In Vitro fertilization: Expenses for any other fertilization procedure, test, treatment or drug;

(100) Vision Therapy: Expenses for vision therapy will not be considered eligible

(101) Wage or Profit: Expenses for or in connection with any Injury or Illness which arises out of or in the course of any occupation for wage or profit (including self-employment) will not be considered eligible.

(102) War: Expenses for the treatment of Illness or Injury resulting from a war or any act of war or terrorism, whether declared or undeclared, civil war, hostilities or invasion, or while in the armed forces of any country or international organization will not be considered eligible.

(103) Weight Loss: Surgical and non-surgical care and treatment of obesity and/or morbid obesity including weight loss or dietary control, whether or not it is in any case a part of a treatment plan for another Illness, will not be considered eligible, except as otherwise covered as a preventive service under the Schedule of Benefits and Medical Covered Charges section of the Plan. Exclusion does not apply Morbid Obesity benefit, listed in Schedule of Benefits.

(104) Weekend Admissions: Expenses for care and treatment billed by a Hospital for non-Medical Emergency admissions on a Friday or Saturday will not be considered eligible, unless Surgery is scheduled within 24 hours.

(105) Worker's Compensation: For work-related sickness or injury eligible for benefits under workers' compensation, employers' liability, Own Occupation, Occupational Accident or similar laws, even when the Covered Person does not file a claim for benefits, or sickness or injury that arises out of, or is the result of, any work for wage or profit. This exclusion will not apply to a Covered Person who is not required to have coverage under any workers' compensation, employers' liability or similar State or Federal law and does not have such coverage. Proof of waiver of coverage will be required for those members eligible who waived or not enroll based on the State and/or Federal law.

PRESCRIPTION DRUG BENEFITS

Pharmacy Drug Charge

Participating pharmacies have contracted with the Plan to charge Covered Persons reduced fees for covered Prescription Drugs. APS is the Pharmacy Benefit Manager (PBM) of the pharmacy drug plan who processes all prescription claims on behalf of the Plan Administrator.

Copayments

The copayment is applied to each covered pharmacy drug or mail order drug charge and is shown in the schedule of benefits. Any one pharmacy or mail order prescription is limited to a 30-day to 90-day supply. For Plan Years beginning on or after January 1, 2015, copayments will apply toward satisfaction of the Plan's Maximum Out-of-Pocket amount.

If a drug is purchased from a non-participating pharmacy, or a participating pharmacy when the Covered Person's ID card is not used, the amount payable in excess of the amounts shown in the schedule of benefits will be the ingredient cost and dispensing fee.

Deductible does apply to prescription drugs.

Percentages Payable

The percentage payable amount is applied to each covered pharmacy drug or mail order drug charge and is shown in the schedule of benefits.

All medications are administered and managed under the pharmacy benefit including medications dispensed from any pharmacy or administered in an outpatient provider setting such as a hospital owned or independent outpatient clinic, infusion suite, doctor’s office, nursing home, or long-term care facility. Unless otherwise authorized by MedalistRx Care, no medications will be administered, managed, or covered under the medical benefit.
High cost and specialty medications may require additional review for coverage determination and if covered, provider administered medications will be delivered to the plan participant or provider from a plan approve pharmacy or medication supplier under the plan’s pharmacy benefit. Provider invoice charges for high cost and specialty medications are not eligible for reimbursement.

Mail Order Drug Benefit Option

The mail order drug benefit option is available for maintenance medications (those that are taken for long periods of time, such as drugs sometimes prescribed for heart disease, high blood pressure, asthma, etc.). Because of volume buying APS is able to offer Covered Persons significant savings on their prescriptions.

Specialty & Select High Costs Prescription Drug Products

NOTE: Specialty and select high-cost medications may require additional review for coverage determination.

Specialty Prescription Drug Products and select high-cost medications may be limited to up to a 30-day supply per Prescription Order or Refill. Specialty Prescription Drug Products and select high-cost medications must be filled at the MedalistRx Care designated Specialty or Retail Pharmacy.

Some specialty and high-cost medications may only be accessible through programs that are able to access medications at reduced cost including but not limited to drug manufacturer patient assistance programs. You will be contacted if a prescribed medication falls under such a program. MedalistRx Care will assist you in completing any registration needed to access these programs. Some programs may require household income and other documentation or action by you to enroll. For members choosing not to participate in these programs, your medication out-of-pocket cost under the plan could increase by as much as 100% of the medication cost. Any such increase will not accrue to any plan deductible or out-of-pocket maximum.
Any fees charged to facilitate the procurement of a specialty drug from a manufacturer, or another source will be treated as an eligible claim expense payable by the Plan, i.e., as a necessary component of the Plan’s costs for obtaining the drug, for all purposes under the Plan (and for purposes of any stop loss coverage obtained by the Plan or the Company).

Covered Prescription Drugs

(1) All drugs prescribed by a Physician that require a prescription either by federal or state law. This includes contraceptives, but excludes any drugs stated as not covered under this Plan.

(2) All compounded prescriptions containing at least one prescription ingredient in a therapeutic quantity.

(3) Insulin and other diabetic supplies when prescribed by a Physician.

(4) Injectable drugs or any prescription directing administration by injection, if medically necessary.

Limits To This Benefit

This benefit applies only when a Covered Person incurs a covered Prescription Drug charge. The covered drug charge for any one prescription will be limited to:

(1) Refills only up to the number of times specified by a Physician.

(2) Refills up to one year from the date of order by a Physician.

COVID-19 At Home Testing Kit Coverage

COVID-19 at home testing kits are covered when obtained through the Plan PBM vendor. Coverage will remain as outlined below through the end of the testing coverage requirement period, as released effective 1/15/2022.

(1) This benefit is limited to 8 tests per 30-day period, per member, without cost-sharing requirements.
(2) Testing kits that are sold in packages containing more than one test will be counted as each test separately.
(3) If OTC COVID-19 tests are unavailable, members are encouraged to seek COVID-19 tests at one of the many new federal testing sites across the country.
(4) If testing kits are not obtained through the PBM vendor as stated above, the maximum reimbursement per test will be limited to the actual price, or up to $12 per test, whichever is lower.
(5) Only FDA approved testing kits are covered as stated above.

Expenses Not Covered

This benefit will not cover a charge for any of the following:

(1) **Administration.** Any charge for the administration of a covered Prescription Drug.

(2) **Appetite suppressants.** A charge for appetite suppressants, dietary supplements or vitamin supplements, except for prenatal vitamins requiring a prescription or prescription vitamin supplements containing fluoride.

(3) **Consumed on premises.** Any drug or medicine that is consumed or administered at the place where it is dispensed.

(4) **Devices.** Devices of any type, even though such devices may require a prescription. These include (but are not limited to) therapeutic devices, artificial appliances, braces, support garments, or any similar device.

(5) **Drugs used for cosmetic purposes.** Charges for drugs used for cosmetic purposes, such as anabolic steroids, Retin A (covered through age 21) or medications for hair growth or removal.

(6) **Experimental.** Experimental drugs and medicines, even though a charge is made to the Covered Person.

(7) **FDA.** Any drug not approved by the Food and Drug Administration.

(8) **Growth hormones.** Charges for drugs to enhance physical growth or athletic performance or appearance.

(9) **Immunization.** Immunization agents or biological sera.

(10) **Impotence.** A charge for impotence medication.

(11) I**npatient medication.** A drug or medicine that is to be taken by the Covered Person, in whole or in part, while Hospital confined. This includes being confined in any institution that has a facility for the dispensing of drugs and medicines on its premises.

(12) **Investigational.** A drug or medicine labeled: "Caution - limited by federal law to investigational use".

(13) **Medical exclusions.** A charge excluded under Medical Plan Exclusions.

(14) **No charge.** A charge for Prescription Drugs which may be properly received without charge under local, state or federal programs.

(15) **Non-FDA use.** A charge for FDA-approved drugs that are prescribed for non-FDA-approved uses.

(16) **Non-legend drugs.** A charge for any medication that can be purchased over-the-counter.

(17) **No prescription.** A drug or medicine that can legally be bought without a written prescription. This does not apply to injectable insulin or to over the counter drugs that are prescribed by a Physician as required for Standard Preventive Care.

(18) **Refills.** Any refill that is requested more than one year after the prescription was written or any refill that is more than the number of refills ordered by the Physician.

Note: Exclusions related to prescription drugs may not be limited to this list.

HOW TO SUBMIT A CLAIM

Benefits under this Plan shall be paid only if the Plan Administrator decides in its discretion that a Covered Person is entitled to them.

When a Covered Person has a Claim to submit for payment that person must:

(1) Obtain a Claim form from the Personnel Office, Human Resources Office or the Plan Administrator.

(2) Complete the Employee/Member portion of the form. ALL QUESTIONS MUST BE ANSWERED.

(3) Have the Physician complete the provider's portion of the form.

(4) For Plan reimbursements, attach bills for services rendered. ALL BILLS MUST SHOW:

- Name of Plan
- Employee/Member's name
- Name of patient
- Name, address, telephone number of the provider of care
- Diagnosis
- Type of services rendered, with diagnosis and/or procedure codes
- Date of services
- Charges

(5) Send the above to the Claims Administrator at this address:

Detego Health LLC
3000 S Hulen Street Ste 124 #1180
Fort Worth, TX, 76109
Phone: (866) 815-6001

WHEN CLAIMS SHOULD BE FILED

Claims should be filed with the Claims Administrator within 180 days of the date charges for the service were incurred. Benefits are based on the Plan's provisions at the time the charges were incurred. Claims filed later than that date may be declined or reduced unless:

(a) it's not reasonably possible to submit the claim in that time; and

(b) the claim is submitted within 180 days from the date incurred. This 180 days period will not apply when the person is not legally capable of submitting the claim.

The Claims Administrator will determine if enough information has been submitted to enable proper consideration of the claim. If not, more information may be requested from the claimant. The Plan reserves the right to have a Plan Participant seek a second medical opinion.

The Plan shall also not be responsible for any payment or reimbursement for any healthcare expenses or claims which are submitted 90 days after a Company has been terminated or non-renewed with the Employer’s Business Alliance.

CLAIMS FILING STATUTE OF LIMITATIONS

No legal action of any kind may be brought by a participant or beneficiary in the Plan more than two years (1) after notice of denial of the claim by the Plan has been sent to that participant or beneficiary; or (2) from the time written proof of loss is required to be furnished under this Plan.

BENEFIT CLAIMS PROCEDURE; PROCEDURES FOR CLAIMS AND APPEALS

The procedures outlined below must be followed by Claimants to obtain payment of benefits under this Plan.

I.1 Notice and Proof of Claim

Written notice and proof of an Incurred Claim should always be filed with the Third Party Administrator as soon as possible. ***Claims must be filed within 12 months from the date the charge for the service to be covered by the Plan is Incurred.*** If an individual's coverage under the Plan ceases, all Claims Incurred prior to termination of coverage **must** be filed within 12 months from the date the charge for the service is Incurred, or the Claims will not be covered by the Plan.

Claims **must** be filed sooner in certain circumstances:

If the Plan is terminated, all Claims Incurred prior to the Plan termination **must** be received within 90 days after the termination or the Claims will not be covered. Any Claims Incurred after termination of Plan coverage for any reason are not covered under the Plan.

For purposes of the Plan's provisions for internal claims and Appeals and external review processes, a "claim" for benefits is defined as a request for a plan benefit made by a claimant in accordance with a plan's reasonable procedure for filing benefit claims. A call from a Provider who wants to know if an individual is covered under the Plan, or if a certain procedure or treatment is a covered expense before the treatment is rendered, is not a "claim" since an actual claim for benefits is not being filed with the Plan. Likewise, presentation of a prescription to a pharmacy does not constitute a claim.

Under the claims regulations adopted by the U.S. Department of Labor, the Plan possibly could have four types of claims: Pre-service (Urgent and Non-urgent), Concurrent Care and Post-service. However, because the Plan does not require the Covered Person to obtain approval of any medical service prior to getting treatment, the Plan only has post-service claims.

1. A "Pre-service Claim" is a claim for a benefit under the Plan where the Plan conditions receipt of the benefit, in whole or in part, on approval of the benefit in advance of obtaining Medical Care.

   A "pre-service urgent care claim" is any claim for Medical Care or treatment with respect to which the application of the time periods for making non-urgent care determinations could seriously jeopardize the life or health of the Covered Person or the Covered Person's ability to regain maximum function, or, in the opinion of a Physician with knowledge of the Covered Person's medical condition, would subject the Covered Person to severe pain that cannot be adequately managed without the care or treatment that is the subject of the claim.
   Because the Plan does not require Claimants to obtain approval of a medical service prior to getting treatment on an urgent or non-urgent basis, there are no "Pre-service Claims." The Claimant simply follows the Plan's procedures with respect to notice that is required after receipt of treatment, and files the Claim as a Post-service Claim.

2. A "Concurrent Claim" arises when the Plan has approved an on-going course of treatment to be provided over a period of time or number of treatments, and either:

   a. The Plan determines that the course of treatment should be reduced or terminated; or
   b. The Claimant requests an extension of the course of treatment beyond that which the Plan has approved.

   Because the Plan does not require Claimants to obtain approval of medical services prior to getting treatment, there is no need to contact the Utilization Review Company to request an extension of a course of treatment. The Claimant simply follows the Plan's procedures with respect to notice that is required after receipt of treatment, and files the Claim as a Post-service Claim.

3. "Post-service Claim" is a Claim for a benefit under the Plan after the services have been rendered. A Post-service Claim is considered to be filed when the following information is received by the Third Party Administrator with a Form CMS-1500 or Form UB92 or any successor forms:

a. The date of service;
b. The name, address, telephone number, and tax identification number of the Provider of the services or supplies;
c. The place where the services were rendered;
d. The diagnosis and procedure codes;
e. The amount of charges (including any PPO repricing information);
f. The name of the Plan;
g. The name of the Employee/Member; and
h. The name of the patient.

Each Claimant claiming benefits under the Plan shall be responsible for supplying, at such times and in such manner as the Plan Administrator in its sole discretion may require, written proof that the expenses were Incurred, or that the benefit is covered under the Plan. If the Plan Administrator in its sole discretion determines that the Claimant has not Incurred a Covered Expense, or that the benefit is not covered under the Plan, or if the Claimant fails to furnish such proof as is requested, no benefits shall be payable under the Plan.

I.2 Claims Determination

The Plan Administrator shall notify the Claimant, in accordance with the provisions set forth below, of any Adverse Benefit Determination within the following timeframes:

1. If the Claimant has provided all of the information needed to process the Claim in a reasonable period of time, but not later than 30 days after receipt of the Claim. This period may be extended by the Plan for up to 15 days, provided that the Plan Administrator:

   a. Determines that such an extension is necessary due to matters beyond the control of the Plan; and
   b. Notifies the Claimant, prior to the expiration of the initial 30-day processing period, of the circumstances requiring the extension of time, and the date by which the Plan expects to render a decision.

   If an extension has been requested, then the Plan Administrator shall notify the Claimant of any Adverse Benefit Determination prior to the end of the 15-day extension period.

2. If additional information is requested from the Claimant to process the Claim during the initial processing period, then the Claimant will be notified of a determination of benefits prior to the end of the extension period. If additional information is requested from the Claimant during the extension period, then the Claimant will be notified of the determination by a date agreed to by the Plan Administrator and the Claimant.

3. Notice to the Claimant of a rescission of coverage will be provided at least 30 days in advance of the retroactive termination of coverage by the Plan.

A Benefit Determination is required to be made within the period of time beginning when a Claim is deemed to be filed in accordance with the procedures of the Plan.

I.3 Notice Of Adverse Benefit Determination

An “adverse benefit determination” is defined as a denial, reduction, or termination of, or a failure to provide or make a payment (in whole or in part) for a benefit, including any such denial, reduction, termination, or failure to provide or make a payment for a claim that is based on:

1. A determination of an individual’s eligibility to participate in a plan or health insurance coverage;
2. A determination that a benefit is not a covered benefit;
3. The imposition of a source-of-injury exclusion, PPO provider network exclusion, or other limitation on otherwise covered benefits; or
4. A determination that a benefit is Experimental, Investigational, or not Medically Necessary or appropriate.

Although it is not a claim for benefits, the definition of an adverse benefit determination also includes a rescission of coverage under the Plan. A “rescission of coverage” is defined as a cancellation or discontinuance of coverage that has retroactive effect, except to the extent it is attributable to a failure to timely pay required premiums or contributions towards the cost of coverage.
If the initial Benefit Determination is an Adverse Benefit Determination, notification will be sent to the Claimant

and will include the following information:

1. Information sufficient to identify the claim involved, including the date of the service, the health care provider, the claim amount (if applicable), and, upon request, the diagnosis code and its corresponding meaning, and the treatment code and its corresponding meaning;
2. The reason or reasons for an adverse benefit determination or final internal adverse benefit determination, including the denial code and its corresponding meaning, as well as a description of the Plan's standard, if any, used in denying the claim. In the case of a final internal adverse benefit determination, this description must also include a discussion of the decision;
3. A reference to the specific portion(s) of the plan document and summary plan description upon which a denial is based;
4. A description of any additional information necessary for the claimant to perfect the claim and an explanation of why such information is necessary;
5. A description of the Plan's review procedures and the time limits applicable to the procedures, including a statement of the claimant's right to bring a civil action under Section 502(a) of ERISA following an adverse benefit determination on final review;
6. A statement that the claimant is entitled to receive, upon request and free of charge, reasonable access to, and copies of, all documents, records and other information relevant to the claimant's claim for benefits;
7. The identity of any medical or vocational experts consulted in connection with a claim, even if the Plan did not rely upon their advice (or a statement that the identity of the expert will be provided, upon request);
8. Any rule, guideline, protocol or similar criterion that was relied upon in making the determination (or a statement that it was relied upon and that a copy will be provided to the claimant, free of charge, upon request); and
9. In the case of denials based upon a medical judgment (such as whether the treatment is medically necessary or experimental), either an explanation of the scientific or clinical judgment for the determination, applying the terms of the Plan to the claimant's medical circumstances, or a statement that such explanation will be provided to the claimant, free of charge, upon request.

Physical Examination

The Plan Administrator or Third Party Administrator has the right to have the Claimant examined as often as reasonably necessary while a Claim is pending. Benefits are payable under this Plan only if they are Medically Necessary for the Illness or Accidental Injury of the Covered Person. This Plan reserves the right to make a Utilization Review to determine whether services are Medically Necessary for the proper treatment of the Covered Person. All such information will be confidential.

Claims Audit

Once a written Claim for benefits is received, the Claims Administrator, acting on the discretionary authority of the Plan Administrator, may elect to have such Claim reviewed or audited for accuracy and limited to, identifying: (a) charges for items/services that may not be covered or may not have been delivered, (b) duplicate charges, and (c) charges beyond the reasonable, necessary, and U&C guidelines as determined by the Plan. In addition, please refer to the section entitled "Claim Review and Audit Program" for information regarding Plan provisions related to the audit and adjudication of certain eligible Claims under that Program.

Payment Of Claims

Plan benefits are payable to the covered Employee/Member, unless the Claimant gives written direction, at the time of filing proof of such loss, to pay directly the health care Provider rendering such services. Such payment to a health care Provider is subject to the approval of the Plan Administrator. If any such benefit remains unpaid at the death of the covered Employee/Member, if the Claimant is a minor, or if the Claimant is (in the opinion of the Plan Administrator) legally incapable of giving a valid receipt and discharge for any payment, the Plan Administrator may, at its option, pay such benefits to any one or more of the following relatives of the Claimant: wife, husband, mother, father, Child or Children, brother or brothers, sister or sisters. Such payment will constitute a complete discharge of the Plan's obligation to the extent of such payment, and the Plan Administrator will not be required to follow-up and determine how such paid money was used.

Disposition of Unclaimed Benefit Payments. In the event that a payee of a benefit check issued in payment of the Plan's obligations, fails within 90 days of the date of its issuance to cash such a benefit check (a "Stale Check"), such monies shall be **forfeited by the Payee and shall revert back to the Plan.** Neither the payee nor

any person covered under this Plan shall have any right to have a Stale Check reissued or to make any claim for benefits related to the services for which the check was originally issued.

Appeal Process

The Plan shall follow the appeal guidelines and Independent Dispute Resolution (IDR) process set forth by the 2022 No Surprises Act.

Full and Fair Review of All Claims

The Plan provides for two levels of appeal following an Adverse Benefit Determination. The Claimant has 180 days following an initial Adverse Benefit Determination to file an appeal of that determination, and 60 days following an Adverse Benefit Determination on the First Level Appeal to file a Second Level Appeal of that determination. The appeal process will provide the Claimant with a reasonable opportunity for a full and fair review of the Claim and Adverse Benefit Determination and will include the following:

a. Receipt of written request by the Claims Administrator from the Claimant, or an Authorized Representative of the Claimant, with the proper form for review of Adverse Benefit Determination, which initiates the appeal process.

b. The Claimant will have the opportunity to submit written comments, documents, records, and other information relating to the Claim.

c. The Claimant will be provided, on request and free of charge: (a) reasonable access to and copies of all documents, records, and other information relevant to the Claimant's Claim in possession of the Plan Administrator, the Claims Audit Decision Maker (DDM) or the Claims Administrator; (b) information regarding any rule, guideline, protocol or other similar criterion relied upon in making the Adverse Benefit Determination; (c) information regarding any voluntary appeals procedures offered by the Plan; and (d) an explanation of the scientific or clinical judgment for the determination, applying the terms of the Plan to the Claimant's medical circumstances.

d. The review of the Adverse Benefit Determination will take into account all comments, documents, records and other information submitted by the Claimant relating to the Claim, without regard to whether such information was submitted or considered in the initial Benefit Determination.

e. No deference will be afforded to the previous Adverse Benefit or Appeal Determination. The party reviewing the appeal may be neither the party who made the prior Adverse Benefit Determination, nor a subordinate of the party who made the prior Adverse Benefit Determination.

f. In deciding an appeal on which the Adverse Benefit Determination was based in whole or in part on a medical judgment, including whether a particular treatment, drug, or other item is Experimental, Investigational, or not Medically Necessary or appropriate, the Claims Administrator, the Claim Audit Decision Maker or the Plan Administrator, as appropriate depending on the level of appeal, will consult with a health care professional who has appropriate training and experience in the field of medicine involving the medical judgment. The health care professional consulted for the appeal will not be the health care professional or a subordinate of the health care professional consulted in connection with the Adverse Benefit Determination that is the subject of the appeal.

g. Medical or vocational experts whose advice was obtained on behalf of the Plan in connection with the Adverse Benefit Determination will be identified, even if the Plan did not rely upon their advice.

h. The first level of appeal will be decided within 30 days of the Claims Administrator's receipt of the request. The second level of appeal will be decided within 30 days of the Plan's receipt of the request.

First Appeal Level

Requirements for First Appeal

The Claimant must file the first Appeal, in writing, within 180 days following receipt of the notice of an Adverse Benefit Determination. The Claimant's Appeal must be addressed as follows:

Detego Health LLC
Appeals Department
3000 S Hulen Street Ste 124 #1180
Fort Worth, TX, 76109
Phone: (866) 815-6001

It shall be the responsibility of the Claimant to submit proof that the Claim is covered and payable under the provisions of the Plan. An appeal must include:

1. The name of the Employee/Member/Claimant;
2. The Employee/Member's/Claimant's Social Security number;
3. The group name or identification number;
4. All facts and theories supporting the Claim for benefits. **Failure to include any theories or facts in the appeal will result in such facts being inadmissible. In other words, the Claimant will lose the right to raise such factual arguments and theories that support this Claim if the Claimant fails to include them in the appeal;**
5. A statement in clear and concise terms of the reason or reasons for the disagreement with the handling of the Claim; and
6. Any material or information that the Claimant has which indicates that the Claimant is entitled to benefits under the Plan.

If the Claimant provides all of the required information, it may be that the expenses will be eligible for payment under the Plan.

Timing of Notification of Benefit Determination on First Appeal

The Plan shall notify the Claimant of the Plan's Benefit Determination on review within a reasonable period of time, but not later than 30 days after receipt of the appeal.

The period of time within which the Plan's determination is required to be made shall begin at the time an appeal is filed in accordance with the procedures of this Plan, without regard to whether all information necessary to make the determination accompanies the filing.

Notice of Benefit Determination on First Appeal

The Claimant will be notified of the Benefit Determination on appeal. If there is an Adverse Benefit Determination on appeal, the notification will include the following information:

1. The reason or reasons for the Adverse Benefit Determination;
2. References to the Plan provisions on which the Adverse Benefit Determination is based;
3. A description of any additional material or information necessary for the Claimant to perfect the Claim, and an explanation of why such material or information is necessary;
4. A statement that the Claimant is entitled to receive, upon request and free of charge, reasonable access to, and copies of, all documents, records, and other information relevant to the Claimant's Claim;
5. A description of the Plan's review procedures and the time limits applicable to such procedures, including a statement of the Claimant's right to bring a civil action under Section 502(a) of ERISA following an Adverse Benefit Determination on final review;
6. A description of voluntary appeal procedures offered by the Plan and, upon the Claimant's request, any additional information about the voluntary appeal procedures;
7. If an internal rule, guideline, protocol, or other similar criterion was relied on in making the Adverse Benefit Determination, either the specific rule, guideline, protocol or other similar criterion or a statement that such was relied on in making the Adverse Benefit Determination, and that a copy of the rule, guideline, protocol or other criterion will be provided free of charge on request;
8. If the Adverse Benefit Determination is based on a medical judgment (such as Medical Necessity or whether or not treatment is Experimental), either an explanation of the scientific or clinical judgment for the determination, applying the terms of the Plan to the Claimant's medical circumstances, or a statement that

such explanation will be provided free of charge on request;
9. The identity of any medical or vocational experts consulted in connection with the Claim, even if the Plan did not rely upon their advice; and
10. The following statement: “You and your Plan may have other voluntary alternative dispute resolution options, such as mediation. One way to find out what may be available is to contact your local U.S. Department of Labor Office and your State Insurance Regulatory Agency.”

Furnishing Documents in the Event of an Adverse Determination

In the case of an Adverse Benefit Determination on review, the Plan Administrator shall provide such access to, and copies of, documents, records, and other information described in the section relating to Notice of Benefit Determination on First Appeal, as appropriate.

Second Appeal Level

Adverse Decision on First Appeal; Requirements for Second Appeal

Upon receipt of notice of the Plan’s Adverse Benefit Determination regarding the first appeal, the Claimant has 60 days to file a second appeal of the denial of benefits. The Claimant again is entitled to a "full and fair review" of any denial made at the first appeal, which means the Claimant has the same rights during the second appeal as he or she had during the first appeal. As with the first appeal, the Claimant's second appeal must be in writing and must include all of the items set forth in the section entitled "Requirements for First Appeal."

Timing of Notification of Benefit Determination on Second Appeal

The Plan shall notify the Claimant of the Plan’s Benefit Determination on review within a reasonable period of time, but not later than 30 days after receipt of the second appeal.

The period of time within which the Plan's determination is required to be made shall begin at the time the second appeal is filed in accordance with the procedures of this Plan, without regard to whether all information necessary to make the determination accompanies the filing.

Manner and Content of Notification of Adverse Benefit Determination on Second Appeal

The same information must be included in the Plan’s response to a second appeal as a first appeal, except for: (a) a description of any additional information necessary for the Claimant to perfect the Claim and an explanation of why such information is needed; and (b) a description of the Plan’s review procedures and the time limits applicable to the procedures. See the section entitled "Notice of Benefit Determination on First Appeal."

Furnishing Documents in the Event of an Adverse Determination

In the case of an Adverse Benefit Determination on the second appeal, the Plan Administrator shall provide such access to, and copies of, documents, records, and other information described in the section relating to the Notice of Benefit Determination on First Appeal, as appropriate.

Decision on Second Appeal to be Final

If, for any reason, the Claimant does not receive a written response to the appeal within the appropriate time period set forth above, the Claimant may assume that the appeal has been denied. The decision will be final, binding and conclusive, and will be afforded the maximum deference permitted by law.

All Claim review procedures provided for in the Plan must be exhausted before any legal action is brought. Any legal action for the recovery of any benefits must be commenced within three years after the Plan's Claim review procedures have been exhausted. Any action with respect to a fiduciary’s breach of any responsibility, duty or obligation hereunder must be brought within three years after the date of service.

Expedited External Review for Urgent or Emergency Care

This Plan does not require a claimant to obtain prior approval for pre-service urgent care claims or emergency care services before getting treatment; therefore, neither the internal appeals nor the external review procedures will apply to these claims. In an emergency or urgent care situation, the claimant should follow instructions from his or her health care provider and file the claim as a post-service claim. If the post-service claim results in an adverse benefit determination, the claimant may file an appeal in accordance with the Plan's provisions for "Appeal Process", which are explained above.

Appeals of claims involving concurrent care will be subject to the Plan's provisions for expedited external review, as explained below.

Procedures for Initiation of an External Review

Standard External Review

A request for an external review must include the same information that is required for an internal appeal, listed above in the section, "Appeal Process". Once the request for a standard external review is filed, the Plan will have five business days to do a preliminary review of the request to determine whether it is eligible and whether all of the information and forms required to process the external review have been provided.

Within one business day following completion of the preliminary review, the Plan will notify the claimant in writing whether the request is eligible for external review.

- If the request is complete but is not eligible for external review, the notice will contain an explanation of the reason that the request is ineligible.
- If the request is incomplete, the notice will describe the information or materials needed to make the request complete. The claimant must submit the information or materials needed within 48 hours following receipt of the notice, or the expiration of the original four-month filing period, whichever is later.

An eligible request, which is complete and timely filed, will be assigned to an independent review organization (IRO) by the Plan. The Plan will have arrangements to access at least three accredited IROs to which external reviews will be assigned on a random or rotated basis to ensure an independent and unbiased review. The assigned IRO will notify the claimant in writing of the request's eligibility and acceptance for external review. This notice will include a statement that the claimant may submit to the IRO, in writing and within 10 business days following receipt of the notice, any additional information that the IRO must consider when conducting the external review.

Within five business days after the date of assignment of the IRO, the Plan must provide to the assigned IRO the documents and any information considered in making the adverse benefit determination or final internal adverse benefit determination. Failure by the Plan to timely provide the documents and information will not delay the conduct of the external review, and the IRO may decide to reverse the adverse benefit determination or final internal adverse benefit determination. In this case, the IRO will notify the Plan and the claimant within one business day following the decision to reverse the determination.

The assigned IRO will forward any information, which is submitted by the claimant to the Plan, and the Plan may reconsider its adverse benefit determination or final internal adverse benefit determination; however, reconsideration by the Plan will not delay the external review. If the Plan decides to reverse its adverse benefit determination or final internal adverse benefit determination, it may terminate the external review and notify the IRO and the claimant within one business day of the decision.

The IRO will provide written notice to the claimant and the Plan of the final external review decision with 45 days following receipt of the request for review. The notice will contain:

1. A general description of the reason for the request for external review, including information sufficient to identify the claim (including the date or dates of service, the health care provider, the claim amount (if applicable), the diagnosis code and its corresponding meaning, the treatment code and its corresponding meaning, and the reason for the previous denial;
2. The date the IRO received the request for external review and the date on which it made the decision;
3. References to the evidence or documentation, including the specific coverage provisions and evidence-based standards, considered in reaching its decision;

4. A discussion of the principal reason or reasons for its decision, including the rationale for its decision and the evidence-based standards that were relied on in making the decision;
5. A statement that the determination is binding except to the extent that other remedies may be available under State or Federal law to either the group health plan or to the claimant;
6. A statement that judicial review may be available to the claimant; and
7. Current contact information, including a phone number, for any applicable office of health insurance consumer assistance or ombudsman established under PHS Act section 2793.

Expedited External Review

A final internal adverse benefit determination concerning an admission, availability of care, continued stay, or health care item or service for which the claimant received emergency services but has not yet been discharged from the facility will be considered for an expedited external review. These are considered to be pre-service **non-urgent** care claims and concurrent claims. The procedures that apply to standard external reviews will apply to expedited external reviews, except that:

a. The preliminary review of the request to determine whether it is eligible and whether all of the information and forms required to process the external review have been provided must be conducted immediately, and the Plan must immediately notify the claimant regarding the eligibility determination;
b. Upon a determination that a request is eligible for external review following the preliminary review, the Plan will immediately assign an IRO pursuant to the requirements set forth for standard external reviews;
c. The Plan must provide or transmit all necessary documents and information considered in making the adverse benefit determination or final internal adverse benefit determination to the assigned IRO electronically, by phone, facsimile or any other available expeditious method; and
d. The IRO must provide notice of the final external review decision as expeditiously as the claimant's medical condition or circumstances require, but in no event more than 72 hours after the IRO receives the request for an expedited external review. If the notice is not in writing, the assigned IRO must provide written confirmation of the decision to the claimant and the Plan within 48 hours following the notice.

Decision Following an External Review

Upon receipt of a notice from the IRO reversing the decision of an adverse benefit determination or final internal adverse benefit determination, the Plan will immediately provide coverage or payment for the claim. An external review decision is binding on the Plan as well as the claimant, except to the extent other remedies are available under State or Federal law.

Time Limit for Legal Action

All claim review procedures provided for in the Plan must be exhausted before any legal action is brought. Any legal action for the recovery of any benefits must be commenced within 3 years after the Plan's claim review procedures have been exhausted. Any action with respect to a fiduciary's breach of any responsibility, duty or obligation hereunder must be brought within 3 years after the date of service.

Appointment of Authorized Representative

A Claimant is permitted to appoint an Authorized Representative to act on his behalf with respect to a benefit claim or appeal of an Adverse Benefit Determination. An assignment of benefits by a Claimant to a provider will not constitute appointment of that provider as an Authorized Representative. To appoint such a representative, the Claimant must complete a form which can be obtained from the Plan Administrator or the Claims Administrator. In the event a Claimant designates an Authorized Representative, all future communications from the Plan will be with the Authorized Representative, rather than the Claimant, unless the Claimant directs the Plan Administrator, in writing, to the contrary.

Provider of Service Appeal Rights

A Claimant may appoint the provider of service as the Authorized Representative with full authority to act on his or her behalf in the appeal of a denied claim. An assignment of benefits by a Claimant to a provider of service will not constitute appointment of that provider as an Authorized Representative. However, in an effort to ensure a full and fair review of the denied claim, and as a courtesy to a provider of service that is not an Authorized Representative, the Plan will consider an appeal received from the provider in the same manner as a Claimant's appeal and will respond to the provider and the Claimant with the results of the review accordingly. Any such

appeal from a provider of service must be made within the time limits and under the conditions for filing an appeal specified under the section, “Appeal Process,” above.

Providers requesting such appeal rights under the Plan must agree to pursue reimbursement for Covered Medical Expenses directly from the Plan, waiving any right to recover such expenses from the Claimant, and comply with the conditions of the section, “Requirements for Appeal,” above.

For purposes of this section, the provider’s waiver to pursue Covered Medical Expenses does not include the following amounts, which will remain the responsibility of the Claimant:

- Deductibles;
- Copayments;
- Coinsurance;
- Penalties for failure to comply with the terms of the Plan;
- Charges for services and supplies which are not included for coverage under the Plan; and
- Amounts which are in excess of any stated Plan maximums or limits.

Note: This does not apply to amounts found to be in excess of Allowable Claim Limits. Please refer to the section entitled “Claim Review and Audit Program” for information regarding Plan provisions related to the audit and adjudication of certain eligible Claims under that Program. The Claimant will not be held responsible for any amounts found to be in excess of Allowable Claim Limits. Also, for purposes of this section, if a provider indicates on a Form UB92 or on a Form HCFA (or similar claim form) that the provider has an assignment of benefits, then the Plan will require no further evidence that benefits are legally assigned to that provider.

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

Claim Review and Audit Program

The Plan has arranged with the Claims Administrator (“TPA”) for a program of claim review and auditing in order to identify charges billed in error, charges for excessive or unreasonable fees and charges for services, which are not medically appropriate. Benefits for claims selected for review and auditing, may be reduced for any charges that are determined to be in excess of Allowable Claim Limits (as defined below). The determination of Allowable Claim Limits under this Program will supersede any other Plan provisions related to application of a usual, customary or reasonable fee determination.

Claim Payment Guidelines

“Allowable Claim Limits” means the charges for services and supplies, listed and included as Covered Medical Expenses under the Plan, which are Medically Necessary for the care and treatment of Illness or Injury, but only to the extent that such fees are within the Allowable Claim Limits. Determination that a charge is within the Allowable Claim Limit will be made by the Administrator and will include, but not be limited to, the following guidelines:
Egregious billing is defined as charges that exceed three times the Medicare rate.

Hospital - The Allowable Claim Limit for charges incurred under this plan will be based upon 140% of the provider’s most recent departmental cost ratio, reported to the Centers for Medicare and Medicaid Services (“CMS”) and published in the American Hospital Directory as the “Medicare Cost Report” (the “CMS Cost Ratio”) or may be based upon the Medicare allowed amount for the services in the geographic region plus an additional 20%, not to exceed a maximum of 200% of the Medicare allowable.

For providers which do not report cost-to-charge ratios or participate with Medicare such as Children’s Hospitals, Independently Owned Cancer Centers, and Physician Owned Hospitals, the Allowable Claim Limits for charges by these types of facilities may be based on 140% of the average of the contracted/discounted rates accepted by nearby providers offering the same or similar services. All hospital billing must follow Medicare guidelines.

Professional Providers - The Allowable Claim Limit for charges incurred under this plan will be based upon 120% of the provider’s most recent departmental cost ratio, reported to the Centers for Medicare and Medicaid Services (“CMS”) and published in the American Hospital Directory as the “Medicare Cost Report” (the “CMS Cost Ratio”) or may be based upon the Medicare allowed amount for the services in the geographic region plus an additional 20%, not to exceed a maximum of 200% of the Medicare allowable. The Allowable Claim Limit for charges incurred by a Specialist will be based upon 130% of the Medicare allowable.

DIRECT CONTRACTS WITH A HOSPITAL, OTHER MEDICAL FACILITY OR PROVIDER
In the event that the Plan Administrator authorizes a direct contract for services with a hospital, other medical facility or provider to provide necessary and appropriate services to Covered Persons, then the terms of those contracts shall be utilized to determine the Allowable Claim limits in lieu of other limits under this Program.

Balance Billing

In the event that a claim submitted by a Network or non-Network Provider is subject to a medical bill review or medical audit under the Claim Review and Audit Program and some or all of the charges in connection with such claim are repriced because of billing errors and/or overcharges or in determining the Allowable Claim Limit, it is the Plan's position that the Participant should not be responsible for payment of any charges denied as a result of the Audit Adjustments and should not be balance billed for the difference between the billed charges and the amount determined to be payable by the Audit Program. However, balance billing is legal in many jurisdictions, and the Plan has no control over non-Network Providers that engage in balance billing practices. The Plan grants Providers a Direct Right of Appeal to object to any such reductions in reimbursements of claims. In return for this right the Provider is required to waive the right to balance bill a member. In the event that a Provider does not appeal, or files and appeal but still balance bills a member for Audit reductions, the Claim Review and Audit Program provides a full legal defense for the Member against the Balance Bill.

In addition, with respect to services rendered by a Network Provider being paid in accordance with a discounted rate, it is the Plan's position that the Participant should not be responsible for the difference between the amount charged by the Network Provider and the amount determined to be payable by the Plan Administrator and should not be balance billed for such difference. Again, the Plan has no control over any Network Provider that engages in balance billing practices, except to the extent that such practices are contrary to the contract governing the relationship between the Plan and the Network Provider.

In either case, in network or out of network or no network, the Participant is responsible for any applicable payment of co-insurances, Deductibles, and out-of-pocket maximums and may be billed for any or all of these claims.

ASSIGNMENT OF BENEFITS

Any benefits payable under the Plan are paid to you unless you specifically request in writing when the claim is submitted that payment be made directly to the provider of service. There is a space provided on the claim form for this purpose.

Most hospitals will require you to sign an “Assignment of Benefits” prior to treatment so that they may be paid directly. Many Physicians will also request that you assign benefits directly to them.

In the event that payment is made directly to the provider of service, you will receive written notification of the payment and how it was computed.

The Claims Administrator reserves the right to elect to make payment for charges to either the Provider or the participant when charges exceed the Plans allowable fee amount.

In the event assignment is made to the participant, it is the responsibility of the participant to make payment to the Provider for allowable charges and charges in excess of the Plans allowable fee amount.

In the event that a valid Federal Identification Number and the legal corporate name of the provider cannot be obtained, no assignment will be made.

COORDINATION OF BENEFITS

Coordination of the benefit plans. Coordination of benefits sets out rules for the order of payment of Covered Charges when two or more plans -- including Medicare -- are paying. When a Covered Person is covered by this Plan and another plan, or the Covered Person's Spouse is covered by this Plan and by another plan or the couple's Covered children are covered under two or more plans, the plans will coordinate benefits when a claim is received.

The plan that pays first according to the rules will pay as if there were no other plan involved. The secondary and subsequent plans will pay the balance due up to 100% of the total Allowable Charges.

If a Covered Person is eligible for benefits under this Plan, and another plan(s), but does not make claims for benefits payable under another plan(s) the benefits payable under this Plan will be reduced to the extent of benefits that would have been payable under another plan had claims been made thereof. This reduction is regardless of coordination payment order.

When an individual is covered under this plan as an Employee/Member or as a Dependent, the Plan will reimburse treatment for End Stage Renal Disease (ESRD) for the initial 30 months at a rate not to exceed 135% of the Medicare allowable for incurred expenses.

Benefit plan. This provision will coordinate the medical benefits of a benefit plan. The term benefit plan means this Plan or any one of the following plans:

(1) Group or group-type plans, including franchise or blanket benefit plans.

(2) Blue Cross and Blue Shield group plans.

(3) Group practice and other group prepayment plans.

(4) Federal government plans or programs. This includes, but is not limited to, Medicare and Tricare.

(5) Other plans required or provided by law. This does not include Medicaid or any benefit plan like it that, by its terms, does not allow coordination.

(6) No Fault Auto Insurance, by whatever name it is called, when not prohibited by law.

Allowable Charge. For a charge to be allowable it must be within the Plans allowable fee charge and at least part of it must be covered under this Plan.

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

In the case of service type plans where services are provided as benefits, the reasonable cash value of each service will be the Allowable Charge.

Automobile limitations. When medical payments are available under vehicle insurance, the Plan shall always be considered the secondary carrier regardless of the individual's election under PIP (personal injury protection) coverage with the auto carrier.

Benefit plan payment order. When two or more plans provide benefits for the same Allowable Charge, benefit payment will follow these rules:

(1) Plans that do not have a coordination provision, or one like it, will pay first. Plans with such a provision will be considered after those without one.

(2) Plans with a coordination provision will pay their benefits up to the Allowable Charge:

(a) The benefits of the plan which covers the person directly (that is, as an Employee/Member, member or subscriber) ("Plan A") are determined before those of the plan which covers the person as a dependent ("Plan B").

(b) The benefits of a benefit plan which covers a person as an Employee/Member who is neither laid off nor retired are determined before those of a benefit plan which covers that person as a laid-off or Retired Employee/Member. The benefits of a benefit plan which covers a person as a Dependent of an Employee/Member who is neither laid off nor retired are determined before those of a benefit plan which covers a person as a Dependent of a laid off or Retired Employee/Member. If the other benefit plan does not have this rule, and if, as a result, the plans do not agree on the order of benefits, this rule does not apply.

(c) The benefits of a benefit plan which covers a person as an Employee/Member who is neither laid off nor retired or a Dependent of an Employee/Member who is neither laid off nor retired are determined before those of a plan which covers the person as a COBRA beneficiary.

End Stage Renal Disease. If a participating Employee/Member or Dependent becomes eligible for other coverage on the basis of end stage renal (kidney) disease (ESRD), then the Plan will be the primary payor for the applicable coordination period as it is then defined under federal law (currently (30) months for individuals who become eligible due to ESRD on or after October 31, 1997). After the expiration of the coordination period, the Plan will become secondary.

Under no circumstances will payment by the Plan exceed 135% of the allowance for expenses incurred due to ESRD. However, after electing COBRA, if the qualified beneficiary should become entitled to other coverage due to ESRD, the qualified beneficiary is no longer eligible for COBRA.

(d) When a child is covered as a Dependent and the parents are not separated or divorced, these rules will apply:

(i) The benefits of the benefit plan of the parent whose birthday falls earlier in a year are determined before those of the benefit plan of the parent whose birthday falls later in that year;

(ii) If both parents have the same birthday, the benefits of the benefit plan which has covered the parent for the longer time are determined before those of the benefit plan which covers the other parent.

(e) When a child's parents are divorced or legally separated, these rules will apply:

(i) This rule applies when the parent with custody of the child has not remarried. The benefit plan of the parent with custody will be considered before the benefit plan of the parent without custody.

(ii) This rule applies when the parent with custody of the child has remarried. The benefit plan of the parent with custody will be considered first. The benefit plan of the stepparent that covers the child as a Dependent will be considered next. The benefit plan of the parent without custody will be considered last.

(iii) This rule will be in place of items (i) and (ii) above when it applies. A court decree may state which parent is financially responsible for medical and dental benefits of the child. In this case, the benefit plan of that parent will be considered before other plans that cover the child as a Dependent.

(iv) If the specific terms of the court decree state that the parents shall share joint custody, without stating that one of the parents is responsible for the health care expenses of the child, the plans covering the child shall follow the order of benefit determination rules outlined above when a child is covered as a Dependent and the parents are not separated or divorced.

(v) For parents who were never married to each other, the rules apply as set out above as long as paternity has been established.

(f) If there is still a conflict after these rules have been applied, the benefit plan which has covered the patient for the longer time will be considered first. When there is a conflict in coordination of benefit rules, the Plan will never pay more than 50% of Allowable Charges when paying secondary.

(3) Medicare will pay primary, secondary or last to the extent stated in federal law. When Medicare would be the primary payer if the person had enrolled in Medicare, this Plan will base its payment upon benefits that would have been paid by Medicare under Parts A and B regardless of whether or not the person was enrolled under any of these parts. The Plan reserves the right to coordinate benefits with respect to Medicare Part D. The Plan Administrator will make this determination based on the information available through CMS. If CMS does not provide sufficient information to determine the amount Medicare would pay, the Plan Administrator will make reasonable assumptions based on published Medicare fee schedules.

(4) If a Plan Participant is under a disability extension from a previous benefit plan, that benefit plan will pay first and this Plan will pay second.

(5) The Plan will pay primary to Tricare and a State child health plan to the extent required by federal law.

Claims determination period. Benefits will be coordinated on a Plan Year basis. This is called the claims determination period.

Right to receive or release necessary information. To make this provision work, this Plan may give or obtain needed information from another insurer or any other organization or person. This information may be given or obtained without the consent of or notice to any other person. A Covered Person will give this Plan the information it asks for about other plans and their payment of Allowable Charges.

Facility of payment. This Plan may repay other plans for benefits paid that the Plan Administrator determines it should have paid. That repayment will count as a valid payment under this Plan.

Right of recovery. This Plan may pay benefits that should be paid by another benefit plan. In this case this Plan may recover the amount paid from the other benefit plan or the Covered Person. That repayment will count as a valid payment under the other benefit plan.

Further, this Plan may pay benefits that are later found to be greater than the Allowable Charge. In this case, this Plan may recover the amount of the overpayment from the source to which it was paid.

The Plan may request or provide information from another insurer or any other organization or person for purposes of determining allowable charges. This information may be provided or obtained without consent or notice to any other person. This Plan will not pay claims that appear to be the liability of another plan or person without having all documentation and guarantee of Plan Rights to Recovery formally agreed to by the Plan Participant and /or Legal Representative.

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

THIRD PARTY RECOVERY PROVISION

RIGHT OF SUBROGATION AND REFUND

SUBROGATION RIGHTS OF THE PLAN:
A covered person may incur medical or other charges related to injuries or illness caused by the act or omission of another person; or another party may be liable or legally responsible for payment of charges incurred in connection with the injuries or illness. If so, the covered person may have a claim against that other person or another party for payment of the medical or other charges. In that event, the Plan will be secondary, not primary, and the Plan will be subrogated to all rights the covered person may have against that other person or another party and will be entitled to 100% reimbursement. Also, the Plan's right to Subrogation still applies if the Recovery received by the Covered Person is less than the claimed damage, and, as a result, the claimant is not made whole.

In addition, the Plan shall have the first lien against any recovery to the extent of benefits paid or to be paid and expenses incurred by the Plan in enforcing this provision. The Plan's first lien rights supersedes any right that the covered person may have to be "made whole." In other words, the Plan is entitled to the right of first reimbursement out of any recovery the covered person procures or may be entitled to procure regardless of whether the covered person has received compensation for any of his or her damages or expenses, including any of his or her attorneys' fees or costs. Additionally, the Plan's right of first reimbursement will not be reduced for any reason, including attorneys' fees, costs, comparative negligence, limits of collectability or responsibility, or otherwise. As a condition to receiving benefits under the Plan, the covered person agrees that acceptance of benefits is constructive notice of this provision.

OBLIGATIONS OF COVERED PERSON

The covered person must:

- Execute and deliver promptly an Accident Detail Reports
- Execute and Deliver promptly a Subrogation Questionnaire and Reimbursement Agreement
- Execute and Deliver promptly a Lien and any Supplemental Lien Covering all claims and expenses;
- Provide and Deliver a copy of any insurance policy and claims paid pursuant to any insurance policy providing coverage for covered persons injuries or illness;
- Notify the Plan in writing of any proposed settlement and obtain the Plan's written consent before signing any release or agreeing to any settlement;
- Cooperate fully with the Plan in its exercise of its rights under these provisions, do nothing that would interfere with or diminish those rights and furnish any information required by the Plan.
- Upon receipt of any recovery, the covered person must immediately reimburse the Plan out of any recovery made from another party, 100% of the amount of medical or other benefits paid for the the injuries or illness under the Plan as well as any expenses incurred by the Plan (including attorneys' fees and costs of suit, regardless of an action's outcome). The covered person shall not be entitled to any deductions incurred by the covered party for his or her attorneys' fees, costs, comparative negligence, limits of collectability or responsibility.

When a right of recovery exists, and as a condition to any payment by the Plan (including payment of future benefits for other illnesses or injuries), the covered person will execute and deliver all required instruments and documents identified herein and provided by the Plan, as well as doing and providing whatever else is needed, to secure the Plan's rights of subrogation and reimbursement, before any medical or other benefits will be paid by the Plan for the injuries or illness. Notwithstanding, the Plan Administrator may determine, in its sole discretion, that it is in the Plan's best interests to pay medical or other benefits for the injuries or illness before

the Documents identified herein are signed and things are done (for example, to obtain a prompt payment discount); however, in that event, the Plan will still be entitled to 100% subrogation and reimbursement. In addition, the covered person will do nothing to prejudice the Plan's right to subrogation and reimbursement. The covered person expressly agrees to waive any and all rights pursuant to the "made-whole doctrines"; "common-fund doctrines" and any similar doctrines. The subrogation rights of the Plan are acknowledged and the Plan precludes operation of the "made-whole doctrines"; "common-fund doctrines" and any similar doctrines. A covered person who receives any recovery (whether by judgment, settlement, compromise, or otherwise) has an absolute obligation to immediately tender the recovery to the Plan under the terms of this provision. A covered person who receives any such recovery and does not immediately tender the recovery to the Plan will be deemed to hold the recovery in constructive trust for the Plan, because the covered person is not the rightful owner of the recovery and should not be in possession of the recovery until the Plan has been fully reimbursed. The Plan Administrator has maximum discretion to interpret the terms of this provision and to make changes as it deems necessary. Any amounts recovered will be subject to subrogation or reimbursement. In no case will the amount subject to subrogation or reimbursement exceed the amount of medical or other benefits paid for the injuries or illness under the Plan and the expenses incurred by the Plan in collecting this amount.

ANOTHER PARTY

"Another party" shall mean any individual or entity, other than the Plan, who is liable or legally responsible to pay expenses, compensation or damages in connection with a covered person's injuries or illness.
"Another party" shall include the party or parties who caused the injuries or illness; the insurer, guarantor or other indemnifier of the party or parties who caused the injuries or illness; a covered person's own insurer, such as uninsured, underinsured, medical payments, no-fault, homeowner's, renter's or any other liability insurer; a workers' compensation insurer; and any other individual or entity that is liable or legally responsible for payment in connection with the injuries or illness.

RECOVERY

"Recovery" shall mean any and all monies paid to the covered person by way of judgment, settlement or otherwise (no matter how those monies may be characterized, designated or allocated) to compensate for any losses caused by, or in connection with, the injuries or illness. Any recovery shall be deemed to apply, first, for reimbursement.

SUBROGATION

"Subrogation" shall mean the Plan's right to pursue the covered person's claims for medical or other charges paid by the Plan against another party.

REIMBURSEMENT

"Reimbursement" shall mean repayment to the Plan for medical or other benefits that it has paid toward care and treatment of the injury or illness and for the expenses incurred by the Plan in collecting this benefit amount.

WHEN A COVERED PERSON RETAINS AN ATTORNEY

If the covered person retains an attorney, the Plan may ask that attorney to also sign the subrogation and reimbursement agreement. If this request is made, the attorney must sign the subrogation and reimbursement agreement as a condition to any payment of benefits and as a condition to any payment of future benefits for other illnesses or injuries. Additionally, the covered person's attorney must recognize and consent to the fact that the Plan precludes the operation of the "made-whole" and "common fund" doctrines and any similar doctrines or defenses, and the attorney must agree not to assert these doctrines in his or her pursuit of recovery. The Plan will not pay the covered person's attorneys' fees and costs associated with the recovery of funds, nor will it reduce its reimbursement pro rata for the payment of the covered person's attorneys' fees and costs. Attorneys' fees will be payable from the recovery only after the Plan has received full reimbursement. An attorney who receives any recovery (whether by judgment, settlement, compromise, or otherwise) has an absolute obligation to immediately tender the recovery to the Plan under the terms of this provision. A covered person's attorney who receives any such recovery and does not immediately tender the recovery to the Plan will be deemed to hold the recovery in constructive trust for the Plan, because neither the covered person nor his or her attorney is the rightful owner of the recovery and should not be in possession of the recovery until the Plan has been fully reimbursed.

WHEN THE COVERED PERSON IS A MINOR OR IS DECEASED

The provisions of this section apply to the parents, trustee, guardian or other representative of a minor covered person and to the heir or personal representative of the estate of a deceased covered person, regardless of applicable law and whether or not the representative has access or control of the recovery.

WHEN A COVERED PERSON DOES NOT COMPLY

When a covered person does not comply with the provisions of this section, the Plan Administrator shall have the authority, in its sole discretion, to deny payment of any claims for benefits by the covered person and to deny or reduce future benefits payable (including payment of future benefits for other injuries or illnesses) under the Plan by the amount due as reimbursement to the Plan. The Plan Administrator may also, in its sole discretion, deny or reduce future benefits (including future benefits for other injuries or illnesses) under any other group benefits plan maintained by the Plan Sponsor. The reductions will equal the amount of the required reimbursement. If the Plan must bring an action against a covered person to enforce the provisions of this section, then that covered person agrees to pay the Plan's costs, including attorneys' fees.

GOVERNMENT PLANS

To the extent that a Plan is a governmental plan as defined in 29 U.S.C. § 1003(b) and exempt from ERISA and therefore exempt from preemption, as determined by or acknowledged by the Plan Administrator, the provisions contained herein shall remain applicable accepting only the applicability of the make whole, common fund or similar doctrines. The covered person and his or her attorney shall still be obligated to execute and deliver all forms and documents identified herein provided that the forms and documents are not inconsistent with the rights of preemption for governmental plans as defined in 29 U.S.C. § 1003(b).

CONTINUATION COVERAGE RIGHTS UNDER COBRA

Under federal law, the Consolidated Omnibus Budget Reconciliation Act of 1985 (COBRA), certain Employee/Members and their families covered under Employer's Business Alliance, Inc. Employee/Member Health Plan (the Plan) will be entitled to the opportunity to elect a temporary extension of health coverage (called "COBRA continuation coverage") where coverage under the Plan would otherwise end. This notice is intended to inform Plan Participants and beneficiaries, in summary fashion, of their rights and obligations under the continuation coverage provisions of COBRA, as amended and reflected in final and proposed regulations published by the Department of the Treasury. This notice is intended to reflect the law and does not grant or take away any rights under the law.

The Plan Administrator is Employer's Business Alliance, Inc. , COBRA continuation coverage for the Plan is administered by Detego Health LLC, 3000 S Hulen Street Ste 124 #1180, Fort Worth, TX, 76109. Complete instructions on COBRA, as well as election forms and other information, will be provided by the Plan Administrator or its designee to Plan Participants who become Qualified Beneficiaries under COBRA.

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

What is COBRA continuation coverage? COBRA continuation coverage is the temporary extension of group health plan coverage that must be offered to certain Plan Participants and their eligible family members (called "Qualified Beneficiaries") at group rates. The right to COBRA continuation coverage is triggered by the occurrence of a life event that results in the loss of coverage under the terms of the Plan (the "Qualifying Event"). The coverage must be identical to the Plan coverage that the Qualified Beneficiary had immediately before the Qualifying Event, or if the coverage has been changed, the coverage must be identical to the coverage provided to similarly situated active Employee/Members who have not experienced a Qualifying Event (in other words, similarly situated non-COBRA beneficiaries).

Who can become a Qualified Beneficiary? In general, a Qualified Beneficiary can be:

(1) Any individual who, on the day before a Qualifying Event, is covered under a Plan by virtue of being on that day either a covered Employee/Member, the Spouse of a covered Employee/Member, or a Dependent child of a covered Employee/Member. If, however, an individual who otherwise qualifies as a Qualified Beneficiary is denied or not offered coverage under the Plan under circumstances in which the denial or failure to offer constitutes a violation of applicable law, then the individual will be considered to have had the Plan coverage and will be considered a Qualified Beneficiary if that individual experiences a Qualifying Event.

(2) Any child who is born to or placed for adoption with a covered Employee/Member during a period of COBRA continuation coverage, and any individual who is covered by the Plan as an alternate recipient under a qualified medical support order. If, however, an individual who otherwise qualifies as a Qualified Beneficiary is denied or not offered coverage under the Plan under circumstances in which the denial or failure to offer constitutes a violation of applicable law, then the individual will be considered to have had the Plan coverage and will be considered a Qualified Beneficiary if that individual experiences a Qualifying Event.

The term "covered Employee/Member" includes any individual who is provided coverage under the Plan due to his or her performance of services for the employer sponsoring the Plan (e.g., common-law Employee/Members (full or part-time), self-employed individuals, independent contractor, or corporate director). However, this provision does not establish eligibility of these individuals. Eligibility for Plan Coverage shall be determined in accordance with Plan Eligibility provisions.

An individual is not a Qualified Beneficiary if the individual's status as a covered Employee/Member is attributable to a period in which the individual was a nonresident alien who received from the individual's Employer no earned income that constituted income from sources within the United States. If, on account of the preceding reason, an individual is not a Qualified Beneficiary, then a Spouse or Dependent child of the individual will also not be considered a Qualified Beneficiary by virtue of the relationship to the individual. A domestic partner is not a Qualified Beneficiary.

Each Qualified Beneficiary (including a child who is born to or placed for adoption with a covered Employee/Member during a period of COBRA continuation coverage) must be offered the opportunity to make an independent election to receive COBRA continuation coverage.

What is a Qualifying Event? A Qualifying Event is any of the following if the Plan provided that the Plan participant would lose coverage (i.e.: cease to be covered under the same terms and conditions as in effect immediately before the Qualifying Event) in the absence of COBRA continuation coverage:

(1) The death of a covered Employee/Member.

(2) The termination (other than by reason of the Employee/Member's gross misconduct), or reduction of hours, of a covered Employee/Member's employment.

(3) The divorce or legal separation of a covered Employee/Member from the Employee/Member's Spouse. If the Employee/Member reduces or eliminates the Employee/Member's Spouse's Plan coverage in anticipation of a divorce or legal separation, and a divorce or legal separation later occurs, then the divorce or legal separation may be considered a Qualifying Event even though the Spouse's coverage was reduced or eliminated before the divorce or legal separation.

(4) A covered Employee/Member's enrollment in any part of the Medicare program.

(5) A Dependent child's ceasing to satisfy the Plan's requirements for a Dependent child (for example, attainment of the maximum age for dependency under the Plan).

If the Qualifying Event causes the covered Employee/Member, or the covered Spouse or a Dependent child of the covered Employee/Member, to cease to be covered under the Plan under the same terms and conditions as in effect immediately before the Qualifying Event, the persons losing such coverage become Qualified Beneficiaries under COBRA if all the other conditions of COBRA are also met. For example, any increase in contribution that must be paid by a covered Employee/Member, or the Spouse, or a Dependent child of the covered Employee/Member, for coverage under the Plan that results from the occurrence of one of the events listed above is a loss of coverage.

The taking of leave under the Family and Medical Leave Act of 1993 ("FMLA") does not constitute a Qualifying Event. A Qualifying Event will occur, however, if an Employee/Member does not return to employment at the end of the FMLA leave and all other COBRA continuation coverage conditions are present. If a Qualifying Event occurs, it occurs on the last day of FMLA leave and the applicable maximum coverage period is measured from this date (unless coverage is lost at a later date and the Plan provides for the extension of the required periods, in which case the maximum coverage date is measured from the date when the coverage is lost.) Note that the covered Employee/Member and family members will be entitled to COBRA continuation coverage even if they failed to pay the Employee/Member portion of premiums for coverage under the Plan during the FMLA leave.

What factors should be considered when determining to elect COBRA continuation coverage? When considering options for health coverage, Qualified Beneficiaries should consider:

- **Premiums:** This plan can charge up to 102% of total plan premiums for COBRA coverage. Other options, like coverage on a spouse's plan or through the Marketplace, may be less expensive. Qualified Beneficiaries have special enrollment rights under federal law (HIPAA). They have the right to request special enrollment in another group health plan for which they are otherwise eligible (such as a plan sponsored by a spouse's employer) within 30 days after Plan coverage ends due to one of the Qualifying Events listed above.

- **Provider Networks:** If a Qualified Beneficiary is currently getting care or treatment for a condition, a change in health coverage may affect access to a particular health care provider. You may want to check to see if your current health care providers participate in a network in considering options for health coverage.

- **Drug Formularies:** For Qualified Beneficiaries taking medication, a change in health coverage may affect costs for medication – and in some cases, the medication may not be covered by another plan. Qualified beneficiaries should check to see if current medications are listed in drug formularies for other health coverage.

- **Severance payments:** If COBRA rights arise because the Employee/Member has lost his job and there is a severance package available from the employer, the former employer may have offered to pay some or all of the Employee/Member's COBRA payments for a period of time. This can affect the timing of coverage available in the Marketplace. In this scenario, the Employee/Member may want to contact the Department of Labor at 1-866-444-3272 to discuss options.

- **Service Areas:** If benefits under the Plan are limited to specific service or coverage areas, benefits may not be available to a Qualified Beneficiary who moves out of the area.

- **Other Cost-Sharing:** In addition to premiums or contributions for health coverage, the Plan requires participants to pay copayments, deductibles, coinsurance, or other amounts as benefits are used. Qualified beneficiaries should check to see what the cost-sharing requirements are for other health coverage options. For example, one option may have much lower monthly premiums, but a much higher deductible and higher copayments.

Are there other coverage options besides COBRA Continuation Coverage? Yes. Instead of enrolling in COBRA continuation coverage, there may be other coverage options for Qualified Beneficiaries through the Health Insurance Marketplace, Medicaid, or other group health plan coverage options (such as a spouse's plan) through what is called a "special enrollment period." Some of these options may cost less than COBRA continuation coverage. You can learn more about many of these options at www.healthcare.gov.

What is the procedure for obtaining COBRA continuation coverage? The Plan has conditioned the availability of COBRA continuation coverage upon the timely election of such coverage. An election is timely if it is made during the election period.

What is the election period and how long must it last? The election period is the time period within which the Qualified Beneficiary must elect COBRA continuation coverage under the Plan. The election period must begin no later than the date the Qualified Beneficiary would lose coverage on account of the Qualifying Event and ends 60 days after the later of the date the Qualified Beneficiary would lose coverage on account of the Qualifying Event or the date notice is provided to the Qualified Beneficiary of her or his right to elect COBRA continuation coverage. If coverage is not elected within the 60 day period, all rights to elect COBRA continuation coverage are forfeited.

Note: If a covered Employee/Member who has been terminated or experienced a reduction of hours qualifies for a trade readjustment allowance or alternative trade adjustment assistance under a federal law called the Trade Act of 2002, and the Employee/Member and his or her covered Dependents have not elected COBRA coverage within the normal election period, a second opportunity to elect COBRA coverage will be made available for themselves and certain family members, but only within a limited period of 60 days or less and only during the six months immediately after their group health plan coverage ended. Any person who qualifies or thinks that he and/or his family members may qualify for assistance under this special provision should contact the Plan Administrator for further information about the special second election period.

The Trade Act of 2002 also created a tax credit for certain TAA-eligible individuals and for certain retired Employee/Members who are receiving pension payments from the Pension Benefit Guaranty Corporation (PBGC) (eligible individuals). Under the new tax provisions, eligible individuals can either take a tax credit or get advance payment of 65% of premiums paid for qualified health insurance, including continuation coverage. If you have questions about these new tax provisions, you may call the Health Coverage Tax Credit Consumer Contact Center toll-free at 1-866-628-4282. TTD/TTY callers may call toll-free at 1-866-626-4282. More information about the Trade Act is also available at www.doleta.gov/tradeact.

Is a covered Employee/Member or Qualified Beneficiary responsible for informing the Plan Administrator of the occurrence of a Qualifying Event? The Plan will offer COBRA continuation coverage to Qualified Beneficiaries only after the Plan Administrator or its designee has been timely notified that a Qualifying Event has occurred. The employer (if the employer is not the Plan Administrator) will notify the Plan Administrator of the Qualifying Event within 30 days following the date coverage ends when the Qualifying Event is:

(1) the end of employment or reduction of hours of employment,

(2) death of the Employee/Member,

(3) commencement of a proceeding in bankruptcy with respect to the employer, or

(4) entitlement of the Employee/Member to any part of Medicare.

IMPORTANT:

For the other Qualifying Events (divorce or legal separation of the Employee/Member and Spouse or a Dependent child's losing eligibility for coverage as a Dependent child), you or someone on your behalf must notify the Plan Administrator or its designee in writing within 60 days after the Qualifying Event occurs, using the procedures specified below. If these procedures are not followed or if the notice is not provided in writing to the Plan Administrator or its designee during the 60-day notice period, any Spouse or Dependent child who loses coverage will not be offered the option to elect continuation coverage. You must send this notice to the COBRA Administrator.

NOTICE PROCEDURES:

Any notice that you provide must be ***in writing***. Oral notice, including notice by telephone, is not acceptable. You must mail, fax or hand-deliver your notice to the person, department or firm listed below, at the following address:

Detego Health LLC
3000 S Hulen Street Ste 124 #1180
Fort Worth, TX, 76109

If mailed, your notice must be postmarked no later than the last day of the required notice period. Any notice you provide must state:

- the **name of the plan or plans** under which you lost or are losing coverage,
- the **name and address of the Employee/Member** covered under the plan,
- the **name(s) and address(es) of the Qualified Beneficiary(ies)**, and
- the **Qualifying Event** and the **date** it happened.

If the Qualifying Event is a **divorce or legal separation**, your notice must include **a copy of the divorce decree or the legal separation agreement.**

Be aware that there are other notice requirements in other contexts, for example, in order to qualify for a disability extension.

Once the Plan Administrator or its designee receives *timely notice* that a Qualifying Event has occurred, COBRA continuation coverage will be offered to each of the qualified beneficiaries. Each Qualified Beneficiary will have an independent right to elect COBRA continuation coverage. Covered Employee/Members may elect COBRA continuation coverage for their Spouses, and parents may elect COBRA continuation coverage on behalf of their children. For each Qualified Beneficiary who elects COBRA continuation coverage, COBRA continuation coverage will begin on the date that plan coverage would otherwise have been lost. If you or your Spouse or Dependent children do not elect continuation coverage within the 60-day election period described above, the right to elect continuation coverage will be lost.

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

Is COBRA coverage available if a Qualified Beneficiary has other group health plan coverage or Medicare? Qualified beneficiaries who are entitled to elect COBRA continuation coverage may do so even if they are covered under another group health plan or are entitled to Medicare benefits on or before the date on which COBRA is elected. However, a Qualified Beneficiary's COBRA coverage will terminate automatically if, after electing COBRA, he or she becomes entitled to Medicare or becomes covered under other group health plan coverage (but only after any applicable preexisting condition exclusions of that other plan have been exhausted or satisfied).

When may a Qualified Beneficiary's COBRA continuation coverage be terminated? During the election period, a Qualified Beneficiary may waive COBRA continuation coverage. Except for an interruption of coverage in connection with a waiver, COBRA continuation coverage that has been elected for a Qualified Beneficiary must extend for at least the period beginning on the date of the Qualifying Event and ending not before the earliest of the following dates:

(1) The last day of the applicable maximum coverage period.

(2) The first day for which Timely Payment is not made to the Plan with respect to the Qualified Beneficiary.

(3) The date upon which the Employer ceases to provide any group health plan (including a successor plan) to any Employee/Member.

(4) The date, after the date of the election, that the Qualified Beneficiary first becomes covered under any other Plan that does not contain any exclusion or limitation with respect to any pre-existing condition, other than such an exclusion or limitation that does not apply to, or is satisfied by, the Qualified Beneficiary.

(5) The date, after the date of the election, that the Qualified Beneficiary first becomes entitled to Medicare (either part A or part B, whichever occurs earlier).

(6) In the case of a Qualified Beneficiary entitled to a disability extension, the later of:

(a) (i) 29 months after the date of the Qualifying Event, or (ii) the first day of the month that is more than 30 days after the date of a final determination under Title II or XVI of the Social Security Act that the disabled Qualified Beneficiary whose disability resulted in the Qualified Beneficiary's entitlement to the disability extension is no longer disabled, whichever is earlier; or

(b) the end of the maximum coverage period that applies to the Qualified Beneficiary without regard to the disability extension.

The Plan can terminate for cause the coverage of a Qualified Beneficiary on the same basis that the Plan terminates for cause the coverage of similarly situated non-COBRA beneficiaries, for example, for the submission of a fraudulent claim.

In the case of an individual who is not a Qualified Beneficiary and who is receiving coverage under the Plan solely because of the individual's relationship to a Qualified Beneficiary, if the Plan's obligation to make COBRA continuation coverage available to the Qualified Beneficiary ceases, the Plan is not obligated to make coverage available to the individual who is not a Qualified Beneficiary.

What are the maximum coverage periods for COBRA continuation coverage? The maximum coverage periods are based on the type of the Qualifying Event and the status of the Qualified Beneficiary, as shown below:

(1) In the case of a Qualifying Event that is a termination of employment or reduction of hours of employment, the maximum coverage period ends 18 months after the Qualifying Event if there is not a disability extension and 29 months after the Qualifying Event if there is a disability extension.

(2) In the case of a covered Employee/Member's enrollment in the Medicare program before experiencing a Qualifying Event that is a termination of employment or reduction of hours of employment, the maximum coverage period for Qualified Beneficiaries ends on the later of:

(a) 36 months after the date the covered Employee/Member becomes enrolled in the Medicare program. This extension does not apply to the covered Employee/Member; or

(b) 18 months (or 29 months, if there is a disability extension) after the date of the covered Employee/Member's termination of employment or reduction of hours of employment.

(3) In the case of a Qualified Beneficiary who is a child born to or placed for adoption with a covered Employee/Member during a period of COBRA continuation coverage, the maximum coverage period is the maximum coverage period applicable to the Qualifying Event giving rise to the period of COBRA continuation coverage during which the child was born or placed for adoption.

(4) In the case of any other Qualifying Event than that described above, the maximum coverage period ends 36 months after the Qualifying Event.

Under what circumstances can the maximum coverage period be expanded? If a Qualifying Event that gives rise to an 18-month or 29-month maximum coverage period is followed, within that 18- or 29-month period, by a second Qualifying Event that gives rise to a 36-months maximum coverage period, the original period is expanded to 36 months, but only for individuals who are Qualified Beneficiaries at the time of and with respect to both Qualifying Events. In no circumstance can the COBRA maximum coverage period be expanded to more than 36 months after the date of the first Qualifying Event. The Plan Administrator must be notified of the second Qualifying Event within 60 days of the second Qualifying Event. This notice must be sent to the COBRA Administrator in accordance with the procedures above.

How does a Qualified Beneficiary become entitled to a disability extension? A disability extension will be granted if an individual (whether or not the covered Employee/Member) who is a Qualified Beneficiary in connection with the Qualifying Event that is a termination or reduction of hours of a covered Employee/Member's employment, is determined under Title II or XVI of the Social Security Act to have been disabled at any time during the first 60 days of COBRA continuation coverage. To qualify for the disability extension, the Qualified Beneficiary must also provide the Plan Administrator with notice of the disability determination on a date that is both within 60 days after the date of the determination and before the end of the original 18-month maximum coverage. This notice should be sent to the COBRA Administrator in accordance with the procedures above.

Does the Plan require payment for COBRA continuation coverage? For any period of COBRA continuation coverage under the Plan, qualified beneficiaries who elect COBRA continuation coverage must pay for COBRA continuation coverage. Qualified beneficiaries will pay up to 102% of the applicable premium and up to 150% of the applicable premium for any expanded period of COBRA continuation coverage covering a disabled Qualified Beneficiary due to a disability extension. The Plan will terminate a Qualified Beneficiary's COBRA continuation coverage as of the first day of any period for which timely payment is not made.

Must the Plan allow payment for COBRA continuation coverage to be made in monthly installments? Yes. The Plan is also permitted to allow for payment at other intervals.

What is Timely Payment for payment for COBRA continuation coverage? Timely Payment means a payment made no later than 30 days after the first day of the coverage period. Payment that is made to the Plan by a later date is also considered Timely Payment if either under the terms of the Plan, covered Employee/Members or Qualified Beneficiaries are allowed until that later date to pay for their coverage for the period or under the terms of an arrangement between the Employer and the entity that provides Plan benefits on the Employer's behalf, the Employer is allowed until that later date to pay for coverage of similarly situated non-COBRA beneficiaries for the period.

Notwithstanding the above paragraph, the Plan does not require payment for any period of COBRA continuation coverage for a Qualified Beneficiary earlier than 45 days after the date on which the election of COBRA continuation coverage is made for that Qualified Beneficiary. Payment is considered made on the date on which it is postmarked to the Plan.

If Timely Payment is made to the Plan in an amount that is not significantly less than the amount the Plan requires to be paid for a period of coverage, then the amount paid will be deemed to satisfy the Plan's requirement for the amount to be paid, unless the Plan notifies the Qualified Beneficiary of the amount of the deficiency and grants a reasonable period of time for payment of the deficiency to be made. A "reasonable period of time" is 30 days after the notice is provided. A shortfall in a Timely Payment is not significant if it is no greater than the lesser of $50 or 10% of the required amount.

IF YOU HAVE QUESTIONS
If you have questions about your COBRA continuation coverage, you should contact the COBRA Administrator. For more information about your rights under ERISA, including COBRA, the Health Insurance Portability and Accountability Act (HIPAA), and other laws affecting group health plans, contact the nearest Regional or District Office of the U.S. Department of Labor's Employee/Member Benefits Security Administration (EBSA). Addresses and phone numbers of Regional and District EBSA Offices are available through EBSA's website at www.dol.gov/ebsa.

KEEP YOUR PLAN ADMINISTRATOR INFORMED OF ADDRESS CHANGES
In order to protect your family's rights, you should keep the Plan Administrator informed of any changes in the addresses of family members. You should also keep a copy, for your records, of any notices you send to the Plan Administrator.

RESPONSIBILITIES FOR PLAN ADMINISTRATION

Plan Administrator and Claims Audit Decision Maker

The Plan is administered by the Plan Administrator in accordance with the provisions of the Employee/Member Retirement Income Security Act of 1974, as amended ("ERISA"). An individual or entity may be appointed by the Plan Sponsor to be Plan Administrator and serve at the convenience of the Plan Sponsor. If the Plan Administrator resigns, dies, is otherwise unable to perform, is dissolved, or is removed from the position, the Plan Sponsor shall appoint a new Plan Administrator as soon as reasonably possible. Notwithstanding any provisions of this Plan Document and Summary Plan Description to the contrary, the Plan Administrator has the authority to, and hereby does, allocate certain fiduciary responsibility to the Claims Audit Decision Maker. The fiduciary responsibility allocated to the Claim Audit Decision Maker includes the discretionary authority and ultimate decision-making authority with respect to any Appeals of denied claims, which shall be referred to the Claim Audit Decision Maker by the Third Party Administrator (the "Referred Appeals"). The Plan Sponsor has allocated additional fiduciary responsibility to the Plan Administrator and the Claims Audit Decision Maker(s) referenced in the section entitled "General Plan Information," including discretionary authority and ultimate decision-making authority with respect to the review and audit of certain claims in accordance with the applicable Plan provisions under the section, "Claim Review and Audit Program". Such claims selected as eligible for review and audit shall be identified by the Third Party Administrator under guidelines to which the Plan Sponsor has agreed and shall be referred to the Claim Audit Decision Maker by the Third Party Administrator.

The Plan Sponsor shall establish the policies, practices and procedures of this Plan. The Plan Administrator shall administer this Plan in accordance with its terms. It is the express intent of this Plan that the Plan Administrator and the Claim Audit Decision Maker (for Referred Appeals only) shall have maximum legal discretionary authority to construe and interpret the terms and provisions of the Plan, to make determinations regarding issues which relate to eligibility for benefits (including the determination of what services, supplies, care and treatments are Experimental), to decide disputes which may arise relative to a Covered Person's rights, and to decide questions of Plan interpretation and those of fact relating to the Plan. The decisions of the Plan Administrator and the Claims Audit Decision Maker (for Referred Appeals only) as to the facts related to any claim for benefits and the meaning and intent of any provision of the Plan, or its application to any claim, shall receive the maximum deference provided by law and will be final and binding on all interested parties. Benefits under this Plan will be paid only if the Plan Administrator or the Claim Audit Decision Maker (for Referred Appeals) in their discretion, that the Covered Person is entitled to them.

Duties of the Plan Administrator

The duties of the Plan Administrator and where applicable to the Claim Review and Audit Program the duties of the Claims Audit Decision Maker include the following:

1. To administer the Plan in accordance with its terms;
2. To determine all questions of eligibility, status and coverage under the Plan;
3. To interpret the Plan, including the authority to construe possible ambiguities, inconsistencies, omissions and disputed terms;
4. To make factual findings;
5. To decide disputes which may arise relative to a Covered Person's rights;
6. To prescribe procedures for filing a claim for benefits, to review claim denials and Appeals relating to them and to uphold or reverse such denials;
7. To keep and maintain the Plan documents and all other records pertaining to the Plan;
8. To appoint and supervise a third party claims administrator to pay claims;
9. To perform all necessary reporting as required by ERISA;
10. To establish and communicate procedures to determine whether a medical child support order or national medical support notice is a QMCSO;
11. To delegate to any person or entity such powers, duties and responsibilities as it deems appropriate;
12. To perform each and every function necessary for or related to the Plan's administration;
13. To perform the duties in conjunction with the provisions of the Claim Review and Audit Program; and
14. To keep and maintain records pertaining to the Claim Review and Audit Program.

Claim Audit Decision Maker

The Claim Audit Decision Maker shall have the following duties with respect to the Referred Appeals:

1. To administer the Plan in accordance with its terms;
2. To determine all questions of eligibility, status and coverage under the Plan;
3. To interpret the Plan, including the authority to construe possible ambiguities, inconsistencies, omissions, and disputed terms;
4. To make factual findings;
5. To decide disputes which may arise relative to a Covered Person's rights;
6. To review Referred Appeals and to uphold or reverse any denials; and
7. To keep and maintain records pertaining to the Referred Appeals.

The duties of the Claim Audit Decision Maker shall be limited to those set forth above.

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

1. The named fiduciary has violated its stated duties under ERISA in appointing the fiduciary, establishing the procedures to appoint the fiduciary or continuing either the appointment or the procedures; or
2. The named fiduciary breached its fiduciary responsibility under Section 405(a) of ERISA.

CLAIMS PROCESSOR IS NOT A FIDUCIARY. A Claims Processor is not a fiduciary under the Plan by virtue of paying claims in accordance with the Plan's rules as established by the Plan Administrator, and this Plan Document.

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

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

FIDUCIARY DUTIES. A fiduciary must carry out his or her duties and responsibilities for the purpose of providing benefits to the Employee/Members and their Dependent(s) and defraying reasonable expenses of administering the Plan. These are duties which must be carried out:

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

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

(3) in accordance with the Plan documents to the extent that they agree with ERISA.

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

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

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

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

COMPLIANCE WITH HIPAA PRIVACY STANDARDS. Certain members of the Employer's workforce perform services in connection with administration of the Plan. In order to perform these services, it is necessary for these Employee/Members from time to time to have access to Protected Health Information (as defined below).

Under the Standards for Privacy of Individually Identifiable Health Information (45 CFR Part 164, the "Privacy Standards"), these Employee/Members are permitted to have such access subject to the following:

(1) **General.** The Plan shall not disclose Protected Health Information to any member of the Employer's workforce unless each of the conditions set out in this HIPAA Privacy section is met. "Protected Health Information" shall have the same definition as set out in the Privacy Standards but generally shall mean individually identifiable health information about the past, present or future physical or mental health or condition of an individual, including information about treatment or payment for treatment.

(2) **Permitted Uses and Disclosures.** Protected Health Information disclosed to members of the Employer's workforce shall be used or disclosed by them only for purposes of Plan administrative functions. The Plan's administrative functions shall include all Plan payment and health care operations. The terms "payment" and "health care operations" shall have the same definitions as set out in the Privacy Standards, but the term "payment" generally shall mean activities taken with respect to payment of premiums or contributions, or to determine or fulfill Plan responsibilities with respect to coverage, provision of benefits, or reimbursement for health care. "Health care operations" generally shall mean activities on behalf of the Plan that are related to quality assessment; evaluation, training or accreditation of health care providers; underwriting, premium rating and other functions related to obtaining or renewing an insurance contract, including stop-loss insurance; medical review; legal services or auditing functions; or business planning, management and general administrative activities. Genetic information will not be used or disclosed for underwriting purposes.

(3) **Authorized Employee/Members.** The Plan shall disclose Protected Health Information only to members of the Employer's workforce who are designated and are authorized to receive such Protected Health Information, and only to the extent and in the minimum amount necessary for these persons to perform duties with respect to the Plan. For purposes of this HIPAA Privacy section, "members of the Employer's workforce" shall refer to all Employee/Members and other persons under the control of the Employer.

(a) **Updates Required.** The Employer shall amend the Plan promptly with respect to any changes in the members of its workforce who are authorized to receive Protected Health Information.

(b) **Use and Disclosure Restricted.** An authorized member of the Employer's workforce who receives Protected Health Information shall use or disclose the Protected Health Information only to the extent necessary to perform his or her duties with respect to the Plan.

(c) **Resolution of Issues of Noncompliance.** In the event that any member of the Employer's workforce uses or discloses Protected Health Information other than as permitted by the Privacy Standards, the incident shall be reported to the privacy official. The privacy official shall take appropriate action, including:

(i) Investigation of the incident to determine whether the breach occurred inadvertently, through negligence, or deliberately; whether there is a pattern of breaches; and the degree of harm caused by the breach;

(ii) Applying appropriate sanctions against the persons causing the breach, which, depending upon the nature of the breach, may include, oral or written reprimand, additional training, or termination of employment;

(iii) Mitigating any harm caused by the breach, to the extent practicable; and

(iv) Documentation of the incident and all actions taken to resolve the issue and mitigate any damages.

(4) Certification of Employer. The Employer must provide certification to the Plan that it agrees to:

(a) Not use or further disclose the Protected Health Information other than as permitted or required by the Plan documents or as required by law;

(b) Ensure that any agent or subcontractor, to whom it provides Protected Health Information received from the Plan, agrees to the same restrictions and conditions that apply to the Employer with respect to such information;

(c) Not use or disclose Protected Health Information for employment-related actions and decisions or in connection with any other benefit or Employee/Member benefit plan of the Employer;

(d) Report to the Plan any use or disclosure of the Protected Health Information of which it becomes aware that is inconsistent with the uses or disclosures hereunder or required by law;

(e) Make available Protected Health Information to individual Plan members in accordance with Section 164.524 of the Privacy Standards;

(f) Make available Protected Health Information for amendment by individual Plan members and incorporate any amendments to Protected Health Information in accordance with Section 164.526 of the Privacy Standards;

(g) Make available the Protected Health Information required to provide any accounting of disclosures to individual Plan members in accordance with Section 164.528 of the Privacy Standards;

(h) Make its internal practices, books and records relating to the use and disclosure of Protected Health Information received from the Plan available to the Department of Health and Human Services for purposes of determining compliance by the Plan with the Privacy Standards;

(i) If feasible, return or destroy all Protected Health Information received from the Plan that the Employer still maintains in any form, and retain no copies of such information when no longer needed for the purpose of which disclosure was made, except that, if such return or destruction is not feasible, limit further uses and disclosures to those purposes that make the return or destruction of the information unfeasible; and

(j) Ensure the adequate separation between the Plan and member of the Employer's workforce, as required by Section 164.504(f)(2)(iii) of the Privacy Standards.

The following members of Employer’s Business Alliance, Inc. 's workforce are designated as authorized to receive Protected Health Information from Employer’s Business Alliance, Inc. 's Employee/Member Health Plan ("the Plan") in order to perform their duties with respect to the Plan:

- Executive Director of Association

COMPLIANCE WITH HIPAA ELECTRONIC SECURITY STANDARDS. Under the Security Standards for the Protection of Electronic Protected Health Information (45 CFR Part 164.300 et. seq., the "Security Standards"), the Employer agrees to the following:

(1) The Employer agrees to implement reasonable and appropriate administrative, physical and technical safeguards to protect the confidentiality, integrity and availability of Electronic Protected Health Information that the Employer creates, maintains or transmits on behalf of the Plan. "Electronic Protected Health Information" shall have the same definition as set out in the Security Standards, but generally shall mean Protected Health Information that is transmitted by or maintained in electronic media.

(2) The Employer shall ensure that any agent or subcontractor to whom it provides Electronic Protected Health Information shall agree, in writing, to implement reasonable and appropriate security measures to protect the Electronic Protected Health Information.

(3) The Employer shall ensure that reasonable and appropriate security measures are implemented to comply with the conditions and requirements set forth in Compliance With HIPAA Privacy Standards provisions (3) Authorized Employee/Members and (4) Certification of Employers described above.

FUNDING THE PLAN AND PAYMENT OF BENEFITS

The cost of the Plan is funded as follows:

For Employee/Member and Dependent Coverage: Funding is derived from the funds of the Employer and contributions made by the covered Employee/Member.

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

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

PLAN IS NOT AN EMPLOYMENT CONTRACT

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

CLERICAL ERROR

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

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

AMENDING AND TERMINATING THE PLAN

If the Plan is terminated, the rights of the Plan Participants are limited to expenses incurred before termination.

The Employer reserves the right, at any time, to amend, suspend or terminate the Plan in whole or in part. This includes amending the benefits under the Plan or the Trust agreement (if any).

CERTAIN PLAN PARTICIPANTS RIGHTS UNDER ERISA

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

> Examine, without charge, at the Plan Administrator's office, all Plan documents and copies of all documents governing the Plan, including a copy of the latest annual report (form 5500 series) filed by the Plan with the U.S. Department of Labor and available at the Public Disclosure Room of the Employee/Member Benefits Security Administration.
>
> Obtain copies of all Plan documents and other Plan information upon written request to the Plan Administrator. The Plan Administrator may make a reasonable charge for the copies.
>
> Continue health care coverage for a Plan Participant, Spouse, or other dependents if there is a loss of coverage under the Plan as a result of a Qualifying Event. Employee/Member or dependents may have to pay for such coverage.
>
> Review this summary plan description and the documents governing the Plan or the rules governing COBRA continuation coverage rights.
>
> Reduction or elimination of exclusionary periods of coverage for Pre-Existing Conditions under this group health Plan, if an Employee/Member or dependent has Creditable Coverage from another plan. The Employee/Member or dependent should be provided a certificate of Creditable Coverage, free of charge, from the group health plan or health insurance issuer when coverage is lost under the plan, when a person becomes entitled to elect COBRA continuation coverage, when COBRA continuation coverage ceases, if a person requests it before losing coverage, or if a person requests it up to 24 months after losing coverage. Without evidence of Creditable Coverage, a Plan Participant may be subject to a Pre-Existing Conditions exclusion for 12 months (18 months for Late Enrollees) after the Enrollment Date of coverage, but only for Plan Years that begin before January 1, 2014.

If a Plan Participant's claim for a benefit is denied or ignored, in whole or in part, the participant has a right to know why this was done, to obtain copies of documents relating to the decision without charge, and to appeal any denial, all within certain time schedules.

Under ERISA, there are steps a Plan Participant can take to enforce the above rights. For instance, if a Plan Participant requests a copy of Plan documents or the latest annual report from the Plan and does not receive them within 30 days, he or she may file suit in a federal court. In such a case, the court may require the Plan Administrator to provide the materials and to pay the Plan Participant up to $110 a day until he or she receives the materials, unless the materials were not sent because of reasons beyond the control of the Plan Administrator. If the Plan Participant has a claim for benefits which is denied or ignored, in whole or in part, the participant may file suit in state or federal court.

In addition, if a Plan Participant disagrees with the Plan's decision or lack thereof concerning the qualified status of a medical child support order, he or she may file suit in federal court.

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

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

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

GENERAL PLAN INFORMATION

TYPE OF ADMINISTRATION

The Plan is a self-funded group health Plan and the administration is provided through a Third Party Claims Administrator. The funding for the benefits is derived from the funds of the Employer and contributions made by covered Employee/Members. The Plan is not insured.

PLAN NAME

Employer's Business Alliance, Inc. Health Plan

PLAN NUMBER: 501

TAX ID NUMBER: 87-4559152

PLAN EFFECTIVE DATE: 6/1

PLAN YEAR ENDS: 5/31

EMPLOYER INFORMATION

Employer's Business Alliance, Inc.
33479 Lake Road
Avon Lake, Ohio, 44012

PLAN ADMINISTRATOR

Employer's Business Alliance, Inc.
33479 Lake Road
Avon Lake, Ohio, 44012

NAMED FIDUCIARY

Employer's Business Alliance, Inc.
33479 Lake Road
Avon Lake, Ohio, 44012

AGENT FOR SERVICE OF LEGAL PROCESS

Employer's Business Alliance, Inc.
33479 Lake Road
Avon Lake, Ohio, 44012

CLAIMS ADMINISTRATOR

Detego Health LLC
3000 S Hulen Street Ste 124 #1180
Fort Worth, TX, 76109
Phone: (866) 815-6001

BY THIS AGREEMENT, Employer's Business Alliance, Inc. Employee/Member Health Plan is hereby adopted as shown.

IN WITNESS WHEREOF, this instrument is executed for Employer's Business Alliance, Inc. on or as of the day and year first below written.

By

_____

Employer's Business Alliance, Inc.

Date _____

Witness_____

Date _____