PLAN DOCUMENT AND SUMMARY PLAN DESCRIPTION

FOR THE AE Insurance, LLC dba American Exchange

EMPLOYEE BENEFIT PLAN

EFFECTIVE: 5/1/2022

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Establishment of the Plan: Adoption of the Plan Document and Summary Plan Description

THIS PLAN DOCUMENT AND SUMMARY PLAN DESCRIPTION ("Plan Document"), made by **AE Insurance, LLC dba American Exchange** (the "Company" or the "Plan Sponsor"), as of 5/1/2022, hereby establishes the **AE Insurance, LLC dba American Exchange** Employee Benefit Plan (the "Plan"), a program of benefits constituting a self-funded "Employee Welfare Benefit Plan" under the Employee Retirement Income Security Act of 1974, as amended (ERISA) and any amendments thereto. Any wording which may be contrary to applicable Federal Laws or Statutes is hereby understood to meet the standards set forth in such. Also, any changes in Federal Laws or Statutes which could affect the Plan are also automatically a part of the Plan, if required as a matter of law.

Effective Date

The Plan Document is effective as of the date first set forth above (the "Effective Date"), and each amendment is effective as of the date set forth therein.

Adoption of this Plan Document and Summary Plan Description

The Plan Sponsor, as the settlor of the Plan, hereby adopts this Plan Document and Summary Plan Description (SPD) as the written description of the Plan. This Plan represents both the Plan Document and the Summary Plan Description, which is required by the Employee Retirement Income Security Act of 1974, 29 U.S.C. et seq. ("ERISA"). This Plan Document and SPD amends and replaces any prior statement of the health care coverage contained in the Plan or any predecessor to the Plan.

IN WITNESS WHEREOF, the Plan Sponsor has caused this Plan Document and Summary Plan Description to be executed as of the date set forth below.

Date: 5/10/2022

AE Insurance, LLC dba American Exchange

By: Andrew Hetzler

Name: Andrew Hetzler

Title: CEO

Introduction and Purpose; General Plan Information

Introduction and Purpose

The Plan Sponsor has established the Plan for the benefit of eligible Employees, and their eligible Dependents, in accordance with the terms and conditions described herein. The Plan is a self-funded group health plan, which is a legal entity distinct from the Company, and the administration of the Plan is provided through a Third Party Administrator. No oral interpretations can change this Plan. Changes in the Plan may occur in any or all parts of the Plan including benefit coverage, deductibles, maximums, exclusions, limitations, definitions, eligibility and the like.

The funding for the benefits of this Plan is derived from the funds of the Company and contributions made by covered Employees. The Plan is not insured. Contributions received from Covered Persons are used to cover Plan costs.

The purpose in establishing the Plan is to protect eligible Employees and their Dependents against certain health expenses and to help defray the financial effects arising from Injury or Illness. To accomplish this purpose, the Plan must be mindful of the need to control and minimize health care costs through innovative and efficient plan design and cost containment provisions, and of abiding by the terms of the Plan Document, to allow the Plan Sponsor to effectively assign the resources available to help a Covered Person in the Plan and to the maximum feasible extent.

The Plan Sponsor is required under ERISA to provide to a Covered Person a Plan Document and a Summary Plan Description. A combined Plan Document and Summary Plan Description, such as this document, is an acceptable structure for ERISA compliance. This Plan Document sets forth the terms and provisions for the payment or reimbursement of eligible benefits. The Plan Document is maintained by **AE Insurance, LLC dba American Exchange** and may be reviewed at any time during normal working hours by a Covered Person.

General Plan Information

Name of Plan:	**AE Insurance, LLC dba American Exchange** Employee Benefit Plan
Plan Effective Date:	5/1/2022
Plan Sponsor:	**AE Insurance, LLC dba American Exchange** 605 Chestnut Street #1210 Chattanooga, TN 37450 Phone: 888-995-1674 Email: andrew.hetzler@americanexchange.com
Plan Administrator: **(Named Fiduciary)**	**AE Insurance, LLC dba American Exchange** 605 Chestnut Street #1210 Chattanooga, TN 37450 Phone: 888-995-1674 Email: andrew.hetzler@americanexchange.com
Tax ID Number:	46-1784303

Source of Funding:	Self-Funded
Plan Status:	Not Grandfathered
Applicable Law:	ERISA
Benefit Year:	May 1 through April 30
Benefit Reference:	501
Plan Type:	Medical Drug Coverage
Third Party Administrator:	Bywater Ltd. 15422 Detroit Ave Lakewood, OH 44107 Phone: 800.337.0792 Fax: 440.295.6905 Email: support@chooseBywater.com Website: www.choosebywater.com
Prescription Drug Plan Administrator:	TrueRX 7 Williams Bros. Drive Washington, IN 47501 Phone: 812-254-7425 Fax: 812-254-7426 Email: customerservice@truerx.com Website: truerx.com
Participating Employer(s):	**AE Insurance, LLC dba American Exchange**
Statutory Agent for Service of Process:	Andrew Hetzler AE Insurance, LLC dba American Exchange 605 Chestnut Street #1210 Chattanooga, TN 37450 Email: andrew.hetzler@americanexchange.com

Non-English Language Notice

This Plan Document contains a summary in English of a Covered Person's rights and benefits under the Plan. If a Covered Person has difficulty understanding any part of this Plan Document, he or she may contact the Plan Administrator at the contact information above.

Legal Entity; Service of Process

The Plan is a legal entity. Legal notice may be filed with, and legal process served upon, the Plan Administrator.

Not a Contract

The Plan is not to be construed as a contract for or of employment.

Mental Health Parity

Pursuant to the Mental Health Parity Act of 1996 (MHPA) and the Mental Health Parity and Addition Equity Act of 2008 (MHPAEA), collectively the mental health parity provisions in Part 7 of ERISA, this Plan applies its terms uniformly and enforces parity between covered health care benefits and covered mental health and substance disorder benefits relating to financial cost sharing restrictions and treatment duration limitations. For further details, please contact the Plan Administrator.

Use of Genetic Information is governed by GINA, which prohibits the offering of reduced premiums or other rewards for providing Genetic Information or using Genetic Information for determining eligibility, computing premiums or contributions, and applying preexisting condition limitations. GINA will not prohibit a Provider from requesting genetic testing. The rules permit the Plan to obtain genetic test results and use them to make Claims payment determinations when it is necessary to do so to determine whether the treatment was Medically Necessary.

Coverage under this Plan is provided regardless of an eligible Employee's and his or her Dependent(s)'s race, color, national origin, disability, age, sex, gender identity or sexual orientation. Variations in the administration, processes or benefits of this Plan that are based on clinically indicated reasonable medical management practices, or are part of permitted wellness incentives, disincentives and/or other programs do not constitute discrimination.

Applicable Law

This is a self-funded benefit plan coming within the purview of the Employee Retirement Income Security Act of 1974 (ERISA). The Plan is funded with Employee and/or Employer contributions. As such, when applicable, Federal law and jurisdiction preempt State law and jurisdiction.

Discretionary Authority

The Plan Administrator shall have sole, full and final discretionary authority to interpret all Plan provisions, including the right to remedy possible ambiguities, inconsistencies and/or omissions in the Plan Document and Summary Plan Description, and related documents; to make determinations in regards to issues relating to eligibility for benefits; to decide disputes that may arise relative to a Covered Person's rights; and to determine all questions of fact and law arising under the Plan to the maximum extent allowed by law.

OVERVIEW OF THE PLAN

This Plan has entered into an agreement with certain Hospitals, Physicians and other health care providers, which are called Participating Providers. Because these Participating Providers have agreed to charge reduced fees to persons covered under the Plan, using a Participating Provider will normally result in a lower cost to the Plan as well as a lower cost to a Covered Person, as the Plan can afford to reimburse a higher percentage of their fees. There is no requirement for anyone to seek care from a Participating Provider. The choice of provider is entirely up to the Covered Person; however additional costs may be incurred by the Covered Person if choosing to use a non-Participating Provider.

A current list of Participating Providers is available, without charge, through the Third Party Administrator at www.choosebywater.com . If the Covered Person does not have access to a computer at his or her home, he or she may contact the Employer or the Network at the phone number on the Employee identification card to obtain a paper copy of the Participating Providers available.

Non-Participating Provider Exceptions: Covered services rendered by a Non-Participating Provider will be paid at the Participating Provider level when one of the following applies:

1. Covered Person has an Emergency Medical Condition requiring immediate care, until such time as the condition no longer requires Emergency Medical Services.
2. Participating Provider is not available in Network for specific services being sought by the Covered Person.
3. Covered Person receives services by a Non-Participating Provider (e.g. anesthesiologists, radiologists, pathologists, etc.) who is regularly practicing at a Network facility.

Not all Providers based in network hospitals or medical facilities are Participating Providers. It is important when entering a Hospital or facility to request all Physician services be performed by Participating Providers. By doing this, you will always receive the greater participating provider level of benefits.

The Plan is not intended to disturb the Physician-patient relationship. Each Covered Person has a free choice of any Physician or surgeon, and the Physician-patient relationship shall be maintained. Physicians and other health care Providers are not agents or delegates of the Plan Sponsor, Company, Plan Administrator, Employer or Third Party Administrator. The delivery of medical and other health care services on behalf of any Covered Person remains the sole prerogative and responsibility of the attending Physician or other health care Provider. The Covered Person, together with his or her Physician, is ultimately responsible for determining the appropriate course of medical treatment, regardless of whether the Plan will pay for all or a portion of the cost of such care.

Costs: A certain portion of the cost of Covered Expenses under the Plan, including (as applicable) any Copay, Deductible and Coinsurance percentage that is not paid by the Plan, up to the Out-of-Pocket Maximum set by the Plan must be paid by a Covered Person.

Deductible: This is an amount of Covered Expenses for which no benefits will be paid. A Covered Person must pay the Deductible each Benefit year, before the Plan's coverage begins. The Deductible may be waived for certain Covered Expenses, including Preventive Care services by Participating Providers. Amounts applied to the Deductible for charges

from Participating Providers are accumulated separately and will not be used to satisfy the Deductible for charges from Non-Participating Providers and vice versa. Refer to the Medical Schedule of Benefits for more information.

The family Deductible maximum, as shown in the Medical Schedule of Benefits, is the maximum amount which must be Incurred by all Covered Persons in the same family during a Benefit Year. However, each individual Covered Person is not required to contribute more than the single Deductible amount to a family Deductible.

Out-of-Pocket Maximum:

The single Out-of-Pocket Maximum applies to a Covered Person with single coverage. When a Covered Person reaches his or her Out-of-Pocket Maximum, the Plan will pay 100% of additional Covered Expenses for that individual during the remainder of that Benefit Year.

The family Out-of-Pocket Maximum applies collectively to all Covered Persons in the same family. The family Out-of-Pocket Maximum is the maximum amount that must be satisfied by all Covered Persons covered in the same family during a Benefit Year. The entire family Out-of-Pocket Maximum must be satisfied; however, each individual in a family is not required to contribute more than the single Out-of-Pocket Maximum amount to the family Out-of-Pocket Maximum before the Plan will 100% of Covered Expenses for any Covered Person in the family during the remainder of that Benefit Year.

The Out-of-Pocket Maximum may be higher for Non-Participating Providers than for Participating Providers. Amounts applied to the Out-of-Pocket Maximum for charges from Participating Providers are accumulated separately and will not be used to satisfy the Out-of-Pocket Maximum for charges from Non-Participating Providers and vice versa. Please note, not all Covered Expenses are eligible to accumulate toward the Out-of-Pocket Maximum. The types of expenses, which are not eligible to accumulate toward your Out-of-Pocket Maximum, ("non-accumulating expenses") include:

1. Charges over the Maximum Allowable Charge; and
2. Charges this Plan does not cover, including precertification penalties.

Reimbursement for any eligible expenses will continue at the percentage payable shown in the Schedule of Benefits, subject to the Plan maximums.

The Plan will not reimburse any expense that is not a Covered Expense. In addition, the Covered Person must pay any expenses that are in excess of the Maximum Allowable Charge. This could result in a significant portion of a claim being paid by the Covered Person. None of these amounts will accumulate toward the Out-of-Pocket Maximum.

Once the Out-of-Pocket Maximum for eligible expenses Incurred during a Benefit Year have been paid, the Plan will reimburse additional Covered Expenses Incurred during that year at 100%.

Questions about whether an expense is a Covered Expense or whether it is eligible for accumulation toward the Out-of-Pocket Maximum can be directed to the Plan Administrator.

MEDICAL MANAGEMENT PROGRAM

Program Overview: Medical Management is a program designed to help ensure that a Covered Person receives necessary and appropriate healthcare while avoiding unnecessary expenses. The program consists of:

A. 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. Utilization Review requires:

1. Pre-Certification of Medical Necessity. The Provider, Covered Person or family member must call the number below to receive Pre-Certification of Medical Necessity for certain services. This call must be made at least as soon as possible in advance of services being rendered or within 48 hours. For admissions on a weekend or holiday, Pre-Certification must be made no later than the first business day following the emergency admission.

Utilization Review Administrator **Phone Number:** 800.337.0792

This plan will only require precertification in these categories if defined or allowed by Cigna's list of CPT codes available for pre-certification.

The following items and/or services must be Pre-Certified before any medical services are provided; this list does not guarantee the benefits are eligible medical expenses under the Plan:

a. Inpatient admissions, including Inpatient admissions to a Skilled Nursing Facility, Extended Care Facility, Rehabilitation Facility, and Inpatient admissions due to a Mental Disorder or Substance Use Disorder (see "Maternity" under Eligible Expenses for special rules);
b. Transplant Services;
c. Hospital observation stays of more than 48 hours;
d. Dialysis services;
e. Chemotherapy and radiation therapy;
f. Reconstructive surgeries;
g. Hyperbaric oxygen treatments;
h. Durable Medical Equipment, if rental longer than 30 days or a purchase, and insulin pumps with the exception of all other diabetic supplies;
i. Outpatient Substance Use Disorder programs;
j. Outpatient Surgeries and Procedures;
k. Outpatient Private Duty Nursing:
l. Diagnostic testing outpatient including outpatient MRI/PET/CT scans;
m. Infusion services;
n. Home health care;
o. Genetic testing, including BRCA and BART;
p. Air and water ambulance transportation;
q. Hospice care;
r. Spinal procedures;
s. Prosthetics;
t. Injection therapy specific to pain management programs;
u. Treatment/Surgical Procedures for Morbid Obesity;
v. Gender Dysphoria surgical treatment.

2. Concurrent Review for continued length of stay and assistance with discharge planning activities.

3. Retrospective review for Medical Necessity where Pre-Certification is not obtained or the Utilization Review Administrator is not notified.

Pre-Certification: Before a Covered Person is admitted to an Institution or receives items or services that require Pre-Certification on a non-Emergency Medical Condition basis (that is, where an Emergency Medical Condition is not involved), the Utilization Review Administrator will, based on clinical information from the Provider, or Physician, certify the care according to the Utilization Review Administrator's policies and procedures.

The Medical Management Program is set in motion by a telephone call from a Covered Person or a representative acting on his or her behalf.

Utilization Review Administrator Phone Number: 800.337.0792

To allow for adequate processing of the request, contact the Utilization Review Administrator at least 48 hours before receiving any item or service that requires Pre-Certification or an Inpatient admission for a Non-Emergency Medical Condition with the following information:

1. Name, identification number and date of birth of the Covered Person;
2. The relationship of the Covered Person to the Employee;
3. Name, identification number, address and telephone number of the Employee;
4. Name of Employer and group number;
5. Name, address, Tax ID # and telephone number of the admitting Physician;
6. Name, address, Tax ID # and telephone number of the Institution with the proposed date of admission and proposed length of stay;
7. Proposed treatment plan; and
8. Diagnosis and/or admitting Diagnosis.

If there is an Inpatient admission with respect to an Emergency Medical Condition, the Covered Person or a representative acting on his or her behalf, including the Institution or admitting Physician, must contact the Utilization Review Administrator within 48 hours after the start of the confinement or on the next business day, whichever is later.

The Utilization Review Administrator, in coordination with the Physician and/or Provider, will make a determination on the number of days certified based on the Utilization Review Administrator's policies, procedures and guidelines. If the confinement will last longer than the number of days certified, a representative of the Physician or the Provider must call the Utilization Review Administrator before those extra days begin and obtain certification for the additional time. If the additional days are not requested and certified, Room and Board expenses will not be payable for any days beyond those certified.

Failure to Pre-Certify will trigger the Pre-Certification penalty below.

In an Emergency requiring immediate hospitalization, the Covered Person or his/her authorized representative must contact the Plan within 48 hours of admission and provide them with pertinent information regarding the admission, or the Pre-Certification penalty will apply. For admissions on a weekend or holiday, Pre-Certification must be made no later than the first business day following the emergency admission.

Pre-Certification penalty: If a Covered Person fails to Pre-Certify for any of the services listed above, the Plan shall reduce the covered and allowed charges under the Plan by a Pre-Certification penalty equal to 10% of Maximum Allowable Charge for the procedures, treatment and hospital room a board, with a maximum of $500. The Covered Person will be responsible for the portion of the billed charges not covered under the Plan due to the Pre-Certification penalty. The Pre-Certification penalty does not accumulate toward the Deductible or the Out-of-Pocket Maximum.

Medical Management Does Not Guarantee Payment: All benefits/payments are subject to the patient's eligibility for benefits under the Plan. For benefit payment, services rendered must be considered a Covered Expense under the Plan and are subject to all other provisions of 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 healthcare provider.

Discharge Planning: Discharge planning needs are part of the Medical Management Program. The Utilization Review Administrator will assist and coordinate the initial implementation of any services the Covered Person will need post hospitalization with the attending Physician and Provider. If the attending Physician feels that it is Medically Necessary for a Covered Person to stay in the Institution for a greater length of time than has been Pre-Certified, the attending Physician or the Provider must request the additional service or days.

Concurrent Inpatient Review: Once the Inpatient setting has been Pre-Certified, the on-going review of the course of treatment becomes the focus of the program. Working directly with the Physician, the Utilization Review Administrator will identify and approve the most appropriate and cost-effective setting for the treatment as it progresses.

To File a Complaint or Request an Appeal to a Non-Certification: Written appeal requests and information regarding the appeal process, as outlined under the section **Claim Procedures** of this Plan, should be directed to the Utilization Review Administrator.

B. **Case Management**: When a Covered Person has an ongoing medical condition or a catastrophic Illness, a Covered Person may require long-term, perhaps lifetime care. After the Covered Person's condition is diagnosed, he or she might need extensive services or might be able to be moved into another type of care setting, including the Covered Person's home.

Case Management is a program whereby a Case Manager is assigned to monitor this Covered Person, and to work with the attending Physician and Covered Person to design a treatment plan and coordinate appropriate Medically Necessary care. The Case Manager will monitor the patient and explore, discuss and recommend coordinated and/or alternate types of appropriate medical care. The Case Manager consults with the Covered Person, family, and the attending Physician in order to develop a plan of care for approval by the Covered Person and his/her attending Physician.

This plan of care may include some or all of the following:

1. Personal support to the Covered Person;
2. Contacting the family to offer assistance and support;
3. Monitoring Institution care;
4. Determining alternate care options; and
5. Assisting in obtaining any necessary equipment and services.

Case management occurs when this benefit will be beneficial to both the Covered Person 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 staff, attending Physician, Covered Person and his/her family must all agree to the alternate treatment plan.

Case management is a voluntary services. There are no reductions of benefits or penalties if the Covered Person 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 Covered Person, even one with the same Diagnosis.

Medical Management will not interfere with the course of treatment or the Physician-patient relationship. All decisions regarding treatment and use of facilities will be the Covered Person's and should be made independently of this program.

MEDICAL SCHEDULE OF BENEFITS

MEDICAL BENEFITS	PARTICIPATING PROVIDERS	NON-PARTICIPATING PROVIDERS
LIFETIME MAXIMUM BENEFIT	Unlimited	
Benefit Year MAXIMUM BENEFIT	Unlimited	
Benefit Year DEDUCTIBLE Single Family	 $6,000 $12,000	 $12,500 $25,000
Amounts applied to the Deductible for charges from Participating Providers are accumulated separately and will not be used to satisfy the Deductible for charges from Non-Participating Providers and vice versa.		
Benefit Year OUT-OF-POCKET MAXIMUM Single Family (includes Deductible, Coinsurance and Copays – combined with Prescription Drug Card)	 $7,500 $15,000	 $25,000 $50,000
The Plan will pay the designated percentage of Covered Expenses until Out of Pocket Maximums are reached, at which time the Plan will pay 100% of the remainder of Covered Expenses for the rest of the Benefit Year unless stated otherwise. The Out of Pocket Maximums for Participating and Non-Participating are separate. The following charges do not apply toward the Out of Pocket Maximum and are never paid at 100%: • Amounts over the Maximum Allowable Charge • Amounts for non-covered services, including Precertification penalties		

MEDICAL BENEFITS	PARTICIPATING PROVIDERS	NON-PARTICIPATING PROVIDERS
Acupuncture	70% After Deductible	30% After Deductible
Benefit Year Maximum Benefit	20 Visits	
Allergy Services	70% After Deductible	30% After Deductible
Benefit Year Maximum Benefit	1 Testing	
Ambulance Services (Emergency)	70% After Deductible	
Limitations	Air/water ambulance subject to $25,000.00 max per occurrence and pre-certification requirement.	
Ambulance Services (Non-Emergency) and/or any other less intensive form of medical transport (water, air, ground) *except as covered under the Ambulance and/or other type of medical transportation benefit.	Not Covered	Not Covered
Cardiac Rehab (Outpatient)	70% After Deductible	30% After Deductible
Benefit Year Maximum Benefit	A single 12 week period with a maximum of 36 sessions	
Chiropractic Care/Spinal Manipulation	70% After Deductible	30% After Deductible
Benefit Year Maximum Benefit	20 visits	
Contraceptive Management	70% After Deductible *Deductible is waived for preventive services required to be covered by applicable law. Note: for these preventive services, over the counter contraceptives must be prescribed by a Physician.*	30% After Deductible *Note: over the counter contraceptives are not covered.*
Diabetic Education and supplies	70% After Deductible	30% After Deductible
Diagnostic Testing, X-Ray and Lab Services (Outpatient) **MRI, CT Scans, and PET Scans**	No Charge 70% After Deductible	30% After Deductible
Dialysis	70% After Deductible	30% After Deductible
Durable Medical Equipment (DME)	70% After Deductible	30% After Deductible
Emergency Services – Emergency Medical Condition	$1,000 Copay, waived if admitted	
Emergency Services - Non-Emergency Medical Condition	Not Covered	Not Covered
Hearing Examination	70% After Deductible	30% After Deductible
Benefit Year Maximum Benefit	1 Exam	
Hearing Aids and Related Supplies	70% After Deductible	30% After Deductible
Benefit Year Maximum Benefit	One hearing aid per ear every 48 months, not to exceed a total of $4,000	
Home Health Care	70% After Deductible	30% After Deductible
Benefit Year Maximum Benefit	60 Visits	
Hospice Care	No Charge	30% After Deductible
Maximum Benefit	180 Days	

MEDICAL BENEFITS	PARTICIPATING PROVIDERS	NON-PARTICIPATING PROVIDERS
Hospital Services (Institution charges)		
Room and Board *Benefits payable at semi-private room rate.**	70% After Deductible	30% After Deductible
Intensive Care Unit *Benefits payable at ICU rate*	70% After Deductible	30% After Deductible
Miscellaneous Services & Supplies	70% After Deductible	30% After Deductible
Outpatient	70% After Deductible	30% After Deductible
* A private room will be considered eligible when Medically Necessary. Charges made by a Hospital having only single or private rooms will be considered at the least expensive rate for a single or private room.		
Infertility		
Testing, Diagnosis and treatment of underlying cause Infertility Treatment and procedures	70% After Deductible Not Covered	30% After Deductible Not Covered
NOTE: Includes any item or service not otherwise covered under the preventive services provision.		
Maternity (Professional Fees)*		
Preventive Prenatal and Breastfeeding Support (other than lactation consultations)	100% No Deductible	30% After Deductible
Lactation Consultations	100% No Deductible	30% After Deductible
All Other Prenatal and Postnatal Care	70% After Deductible	30% After Deductible
Delivery	70% After Deductible	30% After Deductible
* See Preventive Services under Eligible Medical Expenses for limitations.		
Mental Disorders and Substance Use Disorders		
Inpatient	70% After Deductible	30% After Deductible
Outpatient	$65 Copay	30% After Deductible
Office Visit	$125 Copay	30% After Deductible
Oncology Services **(**e.g., chemotherapy, radiation therapy, cancer-related surgery)	70% After Deductible	30% After Deductible
Outpatient Therapies (e.g., physical, speech, occupational)	70% After Deductible	30% After Deductible
Benefit Year Maximum Benefit	20 visits per therapy type/80 visits combined all types	

MEDICAL BENEFITS	PARTICIPATING PROVIDERS	NON-PARTICIPATING PROVIDERS
Physician's Services		
Inpatient/Outpatient Services	70% After Deductible	30% After Deductible
Office Visit		
Primary Care Physician	$65 Copay	30% After Deductible
Specialist	$125 Copay	30% After Deductible
Virtual Visit	PCP $65 Copay Specialist $125 Copay	Not Covered
Injections	70% After Deductible	30% After Deductible
Inpatient Surgery	70% After Deductible	30% After Deductible
Office Surgery	70% After Deductible	30% After Deductible
Oral Surgery	70% After Deductible	30% After Deductible
Outpatient Surgery	70% After Deductible	30% After Deductible
Extraction of Impacted Wisdom Teeth	70% After Deductible	30% After Deductible
Second Surgical Opinion	70% After Deductible	30% After Deductible
Endoscopic Tests (Non-routine)	70% After Deductible	30% After Deductible
Note: Copay applies per visit regardless of what services are rendered, except as specifically stated herein.		
Preventive Services and Routine Care		
Routine Well Care (birth through adult)	100% No Deductible	30% After Deductible

Routine Well Care services and Women's Preventive services will be subject to age and developmentally appropriate frequency limitation as determined by the U.S. Preventive Services Task Force (USPSTF) and Health Resources and Services Administration (HRSA), unless otherwise specifically stated in this Schedule of Benefits, and which can be located using the following website(s):

https://www.uspreventiveservicestaskforce.org/Page/Name/uspstf-a-and-b-recommendations/

https://www.hrsa.gov/womens-guidelines/index.html

Routine Well Care services will include, but will not be limited to, the following routine services:
Office visits, routine physical exams, prostate screening, routine lab and x-ray services, immunizations, routine colonoscopy/flexible sigmoidoscopy, and routine well child care examinations.

Women's Preventive Services, will include, but will not be limited to, the following routine services:
Office visits, well-woman visits, mammogram, gynecological exam, Pap smear, counseling for sexually transmitted infections, human papillomavirus (HPV) testing, counseling and screening for human immune-deficiency virus (HIV), interpersonal and domestic violence, contraceptive methods and counseling as prescribed, sterilization procedures patient education and counseling for all women with reproductive capacity (this does not include birthing classes), preconception, screening for gestational diabetes in pregnant women, breastfeeding support, supplies, and counseling in conjunction with each birth.

MEDICAL BENEFITS	PARTICIPATING PROVIDERS	NON-PARTICIPATING PROVIDERS
Private Duty Nursing (Outpatient)	70% After Deductible	Not Covered
Benefit Year Maximum Benefit	60 visits	
Prosthetics	70% After Deductible	30% After Deductible
Pulmonary Therapy (Outpatient)	70% After Deductible	30% After Deductible
Benefit Year Maximum Benefit	A single 6 week period with a maximum of 36 visits	
Routine Eye Examination – *under preventive care*	100% No Deductible	30% After Deductible
Benefit Year Maximum Benefit	1 Exam	
Skilled Nursing Facility and Rehabilitation Facility (Inpatient)	70% After Deductible	30% After Deductible
Maximum Benefit	120 days per 12 month period	
Transplants	70% After Deductible	30% After Deductible
NOTE: Cornea transplants performed by any provider are covered under the Plan as a separate benefit and paid the same as any other Illness.		
Urgent Care Facility	$125 Copay	30% After Deductible
Note: Copay applies per visit regardless of what services are rendered, except as specifically stated herein.		
Walk-In Clinic	$30 Copay	30% After Deductible
All Other Eligible Medical Expenses	70% After Deductible	30% After Deductible

PRESCRIPTION DRUG SCHEDULE OF BENEFITS

BENEFIT DESCRIPTION	Participating Pharmacy	Non-Participating Pharmacy
Benefit Year OUT-OF-POCKET MAXIMUM Single Family *BENEFITYEAR OUT-OF-POCKET MAXIMUM (Prescription drug co-payments, deductibles, and other expenditures are included in the out of pocket maximums under Medical Benefits).*	See Medical Benefit Schedule See Medical Benefit Schedule	See Medical Benefit Schedule See Medical Benefit Schedule
Retail Pharmacy: 30-day supply		
Generic Drug	$5 Copay	Not Applicable
Brand Name Drug	$25 Copay	Not Applicable
Non-Preferred Drug	$150 Copay	Not Applicable
Preventive Drug (Prescription Drugs classified as a Preventive Drug by HHS)	No Charge	No Charge
Mail Order Pharmacy: 90-day supply		
Generic Drug	$12.50 Copay	Not Applicable
Brand Name Drug	$62.50 Copay	Not Applicable
Non-Preferred Drug	$375 Copay	Not Applicable
Specialty Drugs 30-day supply		
Generic Drug	$600 Copay	Not Applicable
Brand Name Drug	$600 Copay	Not Applicable
Non-Preferred Drug	$600 Copay	Not Applicable

Price paid will be the lower of the Specialty Pharmacy rate or the average wholesale price of the Drug, device, or medication regardless whether purchased through the medical provider or the Pharmacy Benefit Manager. All Prescriptions Drugs are covered under the Prescription Drug program, unless unavailable through the Pharmacy Benefit Manager. Expenses for injectables and consumed on premise Drugs that are not covered under the Prescription Drug Program and are Medically Necessary for the treatment of a covered Illness or Injury will be payable under this Plan subject to any applicable major medical Deductibles and Coinsurance as well as any coverage limitations and exclusions applicable to the major medical component of the Plan.

ELIGIBILITY FOR PARTICIPATION

Eligibility:

The following classes are eligible for coverage under the Plan:

1. All Full-Time, Active Employees
2. All Full-Time, Active Employee's Dependents

The following individuals are not eligible for coverage under the Plan:

1. Employees who are Part-Time Employees, Seasonal Employees, temporary employees, leased employees or, an independent contractor or a person performing services pursuant to a contract under which they are designated an independent contractor (regardless of whether you might later be deemed a common law employee by a court or governmental agency);
2. Individuals living in the Full Time, Active Employee's home, but who are not eligible as defined in this Plan;
3. The divorced former Spouse of a Full Time, Active Employee;
4. Any person who is on active duty in any military service of any country unless coverage is available through the Uniformed Services Employment and Reemployment Rights Act (USERRA) as explained below; or
5. A Full Time, Active Employee covered under the Plan who is a Dependent of another Full Time, Active Employee.

A Full Time, Active Employee will continue to be covered under the Plan if absent from work due to a health factor for up to the legally required time period or the maximum period permissible under the FMLA provisions if FMLA applies. Coverage under the Plan will terminate for the Employee at the end of this time period if the Employee has not returned to Full Time, Active status. The Employee will be eligible for COBRA as set forth in the Plan. If the Employee is reinstated as a Full Time, Active Employee at a later date, coverage will begin immediately upon the first Hour of Service.

If a Covered Person under this Plan changes status from a Full Time, Active Employee to a Dependent, or from Dependent to a Full Time, Active Employee, and was covered continuously under the Plan before, during and after the change in status, credit will be given for Deductibles and all amounts applied to maximums.

If both parents are Full Time, Active Employee's under the Plan, their Child will be covered as a Dependent of one parent or the other, but not of both.

To establish a Dependent relationship, the Plan reserves the right to require documentation satisfactory to the Plan Administrator. At any time, the Plan may require proof that a Spouse and/or Dependent qualifies or continues to qualify as eligible for coverage under the Plan.

Dependent Requirements: The Plan Sponsor has discretionary authority to interpret these terms and determine status of a Spouse, or other Dependent as defined by the Plan, to the extent allowed by law. The following definitions apply to the Plan:

Dependent means one or more of the following person(s):

1. An Employee's present Spouse.

2. An Employee's Child who is less than 26 years of age. NOTE: Coverage of a Dependent Child will continue until the end of the calendar month he or she turns 26 years of age.
3. An Employee's Child, regardless of age, who is continuously covered prior to attaining the limiting age as stated above, who is mentally or physically incapable of sustaining his or her own living.
4. The following shall not be deemed to be Dependent(s):
    a. Active members of any armed force.
    b. Residents of a country other than the United States shall not be deemed to be Dependent(s).

Spouse means an individual who possess a valid marriage license with an Employee that is not annulled or voided in any way. A Spouse shall include a common law spouse when such marital status is legally recognized in the state jurisdiction in which the Employee has his or her principal residence, including all required formalities.

Child means the Employee's natural child, any stepchild unless cover under a Qualified Medical Child Support Order, legally adopted child, or any other child for whom the Employee has been named legal guardian, or an eligible foster child (defined as an individual placed with the Employee by an authorized placement agency or by judgement, decree or other order of court of competent jurisdiction). For purposes of this definition, a legally adopted Child shall include a child placed in an Employee's physical custody in anticipation of adoption. Child shall also mean a covered Employee's Child who is an Alternate Recipient under a Qualified Medical Child Support Order, as required by the Federal Omnibus Budget Reconciliation Act of 1993.

The following criteria must be met to qualify as an eligible Dependent:

1. <u>Spouse.</u> A Spouse must meet the following requirements:

    a. Employee and Spouse shall not have been engaged in a trial separation for more than twelve (12) consecutive months upon the date a Clean Claim for Covered Expense(s) provided to Spouse are received by the Plan.
    b. Employee and Spouse shall have been cohabitating at the same residence for the majority of the applicable Benefit Year. When an Employee or Spouse is traveling or residing elsewhere as part of their profession, to care for a family member (due, for instance, to Illness or Injury), and/or is residing elsewhere due to their own Illness or Injury, for more than half of the applicable Benefit Year (and thus residing with each other for less than the majority of the applicable Benefit Year), but the primary residence of the Employee is also the Spouse's primary residence for all legal, regulatory, and statutory purposes, this constitutes cohabitation as required by this provision.

2. <u>Child mentally or physically incapable of sustaining his or her own living</u>. Such Child must have been mentally or physically incapable of earning his or her own living prior to attaining the limiting age of 26. Written proof provided by a Physician certifying such incapacity and dependency satisfactory to the Plan must be furnished and approved by the Plan within thirty-one (31) days after the Child attains the limiting age of 26.

    a. For a new or re-enrolling Employee, the time limit for written proof by a Physician certifying incapacity and dependency is thirty-one (31) days following the original eligibility date. The Plan may require, at reasonable intervals, subsequent proof satisfactory to the Plan during the next two years after such date. After such two year period the Plan may require such proof, but not more than once a year.

Effective Date of Coverage

Effective Date of Full Time, Active Employee Coverage. A Full Time, Active Employee will become eligible for benefits under the Plan after completing the 30-day bona fide orientation period followed by 60 days of employment. Benefits are effective on the first of the month following the waiting period.

Effective Date of Dependent Coverage. A Spouse's, and/or Dependent's coverage will take effect on the day that he or she satisfies the eligibility requirements (set forth above), provided the Full Time, Active Employee is covered under the Plan, and the Spouse, and/or Dependent has been enrolled for coverage under the Plan.

Determination of Full Time Employee Status

Determining Full Time, Active Employee Status for Employees: Employees who are Full Time, Active Employees as designated by the Employer or who have worked sufficient hours during the previous Benefit Year to satisfy the definition of Full Time are eligible.

If the Employer handbook, published prior to the effective date of this Plan, establishes a different method, the handbook will control.

Enrollment

Enrollment Requirements. A Full Time, Active Employee is required to complete and sign an enrollment application in order to apply for coverage for himself/herself, as well as for any Spouse, and/or Dependent to be covered under the Plan.

Once a Full Time, Active Employee is eligible to participate in the Plan, to enroll the enrollment application for coverage must be submitted, along with arrangements to pay any required Plan contributions, to the Plan Sponsor within thirty-one (31) days after satisfaction of the eligibility requirements, either initially, during open enrollment, or under a Special Enrollment Period. Failure to timely submit a properly executed enrollment application and applicable payment arrangements will result in the Full Time, Active Employee and his/her Spouse, and/or Dependents not being able to enroll in the Plan until the annual Open Enrollment Period or under a subsequent Special Enrollment Period.

As part of the enrollment requirements, a Covered Person will be required to provide his or her social security number. The Plan Sponsor may request this information at any time for continued eligibility under the Plan. Failure to provide the required social security numbers may result in loss of eligibility or loss of continued eligibility under the Plan.

Enrollment Periods

1. **Open Enrollment Period**: A Full Time, Active Employee and Dependents may enroll for coverage during the Plan's open enrollment period, designated by the Plan Sponsor and communicated to you prior to such open enrollment period. During this time you will be permitted to make changes to any existing benefit elections. Benefit elections made during the open enrollment period will be effective as of May 1 and will remain in effect until the next open enrollment period unless there is an applicable Special Enrollment Period.

2. **Special Enrollment Period**: A Special Enrollment Period occurs when the Employee or Employee's Dependent experiences one of the following:

a. *Individuals Losing Other Coverage Creating a Special Enrollment Right*. A Full Time, Active Employee, Spouse, and/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:
    i. The Full Time, Active Employee, Spouse, and/or Dependent were covered under a group health plan or had health insurance coverage at the time coverage under this Plan was last offered to the individual;
    ii. If required by the Plan Sponsor, the Full Time, Active Employee stated in writing at the time that coverage was offered that the other health coverage was the reason for declining enrollment; and
    iii. The Full Time, Active Employee, Spouse, and/or Dependent lost other coverage pursuant to one of the following events:
        1. The Full Time, Active Employee, Spouse, and/or Dependent was under COBRA and the COBRA coverage was exhausted;
        2. The Full Time, Active Employee, Spouse, and/or Dependent was not under COBRA and the other coverage was terminated as a result of loss of eligibility (including as a result of Legal Separation, divorce, loss of Dependent status, death, termination of employment, or reduction in the number of hours worked);
        3. The Full Time, Active Employee, Spouse, and/or Dependent moved out of an HMO service area with no other option available.
        4. The group health plan or health insurance coverage covering the Full Time, Active Employee, Spouse, and/or Dependent is no longer offering benefits to a class of similarly situated individuals.
        5. The benefit package option covering the Full Time, Active Employee, Spouse, and/or Dependent is no longer being offered and no substitute is available.
        6. The employer contributions for the group health plan or health insurance coverage covering the Full Time, Active Employee, Spouse, and/or Dependent were terminated.
    iv. A loss of eligibility does not occur if either of the following applies:
        1. If the Full Time, Active Employee, Spouse, and/or Dependent lost the other coverage as a result of the individual's failure to pay premiums or required contributions or by voluntary termination of coverage or for cause (such as making a fraudulent Claim or an intentional misrepresentation of a material fact in connection with the other plan).

b. *Special Enrollment Rights for New Beneficiaries*.
    i. If the following applies:
        1. The Full Time, Active Employee is a Covered Person under this Plan; and
        2. A person becomes a Spouse, or Dependent of the Full Time, Active Employee through marriage, birth, adoption or placement for adoption;
    ii. Then the Spouse and/or Dependent may be enrolled under the Plan. In the case of the birth or adoption of a child, the Spouse of the covered Full Time, Active Employee may be enrolled if the Spouse is otherwise eligible for coverage.

iii. The “Dependent Special Enrollment Period” is a period of thirty-one (31) days and begins on the date of the marriage, birth, adoption or placement for adoption. To be eligible for this Special Enrollment, the Spouse, Dependent and/or Full Time, Active Employee must request enrollment during this thirty-one (31) day period.

c. *Court Ordered Coverage for a Child*: This Plan will provide for immediate enrollment and benefits to the Child or Children of a Covered Person who are the subject of a Qualified Medical Child Support Order (QMCSO), regardless of whether the Child or Children reside with the Full Time, Active Employee, provided the Child or Children are not already enrolled as an eligible Dependent as described in this Plan. If a QMCSO is issued, then the Child or Children shall become Alternate Recipient(s) of the benefits under this Plan, subject to the same limitations, restrictions, provisions and procedures as any other Covered Person. The Plan Sponsor will determine if the order properly meets the standards described herein. A properly completed National Medical Support Notice (NMSN) will be treated as a QMCSO and will have the same force and effect.

i. To be considered a Qualified Medical Child Support Order, the Medical Child Support Order must contain the following information:
    1. The name and last known mailing address (if any) of the Covered Person and the name and mailing address of each such Alternate Recipient covered by the order.
    2. A reasonable description of the type of coverage to be provided by this Plan to each Alternate Recipient, or the manner in which such type of coverage is to be determined.
    3. The period of coverage to which the order applies.
    4. The name of this Plan.

ii. A National Medical Support Notice shall be deemed a QMCSO if all of the following requirements are met:
    1. It contains the information set forth above in the definition of National Medical Support Notice.
    2. It identifies either the specific type of coverage or all available group health coverage. If the Employer receives a NMSN that does not designate either specific type(s) of coverage or all available coverage, the Employer and the Plan Sponsor will reject the order until sufficient information is provided.
    3. It informs the Plan Sponsor that, if a group health plan has multiple options and the Covered Person is not enrolled, the issuing agency will make a selection after the NMSN is qualified, and, if the agency does not respond within twenty (20) days, the Child will be enrolled under the Plan's default option (if any).
    4. It specifies that the period of coverage may end for the Alternate Recipient(s) only when similarly situated dependents are no longer eligible for coverage under the terms of the Plan, or upon the occurrence of certain specified events.

iii. A NMSN need not be recognized as a QMCSO if it requires the Plan to provide any type or form of benefit, or any option, not otherwise provided to the Covered Person and eligible Child without regard to the provisions herein, except to the extent necessary to meet the requirements of a State law relating to Medical Child Support Orders, as

described in Social Security Act §1908 (as added by Omnibus Budget Reconciliation Act of 1993 §13822).

iv. In the instance of any Medical Child Support Order received by this Plan, the Plan Sponsor shall perform the following:
    1. In writing, promptly notify the Covered Person and each Alternate Recipient covered by such Order (at the address included in the Order) of the receipt of such Order and the Plan's procedures for determining whether the Order qualifies as a QMCSO.
    2. Make an administrative determination, within a reasonable period, if the order is a QMCSO and notify the Covered Person and each affected Alternate Recipient of such determination.

v. In the instance of any National Medical Support Notice received by this Plan, the Plan Sponsor shall perform the following:
    1. Notify the State agency issuing the notice with respect to the Child whether coverage of the Child is available under the terms of the Plan and, if so:
        a. Whether the Child is covered under the Plan.
        b. Either the effective date of the coverage or, if necessary, any steps to be taken by the custodial parent or by the official of a State or political subdivision to effectuate the coverage.
    2. Provide to the custodial parent (or any State official serving in a substitute capacity) a description of the coverage available and any forms or documents necessary to effectuate such coverage.

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

d. *Effective Dates for Special Enrollment*. The coverage of the Full Time, Active Employee, Spouse, and/or Dependent and/or Employee enrolled in the Special Enrollment Period will be effective:
    i. In the case of marriage, the new Spouse must be enrolled in the Plan within thirty-one (31) days after the marriage and the coverage will begin on the first day of the first month after the date of marriage;
    ii. In the case of a Dependent's birth, as of the date of birth;

1. A newborn child of the Full Time, Active Employee or Spouse must be enrolled in the Plan within thirty-one (31) days after birth in order to have coverage as of the date of birth. If the newborn is not timely enrolled, the newborn, including routine well-baby care and nursery expenses, will not be covered under this Plan. If the newborn child is not enrolled in the Plan within thirty-one (31) days of birth, the next opportunity to enroll the newborn will be at the next open enrollment, unless another Special Enrollment period applies. All routine well-baby care and nursery expenses, as well as any expense for treatment of Injury or Illness, will be covered under the newborn's coverage, if properly enrolled.

iii. In the case of a Dependent's adoption or placement for adoption, the date of the adoption or placement for adoption and must be enrolled in the Plan within thirty-one (31) days of the date of adoption or placement of adoption; or

iv. In the case of a QMCSO, the date stated in the order, or if no date is provided the earliest possible date as permitted by the Plan for enrollment once the request for enrollment is received.

Relation to Section 125 Cafeteria Plan: This Plan may also allow additional changes to enrollment due to change in status events under Employer's Section 125 Cafeteria Plan. Refer to the Employer's Section 125 Cafeteria Plan for more information.

TERMINATION OF COVERAGE

Termination of Employee Coverage: Coverage under the Plan will terminate on the earliest of the following dates:

1. The date the Plan terminates, in whole or in part;
2. The beginning of the period for which a required contribution has not been paid;
3. The date the Full Time, Active Employee reports to active military service, unless coverage is continued through the Uniformed Services Employment and Reemployment Rights Act (USERRA) as explained below;
4. The end of the month the Full Time, Active Employee terminates employment or ceases to be included in an eligible class of Employees;
5. The date a Full Time, Active Employee (or any person seeking coverage on his/her behalf) performs an act, practice or omission that constitutes fraud as it relates to the Plan;
6. The date a Full Time, Active Employee (or any person seeking coverage on his/her behalf) makes an intentional misrepresentation of a material fact as it relates to the Plan; or
7. If a Full Time, Active Employee becomes ineligible for coverage under the Plan due to a reduction in work-hours, the Employee's coverage will terminate upon the start of the next Stability Period.

Termination of Dependent Coverage: Coverage under the Plan will terminate on the earliest of the following dates:

1. The date the Plan terminates, in whole or in part;
2. The date the Plan discontinues coverage for Dependents;
3. The date the Dependent becomes covered as a Full Time, Active Employee under the Plan;
4. The date coverage terminates for the Full Time, Active Employee;
5. The beginning of the period for which a required contribution has not been paid;
6. The date the Dependent reports to active military service;
7. The end of the month in which a Dependent Spouse ceases to be a Dependent as defined by the Plan;
8. The date the Dependent (or any person seeking coverage on behalf of the Dependent) performs an act, practice or omission that constitutes fraud as it relates to the Plan; or
9. The date the Dependent (or any person seeking coverage on behalf of the Dependent) makes an intentional misrepresentation of a material fact as it relates to the Plan.

Retroactive Termination of Coverage: Except in cases where the Covered Person fails to pay any required contribution to the cost of coverage, performs an act, practice or omission that constitutes fraud or concealment with respect to the Plan, or unless the individual makes an intentional misrepresentation of material fact as it relates to the Plan, the Plan will not retroactively terminate coverage under the Plan. In such cases, the Plan will provide at least thirty (30) days advance written notice to the Covered Person who is affected with a deadline on which the contributions must be paid in full. If the required contributions have not been paid by the applicable deadline coverage will be retroactively terminated.

Continuation of Coverage under the Family and Medical Leave Act (FMLA): The Plan shall at all times comply with the Family and Medical Leave Act of 1993 (FMLA), as amended and as promulgated in regulations issued by the Department of Labor, if applicable. The Plan will also comply with applicable state FMLA laws.

During any leave taken under the FMLA or any applicable state counterpart, coverage under the Plan may be maintained on the same conditions as coverage would have been provided the Employee had been continuously employed during

the leave period. Failure to make required payments within thirty (30) days of the first day of leave and then the first of each subsequent month will result in the termination of coverage for the Employee and eligible Dependents.

If coverage under the Plan terminates during the FMLA leave, coverage will be reinstated pursuant to the enrollment provisions set forth in this Plan for the Employee and covered Dependents upon return to work at the end of the FMLA leave.

Failure to return to work after the FMLA leave may result in the Employer having the right to recover its contributions toward the cost of coverage during the FMLA leave and automatic termination of coverage for the Covered Person and enrolled Dependents.

Continuation of Coverage under State Family and Medical Leave Laws: To the extent this Plan is required to comply with a state family and medical leave law that is more generous than the FMLA, continuation of coverage under this Plan will be provided in accordance with such state family and medical leave law, as well as under FMLA.

Continuation of Coverage under USERRA: A Full Time, Active Employee may elect to continue Plan coverage under the Uniformed Services Employment and Reemployment Rights Act (USERRA) upon absence from work due to military service in the Uniformed Services (as defined under USERRA). A Full Time, Active Employee may elect to continue coverage for himself or herself and any Dependents that were covered under the Plan at the time of the leave. Dependents do not have an independent right to elect coverage under USERRA; therefore unless the Full Time, Active Employee elects to continue coverage on behalf of his/her Dependents, continuation of separate coverage under USERRA will not be permitted.

To elect coverage under USERRA, the Full Time, Active Employee must submit the election to continue coverage under USERRA, on a form prescribed by the Plan Sponsor to the Plan Sponsor within 60 days after the date of your leave. Coverage under the Plan will become effective as of the date of the Full Time, Active Employee's leave and will continue for the lesser of (a) 24 months (beginning on the date the absence begins); or (b) the period of time beginning on the date the absence begins and ending on the day after the date the return to employment with the Employer or fail to apply for or return to employment with the Employer within the time limit applicable under USERRA.

For leave that is thirty (30) days or less, the required contribution under the Plan remains the same as the amount paid while with the Employer. For leave that is thirty-one (31) days or more, the Full Time, Active Employee will be required to pay up to 102% of the full contribution under the Plan. The Employer will notify the Full Time, Active Employee of the procedures for making payments under this Plan.

Continuation coverage provided under USERRA counts towards the maximum coverage period under COBRA continuation coverage.

A Full Time, Active Employee returning from USERRA-covered military leave who participated in the Plan immediately before going on USERRA leave has the right to resume coverage under the Plan upon return from USERRA leave, as long as the Employee resumes employment within the time limit that applies under USERRA. No waiting period will apply to an Employee returning from USERRA leave (within the applicable time period) unless the waiting period would have applied to the Employee if the Employee had remained continuously employed during the period of military leave.

ELIGIBLE MEDICAL EXPENSES

Eligible expenses shall be the charges actually made for services provided to the Covered Person and will be considered eligible only if the expenses are:

1. Routine care or preventive services provided such services are ordered and performed by a Physician and not otherwise excluded under the Plan; or
2. Due to Illness or Injury provided such services are ordered and performed by a Physician, Medically Necessary and not otherwise excluded under the Plan.

Reimbursement for eligible expenses will be made directly to the provider of the service, unless a receipt showing payment is submitted. All eligible expenses Incurred at a Participating Provider will be reimbursed to the Provider.

Acupuncture: Acupuncture services by a licensed Doctor of Medicine, Doctor of Osteopathic Medicine or Acupuncturist when prescribed by the treating physician and considered Medically Necessary.

Allergy Services: Allergy testing, diagnosis, treatment, allergy serum, and the administration of injections. Coverage is provided for allergy and dermatology services and supplies ordered by and provided by or under the direction of a Physician. Self-injectables are covered under the Prescription Drug Benefits.

Ambulance and/or other type of Medical Transportation: In the case of medical transport, the reduced or least form of professional ground, air, and water service available is covered, unless the reduced or least form of transport could not be provided without adversely affecting the Covered Person's condition or the quality of medical care rendered. Where there is an emergency and the reduced or least form of transportation would have an adverse effect on the Covered Person, ambulance services will be covered.

Transportation, ambulance or a lesser form of medical transport, is covered in the following circumstances:

1. To the nearest Hospital equipped to treat the Illness or Injury in an emergency situation; or
2. To another Hospital in the area when the first Hospital did not have services required and/or facilities to treat the Covered Person; or
3. To and from a Hospital during a period of Hospital confinement to another facility for special services which are not available at the first Hospital; or
4. As to transportation from the Hospital to the patient's home or to a Skilled Nursing Facility, Rehabilitation Facility or any other type of convalescent facility nearest to the patient's home, the least form of medical transportation when there is documentation medical, ground transportation is required.

Professional ambulance charges for convenience are not covered. Eligible expenses will be payable as shown in the Medical Schedule of Benefits and are subject to the most cost-effective form of transport. Air and water ambulance transportation is subject to $25,000.00 maximum per occurrence and Pre-Certification.

Ambulatory Surgical Center: Services and supplies provided by an Ambulatory Surgical Center.

Anesthetics: Anesthetics and their professional administration. Administration of anesthetics must be rendered by a Physician (other than the operating Physician) or Certified Registered Nurse Anesthetist (C.R.N.A.) in connection with a covered procedure.

Attention Deficit Disorder: Diagnosis and assessment; psychological, psychiatric, and medication management (through the Prescription Drug Benefits of this Plan); speech therapy, occupational therapy, and physical therapy for Attention Deficit Disorder (ADD/ADHD). All treatments permitted under the Plan must be prescribed and provided by a Physician within the scope of their license. Eligible expenses, including frequency and duration, will be payable as shown in the Medical Schedule of Benefits for the nature of the prescribed treatment.

Autism: Diagnosis and assessment; psychological, psychiatric, and medication management (through the Prescription Drug Benefits of this Plan); speech therapy, occupational therapy, and physical therapy; or applied behavioral analysis therapy of autism and autistic spectrum disorders. All treatments permitted under the Plan must be prescribed and provided by a Physician within the scope of their license. Eligible expenses, including frequency and duration, will be payable as shown in the Medical Schedule of Benefits for the nature of the prescribed treatment.

Blood and Blood Derivatives: Blood, blood plasma or blood components not donated or replaced. For autologous blood donations, only administration and processing costs are covered.

Cardiac Rehabilitation: Cardiac rehabilitation services which are rendered: (a) under the supervision of a Physician; and (b) in connection with a myocardial infarction, coronary occlusion or coronary bypass Surgery or any other medical condition if medically appropriate; and (c) initiated within 12 weeks after other treatment for the medical condition ends; and (d) in a medical care facility.

Expenses in connection with Phase III cardiac rehabilitation, including to occupational therapy or work hardening programs will not be considered eligible. Phase III is defined as the general maintenance level of treatment, with no further medical improvements being made and exercise therapy that no longer requires the supervision of medical professionals. Eligible expenses will be payable as shown in the Medical Schedule of Benefits.

Chemotherapy: Services and supplies related to chemotherapy.

Chiropractic Care/Spinal Manipulation: Skeletal adjustments, manipulation or other treatment in connection with the correction by manual or mechanical means of structural imbalance or subluxation in the human body performed by a Physician, including x-rays. Eligible expenses will be payable as shown in the Medical Schedule of Benefits.

Circumcision: Services and supplies related to circumcision. Circumcision performed while Hospital confined following birth will be considered as a newborn expense.

Cleft Palate and Cleft Lip: Services and supplies related to cleft palate and cleft lip. Cleft palate is defined as a birth deformity in which the palate (the roof of the mouth) fails to close, and cleft lip is defined as a birth deformity in which the lip fails to close. Eligible expenses include the following when provided by a Physician, or other professional provider:

1. Oral and facial Surgery, surgical management and follow-up care by plastic surgeons and oral surgeons;
2. Habilitative speech therapy;
3. Otolaryngology treatment;
4. Audiological assessments and treatment;
5. Orthodontic treatment;
6. Prosthodontic treatment; and/or

7. Prosthetic treatment such as obturators, speech appliances and feeding appliances.

Cognitive Therapy: Cognitive therapy rendered by a qualified Physician associated with physical rehabilitation when the cognitive deficits have been acquired as a result of neurologic impairment due to trauma, stroke, or encephalopathy, and when the therapy is part of a treatment plan intended to restore previous cognitive function.

Consumed on Premises: Any covered Drug or medicine that is administered or consumed on the premises where it is dispensed, such as in a Physician's office, infusion center, other clinical setting, or the Covered Person's home by a third party, is covered under this Plan at the lesser of the Maximum Allowable Charge or the cost to the Plan pursuant to the Prescription Drug Benefit. Contact the Pharmacy Benefits Manager for Pre-Certification of applicable Drugs.

Contraceptives: Contraceptive procedures and medications are covered under this Plan, including: orals, patches, injections, diaphragms, intrauterine devices (IUD), implants, and any related office visit. Oral contraceptives are covered under the Prescription Drug Benefit Program only. The Plan does not cover contraceptive supplies or devices provided over-the-counter without a Physician's prescription.

Cosmetic Procedures/Reconstructive Surgery: Cosmetic procedures or Reconstructive Surgery will be considered eligible only under the following circumstances:

1. For the correction of a Congenital Anomaly for a minor Dependent Child.
2. Any other Medically Necessary Surgery related to an Illness or Injury.

Cosmetic procedures or Reconstructive Surgery must be for the purpose of restoring the Covered Person to his/her normal function immediately prior to the Illness or Injury.

As required by the Women's Health and Cancer Rights Act (WHCRA) of 1998, this Plan provides coverage for:

1. All stages of reconstruction of the breast on which the mastectomy has been performed;
2. Surgery and reconstruction of the other breast to produce a symmetrical appearance; and
3. Prostheses and physical complications of mastectomy, including lymphedemas, in a manner determined in consultation with the attending Physician and the patient.

Such coverage may be subject to annual deductibles and coinsurance provisions as may be deemed appropriate and are consistent with those established for other benefits under the Plan or coverage. Written notice of the availability of such coverage shall be delivered to the Covered Person upon enrollment and annually thereafter.

Contact the Plan Administrator for more information.

Diabetic Education: The following diabetic education and self-management programs: diabetes Outpatient self-management training and education, including medical nutrition therapy, that is provided by either GEMCARE Wellness accessible by calling 1-888-344-3434 or visiting the website www.myehcs.com/bywater, or by a certified, registered or licensed healthcare professional working in a program consistent with the national standards of diabetes self-management education as established by the American Diabetes Association. Coverage is provided for individuals with diabetes.

Diabetic Supplies: All Physician prescribed medically appropriate and necessary equipment and supplies used in the management and treatment of diabetes that are not available under the supplemental home delivery provided by

Edwards Health Care Services accessible by calling 1-888-344-3434 or visiting the website www.myehcs.com/bywater, or otherwise provided under the Prescription Drug Benefit Program.

Diagnostic Testing, X-ray and Laboratory Services: Diagnostic testing, x-ray and laboratory services, and services of a professional radiologist or pathologist. Dental x-rays are not eligible expenses, except as specified under Dental Care. Eligible expenses will be payable as shown in the Medical Schedule of Benefits.

Dialysis: The Plan covers Physician services, supplies, medications, labs, and facility fees related to Inpatient services, either in a Hospital or other facility, or Outpatient services at the Covered Person's home including the training of one attendant, which may be a family member, as well as the rental of Dialysis equipment and expendable medical supplies for use as shown under the Durable Medical Equipment benefit.

After 34 months, the Plan Sponsor requires a Covered Person who is eligible for Medicare to have Medicare in effect. If a Covered Person is eligible for Medicare coverage that is primary to the Plan, but has failed to enroll when first eligible, the Covered Person will be responsible for the full cost of medical services that Medicare would have covered. As the secondary coverage, the Plan will coordinate benefits up to 100% of the current Medicare allowed amount for Dialysis services.

Durable Medical Equipment: The rental of oxygen, wheelchairs, walkers, special Hospital beds, iron lungs and other Durable Medical Equipment subject to the following:

1. The equipment must be prescribed by a Physician and Medically Necessary; and
2. The equipment will be provided on a rental basis; however such equipment may be purchased, upon Plan approval, when it is less costly and more practical than a rental; and
3. Benefits will be limited to standard models as determined by the Plan; and
4. The Plan will pay benefits once per Covered Person's lifetime for only one of the following unless Medically Necessary due to growth of the Covered Person or if changes to the Covered Person's medical condition requires a different product, as determined by the Plan: a manual wheelchair, motorized wheelchair or motorized scooter; and
5. If the approved equipment is purchased, benefits will be payable for subsequent repairs, excluding batteries, necessary to restore the equipment to a serviceable condition. If such equipment cannot be restored to a serviceable condition, replacement will be considered eligible subject to prior approval by the Plan. In all cases, repairs or replacement due to abuse or misuse, as determined by the Plan, are not covered; and

Expenses for the rental or purchase of any type of air conditioner, air purifier, or any other device or appliance, except as provided under the Eligible Medical Expense section of the Plan, will not be considered eligible. Eligible expenses will be payable as shown in the Medical Schedule of Benefits.

Emergency Services: Eligible expenses will be payable as shown in the Medical Schedule of Benefits. Notwithstanding anything to the contrary, Emergency Services shall include emergency care incurred while traveling outside of the United States.

Gender Dysphoria: A collection of services used to treat Gender Dysphoria, as defined by the latest edition of Diagnostic and Statistical Manual of Mental Disorders, which are considered Medically Necessary. Such services may include hormone treatment and/or gender reassignment surgery, as well as counseling and psychiatric services. Gender reassignment surgery will be considered eligible only when the Covered Person provides the following documentation:

1. A written psychological assessment from at least one qualified behavioral health provider experienced in treating Gender Dysphoria is needed for breast surgery. The assessment must document that an individual meets all of the following criteria:
    a. Persistent, well-documented Gender Dysphoria;
    b. Capacity to make a fully informed decision and to consent for treatment;
    c. Must be at least 18 years of age (age of majority);
    d. If significant medical or mental health concerns are present, they must be reasonably well controlled.
2. A written psychological assessment from at least two qualified behavioral health providers experienced in treating Gender Dysphoria, who have independently assessed the individual, are required for genital surgery. The assessment must document that an individual meets all of the following criteria:
    a. Persistent, well-documented Gender Dysphoria;
    b. Capacity to make a fully informed decision and to consent for treatment;
    c. Must be at least 18 years of age (age of majority);
    d. If significant medical or mental health concerns are present, they must be reasonably well controlled;
    e. Complete at least 12 months of successful continuous full-time real-life experience in the desired gender;
    f. Complete 12 months of continuous cross-sex hormone therapy appropriate for the desired gender (unless medically contraindicated).
3. Treatment plan that includes ongoing follow-up and care by a qualified behavioral health provider experienced in treating Gender Dysphoria.

When the above criteria are met, the following gender reassignment surgical procedures will be covered:

1. Male to Female:
    a. Clitoroplasty (creation of clitoris);
    b. Labiaplasty (creation of labia);
    c. Orchiectomy (removal of testicles);
    d. Penectomy (removal of penis);
    e. Urethroplasty (reconstruction of female urethra);
    f. Vaginoplasty (creation of vagina).
2. Female to Male:
    a. Bilateral mastectomy or breast reduction*;
    b. Hysterectomy (removal of uterus);
    c. Metoidioplasty (creation of penis, using clitoris);
    d. Penile prosthesis;
    e. Phalloplasty (creation of penis);
    f. Salpingo-oophorectomy (removal of fallopian tubes and ovaries);
    g. Scrotoplasty (creation of scrotum);
    h. Testicular prostheses;
    i. Urethroplasty (reconstruction of male urethra);
    j. Vaginectomy (removal of vagina);
    k. Vulvectomy (removal of vulva).

*Bilateral mastectomy or breast reduction may be done as a stand-alone procedure, without having genital reconstruction procedures. In those cases, the individual does not need to complete hormone therapy prior to procedure.

Pre-Certification is required for gender reassignment surgery.

Genetic Testing: Diagnostic testing of Genetic Information and counseling when Medically Necessary to establish a molecular diagnosis of an inheritable Disease when:

1. The Covered Person displays clinical features, or is at direct risk of inheriting the mutation in question (pre-symptomatic); and
2. The result of the test will directly impact the treatment being delivered.

Genetic Testing is covered in addition to and to the extent it is not otherwise included for coverage under the preventive services section of the Plan.

Hearing Examination, Hearing Aids and Related Supplies: Hearing examinations, hearing aids (including the fitting thereof), and related supplies. Hearing exams must be rendered by a:

1. Physician certified as an Otolaryngologist or Otologist; or
2. An audiologist who:
    a. Is legally qualified in audiology; or
    b. Holds a certificate of Clinical Competence in Audiology from the American Speech and Hearing Association (in the absence of any applicable licensing requirements); and
    c. Performs the exam at the written discretion of a licensed Otolaryngologist.

Eligible expenses will be payable as shown in the Medical Schedule of Benefits.

Home Health Care: Services provided by a Home Health Care Agency to a Covered Person in the home. The following are considered eligible home health care services if Medically Necessary to be performed at home:

1. Licensed practical nurse (L.P.N.) or registered nurse (R. N.);
2. Certified home health aides under the direct supervision of a R.N.;
3. Registered therapist performing physical, occupational or speech therapy;
4. Physician calls in the office, home, clinic, or Outpatient department;
5. Services, Drugs, and medical supplies which are Medically Necessary for the treatment of the Covered Person that would have been provided in the Hospital, but not including Custodial Care; and
6. Rental of Durable Medical Equipment or the purchase of this equipment if economically justified, whichever is less.

For the purpose of determining the benefits for home health care available to a Covered Person, each visit by a member of a Home Health Care Agency shall be considered as one home health care visit and each period of up to 4 hours in a 24 hour period of home health aide services shall be considered as one home health care visit. This maximum will not apply to care given by a registered nurse (R. N.) or licensed practical nurse (L.P.N.) when:

1. Care is provided within ten (10) days of discharge from a Hospital or Skilled Nursing Facility as a full-time Inpatient; and
2. Care is needed to transition from the Hospital or Skilled Nursing Facility to home care.

When the above criteria are met, Covered Expenses include up to 12 hours of continuous care in a 24 hour period by a registered nurse (R. N.) or licensed practical nurse (L.P.N.) per day.

Eligible expenses will be payable at the lesser of the cost through the Home Health Care Provider and the Maximum Allowable Charge of the services at an Institution as shown in the Medical Schedule of Benefits.

Hospice Care: Hospice Care on either an Inpatient or Outpatient basis for a terminally ill person rendered under a Hospice treatment plan is covered for 180 days. Charges relating to Hospice Care for a Covered Person who has a life expectancy of six months or less are covered Hospice expenses, limited to:

1. Room and Board for confinement in a Hospice.
2. Ancillary services furnished by the Hospice while the patient is confined therein, not customarily included in Room and Board, including rental of Durable Medical Equipment which is used solely for treating an Injury or Illness.
3. Medical supplies, Drugs and medicines prescribed by the attending Physician, but only to the extent such items are necessary for pain control and management of the terminal condition.
4. Physician services and nursing care by a Registered Nurse, Licensed Practical Nurse or a Licensed Vocational Nurse (L.V.N.).
5. Home health aide services.
6. Home care furnished by a Hospital or Home Health Care Agency, under the direction of a Hospice, including Custodial Care if it is provided during a regular visit by a Registered Nurse, a Licensed Practical Nurse or a home health aide.
7. Medical social services by licensed or trained social workers, Psychologists or counselors.
8. Nutrition services provided by a licensed dietitian.
9. Bereavement counseling, which is a supportive service provided by the Hospice team to Covered Person's Family Unit who are Covered Persons after the death of the terminally ill person, to assist the Family Unit in adjusting to the death. Benefits will be payable up to two (2) visits per Family Unit of Covered Persons if the following requirements are met:
    a. On the date immediately before his or her death, the terminally ill person was in a Hospice Care Program and a Covered Person under the Plan.
    b. Charges for such services are Incurred by the Covered Persons within six months of the terminally ill person's death.

The Hospice Care program must be renewed in writing by the attending Physician every thirty (30) days after the initial 180 days. Hospice Care ceases if the terminal Illness enters remission.

Hospital Services: Charges made by a Hospital for:

1. Inpatient
    a. Room and board, including all regular daily services in a Hospital; care provided in an Intensive Care Unit (including cardiac care (CCU) and burn units); and

b. Miscellaneous services and supplies, including any additional Medically Necessary nursing services furnished while being treated on an Inpatient basis;

2. Outpatient
    a. Services and supplies furnished while being treated on an Outpatient basis.

Eligible expenses will be payable as shown in the Medical Schedule of Benefits.

Infusion Therapy: Services, supplies and equipment necessary for infusion therapy provided:

1. By a free-standing facility;
2. By an Outpatient department of a Hospital;
3. By a Physician in his/her office; or
4. In your home.

Infusion therapy is the intravenous or continuous administration of medications or solutions that are a part of your course of treatment. Charges for the following Outpatient infusion therapy services and supplies, not including the Drugs, are Covered Expenses at the lesser of the negotiated medical or Prescription Drug cost:

1. The pharmaceutical when administered in connection with infusion therapy and any medical supplies, equipment and nursing services required to support the infusion therapy;
2. Professional services;
3. Total parenteral nutrition (TPN);
4. Chemotherapy;
5. Drug therapy (includes antibiotic and antivirals);
6. Pain management (narcotics); and
7. Hydration therapy (includes fluids, electrolytes and other additives).

Eligible Drug expenses will be payable as shown in the Prescription Drug Schedule. Benefits payable for infusion therapy will not count toward any applicable home health care maximum.

Injury to Mouth, Teeth, and Gums: Dental services and x-rays rendered by Dentist or dental surgeon for:

1. Excision of tumors and cysts of the jaws, cheeks, lips, tongue, roof and floor of the mouth;
2. Emergency repair due to Injury to sound natural teeth within one year of the event resulting in the Injury, including the replacement of sound natural teeth. If crowns, dentures, bridges or in-mouth appliances are installed due to Injury, Covered Expenses only include charges for:
    a. The first denture or fixed bridgework to replace lost teeth;
    b. The first crown needed to repair each damaged tooth; and
    c. An in-mouth appliance used in the first course of orthodontic treatment after the Injury.
3. Surgery needed to correct Injuries to the jaws, cheeks, lips, tongue, floor and roof of the mouth;
4. Excision of benign bony growths of the jaw and hard palate;
5. External incision and drainage of cellulitis;
6. Incision of sensory sinuses, salivary glands or ducts;
7. Alter the jaw, jaw joints, or bite relationships by a cutting procedure when appliance therapy alone cannot result in functional improvement; and/or

8. Removal of impacted teeth.

General anesthesia and Hospital expenses are covered for eligible dental care services that would require the service be performed in a Hospital to monitor the patient due to a serious underlying medical condition, such as heart condition, blood disorder, etc. or are necessary due to Injury to sound natural teeth.

Lenses: Initial pair of eyeglasses, contact lenses or an intraocular lens following a Medically Necessary Surgical Procedure to the eye or for aphakic patients. Soft lenses or sclera shells intended for use as corneal bandages.

Maternity: Expenses Incurred by all Covered Persons at a Hospital or Birthing Center for:

1. Pregnancy;
2. Preventive prenatal and breastfeeding support as identified under the preventive services section below;
3. Amniocentesis testing when Medically Necessary;
4. Up to 2 ultrasounds per pregnancy (more than 2 only when it is determined to be Medically Necessary);

Under the Newborns' and Mothers' Health Protection Act of 1996, Hospital stays in connection with childbirth for either the mother or newborn may not be limited to less than 48 hours following a vaginal delivery or 96 hours following a cesarean section. These requirements can only be waived by the attending Physician in consultation with the mother. The Covered Person or Provider is not required to Pre-Certify the maternity admission, unless the stay extends past the applicable 48 or 96 hour stay. A Hospital stay begins at the time of delivery or for deliveries outside the Hospital, the time the newborn or mother is admitted to a Hospital following birth, in connection with childbirth. Stays, for the mother and/or newborn, that exceed the 48 hours (or 96 hours as applicable) will require Pre-Certification authorization or a penalty may be applied.

Expenses of a Dependent Child for Pregnancy and the related birth of a newborn are not covered, except as required as preventive services under the ACA. A newborn Child of a Dependent Child is not eligible for this Plan unless the newborn Child meets the definition of an eligible Dependent.

Medical and Surgical Supplies: Casts, splints, braces, crutches, ostomy supplies, urinary catheters and external urinary collection devices, orthotics (excluding foot orthotics), dressings and other Medically Necessary supplies ordered by a Physician.

Mental or Nervous Disorders:

Subject to the limitations contained in the Summary of Benefits and applicable Exclusions, the Plan will pay Covered Expenses for:

1. Inpatient Benefits. These benefits are also available when receiving treatment during the day only or during the night only at a day/night Psychiatric Hospital and/or Rehabilitation Hospital:
    a. Semi-private Hospital Room and Board.
    b. Miscellaneous facility charges on days a Room and Board charge is covered.
    c. Individual psychotherapy.
    d. Group psychotherapy.
    e. Psychological testing.
    f. Family counseling of Covered Persons only.

g. Convulsive therapy treatment.

2. Outpatient Benefits:
    a. Individual psychotherapy.
    b. Group psychotherapy.
    c. Psychological testing.
    d. Family counseling of Covered Persons only.
    e. Convulsive therapy treatment.
    f. Prescription Drugs or medicines for the treatment of mental Illness.

Morbid Obesity - Non-Surgical Medical Treatment: Non-surgical care and treatment, including charges rendered by a Hospital, Physician, licensed or certified dietician, or nutritional counseling up to six (6) visits per Benefit Year, as required to provide appropriate guidance and education for diet related conditions or risk factors, including diabetes, obesity, high cholesterol and high blood pressure. This does not include any form of food supplement, exercise program, exercise equipment, weight control program, injection of any fluid, use of medications or educational program, if not otherwise covered. Eligible services provided are treated the same as other eligible Physician services as listed in the Schedule of Benefits.

Newborn Care: Hospital and Physician nursery care for newborns who are the Child of the Employee or Spouse and properly enrolled in the Plan, as set forth below. Benefits will be provided under the Employee or Spouse's coverage for:

1. Hospital routine care for a newborn during the Child's initial Hospital confinement at birth.
2. The following Physician services for well-baby care during the newborn's initial Hospital confinement at birth:
    a. The initial newborn examination and a second examination performed prior to discharge from the Hospital.
    b. Circumcision.

NOTE: *The Plan will cover Hospital and Physician nursery care for Illness or* as *any other condition of a newborn Child, provided the Child is properly enrolled in the Plan. These benefits are provided under the Child's coverage.*

Nutritional Supplements: Physician-prescribed nutritional supplements or other enteral supplementation necessary to sustain life or for Covered Persons who are or will become malnourished or suffer from disorders, which left untreated will cause chronic disability or intellectual disability. Covered Expenses include rental or purchase of equipment used to administer nutritional supplements or other enteral supplementation for treatment of inherited metabolic diseases, such as phenylketonuria (PKU), branched-chain ketonuria, galactosemia and homocystinuria when prescribed by a Physician.

Over-the-counter nutritional supplements or infant formulas will not be considered eligible even if prescribed by a Physician.

Occupational Therapy: Rehabilitative occupational therapy rendered by a qualified Physician or a licensed occupational therapist under the recommendation of a Physician. Expenses for Maintenance Therapy or therapy primarily for recreational or social interaction will not be considered eligible. Eligible expenses will be payable as shown in the Medical Schedule of Benefits.

Off-Label Drug Use: Services and supplies related to Off-Label Drug Use (the use of a Drug for a purpose other than that for which it was approved by the FDA) will be eligible for coverage when all of the following criteria have been satisfied:

1. The named Drug is not specifically excluded under the General Exclusions and Limitations section of the Plan; and
2. The named Drug has been approved by the FDA; and
3. The Off-Label Drug Use is appropriate and clinically supported by the medical community for the condition being treated; and
4. If the Drug is used for the treatment of cancer, The American Hospital Formulary Service Drug Information or NCCN Drugs and Biologics Compendium recognize it as an appropriate treatment for that form of cancer and has not been disapproved by either.

Outpatient Pre-Admission Testing: Outpatient pre-admission testing performed within 14 days of a scheduled Inpatient hospitalization or Surgery.

Physical Therapy: Physical therapy rendered by a qualified Physician or a licensed physical therapist under the recommendation of a Physician. Maintenance Therapy will not be considered eligible. Eligible expenses will be payable as shown in the Medical Schedule of Benefits.

Physician's Services: Services of a Physician for medical care or Surgery.

1. Services performed in a Physician's office on the same day for the same or related diagnosis. Services include, but are not limited to: examinations, supplies, injections, allergy shots, x-ray and laboratory tests (including the reading or processing of the tests), cast application and minor Surgery. For Network Physicians, if more than one Physician is seen in the same clinic on the same day, only one Copay will apply.
2. For multiple or bilateral Surgeries performed during the same operative session which are not incidental or not part of some other procedure and which add significant time or complexity (all as determined by the Plan) to the complete procedure, the Maximum Allowable Charge considered will be:
    a. 100% for the primary procedure;
    b. 50% for the secondary procedure, including any bilateral procedure; and
    c. 50% for each additional covered procedure. This applies to all Surgical Procedures, except as determined by the Plan.
3. For surgical assistance by an Assistant Surgeon, the Maximum Allowable Charge will be the lesser of the contract rate or 25% of the Primary Surgeon's Maximum Allowable Charge for the corresponding Surgery.

Eligible expenses will be payable as shown in the Medical Schedule of Benefits.

Podiatry: Treatment for the following foot conditions: (a) bunions, when an open cutting operation is performed; (b) non-routine treatment of corns or calluses; (c) toenails when at least part of the nail root is removed; (d) Medically Necessary Surgical Procedures required for a foot condition. In addition, when an integral part of a leg brace, orthopedic shoes will also be covered.

Preventive Services and Routine Care: The following preventive services and routine care are paid as shown in the Medical Schedule of Benefits:

1. **Preventive Services**

a. Evidence-Based Preventive Services. In compliance with section 2713 of the Affordable Care Act, benefits are available for evidence-based items or services that have in effect a rating of "A" or "B" in the current recommendations of the United States Preventive Services Task Force (USPSTF).
b. Routine Vaccines. Immunizations that have in effect a recommendation from the Advisory Committee on Immunization Practices (ACIP) of the Centers for Disease Control and Prevention (CDC) with respect to the individual involved.
c. Prevention for Children. With respect to infants, children and adolescents, evidence-informed preventive care and screenings provided for in the comprehensive guidelines supported by the Health Resources and Services Administration (HRSA).
d. Prevention for Women. With respect to women, such additional preventive care and screenings, as provided for in comprehensive guidelines supported by the Health Resources and Services Administration (HRSA) not otherwise addressed by the recommendations of the United States Preventive Service Task Force (USPSTF), which will be commonly known as HRSA's Women's Preventive Services Required Health Plan Coverage Guidelines.
    i. For a detailed listing of women's preventive services, please visit the U.S. Department of Health and Human Services website at: https://www.hrsa.gov/womens-guidelines/index.html or at https://healthcare.gov/coverage/preventive-care-benefits/. For a paper copy, please contact the Plan Sponsor. To the extent the above does not cover any preventive service required to be covered under the guidelines published by the Health Resources and Services Administration on August 1, 2011 (or any applicable subsequent guidelines or guidance requiring any additional women's preventive services), the above shall be deemed to be amended to cover such preventive services to the extent required by such guidelines.
e. Preventive Drugs means items which have been identified by the U.S. Department of Health and Human Services (HHS) as a preventive service. You may view the guidelines established by HHS by visiting the following website: https://www.healthcare.gov/what-are-my-preventive-care-benefits. For a paper copy, please contact the Plan Sponsor.
f. For a detailed listing of preventive services, please visit the U.S. Department of Health and Human Services website at: https://www.healthcare.gov/what-are-my-preventive-care-benefits. For a paper copy, please contact the Plan Sponsor. To the extent the above does not cover any preventive service required to be covered by the U.S. Department of Health and Human Services (HHS) the above shall be deemed to be amended to cover such preventive service to the extent required by the HHS.

2. **Routine Care**. Routine care including the office visit, lab tests, x-rays, routine testing, vaccinations or immunizations as described above which includes flu vaccines, well child care, pap smears, mammograms, colon exams and PSA testing. If a Diagnosis is indicated after a routine exam, the exam will still be payable under the routine care benefit, however, all charges related to the Diagnosis (except the initial exam) will be payable as any other Illness.

The above routine care items are covered in addition to and to the extent they are not otherwise included for coverage under the Preventive Services section of the Plan. All Eligible expenses for Preventative and Routine Care will be payable as shown in the Medical Schedule of Benefits.

Private Duty Nursing: 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 for Outpatient nursing care. Charges are covered only when care is Medically Necessary and not Custodial in nature. Charges covered for Outpatient nursing care billed by a Home Health Care Agency are shown under

Home Health Care Services and Supplies. Outpatient private duty nursing care not billed by a Home Health Care Agency must be supported by a certification and a treatment plan from the attending Physician.

Eligible expenses will be payable as shown in the Medical Schedule of Benefits.

Prosthetic Devices: Artificial limbs, eyes, or other prosthetic devices when necessary due to an Illness or Injury, including a speech generating device, an external breast prosthesis, and the first bra made solely for use with it after a mastectomy. This benefit also includes instruction and incidental supplies needed to use a prosthetic device and any necessary repairs to restore the prosthesis to a serviceable condition. If such prosthesis cannot be restored to a serviceable condition, replacement will be considered eligible, subject to prior approval by the Plan. In all cases, repairs or replacement due to abuse or misuse, as determined by the Plan, are not covered. Eligible expenses will be payable as shown in the Medical Schedule of Benefits.

Pulmonary Therapy: Pulmonary therapy under the recommendation of a Physician. Eligible expenses will be payable as shown in the Medical Schedule of Benefits.

Qualified Clinical Trial Expenses: Expenses for any Medically Necessary services, for which benefits are provided by the Plan, when a Covered Person is participating in a phase I, II, lll or IV clinical trial, conducted in relation to the prevention, detection or treatment of a life-threatening Disease or condition, as defined under the ACA, provided:

1. The clinical trial is approved by any of the following:
    a. The Centers for Disease Control and Prevention of the U.S. Department of Health and Human Services.
    b. The National Institute of Health.
    c. The U.S. Food and Drug Administration.
    d. The U.S. Department of Defense.
    e. The U.S. Department of Veterans Affairs.
    f. An institutional review board of an institution that has an agreement with the Office for Human Research Protections of the U.S. Department of Health and Human Services.
2. The research institution conducting the Qualified Clinical Trial and each health professional providing routine patient care through the institution, agree to accept reimbursement at the applicable Allowable Expense, as payment in full for routine patient care provided in connection with the Qualified Clinical Trial.

Coverage will not be provided for:

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

Expenses that are healthcare items and services for the treatment of cancer or any other life threatening condition for a qualifying individual enrolled in a Qualified Clinical Trial that are otherwise consistent with the terms of the Plan and would be covered if the Covered Person did not participate in the Qualified Clinical Trial.

For purposes of this section, any Covered Person who is eligible to participate in a Qualified Clinical Trial according to the trial protocol for treatment of cancer or any other life threatening condition that makes his or her participation in the program appropriate, as determined based on either (i) a conclusion of a referring health care professional or (ii) medical and scientific information provided by the Covered Person.

Radiation Therapy: Radium and radioactive isotope therapy treatment.

Reconstructive Surgery: See Cosmetic Procedures/Reconstructive Surgery.

Rehabilitation Facility: Inpatient care in a Rehabilitation Facility provided such confinement is:

1. Under the recommendation and general supervision of a Physician;
2. For the purpose of receiving medical care necessary for convalescence from the conditions causing or contributing to the precedent Hospital or Skilled Nursing Facility confinement; and
3. Not for Custodial Care.

See the Skilled Nursing Facility benefit for services and supplies provided for confinements in a Skilled Nursing Facility. Eligible expenses will be payable as shown in the Medical Schedule of Benefits.

Second Surgical Opinion: Voluntary second surgical opinions for elective, non-emergency Surgery when recommended.

Benefits for the second opinion will be payable only if the opinion is given by a specialist who:

1. Is certified in the field related to the proposed Surgery; and
2. Is not affiliated in any way with the Physician recommending the Surgery.

If the second opinion conflicts with the first opinion, the Covered Person may obtain a third opinion, although this is not required.

Skilled Nursing Facility: Skilled nursing care in a Skilled Nursing Facility or a convalescent care facility, provided such confinement is:

1. Under the recommendation and general supervision of a Physician;
2. For the purpose of receiving medical care necessary for convalescence from the conditions, Illness, or Injury (excluding drug addiction, chronic brain syndrome, alcoholism, senility, mental retardation or other Mental or Nervous Disorders) causing or contributing to the precedent Hospital or Rehabilitation Facility confinement; and
3. Not for Custodial Care.

See the Rehabilitation Facility benefit for services and supplies provided for confinements in a Rehabilitation Facility. Eligible expenses will be payable as shown in the Medical Schedule of Benefits.

Sleep Disorders: Sleep disorder treatment that is Medically Necessary.

Speech Therapy: Restorative or rehabilitative speech therapy rendered by a qualified Physician or a licensed speech therapist under the recommendation of a Physician, necessary because of loss or impairment due to an Illness, Injury, or Surgery, or therapy to correct a Congenital Anomaly. Eligible expenses will be payable as shown in the Medical Schedule of Benefits.

Substance Abuse and/or Substance Use Disorder: Subject to the limitations contained in the Summary of Benefits and applicable Exclusions, the Plan will pay Covered Expenses for:

1. Inpatient Benefits. These benefits are also available when receiving treatment during the day only or during the night only at a day/night Substance Abuse Treatment Center and/or Rehabilitation Hospital:
    a. Semi-private Hospital Room and Board.
    b. Miscellaneous facility charges on days a Room and Board charge is covered.
    c. Individual psychotherapy.
    d. Group psychotherapy.
    e. Psychological testing.
    f. Family counseling for Covered Persons only.
    g. Convulsive therapy treatment.
2. Outpatient Benefits:
    a. Individual psychotherapy.
    b. Group psychotherapy.
    c. Psychological testing.
    d. Family counseling for Covered Persons only.
    e. Convulsive therapy treatment.
    f. Prescription Drugs or medicines for the treatment of chemical dependency.

Transplants:

Services and supplies in connection with Medically Necessary non-Experimental and/or non-Investigational transplant procedures. A second opinion is required.

1. If both the donor and the recipient are covered under this Plan, eligible expenses Incurred by each person will be treated separately for each person.
2. If the recipient is covered under this Plan and the donor is not covered, eligible expenses Incurred by the donor will be considered eligible if not covered by the donor's plan up to $10,000.
3. If the donor is covered under this Plan and the recipient is not covered, eligible expenses Incurred by the donor will not be covered.

Eligible expenses will be payable as shown in the Medical Schedule of Benefits.

Exclusions from eligible transplant expenses:

1. The fee of securing an organ from the designated live donor, a cadaver or tissue bank, including the surgeon's fees, anesthesiology, radiology and pathology fees for the removal of the organ and a Hospital's charge for storage or transportation of the organ is not covered.
2. Non-human and artificial organ transplants.
3. The purchase price of bone marrow, any organ, tissue or any similar items which are sold rather than donated.
4. Transplants which are not medically recognized and are Experimental and/or Investigational in nature.

5. Lodging expenses, including meals.
6. Expenses related to travel.

Urgent Care Facility: Services and supplies provided by an Urgent Care Facility. Eligible expenses will be payable as shown in the Medical Schedule of Benefits.

Wigs: Wigs after chemotherapy are limited to two (2) wigs per lifetime.

CENTERS OF EXCELLENCE

LifeSource Transplant Network

All Covered Persons have access to LifeSource Transplant Network, which provides a national network of over 800 credentialed transplant programs for organ or bone marrow/stem cell transplants. These programs have met or exceeded the national standards for performance and quality, and each has been classified as a Program of Excellence. Additional benefits include:

- An assigned transplant case manager who will provide guidance before, during and after the transplant
- Access to over 165 in-network facilities which have transplant programs credentialed as a Program of Excellence
- Covered travel benefits including transportation and lodging for the transplant recipient and a companion or caregiver

A Covered Person that has been identified as a potential transplant recipient will be sent an introductory letter and other information from an assigned Cigna LifeSOURCE transplant case manager. A Covered Person can also contact 800-668-9682 to initiate services. Additional information can be found at https://cignalifesource.com/transplant-network/index.html

ALTERNATE BENEFITS

In addition to the benefits specified, the Plan may elect to offer benefits for services furnished by any Provider pursuant to a Plan-approved alternate treatment plan, in which case those charges Incurred for services provided to a Covered Person under an alternate treatment plan to its end, will be more cost effective than those charges to be Incurred for services to be provided under the current treatment plan to its end.

The Plan shall provide such alternate benefits at its sole discretion and only when and for so long as it determines that alternate treatment plan is Medically Necessary and cost effective. If the Plan elects to provide alternate treatment plan benefits for a Covered Person in one instance, it shall not be obligated to provide the same or similar benefits for such Covered Person in any other instance or for other Covered Persons under this Plan in any other instance, nor shall it be construed as a waiver of the Plan Sponsor's rights to administer this Plan thereafter in strict accordance with its express terms.

GENERAL EXCLUSIONS AND LIMITATIONS

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.

Abortion: Abortions, other than for the purposes of addressing complications related to spontaneous miscarriage, to prevent the death of the woman, when pregnancy resulted from a rape reported to the proper law enforcement authorities, or when pregnancy resulted from incest committed against a minor and the perpetrator has been reported to the proper law enforcement authorities, are excluded from coverage.

Allergy Services: The following allergy services and supplies are not covered:

1. Specific non-standard allergy services and supplies, including: skin titration (Rinkle method); cytotoxicity testing (Bryan's test); treatment of non-specific candida sensitivity; and urine autoinjections.
2. Non-Physician allergy services or associated expenses relating to an allergic condition including installation of air filters, air purifiers, or air ventilation system cleaning.
3. Non-prescription allergy medications.
4. Prescription strength non-sedating antihistamines.

Administrative Services: Expenses for completion of claim forms and shipping and handling will not be considered eligible.

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

After Termination Date: Expenses which are Incurred after the termination date of your coverage under the Plan will not be considered eligible.

Alternative Therapies: Expenses for the following non-exhaustive list of therapies will not be considered eligible:

1. Aromatherapy;
2. Carbon dioxide therapy;
3. Computer-aided tomography (CAT) scanning of the entire body;
4. Gastric irrigation;
5. Hair analysis;
6. Hyperbaric therapy, except for the treatment of decompression or to promote healing of wounds;
7. Lovaas therapy;
8. Megavitamin therapy;
9. Primal therapy;
10. Psychodrama;
11. Purging;
12. Sensory or auditory integration therapy;
13. Sleep therapy; or
14. Thermograms and thermography.

Biofeedback: Expenses related to biofeedback and bioenergetic will not be considered eligible.

Cardiac Rehabilitation: Expenses in connection with Phase III cardiac rehabilitation, including occupational therapy or work hardening programs will not be considered eligible. Phase III is defined as the general maintenance level of treatment, with no further medical improvements being made and exercise therapy that no longer requires the supervision of medical professionals.

Chelation Therapy: Expenses for chelation therapy will not be considered eligible, unless due to heavy metal poisoning.

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.

Complications: Expenses for care, services or treatment required as a result of complications from a treatment or procedure which is not covered under the Plan will not be considered eligible, unless otherwise stated in the Plan.

Convenience Items: Expenses for personal hygiene and convenience items will not be considered eligible, including telephone, television, internet, barber or beauty service or other guest services; housekeeping, cooking, cleaning, shopping, monitoring, security or other home services; and travel, transportation, or living expenses, rest cures, recreational, or diversional therapy.

Cosmetic Procedures: Expenses for Cosmetic and reconstructive procedures will not be considered eligible, except as specified under the section entitled Eligible Medical Expenses, including the following cosmetic procedures whether or not for psychological or emotional reasons:

1. Face lifts, body lifts, tummy tucks, liposuctions, removal of excess skin, removal or reduction of non- malignant moles, blemishes, varicose veins, Cosmetic eyelid surgery and other surgical procedures;
2. Procedures to remove healthy cartilage or bone from the nose (even if the Surgery may enhance breathing) or other part of the body;
3. Chemical peels, dermabrasion, laser or light treatments, bleaching, creams, ointments or other treatments or supplies to alter the appearance or texture of the skin;
4. Insertion or removal of any implant that alters the appearance of the body (such as breast or chin implants);
5. Removal of tattoos (except for tattoos applied to assist in covered medical treatments, such as markers for radiation therapy);
6. Repair of piercings and other voluntary body modifications, including removal of injected or implanted substances or devices;
7. Surgery to correct gynecomastia;
8. Breast augmentation; and
9. Otoplasty.

Counseling: Expenses for religious, marital, bereavement, pastoral, career, financial or relationship counseling will not be considered eligible, except as specified under the section entitled Eligible Medical Expenses.

Court-Ordered: Testing and/or treatment ordered by a court or agreed to through a plea bargain, including those required as a condition of parole or release, will not be considered eligible.

Custodial Care: Expenses for Custodial Care will not be considered eligible, except as specified under the Home Health Care and Hospice Care benefits. This includes, but is not limited to the services of a Close Relative, transportation services, housekeeping services and meals, funeral arrangements, financial or legal counseling, etc.

Dental Care: Expenses Incurred in connection with dental care, treatment, x-rays, general anesthesia or Hospital expenses will not be considered eligible under the Medical Plan, except as specified under Eligible Medical Expenses. If Dental coverage is offered, see the Dental Plan for coverage and exclusions.

Developmental Delays: Expenses in connection with the treatment of developmental delays, including 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 Eligible Medical Expense section of the Plan.

Exercise Programs: Expenses for an education or training program when such services are related to the education or training program, whether performed by a Physician or other Provider, except as specifically provided herein, are not Eligible Medical Expenses.

Excess Charges: The part of an expense for the care and treatment of an Illness or Injury that is excess of the Maximum Allowable Charge.

Experimental and/or Investigational: Expenses for treatment, procedures, devices, drugs or medicines which are determined to be Experimental and/or Investigational will not be considered eligible.

Foot Care: Expenses for routine foot care, treatment of weak, unstable or flat feet will not be considered eligible, unless for metabolic or peripheral vascular disease or for foot care to minimize the risk of infection caused by diabetes.

Foot Orthotics: Expenses for foot only orthotics, orthopedic shoes (except those that are an integral part of a leg brace or treatment/prevention of complications of diabetes), arch supports or for the exam, prescription or fitting thereof will not be considered eligible.

Gambling Addiction: Expenses for services related to gambling addiction will not be considered eligible.

Gender Dysphoria: No coverage is provided for the reversal of sex assignment surgery. Certain procedures are considered cosmetic and are not deemed Medically Necessary by the Plan as part of a Gender Dysphoria diagnosis requiring sex assignment surgery, including the following:

1. Abdominoplasty;
2. Blepharoplasty;
3. Body contouring (e.g., fat transfer, lipoplasty, panniculectomy);
4. Breast enlargement, including augmentation mammaplasty and breast implants;
5. Brow lift;
6. Calf implants;
7. Cheek, chin and nose implants;
8. Face/forehead lift and/or neck tightening;
9. Facial bone remodeling for facial feminization and facial implants;
10. Hair removal (e.g., electrolysis or laser);
11. Hair transplantation;
12. Injection of fillers, neurotoxins, or botulinum toxin;

13. Lip augmentation;
14. Lip reduction;
15. Liposuction (suction-assisted lipectomy);
16. Mastopexy;
17. Pectoral implants for chest masculinization;
18. Rhinoplasty;
19. Skin resurfacing (e.g., dermabrasion, chemical peels, laser);
20. Removal of redundant skin;
21. Thyroid cartilage reduction/reduction thyroid chondroplasty/trachea shave (removal or reduction of the Adam's apple);
22. Osteoplasty;
23. Fertility preservation, reproduction services, or cryopreservation;
24. Voice modification surgery (e.g., laryngoplasty, glottoplasty or shortening of the vocal cords);
25. Voice lessons and voice therapy;
26. Other aesthetic or cosmetic procedures not listed.

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).

Growth/Height: Expenses for any treatment, device, drug, service or supply (including Surgical Procedures, devices to stimulate growth and growth hormones), solely to increase or decrease height or alter the rate of growth will not be considered eligible, except as specified under the Prescription Drug Benefit Program.

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

Hazardous Pursuit, Hobby or Activity: An Injury, Illness, or Disease that results from engaging in a hazardous pursuit, hobby or activity. A pursuit, hobby or activity is hazardous if it involves or exposes an individual to risk of a degree or nature not customarily undertaken in the course of the Participant's customary occupation or if it involves leisure time activities commonly considered as involving unusual or exceptional risks, characterized by a constant threat of danger or risk of bodily harm including: hang gliding; skydiving; bungee jumping; parasailing; use of all-terrain vehicles; rock climbing; use of explosives; racing an automobile, motorcycle, aircraft, or speed boat; reckless operation of a vehicle or other machinery; travel to countries with advisory warnings; and other activities reasonably deemed hazardous in the Plan Administrator's sole discretion.

Home and Mobility: Expenses for any addition or alteration to a home, workplace or other environment, or vehicle and any related equipment or device, such as:

1. Purchase or rental of exercise equipment, air purifiers, central or unit air conditioners, water purifiers, waterbeds, and swimming pools;
2. Exercise and training devices, whirlpools, portable whirlpool pumps, sauna baths, or massage devices;
3. Equipment or supplies to aid sleeping or sitting, including non-hospital electric and air beds, water beds, pillows, sheets, blankets, warming or cooling devices, bed tables and reclining chairs;

4. Equipment installed in your home, workplace or other environment, including stair-glides, elevators, wheelchair ramps, or equipment to alter air quality, humidity or temperature;
5. Other additions or alterations to your home, workplace or other environment, including room additions, changes in cabinets, countertops, doorways, lighting, wiring, furniture, communication aids, wireless alert systems, or home monitoring;
6. Services and supplies furnished mainly to provide a surrounding free from exposure that can worsen your Illness or Injury;
7. Removal from your home, worksite or other environment of carpeting, hypo-allergenic pillows, mattresses, paint, mold, asbestos, fiberglass, dust, pet dander, pests or other potential sources of allergies or Illness; and
8. Transportation devices not considered durable medical equipment, including stair-climbing wheelchairs, personal transporters, bicycles, automobiles, vans or trucks, or alterations to any vehicle or transportation device.

Home Births: Expenses for any services and supplies related to births occurring in the home or in a place not licensed to perform deliveries will not be considered eligible, unless approved by the Plan Administrator as less costly to the Plan.

Homeopathic Treatment: Expenses for naturopathic and homeopathic treatments, services and supplies will not be considered eligible, unless approved by the Plan Administrator as less costly to the Plan.

Hypnotherapy: Expenses for hypnotherapy will not be considered eligible, except when performed by a Physician as a form of anesthesia due to an inability to use anesthesia in connection with covered Surgery.

Illegal acts: Expenses for treatment, services and supplies resulting from Injury or Illness which is incurred while the Covered Person is taking part in, or attempting to take part in, an illegal act, even if the proximate cause of the illness or injury is not the illegal act itself. It is not necessary for an arrest to occur, charges to be filed, or a conviction to occur for this exclusion to apply. Notwithstanding the foregoing, any conviction or acquittal on any filed charges shall be conclusory. This exclusion does not apply to an Injury resulting from being a victim of an act of domestic violence or resulting from a documented and verified medical condition (including both physical and mental health conditions).

Infertility: Expenses related to the treatment of Infertility will not be considered eligible, except as specified under Eligible Medical Expenses section. Excluded benefits include, but are not limited to the following procedures related to the treatment of Infertility:

1. Drugs related to the treatment of non-covered benefits;
2. Injectable infertility medications, including menotropins, hCG, GnRH agonists, and IVIG;
3. Any advanced reproductive technology ("ART") procedures or services related to such procedures, including invitro fertilization, GIFT (Gamete Intrafallopian Transfer), ZIFT (Zygote Intrafallopian Transfer, ICSI (intra-cytoplasmic sperm injection); and artificial insemination;
4. Infertility services for couples in which one of the partners has had a previous sterilization procedure, with or without surgical reversal;
5. Procedures, services and supplies to reverse voluntary sterilization;
6. Infertility services for females with FSH levels 19 or greater mIU/ml on day 3 of the menstrual cycle;
7. The purchase of donor sperm and any charges for the storage of sperm; the purchase of donor eggs and any charges associated with care of the donor required for donor egg retrievals or transfers or gestational carriers or surrogacy; donor egg retrieval or fees associated with donor egg programs, including fees for laboratory tests;

8. Expenses associated with cryopreservation or storage of cryopreserved eggs and embryos (e.g., office, Hospital, ultrasounds, laboratory tests, etc.); any charges associated with a frozen embryo or egg transfer, including thawing charges;
9. Expenses associated with embryo and fetal implementation;
10. Expenses related to surrogacy;
11. Home ovulation prediction kits or home pregnancy tests;
12. Any expenses associated with care required to obtain ART services (e.g., office, Hospital, ultrasounds, laboratory tests); and any charges associated with obtaining sperm for any ART procedures; and
13. Ovulation induction and intrauterine insemination services.

Immunizations: Expenses for immunizations due to employment or recreational travel will not be considered eligible, except as otherwise covered as a preventive service under the Eligible Medical Expenses section of the Plan.

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

Mandible Treatment: Expenses for appliances, medical or surgical treatment for correction of a malocclusion or protrusion or recession of the mandible; maxillary or mandibular hyperplasia or maxillary or mandibular hypoplasia will not be considered eligible. (Malocclusion - teeth do not fit together properly, bite problem; mandible protrusion or recession: underbite, chin excessively large or overbite, chin abnormally small; maxillary/mandibular hyperplasia: overbite due to excess growth of upper/lower jaw; maxillary/mandibular hypoplasia: undergrowth of upper/lower jaw). This is considered dental surgery, performed by dental surgeons. This is not considered a medical procedure.

Massage Therapy: Expenses for massage therapy or rolfing will not be considered eligible.

Medical Error: Treatment or services for unintended Injury or Illness resulting from an adverse consequence of care that could reasonably have been prevented, including foreign object left in body after surgery, surgery performed on wrong body part, air embolism, blood incompatibility, etc.

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

Missed Appointments: Expenses for missed appointments will not be considered eligible.

Morbid Obesity - Surgical Treatment: Any elective bariatric surgery procedure and/or other type of surgical treatment for morbid obesity is excluded under this Plan.

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.

Not Specified as Covered: Non-traditional medical services, treatments, and supplies which are not specified as covered under this Plan not be considered eligible.

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.

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.

Nutritional Counseling: Expenses related to nutritional counseling will not be considered eligible, except as otherwise covered as a Preventive Service or as specified under the Eligible Medical Expenses section of the Plan.

Nutritional Supplements: Expenses for nutritional supplements or other enteral supplementation will not be considered eligible, except as specified under Eligible Medical Expenses. Over-the-counter nutritional supplements or infant formulas will not be considered eligible even if prescribed by a Physician.

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.

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, unless approved by the Plan Administrator as less costly to the Plan.

Over-the-Counter (OTC) Medication and Supplies: Expenses for any over-the-counter medication will not be considered eligible, including prescription strength doses of drugs available without a prescription.

Disposable Outpatient supplies or devices, including sheaths, bags, elastic garments, support hose, bandages, bedpans, syringes, blood or urine testing supplies, other home test kits, splints, neck braces, compresses, and other devices not intended for reuse by another patient are not covered.

Plan Maximums: Expenses for charges in excess of Plan Maximums will not be considered eligible.

Pregnancy: Expenses of a Dependent Child for Pregnancy and the related birth of a newborn are not covered, except as required as preventive services under the ACA. A newborn Child of a Dependent Child is not eligible for this Plan unless the newborn Child meets the definition of an eligible Dependent.

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

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

Recreational and Educational Therapy: Expenses for recreational and educational services; learning disabilities; behavior modification services; vocational testing or training; 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. Diabetic education is considered eligible as specified under Eligible Medical Expenses.

Refractive Errors: Expenses for radial keratotomy, Lasik Surgery or any Surgical Procedure to correct refractive errors of the eye will not be considered eligible.

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.

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.

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.

Smoking Cessation: Expenses for smoking cessation programs, including smoking deterrents will not be considered eligible, unless otherwise covered as a Preventive Service under the Eligible Medical Expenses section of the Plan.

Special Education: Expenses for special education to instruct a person whose speech has been lost or impaired, to function without that ability will not be considered eligible. This exclusion includes lessons in sign language.

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

Sterilization: Expenses for the reversal of elective sterilization will not be considered eligible. Elective sterilization procedures are also not covered under this Plan unless they are included for coverage under the preventative services section of this Plan.

Strength and Performance: Expenses related to services, devices and supplies to enhance strength, physical condition, endurance or physical performance, which are not recognized by the medical community as rehabilitation, will not be considered eligible.

Surrogate: Expenses relating to a surrogate pregnancy of any person who is not covered under this Plan and for any Covered Person other than the Employee and Spouse will not be considered eligible, including pre-pregnancy, conception, prenatal, childbirth and postnatal expenses. This exclusion does not apply to Preventive Services for any Covered Person as described under the Eligible Medical Expenses section of the Plan.

Temporomandibular Joint Disorder (TMJ): Expenses related to Temporomandibular Joint Disorder (TMJ) will not be considered eligible.

Travel and Lodging: Expenses for travel and lodging will not be considered eligible, except as specified under Eligible Medical Expenses or the Centers of Excellence Program.

Vision Care: Expenses for vision care, including acuity testing, professional services for the fitting and/or supply of lenses, frames, contact lenses and other fabricated optical devices will not be considered eligible under the Medical Plan. However, benefits will be provided for the necessary initial placement of a pair of eyeglasses, contact lenses or an

intraocular lens following a Medically Necessary Surgical Procedure to the eye. This exclusion does not apply to aphakic patient and soft lenses or sclera shells intended for use as corneal bandages.

If Vision Care coverage is offered, see the Vision Plan for coverage and exclusions.

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.

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.

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

Workers' Compensation: Expenses for or in connection with any Injury or Illness which arises out of or in the course of any occupation for which the Covered Person would be entitled to compensation under any Workers' Compensation Law or occupational disease law or similar legislation will not be considered eligible.

Expenses for Injuries or Illness which were eligible for payment under Workers' Compensation or similar law and have reached the maximum reimbursement paid under Workers' Compensation or similar law will not be eligible for payment under this Plan.

PRESCRIPTION DRUG BENEFIT PROGRAM

Eligible expenses include Prescription Drugs and medicines prescribed by a Physician or authorized prescriber and dispensed by a licensed pharmacist, which are deemed Medically Necessary for treatment of an Illness or Injury. See the Prescription Drugs Schedule of Benefits for the Copayment levels.

NOTICE: This Prescription Drug benefit is a Generic Drug based program. A Covered Person will receive a Generic Drug unless no Generic equivalent exists or the prescribing Physician indicates that there cannot be a Generic Drug substitution for a specific Brand Name Drug by indicating "Dispense As Written" (DAW) on the prescription. If a Covered Person requests a Brand Name Drug that has a Generic Drug equivalent and the prescribing Physician has not designated the prescription as DAW, the Covered Person will pay the entire contracted cost of the Brand Name medication.

Covered services include Prescription Drugs purchased from a Participating Pharmacy with a prescription order from a Physician. Prescription Drugs purchased from a Non-Participating Pharmacy will be processed at a reduced benefit. The Covered Person must present a valid identification card at the time the prescription is dispensed.

When a Prescription Drug is filled at a retail pharmacy, the maximum amount or quantity of Prescription Drugs covered per Copay is a 30-day supply. Maintenance drugs of more than a 30-day supply must be purchased through the mail order program.

When using the mail order program, the maximum amount or quantity of Prescription Drugs covered per Copay is a 90-day supply.

Limitations: Certain Drugs may be subject to Pre-Certification requirements, quantity limits, or step therapy protocols. Please visit truerx.com or contact TrueRX at 812-254-7425 for more information.

Definitions:

Dispense As Written (DAW) means the Physician's handwritten indication on the face of a covered Prescription Drug that a Generic Drug substitution cannot be given for a specific Brand Name Drug.

Participating Pharmacy means a licensed pharmacy which has contracted to provide Prescription Drug services to Covered Persons.

Non-Participating Pharmacy means a licensed pharmacy that is not participating in the contracted pharmacy network.

Specialty Drug means a prescription drug that is classified as high complexity and/or high touch. Specialty drugs are often biologics and used to treat complex, rare chronic conditions, or genetic conditions including Multiple Sclerosis, Psoriasis, Rheumatoid Arthritis, Viral Hepatitis, HIV/Aids, Cancer, Hepatitis, and Hemophilia.

Brand Name Drug means the following: The multisource code field in Medi-Span contains an "M" (co-branded product), "O" (originator brand), or an "N" (single source brand); however, if the Multisource Code is "O" and there is a DAW Code of 3, 4, 5, 6, or 9, the drug shall be considered a Generic Drug. When a Drug is identified as a Brand Name Drug, it shall be considered a Brand Name Drug for all purposes under this Plan.

Generic Drug means the following: The multisource code field in Medi-Span contains a "Y" (generic). An item shall also be considered a Generic Drug if the Multisource Code is "O" and there is a DAW code of 3, 4, 5, 6, or 9. When a Drug is identified as a Generic Drug, it shall be considered a Generic Drug for all purposes under this Plan.

Non-Preferred Drug means any Brand Name drugs that do not appear on the list of Preferred Drugs.

Preferred Drug means a list of Brand Name drugs that has been developed by a Pharmacy and Therapeutics Committee comprised of Physicians, Pharmacists and other health care professionals. The list of Brand Name drugs is subject to periodic review and modification based on a variety of factors such as, but not limited to, Generic Drug availability, Food and Drug Administration (FDA) changes, and clinical information. The Prescription Drug Card Program Administrator will have a list of Preferred Drugs available.

Preventive Medications: The following prescription preventive Drugs, which have been identified by the U.S. Department of Health and Human Services (HHS) as a preventive service are covered at no co-payment as part of the Prescription Drug benefits:

1. Generic prescription fluoride supplements for children up to the age of 6;
2. Generic prescription folic acid supplements for women up to the age of 55;
3. Generic prescription aspirin formulations for members between the ages of 45 and 79 (quantity limits apply);
4. Generic prescription iron supplements for members through the age of 1;
5. Contraceptive products with a prescription, including oral, injectables, implantable devices, transdermal patches, and diaphragms. Over the counter spermicides, and female condoms are also covered;
6. Prescription or over the counter tobacco cessation products. Generic Products Only (exception: branded Nicotrol NS Nasal Spray, Nicotrol Inhaler System and Chantix are included), for a 90-day treatment regimen when prescribed by a Physician, without prior authorization.

You may view the guidelines established by HHS by visiting the following website:https://www.healthcare.gov/what-are-my-preventive-care-benefits. For a paper copy, please contact the Plan Sponsor.

Exclusions: The following are not covered by this Prescription Drug benefit:

1. All Drugs used to treat an Illness or Injury which is excluded under this Plan subject to the General Exclusions and Limitations Section of this Plan;
2. Any charge for administration of a Prescription Drug;
3. Any Prescription Drug for which another pharmacy program is primary in coverage;
4. Any Drugs labeled, "Caution: Limited by Federal Law to Investigational Use", which the Plan determines: (a) are in a testing stage or in early field trials on animals or humans; (b) do not have required final federal regulatory approval for commercial distribution for the specific indications and methods of use assessed; (c) are not generally prescribed in the course of acceptable medical practice; or (d) have not yet been shown to be consistently effective for the Diagnosis or treatment of the Covered Person's condition;*
5. Drugs or medications which do not require a prescription with the exception of over the counter drugs that are part of a step therapy protocol. These over the counter drugs are indicated on the Drug Formulary and are only covered when a prescript is presented to a Participating Pharmacy;
6. Devices and supplies (except insulin needles and syringes) of any type, including therapeutic devices, artificial appliances, support garments, blood glucose test meters and contraceptive devices;**
7. Immunization agents, biological sera, blood or blood plasma;**
8. Total parenteral nutrition (TPN);** and

9. Drugs which are properly received without charge under local, State, or Federal programs.

*This drug benefit covers any drug approved by the United States Food and Drug Administration for use in the treatment of any indication provided the drug has been recognized as safe and effective for treatment of the specific type of indication in any of the following: (1) The American Medical Association drug evaluations; (2) The American Hospital Formulary Service drug information; (3) The United States Pharmacopoeia dispensing information; or (4) two articles from major peer-reviewed professional medical journals that have not had their effectiveness contradicted in another article from a major peer- reviewed professional medical journal.

**These benefits are to be covered first under the Prescription Drug program. Contact the Pharmacy Benefit Manager for applicable Drugs to determine applicability. Expenses for injectables and consumed on premise Drugs are that are not covered under the Prescription Drug Card Program and are Medically Necessary for the treatment of a covered Illness or Injury will be payable under this Plan subject to any applicable major medical Deductibles and Coinsurance as well as any coverage limitations and exclusions applicable to the major medical component of the Plan.

NOTE: Coverage, limitations and exclusions for Prescription Drugs will be determined through the Prescription Drug Card Program elected by the Plan Sponsor and will not be subject to any limitations and exclusions under the major medical component of the Plan (except for as described above). For a complete listing of Prescription Drugs available under the Prescription Drug Card Program, as well as any exclusions or limitations that may apply, please contact the Prescription Drug Card Program Administrator identified in the General Plan Information section of this Plan.

COBRA CONTINUATION COVERAGE

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

Qualified Beneficiary: In general, a Full Time, Active Employee and any Dependents covered under the Plan on the day before a Qualifying Event that causes a loss of coverage under the Plan is considered a "Qualified Beneficiary."

In addition, any Dependent Child who is becomes an eligible Dependent Child of a Qualified Beneficiary during a period of COBRA continuation coverage is considered a "Qualified Beneficiary."

Each Qualified Beneficiary is offered the opportunity to make an independent election to receive COBRA continuation coverage.

Qualifying Event: A Full Time, Active Employee, who is properly enrolled in this Plan, will become a Qualified Beneficiary if he or she loses his or her coverage under the Plan because either one of the following Qualifying Events occur:

1. The hours of employment are reduced.
2. The employment ends for any reason other than gross misconduct.

The Spouse of a covered Employee will become a Qualified Beneficiary if he or she loses his or her coverage under the Plan because any of the following Qualifying Events occur:

1. The Employee dies.
2. The Employee's hours of employment are reduced.
3. The Employee's employment ends for any reason other than his or her gross misconduct.
4. The Employee becomes entitled to Medicare benefits (under Part A, Part B, or both).
5. The Employee becomes divorced or legally separated from his or her Spouse.

Note: Domestic Partners are not eligible for COBRA continuation coverage.

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

1. The parent-covered Employee dies.
2. The parent-covered Employee's hours of employment are reduced.
3. The parent-covered Employee's employment ends for any reason other than his or her gross misconduct.
4. The parent-covered Employee becomes entitled to Medicare benefits (Part A, Part B, or both).
5. The parents become divorced or legally separated.

6. The Child stops being eligible for coverage under the Plan as a Dependent Child.

Filing a proceeding in bankruptcy under title 11 of the United States Code may be a Qualifying Event.

Duration of COBRA Continuation Coverage: The maximum time period shown below shall dictate for how long COBRA Continuation Coverage will be available. The maximum time period for coverage is based on the type of the Qualifying Event and the status of the Qualified Beneficiary. Multiple Qualifying Events that may be combined under COBRA will not ordinarily continue coverage for more than 36 months beyond the date of the original Qualifying Event. When the Qualifying Event is "entitlement to Medicare," the 36 month continuation period is measured from the date of the original Qualifying Event. For all other Qualifying Events, the continuation period is measured from the date of the Qualifying Event, not the date of loss of coverage.

When the Qualifying Event is the death of the covered Employee (or former Employee), the covered Employee's (or former Employee's) becoming entitled to Medicare benefits (under Part A, Part B, or both), a divorce or Legal Separation, or a Dependent Child's losing eligibility as a Dependent Child, COBRA Continuation Coverage lasts for up to a total of 36 months.

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

Otherwise, when the Qualifying Event is the end of employment (for reasons other than gross misconduct) or reduction of the covered Employee's hours of employment, COBRA Continuation Coverage generally lasts for only up to a total of 18 months. There are two ways in which this 18-month period of COBRA Continuation Coverage can be extended.

Extension of 18-Month Continuation Coverage Period:

Disability Extension of COBRA: Continuation Coverage Disability can extend the 18 month period of continuation coverage for a Qualifying Event that is a termination of employment or reduction of hours, if an Employee or anyone in an Employee's family covered under the Plan is determined by the Social Security Administration ("SSA") to be disabled, and the Employee notifies the COBRA Administrator. The Employee and his or her Dependents may thereby be entitled to an additional 11 months of COBRA Continuation Coverage, for a total of 29 months, if the disability started at some time before the 60th day of COBRA Continuation Coverage and lasts at least until the end of the 18 month period of COBRA Continuation Coverage. The Plan can charge 150% of the premium cost for the extended period of coverage.

Second Qualifying Event Extension of COBRA Continuation Coverage: If an Employee's family experiences another Qualifying Event while receiving 18 months of COBRA Continuation Coverage, Dependents may receive up to 18 additional months of COBRA Continuation Coverage, for a maximum of 36 months, if notice of the second Qualifying Event is provided to the Plan Sponsor or COBRA Administrator in accordance with the procedures set forth herein. This extension may be applicable to the Employee's death, Medicare Parts A and/or B eligibility, divorce or Legal Separation,

or a loss of Dependent status under the terms of the Plan if the event would have also caused the spouse or Dependent Child to lose coverage under the Plan regardless of whether the first Qualifying Event had occurred.

Shorter Duration of COBRA Continuation Coverage: COBRA establishes required periods of coverage for continuation health benefits. A plan, however, may provide longer periods of coverage beyond those required by COBRA. COBRA Qualified Beneficiaries generally are eligible for group coverage during a maximum of 18 months after Qualifying Events arising due to employment termination or reduction of hours of work. Certain Qualifying Events, or a second Qualifying Events during the initial period of coverage, may permit a Qualified Beneficiary to receive a maximum of 36 months of coverage.

It is not necessary that COBRA Continuation Coverage be in effect for the maximum period of time, as set forth herein. COBRA Continuation Coverage may conclude prior to the latest possible date if the Employer ceases to provide a group health plan to any Employee; the Qualified Beneficiary fails to make timely payment of any required contributions or premium; the Qualified Beneficiary gains coverage under another group health plan (as an Employee or otherwise) or becomes entitled to either Medicare Part A or Part B (whichever comes first); and/or other event occurs which enables the Plan Sponsor to terminate coverage without offering COBRA Continuation Coverage (such as the commission of fraud by the Qualified Beneficiary and/or their Dependent). COBRA Continuation Coverage shall be extended to the first day of the month 30 days (or more) subsequent to the date upon which the SSA determined that the Qualified Beneficiary is no longer disabled.

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

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

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

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

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

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

MedCom
PO Box 10269
Jacksonville, FL 32247
800-523-7542

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

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

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

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

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

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

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

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

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

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

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

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

14. A statement that the election notice does not fully describe COBRA or the plan and that more information is available from the Plan Sponsor and in the SPD.
15. A certification that the information is true and correct, a signature and date.

If a copy of the decree of divorce or Legal Separation or the SSA's determination cannot be provided by the deadline for providing the notice, complete and provide the notice, as instructed, by the deadline and submit the copy of the decree of divorce or Legal Separation or the SSA's determination within thirty (30) days after the deadline. The notice will be timely if done so. However, no COBRA Continuation Coverage, or extension of such Coverage, will be available until the copy of the decree of divorce or Legal Separation or the SSA's determination is provided.

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

Payment for COBRA Continuation Coverage: Once COBRA Continuation Coverage is elected, the Qualified Beneficiary must pay for the cost of the initial period of coverage within forty-five (45) days. Payments then are due on the first day of each month to continue coverage for that month. If a payment is not received within thirty (30) days of the due date, COBRA continuation coverage will be canceled and will not be reinstated. The amount required to be paid for COBRA continuation coverage is 102% of the actual cost of coverage elected, unless the Qualified Beneficiary qualifies for the eleven (11) month period of extended coverage due to disability (as specified above). In the event of disability, the required amount to be paid is 150% of the actual cost of coverage elected for the eleven (11) month extension period. Notwithstanding anything to the contrary, in no event can COBRA Continuation Coverage be paid by a provider.

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

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

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

Additional Information: Additional information about the Plan and COBRA Continuation Coverage is available from the Plan Sponsor, who is identified on the General Plan Information page of this Plan.

Current Addresses: Important information may be distributed by mail. In order to protect the rights of the Employee's family, the Employee should keep the COBRA Administrator (who has been previously identified in this Continuation of Coverage section) informed of any changes in the addresses of family members.

CLAIM PROCEDURES

A Covered Person will receive an Employee identification card containing important information, including Claim filing directions and contact information. The Employee identification card will show the Participating Provider Network, the Pharmacy Benefit Manager, and the Utilization Review Administrator.

The Employee identification card should be shown to the Provider at the time of each treatment. In most cases, the Provider will file a Claim. A Covered Person may file the Claim by submitting the required information to:

Bywater Ltd.
15422 Detroit Ave
Lakewood, OH 44107
800.337.0792

A call from a Provider who wants to know if an individual is covered under the Plan, or if a certain procedure is covered by the Plan, prior to providing treatment is not a Claim since an actual Claim for benefits is not being filed with the Plan. These are simply requests for information, and any response is not a guarantee of benefits, since payment of benefits is subject to all Plan provisions, limitations and Exclusions. Once treatment is rendered, a Clean Claim must be filed with the Plan, which will be a Post Service Claim. At that time, a determination will be made as to what benefits are payable under the Plan.

A Claim must include the following information in order to be considered filed with the Plan:

1. The date of service;
2. The name, address, telephone number and tax identification number of the Provider;
3. The place where the services were rendered;
4. The Diagnosis and procedure codes;
5. The amount of charges (including Network repricing information);
6. The name of the Plan;
7. The name of the covered Employee; and
8. The name of the Covered Person.

Timely Filing: All Claims must be filed with the Third Party Administrator within one year following the date services were Incurred. Claims filed after this time period will be denied.

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

Procedures for all Claims: The Plan's Claim procedures are intended to reflect the Claims Rules and Regulations as outlined in 29 CFR § 2560.503-1, et. al and should be interpreted accordingly. In the event of any conflict between this Plan and the Regulations, the Regulations will control.

To receive benefits under the Plan, the Claimant must follow the procedures outlined in this section. There are four different types of claims: (1) Urgent Care Claims; (2) Concurrent Care Claims; (3) Pre-Service Claims; and (4) Post Service Claims. The procedures for each type of Claim are more fully described below:

1. Urgent Care Claims. A Claim is considered an Urgent Care Claim if the application of the time periods for making non- urgent care determinations could seriously jeopardize the Claimant's life or health or ability to regain maximum function or, in the opinion of a Physician with knowledge of Claimant's medical condition, would subject the Claimant to severe pain that could not be adequately managed without the care or treatment which is the subject of the Claim. In determining if the initial Claim should be treated as an Urgent Care Claim, the Plan will defer to a determination, if any, by an attending Provider that the Claim should be treated as an Urgent Care Claim, if that determination is timely provided to the Plan.

   If a Claim is considered an Urgent Care Claim, the Plan Administrator will notify the Claimant of the Plan's benefit determination, whether adverse or not, as soon as possible, taking into account the medical exigencies, but not later than 72 hours after the Plan receives the Claim, unless the Claimant fails to provide sufficient information to determine whether or to what extent benefits are covered or payable under the Plan. The Plan Administrator will notify you as soon as possible, but not later than 24 hours after the Plan receives the Claim, of any failure to provide sufficient information and request the specific information necessary to complete the Claim. The notification may be oral unless written notification is requested. The Claimant will be afforded a reasonable amount of time, taking into account the circumstances, but not less than 48 hours, to provide the specified information. The Plan Administrator will notify the Claimant of the Plan's determination as soon as possible, but in no case later than 48 hours after the earlier of (1) the Plan's receipt of the specified additional information or (2) the end of the period afforded the claimant to provide the specified additional information.

2. Concurrent Care Claims. If a Claimant requires an on-going course of treatment over a period of time or via a number of treatments, the Plan may approve of a "Concurrent Claim." In such circumstances, the Claimant must notify the Plan of such necessary ongoing or routine medical care, and the Plan will assess the Concurrent Claim as well as determine whether the course of treatment should be reduced or terminated. The Claimant, in turn, may request an extension of the course of treatment beyond that which the Plan has approved. Any request to extend will be determined, whether adverse or not, within 24 hours after the Plan receives the Claim provided that such Claim is made at least 24 hours prior to the expiration of the prescribed period of time or number of treatments. If the Plan does not require the Claimant to obtain approval of a medical service prior to getting treatment, then there is no need to contact the Plan Administrator to request an extension of a course of treatment, and the Claimant must simply comply with the Plan's requirements with respect to notice required after receipt of treatment, as herein described.

   Any reduction or termination by the Plan of the previously approved course of treatment (other than by Plan amendment or termination) before the approved time period or number of treatments constitutes an Adverse Determination. In such a case, the Plan Administrator will notify the Claimant of the Adverse

Determination at a time sufficiently in advance of the reduction or termination to allow the Claimant to appeal and obtain a determination on review of that Adverse Determination before reduction or termination of the benefit.

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

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

   A claim for benefits is considered a pre-service claim if the claim requires approval through Pre-Certification, in part or in whole, in advance of obtaining the health care in question. Pre-Certification of a non-Emergency Hospital admission is a Claim only to the extent of the determination made - that the type of procedure or condition warrants Inpatient confinement for a certain number of days. The rules regarding Pre-service Claims will apply to that determination only. Once a Claimant has the treatment in question, the claim for benefits relating to that treatment will be treated as a Post Service Claim.

   For a Pre-Service Claim, the Plan Administrator will notify the Claimant of the Plan's benefit determination, whether adverse or not, within a reasonable period of time appropriate to the medical circumstances, but not later than fifteen (15) days after the Plan receives the Claim. If, due to matters beyond the control of the Plan, the Plan Administrator needs additional time to process a Claim, the Plan Administrator may extend the time to notify Claimant of the Plan's benefit determination for up to fifteen (15) days provided that the Plan Administrator notifies the Claimant within fifteen (15) days after the Plan receives the Claim of those special circumstances and of when the Plan Administrator expects to make its decision. However, if such an extension is necessary due to the failure of Claimant to submit the information necessary to decide the claim, the notice of extension must specifically describe the required information and the Claimant will be afforded at least 45 days from receipt of the notice within which to provide the specified information.

4. Post Service Claims. For Post Service Claims, the Plan Administrator will notify the Claimant of the Plan's Adverse Determination within a reasonable period of time, but not later than thirty (30) days after receipt of the Claim. If, due to special circumstances, the Plan Administrator needs additional time to process a Claim, the Plan Administrator may extend the time for notifying the Claimant of the Plan's benefit determination on a one-time basis for up to fifteen (15) days provided that the Plan Administrator notifies the Claimant within thirty (30) days after the Plan receives the Claim of those special circumstances and of the date by which the reviewer expects to make a decision. However, if such a decision is necessary due to the Claimant’s failure to submit the information necessary to decide the Claim, the notice of extension will specifically describe the required information and you will be afforded at least forty-five (45) days from receipt of the notice within which to provide the specified information.

Manner and Content of Notice of Initial Adverse Determination: Denial by the Plan Administrator of a Claim must be in writing or by electronic communication and provide the following information:

1. An explanation of the specific reasons for the denial;
2. A reference to the Plan provision or insurance contract provision upon which the denial is based;
3. A description of any additional information or material the Claimant must provide in order to perfect the Claim;
4. An explanation of why the additional material or information is necessary;
5. Notice of Claimant's right to request a review of the Claim denial and information on the steps to be taken to request a review of the Claim denial along with the time limits applicable to a request for review;
6. A statement describing the right to request an external review (or, if applicable, to request a second level appeal) or, if applicable, to bring an action under ERISA Section 502(a);
7. A copy of any rule, guideline, protocol or other similar criterion relied upon in making the Adverse Determination or a statement that the same will be provided upon request and without charge; and
8. If the Adverse Determination is based on the Plan's Medical Necessity, Experimental Treatment or similar exclusion or limit, either:
    a. an explanation of the scientific or clinical judgment applying the exclusion or limit to the medical circumstances or
    b. a statement that the same will be provided upon request and without charge.

Any notice of Adverse Determination also will include the following information:

1. Information sufficient to identify the Claim involved, including the date of service, the Provider and the claim amount (if applicable);
2. As part of the explanation of the determination, a discussion of the decision, as well as disclosure of any denial code used (and an explanation of its meaning) and a description of the Plan's standard, if any, that was used in denying the Claim;
3. A description of available internal appeals and external review processes, including information regarding how to initiate an appeal;
4. Information (including contact information) about the availability of any applicable office of health insurance consumer assistance or ombudsmen established pursuant to the Patient Protection and Affordable Care Act (PPACA) to assist individuals with internal claims and appeals and external review processes; and
5. A statement describing the availability, upon request, of any applicable diagnosis code (and an explanation of its meaning) and any applicable treatment code (and an explanation of its meaning).

For an Adverse Determination concerning an Urgent Care Claim, the information described in this Section may be provided to you orally within the permitted time frame provided that a written or electronic notification in accordance with this section is furnished to you no later than three (3) days after the oral notification.

Appeals of Adverse Determination:

A Claimant may appeal an Adverse Determination. The Plan offers a two-level internal review procedure and an external review procedure to provide the Claimant with a full and fair review of the Adverse Determination.

A written appeal letter to the Claims Administrator/TPA should include:

1. Covered Person's name,

2. ID number,
3. Group health plan name, and
4. A statement of why the Claimant disagrees with the Adverse Benefit Determination.

The Claimant may include any additional supporting information, even if not initially submitted with the Claim. The initial appeal should be addressed to:

Bywater Ltd.
15422 Detroit Ave
Lakewood, OH 44107

A Covered Person, or his/her Authorized Representative, has one hundred eighty (180) calendar days following receipt of an Adverse Determination notice to submit a written **first level appeal** to the Third Party Administrator.

If an appeal relates to an Urgent Care Claim, the Covered Person will be notified of the appeal determination as soon as possible, but not later than seventy-two (72) hours after receipt of the appeal request. If the appeal relates to an Urgent Care Claim involving a Concurrent Review Adverse Determination, the Covered Person will be provided advance notice and an opportunity for advance review, unless it is an initial unauthorized admission.

If an appeal relates to a non-urgent Pre-Service or Concurrent Claim, the Covered Person will be notified of the appeal determination no later than fifteen (15) calendar days after receipt of the appeal request.

If the appeal relates to a Post Service Claim, the Covered Person will be notified of the appeal determination no later than thirty (30) calendar days after receipt of the appeal request.

Any individual involved in the initial Adverse Determination will not participate in the determination of the appeal. The Covered Person may submit comments, documents and other supporting information in conjunction with the appeal. Upon written request, and free of charge, reasonable access to the Plan's documents and information relevant to the appealed Claim will be provided. As part of the appeal process, a full and fair review of all comments and documentation will be provided on an unbiased basis.

Prior to the exhaustion of the **first level appeal** process, any new or additional evidence considered, relied upon, or generated in connection with the Claim or **first level appeal** of an Adverse Determination, will be provided to the Covered Person, or their authorized representative, free of charge to provide them an opportunity to respond to such new evidence or rationale.

If the appeal determination is to uphold the initial Claim processing, the written notification will include all mandated notices required for Adverse Determinations, and also include a description of the Covered Person's right to further action.

If the Covered Person remains dissatisfied with the first appeal determination, they may submit a **second level appeal** in writing within sixty (60) calendar days of receipt of the **first level appeal** determination notice. The second level appeal will be reviewed by individuals who were not involved in the **first level appeal** determination. A **second level appeal**, including all relevant information, may be sent to the address listed below.

All appeal procedures specified must be exhausted before any legal action is filed. No legal action can be filed more than one year after the **second level appeal** determination notice. Second level appeals must be sent to the Plan Administrator, care of the Bywater Ltd. at the following address:

Bywater Ltd.
15422 Detroit Ave
Lakewood, OH 44107
800.337.0792

External Review: An external review is available when an Adverse Determination involves medical judgment or rescission of coverage and the **first and second level appeal** process is exhausted, or if the Plan fails to adhere to the requirements of Claim and appeal processing.

Upon issuance of a final Adverse Determination of a **second level appeal** on benefits involving medical judgments and coverage rescissions from the **first and second level appeals** and appeal procedures discussed above, the Covered Person, or an authorized representative, has four (4) months to file a request for an external review. If the last day for filing a request for an external review falls on a Saturday, Sunday or Federal holiday, the last filing date is extended to the next day that is not a Saturday, Sunday or Federal holiday. Within five (5) business days following receipt of an external review request, the Plan will complete a preliminary review to determine if:

1. The Covered Person was covered at the time the health care service was provided;
2. The final Adverse Determination does not relate to the Covered Person's failure to meet eligibility requirements under the Plan;
3. The Covered Person exhausted the Plan's internal review and appeal process; and
4. The Covered Person has provided all the information and forms required to process an external review.

Within one (1) business day after completion of the preliminary review, the Plan will issue written notice that either:

1. The external review request is complete but ineligible for external review, the reasons for ineligibility and contact information for the Employee Benefits Security Administration (866-444-3272); or
2. The external review request is not complete, the description of information or materials needed to make the external review request complete within the four (4) month filing period or within the forty-eight (48) hour period following receipt of the notice, whichever is later.

Within five (5) days after the complete request for external review has been assigned to an Independent Review Organization ("IRO"), the Plan will provide the IRO the documents and information considered in making the final Adverse Determination. If the Covered Person submits any information to the IRO, the IRO must forward any such information to the Plan within one (1) business day. The Plan may reconsider its final Adverse Determination. If the Plan decides to reverse its final Adverse Determination before the IRO's external review decision, the Plan will notify in writing, within one (1) business day, the Covered Person and IRO of its reversal. The IRO must provide a decision within thirty (30) calendar days from the date of request for the external review. The Plan will comply with the IRO's determination.

Request for Expedited External Review: A group health plan must allow a Covered Person to make a request for an expedited external review if it involves a medical condition where the time for completion of a standard external review process would seriously jeopardize the Claimant's life or health or the Claimant's ability to regain maximum function, or

if the final internal Adverse Determination concerns an admission, availability of care, continued stay, or health care item or service for which the Claimant received Emergency Services, but has not been discharged from a facility.

The IRO must provide a notice of the final external review decision as expeditiously as the Claimant's medical condition or circumstance require, but ***in no event more than seventy-two (72) hours*** after the IRO receives the request for an expedited external review. If the notice is not in writing, ***within forty-eight (48) hours*** after providing the notice, the IRO must provide written confirmation of the decision to both the Claimant and the Plan.

Filing an External Review: The Covered Person, or his/her authorized representative, may file an External Review by submitting a written request, to include all supporting documentation to:

Bywater Ltd.
15422 Detroit Ave
Lakewood, OH 44107

Statute of Limitations for Plan Claims: Please note that no legal action may be commenced or maintained to recover benefits under the Plan more than 12 months after the final review/appeal decision by the Plan Administrator has been rendered (or deemed rendered).

Appointment of Authorized Representative: A Covered Person is permitted to appoint an authorized representative to act on his or her behalf with respect to a benefit Claim or appeal of an Adverse Benefit Determination; provided, however, that an Assignment of Benefits by a Covered Person to a Hospital or Physician of the Medical Care will not constitute appointment of that Hospital or Physician of the Medical Care as an Authorized Representative. To appoint such a representative, the Covered Person must complete a form which can be obtained from the Plan Administrator or the TPA. However, in connection with a claim involving Urgent Care, the Plan will permit a health care professional with knowledge of the Covered Person's medical condition to act as the Covered Person's Authorized Representative without completion of this form. In the event a Covered Person designates an Authorized Representative, all future communications from the Plan concerning that Claim will be with the Authorized Representative, rather than the Covered Person, unless the Covered Person directs the Plan Administrator or TPA, in writing, to the contrary.

Physical Examinations: The Plan reserves the right to have a Physician of its own choosing examine any Covered Person whose Illness or Injury is the basis of a Claim. All such examinations will be at the expense of the Plan. This right may be exercised when and as often as the Plan Administrator may reasonably require during the pendency of a Claim. The Covered Person must comply with this requirement as a necessary condition to coverage.

COORDINATION OF BENEFITS

Benefits Subject to This Provision: This provision applies to all benefits provided under any section of this Plan.

Excess Insurance: If at the time of Injury, Illness, Disease or disability there is available or potentially available, any coverage (including coverage resulting from a judgment at law or settlements), the benefits under the Plan shall apply only as an excess over such other sources of coverage.

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

1. Any primary payer besides the Plan;
2. Any first party insurance through medical payment coverage, personal injury protection, no-fault coverage, uninsured or underinsured motorist coverage;
3. Any policy of insurance from any insurance company or guarantor of a third-party;
4. Workers' Compensation or other liability insurance company; or
5. Any other source, including crime victim restitution funds, any medical, disability or other benefit payments and school insurance coverage.

Vehicle Limitation: When medical payments are available (or, under applicable law should be available) under any vehicle insurance, the Plan shall pay excess benefits only, without reimbursement for vehicle plan and/or policy deductibles. This Plan shall always be considered secondary to such plans and/or policies. This applies to all forms of medical payments under vehicle plans and/or policies regardless of its name, title or classification. If medical payments would have been available under a vehicle insurance policy if minimum legally required levels of coverage had been in effect, but the minimum level of coverage was not in effect, the Plan shall pay excess benefits only, determined as if the minimum legally required level of coverage had been in effect at the applicable time.

Application to Benefit Determinations: The plan that pays first according to the rules in the section entitled "Order of Benefit Determination" will pay as if there were no other plan involved. When this Plan is secondary, this Plan will always pay either its benefits in full or a reduced amount which, when added to the benefits payable by the Other Plan(s), will not exceed 100% of the Maximum Allowable Charge. When there is a conflict in the order of benefit determination, this Plan will never pay more than 50% of the Maximum Allowable Charge.

When some Other Plan pays first in accordance with the Application to Benefit Determinations provision in the Coordination of Benefits section, this Plan's Maximum Allowable Charge shall in no event exceed the Other Plan's Maximum Allowable Charge.

When some Other Plan provides benefits in the form of services (rather than cash payments), the Plan Administrator shall assess the value of said benefit(s) and determine the reasonable cash value of the service or services rendered by determining the amount that would be payable in accordance with the terms of the Plan. Benefits payable under any Other Plan includes the benefits that would have been payable had the Claim been duly made therefore, whether or not it is actually made.

Order of Benefit Determination: For the purposes of the section entitled "Application to Benefit Determinations," the rules establishing the order of benefit determination are listed below. The Plan will consider these rules in the order in which they are listed and will apply the first rule that satisfies the circumstances of the Claim:

1. A plan without a coordinating provision will always be the primary plan;
2. The plan covering the person directly rather than as an Employee's Dependent is primary and the other plans are secondary;
3. Active/laid-off Employees or Retirees: The plan which covers a person as a Full Time, Active Employee (or as that employee's dependent) determines its benefits before the plan which covers a person as a laid-off or retired employee (or as that employee's dependent). If the plan which covers that person has not adopted this rule and if, as a result, the plans do not agree on the order of benefits, this rule will not apply;
4. Dependent Children of parents not separated or divorced or unmarried parents living together: The plan covering the parent whose birthday falls earlier in the year pays first. The plan covering the parent whose birthday falls later in the year pays second. However, if the other plan does not have this rule but instead has a rule based upon the gender of the parent and if as a result the plans do not agree on the order of benefits, the rule in the other plan will determine the order of benefits;
5. Dependent Children of separated or divorced parents or unmarried parents not living together: When parents are separated or divorced or unmarried and not living together, neither the male/female nor the birthday rules apply. Instead:
    a. The plan of the parent with custody pays first;
    b. The plan of the spouse of the parent with custody (the step-parent) pays next;
    c. The plan of the parent without custody pays next; and
    d. The plan of the spouse of the non-custodial parent pays last.
    e. Notwithstanding the above provisions, if there is a court decree that would otherwise establish financial responsibility for the Child's health care expenses, the benefits of the plan that covers the Child as a dependent of the parent with such financial responsibility shall be determined before the benefits of any other plan that covers the child as a dependent child.
6. If a person whose coverage is provided under a right of continuation pursuant to State or Federal law (e.g., COBRA) is also covered under another plan, the plan covering the person as an employee, member, subscriber or retiree (or as that person's dependent) is primary and the continuation coverage is secondary. If the other plan does not have this rule and if, as a result, the plans do not agree on the order of benefits, this rule is ignored.
7. To the extent required by Federal and State regulations, this Plan will pay before any Medicare, Tricare, Medicaid, State child health benefits or other applicable State health benefits program.

When the rules above do not establish an order of benefit determination, the benefits of a plan which has covered the person on whose expenses claim is based for the longer period of time shall be determined before the benefits of a plan which has covered such person the shorter period of time.

Right to Receive and Release Necessary Information: For the purpose of determining the applicability of and implementing the terms of this coordination of benefits provision or any provision of similar purpose of any other plan, this Plan may, without notice to any person, release to or obtain from any insurance company or

other organization or individual, any information with respect to any person, which the Plan deems to be necessary for such purposes. Any person claiming benefits under this Plan is deemed to consent to the release and receipt of such information and agrees to furnish to the Plan such information as may be necessary to implement this provision.

Facility of Payment: Whenever payments which should have been made under this Plan in accordance with this provision have been made under any other plans, the Plan Administrator may, in its sole discretion, pay any organizations making such other payments any amounts it shall determine to be warranted in order to satisfy the intent of this provision and amounts so paid shall be deemed to be benefits paid under this Plan and, to the extent of such payments, this Plan shall be fully discharged from liability.

Recovery of Payments: Occasionally, benefits are paid more than once, are paid based upon improper billing or a misstatement in a proof of loss or enrollment information, are not paid according to the Plan's terms, conditions, limitations or exclusions or should otherwise not have been paid by the Plan. This Plan may also inadvertently pay benefits that are later found to be greater than the Maximum Allowable charge. Under these circumstances, the Plan may recover the amount of the overpayment from the person or entity to which it was paid, primary payers or from the party on whose behalf the charge(s) were paid. A Covered Person, Provider, Other Plan, insurer, or any other person or entity who receives a payment exceeding the amount of benefits payable under the terms of the Plan or on whose behalf such payment was made, shall return or refund the amount of such erroneous payment to the Plan within thirty (30) days of discovery or demand. The Plan Administrator shall have discretion in deciding whether to obtain payment for the expense for which the erroneous payment was made or to which it was applied.

The person or entity receiving an erroneous payment may not apply such payment to another expense. The Plan Administrator shall have the sole discretion to choose who will repay the Plan for an erroneous payment and whether such payment shall be reimbursed in a lump sum. When a Covered Person or other entity does not comply with the provisions of this section, the Plan Administrator shall have the authority, in its sole discretion, to deny payment of any Claims by the Covered Person and to deny or reduce future benefits payable (including payment of future benefits for any other Injury or Illness) 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 any other Injury or Illness) under any other group benefits plan maintained by the Plan Administrator. The reductions will equal the amount of the required reimbursement.

Providers and any other person or entity accepting payment from the Plan or to whom a right to benefits has been assigned, in consideration of services rendered, payments and/or rights, agree to be bound by the terms of this Plan and agree to submit Claims for reimbursement in strict accordance with their state's health care practice acts, most recent edition of the ICD or CPT standards, Medicare guidelines, HCPCS standards or other standards approved by the Plan Administrator or insurer. Any payments made on Claims for reimbursement not in accordance with the above provisions shall be repaid to the Plan within 30 days of discovery or demand or incur prejudgment interest of 1.5% per month. If the Plan must bring an action against a Covered Person, provider or other person or entity to enforce the provisions of this section, then that Covered Person, provider

or other person or entity agrees to pay the Plan's attorneys' fees and costs, regardless of the action's outcome.

Further, a Covered Person and/or his or her Dependents, beneficiaries, estate, heirs, guardian, personal representative or assigns ("Plan Participants") shall assign or be deemed to have assigned to the Plan their right to recover said payments made by the Plan, from any other party and/or recovery for which the Plan Participant(s) are entitled, for or in relation to facility-acquired condition(s), provider error(s) or damages arising from another party's act or omission for which the Plan has not already been reimbursed.

The Plan reserves the right to deduct from any benefits properly payable under this Plan the amount of any payment which has been made:

1. In error;
2. Pursuant to a misstatement contained in a proof of loss or a fraudulent act;
3. Pursuant to a misstatement made to obtain coverage under this Plan within two (2) years after the date such coverage commences;
4. With respect to an ineligible person;
5. In anticipation of obtaining a recovery if a Covered Person fails to comply with the Plan's Subrogation, Third Party Recovery and Reimbursement provisions; or
6. Pursuant to a Claim for which benefits are recoverable under any policy or act of law providing for coverage for occupational Injury or Disease to the extent that such benefits are recovered. This provision shall not be deemed to require the Plan to pay benefits under this Plan in any such instance.

The deduction may be made against any Claim under this Plan by a Covered Person if such payment is made with respect to the Covered Person.

If the Plan seeks to recoup funds from a Provider, due to a claim being made in error, a Claim being fraudulent on the part of the provider and/or the Claim that is the result of the Provider's misstatement, said provider shall, as part of its assignment to benefits from the Plan, abstain from billing the Covered Person for any outstanding amount(s).

Medicaid Coverage: A Covered Person's eligibility for any state Medicaid benefits will not be taken into account in determining or making any payments for benefits. Any such benefit payments will be subject to the State's right to reimbursement for benefits it has paid on behalf of such person, as required by the State Medicaid program; and the Plan will honor any subrogation rights the State may have with respect to benefits which are payable under the Plan.

Coordination of Benefits with Medicaid: In all cases, benefits available through a State or Federal Medicaid program will be secondary or subsequent to the benefits of this Plan.

Coordination of Benefits with Medicare:

Applicable to Full Time, Active Employees and Their Spouses Ages 65 and Over: A Full Time, Active Employee and his or her Spouse (ages 65 and over) may, at the option of such Employee, elect or reject coverage under this Plan. If such Employee elects coverage under this Plan, the benefits of this Plan shall be determined

before any benefits provided by Medicare to the extent required by Federal regulations. If coverage under this Plan is rejected by such Employee, benefits listed herein will not be payable even as secondary coverage to Medicare.

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

Applicable to Medicare Services Furnished to End Stage Renal Disease ("ESRD") Covered Persons Who Are Covered Under This Plan: If any Covered Person is eligible for Medicare benefits because of ESRD, the benefits of the Plan will be determined before Medicare benefits for the first 30 months of Medicare entitlement (with respect to charges Incurred on or after August 5, 1997), unless applicable Federal law provides to the contrary, in which event the benefits of the Plan will be determined in accordance with such law. There may be up to a three (3) month wait to obtain Medicare coverage, which may result in a variation of the Plan's primary payment responsibility up to three (3) months.

Medicare and COBRA: For most COBRA beneficiaries, Medicare rules state that Medicare will be primary to COBRA continuation coverage and this would apply to this Plan's Continuation of Benefits (COBRA) coverage. For an ESRD-related Medicare beneficiary, COBRA Continuation Coverage (if elected) is generally primary to Medicare during the 30-month coordination period.

Coordination of Benefits with TRICARE: At all times, the Plan will be operated in accordance with any applicable TRICARE secondary payer and non- discrimination rules issued by the Department of Defense.

SUBROGATION, THIRD-PARTY RECOVERY AND REIMBURSEMENT

By enrollment in the Plan, a Covered Person agrees to the provisions of this Section as a condition precedent to receiving benefits under this Plan. If the Covered Person fails to comply with the requirements of this Section, the Plan may reduce or deny benefits otherwise available under the Plan.

Payment Condition:

1. The Plan, in its sole discretion, may elect to conditionally advance payment of benefits in those situations where an Injury, Illness, Disease or disability is caused in whole or in part by, or results from the acts or omissions of an eligible Employee and/or his/her Dependents, plan beneficiaries and/or their Dependents, beneficiaries, estate, heirs, guardian, personal representative, or assigns (collectively referred to hereinafter in this section as "Covered Person") or a third party, where any party besides the Plan may be responsible for expenses arising from an incident, and/or other insurance or other funds are available, including no-fault, uninsured motorist, underinsured motorist, medical payment provisions, third party assets, third party insurance, and/or guarantor(s) of a third party (collectively "Coverage").
2. The Covered Person, his or her attorney, and/or legal guardian of a minor or incapacitated individual agrees that acceptance of the Plan's conditional payment of medical benefits is constructive notice of these provisions in their entirety and agrees to maintain 100% of the Plan's conditional payment of benefits or the full extent of payment from any one or combination of first and third party sources in trust, without disruption except for reimbursement to the Plan or the Plan's assignee. By accepting benefits the Covered Person agrees the Plan shall have an equitable lien on any funds received by the Covered Person and/or their attorney from any source and said funds shall be held in trust until such time as the obligations under this provision are fully satisfied. The Covered Person agrees to include the Plan's name as a co-payee on any and all settlement drafts. Further, by accepting benefits the Covered Person understands that any recovery obtained pursuant to this section is an asset of the Plan to the extent of the amount of benefits paid by the Plan and that the Covered Person shall be a trustee over those Plan assets.
3. In the event a Covered Person settles, recovers or is reimbursed by any Coverage, the Covered Person agrees to reimburse the Plan for all benefits paid or that will be paid by the Plan on behalf of the Covered Person. If the Covered Person fails to reimburse the Plan out of any judgment or settlement received, the Covered Person will be responsible for any and all expenses (fees and costs) associated with the Plan's attempt to recover such money.
4. If there is more than one party responsible for charges paid by the Plan, or may be responsible for charges paid by the Plan, the Plan will not be required to select a particular party from whom reimbursement is due. Furthermore, unallocated settlement funds meant to compensate multiple injured parties of which the Covered Person is/are only one or a few, that unallocated settlement fund is considered designated as an "identifiable" fund from which the Plan may seek reimbursement.

Subrogation:

1. As a condition to participating in and receiving benefits under this Plan, the Covered Person agrees to assign to the Plan the right to subrogate and pursue any and all Claims, causes of action or rights that

may arise against any person, corporation or entity and to any Coverage to which the Covered Person is entitled, regardless of how classified or characterized, at the Plan's discretion.

2. If a Covered Person receives or becomes entitled to receive benefits, an automatic equitable lien attaches in favor of the Plan to any Claim, which any Covered Person may have against any Coverage and/or party causing the Illness or Injury to the extent of such conditional payment by the Plan plus reasonable costs of collection. The Covered Person is obligated to notify the Plan or its authorized representative of any settlement prior to finalization of the settlement, execution of a release, or receipt of applicable funds. The Covered Person is also obligated to hold any and all funds so received in trust on the Plan's behalf and function as a trustee as it applies to those funds until the Plan's rights described herein are honored and the Plan is reimbursed.
3. The Plan may, at its discretion, in its own name or in the name of the Covered Person, commence a proceeding or pursue a Claim against any party or Coverage for the recovery of all damages to the full extent of the value of any such benefits or conditional payments advanced by the Plan.
4. The Covered Person authorizes the Plan to pursue, sue, compromise and/or settle any such Claims in the Covered Persons and/or the Plan's name and agrees to fully cooperate with the Plan in the prosecution of any such Claims if the Covered Person fails to file a Claim or pursue damages against:
    a. The responsible party, its insurer or any other source on behalf of that party;
    b. Any first party insurance through medical payment coverage, personal injury protection, no-fault coverage, uninsured or underinsured motorist coverage;
    c. Any policy of insurance from any insurance company or guarantor of a third party;
    d. Workers' Compensation or other liability insurance company; or
    e. Any other source, including crime victim restitution funds, any medical, disability or other benefit payments and school insurance coverage.

The Covered Person assigns all rights to the Plan or its assignee to pursue a Claim and the recovery of all expenses from any and all sources listed above. Should the policy holder fail to pursue such a claim or fail to fully cooperate with the Plan in the prosecution of any such Claim, and should the Plan then become liable to make payments under the terms and conditions of this contract then the Plan shall determine its payment under this contract as if the Covered person had in fact pursued his/her legal remedies and had been successful.

Right of Reimbursement:

1. The Plan shall be entitled to recover 100% of the benefits paid, without deduction for attorneys' fees and costs or application of the common fund doctrine, make whole doctrine, or any other similar legal theory, without regard to whether the Covered Person is fully compensated by his or her recovery from all sources. The Plan shall have an equitable lien which supersedes all common law or statutory rules, doctrines, and laws of any state prohibiting assignment of rights which interferes with or compromises in any way the Plan's equitable lien and right to reimbursement. The obligation to reimburse the Plan in full exists regardless of how the judgment or settlement is classified and whether or not the judgment or settlement specifically designates the recovery or a portion of it as including medical, disability, or other expenses. If the Covered Persons' recovery is less than the benefits paid, then the Plan is entitled to be paid all of the recovery achieved. Any funds received by the Covered Person are deemed held in constructive trust and should not be dissipated or disbursed

until such time as the Covered Person's obligation to reimburse the Plan has been satisfied in accordance with these provisions. The Covered Person is also obligated to hold any and all funds so received in trust on the Plan's behalf and function as a trustee as it applies to those funds until the Plan's rights described herein are honored and the Plan is reimbursed.

2. No court costs, experts' fees, attorneys' fees, filing fees, or other costs or expenses of litigation may be deducted from the Plan's recovery without the prior, express written consent of the Plan
3. The Plan's right of subrogation and reimbursement will not be reduced or affected as a result of any fault or claim on the part of the Covered Person, whether under the doctrines of causation, comparative fault or contributory negligence, or other similar doctrine in law. Accordingly, any lien reduction statutes, which attempt to apply such laws and reduce a subrogating Plan's recovery will not be applicable to the Plan and will not reduce the Plan's reimbursement rights.
4. These rights of subrogation and reimbursement shall apply without regard to whether any separate written acknowledgment of these rights is required by the Plan and signed by the Covered Person.
5. This provision shall not limit any other remedies of the Plan provided by law. These rights of subrogation and reimbursement shall apply without regard to the location of the event that led to or caused the applicable Illness, Injury, Disease or disability.

Reimbursement Due to Surrogacy Arrangement

If a Covered Person enters into a Surrogacy Arrangement, the Covered Person must reimburse the Plan for Covered Services received related to conception, pregnancy, delivery, or postpartum care in connection with that Surrogacy Arrangement. The reimbursed amount shall not exceed the payments or other compensation the Covered Person or another person is entitled to receive under the Surrogacy Arrangement.

A "Surrogacy Arrangement" is one in which a Covered Person agrees to become pregnant and to surrender the baby (or babies) to another person or persons who intend to raise the child (or children), whether or not the Covered Person receives payment for being a surrogate.

A Surrogacy Arrangement does not affect a Covered Person's obligation to pay any and all patient responsibility amounts for these services. These amounts will be taken into account at the time of reimbursement.

After a Covered Person surrenders a baby to the legal parents, the Plan is not obligated to pay for any Services that the baby receives (the legal parents are financially responsible for any Services that the baby receives).

As set forth above, as a condition precedent to the Covered Person receiving benefits under the Plan, the Covered Person automatically assigns to the Plan any right to receive payments that are payable to the Covered Person or any other payee under the Surrogacy Arrangement, regardless of whether those payments are characterized as being for medical expenses. To secure the Plan's rights, the Plan will also have a lien on those payments and on any escrow account, trust, or any other account that holds those payments. Those payments (and amounts in any escrow account, trust, or other account that holds those payments) shall first be applied to satisfy the Plan's lien.

Within 30 days after entering into a Surrogacy Arrangement, you must send written notice of the arrangement to the Plan, including all of the following information:

- Names, addresses, and telephone numbers of all parties to the arrangement;
- Names, addresses, and telephone numbers of any escrow agent or trustee;
- Names, addresses, and telephone numbers of the intended parents and any other parties who are

financially responsible for the services the baby (or babies) receive, including names, addresses, and telephone numbers for any health insurance that will cover the services that the baby (or babies) receive;
- A signed copy of any contracts and other documents explaining the details of the Surrogacy Arrangement; and
- Any other information the Plan requests in order to satisfy its rights.

You must send this information to:

Bywater Ltd.
15422 Detroit Ave
Lakewood, OH 44107

The Covered Person must complete and send the Plan all consents, releases, authorizations, lien forms, and other documents that are reasonably necessary for the Plan to determine the existence of any rights the Plan may have under this Surrogacy Arrangement and to satisfy those rights. The Covered Person may not agree to waive, release, or reduce the Plan's rights without the Plan's prior, written consent.

If a Covered Person's estate, parent, guardian, or conservator asserts a claim against a third party based on the Surrogacy Arrangement, the estate, parent, guardian, or conservator and any settlement or judgment recovered by the estate, parent, guardian, or conservator shall be subject to the Plan's liens and other rights to the same extent as if the Covered Person had asserted the claim against the third party. The Plan may assign its rights to enforce its liens and/or other rights.

Covered Person is a Trustee Over Plan Assets:

1. Any Covered Person who receives benefits and is therefore subject to the terms of this section is hereby deemed a recipient and holder of Plan assets and is therefore deemed a trustee of the Plan solely as it relates to possession of any funds which may be owed to the Plan as a result of any settlement, judgment or recovery through any other means arising from any Injury. By virtue of this status, the Covered Person understands that he/she is required to:
    a. Notify the Plan or its authorized representative;
    b. Settlement prior to finalization of the settlement, execution of a release, or receipt of applicable funds;
    c. Instruct his/her attorney to ensure that the Plan and/or its authorized representative is included as a payee on all settlement drafts;
    d. In circumstances where the Covered Person is not represented by an attorney, instruct the insurance company or any third party from whom the Covered Person obtains a settlement, judgment or other source of Coverage to include the Plan or its authorized representative as a payee on the settlement draft; and,
    e. Hold any and all funds so received in trust, on the Plan's behalf, and function as a trustee as it applies to those funds, until the Plan's rights described herein are honored and the Plan is reimbursed.
2. To the extent the Covered Person disputes this obligation to the Plan under this section, the Covered Person or any of its agents or representatives is also required to hold any/all settlement funds, including the entire settlement if the settlement is less than the Plan's interests, and without

reduction in consideration of attorneys' fees, for which he/she exercises control, in an account segregated from their general accounts or general assets until such time as the dispute is resolved.

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

Excess Insurance: If at the time of Injury, Illness, Disease or disability, there is available or potentially available any coverage (including coverage resulting from a judgment at law or settlements), the benefits under this Plan shall apply only as an excess over such other sources of coverage, except as otherwise provided for under the Plan's "Coordination of Benefits" section.

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

1. The responsible party, its insurer or any other source on behalf of that party;
2. Any first party insurance through medical payment coverage, personal injury protection, no-fault coverage, uninsured or underinsured motorist coverage;
3. Any policy of insurance from any insurance company or guarantor of a third party;
4. Workers' Compensation or other liability insurance company; or
5. Any other source, including crime victim restitution funds, any medical, disability or other benefit payments and school insurance coverage.

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

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

Obligations:

1. It is the Covered Person's obligation at all times, both prior to and after payment of medical benefits by the Plan:
    a. To cooperate with the Plan or any representatives of the Plan, in protecting its rights, including the filing of a lawsuit, participating in discovery, attending depositions, and cooperating in trial to preserve the Plan's rights;
    b. To provide the Plan with pertinent information regarding the Illness, Disease, disability or Injury, including accident reports, settlement information and any other requested additional information;
    c. To take such action and execute such documents as the Plan may require to facilitate enforcement of its subrogation and reimbursement rights;

d. To do nothing to prejudice the Plan's rights of subrogation and reimbursement;
e. To promptly reimburse the Plan when a recovery through settlement, judgment, award or other payment is received;
f. To notify the Plan or its authorized representative of any settlement prior to finalization of the settlement;
g. To not settle or release, without the prior consent of the Plan, any claim to the extent that the Covered Person may have against any responsible party or coverage;
h. To instruct his/her attorney to ensure that the Plan or its authorized representative is included as a payee on any settlement draft;
i. In circumstances where the Covered Person is not represented by an attorney, instruct the insurance company or any third party from whom the Covered Person obtains a settlement to include the Plan or its authorized representative as a payee on the settlement draft; and
j. To make good faith efforts to prevent disbursement of settlement funds until such time as any dispute between the Plan and Covered Person over settlement funds is resolved.

2. If the Covered Person and/or his or her attorney fails to reimburse the Plan for all benefits paid or to be paid, as a result of said Injury or condition, out of any proceeds, judgment or settlement received, the Covered Person will be responsible for any and all expenses (whether fees or costs) associated with the Plan's attempt to recover such money from the Covered Person.
3. The Plan's rights to reimbursement and/or subrogation are in no way dependent upon the Covered Persons' cooperation or adherence to these terms.

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

Minor Status:

1. In the event the Covered Person is a minor as that term is defined by applicable law, the minor's parents or court-appointed guardian shall cooperate in any and all actions by the Plan to seek and obtain requisite court approval to bind the minor and his or her estate insofar as these subrogation and reimbursement provisions are concerned.
2. If the minor's parents or court-appointed guardian fail to take such action, the Plan shall have no obligation to advance payment of medical benefits on behalf of the minor. Any court costs or legal fees associated with obtaining such approval shall be paid by the minor's parents or court-appointed guardian.

Language Interpretation: The Plan Administrator retains sole, full and final discretionary authority to construe and interpret the language of this provision, to determine all questions of fact and law arising under this provision and to administer the Plan's subrogation and reimbursement rights.

Severability: In the event that any section of this provision is considered invalid or illegal for any reason, said invalidity or illegality shall not affect the remaining sections of this provision and Plan. The section shall be

fully severable. The Plan shall be construed and enforced as if such invalid or illegal sections had never been inserted in the Plan.

Notwithstanding anything contained herein to the contrary, to the extent this Plan is not governed by ERISA, the Plan's right to subrogation and reimbursement may be subject to applicable State subrogation laws.

PLAN ADMINISTRATION

Delegation of Responsibility: The Plan Administrator is a named fiduciary of the Plan with full discretionary authority for the control and management of the operation and administration of the Plan. The Plan Administrator may delegate fiduciary and other responsibilities to any individual or entity. Any person to whom any responsibility is delegated may serve in more than one fiduciary capacity with respect to the Plan and may be a participant in the Plan.

Authority to Make Decisions: The Plan is administered by the Plan Administrator in accordance with ERISA. The Plan Administrator has retained the services of the Third Party Administrator to provide certain claims processing and other ministerial services. The Plan Administrator shall administer this Plan in accordance with its terms and establish its policies, interpretations, practices, and procedures. It is the express intent of this Plan that the Plan Administrator shall have maximum legal discretionary authority to construe and interpret the terms and provisions of the Plan, to make determinations regarding issues which relate to eligibility for benefits, to decide disputes which may arise relative to a Plan member's rights, and to decide questions of Plan interpretation and those of fact relating to the Plan. The decisions of the Plan Administrator will be final and binding on all interested parties. Benefits under this Plan will be paid only if the Plan Administrator decides, in its discretion, that a Covered Person is entitled to them.

The duties of the Plan Administrator include the following:

1. To administer the Plan in accordance with its terms;
2. To determine all questions of eligibility, status and coverage under the Plan;
3. To interpret the Plan, including the authority to construe possible ambiguities, inconsistencies, omissions and disputed terms;
4. To make factual findings;
5. To decide disputes which may arise relative to a Covered Person's rights;
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; or, alternatively, to appoint a qualified administrator to carry out these functions on the Plan Administrator's behalf;
7. To keep and maintain the Plan documents and all other records pertaining to the Plan;
8. To appoint and supervise a Third Party Administrator to pay Claims;
9. To perform all necessary reporting as required by Federal or State law;
10. To establish and communicate procedures to determine whether a child support order or decree is a QMCSO;
11. To delegate to any person or entity such powers, duties and responsibilities as it deems appropriate; and
12. To perform each and every function necessary for or related to the Plan's administration.

Amendment or Termination of Plan:

The Plan Administrator fully intends to maintain this Plan indefinitely; however, the Employer reserves the right to terminate, suspend, or amend this Plan at any time, in whole or in part, including making modifications to the benefits under this Plan. No person or entity has any authority to make any oral change

or amendments to this Plan. No agent or representative of this Plan will have the authority to legally change the Plan terms or SPD or waive any of its provisions, either purposefully or inadvertently. If a misstatement affects the existence of coverage, the relevant facts will be used in determining whether coverage is in force under the terms of this Plan and in what amount. The Plan Administrator will provide written notice to Covered Persons within 60 days following the adopted formal action that makes material reduction of benefits to the Plan, or may, alternatively, furnish such notification through communications maintained by the Plan Administrator at regular intervals of no greater than 90 days.

COVERED PERSON'S RIGHTS IF PLAN IS AMENDED OR TERMINATED

If this Plan is amended, a Covered Person's rights are limited to Plan benefits in force at the time expenses are Incurred, whether or not the Covered Person has received written notification from the Plan Administrator that the Plan has been amended. If this Plan is terminated, the rights of a Covered Person are limited to Covered Expenses Incurred before the Covered Person receives notice of termination. All claims Incurred prior to termination, but not submitted to either the Plan Administrator or the Third Party Administrator within 75 days of the Effective Date of termination of this Plan due to bankruptcy, will be excluded from any benefit consideration. The Plan will assume that the Covered Person receives the written amendment or termination letter from the Plan Administrator seven days after the letter is mailed to the Covered Person. No person will become entitled to any vested rights under this Plan.

DISTRIBUTION OF ASSETS UPON TERMINATION OF PLAN

Post-tax contributions paid by COBRA beneficiaries, if applicable, will be used for the exclusive purpose of providing benefits and defraying reasonable expenses related to Plan administration, and will not inure to the benefit of the Employer.

DEFINITIONS

In this section you will find the definitions for the capitalized words found throughout this Plan. There may be additional words or terms that have a meaning that pertains to a specific section, in which case those definitions will be found in that section provided and shall have such meaning when used in any other section. These definitions are not an indication that charges for particular care, supplies or services are eligible for payment under the Plan. Please refer to the appropriate sections of this Plan for that information.

Active Employee means an Employee who is on the regular payroll of the Employer, who has begun to perform the duties of his or her job with the Employer, and continues to perform duties unless covered by eligible and approved time off as required by law or the employee handbook of Plan Sponsor.

Administrative Period means the two (2) consecutive calendar month period immediately after the Measurement Period ends, during which an Employer can determine which Employees are Full-Time Employees to notify and enroll eligible Employees in coverage, etc.

Adverse Determination means any denial in benefits, including:

1. A reduction in benefits.
2. A recession of coverage, even if the recession does not impact a current Claim for benefits.
3. A termination of benefits.
4. A failure to provide or make payment (in whole or in part) for a benefit, including any such denial, reduction, termination, or failure to provide or make payment that is based on a determination of a Claimant's eligibility to participate in the Plan.

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

Ambulatory Surgical Center means a free-standing surgical center, which is not part of a Hospital and which:

1. Has an organized medical staff of Physicians;
2. Is a permanent facility equipped and operated primarily for the purpose of performing Surgical Procedures;
3. Has continuous Physician's services and registered graduate nursing (R.N.) services whenever a patient is in the facility;
4. Is State licensed and approved (where required by law) by the jurisdiction in which it is located; and
5. Does not provide for overnight accommodations.

Assignment of Benefits means an arrangement whereby a Claimant of the Plan, at the discretion of the Plan Administrator, assigns its right to seek and receive payment of eligible Plan benefits, less Deductible, Copayments and Coinsurance amounts, to a Provider.

Assistant Surgeon means a Physician who actively assists the Physician in charge of a case in performing a Surgical Procedure. Depending on the type of Surgery to be performed, an operating surgeon may have 1 or 2 Assistant Surgeons. The technical aspects based on procedure codes of the Surgery involved dictate the need for an Assistant Surgeon.

Authorized Representative means an individual chosen by a Covered Person, in writing, to discuss, act, and make decisions on the Covered Person's behalf with the Plan, such as a family member or other trusted person.

Benefit Year means the twelve (12) month period beginning on either the Effective Date of the Plan, which is defined as the plan year under ERISA, or on the day following the end of the first Benefit Year that is a short Benefit Year.

Birthing Center means a place licensed as such by an agency of the state. If the state does not have any licensing requirements, it must meet all of the following tests: (1) is primarily engaged in providing birthing services for low risk pregnancies; (2) is operated under the supervision of a Physician; (3) has at least one registered nurse (R.N.) certified as a nurse midwife in attendance at all times; (4) has a written agreement with a licensed ambulance for that service to provide immediate transportation of the Covered Person to a Hospital if an emergency arises; and (5) has a written agreement with a Hospital located in the immediate geographical area of the Birthing Center to provide emergency admission of the Covered Person.

Calendar Year means the twelve (12) month period from January 1 – December 31 of each year.

Center(s) of Excellence means medical care facilitates that have met stringent criteria for quality care in the specialized procedures. These centers have the greatest experience in performing the specialized procedures and the best survival rates. The Plan Administrator shall determine what Network Center(s) of Excellence are to be used. Please see the section on "Centers of Excellence" in this Plan.

Additional information about this option, as well as a list of Centers of Excellence, will be given to Covered Persons and updated as requested.

Claim means a written request for a Plan benefit, made by a Claimant, which complies with the reasonable procedures of the Plan. A Claim does not include a request for determination of eligibility under the Plan from a Provider, a determination of a certain procedure or treatment as a Covered Expense before the treatment is rendered by a Provider, or a presentation of a prescription to a pharmacy.

Claimant means a Covered Person, or entity/person acting on his or her behalf, authorized to submit claims to the Plan for Processing, and/or appeal an Adverse Benefit Determination.

Clean Claim means a Claim that can be processed in accordance with the terms of this document without obtaining additional information form 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 review for Medical Necessity and Reasonableness, or fees under review for Usual and Customariness, or any other matter that may prevent the charge(s) from being Covered Expenses in accordance with this document.

Close Relative means a Covered Person's Spouse, parent, sibling, child, grandparent, grandchild, aunt, uncle, cousin, step relative or in-law.

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

Coinsurance means a cost sharing feature of this health plan as set forth in the Schedule of Benefits.

Concurrent Review means a review of medical information by the Utilization Review Administrator.

Congenital Anomaly means a physical developmental defect that is present at birth.

Copay or Copayment means a portion, whether dollar amount or percentage, the Covered Person pays for certain covered services at the time such services are rendered as provided in the Medical Schedule of Benefits. A Copay is applied for each occurrence of such covered medical service and is not applied toward satisfaction of the Deductible.

Cosmetic means any care, treatment of, or operations which are performed for plastic, reconstructive, or appearance purposes or any other service or supply which is primarily used to improve, alter, or enhance appearance of a physical characteristic.

Covered Expense means:

1. A service or supply listed in the Plan as an eligible medical expense for which the Plan provides coverage as an eligible Medically Necessary service, treatment, or supply meant to improve a condition or the health of a Covered Persons, so long as the charge does not exceed the Maximum Allowable Charge.
2. For Prescription Drug expenses, any Prescription Drugs or medicines eligible for coverage under the Prescription Benefit Program.

Covered Person means, individually, an Employee and each of his or her Dependents who is eligible, has elected coverage, and is enrolled under the Plan.

Custodial Care means care or confinement provided primarily for the maintenance of the Covered Person, essentially designed to assist the Covered Person, whether or not totally disabled, in the activities of daily living, which could be rendered at home or by persons without professional skills or training. This care is not reasonably expected to improve the underlying medical condition, even though it may relieve symptoms or pain. Such care includes, but is not limited to, bathing, dressing, feeding, preparation of special diets, assistance in walking or getting in and out of bed, supervision over medication which can normally be self-administered and all domestic activities.

Deductible means the aggregate amount for certain expenses for covered services that is the responsibility of the Covered Person to pay for him or herself each Benefit Year before the Plan will begin its payments.

However, if the Plan is a Health Savings Account (HSA) qualified High Deductible Health Plan (HDHP) certain covered benefits may be considered Preventative Care and paid first dollar. The Covered Person's ability to contribute to a HSA on a tax favored basis may be affected by any arrangement that waives this Plan's Deductible.

Dentist means an individual who is duly licensed to practice dentistry or to perform oral surgery in the state where the service is performed and is operating within the scope of such license. A Physician will be considered a Dentist when performing any covered dental services allowed within such license.

Diagnosis means the identification or determination by a Physician of the nature and cause of an Injury or Illness though evaluation of patient history, examination, and review of laboratory data.

Disease means a pathological condition of a body part, an organ, or a system resulting from various causes, such as infection, genetic defect, or environmental stress, and characterized by an identifiable group of signs or symptoms which does not arise out of, which is not caused or contributed to by, and which is not a consequence of, any employment or occupation for compensation or profit; however, if evidence satisfactory to the Plan shows the individual is not covered, or not fully covered, as an Employee under a workers' compensation law, occupational disease law or any other legislation of similar purpose, then, for the purposes of the Plan, it shall be regarded as an Illness or Disease.

Dialysis means the clinical purification of blood as a substitute for the natural function of the kidneys, including treatment and/or services for hemodialysis, peritoneal dialysis, and hemofiltration.

Drug or Prescription Drug means a Food and Drug Administration (FDA) approved drug or medicine that is listed with approval in the *United States Pharmacopeia*, *National Formulary*, or *AMA Drug Evaluations* published by the American Medical Association (AMA), that is prescribed for human consumption, and that is required by law to bear the legend: "Caution – Federal Law prohibits dispensing without prescription," or a State restricted drug (any medical substance which may be dispensed only by prescription, according to State law), legally obtained and dispensed by a licensed drug dispenser only, according to a written prescription given by a Physician and/or duly licensed Provider. This definition does not include any medical substance prohibited by Federal law. Drug also means insulin for purposes of injection.

Durable Medical Equipment means equipment and/or supplies ordered by a health care Provider for everyday or extended use which meets off of the following requirements:

1. Can withstand repeated use;
2. Is primarily and customarily used to serve a medical purpose;
3. Generally is not useful to a person in the absence of an Illness or Injury; and
4. Is appropriate for use in the home.

Emergency Medical Condition/Emergency means a situation or medical condition with symptoms of sufficient severity (including severe pain) that a prudent layperson, possessing an average knowledge of health and medicine, could expect the absence of immediate medical attention and treatment to result in:

1. Placing the health of the individual (or, with respect to a pregnant woman, the health of the woman or her unborn child) in serious jeopardy;
2. Serious impairment to bodily functions; or
3. Serious dysfunction of any bodily organ or part.

Emergency Medical Conditions or Emergencies may be considered on receipt of proof, satisfactory to the Plan, per the Plan Administrator's discretion, that an Emergency did exist. The Plan may, at its own discretion, request satisfactory proof that an Emergency or acute condition did exist.

Emergency Services means, with respect to an Emergency Medical Condition:

1. A medical screening examination (as required under section 1867 of the Social Security Act, 42 U.S.C. 1395dd) that is within the capability of the emergency department of a Hospital, including ancillary services routinely available to the emergency department to evaluate such Emergency Medical Condition; and
2. Such further medical examination and treatment, to the extent they are within the capabilities of the staff and facilities available at the Hospital, as are required under section 1867 of the Social Security Act (42 U.S.C. 1395dd(e)(3)) to Stabilize the individual.

Employee means a person who is regularly scheduled to work for the Employer in an Employee/Employer relationship.

Employer means AE Insurance, LLC dba American Exchange or any successor thereto.

ERISA means the Employee Retirement Income Security Act of 1974, as amended.

Experimental and/or Investigational means services, supplies, care, procedures, treatments or courses of treatment which do 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 reasonable segment of the medical community or government oversight agencies at the time rendered.

The Plan Administrator must make an independent evaluation of 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 then Plan. The Plan Administrator will be guided by the following principles:

A drug, device, or medical treatment or procedure is Experimental if one of the following requirements is met:

1. If the drug or device cannot be lawfully marketed without approval of the U.S. FDA 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. Except as provided under the Clinical Trial benefit in the Medical Benefits section, if reliable evidence shows that the drug, device, or medical treatment or procedure is the subject of ongoing Phase I, II, or III clinical trials, is the research, experimental, study or Investigational arm of ongoing phase III clinical trials, or is otherwise under study to determine the following:

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

4. If reliable evidence shows that the consensus among experts regarding the drug, device, or medical treatment or procedure is that further studies or clinical trials are necessary to determine all of the following:
    a. Maximum tolerated dose.
    b. Toxicity.
    c. Safety.
    d. Efficacy.
    e. Efficacy as compared with the standard means of treatment or Diagnosis.

Reliable evidence shall mean one or more of the following:

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

Notwithstanding the above, a prescription drug for a treatment that has been approved by the FDA but is used in a non-approved treatment shall not be considered Experimental and/or Investigational for purposes of this Plan and shall be afforded coverage to the same extent as any other prescription drug, provided that the drug is recognized by one of the following as being Medically Necessary for the specific treatment for which it has been prescribed:

1. The American Medical Association Drug Evaluations.
2. The American Hospital Formulary Service Drug Information.
3. The United States Pharmacopeia Drug Information.
4. Reputable medical Compendia.

Family Unit means the Employee and his or her Dependents covered under the Plan.

Full-Time Employee means an Employee who normally works at least 30 hours per week or 130 hours per month and is not a Seasonal Employee.

FMLA means the Family and Medical Leave Act of 1993, as amended.

GINA means the Genetic Information Nondiscrimination Act of 2008 (Public Law No. 110-233).

Genetic Information means, with respect to any individual, information about any of the following:

1. Such individual's genetic tests.
2. The genetic tests of family members of such individual.
3. The manifestation of a Disease or disorder in family members of such individual.

The term "Genetic Information" includes participating in clinical research involving genetic services. Genetic tests would include analysis of human DNA, RNA, chromosomes, proteins, or metabolites that detect genotypes, mutations, or chromosomal changes. Genetic information is a form of Protected Health Information (PHI) as defined by and in accordance with the Health Insurance Portability and Accountability Act of 1996 (HIPAA), and is subject to applicable Privacy and Security Standards.

HIPAA means the Health Insurance Portability and Accountability Act of 1996 (HIPAA), as amended.

Home Health Care Agency means an agency or organization which provides a program of home health care and which meets one of the following requirements:

1. Is a Federally certified Home Health Care Agency and approved as such under Medicare.
2. Meets the established standards and is operated pursuant to applicable laws in the jurisdiction in which it is located and, is licensed and approved by the regulatory authority having the responsibility for licensing, where licensing is required.
3. Meets all of the following requirements:
    a. It is an agency which holds itself forth to the public as having the primary purpose of providing a Home Health Care delivery system bringing supportive services to the home.
    b. It has a full time administrator.
    c. It maintains written records of services provided to the patient.
    d. Its staff includes at least one Registered Nurse (RN) or it has nursing care by a Registered Nurse (RN) available.
    e. Its employees are bonded and it provides malpractice insurance.

Hospice means an agency that provides counseling and incidental medical services and may provide Room and Board to terminally ill individuals and meets all of the following requirements:

1. Obtained any required state or governmental Certificate of Need approval;
2. Provides 24-hour-a-day, 7 days-a-week service;
3. Under the direct supervision of a duly qualified Physician;
4. A nurse coordinator who is a registered nurse (R.N.) with 4 years of full-time clinical experience, at least 2 of which involved caring for terminally ill patients;
5. A social- service coordinator who is licensed in the jurisdiction in which it is located;
6. An agency that has as its primary purpose the provision of hospice services;
7. A full-time administrator;
8. Maintains written records of services provided to the patient;
9. Employees are bonded and it provides malpractice and malplacement insurance;

10. Established and operated in accordance with the applicable laws in the jurisdiction in which it is located and, where licensing is required, has been licensed and approved by the regulatory authority having responsibility for licensing under the law;
11. Provides nursing care by a registered nurse (R.N.), a licensed practical nurse (L.P.N.), a licensed physical therapist, certified occupational therapist, American Speech Language and Hearing Association certified speech therapist or a certified respiratory therapist; and
12. Provides a home health aide acting under the direct supervision of one of the above persons while performing services specifically ordered by a Physician.

Hospital means an Institution, accredited by the Joint Commission on Accreditation of Hospitals (sponsored by the AMA and the AHA), under the supervision of a staff of Physicians that maintains diagnostic and therapeutic facilities on premises, for the provision of medical (including Surgical facilities for all Institutions other than those specializing in the care and treatment of mentally ill patients, provided such Institution is accredited as such a facility by the Joint Commission on Accreditation of Hospitals sponsored by the AMA and the AHA), Diagnosis, treatment, and care to Injured or sick persons with 24 hour a day nursing service by Registered Nurses.

To be deemed a "Hospital," the facility must be duly licensed if it is not a State tax supported Institution, and must not be primarily a place for rest, the aged, and/or a nursing home, custodial, or training institution; or an Institution which is supported in whole or in part by a Federal government fund.

Institutions and/or facilities not deemed to be a Hospital in accordance with Medicare, shall not be deemed to be Hospitals for this Plan's purposes.

Hour(s) of Service means each hour for which an Employee is paid, or entitled to payment, for the performance of duties for the Employer (or a related Employer) and for a period of time during which no duties are performed due to vacation, holiday, Illness, incapacity (including disability), layoff, jury duty, military duty, or leave of absence, but excluding Hours of Service to the extent that the compensation for those services constitutes income from sources outside the United States or performed as (1) a bona fide volunteer (as defined in Treas. Reg. Section 54.4980H-1(a)(7)) or (2) part of a federal or state work study program.

For Employees paid on an hourly basis, an Employer must calculate actual Hours of Service from records of hours worked and hours for which payment is made or due (the “actual method”). For Employees paid on a non-hourly basis, the Employer must calculate Hours of Service based on the actual method or, provided doing so does not substantially understate the Employee’s hours, using an equivalency method where the Employee is credited with either: (1) 8 Hours of Service for each day for which the Employee would be required to be credited with one Hour of Service; or (2) 40 Hours of Service for each week for which the Employee would be required to be credited with at least one Hour of Service.

Illness means any disorder (physical, mental, or substance abuse), disease, physical sickness, pregnancy (including childbirth and miscarriage), which does not arise out of, which is not caused or contributed to by, and which is not a consequence of, any employment or occupation for compensation or profit; however, if evidence satisfactory to the Plan shows the individual is not covered, or not fully covered, as an Employee

under a workers' compensation law, occupational disease law or any other legislation of similar purpose, then, for the purposes of the Plan, it shall be regarded as an Illness or Disease.

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

Initial Measurement Period means the "look back period" of twelve (12) consecutive calendar months during which an Employer measures the Hours of Service for its New Employees in order to determine their status as a Full Time Employee or Part Time Employee beginning on the first day of the first calendar month starting on or after the date the Employee completes at least one Hour of Service for the Employer. For purposes of this definition, an Employee who has been rehired by the Employer is treated as a New Employee for the Employer on his or her most recent reemployment date only if more than 13 consecutive weeks, or 26 weeks for educational organizations as required under the ACA, have passed since the Employee was last credited with an Hour of Service with the Employer (or with any affiliated company organization that is required to be treated as the same Employer for purposes of Code Section 4980H).

Injury means physical damage or harm to the body, caused by an external force and which is due, directly and independently of all other causes, to unexpected and unforeseen means, and which is not a consequence of any employment or occupation for compensation or profit.

Inpatient means any person who, while confined and registered to a Hospital, is assigned to a bed in any department of the Hospital other than its Outpatient department and for whom a charge for Room and Board is made by the Hospital.

Institution means a facility created and/or maintained for the purpose of practicing medicine and providing organized health care and treatment to individuals, operating within the scope of its license, such as a Hospital, Ambulatory Surgical Center, Psychiatric Hospital, community mental health center, residential treatment facility, psychiatric treatment facility, Substance Abuse Treatment Center, alternative birthing center, Home Health Care Agency, or any other such facility that the Plan approves.

Intensive Care Unit means a separate, clearly designated service area, which is maintained within a Hospital solely for the care and treatment of patients who are critically ill, including in what is referred to as a "coronary care unit" or an "acute care unit," which meets all of the following requirements:

1. It is solely for the care and treatment of critically ill patients who require special medical attention.
2. The facilities provide the confined area with special nursing care and observation of a continuous and constant nature not available in regular rooms and wards of the Hospital;
3. A concentration of special lifesaving equipment which is immediately available at all times for the patients in the confined area;
4. At least two (2) beds for the accommodation of the critically ill; and

5. At least one (1) professional Registered Nurse (R.N.) in continuous and constant attendance of the confined area twenty-four (24) hours a day.

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 an individual that is placed with such person by judgment, decree or other order of any court of competent jurisdiction.

Maintenance Therapy means medical and non-medical health-related services that do not seek to cure or that are provided during periods when the medical condition of the individual is not changing or does not require continued administration by Physician.

Measurement Period means the "look back period" consisting of twelve (12) consecutive calendar months during which an Employer measures the Hours of Service for its Employees in order to determine their status as a Full Time Employee or Part Time Employee after the Initial Measurement Period.

Solely for purposes of computing average Hours of Service for a continuing Employee during any Measurement Period that includes any portion of an "employment break period", a preliminary average will first be determined by disregarding the employment break period. The Employee will then be credited with additional Hours of Service for each Calendar Year equal to the lesser of (1) 501 Hours of Service or (2) the number of Hours of Service that would be needed for the Employee's average for the entire Measurement Period (disregarding "special unpaid leave") to equal the preliminary average. The Employee's final average, which will be used to determine if the Employee is a Full-Time Employee, will then be determined by dividing the total Hours of Service credited by the length of the Measurement Period (disregarding "special unpaid leave").

"Special unpaid leave" means unpaid leave for jury duty, unpaid leave that is subject to the Family and Medical Leave Act of 1993, or unpaid leave that is subject to the Uniformed Services Employment and Reemployment Rights Act of 1994.

Maximum Amount and/or Maximum Allowable Charge means 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; or
4. The actual billed charges for the covered services.

The Plan has the discretionary authority to decide if a charge is Usual and Customary and for a Medically Necessary and Reasonable service.

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

Medically Necessary/Medical Necessity means health care services ordered by a Physician exercising prudent clinical judgment provided for the purposes of evaluation, Diagnosis or treatment of a Covered Person's Injury or Illness, and must meet all of the following requirements:

1. It must be clinically appropriate in terms of type, frequency, extent, site and duration for the Diagnosis or treatment of the Covered Person's Injury or Illness.
2. The setting and level of service is that setting and level of service which, considering the Covered Person's medical symptoms and conditions, cannot be provided in a less intensive medical setting.
3. It must not be Maintenance Therapy or maintenance treatment.
4. Its purpose must be to restore health.
5. It must not be primarily custodial in nature.
6. It must not be a listed item or treatment in which reimbursement by the Centers for Medicare and Medicaid Services (CMS) is not permitted as provided at https://www.cms.gov/medicare-coverage-database/indexes/national-and-local-indexes.aspx.
7. The Plan reserves the right to incorporate CMS guidelines in effect on the date of treatment as additional criteria for determination of Medical Necessity and/or an Allowable Expense.

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

To be Medically Necessary, all of these criteria must be met. The determination of whether a service, supply, or treatment is or is not Medically Necessary may include findings of the American Medical Association and the Plan Administrator's own medical advisors. The Plan Administrator has the discretionary authority to decide whether care or treatment is Medically Necessary.

Off-label Drug use is considered Medically Necessary when all of the following conditions are met:

1. The Drug is approved by the Food and Drug Administration (FDA).
2. The prescribed Drug use is supported by one of the following standard reference sources:
    a. Micromedex® DRUGDEX.
    b. The American Hospital Formulary Service Drug Information.
    c. Medicare approved Compendia.
    d. Scientific evidence supported in well-designed clinical trials published in two (2) major peer-reviewed medical journals with supporting data that the Drug is safe and effective for the specific condition.
3. The Drug is Medically Necessary to treat the specific condition, including life threatening conditions or chronic and seriously debilitating conditions.

Medicare means the Federal program by which health care is provided to individuals who are 65 or older, certain younger individuals with disabilities, and individuals with End-Stage Renal Disease, administered in accordance with parameters set forth by the Centers for Medicare and Medicaid Services (CMS) and Title XVIII of the Social Security Act of 1965, as amended, by whose terms it was established.

Mental Disorder means any Disease, Illness, or condition, regardless of whether the cause is organic, that is classified as a Mental Disorder in the current edition of the International Classification of Diseases published

by the U.S. Department of Health and Human Services, is listed in the current edition of Diagnostic and Statistical Manual of Mental Disorders, published by the American Psychiatric Association or other relevant State guideline or applicable sources.

Morbid Obesity means (1) a body mass index (BMI) of 40 or greater or (2) a BMI of 35 or greater in conjunction with a severe co-morbidity, such as obesity hypoventilation, sleep apnea, diabetes, hypertension, cardiomyopathy or musculoskeletal dysfunction.

New Employee means any Employee who has yet to be employed for a full Measurement Period or who resumed employment with the Employer (or a related entity that would be considered the same Employer for purposes of Code Section 4980H) after at least 26 consecutive weeks during which the Employee was not credited with an Hour of Service for the Employer (or a related entity).

Non-Participating Provider means facilities, Providers, and suppliers that have not contracted directly with the Plan or an entity contracting on behalf of the Plan to provide such services to Plan enrollees.

Other Plan means any of the following plans, other than this Plan, providing benefits or services for medical or dental care or treatment:

1. Group, blanket or franchise insurance coverage;
2. Any group Hospital service prepayment, group medical or dental service prepayment, group practice or other group prepayment coverage;
3. Any coverage under labor-management trusteed plans, union welfare plans, employer organization plans, school insurance or employee benefit organization plans;
4. Coverage under Medicare and any other governmental program that the Covered Person is liable for payment, except state-sponsored medical assistance programs and TRICARE, in which case this Plan pays primary;
5. Coverage under any Health Maintenance Organization (HMO); or
6. Any mandatory automobile insurance (such as no-fault) providing benefits under a medical expense reimbursement provision for health care services because of Injuries arising out of a motor vehicle accident and any other medical and liability benefits received under any automobile policy.

Outpatient means a person who receives Emergency Services, observation services, Surgery, lab tests, X-rays, or any other Provider services and the Physician has not written an order to admit the individual to a Hospital as an Inpatient. In these cases, an individual is an Outpatient even if the night is spent in the Hospital.

Part Time Employee means for any New Employee, an Employee who the Employer reasonably expects to work, on average, less than 30 Hours of Service per week during the Initial Measurement Period. For a continuing Employee, an Employee who has been determined during the Measurement Period to average less than 30 Hours of Service per week.

Participating Provider means facilities, Providers, and suppliers that have contracted directly with the Plan or an entity contracting on behalf of the Plan to provide services to Plan enrollees and grant access to discounted fees for service(s) provided to Covered Persons, and for which the Assignment of Benefits and the discounted fees thereby paid to them by the Plan as payment in full for Covered Expenses.

Physician means a legally licensed Physician who is acting within the scope of their license and any other licensed practitioner required to be recognized for benefit payment purposes under the laws of the state in which they practice and who is acting within the scope of their license. The definition of Physician includes: Doctor of Medicine (M.D.), Doctor of Osteopathy (D.O.), Chiropractor, Licensed Consulting Psychologist, Licensed Psychologist, Licensed Clinical Social Worker, Occupational Therapist, Optometrist, Ophthalmologist, Physical Therapist, Podiatrist, Registered Nurse (R.N.), Licensed Practical Nurse (L.P.N.), Nurse Practitioner, Physician's Assistant, Speech Therapist, Speech Pathologist and Licensed Midwife (if covered by the Plan).

Plan means the AE Insurance, LLC dba American Exchange Employee Benefit Plan.

Plan Administrator means AE Insurance, LLC dba American Exchange or any successor thereto.

Plan Sponsor means AE Insurance, LLC dba American Exchange or any successor thereto. The Plan Sponsor may delegate fiduciary and other responsibilities.

Primary Care Physician means a licensed Physician practicing in one of the following fields: (1) family practice; (2) general practice; (3) internal medicine; (4) obstetrics and gynecology; or (5) pediatrics.

Pre-Certify or Pre-Certification means the process of obtaining eligibility, authorization, or approval under the Plan prior to receipt of a particular medical service, treatment, or Prescription Drug.

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

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

Psychiatric Hospital means an Institution, appropriately licensed as a psychiatric hospital, established for the primary purpose of providing diagnostic and therapeutic psychiatric services for the treatment of mentally ill persons either by, or under the supervision of, a Physician. As such, to be deemed a Psychiatric Hospital, the Institution must ensure every patient is under the care of a Physician and their staffing pattern must ensure the availability of a Registered Nurse 24 hours each day. Should the Institution fail to maintain clinical medical records on all patients permitting the determination of the degree and intensity of treatment to be provided that Institution will not be deemed to be a Psychiatric Hospital.

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

1. The clinical trial is intended to treat cancer or other life threatening condition in a patient who has been Diagnosed;
2. The study or investigation is approved or funded (which may include funding though in-kind contributions) by one or more of the following:
    a. The Centers for Disease Control and Prevention of the U.S. Department of Health and Human Services.
    b. The National Institute of Health.
    c. The U.S. Food and Drug Administration.
    d. The U.S. Department of Defense.
    e. The U.S. Department of Veterans Affairs.
    f. An institutional review board of an institution that has an agreement with the Office for Human Research Protections of the U.S. Department of Health and Human Services.
3. The facility and personnel conducting the clinical trial are capable of doing so by virtue of their experience and training and treat a sufficient volume of patients to maintain that expertise;
4. The Covered Person meets the selection criteria enunciated in the study protocol for participation in the clinical trial;
5. The Covered person has provided informed consent for participation in the clinical trial in a manner consistent with current legal and ethical standards;
6. The available clinical or pre-clinical data provide a reasonable expectation that the Covered Person's participation in the clinical trial will provide a medical benefit that is commensurate with the risks of participation in the clinical trial; and
7. The clinical trial must have a preventive, diagnostic, or therapeutic intent and must, to some extent, assess the effect of the intervention on the Covered Person.

Reasonable means in the Plan 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's error or mistake. 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 evidence-based guidelines, and the findings and assessments of the following entities: (a) The National Medical Associations, Societies, and organizations; (b) The Centers for Medicare and Medicaid Services (CMS) and (c) The Food and Drug Administration. A finding of Provider negligence and/or malpractice is not required for service(s) and/or fee(s) to be considered not Reasonable.

To be Reasonable, service(s) and/or fee(s) must also be in compliance with generally accepted billing practices for unbundling or multiple procedures. 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.

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

Reconstructive Surgery means Surgery that is incidental to an Injury, Illness or Congenital Anomaly when the primary purpose is to improve physiological functioning of the involved part of the body. The fact that physical appearance may change or improve as a result of Reconstructive Surgery does not classify such Surgery as Cosmetic when a physical impairment exists and the Surgery restores or improves function. Additionally, the fact that a Covered Person may suffer psychological consequences or socially avoidant behavior as a result of an Injury, Illness or Congenital Anomaly does not classify Surgery to relieve such consequences or behavior as Reconstructive Surgery.

Rehabilitation Hospital means an appropriately licensed Institution, which is established in accordance with all relevant Federal, State and other applicable laws, to provide therapeutic and restorative services to individuals seeking to maintain, reestablish, or improve motor-skills and other functioning deemed Medically Necessary for daily living, that have been lost or impaired due to Illness and/or Injury. To be deemed a Rehabilitation Hospital, the Institution must be legally constituted, operated, and accredited for its stated purpose by either the Joint Commission on Accreditation of Hospitals or the Commission on Accreditation for Rehabilitation Facilities, as well as approved for its stated purpose by the Centers for Medicare and Medicaid Services (CMS) for Medicare purposes.

To be deemed a Rehabilitation Hospital, the Institution must not be primarily a place for rest, the aged, and/or a nursing home, Skilled Nursing Facility, custodial, or training institution.

Room and Board means a Hospital's charge for any of the following:

1. Room and complete linen service.
2. Dietary service including all meals, special diets, therapeutic diets, required nourishment's, dietary supplements and dietary consultation.
3. All general nursing services including coordinating the delivery of care, supervising the performance of other staff members who have delegated member care and member education.
4. Other conditions of occupancy which are Medically Necessary.

Seasonal Employee means an Employee who is hired into a position that recurs annually at about the same time each year for which the customary annual employment is 6 months or less.

Security Standards means the final rule implementing HIPAA's Security Standards for the Protection of Electronic PHI, as amended.

Semi-Private Room means a Hospital room shared by two (2) or more patients.

Skilled Nursing Facility is a facility that meets all of the following requirements:

1. It is licensed to provide professional nursing services on an Inpatient basis to persons convalescing from Injury or Illness. 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, developmentally 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 an Institution referring to itself as an extended care facility, convalescent nursing home, or long-term acute care facility.

Special Enrollee is an eligible Employee or eligible Dependent that does not elect coverage under this Plan during their original 31-day eligibility period and who later enrolls in the Plan due to a Special Enrollment Event.

Specialist means a licensed Physician that provides services to a Covered Person within the range of their specialty (e.g. cardiologist, neurologist, etc.).

Stability Period means the Benefit Year during which Employees are considered Full Time Employees or Part Time Employees based on the Employee's Hours of Service during the Measurement Period; regardless of how many hours the individual works during the Stability Period.

Stabilize means, with respect to an Emergency Medical Condition, to provide such medical treatment for the condition as may be necessary to assure, within reasonable medical probability that no material deterioration of the condition is likely to result from or occur during the transfer of the individual from a facility; or with respect to an Emergency Medical Condition of a pregnant woman who is having contractions and (1) there is inadequate time to effect a safe transfer to another Hospital before delivery or (2) transfer may pose a threat to the health or safety of the woman or her unborn child to deliver (including the placenta).

Substance Abuse and/or Substance Use Disorder means any use of alcohol, any drug (whether obtained legally or illegally), any narcotic, or any hallucinogenic or other illegal substance, which produces a pattern of pathological use, causing impairment in social or occupational functioning, or which produces physiological dependency evidenced by physical tolerance or withdrawal. It is the excessive use of a substance, especially alcohol or a drug. The Diagnostic and Statistical Manual of Mental Disorders (DSM) definition of Substance Use Disorder is applied as outlined below.

A maladaptive pattern of substance use leading to clinically significant impairment or distress, as manifested by one or more of the following, occurring within a 12 month period:

1. Recurrent substance use resulting in a failure to fulfill major role obligations at work, school or home (e.g., repeated absences or poor work performance related to substance use; substance related absences, suspensions or expulsions from school; neglect of children or household).

2. Recurrent substance use in situations in which it is physically hazardous (e.g., driving an automobile or operating a machine when impaired by substance use).
3. Craving or a strong desire or urge to use a substance.
4. Continued substance use despite having persistent or recurrent social or interpersonal problems caused or exacerbated by the effects of the substance (e.g., arguments with spouse about consequences of intoxication, physical fights).

Surgery or Surgical Procedure means with instruments designed specifically for the intended purpose, and the performance of generally accepted operative procedures, performed within the scope of the Provider's license any of the following:

1. The incision, excision, debridement or cauterization of any organ or part of the body and the suturing of a wound;
2. The manipulative reduction of a fracture or dislocation or the manipulation of a joint including application of cast or traction;
3. The removal by endoscopic means of a stone or other foreign object from any part of the body or the diagnostic examination by endoscopic means of any part of the body;
4. The induction of artificial pneumothorax and the injection of sclerosing solutions;
5. Arthrodesis, paracentesis, arthrocentesis and all injections into the joints or bursa;
6. Obstetrical delivery and dilation and curettage; or
7. Biopsy.

Third Party Administrator means the claims administrator which provides customer service and claims payment services on behalf of the Plan and does not assume any financial risk or obligation with respect to those claims; Bywater Ltd., 15422 Detroit Ave, Lakewood, OH 44107.

Total Disability and/or Totally Disabled means an individual is determined as being disabled for Social Security purposes and provides such evidence to the Plan of the determination as the Plan Administrator may, in its sole discretion, require.

Urgent Care Facility means a facility which is engaged in providing minor emergency and episodic medical care to a Covered Person. A board-certified Physician, a registered nurse and a registered x-ray technician must be in attendance at all times that the facility is open. The facility must include x-ray and laboratory equipment and a life support system. For the purpose of this Plan, a facility meeting these requirements will be considered to be an Urgent Care Facility, by whatever actual name it may be called; however, an after-hours clinic shall be excluded from the terms of this definition.

USERRA means the Uniformed Services Employment and Reemployment Rights Act of 1994 (USERRA), as amended.

Usual and Customary means the lesser of the fee or fees most frequently accepted as payment by like health care providers in the same geographical area for the same or like services or treatment, Drugs, or supplies, or the negotiated fee schedule of a preferred provider organization (PPO). "Geographical area" shall mean a metropolitan area, county or such greater area as is necessary to obtain a representative cross-section of providers rendering such services, treatment or supplies for which a specific charge is made. To be Usual and

Customary, fees must be in compliance with generally accepted billing practices under generally accepted and published industry standards, including the use of normative data such as Medicare cost to charge ratios. When data is not available to determine Usual and Customary pursuant to this definition, the fee will be paid at 150% of Medicare. The Plan Administrator will determine the usual charge for any procedure, service or supply, and whether a specific procedure, service or supply is customary.

Variable Hour Employee means an Employee who, at the time of hire, the Employer cannot reasonably determine if he or she will average at least 30 Hours of Service per week.

Walk-In Clinic means a free-standing health care facility used as an alternative to a Physician's office visit for unscheduled treatment of minor Illness and Injury and the administration of certain immunizations. Walk-In Clinics are not an alternative for emergency room services or the ongoing care provided by a Physician. Neither an emergency room nor the Outpatient department of a Hospital shall be considered a Walk-In Clinic.

All other defined terms in this Plan Document shall have the meanings specified in the Plan Document where they appear.

MISCELLANEOUS INFORMATION

Administration of Assignment of Benefits: If a Participating Provider accepts an Assignment of Benefits, the Provider's rights to receive Plan benefits are equal to those of the Claimant, and are limited by the terms of this Plan Document. A Provider that accepts this arrangement indicates acceptance of an Assignment of Benefits and Deductibles, Copayments, and Coinsurance amounts, as consideration in full for treatment rendered. The Plan Administrator may revoke an Assignment of Benefits at its discretion and treat the Covered Person of the Plan as the sole beneficiary. Benefits for medical expenses covered under this Plan may be assigned by a Claimant to the Provider as consideration in full for services rendered; however, if those benefits are paid directly to the Covered Person, the Plan will be deemed to have fulfilled its obligations with respect to such benefits. The Plan will not be responsible for determining whether any such assignment is valid. Payment of benefits which have been assigned may be made directly to the assignee unless a written request not to honor the assignment, signed by the Covered Person, has been received before the proof of loss is submitted, or the Plan Administrator – at its discretion – revokes the assignment. No Claimant shall at any time, either during the time in which he or she is a Claimant in the Plan, or following his or her termination as a Claimant, in any manner, have any right to assign his or her right to sue to recover benefits under the Plan, to enforce rights due under the Plan or to any other causes of action which he or she may have against the Plan or its fiduciaries. A medical Provider which accepts an Assignment of Benefits does as consideration in full for services rendered and is bound by the rules and provisions set forth within the terms of this document.

Other than as provided above, no benefit under the Plan shall be subject in any manner to anticipation, alienation, sale, transfer, assignment, pledge, encumbrance or charge and any attempt to do so shall be void. No benefit under the Plan shall in any manner be liable for or subject to the debts, contracts, liabilities, engagements or torts of any person.

Notwithstanding the foregoing, the Plan will honor any Qualified Medical Child Support Order ("QMCSO") which provides for coverage under the Plan for an alternate recipient, in the manner described in ERISA Section 609(a) and in the Plan's QMCSO procedures.

Clerical Error: Clerical errors made on the records of the Plan and delays in making entries on such records shall not invalidate coverage nor cause coverage to be in force or to continue in force. Rather, the effective dates of coverage shall be determined solely in accordance with the provisions of this Plan regardless of whether any contributions with respect to Covered Persons have been made or have failed to be made because of such errors or delays. Upon discovery of any such error or delay, an equitable adjustment of any such contributions will be made.

Conformity with Applicable Laws: This Plan shall be deemed automatically to be amended to conform as required by any applicable law, regulation or the order or judgment of a court of competent jurisdiction governing provisions of this Plan, including stated maximums, exclusions or limitations. In the event that any law, regulation or the order or judgment of a court of competent jurisdiction causes the Plan Administrator to pay claims that are otherwise limited or excluded under this Plan, such payments will be considered as being

in accordance with the terms of Plan. It is intended that the Plan will conform to the requirements of any applicable Federal or State law.

Fraud: Under this Plan, coverage may be retroactively canceled or terminated (rescinded) if a Covered Person acts fraudulently or intentionally makes material misrepresentations of fact as it pertains to the Plan. It is a Covered Person's responsibility to provide complete and accurate information and to make accurate and truthful statements, including information and statements regarding family status, age, relationships, etc. It is also a Covered Person's responsibility to update previously provided information and statements. Failure to do so may result in coverage of Covered Persons being canceled, and such cancellation may be retroactive.

If a Covered Person, or any other entity, submits or attempts to submit a claim for or on behalf of a person who is not a Covered Person of the Plan; submits a Claim for services or supplies not rendered; provides false or misleading information in connection with enrollment in the Plan; or provides any false or misleading information to the Plan as it relates to any element of its administration; that shall be deemed to be fraud.

If a Covered Person is aware of any instance of fraud, and fails to bring that fraud to the Plan Administrator's attention, that shall also be deemed to be fraud. Fraud will result in immediate termination of all coverage under this Plan for the Covered Person and their entire Family Unit of which the Covered Person is a member.

A determination by the Plan that a rescission is warranted will be considered an Adverse Benefit Determination for purposes of review and appeal. A Covered Person whose coverage is being rescinded will be provided a thirty (30) day notice period as described under the Affordable Care Act (ACA) and regulatory guidance. Claims Incurred after the retroactive date of termination shall not be further processed and/or paid under the Plan. Claims Incurred after the retroactive date of termination that were paid under the Plan will be treated as erroneously paid claims under this Plan.

Headings: The headings used in this Plan Document are used for convenience of reference only. Covered Persons are advised not to rely on any provision because of the heading.

Word Usage: Wherever any words are used herein in the singular or plural, they shall be construed as though they were in the plural or singular, as the case may be, in all cases where they would so apply.

Plan Contributions: The Plan Sponsor shall, from time to time, evaluate the funding method of the Plan and determine the amount to be contributed by the Participating Employer and the amount to be contributed (if any) by each Covered Person.

The Plan Sponsor shall fund the Plan in a manner consistent with the provisions of the Internal Revenue Code, ERISA, and such other laws and regulations as shall be applicable to the end that the Plan shall be funded on a lawful and sound basis. The manner and means by which the Plan is funded shall be solely determined by the Plan Sponsor, to the extent allowed by applicable law.

Notwithstanding any other provision of the Plan, the Plan Sponsor's obligation to pay claims otherwise allowable under the terms of the Plan shall be limited to its obligation to make contributions to the Plan as set

forth in the preceding paragraph. Payment of said claims in accordance with these procedures shall discharge completely the Company's obligation with respect to such payments.

In the event that the Company terminates the Plan, then as of the effective date of termination, the Employer and eligible Employees shall have no further obligation to make additional contributions to the Plan and the Plan shall have no obligation to pay claims Incurred after the termination date of the Plan.

Minimum Essential Coverage: Refer to the Employer's Summary of Benefits and Coverage (SBC) for determination as to whether the Plan provides "minimum essential coverage" within the meaning of Code Section 5000A(f) and any accompanying regulations or guidance and whether it provides "minimum value" within the meaning of Code Section 36B(c)(2)(C)(ii) and any accompanying regulations or guidance (e.g. the Plan provides at least 60% actuarial value).

No Contract of Employment: This Plan and any amendments constitute the terms and provisions of coverage under this Plan. The Plan shall not be deemed to constitute a contract of any type between the Employer and any person or to be consideration for or an inducement or condition of, the employment of any Employee. Nothing in this Plan shall be deemed to give any Employee the right to be retained in the service of the Employer or to interfere with the right of the Employer to discharge any Employee at any time.

Release of Information: For the purpose of determining the applicability of and implementing the terms of these benefits, the Plan Administrator may, without the consent of or notice to any person, release or obtain any information necessary to determine the acceptability of any applicant or person covered for benefits under this Plan. In so acting, the Plan Administrator shall be free from any liability that may arise with regard to such action; however, the Plan Administrator at all times will comply with the applicable privacy standards. Any Covered Person claiming benefits under this Plan shall furnish to the Plan Administrator such information as may be necessary to implement this provision.

Workers' Compensation: This Plan excludes coverage for any Injury or Illness that is eligible for coverage under any Workers' Compensation policy or law regardless of the date of onset of such Injury or Illness. However, if benefits are paid by the Plan and it is later determined that the Covered Person received or is eligible to receive Workers' Compensation coverage for the same Injury or Illness, the Plan is entitled to full recovery for the benefits it has paid. This exclusion applies to past and future expenses for the Injury or Illness regardless of the amount or terms of any settlement received from Workers' Compensation. The Plan will exercise its right to recover. The Plan reserves its right to exercise its rights under this section and the section entitled "Recovery of Payment" even though:

1. The Workers' Compensation benefits are in dispute or are made by means of settlement or compromise;
2. No final determination is made that the Injury or Illness was sustained in the course of or resulted from employment;
3. The amount of Workers' Compensation benefits due specifically to health care expense is not agreed upon or defined by the Covered Person or the Workers' Compensation carrier; or

4. The health care expense is specifically excluded from the Workers' Compensation settlement or compromise.

The Covered Person is required to notify the Plan Administrator immediately upon filing a claim for coverage under Workers' Compensation if a Claim for the same Injury or Illness is or has been filed with this Plan. Failure to do so or to reimburse the Plan for any expenses it has paid for which coverage is available through Workers' Compensation, will be considered a fraudulent claim subject to any and all remedies available to the Plan for recovery and disciplinary action.

STATEMENT OF ERISA RIGHTS

As a Covered Person in the Plan, certain rights and protections are entitled under ERISA. ERISA provides that all Covered Persons are entitled to:

Receive Information About Your Plan and Benefits: Examine, without charge, at the Plan Administrator's office and at other specified locations, such as worksites, all documents governing the Plan, including insurance contracts (if any) and copies 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 Benefits Security Administration.

Obtain, upon written request to the Plan Administrator, copies of documents governing the operation of the Plan, including insurance contracts (if any) and copies of the latest annual report (Form 5500 Series) and updated Summary Plan Description. The Plan Administrator may make a reasonable charge for the copies.

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

Continue Group Health Plan Coverage: Continue health care coverage for Covered Persons if there is a loss of coverage under the Plan as a result of a qualifying event. The Employee or eligible Dependents may have to pay for such coverage. Review this Summary Plan Description and the documents governing the Plan on the rules governing COBRA Continuation Coverage rights.

Prudent Actions by Plan Fiduciaries: In addition to creating rights for Covered Persons, ERISA imposes duties upon the people who are responsible for the operation of the Plan. The people who operate the Plan, called "fiduciaries" of the Plan, have a duty to do so prudently and in the interest of Covered Persons and beneficiaries. No one, including the Employer, may fire the Employee or otherwise discriminate against the Employee in any way to prevent the Employee from obtaining a welfare benefit or exercising the Covered Person's rights under ERISA.

Enforce Your Rights: If a Covered Person's Claim for a welfare benefit is denied or ignored, in whole or in part, the Covered Person 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 the Covered Person can take to enforce the above rights. For instance, if the Covered Person requests a copy of Plan documents or the latest annual report from the Plan and do not receive them within thirty (30) days, the Covered Person may file suit in a Federal court. In such a case, the court may require the Plan Administrator to provide the materials and pay the Covered Person up to $110 a day until the Covered Person receives the materials, unless the materials were not sent because of reasons beyond the control of the Plan Administrator. If the Covered Person has a Claim for benefits which is denied or ignored, in whole or in part, the Covered Person may file suit in a State or Federal court. In addition, if the Covered Person disagrees with the Plan's decision or lack thereof concerning the qualified status of a domestic relations order or a Medical Child Support Order, the Covered Person may file suit in Federal court. If it should happen that Plan fiduciaries misuse the Plan's money, or if the Covered Person is discriminated against for asserting his or her rights, the

Covered Person may seek assistance from the U.S. Department of Labor, or the Covered Person may file suit in a Federal court. The court will decide who would pay court costs and legal fees. If the Covered Person is successful, the court may order the person the Covered Person sued to pay these costs and fees. If the Covered Person loses, the court may order the Covered Person to pay these costs and fees, for example, if it finds the Covered Person's claim is frivolous.

Assistance with Your Questions: If the Covered Person has any questions about the Plan, he/she should contact the Plan Administrator. If the Covered Person has any questions about this statement or about the Covered Person's rights under ERISA or needs assistance in obtaining documents from the Plan Administrator, the Covered Person should contact the nearest Office of the Employee Benefits Security Administration, U.S. Department of Labor, listed in the telephone directory or the Division of Technical Assistance and Inquiries, Employee Benefits Security Administration, U.S. Department of Labor, 200 Constitution Avenue, N.W., Washington, D.C. 20210. The Covered Person may also obtain certain publications about his or her rights and responsibilities under ERISA by calling the publications hotline of the Employee Benefits Security Administration.

HIPAA PRIVACY

The Plan provides each Covered Person with a separate Notice of Privacy Practices. This Notice describes how the Plan uses and discloses a Covered Person's personal health information. It also describes certain rights the Covered Person has regarding this information. Additional copies of the Plan's Notice of Privacy Practices are available by calling 800.337.0792.

Definitions:

- **Breach** means an unauthorized acquisition, access, use or disclosure of Protected Health Information ("PHI") or Electronic Protected Health Information ("ePHI") that violates the HIPAA Privacy Rule and that compromises the security or privacy of the information.
- **Protected Health Information ("PHI")** means individually identifiable health information, as defined by HIPAA, that is created or received by the Plan and that relates to the past, present, or future physical or mental health or condition of an individual; the provision of health care to an individual; or the past, present, or future payment for the provision of health care to an individual; and that identifies the individual or for which there is a reasonable basis to believe the information can be used to identify the individual. PHI includes information of persons living or deceased.

Commitment to Protecting Health Information: The Plan will comply with the Standards for Privacy of Individually Identifiable Health Information (i.e., the "Privacy Rule") set forth by the U.S. Department of Health and Human Services ("HHS") pursuant to the Health Insurance Portability and Accountability Act of 1996 ("HIPAA"). Such standards control the dissemination of "protected health information" ("PHI") of Covered Persons. Privacy Standards will be implemented and enforced in the offices of the Employer and Plan Administrator and any other entity that may assist in the operation of the Plan.

The Plan is required by law to take reasonable steps to ensure the privacy of the Covered Person's PHI, and inform him/her about:

1. The Plan's disclosures and uses of PHI.
2. The Covered Person’s privacy rights with respect to his or her PHI.
3. The Plan's duties with respect to his or her PHI.
4. The Covered Person's right to file a complaint with the Plan and with the Secretary of HHS.
5. The person or office to contact for further information about the Plan's privacy practices.

Within this provision capitalized terms may be used, but not otherwise defined. These terms shall have the same meaning as those terms set forth in 45 CFR Sections 160.103 and 164.501. Any HIPAA regulation modifications altering a defined HIPAA term or regulatory citation shall be deemed incorporated into this provision.

How Health Information May Be Used and Disclosed: In general, the Privacy Rules permit the Plan to use and disclose, the minimum necessary amount, an individual's PHI, without obtaining authorization, only if the use or disclosure is for any of the following:

1. To carry out payment of benefits.

2. For health care operations.
3. For treatment purposes.
4. If the use or disclosure falls within one of the limited circumstances described in the rules (e.g., the disclosure is required by law or for public health activities).

Disclosure of PHI to the Plan Administrator for Plan Administration Purposes: In order that the Plan Administrator may receive and use PHI for plan administration purposes, the Plan Administrator agrees to:

1. Not use or further disclose PHI other than as permitted or required by the Plan documents or as required by law (as defined in the Privacy Standards).
2. Ensure that any agents, including a subcontractor, to whom the Plan Administrator provides PHI received from the Plan, agree to the same restrictions and conditions that apply to the Plan Administrator with respect to such PHI.
3. Establish safeguards for information, including security systems for data processing and storage.
4. Maintain the confidentiality of all PHI, unless an individual gives specific consent or authorization to disclose such data or unless the data is used for health care payment or Plan operations.
5. Receive PHI, in the absence of an individual's express authorization, only to carry out Plan administration functions.
6. ***If a Plan engages in underwriting****:* Not use or disclose Genetic Information for underwriting purposes.
7. Not use or disclose PHI for employment-related actions and decisions or in connection with any other benefit or Employee benefit plan of the Plan Administrator, except pursuant to an authorization which meets the requirements of the Privacy Standards.
8. Report to the Plan any PHI use or disclosure that is inconsistent with the uses or disclosures provided for of which the Plan Administrator becomes aware.
9. Make available PHI in accordance with section 164.524 of the Privacy Standards (45 CFR 164.524).
10. Make available PHI for amendment and incorporate any amendments to PHI in accordance with section 164.526 of the Privacy Standards (45 CFR 164.526).
11. Make available the information required to provide an accounting of disclosures in accordance with section 164.528 of the Privacy Standards (45 CFR 164.528).
12. Make its internal practices, books and records relating to the use and disclosure of PHI received from the Plan available to the Secretary of the U.S. Department of Health and Human Services ("HHS"), or any other officer or Employee of HHS to whom the authority involved has been delegated, for purposes of determining compliance by the Plan with part 164, subpart E, of the Privacy Standards (45 CFR 164.500 et seq).
13. Train Employees in privacy protection requirements and appoint a Privacy Officer responsible for such protections.
14. If feasible, return or destroy all PHI received from the Plan that the Plan Administrator still maintains in any form and retain no copies of such PHI when no longer needed for the purpose for which disclosure was made, except that, if such return or destruction is not feasible, limit further uses and disclosures to those purposes that make the return or destruction of the PHI infeasible.
15. Ensure that adequate separation between the Plan and the Plan Administrator, as required in section 164.504(f)(2)(iii) of the Privacy Standards (45 CFR 164.504(f)(2)(iii)), is established as follows:
    a. The following Employees, or classes of Employees, or other persons under control of the Plan Administrator, shall be given access to the PHI to be disclosed:

i. Privacy Officer.

b. The access to and use of PHI by the individuals identified above shall be restricted to the plan administration functions that the Plan Administrator performs for the Plan.

c. In the event any of the individuals described above do not comply with the provisions of the Plan documents relating to use and disclosure of PHI, the Plan Administrator shall impose reasonable sanctions as necessary, in its discretion, to ensure that no further non-compliance occurs. The Plan Administrator will promptly report such violation or noncompliance to the Plan, and will cooperate with the Plan to correct violation or noncompliance and to impose appropriate disciplinary action or sanctions. Such sanctions shall be imposed progressively (for example, an oral warning, a written warning, time off without pay and termination), if appropriate, and shall be imposed so that they are commensurate with the severity of the violation.

Disclosure of Summary Health Information to the Plan Sponsor: The Plan may disclose PHI to the Plan Sponsor of the group health plan for purposes of plan administration or pursuant to an authorization request signed by the Covered Person. The Plan may use or disclose "summary health information" to the Plan Sponsor for obtaining premium bids or modifying, amending, or terminating the group health plan. "Summary health information" may be individually identifiable health information and it summarizes the Claims history, Claims expenses, or the type of Claims experienced by individuals in the plan, but it excludes all identifiers that must be removed for the information to be de-identified, except that it may contain geographic information to the extent that it is aggregated by five-digit zip code.

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

Disclosure of PHI to Obtain Stop-loss or Excess Loss Coverage: The Plan Sponsor may hereby authorize and direct the Plan, through the Plan Sponsor or the Third Party Administrator, to disclose PHI to stop-loss carriers, excess loss carriers or managing general underwriters ("MGUs") for underwriting and other purposes in order to obtain and maintain stop-loss or excess loss coverage related to benefit claims under the Plan. Such disclosures shall be made in accordance with the Privacy Standards.

Other Disclosures and Uses of PHI:

Primary Uses and Disclosures of PHI

1. Treatment, Payment and Health Care Operations: The Plan has the right to use and disclose a Covered Person's PHI for all activities as included within the definitions of Treatment, Payment, and Health Care Operations and pursuant to the HIPAA Privacy Rule.
2. Business Associates: The Plan contracts with individuals and entities (Business Associates) to perform various functions on its behalf. In performance of these functions or to provide services, Business Associates will receive, create, maintain, use, or disclose PHI, but only after the Plan and the Business

Associate agree in writing to contract terms requiring the Business Associate to appropriately safeguard the Covered Person's information.

3. Other Covered Entities: The Plan may disclose PHI to assist health care Providers in connection with their treatment or payment activities or to assist other covered entities in connection with payment activities and certain health care operations. For example, the Plan may disclose PHI to a health care Provider when needed by the Provider to render treatment to a Covered Person, and the Plan may disclose PHI to another covered entity to conduct health care operations. The Plan may also disclose or share PHI with other insurance carriers (such as Medicare, etc.) in order to coordinate benefits, if a Covered Person has coverage through another carrier.

Other Possible Uses and Disclosures of PHI

1. Required by Law: The Plan may use or disclose PHI when required by law, provided the use or disclosure complies with and is limited to the relevant requirements of such law.
2. Public Health and Safety: The Plan may use or disclose PHI when permitted for purposes of public health activities, including disclosures to:
    a. A public health authority or other appropriate government authority authorized by law to receive reports of Child abuse or neglect.
    b. Report reactions to medications or problems with products or devices regulated by the Federal Food and Drug Administration (FDA) or other activities related to quality, safety, or effectiveness of FDA-regulated products or activities.
    c. Locate and notify persons of recalls of products they may be using.
    d. A person who may have been exposed to a communicable Disease or may otherwise be at risk of contracting or spreading a Disease or condition, if authorized by law.
3. Government Authority: The Plan may disclose PHI to a government authority, except for reports of Child abuse or neglect, when required or authorized by law, or with the Covered Person's agreement, if the Plan reasonably believes he or she to be a victim of abuse, neglect, or domestic violence. In such case, the Plan will promptly inform the Covered Person that such a disclosure has been or will be made unless the Plan believes that informing him/her would place him/her at risk of serious harm (but only to someone in a position to help prevent the threat). Disclosure generally may be made to a minor's parents or other representatives although there may be circumstances under Federal or State law when the parents or other representatives may not be given access to the minor's PHI.
4. Health Oversight Activities: The Plan may disclose PHI to a health oversight agency for oversight activities authorized by law. This includes civil, administrative or criminal investigations; inspections; claim audits; licensure or disciplinary actions; and other activities necessary for appropriate oversight of a health care system, government health care program, and compliance with certain laws.
5. Lawsuits and Disputes: The Plan may disclose PHI when required for judicial or administrative proceedings. For example, the Covered Person's PHI may be disclosed in response to a subpoena, discovery requests, or other required legal processes when the Plan is given satisfactory assurances that the requesting party has made a good faith attempt to advise the Covered Person of the request or to obtain an order protecting such information, and done in accordance with specified procedural safeguards.
6. Law Enforcement: The Plan may disclose PHI to a law enforcement official when required for law enforcement purposes concerning identifying or locating a suspect, fugitive, material witness or

missing person. Under certain circumstances, the Plan may disclose the Covered Person's PHI in response to a law enforcement official's request if he or she is, or are suspected to be, a victim of a crime and if it believes in good faith that the PHI constitutes evidence of criminal conduct that occurred on the Sponsor's or Plan's premises.

7. Decedents: The Plan may disclose PHI to family members or others involved in decedent's care or payment for care, a coroner, funeral director or medical examiner for the purpose of identifying a deceased person, determining a cause of death or as necessary to carry out their duties as authorized by law. The decedent's health information ceases to be protected after the individual is deceased for 50 years.
8. Research: The Plan may use or disclose PHI for research, subject to certain limited conditions.
9. To Avert a Serious Threat to Health or Safety: The Plan may disclose PHI in accordance with applicable law and standards of ethical conduct, if the Plan, in good faith, believes the use or disclosure is necessary to prevent or lessen a threat to health or safety of a person or to the public.
10. Workers' Compensation: The Plan may disclose PHI when authorized by and to the extent necessary to comply with workers' compensation or other similar programs established by law.
11. Military and National Security: The Plan may disclose PHI to military authorities or armed forces personnel under certain circumstances. As authorized by law, the Plan may disclose PHI required for intelligence, counter-intelligence, and other national security activities to authorized Federal officials.

Required Disclosures of PHI

1. Disclosures to Covered Persons: The Plan is required to disclose to a Covered Person most of the PHI in a Designated Record Set when the Covered Person requests access to this information. The Plan will disclose a Covered Person's PHI to an individual who has been assigned as his or her representative and who has qualified for such designation in accordance with the relevant State law. Before disclosure to an individual qualified as a personal representative, the Plan must be given written supporting documentation establishing the basis of the personal representation.

   The Plan may elect not to treat the person as the Covered Person's personal representative if it has a reasonable belief that the Covered Person has been, or may be, subjected to domestic violence, abuse, or neglect by such person, it is not in the Covered Person's best interest to treat the person as his or her personal representative, or treating such person as his or her personal representative could endanger the Covered Person.

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

Instances When Required Authorization Is Needed From Covered Persons Before Disclosing PHI

1. ***If the Plan maintains psychotherapy notes***: Most uses and disclosures of psychotherapy notes.
2. Uses and disclosures for marketing.
3. Sale of PHI.

4. Other uses and disclosures not described in this section can only be made with authorization from the Covered Person. The Covered Person may revoke this authorization at any time.

Covered Person's Rights: The Covered Person has the following rights regarding PHI about him/her:

1. Request Restrictions: The Covered Person has the right to request additional restrictions on the use or disclosure of PHI for treatment, payment, or health care operations. The Covered Person may request that the Plan restrict disclosures to family members, relatives, friends or other persons identified by him/her who are involved in his or her care or payment for his or her care. The Plan is not required to agree to these requested restrictions.
2. Right to Receive Confidential Communication: The Covered Person has the right to request that he or she receive communications regarding PHI in a certain manner or at a certain location. The request must be made in writing and how the Covered Person would like to be contacted. The Plan will accommodate all reasonable requests.
3. Right to Receive Notice of Privacy Practices: The Covered Person is entitled to receive a paper copy of the plan's Notice of Privacy Practices at any time. To obtain a paper copy, contact the Privacy Officer.
4. Accounting of Disclosures: The Covered Person has the right to request an accounting of disclosures the Plan has made of his or her PHI. The request must be made in writing and does not apply to disclosures for treatment, payment, health care operations, and certain other purposes. The Covered Person is entitled to such an accounting for the six years prior to his or her request. Except as provided below, for each disclosure, the accounting will include: (a) the date of the disclosure, (b) the name of the entity or person who received the PHI and, if known, the address of such entity or person; (c) a description of the PHI disclosed, (d) a statement of the purpose of the disclosure that reasonably informs the Covered Person of the basis of the disclosure, and certain other information. If the Covered Person wishes to make a request, please contact the Privacy Officer.
5. Access: The Covered Person has the right to request the opportunity to look at or get copies of PHI maintained by the Plan about him/her in certain records maintained by the Plan. If the Covered Person requests copies, he or she may be charged a fee to cover the costs of copying, mailing, and other supplies. If a Covered Person wants to inspect or copy PHI, or to have a copy of his or her PHI transmitted directly to another designated person, he or she should contact the Privacy Officer. A request to transmit PHI directly to another designated person must be in writing, signed by the Covered Person and the recipient must be clearly identified. The Plan must respond to the Covered Person's request within thirty (30) days (in some cases, the Plan can request a thirty (30) day extension). In very limited circumstances, the Plan may deny the Covered Person's request. If the Plan denies the request, the Covered Person may be entitled to a review of that denial.
6. Amendment: The Covered Person has the right to request that the Plan change or amend his or her PHI. The Plan reserves the right to require this request be in writing. Submit the request to the Privacy Officer. The Plan may deny the Covered Person's request in certain cases, including if it is not in writing or if he or she does not provide a reason for the request.
7. Fund raising contacts: The Covered Person has the right to opt out of fundraising contacts.

Questions or Complaints: If the Covered Person wants more information about the Plan's privacy practices, has questions or concerns, or believes that the Plan may have violated his or her privacy rights, please contact the Plan using the following information. The Covered Person may submit a written complaint to the U.S.

Department of Health and Human Services or with the Plan. The Plan will provide the Covered Person with the address to file his or her complaint with the U.S. Department of Health and Human Services upon request.

The Plan will not retaliate against the Covered Person for filing a complaint with the Plan or the U.S. Department of Health and Human Services.

Contact Information:

Privacy Officer Contact Information:
AE Insurance, LLC dba American Exchange
605 Chestnut Street #1210
Chattanooga, TN 37450
Phone: 888-995-1674
Email: andrew.hetzler@americanexchange.com

HIPAA SECURITY

Disclosure of Electronic Protected Health Information ("Electronic PHI") to the Plan Sponsor for Plan Administration Functions: STANDARDS FOR SECURITY OF INDIVIDUALLY IDENTIFIABLE HEALTH INFORMATION ("SECURITY RULE")

The Health Insurance Portability and Accountability Act (HIPAA) and other applicable law shall override the following wherever there is a conflict, or a term or terms is/are not hereby defined.

The Security Rule imposes regulations for maintaining the integrity, confidentiality and availability of protected health information that it creates, receives, maintains, or maintains electronically that is kept in electronic format (ePHI) as required under HIPAA.

Definitions:

- **Electronic Protected Health Information (ePHI),** as defined in Section 160.103 of the Security Standards (45 C.F.R. 160.103), means individually identifiable health information transmitted or maintained in any electronic media.
- **Security Incidents,** as defined within Section 164.304 of the Security Standards (45 C.F.R. 164.304), means the attempted or successful unauthorized access, use, disclosure, modification, or destruction of information or interference with systems operation in an information system.

Plan Sponsor Obligations: To enable the Plan Sponsor to receive and use Electronic PHI for Plan Administration Functions (as defined in 45 CFR §164.504(a)), the Plan Sponsor agrees to:

1. Implement administrative, physical, and technical safeguards that reasonably and appropriately protect the confidentiality, integrity and availability of the Electronic PHI that it creates, receives, maintains, or transmits on behalf of the Plan.
2. Ensure that adequate separation between the Plan and the Plan Sponsor, as required in 45 CFR § 164.504(f)(2)(iii), is supported by reasonable and appropriate Security Measures.
3. Ensure that any agent, including a subcontractor, to whom the Plan Sponsor provides Electronic PHI created, received, maintained, or transmitted on behalf of the Plan, agrees to implement reasonable and appropriate administrative, physical, and technical safeguards to protect the confidentiality, integrity, and availability of the Electronic PHI and report to the Plan any security incident of which it becomes aware.
4. Report to the Plan any security incident of which it becomes aware.

Notification Requirements in the Event of a Breach of Unsecured PHI: The required breach notifications are triggered upon the discovery of a breach of unsecured PHI. A breach is discovered as of the first day the breach is known, or reasonably should have been known.

When a breach of unsecured PHI is discovered, the Plan will:

1. Notify the Covered Person whose PHI has been, or is reasonably believed to have been, assessed, acquired, used, or disclosed as a result of the breach, in writing, without unreasonable delay and in no

case later than sixty (60) calendar days after discovery of the breach. Breach notification must be provided to the affected individual(s) by:

a. Written notice by first-class mail to the Covered Person (or next of kin) at the last known address or, if specified by the Covered Person, e-mail.
b. If the Plan has insufficient or out-of-date contact information for the Covered Person, the Covered Person must be notified by a "substitute form".
c. If an urgent notice is required, the Plan may contact the Covered Person by telephone. The breach notification will have the following content:
    i. Brief description of what happened, including date of breach and date discovered.
    ii. Types of unsecured PHI involved (e.g., name, Social Security number, date of birth, home address, account number).
    iii. Steps the Covered Person should take to protect from potential harm.
    iv. What the Plan is doing to investigate the breach, mitigate losses and protect against further breaches.

2. Notify the media if the breach affected more than 500 residents of a State or jurisdiction. Notice must be provided to prominent media outlets serving the State or jurisdiction without unreasonable delay and in no case later than sixty (60) calendar days after the date the breach was discovered.
3. Notify the HHS Secretary if the breach involves 500 or more individuals, contemporaneously with the notice to the affected individual and in the manner specified by HHS. If the breach involves less than 500 individuals, an internal log or other documentation of such breaches must be maintained and annually submitted to HHS within sixty (60) days after the end of each Calendar Year.
4. When a Business Associate, which provides services for the Plan and comes in contact with PHI in connection with those services discovers a breach has occurred, that Business Associate will notify the Plan without unreasonable delay and in no case later than sixty (60) calendar days after discovery of a breach so that the affected Covered Persons may be notified. To the extent possible, the Business Associate should identify each individual whose unsecured PHI has been, or is reasonably believed to have been, breached.