ARDENT HEALTH SERVICES GROUP HEALTH OPEN ACCESS PLAN

Plan Document and Summary Plan Description

Effective: January 01, 2024

Administered by

HealthFIRST

TABLE OF CONTENTS

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. Plan benefits are self-funded through a benefit fund or a trust established by the Plan Sponsor with contributions from Participants and/or the Plan Sponsor. Participants in the Plan may be required to contribute toward their benefits. Contributions received from Participants are used to cover Plan costs and are expended immediately.

The Plan Sponsor's 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 Sickness. To accomplish this purpose, the Plan Sponsor 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 Participants in the Plan to the maximum feasible extent.

The Plan Sponsor is required under ERISA to provide to Participants 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. The Plan Sponsor has adopted this Plan Document as the written description of the Plan to set forth the terms and provisions of the Plan that provide for the payment or reimbursement of all or a portion of certain expenses for eligible benefits. The Plan Document is maintained by **AHS MANAGEMENT COMPANY, INC.** and may be reviewed at any time during normal working hours by any Participant.

General Plan Information

Name of Plan:
ARDENT HEALTH SERVICES GROUP HEALTH OPEN ACCESS PLAN

Plan Sponsor:
AHS MANAGEMENT COMPANY, INC.
340 Seven Springs Way Ste 100
Brentwood, TN 37027
Phone: 1-615-296-3000

Plan Administrator:
(Named Fiduciary)
AHS MANAGEMENT COMPANY, INC.
340 Seven Springs Way Ste 100
Brentwood, TN 37027
Phone: 1-615-296-3000

Plan Sponsor ID No. (EIN):
62-1743438

Source of Funding:
Self-Funded

Plan Status:
Non-Grandfathered

Applicable Law:
ERISA

Plan Year:
January 1 through December 31

Plan Number:
502

Plan Type:
Medical

Prescription

Third Party Administrator:
HEALTHFIRST TPA
821 ESE LOOP 323 SUITE 200
TYLER TX 75701
Phone: 1-903-581-2600
Website/Email: www.hfbenefits.com

Prescription Drug Plan Administrator:
OPTUM RX
Phone: 1-844-783-1405
Website/Email: www.optumrx.com

Participating Employer(s):
AHS UT HEALTH EAST TEXAS
1000 S BECKHAM
TYLER TX 75701
Phone: 1-903-597-0351

Agent for Service of Process:
AHS MANAGEMENT COMPANY, INC.
340 Seven Springs Way Ste 100
Brentwood, TN 37027
Phone: 1-615-296-3000

The Plan shall take effect for each Participating Employer on the Effective Date, unless a different date is set forth above opposite such Participating Employer's name.

Non-English Language Notice

This Plan Document contains a summary in English of a Participant's plan rights and benefits under the Plan. If a Participant 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

This Plan Document and any amendments constitute the terms and provisions of coverage under this Plan. The Plan Document is not to be construed as a contract of any type between the Company and any Participant or to be consideration for, or an inducement or condition of, the employment of any Employee. Nothing in this Plan Document shall be deemed to give any Employee the right to be retained in the service of the Company or to interfere with the right of the Company to discharge any Employee at any time; provided, however, that the foregoing shall not be deemed to modify the provisions of any collective bargaining agreements which may be entered into by the Company with the bargaining representatives of any Employees.

Mental Health Parity

Pursuant to the Mental Health Parity Act (MHPA) of 1996 and the Mental Health Parity and Addiction 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.

Non-Discrimination

No eligibility rules or variations in contribution amounts will be imposed based on an eligible Employee's and his or her Dependent's/Dependents' health status, medical condition, claims experience, receipt of health care, medical history, genetic information, evidence of insurability, disability, or any other health status related factor. Coverage under this Plan is provided regardless of an eligible Employee's and his or her Dependent's/Dependents' 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 and related documents; to make determinations in regards to issues relating to eligibility for benefits; to decide disputes that may arise relative to a Participant's rights; and to determine all questions of fact and law arising under the Plan.

DEFINITIONS

The following words and phrases shall have the following meanings when used in the Plan Document. Some of the terms used in this document begin with a capital letter, even though the term normally would not be capitalized. These terms have special meaning under the Plan. Most terms will be listed in this Definitions section, but some terms are defined within the provision the term is used. Becoming familiar with the terms defined in the Definitions section will help to better understand the provisions of this Plan.

The following definitions are not an indication that charges for particular care, supplies or services are eligible for payment under the Plan, however they may be used to identify ineligible expenses; please refer to the appropriate sections of the Plan Document for that information.

"Accident"
"Accident" shall mean an event which takes place without one's foresight or expectation, or a deliberate act that results in unforeseen consequences.

"Accidental Bodily Injury" or "Accidental Injury"
"Accidental Bodily Injury" or "Accidental Injury" shall mean an Injury sustained as the result of an Accident and independently of all other causes by an outside traumatic event or due to exposure to the elements.

"Actively at Work" or "Active Employment"
An Employee is "Actively at Work" or in "Active Employment" on any day the Employee performs in the customary manner all of the regular duties of employment. An Employee will be deemed Actively at Work on each day of a regular paid vacation or on a regular non-working day, provided the covered Employee was Actively at Work on the last preceding regular work day. An Employee shall be deemed Actively at Work if the Employee is absent from work due to a health factor, as defined by HIPAA, subject to the Plan's Leave of Absence provisions (including any State-mandated leave). An Employee will not be considered under any circumstances Actively at Work if he or she has effectively terminated employment.

"Activities of Daily Living (ADL)"
"Activities of Daily Living" include the following, with or without assistance: bathing, dressing, toileting, and associated personal hygiene; transferring (moving in or out of a bed, chair, wheelchair, tub or shower); mobility; eating (getting nourishment into the body by any means other than intravenous); and continence (voluntarily maintaining control of bowel and/or bladder function, or, in the event of incontinence, maintaining a reasonable level of personal hygiene).

"Acupuncture"
"Acupuncture", a technique used to deliver anesthesia or analgesia, to treat conditions of the body (when clinical efficacy has been established for treatment of such conditions) by passing long, think needles through the skin.

"ADA"
"ADA" shall mean the American Dental Association.

"Adverse Benefit Determination"
"Adverse Benefit Determination" shall mean any of the following:
A denial in benefits.

1. A reduction in benefits.
2. A rescission of coverage, even if the rescission 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.
5. A denial, reduction, or termination of, or a failure to provide or make payment (in whole or in part) for, a benefit resulting from the application of any utilization review.
6. A failure to cover an item or service for which benefits are otherwise provided because it is determined to be Experimental or Investigational or not Medically Necessary or appropriate.

"Affordable Care Act (ACA)"
The "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 was signed into law on March 23, 2010 and was amended by the Health Care and Education Reconciliation Act on 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 Act (ACA) to refer to the health care reform law.

"AHA"
"AHA" shall mean the American Hospital Association.
"**Allowable Claim Limits"**
"Allowable Claim Limits" shall mean the charges for services and supplies, listed and included as covered medical expenses under the Plan, which are medically necessary for the care and treatment of a covered illness or injury, but only to the extent that such fees are within the allowable claim limits. Please refer to the section, "Claim Review and Audit Program" for additional information regarding allowable claim limits.

"**Allowable Expense(s)"**
"Allowable Expense(s)" shall mean the Maximum Allowable Charge for any Medically Necessary, eligible item of expense, at least a portion of which is covered under this Plan. When some Other Plan pays first in accordance with the Application to Benefit Determinations provision in the Coordination of Benefits section, this Plan's Allowable Expenses shall in no event exceed the Other Plan's Allowable Expenses.

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 include the benefits that would have been payable had the claim been duly made therefore, whether or not it is actually made.

"Alternate Facility"
"Alternate Facility" is a Health care facility that is not a Hospital and that provides one or more of the following services on an Outpatient basis, as permitted by law:

1. Surgical Services
2. Emergency services; or
3. Rehabilitative, laboratory, diagnostic, or therapeutic services

"Alternate Recipient"
"Alternate Recipient" shall mean any Child of a Participant who is recognized under a Medical Child Support Order as having a right to enrollment under this Plan as the Participant's eligible Dependent. For purposes of the benefits provided under this Plan, an Alternate Recipient shall be treated as an eligible Dependent, but for purposes of the reporting and disclosure requirements under ERISA, an Alternate Recipient shall have the same status as a Participant.

"AMA"
"AMA" shall mean the American Medical Association.

"Ambulance Transportation"
"Ambulance Transportation" shall mean Professional ground or air transportation by a vehicle designed, equipped, and used only to transport the sick and injured in an Emergency situation, or when Medically Necessary, which is:

1. To the closest facility most able to provide the specialized treatment required; and
2. The most appropriate mode of transportation consistent with the well-being of You or Your Dependent.

"Ambulatory Surgical Center"
"Ambulatory Surgical Center" shall mean any permanent public or private State licensed and approved (whenever required by law) establishment that operates exclusively for the purpose of providing Surgical Procedures to patients not requiring hospitalization with an organized medical staff of Physicians, with continuous Physician and nursing care by Registered Nurses (R.N.s). The patient is admitted to and discharged from the facility within the same working day as the facility does not provide service or other accommodations for patients to stay overnight.

“Approved Clinical Trial”
“Approved Clinical Trial” means a phase I, II, III or IV trial that is Federally funded by specified Agencies (National Institutes of Health (NIH), Centers for Disease Control and Prevention (CDCP), Agency for Healthcare Research and Quality (AHRQ), Centers for Medicare and Medicaid Services (CMS), Department of Defense (DOD) or Veterans Affairs (VA), or a non-governmental entity identified by NIH guidelines) or is conducted under an Investigational new drug application reviewed by the Food and Drug Administration (FDA) (if such application is required).

The Affordable Care Act requires that if a “qualified individual” is in an “Approved Clinical Trial,” the Plan cannot deny coverage for related services (“routine patient costs”).

A “qualified individual” is someone who is eligible to participate in an “Approved Clinical Trial” and either the individual’s doctor has concluded that participation is appropriate or the Participant provides medical and scientific information establishing that their participation is appropriate.

“Routine patient costs” include all items and services consistent with the coverage provided in the plan that is typically covered for a qualified individual who is not enrolled in a clinical trial. Routine patient costs do not include 1) the Investigational item, device or service itself; 2) items and services that are provided solely to satisfy data collection and analysis needs and that are not used in the direct clinical management of the patient; and 3) a service that is clearly inconsistent with the widely accepted and established standards of care for a particular Diagnosis. Plans are not required to provide benefits for routine patient care services provided outside of the Plan’s Network area unless Out-of-Network benefits are otherwise provided under the Plan.

“Ancillary Services”
“Ancillary Service” shall mean services rendered in connection with Inpatient or Outpatient care in a Hospital or in connection with a medical Emergency, including the following: Ambulance Transportation, anesthesiology, assistant surgeon services, pathology, and radiology. This term also includes services of the attending Physician or primary surgeon in the event of a medical Emergency.

“Birthing Center”
“Birthing Center” shall mean a Legally operating institution or facility that is licensed and equipped to provide immediate prenatal care, delivery services and postpartum care to the pregnant individual under the direction and supervision of one or more Physicians specializing in obstetrics or gynecology or a certified nurse midwife. It must provide for 24-hour nursing care provided by registered nurses or certified nurse midwives.

“Calendar Year”
“Calendar Year” shall mean the 12 month period from January 1 through December 31 of each year.

“Cardiac Care Unit”
“Cardiac Care Unit” shall mean a separate, clearly designated service area which is maintained within a Hospital and which meets all the following requirements:
It is solely for the care and treatment of critically ill patients who require special medical attention because of their critical condition.

1. It provides within such area special nursing care and observation of a continuous and constant nature not available in the regular rooms and wards of the Hospital.
2. It provides a concentration of special lifesaving equipment immediately available at all times for the treatment of patients confined within such area.
3. It contains at least two beds for the accommodation of critically ill patients.
4. It provides at least one professional Registered Nurse, in continuous and constant attendance of the patient confined in such area on a 24 hour a day basis.

“CDC”
“CDC” shall mean Centers for Disease Control and Prevention.

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

“Child” and/or “Children”
“Child” and/or "Children" shall mean any of the following individuals with respect to an Employee; a natural biological Child, a stepchild; a legally adopted Child or a Child legally Placed for Adoption, a Child under the Employee’s or spouse’s or Domestic Partner’s Legal Guardianship provided the Domestic Partner if applicable is properly enrolled for coverage under the Plan; a Child of Domestic Partner provided the Domestic Partner is properly enrolled for coverage und the Plan, or a Child who is considered an alternate recipient under a QMSCO (even if the Child does not meet the definition of “Dependent”).

“CHIP”
“CHIP” refers to the Children’s Health Insurance Program or any provision or section thereof, which is herein specifically referred to, as such act, provision or section may be amended from time to time.

“CHIPRA”
“CHIPRA” refers to the Children’s Health Insurance Program Reauthorization Act of 2009 or any provision or section thereof, which is herein specifically referred to, as such act.

“Chiropractic Care”
“Chiropractic Care” shall mean the detection and correction, by manual or mechanical means, of the interference with nerve transmissions and expressions resulting from distortion, misalignment or dislocation of the spinal (vertebrae) column.

“Claim Determination Period”
“Claim Determination Period” shall mean each Calendar Year.

“Claimant”
“Claimant” shall mean a Participant of the Plan, or entity acting on his or her behalf, authorized to submit claims to the Plan for processing, and/or appeal an Adverse Benefit Determination.

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

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

“Close Relative”
“Close Relative” shall mean a member of the immediate family. Immediate family includes the Employee, spouse, Domestic Partner, mother, father, grandmother, grandfather, stepparents, step-grandparents, siblings, stepsiblings, half-siblings, Children, Domestic Partner’s Children, stepchildren, and grandchildren.

“Common-Law Marriage”
“Common-Law Marriage” shall mean a partnership whereby two adult individuals are considered married because they have lived together for a certain period of time, hold themselves to be married even without a license and a formal ceremony, and meet other applicable requirements of the state in which the Common-Law Marriage was established.

“CMS”
“CMS” shall mean Centers for Medicare and Medicaid Services.

"COBRA"
"COBRA" shall mean Title X of the Consolidated Omnibus Budget Reconciliation Act of 1985, as amended from time to time, and applicable regulations. This law gives Covered Persons the right, under certain circumstances, to elect continuation coverage under the Plan when active coverage ends due to Qualifying Events.

"Coinsurance"
"Coinsurance" shall mean a cost sharing feature of many plans. It requires a Participant to pay out-of-pocket a prescribed portion of the cost of Covered Expenses. The defined Coinsurance that a Participant must pay out-of-pocket is based upon his or her health plan design. Coinsurance is established as a predetermined percentage of the Maximum Allowable Charge for covered services and usually applies after a Deductible is met in a Deductible plan.

"Copayment" or "Copay"
"Copayment" or "Copay" shall mean a dollar amount the Participant pays for health care expenses. In most plans, the Participant pays this after he or she meets his or her Deductible limit.

"Cosmetic Surgery"
"Cosmetic Surgery" shall mean any expenses Incurred in connection with the care and treatment of, or operations which are performed for plastic, reconstructive, or cosmetic purposes or any other service or supply which are primarily used to improve, alter, or enhance appearance of a physical characteristic which is within the broad spectrum of normal but which may be considered displeasing or unattractive, except when required by an Injury.

"Covered Expense(s)"
"Covered Expense(s)" shall mean any medically necessary item or expense, for which the charge is reasonable and necessary, within Allowable Claim Limits, or is based on the contracted fee schedule of an alternate care delivery system. The Allowable Expense will be determined by the Plan Administrator, in its sole discretion.

"Covered Person"
"Covered Person" shall mean an Employee or Dependent who is enrolled under this Plan.

"Custodial Care"
"Custodial Care" shall mean care or confinement designated principally for the assistance and maintenance of the Participant, in engaging in the activities of daily living, whether or not totally disabled. This care or confinement could be rendered at home or by persons without professional skills or training. This care may relieve symptoms or pain but is not reasonably expected to improve the underlying medical condition. Custodial Care includes, but is not limited to, assistance in eating, dressing, bathing and using the toilet, preparation of special diets, supervision of medication which can normally be self-administered, assistance in walking or getting in and out of bed, and all domestic activities.

"Deductible"
"Deductible" shall mean an aggregate amount for certain expenses for covered services that is the responsibility of the Participant to pay for him or herself each Calendar Year before the Plan will begin its payments. However, certain covered benefits may be considered Preventive Care and paid first dollar. The Participant's ability to contribute to a Health Savings Account (HSA) on a tax favored basis may be affected by any arrangement that waives this Plan's Deductible.

"Dentist"
"Dentist" shall mean a properly trained person holding a D.D.S. or D.M.D. degree and practicing within the scope of a license to practice dentistry within their applicable geographic venue.

"Dependent"
See the Eligibility and Enrollment section of this SPD.

NOTE: Tax treatment for certain dependents. Federal tax law generally does not recognize former spouses, Legally Separated spouses, civil union or domestic partners, or the children of these partners, as dependents under the federal tax code unless the spouse, partner, or child otherwise qualifies as a dependent under the Internal Revenue Code §152. Therefore, the Employer may be required to automatically include the value of the health care coverage provided to any of the aforementioned individuals, who may be covered under this Plan as eligible Dependents, as additional income to the Employee.

“Development Delays”
“Development Delays” shall mean conditions that are characterized by impairment in various areas of development, such as social interaction skills, adaptive behavior, and communication skills. Development Delays may not necessarily have a history of birth trauma or other illness that could be causing the impairment, such as a hearing problem, mental illness, or other neurological symptoms or illness.

“Diagnosis”
“Diagnosis” shall mean the act or process of identifying or determining the nature and cause of a Disease or Injury through evaluation of patient history, examination, and review of laboratory data.

“Diagnostic Service”
“Diagnostic Service” shall mean an examination, test, or procedure performed for specified symptoms to obtain information to aid in the assessment of the nature and severity of a medical condition or the identification of a Disease or Injury. The Diagnostic Service must be ordered by a Physician or other professional Provider.

“Direct Agreement”
“Direct Agreement” shall mean a complete agreement between a Directly Contracted Provider and the contracted Third Party Administrator or the Plan Sponsor which contains the terms and conditions under which the Covered Person may access discounted fees and/or negotiated or scheduled reimbursement rates which the Plan adopts as Allowable Claims Limits for claims submitted by a directly contracted provider.

“Directly Contracted Provider”
“Directly Contracted Provider” shall mean a medical provider, supplemental benefit provider, and/or supplemental network partner which has entered into a Direct Agreement with the contracted Third Party Administrator, including any affiliates, or the Plan Sponsor to provide certain medical services to Covered Persons at agreed upon Allowable Claim Limits. Directly Contracted Providers shall also include those providers contracted with the Partners Direct Health Network.

“Disease”
“Disease” shall mean any disorder 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 is furnished showing that the individual concerned is covered as an Employee under any workers’ compensation law, occupational disease law or any other legislation of similar purpose, or under the maritime doctrine of maintenance, wages, and cure, but that the disorder involved is one not covered under the applicable law or doctrine, then such disorder shall, for the purposes of the Plan, be regarded as a Sickness, Illness or Disease.

“Domestic Partner”
“Domestic Partner” shall mean an unmarried person of the same or opposite sex with whom the covered Employee shares a committed relationship, who is jointly responsible for the other’s welfare and financial obligations, who is at least 18 years of age, who is not related by blood, who maintains the same residence, and who is not married to or legally separated from anyone else.
In order for Your Domestic Partner to qualify as a Dependent, You and Your partner must complete a certification declaring that You and Your partner:

1. Are in a relationship of mutual support, care, and commitment and are responsible for each other’s welfare;
2. Have maintained this relationship for the past six months and intend to do so indefinitely:
3. Have shared a primary residence for the past six months and intend to do so indefinitely;
4. Are not married to anyone else and do not have other Domestic Partners;
5. Are financially interdependent.

“Drug”
“Drug” shall mean 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 medicinal 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. “Drug” shall also mean insulin for purposes of injection.

“Durable Medical Equipment”
“Durable Medical Equipment” shall mean equipment and/or supplies ordered by a health care Provider for everyday or extended use which meets all 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.
4. Is appropriate for use in the home
5. A cochlear implant is not considered Durable Medical Equipment.

“Effective Date”
The first day of coverage under this Plan. The Covered Person’s Effective Date may or may not be the same as his or her Enrollment Date, as Enrollment Date defined by the Plan.

“Emergency”
“Emergency” shall mean a situation or medical condition with symptoms of sufficient severity (including severe pain) that the absence of immediate medical attention and treatment would reasonably be expected to result in: (a) serious jeopardy to the health of the individual (or, with respect to a pregnant woman, the woman's unborn child); (b) serious impairment to bodily functions; or (c) serious dysfunction of any bodily organ or part. An Emergency includes, but is not limited to, severe chest pain, poisoning, unconsciousness, and hemorrhage. Other Emergencies and acute conditions 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 Medical Condition”
“Emergency Medical Condition” shall mean a medical condition manifesting itself by acute symptoms of sufficient severity (including severe pain) so that a prudent layperson, who possesses an average knowledge of health and medicine, could reasonably expect the absence of immediate medical attention to result in a condition described in clause (i), (ii), or (iii) of section 1867(e)(1)(A) of the Social Security Act (42 U.S.C. 1395dd(e)(1)(A)). In that provision of the Social Security Act, clause (i) refers to 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; clause (ii) refers to serious impairment to bodily functions; and clause (iii) refers to serious dysfunction of any bodily organ or part.

“Emergency Services”
“Emergency Services” shall mean, with respect to an Emergency Medical Condition, the following:

1. An appropriate 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 or of an Independent Freestanding Emergency Department, as applicable, including ancillary services routinely available to the emergency department to evaluate such Emergency Medical Condition; and
2. Within the capabilities of the staff and facilities available at the Hospital or the Independent Freestanding Emergency Department, as applicable, such further medical examination and treatment as are required under section 1867 of the Social Security Act (42 U.S.C. 1395dd), or as would be required under such section if such section applied to an Independent Freestanding Emergency Department, to stabilize the patient (regardless of the department of the Hospital in which such further examination or treatment is furnished).

When furnished with respect to an Emergency Medical Condition, Emergency Services shall also include an item or service provided by a Non-Network Provider or Non-Participating Health Care Facility (regardless of the department of the Hospital in which items or services are furnished) after the Participant is stabilized and as part of Outpatient observation or an Inpatient or Outpatient stay with respect to the visit in which the Emergency Services are furnished, until such time as the Provider determines that the Participant is able to travel using non-medical transportation or non-emergency medical transportation, and the Participant is in a condition to, and in fact does, give informed consent to the Provider to be treated as a Non-Network Provider.

“Employee”
See the Eligibility and Enrollment section of this SPD.

“Employer”
“Employer” is AHS MANAGEMENT COMPANY, INC.

"Enrollment Date"

1. For anyone who applies for coverage when first eligible, the first day of the Waiting Period.
2. For anyone who enrolls under the Special Enrollment Provision, or for Late Enrollees, the first day coverage begins.

"ERISA"
"ERISA" shall mean the Employee Retirement Income Security Act of 1974, as amended from time to time, and applicable regulations.

"Essential Health Benefits"
"Essential Health Benefits" shall mean, under section 1302(b) of the Affordable Care Act, those health benefits to include at least the following general categories and the items and services covered within the categories: ambulatory patient services; Emergency Services; hospitalization; maternity and newborn care; mental health and substance abuse disorder services, including behavioral health treatment; prescription Drugs; rehabilitative and Habilitative Services and devices; laboratory services; preventive and wellness services and chronic disease management; and pediatric services, including oral and vision care.

"Exclusion"
"Exclusion" shall mean conditions or services that this Plan does not cover.

"Experimental" and/or "Investigational"
"Experimental" and/or "Investigational" ("Experimental") shall mean services or treatments that are not widely used or accepted by most practitioners or lack credible evidence to support positive short or long-term outcomes from those services or treatments and that are not the subject of, or in some manner related to, the conduct of an Approved Clinical Trial, as such term is defined herein; these services are not included under or as Medicare reimbursable procedures, and include services, supplies, care, procedures, treatments or courses of treatment which meet either of the following requirements:

1. Do not constitute accepted 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.
2. Are rendered on a research basis as determined by the United States Food and Drug Administration and the AMA's Council on Medical Specialty Societies.

A drug, device, or medical treatment or procedure is Experimental if one of the following requirements is met:
If the drug or device cannot be lawfully marketed without approval of the U.S. Food and Drug Administration and approval for marketing has not been given at the time the drug or device is furnished:

1. 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 or under study 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.

2. 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:
Only published reports and articles in the authoritative medical and scientific literature.

1. 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.

2. The written informed consent used by the treating facility or by another facility studying substantially the same drug, device, or medical treatment or procedure.

The Plan Administrator retains maximum legal authority and discretion to determine what is Experimental.

"Explanation of Benefits (EOB)"
"Explanation of Benefits" shall mean a statement a health plan sends to a Participant which shows charges, payments and any balances owed. It may be sent by mail or e-mail. An Explanation of Benefits may serve as an Adverse Benefit Determination.

"Extended Care Facility"
"Extended Care Facility" shall mean a facility including, but not limited to, a skilled nursing, rehabilitation, convalescent, or subacute facility. It is an institution or a designated part of an institution that is operating pursuant to the law for such an institution and is under the full-time supervision of a Physician or registered nurse. In addition, the Plan requires that the facility; provide 24 hour-per-day service to include skilled nursing care and Medically Necessary therapies for the recovery of health or physical strength; not be a place primarily for Custodial Care; require compensation from its patients; admit patients only upon Physician orders; have an agreement to have a Physician's services available when needed: maintain adequate medical records for all patients; and have a written transfer agreement with at least one Hospital, be licensed by the state in which it operates, and provides the services to which the licensure applies.

"Facility"
"Facility" shall mean a healthcare institution which meets all applicable state or local licensure requirements. For the purposes of the Claim Review and Audit Program, facility includes but is not limited to, hospitals, emergency , rehabilitations and skilled nursing centers, ambulatory surgical facility, laboratories, X-ray, MRI or other CT facilities, and any other health care facility.
"Family Unit"
"Family Unit" shall mean the Employee and his or her Dependents covered under the Plan.

"FDA"
"FDA" shall mean Food and Drug Administration.

"Final Internal Adverse Benefit Determination"
"Final Internal Adverse Benefit Determination" shall mean an Adverse Benefit Determination that has been upheld by the Plan at the conclusion of the internal claims and appeals process, or an Adverse Benefit Determination with respect to which the internal claims and appeals process has been deemed exhausted.

"FMLA"
"FMLA" shall mean the Family and Medical Leave Act of 1993, as amended.

"FMLA Leave"
"FMLA Leave" shall mean an unpaid, job protected Leave of Absence for certain specified family and medical reasons, which the Company is required to extend to an eligible Employee under the provisions of the FMLA.

"Gender Dysphoria"
"Gender Dysphoria" means a disorder characterized by the following diagnostic criteria classified in the current edition of the Diagnostic and Statistical Manual of the American Psychiatric Association:

Diagnostic criteria for adults and adolescents:

1. A marked incongruence exists between one's experienced/expressed gender and one's assigned gender, of at least six months' duration, as manifested by at least two of the following:

    a. A marked incongruence between one's experienced/expressed gender and primary and/or secondary sex characteristics (or, in young adolescents, the anticipated secondary sex characteristics).
    b. A strong desire to be rid of one's primary and/or secondary sex characteristics because of a marked incongruence with one's experienced/expressed gender (or, in young adolescents, a desire to prevent the development of the anticipated secondary sex characteristics).
    c. A strong desire for the primary and/or secondary sex characteristics of the other gender.
    d. A strong desire to be of the other gender (or some alternative gender different from one's assigned

gender).
e. A strong desire to be treated as the other gender (or some alternative gender different from one's assigned gender).
f. A strong conviction that one has the typical feelings and reactions of the other gender (or some alternative gender different from one's assigned gender).

The condition must be associated with clinically significant distress or impairment in social, occupational, or other important areas of functioning.

Diagnostic criteria for children:

2. A marked incongruence exists between one's experienced/expressed gender and one's assigned gender, of at least six months' duration, as manifested by at least six of the following (one of which must be the criterion shown in the first bullet below):

a. A strong desire to be of the other gender or an insistence that one is the other gender (or some alternative gender different from one's assigned gender).
b. In boys (assigned gender), a strong preference for cross-dressing or simulating female attire; or in girls (assigned gender), a strong preference for wearing only typical masculine clothing and a strong resistance to the wearing of typical feminine clothing.
c. A strong preference for cross-gender roles in make-believe play or fantasy play.
d. A strong preference for the toys, games, or activities stereotypically used or engaged in by the other gender.
e. A strong preference for playmates of the other gender.
f. In boys (assigned gender), a strong rejection of typically masculine toys, games, and activities and a strong avoidance of rough-and-tumble play; or in girls (assigned gender), a strong rejection of typically feminine toys, games, and activities.
g. A strong dislike of one's sexual anatomy.
h. A strong desire for the primary and/or secondary sex characteristics that match one's experienced gender.

The condition must be associated with clinically significant distress or impairment in social, school, or other important areas of functioning.

"GINA"
"GINA" shall mean the Genetic Information Nondiscrimination Act of 2008 (Public Law No. 110-233), which prohibits group health plans, issuers of individual health care policies, and employers from discriminating on the basis of genetic information.

"Habilitation/Habilitative Services"
"Habilitation/Habilitative Services" shall mean health care services that help a person keep, learn, or improve skills and functioning for daily living. Examples include therapy for a child who is not walking or talking at the expected age. These services may include physical and occupational therapy, speech-language pathology and other services for people with disabilities in a variety of Inpatient and/or Outpatient settings.

"High Deductible Health Plan (HDHP)"
"High Deductible Health Plan" shall mean a health plan which has to meet federal rules. This is so Participants can put money into a Health Savings Account or health reimbursement arrangement to help pay for health care. The plan Deductible is higher than a standard health plan.

"HIPAA"
"HIPAA" shall mean the Health Insurance Portability and Accountability Act of 1996, as amended.

"Home Health Care"
"Home Health Care" shall mean the continual care and treatment of an individual if all of the requirements are met:

1. The institutionalization of the individual would otherwise have been required if Home Health Care was not provided.
2. The treatment plan covering the Home Health Care service is established and approved in writing by the attending Physician.
3. The Home Health Care is the result of an Illness or Injury.

“Home Health Care Agency”
“Home Health Care Agency” shall mean an agency or organization which provides a program of Home Health Care and which meets one of the following requirements:
Is a Federally Certified Home Health Care Agency and approved as such under Medicare.

1. 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.
2. 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 (R.N.) or it has nursing care by a Registered Nurse (R.N.) available.
    e. Its employees are bonded and it provides malpractice insurance.

“Hospice”
“Hospice” shall mean a health care program providing a coordinated set of services rendered at home, in Outpatient settings, or in Inpatient settings for a Covered Person suffering from a condition that has a terminal prognosis. Non-curative supportive care is provided through an interdisciplinary group of personnel. A hospice must meet the standards of the National Hospice Organization and applicable state licensing.

“Hospital”
“Hospital” shall mean 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, on an Inpatient basis, 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.
“Hospital” shall also have the same meaning, where appropriate in context, set forth in the definition of “Ambulatory Surgical Center.”

“HRSA”
“HRSA” shall mean Health Resources and Services Administration.

“Incurred”
A Covered Expense is “incurred” on 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, Covered 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.

“Illness”
“Illness” shall mean a bodily disorder, disease, physical or mental sickness, functional nervous disorder, pregnancy, or complication of pregnancy. The term “Illness,” when used in connection with a newborn Child, includes, but is not limited to, congenital defects and birth abnormalities, including premature birth

“Imaging”
“Imaging” shall mean the action or process of producing an image of a part of the body by radiographic techniques using high-end radiology such as MRA, MRI, CT, or PET scans and nuclear medicine.

“Impregnation and Infertility Treatment”
“Impregnation and Infertility Treatment” shall mean any services, supplies or Drugs related to the Diagnosis or treatment of infertility.

“Incurred”
A Covered Expense is “Incurred” on 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, Covered 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.

“Independent Contractor”
Someone who signs an agreement with the employer as an Independent Contractor, or an entity or individual who performs services to or on behalf of the employer who is not an Employee or an officer of the employer and who retains control over how work is completed. The employer who hires the Independent Contractor controls only the outcome of the work and not the performance of the hired service. Determination as to whether an individual or entity is an Independent Contractor will be made consistent with Section 530 of the Internal Revenue Code.

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

“Infertility Treatment”
“Infertility Treatment” shall mean services, tests, supplies, devices, or drugs that are intended to promote fertility, achieve a condition of pregnancy, or treat an Illness causing an infertility condition when such treatment is performed in an attempt to bring about a pregnancy.

For purposes of this definition, Infertility Treatment includes, but is not limited to fertility tests and drugs; tests and exams performed to prepare for induced conception; surgical reversal of a sterilized state that was a result of a previous surgery; sperm-enhancement procedures; direct attempts to cause pregnancy by any means, including, but not limited to: hormone therapy or drugs; artificial insemination; in vitro fertilization; Gamete Intrafallopian Transfer (GIFT), or Zygote Intrafallopian Transfer (ZIFT); embryo transfer; and freezing or storage of embryo, eggs, or semen.

“Injury”
“Injury” shall mean an Accidental Bodily Injury, 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.

“Inpatient”
“Inpatient” shall mean a Participant who receives care as a registered and assigned bed patient while confined in a Hospital, other than in its outpatient department, where a room and board is charged by the Hospital.

“Institution”
“Institution” shall mean 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, or any other such facility that the Plan approves.

“Intensive Care Unit”
“Intensive Care Unit” shall have the same meaning set forth in the definition of “Cardiac Care Unit.”

“Intensive Outpatient Services”
“Intensive Outpatient Services” shall mean programs that have the capacity for planned, structured, service provision of at least two hours per day and three days per week. The range of services offered could include group, individual, family or multi-family group psychotherapy, psychoeducational services, and medical monitoring. These services would include multiple or extended treatment/rehabilitation/counseling visits or professional supervision and support. Program models include structured “crisis intervention programs,” “psychiatric or psychosocial rehabilitation,” and some “day treatment.”

“Leave of Absence”
“Leave of Absence” shall mean a period of time during which the Employee must be away from his or her primary job with the Employer, while maintaining the status of Employee during said time away from work, generally requested by an Employee and having been approved by his or her Participating Employer, and as provided for in the Participating Employer’s rules, policies, procedures and practices where applicable.

“Legal Guardianship/Legal Guardian”
“Legal Guardianship/Legal Guardian” shall mean an individual recognized by a court of law as having the duty of taking care of a person and managing the individual’s property and rights.

“Legal Separation” or “Legally Separated”
“Legal Separation” and/or “Legally Separated” shall mean an arrangement under the applicable state laws to remain married but maintain separate lives, pursuant to a valid court order.

“Manipulation”
“Manipulations” shall mean the act, process, or instance of manipulating a body part by manual examination and treatment, such as in the reduction of faulty structural relationships by manual means and/or the reduction of fractures or dislocations or the breaking down of adhesions.

“Mastectomy”
“Mastectomy” shall mean the Surgery to remove all or part of breast tissue as a way to treat or prevent breast cancer.

“Maximum Allowable Charge”
The “Maximum Allowable Charge” shall mean the amount payable for a specific covered item under this Plan. The Maximum Allowable Charge will be a negotiated rate, if one exists. For claims under the Claim Review and Audit Program, the Maximum Allowable Charge is the Allowable Claim Limit.

If no negotiated rate exists, the Maximum Allowable Charge will be an amount deemed payable by a Certified IDR Entity or a court of competent jurisdiction, if applicable. If neither of these factors is applicable, the Plan Administrator will exercise its discretion to determine the Maximum Allowable Charge based on any of the following: Medicare reimbursement rates, Medicare cost data, amounts actually collected by Providers in the area for similar services, or average wholesale price (AWP) or manufacturer’s retail pricing (MRP). These ancillary factors will take into account generally-accepted billing standards and practices.

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

“Medical Child Support Order”
“Medical Child Support Order” shall mean any judgment, decree or order (including approval of a domestic relations settlement agreement) issued by a court of competent jurisdiction that meets one of the following requirements:

1. Provides for child support with respect to a Participant’s Child or directs the Participant to provide coverage under a health benefits plan pursuant to a State domestic relations law (including a community property law).
2. Is made pursuant to a law relating to medical child support described in §1908 of the Social Security Act (as added by Omnibus Budget Reconciliation Act of 1993 §13822) with respect to a group health plan.

“Medical Record Review”
“Medical Record Review” is the process by which the Plan, based upon a Medical Record Review and audit, determines that a different treatment or different quantity of a Drug or supply was provided which is not supported in the billing, then the Plan Administrator may determine the Maximum Allowable Charge according to the Medical Record Review and audit results.

"Medically Necessary"
"Medically Necessary", "Medical Necessity" and similar language refers to health care services ordered by a Physician exercising prudent clinical judgment provided to a Participant for the purposes of evaluation, Diagnosis or treatment of that Participant's Sickness or Injury. Such services, to be considered Medically Necessary, must be clinically appropriate in terms of type, frequency, extent, site and duration for the Diagnosis or treatment of the Participant's Sickness or Injury. The Medically Necessary setting and level of service is that setting and level of service which, considering the Participant's medical symptoms and conditions, cannot be provided in a less intensive medical setting. Such services, to be considered Medically Necessary must be no more costly than alternative interventions, including no intervention and are at least as likely to produce equivalent therapeutic or diagnostic results as to the Diagnosis or treatment of the Participant's Sickness or Injury without adversely affecting the Participant's medical condition. The service must meet all of the following requirements:

1. Its purpose must be to restore health.
2. It must not be primarily custodial in nature.
3. It is ordered by a Physician for the Diagnosis or treatment of a Sickness or Injury.
4. 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 Participant is receiving or the severity of the Participant'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 necessarily mean that it is "Medically Necessary." In addition, the fact that certain services are specifically excluded from coverage under this Plan because they are not "Medically Necessary" does not mean that all other services are "Medically Necessary."

To be Medically Necessary, all of the above criteria must be met. The Plan Administrator has the discretionary authority to decide whether care or treatment is Medically Necessary based on recommendations of the Plan Administrator's own medical advisors, the findings of the American Medical Association or similar organization, or any other sources that the Plan Administrator deems appropriate.

"Medically Necessary Leave of Absence"
"Medically Necessary Leave of Absence" shall mean a Leave of Absence by a full-time student Dependent at a postsecondary educational institution that meets all of the following requirements:
Commences while such Dependent is suffering from an Illness or Injury.

1. Is Medically Necessary.
2. Causes such Dependent to lose student status for purposes of coverage under the terms of the Plan.

"Medicare"
"Medicare" shall mean 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 Health Parity Act of 1996 (MHPA) and Mental Health Parity and Addiction Equity Act of 2008 (MHPAEA), Collectively, the Mental Health Parity Provisions in Part 7 of ERISA"
"The Mental Health Parity Provisions" shall mean in the case of a group health plan (or health insurance coverage offered in connection with such a plan) that provides both medical and surgical benefits and mental health or Substance Use Disorder benefits, such plan or coverage shall ensure that all of the following requirements are met:

1. The financial requirements applicable to such mental health or Substance Use Disorder benefits are no more restrictive than the predominant financial requirements applied to substantially all medical and surgical benefits covered by the Plan (or coverage).
2. There are no separate cost sharing requirements that are applicable only with respect to mental health or Substance Use Disorder benefits, if these benefits are covered by the group health plan (or health insurance coverage is offered in connection with such a plan).
3. The treatment limitations applicable to such mental health or Substance Use Disorder benefits are no more restrictive than the predominant treatment limitations applied to substantially all medical and surgical benefits covered by the Plan (or coverage).

4. There are no separate treatment limitations that are applicable only with respect to mental health or Substance Use Disorder benefits, if these benefits are covered by the group health plan (or health insurance coverage is offered in connection with such a plan).

"Mental or Nervous Disorder"
"Mental or Nervous Disorder" shall mean any Disease or condition, regardless of whether the cause is organic, that is classified as a Mental or Nervous Disorder in the current edition of 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. The fact that a disorder is listed in any of these sources does not mean that treatment of the disorder is covered by the Plan.

"Morbid Obesity"
"Morbid Obesity" shall mean a Body Mass Index (BMI) that is greater than or equal to 40 kg/m2. If there are serious (life-threatening) medical condition(s) exacerbated by, or caused by, obesity not controlled despite maximum medical therapy and patient compliance with a medical treatment plan, a BMI greater than or equal to 35 kg/m2 is applied. Morbid Obesity for a Covered Person who is less than 19 years of age means a BMI that falls above the 95th percentile on the growth chart.

"National Medical Support Notice" or "NMSN"
"National Medical Support Notice" or "NMSN" shall mean a notice that contains all of the following information:

1. The name of an issuing State child support enforcement agency.
2. The name and mailing address (if any) of the Employee who is a Participant under the Plan or eligible for enrollment.
3. The name and mailing address of each of the Alternate Recipients (i.e., the Child or Children of the Participant) or the name and address of a State or local official may be substituted for the mailing address of the Alternate Recipients(s).
4. Identity of an underlying child support order.

"Network" or "In-Network"
"Network" or "In-Network" shall mean the facilities, providers and suppliers who have by contract via a medical Provider Network agreed to allow the Plan access to discounted fees for service(s) provided to Participants, and by whose terms the Network's Providers have agreed to accept assignment of benefits and the discounted fees thereby paid to them by the Plan as payment in full for Covered Expenses. The applicable Provider Network will be identified on the Participant's identification card.

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

"Non-Network" or "Out-of-Network"
"Non-Network" or "Out-of-Network" shall mean the facilities, Providers and suppliers that do not have an agreement with a designated Network to provide care to Participants.

"Nurse"
"Nurse" shall mean an individual who has received specialized nursing training and is authorized to use the designation Registered Nurse (R.N.), Licensed Vocational Nurse (L.V.N.) or Licensed Practical Nurse (L.P.N.), and who is duly licensed by the State or regulatory agency responsible for such license in the State in which the individual performs the nursing services.

"Open Enrollment Period"
"Open Enrollment Period" shall mean the time frame specified by the Plan Administrator.

"Other Plan"
1. "Other Plan" shall mean any group health plan or health insurance coverage as defined in 42 U.S. Code § 300gg-91 from which a Participant is entitled to benefits

“Outpatient”
“Outpatient” shall mean treatment including services, supplies, and medicines provided and used at a Hospital under the direction of a Physician to a person not admitted as a registered bed patient; or services rendered in a Physician’s office, laboratory, or x-ray facility, an Ambulatory Surgical Center, or the patient’s home.

“Partial Hospitalization”
“Partial Hospitalization” shall mean medically directed intensive, or intermediate short-term mental health and Substance Abuse treatment, for a period of less than twenty-four (24) hours but more than four (4) hours in a day in a licensed or certified facility or program.

“Participant”
“Participant” shall mean any Employee, Dependent, or individual that is covered under the Plan through COBRA continuation, who is eligible for benefits (and enrolled) under the Plan.

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

“Partners Direct Health Network”
"Partners Direct Health Network” is a network of professional and ancillary providers who have entered into an agreement with Partners Direct Health or any of its affiliates, to perform services at pre-negotiated, preferred rates. Partners Direct Health Network may include providers contracted with other networks, such as Preferred Medical Claims Solutions (PMCS), and/or Healthsmart Preferred Care II, L.P./Healthsmart Preferred Network II, Inc. (Healthsmart).

“Patient Protection and Affordable Care Act (PPACA)”
The “Patient Protection and Affordable Care Act (PPACA)” means the health care reform law enacted in March 2010, Public Law 111-148; PPACA, together with the Health Care and Education Reconciliation Act, is commonly referred to as Affordable Care Act (ACA). (See “Affordable Care Act”).

“Physician”
“Physician” shall mean a Doctor of Medicine (M.D.), Doctor of Medical Dentistry, including an oral surgeon (DMD) , Doctor of Osteopathy (D.O.), Doctor of Dental Surgery (D.D.S.), Doctor of Podiatry (D.P.M.), Doctor of Chiropractic (D.C.), Doctor of Optometry (OPT), Psychologist (Ph.D.), Audiologist, Certified Nurse Anesthetist, Licensed Professional Counselor, Licensed Professional Physical Therapist, Master of Social Work (M.S.W.), Occupational Therapist, Physiotherapist, Speech Language Pathologist, psychiatrist, midwife, and any other practitioner of the healing arts who is licensed and regulated by a State or Federal agency, acting within the scope of that license.

“Plan Year”
“Plan Year” shall mean a period commencing on the Effective Date or any anniversary of the adoption of this Plan and continuing until the next succeeding anniversary.

“Pre-Admission Tests”
“Pre-Admission Tests” shall mean those medical tests and Diagnostic Services completed prior to a scheduled procedure, including Surgery, or scheduled admissions to the Hospital or Inpatient health care facility provided that all of the following requirements are met:
The Participant obtains a written order from the Physician.

1. The tests are approved by both the Hospital and the Physician.
2. The tests are performed on an Outpatient basis prior to Hospital admission.
3. The tests are performed at the Hospital into which confinement is scheduled, or at a qualified facility designated by the Physician who will perform the procedure or Surgery.

“Pregnancy”
“Pregnancy” shall mean 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 a Sickness for the purpose of determining benefits under this Plan.

"Preventive Care"
"Preventive Care" shall mean certain Preventive Care services.
To comply with the ACA, and in accordance with the recommendations and guidelines, plans shall provide In-Network coverage for all of the following:

Evidence-based items or services rated A or B in the United States Preventive Services Task Force recommendations.

1. Recommendations of the Advisory Committee on Immunization Practices adopted by the Director of the Centers for Disease Control and Prevention.
2. Comprehensive guidelines for infants, children, and adolescents supported by the Health Resources and Services Administration (HRSA).
3. Comprehensive guidelines for women supported by the Health Resources and Services Administration (HRSA).

Copies of the recommendations and guidelines may be found at the following websites:
https://www.healthcare.gov/coverage/preventive-care-benefits/;
https://www.uspreventiveservicestaskforce.org/uspstf/recommendation-topics/uspstf-a-and-b-recommendations;
https://www.cdc.gov/vaccines/hcp/acip-recs/index.html;
https://www.aap.org/en/practice-management/care-delivery-approaches/periodicity-schedule/;
https://www.hrsa.gov/womensguidelines/.

"Preventive / Routine Care"
"Preventive/Routine Care" shall mean a prescribed standard procedure that is ordered by a Physician to evaluate or assess the Covered Person's health and well-being, screen for possible detection of unrevealed Illness or Injury, improve the Covered Person's health, or extend the Covered Person's life expectancy. Generally, a procedure is routine if there is no personal history of the Illness or Injury for which the Covered Person is being screened, except as required by applicable law. Benefits included as Preventive/Routine Care are listed in the Schedule of Benefits and will be paid subject to any listed limits or maximums. Whether an immunization is considered Preventive/Routine is based upon the recommendations of the Center for Disease Control and Prevention. Preventive/Routine Care does not include benefits specifically excluded by this Plan, or treatment after the diagnosis of an Illness or Injury, except as required by applicable law.

(Applies to HDHP Plus and HDHP) For a High Deductible Health Plan, Preventive/Routine Care means care consistent with IRS Code §223(c)(2)(c) and as listed in the Schedule of Benefits, that may be paid by a high deductible health plan (HDHP) without the Covered Person satisfying the minimum Deductible under the Plan.

"Primary Care Physician (PCP)"
"Primary Care Physician (PCP)" shall mean family practitioners, general practitioners, internists, OBGYNs, pediatricians, Physicians treating mental health/substance use disorders, and office-based nurse practitioners and physician's assistants. All other Physicians are considered specialists.

"Prior Plan"
"Prior Plan" shall mean the coverage provided on a group or group type basis by the group insurance policy, benefit plan or service plan that was terminated on the day before the Effective Date of the Plan and replaced by the Plan.

"Prior to Effective Date" or "After Termination Date"
"Prior to Effective Date" or "After Termination Date" are dates occurring before a Participant gains eligibility from the Plan, or dates occurring after a Participant loses eligibility from the Plan, as well as charges Incurred Prior to the Effective Date of coverage under the Plan or after coverage is terminated, unless continuation of benefits applies.

"Privacy Standards"
"Privacy Standards" shall mean the standards of the privacy of individually identifiable health information, as pursuant to HIPAA.

"Provider"
"Provider" shall mean 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 facilities must meet the standards as set forth within the applicable definitions of the Plan as it relates to the relevant provider type.

"Psychiatric Hospital"
"Psychiatric Hospital" shall mean 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."

To be deemed a "Psychiatric Hospital," the Institution must be duly licensed and must not be primarily a place for rest, the aged, and/or a nursing home, custodial, or training institution.

"Qualified Medical Child Support Order" or "QMCSO"
"Qualified Medical Child Support Order" or "QMCSO" shall mean a Medical Child Support Order, in accordance with applicable law, and which creates or recognizes the existence of an Alternate Recipient's right to, or assigns to an Alternate Recipient the right to, receive benefits for which a Participant or eligible Dependent is entitled under this Plan.

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

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

"Reconstructive Surgery"
"Reconstructive Surgery" shall mean a surgical procedures performed on abnormal structures of the body caused by congenital Illness or anomaly, Accident, or Illness. The fact that physical appearance may change or improve as a result of Reconstructive Surgery does not classify surgery as Cosmetic Treatment when a physical impairment exists and the surgery restores or improves function.

"Rehabilitation"
"Rehabilitation" shall mean treatment(s) designed to facilitate the process of recovery from Injury, Illness, or Disease to as normal a condition as possible.

"Rehabilitation Hospital"
"Rehabilitation Hospital" shall mean 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 Sickness 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 be duly licensed and must not be primarily a place for rest, the aged, and/or a nursing home, custodial, or training institution.

“Residential Treatment Facility”
“Residential Treatment Facility” shall mean a facility licensed or certified as such by the jurisdiction in which it is located to operate a program for the treatment and care of Participants diagnosed with alcohol, drug or Substance Abuse disorders or mental illness.

“Room and Board”
“Room and Board” shall mean 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 but not limited to 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.

“Security Standards”
“Security Standards” shall mean the final rule implementing HIPAA’s Security Standards for the Protection of Electronic Protected Health Information (PHI), as amended.

“Service Waiting Period”
“Service Waiting Period” shall mean an interval of time that must pass before an Employee or Dependent is eligible to enroll under the terms of the Plan. The Employee must be a continuously Active Employee of the Employer during this interval of time.

“Sickness”
“Sickness” shall have the meaning set forth in the definition of “Disease.”

“Skilled Nursing Facility”
“Skilled Nursing Facility” shall mean a facility that fully meets all of the following requirements:
It is licensed to provide professional nursing services on an Inpatient basis to persons convalescing from Injury or Sickness. The service must be rendered by a Registered Nurse (R.N.) or by a Licensed Practical Nurse (L.P.N.) under the direction of a Registered Nurse. Services to help restore patients to self-care in essential daily living activities must be provided.

1. Its services are provided for compensation and under the full-time supervision of a Physician.
2. It provides 24 hour per day nursing services by licensed nurses, under the direction of a full-time Registered Nurse.
3. It maintains a complete medical record on each patient.
4. It has an effective utilization review plan.
5. It is not, other than incidentally, a place for rest, the aged, drug addicts, alcoholics, mentally disabled, Custodial Care, educational care or care of Mental or Nervous Disorders.
6. It is approved and licensed by Medicare.

“Specialty Drug(s)”
“Specialty Drug(s)” shall mean high-cost prescription medications used to treat complex, chronic conditions like cancer, rheumatoid arthritis and multiple sclerosis. Specialty Drugs often require special handling (like refrigeration during shipping) and administration (such as injection or infusion). Please contact the Prescription Drug Plan Administrator to determine specific drug coverage.

“Substance Abuse” and/or “Substance Use Disorder”
“Substance Abuse” and/or “Substance Use Disorder” shall mean any disease or condition that is classified as a Substance Use Disorder as listed in the current edition of the International Classification of Diseases, published by the U.S. Department of Health and Human Services, as 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.
The fact that a disorder is listed in any of the above publications does not mean that treatment of the disorder is covered by the Plan.

"Substance Abuse Treatment Center"
"Substance Abuse Treatment Center" shall mean an Institution whose facility is licensed, certified or approved as a Substance Abuse Treatment Center by a Federal, State, or other agency having legal authority to so license; which is affiliated with a Hospital and whose primary purpose is providing diagnostic and therapeutic services for treatment of Substance Abuse. To be deemed a "Substance Abuse Treatment Center," the Institution must have a contractual agreement with the affiliated Hospital by which a system for patient referral is established, and implement treatment by means of a written treatment plan approved and monitored by a Physician. Where applicable, the "Substance Abuse Treatment Center" must also be appropriately accredited by the Joint Commission on Accreditation of Hospitals.

"Surgery"
"Surgery" shall in the Plan Administrator's discretion mean the treatment of Injuries or disorders of the body by incision or manipulation, especially with instruments designed specifically for that purpose, and the performance of generally accepted operative and cutting procedures, performed within the scope of the Provider's license.

"Surgical Center"
"Surgical Center" shall mean a licensed facility that is under the direction of an organized medical staff of Physicians; has facilities that are equipped and operated primarily for the purpose of performing surgical procedures; has continuous Physician services and registered professional nursing services available whenever a patient is in the facility; generally does not provide Inpatient services or other accommodations; and offers the following services whenever a patient is in the center:

1. It provides drug services as needed for medical operations and procedures performed;
2. It provides for the physical and emotional well-being of the patients;
3. It provides Emergency services;
4. It has organized administration structure and maintains statistical and medical records.

"Surgical Procedure"
"Surgical Procedure" shall have the same meaning set forth in the definition of "Surgery."

"Telemedicine"
"Telemedicine" shall mean the practice of health care delivery, diagnosis, consultation, treatment, and transfer of medical data and education using interactive audio, video, or data communications.
Telemedicine services shall be rendered by a specific Telemedicine vendor as designated by the Plan.

"Temporomandibular Joint Disorder (TMJ)"
"Temporomandibular Joint Disorder" shall mean a disorder of the jaw joint(s) and/or associated parts resulting in pain or inability of the jaw to function properly.

"Terminal Illness"
"Terminal Illness" shall mean a life expectancy of approximately six months.

"**Totally Disabled"**
As determined by the Plan in its sole discretion:

1. That an Employee is prevented from engaging in any job or occupation for wage or profit for which the Employee is qualified by education, training or experience; or
2. That a covered Dependent has been diagnosed with a physical, psychiatric, or developmental disorder, or some combination thereof, and as a result cannot engage in Activities of Daily Living and/or substantial gainful activities that a person of like age and sex in good health can perform, preventing an Individual from attaining self-sufficiency.
3. Diagnosis of one or more of the following conditions is not considered proof of Total Disability. Conditions are listed in the most recent American Psychiatric Association Diagnostic and Statistical Manual (DSM) or or the most recent revision of the International Classification of Diseases – Clinical Modification manual (ICD-CM) in the following categories:

    a. Personality disorders; or
    b. Behavior and impulse control disorders; or
    c. "V" codes.

“Third Party Administrator”
“Third Party Administrator” shall mean the claims administrator, which provides customer service and claims payment services only and does not assume any financial risk or obligation with respect to those claims. The Third Party Administrator is not an insurer of health benefits under this Plan, is not a fiduciary of the Plan, and does not exercise any of the discretionary authority and responsibility granted to the Plan Administrator. The Third Party Administrator is not responsible for Plan financing and does not guarantee the availability of benefits under this Plan.

“Uniformed Services”
“Uniformed Services” shall mean the Armed Forces, the Army National Guard and the Air National Guard, when engaged in active duty for training, inactive duty training, or full time National Guard duty, the commissioned corps of the Public Health Service, and any other category of persons designated by the President of the United States in time of war or Emergency.

“Urgent Care”
“Urgent Care” shall mean the delivery of ambulatory care in a facility dedicated to the delivery of care outside of a Hospital Emergency department, usually on an unscheduled, walk-in basis. Urgent Care centers are primarily used to treat patients who have Injuries or Illnesses that require immediate care but are not serious enough to warrant a visit to an Emergency room. Often Urgent Care centers are not open on a continuous basis, unlike a Hospital Emergency room that would be open at all times.

“Waiting Period”
“Waiting Period” shall mean the period of time that must pass before coverage becomes effective for an Employee or Dependent who is otherwise eligible to enroll under the terms of this Plan. Refer to the Eligibility section of this Plan to determine if a Waiting Period applies.

“Walk-In Retail Health Clinics”
“Walk-In Retail Health Clinics” shall mean Health clinics located in retail stores, supermarkets, or pharmacies that provide a limited scope of preventive and/or clinical services to treat routine family Illnesses. Such a clinic must be operating under applicable state and local regulations and overseen by a Physician where required by law.

“You / Your”
Means the Employee.

“USERRA”
“USERRA” shall mean the Uniformed Services Employment and Reemployment Rights Act of 1994 (“USERRA”).

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

ELIGIBILITY AND ENROLLMENT

Eligibility and Enrollment Procedures

You are responsible for enrolling in the manner and form prescribed by Your employer. The Plan's eligibility and enrollment procedures include administrative safeguards and processes designed to ensure and verify that eligibility and enrollment determinations are made in accordance with the Plan. From time to time, the Plan may request documentation from You or Your Dependents in order to make determinations for continuing eligibility. The coverage choices that will be offered to You will be the same choices offered to other similarly situated Employees.

Waiting Period

If eligible, You must complete a Waiting Period before coverage becomes effective for You and Your Dependents. A Waiting Period is a period of time that must pass before an Employee or Dependent becomes eligible for coverage under the terms of this Plan.

You are eligible for coverage on the date listed below under the Effective Date section, upon completion of 30 calendar days of regular employment in a covered position.

The start of Your Waiting Period is the first full day of employment for the job that made You eligible for coverage under this Plan.

Eligibility Requirements

An **eligible Employee** is a person who is classified by the employer on both payroll and personnel records as an Employee who regularly works full-time 30 or more hours per week or part-time 20 hours per week, but for purposes of this Plan, it does not include the following classifications of workers except as determined by the employer in its sole discretion:

1. Leased Employees.
2. Independent Contractors.
3. Consultants who are paid on other than a regular wage or salary basis by the employer.
4. Members of the employer's Board of Directors, owners, partners, or officers, unless engaged in the conduct of the business on a full-time, regular basis.

For purposes of this Plan, eligibility requirements are used only to determine a person's initial eligibility for coverage under this Plan. An Employee may retain eligibility for coverage under this Plan if the Employee is temporarily absent on an approved leave of absence, which is combined with the employer's short-term disability policy, with the expectation of returning to work following the approved leave as determined by the employer's leave policy, provided that contributions continue to be paid on a timely basis. COBRA is not applicable until short-term disability is exhausted. Employees who meet eligibility requirements during a measurement period as required by the Affordable Care Act (ACA) regulations will have been deemed to have met the eligibility requirements for the resulting stability period as required by the ACA regulations. The employer's classification of an individual is conclusive and binding for purposes of determining eligibility under this Plan. No reclassification of a person's status, for any reason, by a third party, whether by a court, governmental agency, or otherwise, without regard to whether or not the employer agrees to such reclassification, will change a person's eligibility for benefits.

Note: Eligible Employees and Dependents who decline to enroll in this Plan must state so in writing. In order to preserve potential special enrollment rights, eligible individuals declining coverage must state in writing that enrollment is declined due to coverage under another group health plan or health insurance policy. Proof of such plan or policy may be required upon application for special enrollment. See the Special Enrollment Provision section of this Plan.

An **eligible Dependent** includes:

1. Your legal spouse, provided he or she is not covered as an Employee under this Plan. An eligible Dependent does not include an individual from whom You have obtained a legal separation or divorce or who no longer meets the definition of a Common-Law Marriage spouse. Documentation on a Covered Person's marital status may be required by the Plan Administrator. Coverage under this Plan is available to the spouse of an eligible Employee even if the spouse works full-time and is eligible for health coverage through his or her own employer benefits paid under the Plan, but this Plan will only pay on a secondary basis.

2. Your Domestic Partner, as long as he or she meets the definition of Domestic Partner as stated in the Definitions, and the person is not covered as an Employee under this Plan. When a person no longer meets

the definition of Domestic Partner, that person no longer qualifies as Your Dependent. Coverage under this Plan is available to the Domestic Partner of an eligible Employee even if the Domestic Partner works full-time and is eligible for health coverage through his or her own employer benefits paid under the Plan, but this Plan will only pay on a secondary basis.

3. A Dependent Child until the Child reaches his or her 26th birthday. The term "**Child**" includes the following Dependents:

    a. A natural biological Child;
    b. A stepchild;
    c. A legally adopted Child or a Child legally Placed for Adoption as granted by action of a federal, state, or local governmental agency responsible for adoption administration or a court of law if the Child has not attained age 26 as of the date of such placement;
    d. A Child or Grandchild under Your (or Your spouse's or Domestic Partner's) Legal Guardianship as ordered by a court; provided, however that if such Child or Grandchild is under your Domestic Partners Legal Guardianship and is not also your tax dependent. Your Domestic Partner must be properly enrolled in this Plan for such Child or Grandchild to be enrolled in the Plan.
    e. A Child who is considered an alternate recipient under a QMCSO;
    f. A Child of a Domestic Partner (provided such Domestic Partner is properly enrolled in the Plan).

4. A Dependent does not include the following:

    a. A grandchild not under Your (or Yours spouse's or Domestic Partner's) legal guardianship as ordered by a court;
    b. A Dependent Child if the Child is covered as a Dependent of another Employee at this company;
    c. Any other relative or individual unless explicitly covered by this Plan.
    d. A Child of Your Domestic Partner, if such Domestic Partner is not properly enrolled in the Plan or such Child is not also Your tax dependent.

Note: Coverage under this plan is only available as secondary coverage if the Domestic Partner or Spouse is eligible for health coverage through his or her own employer.

Note: An Employee must be covered under this Plan in order for Dependents to qualify for and obtain coverage.

Eligibility Criteria: To be an eligible Totally Disabled Dependent Child, the following conditions must all be met:

1. A Totally Disabled Dependent Child age 26 or over must be dependent upon the Employee for more than 50 percent of his or her support and maintenance. This financial requirement does not apply to Children who are enrolled in accordance with a QMCSO because of the Employee's divorce or separation decree.

Non-Duplication of Coverage: Any person who is covered as an eligible Employee will not also be considered an eligible Dependent under this Plan.

Right to Check a Dependent's Eligibility Status: The Plan reserves the right to check the eligibility status of a Dependent at any time throughout the year. You and Your Dependent have an obligation to notify the Plan should the Dependent's eligibility status change during the Plan Year. Please notify Your Human Resources Department regarding status changes.

Extended Coverage for Dependent Children

A Dependent Child may be eligible for extended Dependent coverage under this Plan under the following circumstances:

1. The Dependent Child was covered by this Plan on the day before the Child's 26th birthday; or
2. The Dependent Child is a Dependent of an Employee newly eligible for the Plan; or
3. The Dependent Child is eligible due to a special enrollment event or a Qualifying Status Change event, as outlined in the Section 125 Plan.

The Dependent Child must also fit the following category:

If You have a Dependent Child covered under this Plan who is under the age of 26 and Totally Disabled, either mentally or physically, that Child's health coverage may continue beyond the day the Child would otherwise cease to be a Dependent under the terms of this Plan. You must submit written proof that the Child is Totally Disabled within 30 calendar days after the day coverage for the Dependent would normally end. The Plan may, for three years, ask for additional proof at any time, after which the Plan can ask for proof not more than once per year.

Coverage may continue subject to the following minimum requirements:

1. The Dependent must not be able to hold a self-sustaining job due to the disability; and
2. Proof of the disability must be submitted as required (Notice of Award of Social Security Income is acceptable); and
3. The Employee must still be covered under this Plan.

A Totally Disabled Dependent Child older than 26 who loses coverage under this Plan may not re-enroll in the Plan under any circumstances.

IMPORTANT: It is our responsibility to notify the Plan Sponsor within 60 days if Your Dependent no longer meets the criteria listed in this section. If, at any time, the Dependent fails to meet the qualifications of a Totally Disabled Dependent, the Plan has the right to be reimbursed from the Dependent or Employee for any medical claims paid by the Plan during the period that the Dependent did not qualify for extended coverage. Please refer to the COBRA Continuation of Coverage section in this document.

Employees have the right to choose which eligible Dependents are covered under the Plan.

Effective Date of Employee's Coverage

Your coverage will begin on the later of the following dates:

1. If You apply within Your Waiting Period, Your coverage will become effective the first day of the month coinciding with or following the date You complete Your Waiting Period. If Your Waiting Period ends on the first day of the month, Your coverage will begin on that day; or
2. If You are eligible to enroll under the Special Enrollment Provision, Your coverage will become effective on the date set forth under the Special Enrollment Provision if application is made within 31 calendar days of the event; or
3. If You transfer or change status (part-time to full-time to part-time) Your coverage will be effective on the first of the month following the date of the transfer or status change.

Effective Date of Coverage for Your Dependents

Your Dependent's coverage will be effective on the later of:

1. The date Your coverage under the Plan begins if You enroll the Dependent at that time; or
2. The date You acquire Your Dependent if application is made within 31 calendar days of acquiring the Dependent; or
3. The date set forth under the Special Enrollment Provision if Your Dependent is eligible to enroll under the Special Enrollment Provision and application is made within 31 calendar days following the event; or
4. The date specified in a QMCSO or the date the Plan Administrator determines that the order is a QMCSO.

A contribution will be charged from the first day of coverage for the Dependent if an additional contribution is required. In no event will Your Dependent be covered prior to the day Your coverage begins.

Annual Open Enrollment Period

During the annual open enrollment period, eligible Employees will be able to enroll themselves and their eligible Dependents for coverage under this Plan. Covered Employees will be able to make changes in coverage for themselves and their eligible Dependents.

Coverage Waiting Periods are waived during the annual open enrollment period for covered Employees and covered Dependents changing from one Plan to another Plan or changing coverage levels within the Plan.

If You and/or Your Dependent becomes covered under this Plan as a result of electing coverage during the annual open enrollment period, the following will apply:

1. The employer will give eligible Employees written notice prior to the start of an annual open enrollment period; and
2. This Plan does not apply to charges for services performed or treatment received prior to the Effective Date of the Covered Person's coverage; and

The Effective Date of coverage will be January 1 following the annual open enrollment period.

Special Enrollment Provision Under the Health Insurance Portability and Accountability Act

This Plan gives each eligible person special enrollment rights if the person experiences a loss of other health coverage or a change in family status as explained below. The coverage choices that will be offered to You will be the same choices offered to other similarly situated Employees.

Loss of Health Coverage
You and Your Dependents may have a special opportunity to enroll for coverage under this Plan if You experience a loss of other health coverage.

In order for You to be eligible for special enrollment rights, You must meet the following conditions:

1. You and/or Your Dependents meet the eligibility requirements under the plan; and
2. You and/or Your Dependents were covered under a group health plan or health insurance policy at the time coverage under this Plan was offered; and
3. You and/or Your Dependents stated in writing that You declined coverage due to coverage under another group health plan or health insurance policy; and
4. The coverage under the other group health plan or health insurance policy was:

    a. COBRA continuation coverage and that coverage was exhausted; or
    b. Terminated because the person was no longer eligible for coverage under the terms of that plan or policy; or
    c. Terminated and no substitute coverage was offered; or
    d. No longer receiving any monetary contribution toward the premium from the employer.

You or Your Dependent must request and apply for coverage under this Plan no later than 31 calendar days after the date the other coverage ended. Notwithstanding the preceding, if You and/or Your Dependents were covered under a Medicaid plan or state child health plan and Your or Your Dependents' coverage was terminated due to loss of eligibility. You must request coverage under this Plan within 60 days after the date of termination of such coverage.
You or Your Dependents may not enroll for health coverage under this Plan due to loss of health coverage under the following conditions:

1. Coverage was terminated due to failure to pay timely premiums or for cause, such as making a fraudulent claim or an intentional misrepresentation of material fact, or
2. You or Your Dependent voluntarily canceled the other coverage, unless the current or former employer no longer contributed any money toward the premium for that coverage.

Newly Eligible for Premium Assistance Under Medicaid or Children's Health Insurance Program
A current Employee and his or her Dependents may be eligible for a special enrollment period if the Employee and/or Dependents are determined eligible, under a state's Medicaid plan or state child health plan, for premium assistance with respect to coverage under this Plan. The Employee must request coverage under this Plan within 60 days after the date the Employee and/or Dependents are determined to be eligible for such assistance.

Change in Family Status
Current Employees and their Dependents, COBRA Qualified Beneficiaries, and other eligible persons have special opportunities to enroll for coverage under this Plan if they experience changes in family status.
If a person becomes an eligible Dependent through marriage, birth, adoption or Placement for Adoption, the Employee, spouse, and newly acquired Dependent(s) who are not already enrolled may enroll for health coverage under this Plan during a special enrollment period. The Employee must request and apply for coverage within 31 calendar days of the marriage, birth, adoption, or Placement for Adoption.

Effective Date of Coverage Under Special Enrollment Provision
If an eligible person properly applies for coverage during this special enrollment period, the coverage will become effective as follows:

1. In the case of marriage, on the date of the marriage (note that eligible individuals must submit their enrollment forms prior to the Effective Dates of coverage in order for salary reductions to have preferred tax treatment from the date coverage begins); or
2. In the case of a Dependent's birth, on the date of such birth; or
3. In the case of a Dependent's adoption, the date of such adoption or Placement for Adoption; or
4. In the case of eligibility for premium assistance under a state's Medicaid plan or state child health plan, on the date the approved request for coverage is received; or

5. In the case of loss of coverage, on the date following loss of coverage.

Relation to The Ardent Health Services Flexible Benefits Plan

This Plan may also allow additional changes to enrollment due to change in status events under the Ardent Health Services Flexible Benefits Plan. Refer to Ardent Health Services Flexible Benefits Plan for more information.

TERMINATION

For information about continuing coverage, refer to the COBRA Continuation of Coverage section of this SPD.

Employee's Coverage

Your coverage under this Plan will end on the earliest of:

1. The end of the period for which Your last contribution is made if You fail to make any required contribution toward the cost of coverage when due; or
2. The date this Plan is terminated; or
3. The date coverage for Your benefit class is eliminated; or
4. The last day of the month in which You tell the Plan to cancel Your coverage if You are voluntarily canceling it while remaining eligible because of a change in status, because of special enrollment or at annual open enrollment periods; or
5. The end of the stability period in which You became a member of a non-covered class, as determined by the employer except as follows:

    a. If You are temporarily absent from work due to an approved leave of absence for medical or other reasons, Your coverage under this Plan will continue during that leave for up to six months, provided the applicable Employee contribution is paid when due.
    b. If You are temporarily absent from work due to active military duty, refer to USERRA under the Uniformed Services Employment and Reemployment Rights Act of 1994 section; or

6. The last day of the month in which Your employment ends; or
7. The date You submit a false claim or are involved in any other fraudulent act related to this Plan or any other group plan.

Your Dependent's Coverage

Coverage for Your Dependent will end on the earliest of the following:

1. The end of the period for which Your last contribution is made if You fail to make any required contribution toward the cost of Your Dependent's coverage when due; or
2. The day of the month in which Your coverage ends; or
3. The day of the month in which Your Dependent is no longer Your legal spouse or does not meet the definition of Common-Law Marriage spouse due to legal separation or divorce, as determined by the law of the state in which You reside; or
4. For Your Domestic Partner and his or her Children covered und the Plan who are not also Your tax dependent, the last day of the month in which Your Dependent no longer qualifies as a Domestic Partner, or
5. The last day of the month in which Your Dependent Child attains the limiting age listed under the Eligibility and Enrollment section; or
6. If Your Dependent Child qualifies for extended Dependent coverage because he or she is Totally Disabled, the last day of the month in which Your Dependent Child is no longer deemed Totally Disabled under the terms of the Plan; or
7. The last day of the month in which Your Dependent Child no longer satisfies a required eligibility criterion listed in the Eligibility and Enrollment section; or
8. The date Dependent coverage is no longer offered under this Plan; or
9. The last day of the month in which You tell the Plan to cancel Your Dependent's coverage if You are voluntarily canceling it while remaining eligible because of a change in status, because of special enrollment, or at annual open enrollment periods; or
10. The last day of the month in which the Dependent becomes covered as an Employee under this Plan; or
11. The date You or Your Dependent submits a false claim or is involved in any other fraudulent act related to this Plan or any other group plan.

Rescission of Coverage

As permitted by the Patient Protection and Affordable Care Act, the Plan reserves the right to rescind coverage. A rescission of coverage is a retroactive cancellation or discontinuance of coverage due to fraud or intentional misrepresentation of material fact.

A cancellation/discontinuance of coverage is **not** a rescission if:

1. it has only a prospective effect; or
2. it is attributable to non-payment of premiums or contributions; or
3. it is initiated by You or Your personal representative.

Reinstatement of Coverage

If Your coverage ends due to termination of employment, leave of absence, reduction of hours, or layoff and:

1. You qualify for eligibility under this Plan again (are rehired or considered to be rehired for purposes of the Affordable Care Act) within 13 weeks from the date Your coverage ended, Your coverage will be reinstated.
2. You do not qualify for eligibility under this Plan again (are not rehired or considered to be rehired for purposes of the Affordable Care Act) within 13 weeks from the date Your coverage ended, and You did not perform any hours of service that were credited within the 13-week period, You will be treated as a new hire and will be required to meet all the requirements of a new Employee.

Refer to the information on the Family and Medical Leave Act and the Uniformed Services Employment and Reemployment Rights Act for possible exceptions, or contact Your Human Resources or Personnel office.

Qualified Medical Child Support Orders

This Plan will provide for immediate enrollment and benefits to the Child or Children of a Participant, not including an ex-stepchild or ex-stepchildren, who are the subject of a Qualified Medical Child Support Order (QMCSO), regardless of whether the Child or Children reside with the Participant, 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 Participant. The Plan Administrator 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.

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 Participant 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.

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 in the Definitions section 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 Administrator will assume that all are designated.
3. It informs the Plan Administrator that, if a group health plan has multiple options and the Participant is not enrolled, the issuing agency will make a selection after the NMSN is qualified, and, if the agency does not respond within 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.

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 Participants and eligible Participants 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).

In the instance of any Medical Child Support Order received by this Plan, the Plan Administrator shall, as soon as administratively possible, perform the following:

1. In writing, notify the Participant 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 if the order is a QMCSO and notify the Participant and each affected Alternate Recipient of such determination.

In the instance of any National Medical Support Notice received by this Plan, the Plan Administrator 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.

As required by Federal law, the Plan Administrator shall perform the following:

1. Establish reasonable procedures to determine whether Medical Child Support Order or National Medical Support Notice 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.

A Participant of this Plan may obtain, without charge, a copy of the procedures governing QMCSO determinations from the Plan Administrator.

Acquired Companies

Eligible Employees of an acquired company who are Actively at Work and were covered under the Prior Plan of the acquired company will be eligible for the benefits under this Plan on the date of acquisition. Any waiting period previously satisfied under the prior health plan will be applied toward satisfaction of the Service Waiting Period of this Plan. In the event that an acquired company did not have a health plan, all eligible Employees will be eligible on the date of the acquisition.

Genetic Information Nondiscrimination Act ("GINA")

"GINA" prohibits group health plans, issuers of individual health care policies, and employers from discriminating on the basis of genetic information.

The term "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.

Family members as it relates to GINA include dependents, plus all relatives to the fourth degree, without regard to whether they are related by blood, marriage, or adoption. Underwriting as it relates to GINA includes any rules for determining eligibility, computing premiums or contributions, and applying pre-existing condition limitations. Offering reduced premiums or other rewards for providing genetic information would be impermissible underwriting.

GINA will not prohibit a health care Provider who is treating an individual from requesting that the patient undergo 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 provided to the patient was medically advisable and/or necessary.

The Plan may request, but not require, genetic testing in certain very limited circumstances involving research, so long as the results are not used for underwriting, and then only with written notice to the individual that participation is voluntary and will not affect eligibility for benefits, premiums or contributions. In addition, the Plan will notify and describe its activity to the Health and Human Services secretary of its activities falling within this exception.

While the Plan may collect genetic information after initial enrollment, it may not do so in connection with any annual renewal process where the collection of information affects subsequent enrollment. The Plan will not adjust premiums or increase group contributions based upon genetic information, request or require genetic testing or collect genetic information either prior to or in connection with enrollment or for underwriting purposes.

CONTINUATION OF COVERAGE

Continuation During Family and Medical Leave Act (FMLA) Leave

The Plan shall at all times comply with FMLA. It is the intention of the Plan Administrator to provide these benefits only to the extent required by applicable law and not to grant greater rights than those so required. If an Employee is on a family or medical leave of absence that meets the eligibility requirements under the Family and Medical Leave Act of 1993 (FMLA), his or her employer will continue coverage under this Plan in accordance with state and federal FMLA regulations, provided the following conditions are met:

1. Contributions are paid; and
2. The Employee has a written, approved leave from the employer.

Coverage will be continued for up to the greater of:

1. The leave period required by the federal FMLA and any amendment; or
2. The leave period required by applicable state law.

An Employee may choose not to retain group health coverage during an FMLA leave. When the Employee returns to work following the FMLA leave, the Employee's coverage will usually be restored to the level the Employee would have had if the FMLA leave had not been taken. For more information, please contact Your Human Resources or Personnel office.

Continuation During USERRA

Participants who are absent from employment because they are in the Uniformed Services, and who are on active military duty, must be offered the right to continue health care benefits. If the military leave orders are for a period of 30 days or less, Participants cannot be required to pay more than the normal Participant contribution amount. After this period, Participants may elect to continue their coverage under this Plan for up to 24 months and Participants cannot be required to pay more than 102 percent of the full contribution amount during that time.

To continue coverage, Participants must comply with the terms of the Plan, and pay their contributions, if any. In addition, USERRA also requires that, regardless of whether a Participant elected to continue his or her coverage under the Plan, his or her coverage and his or her Dependents' coverage be reinstated immediately upon his or her return to employment, so long as he or she meets certain requirements contained in USERRA. Participants should contact their participating Employer for information concerning their eligibility for USERRA and any requirements of the Plan.

Extended Coverage Runs Concurrently

Employees and their Dependents may be eligible for both COBRA and USERRA at the same time. Election of either the COBRA or USERRA extension by an Employee on leave for military service will be deemed an election under both laws, and the coverage offering the most benefit to the Employee will generally be extended. Coverage under both laws will run concurrently. Dependents who choose to independently elect extended coverage will be deemed eligible for the COBRA extension only because they are not eligible for a separate, independent right of election under USERRA.

Continuation During COBRA – Introduction

The right to this form of continued coverage was created by a Federal law, under the Consolidated Omnibus Budget Reconciliation Act of 1985, as amended ("COBRA"). COBRA Continuation Coverage can become available to Participants when they otherwise would lose their group health coverage. It also can become available to other members of the Participant's family who are covered under the Plan when they otherwise would lose their group health coverage. Under the Plan, certain Participants and their eligible family members (called 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 Participant or their covered Dependents to make timely payment of contributions or premiums. For additional information, Participants should contact the Participating Employer to determine if COBRA applies to him or her and/or his or her covered Dependents.

Participants may have other options available when group health coverage is lost. For example, a Participant may be eligible to buy an individual plan through the Health Insurance Marketplace. By enrolling in coverage through the Marketplace, the Participant may qualify for lower costs on his or her monthly premiums and lower out-of-pocket costs. Participants can learn more about many of these options at www.healthcare.gov. Additionally, the Participant may qualify for a 30-day special enrollment period for another group health plan for which the Participant is eligible (such as a spouse's plan), even if that plan generally doesn't accept late enrollees.

COBRA Continuation Coverage
"COBRA Continuation Coverage" is a continuation of Plan coverage when coverage would otherwise end because of a life event known as a "Qualifying Event." COBRA (and the description of COBRA Continuation Coverage contained in this Plan) does not apply to the following benefits (if available as part of the Employer's plan): life insurance, accidental death and dismemberment benefits and weekly income or long term disability benefits. The aforementioned benefits are not considered for continuation under COBRA. The Plan provides no greater COBRA rights than what COBRA requires – nothing in this Plan is intended to expand the Participant's rights beyond COBRA's requirements.

Qualifying Events
A qualifying event is any of those listed below if the Plan provided that the Participant would lose coverage (i.e., cease to be covered under the same terms and conditions as in effect immediately before the qualifying event) in the absence of COBRA continuation coverage. After a Qualifying Event, COBRA Continuation Coverage must be offered to each person who is a "Qualified Beneficiary." A Qualified Beneficiary is someone who is or was covered by the Plan, and has lost or will lose coverage under the Plan due to the occurrence of a Qualifying Event. The Employee and/or Employee's Dependents could therefore become Qualified Beneficiaries if applicable coverage under the Plan is lost because of the Qualifying Event.

An Employee, who is properly enrolled in this Plan and is a covered Employee, 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 happens:

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 happens:

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.

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

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.

Continued Coverage for Domestic Partners
Domestic Partners do not qualify as Qualified Beneficiaries und COBRA. Therefore, a Domestic Partner does not have the right to elect COBRA independently and separately from an eligible Employee.

This Plan allows eligible Employees to choose which eligible Dependents (including Domestic Partners) will continue to be covered under a COBRA extension Qualifying Event. Only by selecting a COBRA extension that covers the individual and his or her family may an eligible Employee extend COBRA coverage to a Domestic Partner.

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. These circumstances are any of the following:

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. The COBRA Administrator is:

BenefitConnect
PO Box 981915
El Paso TX 79998
Phone: 1-877-292-6272

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 18 months of COBRA Continuation Coverage.

For a change in disability status described above, the notice must be furnished by the date that is 30 days after the later 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 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 Participant 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 Dependent status, entitlement to Medicare by the covered Employee or former Employee, death of the covered Employee or former Employee, disability of a Qualified Beneficiary or loss 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 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 Administrator 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 Administrator 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 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.

Electing COBRA Continuation Coverage

Complete instructions on how to elect COBRA Continuation Coverage will be provided by the COBRA Administrator within 14 days of receiving the notice of the Qualifying Event. The individual then has 60 days in which to elect COBRA Continuation Coverage. The 60 day period is measured from the later of the date coverage terminates or the date of the notice containing the instructions. If COBRA Continuation Coverage is not elected in that 60 day period, then the right to elect it ceases.

Each Qualified Beneficiary will have an independent right to elect COBRA Continuation Coverage. Covered Employees may elect COBRA Continuation Coverage on behalf of all other Qualified Beneficiaries, including their spouses, and parents or a legal guardian may elect COBRA Continuation Coverage on behalf of their Children.

In the event that the COBRA Administrator determines that the individual is not entitled to COBRA Continuation Coverage, the COBRA Administrator will provide to the individual an explanation as to why he or she is not entitled to COBRA Continuation Coverage.

Waiver Before the End of the Election Period

If, during the election period, a Qualified Beneficiary waives COBRA continuation coverage, the waiver can be revoked at any time before the end of the election period. Revocation of the waiver is an election of COBRA continuation coverage. However, if a waiver is later revoked, coverage need not be provided retroactively (that is, from the date of the loss of coverage until the waiver is revoked). Waivers and revocations of waivers are considered made on the date they are sent to the Plan Administrator or its designee, as applicable.

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 eighteen month period of COBRA Continuation Coverage can be extended.

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 Administrator 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 any other event occurs which enables the Plan Administrator 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.

Contribution and/or Premium Requirements
The cost of the elected COBRA Continuation Coverage must be paid within 45 days of its election. Payments will then be subsequently due on the first day of each month. COBRA Continuation Coverage will be canceled and will not be reinstated if any payment is made late; however, the Plan Administrator must allow for a 30 day grace period during which a late payment may still be made without the loss of COBRA Continuation Coverage.

Additional Information
Please contact the COBRA Administrator with any questions about the Plan and COBRA Continuation Coverage at the following:

BenefitConnect
PO Box 981915
El Paso TX 79998
Phone: 1-877-292-6272
Website/Email: cobra.ehr.com

Questions concerning the Plan or COBRA continuation coverage rights should be addressed to the contact or contacts identified above. For more information about a Participant's rights under the Employee Retirement Income Security Act (ERISA), including COBRA, HIPAA, the Affordable Care Act, and other laws affecting group health plans, contact the nearest Regional or District Office of the U.S. Department of Labor's Employee Benefits Security Administration (EBSA) or visit https://www.dol.gov/agencies/ebsa. (Addresses and phone numbers of Regional and

District EBSA Offices are available through EBSA's website.) For more information about the Marketplace, visit www.HealthCare.gov.

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.

PROVIDER NETWORK

The word **"Network"** means an outside organization that has contracted with various providers to provide health care services to Covered Persons at a Negotiated Rate. Providers who participate in a Network have agreed to accept the negotiated fees as payment in full, including any portion of the fees that the Covered Person must pay due to the Deductible, Plan Participation amounts, or other out-of-pocket expenses. The allowable charges used in the calculation of the payable benefit to participating providers will be determined by the Negotiated Rates in the Network contract. A provider who does not participate in a Network may bill Covered Persons for additional fees over and above what the Plan pays.

Knowing to which Network a provider belongs will help a Covered Person determine how much he or she will need to pay for certain services. To obtain the highest level of benefits under this Plan, Covered Persons should receive services from In-Network providers. However, this Plan does not limit a Covered Person's right to choose his or her own provider of medical care at his or her own expense if a medical expense is not a Covered Expense under this Plan, or is subject to a limitation or exclusion.

To find out to which Network a provider belongs, please refer to the Provider Directory, or call the toll-free number that is listed on the back of the Plan's identification card. The participation status of providers may change from time to time.

1. If a provider belongs to one of the following Networks, claims for Covered Expenses will normally be processed in accordance with the **In-Network** benefit levels that are listed on the Schedule of Benefits Deductibles and Out-of-Pocket Maximums listed on the Schedule of Benefits for these In-Network Tiers cross apply:

   Ardent Network – Tier 1
   Access Direct Platinum Network– Tier 2
   Access Direct Platinum Network is the primary network for the UT Health East Texas system. This network offers a choice of providers and facilities covering nine counties: Smith, Cherokee, Rusk, Panola, Henderson, Van Zandt, Wood, Camp and Gregg.
   Services not available at UT Health East Texas will be covered at Children's Medical Center or UT Southwestern at the ADP tier of benefits.

2. For services received from any Non-Network provider, claims for Covered Expenses will normally be processed in accordance with the Tier 3 benefit levels that are listed on the Schedule of Benefits and the "Claim Review and Audit Program" procedures. These providers charge their normal rates for services, so Covered Persons may need to pay more.

Reimbursement for Covered Expenses received from non-Network Physicians or health care facilities are determined based on one of the following:

1. Fee(s) that are negotiated with the Physician or facility;
2. If fees have not been negotiated:
   a. Allowable Claim Limits. Please see Claim Review and Audit Program section for additional details.

EXCEPTIONS TO THE PROVIDER NETWORK RATES

Some benefits may be processed at In-Network benefit levels when provided by Tier 3 providers. When Tier 3 charges are covered in accordance with Network benefits, the charges are still subject to the Maximum Allowable Charge limitations and Claim Review and Audit Program. The following exceptions may apply:

1. Covered services (including Preventive Services) provided by a radiologist, anesthesiologist, certified registered nurse anesthetist, or pathologist will be payable at the In-Network level of benefits when services are provided at a Network facility even if the provider is a Tier 3 provider.
2. Covered services provided by a Physician during an Inpatient stay will be payable at the In-Network level of benefits when provided at an In-Network Hospital.
3. Covered services provided by an Emergency room Physician will be payable at the Tier 1 level of benefits when provided at an AHS facility.
4. Covered Outpatient services provided by an Outpatient Physician will be payable at the Tier 1 level of benefits when provided at an AHS facility.
5. No coverage will be offered at the CHRISTUS Trinity Mother Frances Health System except for emergency and

NICU services for newborns under 34 weeks.

6. Services at Baylor Scott & White Texas Spine & Joint will not be covered except for emergency services and Ear, Nose & Throat (ENT) procedures.
7. No coverage will be offered at the Northwest Texas Healthcare System (TX), Presbyterian Health Services (NM), or Ascension St. John (OK) except for emergency, mental health and alcohol/drug treatment.
8. No coverage will be offered at the St. Francis Health System (OK) except for emergency, mental health, alcohol/drug treatment and pediatric services (for members under age 17).
9. No coverage will be offered at Akumin Amarillo/Preferred Imaging (TX).

Provider Directory Information

Each covered Employee, COBRA participant, and Child or guardian of a Child who is considered an alternate recipient under a QMCSO will automatically be given or electronically provided a separate document, at no cost, that lists the participating Network providers for this Plan. The Employee should share this document with other covered individuals in his or her household. If a covered spouse or Dependent wants a separate provider list, he or she may make a written request to the Plan Administrator. The Plan Administrator may make a reasonable charge to cover the cost of furnishing complete copies to the spouse or other covered Dependents.

Transitional Care

Certain eligible expenses that would have been considered at the In-Network benefit level by the prior claims administrator, but that are not considered at the In-Network benefit level by the current claims administrator, may be paid at the applicable In-Network benefit level if the Covered Person is currently under a treatment plan by a Physician who was a member of this Plan's previous PPO but who is not a member of the Plan's current PPO in the Employee's or Dependent's Network area. In order to ensure continuity of care for certain medical conditions already under treatment, the In-Network medical plan benefit level may continue for 90 days for conditions approved as transitional care. Examples of medical conditions appropriate for consideration for transitional care include, but are not limited to:

1. Cancer if under active treatment with chemotherapy and/or radiation therapy.
2. Organ transplants for patients under active treatment (e.g., seeing a Physician on a regular basis, being on a transplant waiting list, or being ready at any time for a transplant).
3. Being an Inpatient in a Hospital on the Covered Person's Effective Date.
4. Post-acute Injury or surgery within the past three months.
5. Pregnancy in the second or third trimester and up to eight weeks postpartum.
6. Behavioral health (any previous treatment).

You or Your Dependent must call Medical Management Solutions within 30 days prior to Your Effective Date or within 30 days after Your Effective Date to see if You or Your Dependent is eligible for this benefit.

Routine procedures, treatment for stable chronic conditions, treatment for minor Illnesses, and elective surgical procedures will not be covered by transitional level benefits.

GENERAL AND PLAN SPECIFIC LIMITATIONS AND EXCLUSIONS

Some health care services are not covered by the Plan. Coverage is not available from the Plan for charges arising from care, supplies, treatment, and/or services:

Abortion. Incurred directly or indirectly as the result of an abortion except when the life of the mother is endangered by the continued Pregnancy or for medical complications that arise from an abortion, or the Pregnancy is the result of rape or incest;

Administrative Costs. That are solely for and/or applicable to administrative costs of completing claim forms or reports or for providing records wherever allowed by applicable law and/or regulation.

After the Termination Date. That are Incurred by the Participant on or after the date coverage terminates, even if payments have been predetermined for a course of treatment submitted before the termination date, unless otherwise deemed to be covered in accordance with the terms of the Plan or applicable law and/or regulation.

Alcohol. Involving a Participant who has taken part in any activity made illegal either due to the use of alcohol or a state of intoxication. It is not necessary that an arrest occur, criminal charges be filed, or, if filed, that a conviction result. Proof beyond a reasonable doubt is not required to be deemed an activity made illegal due to the use of alcohol or a state of intoxication. Expenses will be covered for Injured Participants other than the person partaking in an activity made illegal due to the use of alcohol or a state of intoxication, and expenses may be covered for Substance Abuse treatment as specified in this Plan, if applicable. This Exclusion does not apply if the Injury (a) resulted from being the victim of an act of domestic violence, or (b) resulted from a documented medical condition (including both physical and mental health conditions) even if the condition is not diagnosed before the injury.

Alternative Medicine. For holistic or homeopathic treatment, naturopathic services, and thermography, including drugs.

Assistance with Activities of Daily Living.

Assistant Surgeon Services, unless determined to be Medically Necessary by the Plan.

Auto Excess: Illness or bodily Injury for which there is a medical payment or expense coverage provided or payable under any automobile coverage.

Before Enrollment and After Termination: Services, supplies or treatment rendered before coverage begins or after coverage ends under this Plan.

Biofeedback. For biofeedback.

Blood: Blood donor expenses.

Blood Pressure Cuffs / Monitors.

Broken Appointments. That are charged solely due to the Participant's having failed to honor an appointment.

Cardiac Rehabilitation beyond Phase II, including self-regulated physical activity that the Covered Person performs to maintain health that is not considered to be a treatment program.

Chelation Therapy, except in the treatment of conditions considered to be Medically Necessary, medically appropriate, and not Experimental, Investigational, or Unproven for the medical condition for which the treatment is recognized.

Claims received later than 12 months from the date of service.

Complications of Non-Covered Services. That are required as a result of complications from a service not covered under the Plan, unless expressly stated otherwise.

Cosmetic Surgery. That are incurred in connection with the care and/or treatment of Surgical Procedures which are performed for plastic, reconstructive or cosmetic purposes or any other service or supply which are primarily

used to improve, alter or enhance appearance, whether or not for psychological or emotional reasons, except to the extent where it is needed for: (a) repair or alleviation of damage resulting from an Accident; (b) because of infection or Illness; (c) because of congenital Disease, developmental condition or anomaly of a covered Dependent Child which has resulted in a functional defect. A treatment will be considered cosmetic for either of the following reasons: (a) its primary purpose is to beautify or (b) there is no documentation of a clinically significant impairment, meaning decrease in function or change in physiology due to Injury, Illness or congenital abnormality. The term "cosmetic services" includes those services which are described in IRS Code Section 213(d)(9).

Contraceptive Products and Counseling, unless covered elsewhere in this SPD.

Court-Ordered: Any treatment or therapy that is court-ordered, or that is ordered as a condition of parole, probation, or custody or visitation evaluation, unless such treatment or therapy is normally covered by this Plan. This Plan does not cover the cost of classes ordered after a driving-while- intoxicated conviction or other classes ordered by the court.

Criminal Activity: Illness or Injury resulting from taking part in the commission of an assault or battery (or a similar crime against a person) or a felony for which the individual is charged.

Custodial Care. That do not restore health, unless specifically mentioned otherwise.

Deductible. That are amounts applied toward satisfaction of Deductibles and expenses that are defined as the Participant's responsibility in accordance with the terms of the Plan.

Dental Services:

1. The care and treatment of teeth or gums, or alveolar processes, dentures, appliances or supplies used in such care or treatment, or drugs prescribed in connection with dental care. This exclusion does not apply to Hospital charges, including professional charges for X-rays, labs, and anesthesia; to charges for treatment of Injuries to natural teeth, including replacement of such teeth with dentures; or to charges for the setting of a jaw that was fractured or dislocated in an Accident.
2. Injuries or damage to teeth, natural or otherwise, as a result of or caused by the chewing of food or similar substances.
3. Dental implants, including preparation for implants.

Duplicate Services and Charges or Inappropriate Billing, including the preparation of medical reports and itemized bills.

Education or Training Program. Charges for education, special education, job training, music therapy, and recreational therapy, whether or not given in a facility providing medical or psychiatric care. This exclusion does not apply to self-management education programs for diabetics.

Environmental Devices: Environmental items such as, but not limited to, air conditioners, air purifiers, humidifiers, dehumidifiers, furnace filters, heaters, vaporizers, and vacuum devices.

Examinations. Any health examination required by any law of a government to secure insurance or school admissions or professional or other licenses, except as required under applicable federal law.

Excess. That exceed Plan limits, set forth herein and including (but not limited to) the Maximum Allowable Charge in the Plan Administrator's discretion and as determined by the Plan Administrator, in accordance with the Plan terms as set forth by and within this document.

Experimental, Investigational, or Unproven: Services, supplies, medicines, treatment, facilities, or equipment that the Plan determines are Experimental, Investigational, or Unproven, including administrative services associated with Experimental, Investigational, or Unproven treatment. This exclusion does not apply to Qualifying Clinical Trials as described in the Covered Medical Benefits section of this SPD.

Extended Care: Any Extended Care Facility Services that exceed the appropriate level of skill required for treatment as determined by the Plan.

Family Member. That are performed by a person who is related to the Participant as a spouse, parent, Child, brother or sister, whether the relationship exists by virtue of "blood" or "in law."

Family Planning: Consultations for family planning.

Financial Counseling.

Fitness Programs: General fitness programs, exercise programs, exercise equipment, and health club memberships, or other utilization of services, supplies, equipment, or facilities in connection with weight control or bodybuilding.

Foot Care (Podiatry): Routine foot care.

Foreign Travel. That are received outside of the United States if travel is for the purpose of obtaining medical services, unless otherwise approved by the Plan Administrator.

Gender Dysphoria:
Cosmetic procedures, including the following:

- Abdominoplasty.
- Blepharoplasty.
- Body contouring, such as lipoplasty.
- Brow lift.
- Calf implants.
- Cheek, chin, and nose implants.
- Injection of fillers or neurotoxins.
- Face lift, forehead lift, or neck tightening.
- Facial bone remodeling for facial feminizations.
- Hair removal.
- Hair transplantation.
- Lip augmentation.
- Lip reduction.
- Liposuction.
- Mastopexy.
- Pectoral implants for chest masculinization.
- Rhinoplasty.
- Skin resurfacing.

Genetic Counseling other than based on Medical Necessity, unless covered elsewhere in this SPD.

Genetic Testing, other than testing that meets requirements set forth in Covered Services section of this SPD.

Government. That the Participant obtains, but which is paid, may be paid, is provided or could be provided for at no cost to the Participant through any program or agency, in accordance with the laws or regulations of any government, or where care is provided at government expense, unless there is a legal obligation for the Participant to pay for such treatment or service in the absence of coverage. This Exclusion does not apply when otherwise prohibited by law, including laws applicable to Medicaid and Medicare.

Government-Operated Facilities. That meet the following requirements:

1. That are services furnished to the Participant in any veteran's Hospital, military Hospital, Institution or facility operated by the United States government or by any State government or any agency or instrumentality of such governments.
2. That are services or supplies which can be paid for by any government agency, even if the patient waives his rights to those services or supplies.

NOTE: This Exclusion does not apply to treatment of non-service related disabilities or for Inpatient care provided in a military or other Federal Government Hospital to Dependents of active duty armed service personnel or armed service retirees and their Dependents. This Exclusion does not apply where otherwise prohibited by law.

Growth Hormones.

Home Births and associated costs.

Home Modifications: Modifications to Your home or property, such as, but not limited to, escalators, elevators, saunas, steam baths, pools, hot tubs, whirlpools, tanning equipment, wheelchair lifts, stair lifts, or ramps.

Infant Formula not administered through a tube as the sole source of nutrition for the Covered Person.

Hypnosis. Related to the use of hypnosis.

Illegal Acts. That are for any Injury or Sickness which is Incurred while taking part or attempting to take part in an illegal activity, including but not limited to misdemeanors and felonies. It is not necessary that an arrest occur, criminal charges be filed, or, if filed, that a conviction result. Proof beyond a reasonable doubt is not required to be deemed an illegal act. This Exclusion does not apply if the Injury (a) resulted from being the victim of an act of domestic violence, or (b) resulted from a documented medical condition (including both physical and mental health conditions) even if the condition is not diagnosed before the injury.

Immunizations. For immunizations and vaccinations for the purpose of travel outside of the United States.

Incurred by Other Persons. That are expenses actually Incurred by other persons.

Infertility Treatment:

1. Fertility tests.
2. Surgical reversal of a sterilized state that was a result of a previous surgery.
3. Direct attempts to cause pregnancy by any means, including, but not limited to, hormone therapy or drugs.
4. Artificial insemination; in vitro fertilization; gamete intrafallopian transfer (GIFT), or zygote intrafallopian transfer (ZIFT).
5. Embryo transfer.
6. Freezing or storage of embryo, eggs, or semen.
7. Genetic testing.

This exclusion does not apply to services required to treat or correct underlying causes of infertility where such services cure the condition of, slow the harm to, alleviate the symptoms of, or maintain the current health status of the Covered Person.

Intraocular Lenses Other Than Conventional Intraocular Cataract Lenses.

Lamaze Classes or other childbirth classes.

Liposuction, regardless of purpose.

Maintenance Therapy if, based on medical evidence, treatment or continued treatment could not be expected to resolve or improve a condition, or if that clinical evidence indicates that a plateau has been reached in terms of improvement from such services.

Mammoplasty or Breast Augmentation, unless covered elsewhere in this SPD.

Marriage Counseling.

Massage Therapy.

Maximum Benefit. Charges in excess of the Maximum Benefit allowed by the Plan.

Military Service. That are related to conditions determined by the Veteran's Administration to be connected to active service in the military of the United States, except to the extent prohibited or modified by law.

Negligence. That are for Injuries resulting from negligence, misfeasance, malfeasance, nonfeasance or malpractice on the part of any caregiver, Institution, or Provider, as determined by the Plan Administrator, in its discretion, in light of applicable laws and evidence available to the Plan Administrator.

Nocturnal Enuresis Alarm (Bed wetting).

No Coverage. That are Incurred at a time when no coverage is in force for the applicable Participant and/or Dependent.

No Legal Obligation. That are for services provided to a Participant for which the Provider of a service does not and/or would not customarily render a direct charge, or charges Incurred for which the Participant or Plan has no legal obligation to pay, or for which no charges would be made in the absence of this coverage, including but not limited to charges for services not actually rendered, fees, care, supplies, or services for which a person, company or any other entity except the Participant or the Plan, may be liable for necessitating the fees, care, supplies, or services.

Non-Custom-Molded Shoe Inserts.

Non-Prescription Drugs or Over-the-Counter Medications, products, Supplies or Devices. For drugs for use outside of a Hospital or other Inpatient facility that can be purchased over-the-counter and without a Physician's written prescription. Drugs for which there is a non-prescription equivalent available. This does not apply to the extent the non-prescription drug must be covered under Preventive Care, subject to the Affordable Care Act or if covered elsewhere in this SPD.

Non-Professional Care. Medical or surgical care that is not performed according to generally accepted professional standards, or that is provided by a provider acting outside the scope of his or her license.

Not Acceptable. That are not accepted as standard practice by the American Medical Association (AMA), American Dental Association (ADA), or the Food and Drug Administration (FDA).

Not Covered Provider. That are performed by Providers that do not satisfy all the requirements per the Provider definition as defined within this Plan.

Not Medically Necessary. Services, supplies, treatment, facilities, or equipment that the Plan determines are not Medically Necessary. Furthermore, this Plan excludes services, supplies, treatment, facilities, or equipment that reliable scientific evidence has shown does not cure the condition, slow the degeneration/deterioration or harm attributable to the condition, alleviate the symptoms of the condition, or maintain the current health status of the Covered Person. See also Maintenance Therapy above.

Nursery and Newborn Expenses for a grandchild of a covered Employee or spouse

Nutritional Supplements. For nutritional supplements unless covered elsewhere in this SPD.

Occupational. That are for any condition, Illness, Injury or complication thereof arising out of or in the course of employment, including self-employment, or an activity for wage or profit. Participants that are self-employed or employed by an employer that does not provide health benefits should ensure that they have other medical benefits to provide for medical care in the event they are hurt on the job. In most cases workers' compensation insurance will cover the costs, but if the Participant does not have such coverage he or she may end up with no coverage at all.

Orthognathic, Prognathic, and Maxillofacial Surgery.

Other than Attending Physician. That are other than those certified by a Physician who is attending the Participant as being required for the treatment of Injury or Disease, and performed by an appropriate Provider.

Palliative Foot Care.

Panniculectomy / Abdominoplasty, unless determined by the Plan to be Medically Necessary.

Personal Convenience Items. Services or supplies for personal comfort or convenience, such as, but not limited to, private rooms, televisions, telephones and guest trays.

Pharmacy Consultations. Charges for or related to consultative information provided by a pharmacist regarding a Prescription order, including, but not limited to, information related to dosage instruction, drug interactions, side effects, and the like.

Postage, Shipping, Handling Charges, Etc. That are for any postage, shipping or handling charges which may occur in the transmittal of information to the Third Party Administrator; including interest or financing charges.

Preventive / Routine Care Services, unless covered elsewhere in this SPD

Prior to Coverage. That are rendered or received prior to or after any period of coverage hereunder, except as specifically provided herein.

Private Duty Nursing. Private duty nursing.

Professional (and Semi-Professional) Athletics (Injury/Illness). That are in connection with any Injury or Illness arising out of or in the course of any employment for wage or profit; or related to professional or semi-professional athletics, including practice.

Prohibited by Law. That are themselves prohibited by applicable law, in general or within the context of the course of treatment, or to the extent that payment under this Plan is prohibited by applicable law.
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Provider Error. That are required as a result of unreasonable Provider error.

Reconstructive Surgery when performed only to achieve a normal or nearly normal appearance, and not to correct an underlying medical condition or impairment, as determined by the Plan, unless covered elsewhere in this SPD.

Return to Work / School: Telephone or Internet consultations, or the completion of claim forms or forms necessary for a return to work or school.

Reversal of Sterilization: Procedures or treatments to reverse prior voluntary sterilization.

Room and Board Fees when surgery is performed other than at a Hospital or Surgical Center

Routine Patient Costs for Participation in an Approved Clinical Trial. For costs for participation in an Approved Clinical Trial. The following items are excluded from approved clinical trial coverage under this Plan:

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 Approved 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 an Approved 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 an Approved 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 Approved Clinical Trial and that are customarily paid for by the research institution conducting the Approved Clinical Trial.

If one or more participating Providers do participate in the Approved Clinical Trial, the qualified plan Participant must participate in the Approved Clinical Trial through a participating, Network Provider, if the Provider will accept the Participant into the trial.

The Plan does not cover routine patient care services that are provided outside of this Plan's health care Provider Network unless Non-Network benefits are otherwise provided under this Plan.

Self-Administered Services or procedures that can be performed by the Covered Person without the presence of

medical supervision/

Self-Inflicted. That are the result of intentionally self-inflicted Injuries or Illnesses. This exclusion does not apply (a) if the Injury resulted from being the victim of an act of domestic violence, or (b) resulted from a documented medical condition (including both physical and mental health conditions);

Services at No Charge or Cost: Services for which the Covered Person would not be obligated to pay in the absence of this Plan or that are available to the Covered Person at no cost, or for which the Plan has no legal obligation to pay, except for care provided in a facility of the uniformed services as per Title 32 of the National Defense Code, or as required by law.

Services that should legally be provided by a school.

Sex Therapy.

Sexual Function: Diagnostic service, non-surgical and surgical procedures and Prescription drugs (unless covered under the Prescription Drug Benefits section of this SPD) in connection with treatment for male or female impotence.

Standby Surgeon Charges.

Subrogation, Reimbursement, and/or Third Party Responsibility. That are for an Illness, Injury or Sickness not payable by virtue of the Plan's subrogation, reimbursement, and/or third party responsibility provisions.

Surrogate Parenting and Gestational Carrier Services, including any services or supplies provided in connection with a surrogate parent, including pregnancy and maternity charges Incurred by a Covered Person acting as a surrogate parent if the Covered Person is being compensated or has other coverage that would be primary.

Taxes: Sales taxes and shipping and handling charges, unless covered elsewhere in this SPD.

Temporomandibular Joint Disorder. For the Diagnosis and treatment of, or in connection with, temporomandibular joint disorders, myofascial pain dysfunction or orthognathic treatment.

Tobacco Addiction: Diagnoses, services, treatment, or supplies related to addiction to or dependency on nicotine, unless covered elsewhere in this SPD.

Transportation: Transportation services that are solely for the convenience of the Covered Person, the Covered Person's Close Relative, or the Covered Person's Physician.

Travel: Travel costs, whether or not recommended or prescribed by a Physician, unless covered elsewhere in this SPD.

Unreasonable. That are not reasonable in nature or in charge (see definition of Maximum Allowable Charge), or are required to treat Illness or Injuries arising from and due to a Provider's error, wherein such Illness, Injury, infection or complication is not reasonably expected to occur. This Exclusion will apply to expenses directly or indirectly resulting from circumstances that, in the opinion of the Plan Administrator in its sole discretion, gave rise to the expense and are not generally foreseeable or expected amongst professionals practicing the same or similar type(s) of medicine as the treating Provider whose error caused the loss(es).

Vision Care, unless covered elsewhere in this SPD.

Vitamins, Minerals, and Supplements, even if prescribed by a Physician, except for Vitamin B-12 injections and IV iron therapy that are prescribed by a Physician for Medically Necessary purposes or related to Preventative and Wellness Services as specified by the Affordable Care Act of 2010.

Vocational Services: Vocational and educational services rendered primarily for training or education purposes. This Plan also excludes work hardening, work conditioning, and industrial rehabilitation services rendered for Injury prevention education or return-to-work programs.

War/Riot. That Incurred as a result of war or any act of war, whether declared or undeclared, or any act of aggression by any country, including rebellion or riot, when the Participant is a member of the armed forces of any

country, or during service by a Participant in the armed forces of any country, or voluntary participation in a riot. This Exclusion does not apply to any Participant who is not a member of the armed forces, and does not apply to victims of any act of war or aggression.

Weekend Admissions to Hospital confinement (admissions taking place after 3:00 pm on Fridays or before noon on Sundays) unless the admission is deemed an Emergency or is for care related to pregnancy that is expected to result in childbirth.

Weight Control: Treatment, services, or surgery for weight control**,** whether or not prescribed by a Physician or associated with an Illness, except as specifically stated for preventive counseling. This exclusion does not apply to specific services for Morbid Obesity as listed in the Covered Medical Benefits section of this SPD.

Wigs (Cranial Prostheses), Toupees, Hairpieces, Hair Implants or Transplants, or Hair Weaving, or any similar item for replacement of hair regardless of the cause of hair loss, unless covered elsewhere in this SPD.

Workers' Compensation: An Illness or Injury arising out of, or in the course of, any employment for wage or profit including self-employment, for which the Covered Person was or could have been entitled to benefits under any Workers' Compensation, U.S. Longshoremen and Harbor Workers' or other occupational disease legislation, policy or contract, whether or not such policy or contract is actually in force.

Wrong Surgeries: Additional costs and/or care related to wrong surgeries. Wrong surgeries include, but are not limited to, surgery performed on the wrong body part, surgery performed on the wrong person, objects left in patients after surgery, etc.

With respect to any Injury which is otherwise covered by the Plan, the Plan will not deny benefits otherwise provided for treatment of the Injury if the Injury results from being the victim of an act of domestic violence or a documented medical condition. To the extent consistent with applicable law, this exception will not require this Plan to provide particular benefits other than those provided under the terms of the Plan.

CLAIM REVIEW AND AUDIT PROGRAM

Introduction

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

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

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

The Plan Administrator is identified in the General Information section of this Summary Plan Description. ELAP may be contacted at:

ELAP Services, LLC
1550 Liberty Ridge
Suite 330
Wayne, PA 19087
Phone: 610-321-1030; Fax 610-321-1031

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

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

In the following provisions of the Claim Review and Audit Program, the term "Plan Administrator" shall be deemed to mean ELAP Services, LLC ("ELAP"):

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

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

a. Facilities. The Allowable Claim Limit for claims by a facility, including but not limited to, hospitals, emergency and urgent care centers, rehabilitation and skilled nursing centers, and any other health care facility, shall be the greater of (I) 112% of the facility's most recent departmental cost ratio, reported to the Centers for Medicare and Medicaid Services ("CMS") and published in the American Hospital Directory as the "Medicare Cost Report" (the "CMS Cost Ratio"), or (II) the Medicare allowed amount for the services in the geographic area plus an additional 20%. The Allowable Claim Limit for (I) shall not exceed 250% of the federal non-commercial Medicare allowed amount, except for children's hospitals, which shall not exceed 350% of the federal non-commercial Medicare allowed amount. If insufficient information is available to identify either the facility's most recent departmental cost ratio or the Medicare allowed amount, the Allowable Claim Limit shall be either (I) or (II) herein that can be identified.

b. Ambulatory Health Care Centers. The Allowable Claim Limit for ambulatory health care centers, including ambulatory surgery centers, which are independent facilities shall be the Medicare allowed amount for the services in the geographic area plus an additional 20%. In the event that insufficient information is available to identify the Medicare allowed amount, the Allowable Claim Limit for such services shall be to the extent available either the outpatient or inpatient Medicare allowed amount for the service, plus an additional 20%.

c. Professional Providers. The Allowable Claim Limits for professional providers shall be determined using the following:

i. For general medical and primary care claims, the Medicare allowed amount in the geographic area plus an additional 40%;
ii. For specialist medical and surgical care claims, the Medicare allowed amount in the geographic area plus an additional 55%;
iii. For anesthesiologist claims, the Medicare allowed amount in the geographic area plus an additional 100%;
iv. For ambulance and air ambulance claims, the Medicare allowed amount in the geographic area plus an additional 20%; or
v. For other non-facility claims and supplies (such as, but not limited to, Durable Medical Equipment, laboratory services and supplies, and mid-level providers, etc.), the Medicare allowed amount in the geographic area.

For purposes of determining the proper Allowable Claim Limits for professional providers in categories (i), (ii), (iii), (iv), or (v), above, the Plan Administrator shall determine the applicable category for each claim based on the taxonomy code used by the professional provider for that claim. The Plan Administrator determines in its sole discretion the type of provider for determining Allowable Claim Limits, as detailed above.

While this Plan typically pays professional providers based on the Medicare allowed amounts above, certain services may be reimbursed at 110% of the Medicare allowed amount for the service. These services may include, but are not limited to, routine diagnostic tests, evaluation services, telehealth and services for ongoing therapy. A full list of services subject to this rule can be found here: www.planlimit.com/prof1. This list will be updated at least annually to reflect the Plan's current plan design.

d. Directly Contracted Providers. The Allowable Claim Limits for Directly Contracted Providers shall be the negotiated rate as agreed under the Direct Agreement. For Preferred Medical Claims Solutions (PMCS) Directly Contracted Providers, the Allowable Claim Limit shall be based upon the 95th percentile of Fair Health (FH®) Allowed Benchmarks.

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

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

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

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

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

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

CLAIM PROCEDURES; PAYMENT OF CLAIMS

Introduction

In accordance with applicable law, the Plan will allow an authorized representative to act on a Claimant's behalf in pursuing or appealing a benefit claim.
The availability of health benefit payments is dependent upon Claimants complying with the following:

Health Claims

Full and final authority to adjudicate claims and make determinations as to their payability by and under the Plan belongs to and resides solely with the Plan Administrator. The Plan Administrator shall make claims adjudication determinations after full and fair review and in accordance with the terms of this Plan, applicable law, and with ERISA. To receive due consideration, claims for benefits and questions regarding said claims should be directed to the Third Party Administrator. The Plan Administrator may delegate to the Third Party Administrator responsibility to process claims in accordance with the terms of the Plan and the Plan Administrator's directive(s). The Third Party Administrator is not a fiduciary of the Plan and does not have discretionary authority to make claims payment decisions or interpret the meaning of the Plan terms.

Written proof that expenses eligible for Plan reimbursement and/or payment were Incurred, as well as proof of their eligibility for payment by the Plan, must be provided to the Plan Administrator via the Third Party Administrator. Although a provider of medical services and/or supplies may submit such claims directly to the Plan by virtue of an assignment of benefits, ultimate responsibility for supplying such written proof remains with the Claimant. The Plan Administrator may determine the time and fashion by which such proof must be submitted. No benefits shall be payable under the Plan if the Plan Administrator so determines that the claims are not eligible for Plan payment, or, if inadequate proof is provided by the Claimant or entities submitting claims to the Plan on the Claimant's behalf.

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 Claimant has the right to request a review of an Adverse Benefit Determination. If the claim is denied at the end of the appeal process, as described below, the Plan's final decision is known as a Final Internal Adverse Benefit Determination. If the Claimant receives notice of a Final Internal Adverse Benefit Determination, or if the Plan does not follow the claims procedures properly, the Claimant then has the right to request an independent external review. The external review procedures are described below.

The claims procedures are intended to provide a full and fair review. This means, among other things, that claims and appeals will be decided in a manner designed to ensure the independence and impartiality of the persons involved in making these decisions.

Benefits will be payable to a Claimant, or to a Provider that has accepted an assignment of benefits as consideration in full for services rendered. The Plan Administrator may revoke an assignment of benefits previously issued to a Provider at its discretion and treat the Participant as the sole beneficiary.

According to Federal regulations which apply to the Plan, there are four types of claims: Pre-service (Urgent and Non-urgent), Concurrent Care and Post-service.

1. Pre-service Claims. A "Pre-service Claim" occurs when issuance of payment by the Plan is dependent upon determination of payability prior 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."

   Urgent care or Emergency medical services or admissions will not require notice to the Plan prior to the receipt of care. Furthermore, if in the opinion of a Physician with knowledge of the Claimant's medical condition, pre-determination of payability by the Plan prior to the receipt of medical care (a Pre-service Claim) would result in a delay adequate to jeopardize the life or health of the Claimant, hinder the Claimant's ability to regain maximum function (compared to treatment without delay), or subject the Claimant to severe pain that cannot be adequately managed without the care or treatment that is the

subject of the claim, said claim may be deemed to be a "Pre-service Urgent Care Claim." In such circumstances, the Claimant is urged to obtain the applicable care without delay, and communicate with the Plan regarding their claim(s) as soon as reasonably possible.

If, due to Emergency or urgency as defined above, a Pre-service claim is not possible, the Claimant must comply with the Plan's requirements with respect to notice required after receipt of treatment, and must file the claim as a Post-service Claim, as herein described.

Pre-admission 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.

2. Concurrent 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. 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.

3. Post-service Claims. A "Post-service Claim" is a claim for benefits from the Plan after the medical services and/or supplies have already been provided.

When Claims Must Be Filed
Post-service health claims (which must be Clean Claims) must be filed with the Third Party Administrator within 365 days of the date charges for the service(s) and/or supplies were Incurred. Benefits are based upon the Plan's provisions at the time the charges were Incurred. Claims filed later than that date shall be denied.

A Pre-service Claim (including a Concurrent claim that also is a Pre-service claim) is considered to be filed when the request for approval of treatment or services is made and received by the Third Party Administrator in accordance with the Plan's procedures.

A Post-service Claim is considered to be filed when the following information is received by the Third Party Administrator, together with the industry standard claim form:

1. The date of service.
2. The name, address, telephone number and tax identification number of the Provider of the services or supplies.
3. The place where the services were rendered.
4. The Diagnosis and procedure codes.
5. Any applicable pre-negotiated rate.
6. The name of the Plan.
7. The name of the covered Employee.
8. The name of the patient.

Upon receipt of this information, the claim will be deemed to be initiated with the Plan.

The Third Party Administrator will determine if enough information has been submitted to enable proper consideration of the claim (a Clean Claim). If not, more information may be requested as provided herein. This additional information must be received by the Third Party Administrator within 45 days (48 hours in the case of Pre-service urgent care claims) from receipt by the Claimant of the request for additional information. **Failure to do so may result in claims being declined or reduced.**

Timing of Claim Decisions
The Plan Administrator shall notify the Claimant, in accordance with the provisions set forth below, of any Adverse Benefit Determination (and, in the case of Pre-service claims and Concurrent claims, of decisions that a claim is payable in full) within the following timeframes:

1. Pre-service Urgent Care Claims:

    a. If the Claimant has provided all of the necessary information, as soon as possible, taking into account the medical exigencies, but not later than 72 hours after receipt of the claim.
    b. If the Claimant has not provided all of the information needed to process the claim, then the Claimant will be notified as to what specific information is needed as soon as possible, but not later than 24 hours after receipt of the claim.
    c. The Claimant will be notified of a determination of benefits as soon as possible, but not later than 48 hours, taking into account the medical exigencies, after the earliest of:
        i. The end of the period afforded the Claimant to provide the information.
        ii. The Plan's receipt of the specified information.
    d. If there is an Adverse Benefit Determination, a request for an expedited appeal may be submitted orally or in writing by the Claimant. All necessary information, including the Plan's benefit determination on review, may be transmitted between the Plan and the Claimant by telephone, facsimile, or other similarly expeditious method. Alternatively, the Claimant may request an expedited review under the external review process.

2. Pre-service Non-urgent Care Claims:

    a. If the Claimant has provided all of the information needed to process the claim, in a reasonable period of time appropriate to the medical circumstances, but not later than 15 days after receipt of the claim, unless an extension has been requested, then prior to the end of the 15 day extension period.
    b. If the Claimant has not provided all of the information needed to process the claim, then the Claimant will be notified as to what specific information is needed as soon as possible. The Claimant will be notified of a determination of benefits in a reasonable period of time appropriate to the medical circumstances, either prior to the end of the extension period (if additional information was requested during the initial processing period), or by the date agreed to by the Plan Administrator and the Claimant (if additional information was requested during the extension period).

3. Concurrent Claims:

    a. Plan Notice of Reduction or Termination. If the Plan Administrator is notifying the Claimant of a reduction or termination of a course of treatment (other than by Plan amendment or termination), notification will occur before the end of such period of time or number of treatments. The Claimant will be notified sufficiently in advance of the reduction or termination to allow the Claimant to appeal and obtain a determination on review of that Adverse Benefit Determination before the benefit is reduced or terminated. This rule does not apply if benefits are reduced or eliminated due to plan amendment or termination. A similar process applies for claims based on a rescission of coverage for fraud or misrepresentation.
    b. Request by Claimant Involving Urgent Care. If the Plan Administrator receives a request from a Claimant to extend the course of treatment beyond the period of time or number of treatments involving urgent care, notification will occur as soon as possible, taking into account the medical exigencies, but not later than 24 hours after receipt of the claim, as long as the Claimant makes the request at least 24 hours prior to the expiration of the prescribed period of time or number of treatments. If the Claimant submits the request with less than 24 hours prior to the expiration of the prescribed period of time or number of treatments, the request will be treated as a claim involving urgent care and decided within the urgent care timeframe.
    c. Request by Claimant Involving Non-urgent Care. If the Plan Administrator receives a request from the Claimant for a claim not involving urgent care, the request will be treated as a new benefit claim and decided within the timeframe appropriate to the type of claim (either as a Pre-service Non-urgent claim or a Post-service claim).
    d. Request by Claimant Involving Rescission. With respect to rescissions, the following timetable applies:

i. Notification to Claimant 30 days
ii. Notification of Adverse Benefit Determination on appeal 30 days

4. Post-service Claims:

   a. If the Claimant has provided all of the information needed to process the claim, in a reasonable period of time, but not later than 30 days after receipt of the claim, unless an extension has been requested, then prior to the end of the 15 day extension period.
   b. If such an extension is necessary due to a failure of the Claimant to submit the information necessary to decide the claim, the notice of extension shall specifically describe the required information, and the Claimant shall be afforded at least 45 days from receipt of the notice within which to provide the specified information.
   c. If the Claimant has not provided all of the information needed to process the claim and additional information is requested during the initial processing period, then the Claimant will be notified of a determination of benefits prior to the end of the extension period, unless additional information is requested during the extension period, then the Claimant will be notified of the determination by a date agreed to by the Plan Administrator and the Claimant.

5. Extensions:

   a. Pre-service Urgent Care Claims. No extensions are available in connection with Pre-service urgent care claims.
   b. Pre-service Non-urgent Care Claims. This period may be extended by the Plan for up to 15 days, provided that the Plan Administrator both determines that such an extension is necessary due to matters beyond the control of the Plan and notifies the Claimant, prior to the expiration of the initial 15 day processing period, of the circumstances requiring the extension of time and the date by which the Plan expects to render a decision.
   c. Post service Claims. This period may be extended by the Plan for up to 15 days, provided that the Plan Administrator both determines that such an extension is necessary due to matters beyond the control of the Plan and notifies the Claimant, prior to the expiration of the initial 30 day processing period, of the circumstances requiring the extension of time and the date by which the Plan expects to render a decision.

6. Calculating Time Periods. The period of time within which a benefit determination is required to be made shall begin at the time a claim is deemed to be filed in accordance with the procedures of the Plan.

Notification of an Adverse Benefit Determination
The Plan Administrator shall provide a Claimant with a notice, either in writing or electronically (or, in the case of pre-service urgent care claims, by telephone, facsimile or similar method, with written or electronic notice following within three days), containing the following information:
Information sufficient to allow the Claimant to identify the claim involved (including date of service, the health care Provider, the claim amount, if applicable, and a statement describing the availability, upon request, of the Diagnosis code and its corresponding meaning, and the treatment code and its corresponding meaning).

1. A reference to the specific portion(s) of the Plan Document upon which a denial is based.
2. Specific reason(s) for a denial, including the denial code and its corresponding meaning, and a description of the Plan's standard, if any, that was used in denying the claim.
3. A description of any additional information necessary for the Claimant to perfect the claim and an explanation of why such information is necessary.
4. A description of the Plan's review procedures and the time limits applicable to the procedures, including a statement of the Claimant's right to bring a civil action under Section 502(a) of ERISA following an Adverse Benefit Determination on final review.
5. A statement that the Claimant is entitled to receive, upon request and free of charge, reasonable access to, and copies of, all documents, records and other information relevant to the Claimant's claim for benefits.
6. Upon request, the identity of any medical or vocational experts consulted in connection with a claim, even if the Plan did not rely upon their advice (or a statement that the identity of the expert will be provided, upon request).
7. Any rule, guideline, protocol or similar criterion that was relied upon in making the determination (or a statement that it was relied upon and that a copy will be provided to the Claimant, free of charge, upon request).

8. In the case of denials based upon a medical judgment (such as whether the treatment is Medically Necessary or Experimental), either an explanation of the scientific or clinical judgment for the determination, applying the terms of the Plan to the Claimant's medical circumstances, or a statement that such explanation will be provided to the Claimant, free of charge, upon request.
9. In a claim involving urgent care, a description of the Plan's expedited review process.

Appeal of Adverse Benefit Determinations

Full and Fair Review of All Claims
In cases where a claim for benefits is denied, in whole or in part, and the Claimant believes the claim has been denied wrongly, the Claimant may appeal the denial and review pertinent documents. The claims procedures of this Plan provide a Claimant with a reasonable opportunity for a full and fair review of a claim and Adverse Benefit Determination. More specifically, the Plan provides:

1. A 180 day timeframe following receipt of a notification of an initial Adverse Benefit Determination within which to appeal the determination. The Plan will not accept appeals filed after a 180 day timeframe.
2. The opportunity to submit written comments, documents, records, and other information relating to the claim for benefits.
3. The opportunity to review the Claim file and to present evidence and testimony as part of the internal claims and appeals process.
4. A review that does not afford deference to the previous Adverse Benefit Determination and that is conducted by an appropriate named fiduciary of the Plan, who shall be neither the individual who made the Adverse Benefit Determination that is the subject of the appeal, nor the subordinate of such individual.
5. A review that takes into account all comments, documents, records, and other information submitted by the Claimant relating to the claim, without regard to whether such information was submitted or considered in the prior benefit determination.
6. That, in deciding an appeal of any Adverse Benefit Determination that is based in whole or in part upon a medical judgment, the Plan fiduciary shall consult with a health care professional who has appropriate training and experience in the field of medicine involved in the medical judgment, who is neither an individual who was consulted in connection with the Adverse Benefit Determination that is the subject of the appeal, nor the subordinate of any such individual.
7. Upon request, the identity of medical or vocational experts whose advice was obtained on behalf of the Plan in connection with a claim, even if the Plan did not rely upon their advice.
8. That a Claimant will be provided, free of charge: (a) reasonable access to, and copies of, all documents, records, and other information relevant to the Claimant's claim in possession of the Plan Administrator or Third Party Administrator; (b) information regarding any voluntary appeals procedures offered by the Plan; (c) information regarding the Claimant's right to an external review process; (d) any internal rule, guideline, protocol or other similar criterion relied upon, considered or generated in making the adverse determination; and (e) an explanation of the scientific or clinical judgment for the determination, applying the terms of the Plan to the Claimant's medical circumstances.
9. That a Claimant will be provided, free of charge, and sufficiently in advance of the date that the notice of Final Internal Adverse Benefit Determination is required to be provided with new or additional evidence considered, relied upon, or generated by the Plan in connection with the Claim, as well as any new or additional rationale for a denial at the internal appeals stage, and a reasonable opportunity for the Claimant to respond to such new evidence or rationale.
10. That in case of urgent care claims an expedited review process for an appeal of an adverse benefit determination which may be submitted orally or in writing by the claimant and all the necessary information shall be transmitted between the plan and the claimant via phone, facsimile or other similarly expeditious methods

Requirements for First Level Appeal
The Claimant must file the appeal in writing (although oral appeals are permitted for pre service urgent care claims) within 180 days following receipt of the notice of an Adverse Benefit Determination.

For Pre-service Claims. Oral appeals should be submitted in writing as soon as possible after it has been initiated. To file any appeal in writing, the Claimant's appeal must be addressed as follows:

HEALTHFIRST TPA
821 ESE LOOP 323 SUITE 200
TYLER TX 75701

Phone: 1-903-581-2600
www.hfbenefits.com
appeals@hfbenefits.com

For Post-service Claims. To file any appeal in writing, the Claimant's appeal must be addressed as follows:

HEALTHFIRST TPA
821 ESE LOOP 323 SUITE 200
TYLER TX 75701
Phone: 1-903-581-2600
www.hfbenefits.com
appeals@hfbenefits.com

It shall be the responsibility of the Claimant or authorized representative to submit an appeal under the provisions of the Plan. Any appeal must include:

1. The name of the Employee/Claimant.
2. The Employee/Claimant's social security number.
3. The group name or identification number.
4. All facts and theories supporting the claim for benefits.
5. A statement in clear and concise terms of the reason or reasons for disagreement with the handling of the claim.
6. Any material or information that the Claimant has which indicates that the Claimant is entitled to benefits under the Plan.

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

Timing of Notification of Benefit Determination on Review
The Plan Administrator shall notify the Claimant of the Plan's benefit determination on review within the following timeframes:

1. Pre-service Urgent Care Claims: As soon as possible, taking into account the medical exigencies, but not later than 72 hours after receipt of the appeal.
2. Pre-service Non-urgent Care Claims: Within a reasonable period of time appropriate to the medical circumstances, but not later than 15 days after receipt of the appeal.
3. Concurrent Claims: The response will be made in the appropriate time period based upon the type of claim: Pre-service Urgent, Pre-service Non-urgent or Post-service.
4. Post-service Claims: Within a reasonable period of time, but not later than 30 days per internal appeal.

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

Manner and Content of Notification of Adverse Benefit Determination on Review
The Plan Administrator shall provide a Claimant with notification, with respect to Pre-service urgent care claims, by telephone, facsimile or similar method, and with respect to all other types of claims, in writing or electronically, of a Plan's Adverse Benefit Determination on review, setting forth:

1. Information sufficient to allow the Claimant to identify the claim involved (including date of service, the health care Provider, the claim amount, if applicable, and a statement describing the availability, upon request, of the Diagnosis code and its corresponding meaning, and the treatment code and its corresponding meaning).
2. Specific reason(s) for a denial, including the denial code and its corresponding meaning, and a description of the Plan's standard, if any, that was used in denying the claim, and a discussion of the decision.
3. A reference to the specific portion(s) of the summary plan description on which the denial is based.
4. The identity of any medical or vocational experts consulted in connection with a claim, even if the Plan did not rely upon their advice (or a statement that the identity of the expert will be provided, upon request).

5. A statement that the Claimant is entitled to receive, upon request and free of charge, reasonable access to, and copies of, all documents, records, and other information relevant to the Claimant's claim for benefits.
6. Any rule, guideline, protocol or similar criterion that was relied upon, considered, or generated in making the determination will be provided free of charge. If this is not practical, a statement will be included that such a rule, guideline, protocol or similar criterion was relied upon in making the determination and a copy will be provided to the Claimant, free of charge, upon request.
7. A description of any additional information necessary for the Claimant to perfect the claim and an explanation of why such information is necessary.
8. A description of available internal appeals and external review processes, including information regarding how to initiate an appeal.
9. A description of the Plan's review procedures and the time limits applicable to the procedures. This description will include information on how to initiate the appeal and a statement of the Participant's right to bring a civil action under section 502(a) of ERISA following an Adverse Benefit Determination on final review.
10. In the case of denials based upon a medical judgment (such as whether the treatment is Medically Necessary or Experimental), either an explanation of the scientific or clinical judgment for the determination, applying the terms of the Plan to the Claimant's medical circumstances, will be provided. If this is not practical, a statement will be included that such explanation will be provided to the Claimant, free of charge, upon request.
11. Information about the availability of, and contact information for, an applicable office of health insurance consumer assistance or ombudsman established under applicable federal law to assist Participants with the internal claims and appeals and external review processes.
12. The following statement: "You and your Plan may have other voluntary alternative dispute resolution options, such as mediation. One way to find out what may be available is to contact your local U.S. Department of Labor Office and your State insurance regulatory agency.

Furnishing Documents in the Event of an Adverse Determination
In the case of an Adverse Benefit Determination on review, the Plan Administrator shall provide such access to, and copies of, documents, records, and other information described in the provision relating to "Manner and Content of Notification of Adverse Benefit Determination on Review" as appropriate.

Decision on Review
The decision by the Plan Administrator or other appropriate named fiduciary of the Plan on review will be final, binding and conclusive and will be afforded the maximum deference permitted by law. All claim review procedures provided for in the Plan must be exhausted before any legal action is brought.

Requirements for Second Level Appeal
The Claimant must file an appeal regarding a Post-service claim and applicable Adverse Benefit Determination, in writing within 60 days following receipt of the notice of the first level Adverse Benefit Determination.

Two Levels of Appeal
This Plan requires two levels of appeal (Post-service) by a Claimant before the Plan's internal appeals are exhausted. For each level of appeal, the Claimant and the Plan are subject to the same procedures, rights, and responsibilities as stated within this Plan. Each level of appeal is subject to the above outlined submission and response guidelines.
Once a Claimant receives an Adverse Benefit Determination in response to an initial claim for benefits, the Claimant may appeal that Adverse Benefit Determination, which will constitute the initial appeal. If the Claimant receives an Adverse Benefit Determination in response to that initial appeal, the Claimant may appeal that Adverse Benefit Determination as well, which will constitute the final internal appeal. If the Claimant receives an Adverse Benefit Determination in response to the Claimant's second appeal, such Adverse Benefit Determination will constitute the Final Internal Adverse Benefit Determination, and the Plan's internal appeals procedures will have been exhausted.

Deemed Exhaustion of Internal Claims Procedures and De Minimis
Exception to the Deemed Exhaustion Rule
A Claimant will not be required to exhaust the internal claims and appeals procedures described above if the Plan fails to adhere to the claims procedures requirements. In such an instance, a Claimant may proceed immediately to make a claim in court. However, the internal claim and appeals procedures will not be deemed exhausted (meaning the Claimant must adhere to them before bringing a claim in court) in the event of a de minimis violation that does not cause, and is not likely to cause, prejudice or harm to the Claimant as long as the Plan Administrator demonstrates that the violation was for good cause or due to matters beyond the control of the Plan, the violation

occurred in the context of an ongoing, good faith exchange of information between the Plan and the Claimant, and the violation is not reflective of a pattern or practice of non- compliance.

If a Claimant believes the Plan Administrator has engaged in a violation of the claims procedures and would like to pursue an immediate review, the Claimant may request that the Plan provide a written explanation of the violation, including a description of the Plan's basis for asserting that the violation should not result in a "deemed exhaustion" of the claims procedures. The Plan will respond to this request within ten days. If a court rejects a request for immediate review because the Plan has met the requirements for the "de minimis" exception described above, the Plan will provide the Claimant with notice of an opportunity to resubmit and pursue an internal appeal of the claim.

External Review Process
The Federal external review process does not apply to a denial, reduction, termination, or a failure to provide payment for a benefit based on a determination that a Claimant or beneficiary fails to meet the requirements for eligibility under the terms of a group health plan.

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

1. Any eligible Adverse Benefit Determination (including a Final Internal Adverse Benefit Determination) by a plan or issuer that involves medical judgment (including, but not limited to, those based on the plan's or issuer's requirements for Medical Necessity, appropriateness, health care setting, level of care, or effectiveness of a covered benefit; its determination that a treatment is Experimental or Investigational; its determination whether a Claimant or beneficiary is entitled to a reasonable alternative standard for a reward under a wellness program; its determination whether a plan or issuer is complying with the nonquantitative treatment limitation provisions of Code section 9812 and § 54.9812-1, which generally require, among other things, parity in the application of medical management techniques), as determined by the external reviewer.
2. An Adverse Benefit Determination that involves consideration of whether the Plan is complying with the surprise billing and cost-sharing protections set forth in the No Surprises Act.
3. A rescission of coverage (whether or not the rescission has any effect on any particular benefit at that time).

Standard external review
Standard external review is an external review that is not considered expedited (as described in the "expedited external review" paragraph in this section).

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

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

    a. The Claimant is or was covered under the Plan at the time the health care item or service was requested or, in the case of a retrospective review, was covered under the Plan at the time the health care item or service was provided.
    b. The Adverse Benefit Determination or the Final Internal Adverse Benefit Determination does not relate to the Claimant's failure to meet the requirements for eligibility under the terms of the Plan (e.g., worker classification or similar determination).
    c. The Claimant has exhausted the Plan's internal appeal process unless the Claimant is not required to exhaust the internal appeals process under the final regulations.
    d. The Claimant has provided all the information and forms required to process an external review. Within one business day after completion of the preliminary review, the Plan will issue a notification in writing to the Claimant. If the request is complete but not eligible for external review, such notification will include the reasons for its ineligibility and contact information for the Employee Benefits Security Administration (toll-free number 866-444-EBSA (3272)). If the request is not complete, such notification will describe the information or materials needed to make the request

complete and the Plan will allow a Claimant to perfect the request for external review within the four-month filing period or within the 48 hour period following the receipt of the notification, whichever is later.

3. Referral to Independent Review Organization. The Plan will assign an independent review organization (IRO) that is accredited by URAC or by a similar nationally-recognized accrediting organization to conduct the external review. Moreover, the Plan will take action against bias and to ensure independence. Accordingly, the Plan will contract with (or direct the Third Party Administrator to contract with, on its behalf) at least three IROs for assignments under the Plan and rotate claims assignments among them (or incorporate other independent unbiased methods for selection of IROs, such as random selection). In addition, the IRO may not be eligible for any financial incentives based on the likelihood that the IRO will support the denial of benefits.

4. Reversal of Plan's decision. Upon receipt of a notice of a final external review decision reversing the Adverse Benefit Determination or Final Internal Adverse Benefit Determination, the Plan will provide coverage or payment for the claim without delay, regardless of whether the plan intends to seek judicial review of the external review decision and unless or until there is a judicial decision otherwise.

Expedited external review

1. Request for expedited external review. The Plan will allow a Claimant to make a request for an expedited external review with the Plan at the time the Claimant receives:

    a. An Adverse Benefit Determination if the Adverse Benefit Determination involves a medical condition of the Claimant for which the timeframe for completion of a standard internal appeal under the final regulations would seriously jeopardize the life or health of the Claimant or would jeopardize the Claimant's ability to regain maximum function and the Claimant has filed a request for an expedited internal appeal.
    b. A Final Internal Adverse Benefit Determination, if the Claimant has a medical condition where the timeframe for completion of a standard external review would seriously jeopardize the life or health of the Claimant or would jeopardize the Claimant's ability to regain maximum function, or if the Final Internal Adverse Benefit Determination concerns an admission, availability of care, continued stay, or health care item or service for which the Claimant received Emergency Services, but has not been discharged from a facility.

2. Preliminary review. Immediately upon receipt of the request for expedited external review, the Plan will determine whether the request meets the reviewability requirements set forth above for standard external review. The Plan will immediately send a notice that meets the requirements set forth above for standard external review to the Claimant of its eligibility determination.

3. Referral to Independent Review Organization. Upon a determination that a request is eligible for external review following the preliminary review, the Plan will assign an IRO pursuant to the requirements set forth above for standard review. The Plan will provide or transmit all necessary documents and information considered in making the Adverse Benefit Determination or Final Internal Adverse Benefit Determination to the assigned IRO electronically or by telephone or facsimile or any other available expeditious method. The assigned IRO, to the extent the information or documents are available and the IRO considers them appropriate, will consider the information or documents described above under the procedures for standard review. In reaching a decision, the assigned IRO will review the claim de novo and is not bound by any decisions or conclusions reached during the Plan's internal claims and appeals process.

4. Notice of final external review decision. The Plan's (or Third Party Administrator's) contract with the assigned IRO will require the IRO to provide notice of the final external review decision, in accordance with the requirements set forth above, as expeditiously as the Claimant's medical condition or circumstances require, but in no event more than 72 hours after the IRO receives the request for an expedited external review. If the notice is not in writing, within 48 hours after the date of providing that notice, the assigned IRO will provide written confirmation of the decision to the Claimant and the Plan.

Appointment of Authorized Representative

A Claimant may designate another individual to be an authorized representative and act on his or her behalf and communicate with the Plan with respect to a specific benefit claim or appeal of a denial. This authorization must be in writing, signed and dated by the Claimant, and include all the information required in the authorized representative form. The appropriate form can be obtained from the Plan Administrator or the Third Party Administrator.

The Plan will permit, in a medically urgent situation, such as a claim involving Urgent Care, a Claimant's treating health care practitioner to act as the Claimant's authorized representative without completion of the authorized representative form.

Should a Claimant designate an authorized representative, all future communications from the Plan will be conducted with the authorized representative instead of the Claimant, unless the Plan Administrator is otherwise notified in writing by the Claimant. A Claimant can revoke the authorized representative at any time. A Claimant may authorize only one person as an authorized representative at a time.

Recognition as an authorized representative is completely separate from a Provider accepting an assignment of benefits, requiring a release of information, or requesting completion a similar form. An assignment of benefits by a Claimant shall not be recognized as a designation of the Provider as an authorized representative. Assignment and its limitations under this Plan are described below.

Autopsy

Upon receipt of a claim for a deceased Claimant for any condition, Sickness, or Injury is the basis of such claim, the Plan maintains the right to request an autopsy be performed upon said Claimant. The request for an autopsy may be exercised only where not prohibited by any applicable law.

Payment of Benefits

Where benefit payments are allowable in accordance with the terms of this Plan, payment shall be made in U.S. Dollars (unless otherwise agreed upon by the Plan Administrator). Payment shall be made, in the Plan Administrator's discretion, to an assignee of an assignment of benefits, but in any instance may alternatively be made to the Claimant, on whose behalf payment is made and who is the recipient of the services for which payment is being made. Should the Claimant be deceased, payment shall be made to the Claimant's heir, assign, agent or estate (in accordance with written instructions), or, if there is no such arrangement and in the Plan Administrator's discretion, the institute and/or Provider who provided the care and/or supplies for which payment is to be made – regardless of whether an assignment of benefits occurred.

Provider of Service Appeal Rights

A Claimant may appoint the provider of service as the Authorized Representative with full authority to act on his or her behalf in the appeal of a denied claim. An assignment of benefits by a Claimant to a provider of service will not constitute appointment of that provider as an Authorized Representative. However, in an effort to ensure a full and fair review of the denied claim, and as a courtesy to a provider of service that is not an Authorized Representative, the Plan will consider an appeal received from the provider in the sam manner as a Claimant's appeal, and will respond to the provider and the Claimant with the results of the review accordingly. Any such appeal from a provider of service must be made within the teim limits and under the conditions for filing an appeal specified under the section, "Appeal Process, " above. Providers requesting such appeal rights under the Plan must agree to pursue reimbursement for Covered Medical Expenses directly from the Plan, waiving any right to recover such expenses from the Claimant, and comply with the conditions of the section, "Requirements for First Appeal" above.

For purposes of this section, the provider's waiver to pursue Covered Medical Expenmses does not include the following amounts, which are the responsibility of the Claimant:

1. Deductibles;
2. Copayments;
3. Coinsurance;
4. Penalties for failure to comply with the terms of the Plan;
5. Charges for services and supplies which are not included for coverage under the Plan; and
6. Amounts which are in excess of any stated Plan maximums or limits. Note: this does not apply to amounts found to be in excess of Allowable Claim Limits, as defined in the section, "Claim Review and Audit Program". The provider must agree to waive the right to balance bill for these amounts.

Also, for purposes of this section, if a provider indicates on a Form UB92 or on a CMS 1500 Form (or similar claim form) that the provider has an assignment of benefits, then the Plan will require no further evidence that benefits are legally assigned to that provider.

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

Assignments
For this purpose, the term "Assignment of Benefits" (or "AOB") is defined as an arrangement whereby a Participant 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 medical Provider. If a Provider accepts said arrangement, the Provider's rights to receive Plan benefits are equal to those of the Participant, and are limited by the terms of this Plan Document. A Provider that accepts this arrangement indicates acceptance of an AOB and Deductibles, Copayments, and Coinsurance amounts, as consideration in full for treatment rendered.

The Plan Administrator may revoke an AOB at its discretion and treat the Participant of the Plan as the sole beneficiary. Benefits for medical expenses covered under this Plan may be assigned by a Participant to the Provider as consideration in full for services rendered; however, if those benefits are paid directly to the Participant, 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 Participant, has been received before the proof of loss is submitted, or the Plan Administrator – at its discretion – revokes the assignment.

No Participant shall at any time, either during the time in which he or she is a Participant in the Plan, or following his or her termination as a Participant, in any manner, have any right to assign his or her right to which he or she may have against the Plan or its fiduciaries. A medical Provider which accepts an AOB does as consideration in full for services rendered and is bound by the rules and provisions set forth within the terms of this document.

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. As such this Plan may pay benefits that are later found to be greater than the Maximum Allowable Charge. In this case, this Plan may recover the amount of the overpayment from the source to which it was paid, primary payers, or from the party on whose behalf the charge(s) were paid. As such, whenever the Plan pays benefits exceeding the amount of benefits payable under the terms of the Plan, the Plan Administrator has the right to recover any such erroneous payment directly from the person or entity who received such payment and/or from other payers and/or the Claimant or Dependent on whose behalf such payment was made.

A Claimant, Dependent, Provider, another benefit plan, insurer, or any other person or entity who receives a payment exceeding the amount of benefits payable under the terms of the Plan or on whose behalf such payment was made, shall return or refund the amount of such erroneous payment to the Plan within 30 days of discovery or demand. The Plan Administrator shall have no obligation to secure payment for the expense for which the erroneous payment was made 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 Claimant or other entity does not comply with the provisions of this section, the Plan Administrator shall have the authority, in its sole discretion, to deny payment of any claims for benefits by the Claimant and to deny or reduce future benefits payable (including payment of future benefits for other injuries or Illnesses) under the Plan by the amount due as reimbursement to the Plan. The Plan Administrator may also, in its sole discretion, deny or reduce future benefits (including future benefits for other injuries or Illnesses) under any other group benefits plan maintained by the Plan Sponsor. The reductions will equal the amount of the required reimbursement.

Providers and any other person or entity accepting payment from the Plan or to whom a right to benefits has been assigned, in consideration of services rendered, payments and/or rights, agrees to be bound by the terms of this Plan and agree to submit claims for reimbursement in strict accordance with their State's health care practice acts, ICD or CPT standards, Medicare guidelines, HCPCS standards, or other standards approved by the Plan Administrator or insurer. Any payments made on claims for reimbursement not in accordance with the above

provisions shall be repaid to the Plan within 30 days of discovery or demand or incur prejudgment interest of 1.5% per month. If the Plan must bring an action against a Claimant, Provider or other person or entity to enforce the provisions of this section, then that Claimant, Provider or other person or entity agrees to pay the Plan's attorneys' fees and costs, regardless of the action's outcome.

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

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

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 years after the date such coverage commences.
4. With respect to an ineligible person.
5. In anticipation of obtaining a recovery if a Claimant fails to comply with the Plan's Third Party Recovery, Subrogation and Reimbursement provisions.
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 (6) 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 for benefits under this Plan by a Claimant or by any of his covered Dependents if such payment is made with respect to the Claimant or any person covered or asserting coverage as a Dependent of the Claimant.

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

Medicaid Coverage
A Claimant's eligibility for any State Medicaid benefits will not be taken into account in determining or making any payments for benefits to or on behalf of such Claimant. Any such benefit payments will be subject to the State's right to reimbursement for benefits it has paid on behalf of the Claimant, 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.

Limitation of Action
A Claimant cannot bring any legal action against the Plan for a claim of benefits until 90 days after all appeal processes have been exhausted. After 90 days, if the Claimant wants to bring a legal action against the Plan, he or she must do so within three years of the date he or she is notified of the final decision on the final appeal or he or she will lose any rights to bring such an action against the Plan.

PLAN ADMINISTRATION

The Plan Administrator has been granted the authority to administer the Plan. The Plan Administrator has retained the services of the Third Party Administrator to provide certain claims processing and other technical services. Subject to the claims processing and other technical services delegated to the Third Party Administrator, the Plan Administrator reserves the unilateral right and power to administer and to interpret, construe and construct the terms and provisions of the Plan, including without limitation, correcting any error or defect, supplying any omission, reconciling any inconsistency and making factual determinations.

Plan Administrator

The Plan is administered by the Plan Administrator within the purview of ERISA and in accordance with these provisions. An individual, committee, or entity may be appointed by the Plan Sponsor to be Plan Administrator and serve at the convenience of the Plan Sponsor. If the appointed Plan Administrator or a committee member resigns, dies, is otherwise unable to perform, is dissolved, or is removed from the position, the Plan Sponsor shall appoint a new Plan Administrator as soon as reasonably possible.

The Plan Administrator may delegate to one or more individuals or entities part or all of its discretionary authority under the Plan, provided that any such delegation must be made in writing.

The Plan shall be administered by the Plan Administrator, in accordance with its terms. Policies, interpretations, practices, and procedures are established and maintained by the Plan Administrator. 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 all interpretive and factual determinations as to whether any individual is eligible and entitled to receive any benefit under the terms of this Plan, to decide disputes which may arise with respect to a Participant'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 will be paid under this Plan only if the Plan Administrator, in its discretion, determines that the Participant is entitled to them.

If due to errors in drafting, any Plan provision does not accurately reflect its intended meaning, as demonstrated by prior interpretations or other evidence of intent, or as determined by the Plan Administrator in its sole and exclusive judgment, the provision shall be considered ambiguous and shall be interpreted by the Plan Administrator in a fashion consistent with its intent, as determined by the Plan Administrator. The Plan may be amended retroactively to cure any such ambiguity, notwithstanding anything in the Plan to the contrary.

The foregoing provisions of this Plan may not be invoked by any person to require the Plan to be interpreted in a manner which is inconsistent with its interpretations by the Plan Administrator. All actions taken and all determinations by the Plan Administrator shall be final and binding upon all persons claiming any interest under the Plan subject only to the claims appeal procedures of the Plan.

Plan Administrator and ELAP

Notwithstanding any provisions of this Plan Document and Summary Plan Description to the contrary, the Plan Sponsor has the authority to, and hereby does, allocate certain responsibility to ELAP Services, LLC ("ELAP"). The responsibility allocated to ELAP is limited to discretionary authority and decision-making authority with respect to any appeals of denied claims which are referred to ELAP by the Plan Administrator. The Plan Sponsor has allocated additional responsibility to ELAP, limited to discretionary authority and decision-making authority with respect to the review and audit of certain claims in accordance with the applicable Plan provisions under the section, "Claim Review and Audit Program". Such claims selected as eligible for review and audit shall be identified by ELAP under guidelines to which the Plan Sponsor has agreed and shall be referred to ELAP by the Plan Administrator. ELAP shall have no authority, responsibility or liability other than with respect to the Referred Appeals and its duties under the Claim Review and Audit Program.

The Plan Administrator shall establish the policies, practices and procedures of this Plan. The Plan Administrator and ELAP shall administer this Plan in accordance with its terms. It is the express intent of this Plan that the Plan Administrator and ELAP shall have maximum legal discretionary authority to construe and interpret the terms and provisions of the Plan, to make determinations regarding issues which relate to eligibility for benefits (including the determination of what services, supplies, care and treatments are experimental), to decide disputes which may arise relative to a Plan participant's rights,

and to decide questions of Plan interpretation and those of fact relating to the Plan. The decisions of the Plan Administrator and/or ELAP as to the facts related to any claim for benefits and the meaning and intent of any provision of the Plan, or its application to any claim, shall receive the maximum deference provided by law and will be final and binding on all interested parties. Benefits under this Plan will be paid only if the Plan Administrator or ELAP decides, in its discretion, that the Plan participant is entitled to them.

Duties of ELAP
ELAP shall have the following duties with respect to the Referred Appeals:

1. To administer the Plan in accordance with its terms;
2. To determine all questions of eligibility, status and coverage under the Plan;
3. To interpret the Plan, including the authority to construe possible ambiguities, inconsistencies, omissions, and disputed terms;
4. To make factual findings;
5. To decide disputes which may arise relative to benefits payable under the Plan and negotiating settlements, if appropriate;
6. To review Referred Appeals and to uphold or reverse any denials;
7. To keep and maintain records pertaining to the referred appeals;
8. To perform the duties in conjunction with the provisions of the Claim Review and Audit Program; and
9. To keep and maintain records pertaining to the Claim Review and Audit Program.

The duties of ELAP shall be limited to those set forth above.

Duties of the Plan Administrator
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 Participant's rights and/or availability of benefits.
6. To prescribe procedures for filing a claim for benefits, to review claim denials and appeals relating to them and to uphold or reverse such denials.
7. To keep and maintain the Plan documents and all other records pertaining to the Plan.
8. To appoint and supervise a Third Party Administrator to pay claims.
9. To perform all necessary reporting as required by ERISA.
10. To establish and communicate procedures to determine whether a Medical Child Support Order is a QMCSO.
11. To delegate to any person or entity such powers, duties and responsibilities as it deems appropriate.
12. To perform each and every function necessary for or related to the Plan's administration.

Amending and Terminating the Plan

This Plan was established for the exclusive benefit of the Employees with the intention it will continue indefinitely; however, as the settlor of the Plan, the Plan Sponsor, through its directors and officers, may, in its sole discretion, at any time, amend, suspend or terminate the Plan in whole or in part. This includes amending the benefits under the Plan or the trust agreement (if any). All amendments to this Plan shall become effective as of a date established by the Plan Sponsor.

Any amendment to the Plan that is not made effective at the beginning of a normal Plan Year by integration into a full Plan Document restatement, including suspension and/or termination, shall follow the amendment procedure outlined in this section. The amendment procedure is accomplished by a separate, written amendment decided upon and/or enacted by resolution of the Plan Sponsor's directors or officers (in compliance with its articles of incorporation or bylaws and if these provisions are deemed applicable), or by the sole proprietor in his or her own

discretion if the Plan Sponsor is a sole proprietorship, but always in accordance with applicable Federal and State law, including – where applicable – notification rules provided for and as required by ERISA.

If the Plan is terminated, the rights of the Participants are limited to expenses Incurred before termination. In connection with the termination, the Plan Sponsor may establish a deadline by which all claims must be submitted for consideration. Benefits will be paid only for Covered Expenses Incurred prior to the termination date and submitted in accordance with the rules established by the Plan Sponsor. Upon termination, any Plan assets will be used to pay outstanding claims and all expenses of Plan termination. As it relates to distribution of assets upon termination of the Plan, any contributions paid by Participants 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.

Summary of Material Modification (SMM)

A Summary of Material Modifications reports changes in the information provided within the Summary Plan Description. Examples include a change to Deductibles, eligibility or the addition or deletion of coverage.

The Plan Administrator shall notify all covered Employees of any plan amendment considered a Summary of Material Modifications by the Plan as soon as administratively feasible after its adoption, but no later than within 210 days after the close of the Plan Year in which the changes became effective. If said Material Modification is affected by amendment as described above, distribution of a copy of said written amendment, within all applicable time limits, shall be deemed sufficient notification to satisfy the Plan's Summary of Material Modifications requirements.

NOTE: The Affordable Care Act (ACA) requires that if a Plan's Material Modifications are not reflected in the Plan's most recent Summary of Benefits and Coverage (SBC) then the Plan must provide written notice to Participants at least 60 days before the effective date of the Material Modification.

Summary of Material Reduction (SMR)

A Summary of Material Reduction (SMR) is a type of SMM. A Material Reduction generally means any modification that would be considered by the average participant to be an important reduction in covered services or benefits. Examples include reductions in benefits or increases in Deductibles or Copayments.

The Plan Administrator shall notify all eligible Employees of any plan amendment considered a Material Reduction in covered services or benefits provided by the Plan as soon as administratively feasible after its adoption, but no later than 60 days after the date of adoption of the reduction. Eligible Employees and beneficiaries must be furnished a summary of such reductions, and any changes so made shall be binding on each Participant. The 60 day period for furnishing a summary of Material Reduction does not apply to any Employee covered by the Plan who would reasonably expect to receive a summary through other means within the next 90 days.

If said Material Reduction is affected by amendment as described above, distribution of a copy of said written amendment, within all applicable time limits, shall be deemed sufficient notification to satisfy the Plan's Summary of Material Reduction requirements.

Material Reduction disclosure provisions are subject to the requirements of ERISA and the Health Insurance Portability and Accountability Act of 1996 (HIPAA) and any related amendments.

Misuse of Identification Card

If an Employee or covered Dependent permits any person who is not a covered Participant of the Family Unit to use any identification card issued, the Plan Sponsor may give Employee written notice that his (and his family's) coverage will be terminated in accordance with the Plan's provisions.

COORDINATION OF BENEFITS

Coordination of the Benefit Plans

Coordination of benefits sets out rules for the order of payment of Covered Expenses when two or more plans, including Medicare, are paying. When a Participant is covered by this Plan and another plan, the plans will coordinate benefits when a claim is received.

Non-Duplication/Maintenance of Benefits

The plan that pays first according to the rules will pay as if there were no Other Plan involved. The secondary will pay up to its own plan formula minus whatever the primary plan paid.

Benefits Subject to This Provision

The following only applies to the Medical benefits of the Plan.

Excess Insurance

If at the time of Injury, Sickness, Disease or disability there is available, or potentially available any other source of coverage (including but not limited to coverage resulting from a judgment at law or settlements), the benefits under this Plan shall apply only as an excess over such other sources of coverage.

The Plan's benefits will be excess to, whenever possible, any of the following:

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, including any similar coverage under a different name in a particular state.
3. Any policy of insurance from any insurance company or guarantor of a third party.
4. Workers' compensation or other liability insurance company.
5. Any other source, including but not limited to crime victim restitution funds, any medical, disability or other benefit payments, and school insurance coverage.
6. Specified disease policies.
7. Foreign health care coverage.
8. Medical care components of group long-term care contracts, such as skilled nursing care.
9. Medical benefits under homeowner's insurance policies.
10. Medicare or other governmental benefits, as permitted by law, not including Medicaid.

When this Plan is secondary, and when not in conflict with a Network contract requiring otherwise, covered charges will not include any amount that is not payable under the Primary Plan as a result of a contract between the Primary Plan and a provider of service in which such provider agrees to accept a reduced payment and not to bill the Covered Person for the difference between the provider's contracted amount and the provider's regular billed charge.

Vehicle Limitation

When medical payments are 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 and will exclude benefits subject to the Exclusions in this Plan up the maximum amount available to the Participant under applicable state law, regardless of a Participant's election of lesser coverage amount. This applies to all forms of medical payments under vehicle plans and/or policies regardless of its name, title or classification.

Effect on Benefits

Application to Benefit Determinations

The plan that pays first according to the rules in the provision entitled "Order of Benefit Determination" will pay as if there were no Other Plan involved. The secondary and subsequent plans will pay the balance due up to each one's plan formula minus the amount the primary plan paid. When there is a conflict in the rules, this Plan will never pay more than 50% of Allowable Expenses when paying secondary. Benefits will be coordinated on the basis of a Claim Determination Period.

When medical payments are available under automobile insurance, this Plan will pay excess benefits only, without reimbursement for automobile plan deductibles. This Plan will always be considered the secondary carrier regardless of the individual's election under personal injury protection (PIP) coverage with the automobile insurance carrier.

In certain instances, the benefits of the Other Plan will be ignored for the purposes of determining the benefits under this Plan. This is the case when all of the following occur:

1. The Other Plan would, according to its rules, determine its benefits after the benefits of this Plan have been determined.
2. The rules in the provision entitled "Order of Benefit Determination" would require this Plan to determine its benefits before the Other Plan.

Order of Benefit Determination
For the purposes of the provision entitled "Application to Benefit Determinations," the rules establishing the order of benefit determination between the Plan and an Other Plan are:

1. A plan without a coordinating provision will always be the primary plan.
2. The benefits of a plan which covers the person on whose expenses claim is based, other than as a dependent, shall be determined before the benefits of a plan which covers such person as a Dependent.
3. Benefits of this plan will only pay on a secondary basis for a Dependent spouse when that spouse of an eligible employee works full-time and is eligible for health coverage through his or her own employer benefits.
4. If the person for whom claim is made is a dependent child covered under both parents' plans, the plan covering the parent whose birthday (month and day of birth, not year) falls earlier in the year will be primary, except:
    a. When the parents were never married, are separated, or are divorced, the benefits of a plan which covers the child as a dependent of the parent with custody will be determined before the benefits of a plan which covers the child as a dependent of the parent without custody.
    b. When the parents are divorced and the parent with custody of the child has remarried, the benefits of a plan which covers the child as a dependent of the parent with custody shall be determined before the benefits of a plan which covers that child as a dependent of the stepparent, and the benefits of a plan which covers that child as a dependent of the stepparent will be determined before the benefits of a plan which covers that child as a dependent of the parent without custody.

    Notwithstanding the above, if there is a court decree which would otherwise establish financial responsibility for the child's health care expenses, the benefits of the plan which covers the child as a dependent of the parent with such financial responsibility shall be determined before the benefits of any Other Plan which covers the child as a dependent child.

    In the event both parents have the same birthday, the plan that has covered either of the parents the longest is primary.

5. If an individual is covered under a spouse's Plan and also under his or her parent's plan, the Primary Plan is the plan of the individual's spouse. The plan of the individual's parent(s) is the Secondary Plan.
6. 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.
7. Active or Inactive Employee: If an individual is covered under one plan as an active Employee (or Dependent of an active Employee), and is also covered under another plan as a retired or laid-off Employee (or Dependent of a retired or laid-off Employee), the plan that covers the person as an active Employee (or Dependent of an active Employee) will be primary. This rule does not apply if the rule in the third paragraph (above) can determine the order of benefits. If the other plan does not have this rule, this rule is ignored.
8. Continuation Coverage Under COBRA or State Law: If a person has elected continuation of coverage under COBRA or state law and also has coverage under another plan, the continuation coverage is secondary. This is true even if the person is enrolled in another plan as a Dependent. If the two plans do not agree on the order of benefits, this rule is ignored. This rule does not apply if one of the first four bullets above applies. (See the exception in the Medicare section.)
9. If an active Employee is on leave due to active duty in the military in excess of 30 days, the plan that covers the person as an active Employee, member, or subscriber is considered primary.
10. 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

The Plan Administrator may, without notice to or consent of any person, release to or obtain any information from any insurance company or other organization or individual any information regarding coverage, expenses, and benefits which the Plan Administrator, at its sole discretion, considers necessary to determine, implement and apply the terms of this provision or any provision of similar purpose of any Other Plan. Any Participant claiming benefits under this Plan shall furnish to the Plan Administrator such information as requested and as may be necessary to implement this provision.

Facility of Payment

A payment made under any Other Plan may include an amount that should have been paid under this Plan. 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. Any such amount paid under this provision shall be deemed to be benefits paid under this Plan. The Plan Administrator will not have to pay such amount again and this Plan shall be fully discharged from liability.

Right of Recovery

In accordance with the Recovery of Payments provision, whenever payments have been made by this Plan with respect to Allowable Expenses in a total amount, at any time, in excess of the maximum amount of payment necessary at that time to satisfy the intent of this Coordination of Benefits section, the Plan shall have the right to recover such payments, to the extent of such excess, from any one or more of the following as this Plan shall determine: any person to or with respect to whom such payments were made, or such person's legal representative, any insurance companies, or any other individuals or organizations which the Plan determines are responsible for payment of such Allowable Expenses, and any future benefits payable to the Participant or his or her Dependents. Please see the Recovery of Payments provision above for more details.

TRICARE

If an eligible Employee is on active military duty, TRICARE is the primary coverage. Benefits are not coordinated with the Employee's health insurance plan.

In all instances where an eligible Employee is also a TRICARE beneficiary, TRICARE will pay secondary to this employer-provided Plan.

MEDICARE

Applicable to Active Employees and Their Spouses Ages 65 and Over

An 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. 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 Participants 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") Participants Who Are Covered Under This Plan

If any Participant 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, unless applicable Federal law provides to the contrary, in which event the benefits of the Plan will be determined in accordance with such law.

Order of Benefit Determination Rules for Medicare

This Plan generally pays first under the following circumstances:

1. You continue to be actively employed by the employer and You or Your covered spouse becomes eligible for and enrolls in Medicare because of age or disability.
2. You continue to be actively employed by the employer, Your covered spouse becomes eligible for and enrolls in Medicare, and Your spouse is also covered under a retiree plan through his or her former employer. In this case, this Plan pays first for You and Your covered spouse, Medicare pays second, and the retiree plan pays last.
3. For a Covered Person with End-Stage Renal Disease (ESRD), this Plan usually has primary responsibility for the claims of a Covered Person for 30 months from the date of Medicare eligibility based on ESRD. The 30-month period may also include COBRA continuation coverage or another source of coverage. At the end of the 30-month period, Medicare becomes the primary payer.

Medicare generally pays first under the following circumstances:

1. You are no longer actively employed by an employer; and
2. You or Your spouse has Medicare coverage due to age, plus You or Your spouse also has COBRA continuation coverage through the Plan; or
3. You or a covered family member has Medicare coverage based on a disability, plus You also have COBRA continuation coverage through the Plan. Medicare normally pays first; however, COBRA may pay first for Covered Persons with ESRD until the end of the 30- month period; or
4. You or Your covered spouse has retiree coverage plus Medicare coverage; or
5. Upon completion of 30 months of Medicare eligibility for an individual with ESRD, Medicare becomes the primary payer. (Note that if a person with ESRD was eligible for Medicare based on age or other disability **before** being diagnosed with ESRD and Medicare was previously paying as the Primary Plan, the person may continue to receive Medicare benefits on a primary basis).

Medicare is the secondary payer when no-fault insurance, Workers' Compensation, or liability insurance is available as primary payer.

THIRD PARTY RECOVERY, SUBROGATION AND REIMBURSEMENT

Payment Condition

The Plan, in its sole discretion, may elect to conditionally advance payment of benefits in those situations where an Injury, Illness or disability is caused in whole or in part by, or results from the acts or omissions of Participants, and/or their Dependents, beneficiaries, estate, heirs, guardian, personal representative, or assigns (collectively referred to hereinafter in this section as "Participant(s)") or a third party, where any party besides the Plan may be responsible for expenses arising from an incident, and/or other funds are available, including but not limited to crime victim restitution funds, civil restitution funds, no-fault restitution funds (including vaccine injury compensation funds), uninsured motorist, underinsured motorist, medical payment provisions, third party assets, third party insurance, and/or guarantor(s) of a third party, any medical, applicable disability, or other benefit payments, and school insurance coverage (collectively "Coverage").

Participant(s), his or her attorney, and/or legal guardian of a minor or incapacitated individual agrees that acceptance of the Plan's conditional payment of medical benefits is constructive notice of these provisions in their entirety and agrees to maintain 100% of the Plan's conditional payment of benefits or the full extent of payment from any one or combination of first and third party sources in trust, without disruption except for reimbursement to the Plan or the Plan's assignee. The Plan shall have an equitable lien on any funds received by the Participant(s) and/or their attorney from any source and said funds shall be held in trust until such time as the obligations under this provision are fully satisfied. The Participant(s) agrees to include the Plan's name as a co-payee on any and all settlement drafts. Further, by accepting benefits the Participant(s) understands that any recovery obtained pursuant to this section is an asset of the Plan to the extent of the amount of benefits paid by the Plan and that the Participant shall be a trustee over those Plan assets.

In the event a Participant(s) settles, recovers, or is reimbursed by any Coverage, the Participant(s) agrees to reimburse the Plan for all benefits paid or that will be paid by the Plan on behalf of the Participant(s). When such a recovery does not include payment for future treatment, the Plan's right to reimbursement extends to all benefits paid or that will be paid by the Plan on behalf of the Participant(s) for charges Incurred up to the date such Coverage or third party is fully released from liability, including any such charges not yet submitted to the Plan. If the Participant(s) fails to reimburse the Plan out of any judgment or settlement received, the Participant(s) will be responsible for any and all expenses (fees and costs) associated with the Plan's attempt to recover such money. Nothing herein shall be construed as prohibiting the Plan from claiming reimbursement for charges Incurred after the date of settlement if such recovery provides for consideration of future medical expenses.

If there is more than one party responsible for charges paid by the Plan, or may be responsible for charges paid by the Plan, the Plan will not be required to select a particular party from whom reimbursement is due. Furthermore, unallocated settlement funds meant to compensate multiple injured parties of which the Participant(s) is/are only one or a few, that unallocated settlement fund is considered designated as an "identifiable" fund from which the plan may seek reimbursement.

Subrogation

As a condition to participating in and receiving benefits under this Plan, the Participant(s) agrees to assign to the Plan the right to subrogate and pursue any and all claims, causes of action or rights that may arise against any person, corporation and/or entity and to any Coverage to which the Participant(s) is entitled, regardless of how classified or characterized, at the Plan's discretion, if the Participant(s) fails to so pursue said rights and/or action.

If a Participant(s) receives or becomes entitled to receive benefits, an automatic equitable lien attaches in favor of the Plan to any claim, which any Participant(s) may have against any Coverage and/or party causing the Illness or Injury to the extent of such conditional payment by the Plan plus reasonable costs of collection. The Participant is obligated to notify the Plan or its authorized representative of any settlement prior to finalization of the settlement, execution of a release, or receipt of applicable funds. The Participant is also obligated to hold any and all funds so received in trust on the Plan's behalf and function as a trustee as it applies to those funds until the Plan's rights described herein are honored and the Plan is reimbursed.

The Plan may, at its discretion, in its own name or in the name of the Participant(s) commence a proceeding or pursue a claim against any party or Coverage for the recovery of all damages to the full extent of the value of any such benefits or conditional payments advanced by the Plan.

If the Participant(s) fails to file a claim or pursue damages against:

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, including any similar coverage under a different name in a particular state.
3. Any policy of insurance from any insurance company or guarantor of a third party, including but not limited to an employer's policy.
4. Workers' compensation or other liability insurance company.
5. Any other source of Coverage, including, but not limited to, the following:
    a. Crime victim restitution funds
    b. Civil restitution funds
    c. No-fault restitution funds such as vaccine injury compensation funds
    d. Any medical, applicable disability or other benefit payments
    e. School insurance coverage

the Participant(s) authorizes the Plan to pursue, sue, compromise and/or settle any such claims in the Participant's/Participants' and/or the Plan's name and agrees to fully cooperate with the Plan in the prosecution of any such claims. The Participant(s) assigns all rights to the Plan or its assignee to pursue a claim and the recovery of all expenses from any and all sources listed above.

Right of Reimbursement

The Plan shall be entitled to recover 100% of the benefits paid or payable benefits Incurred, that have been paid and/or will be paid by the Plan, or were otherwise Incurred by the Participant(s) prior to and until the release from liability of the liable entity, as applicable, without deduction for attorneys' fees and costs or application of the common fund doctrine, made whole doctrine, or any other similar legal or equitable theory, and without regard to whether the Participant(s) is fully compensated by his or her recovery from all sources. The Plan shall have an equitable lien which supersedes all common law or statutory rules, doctrines, and laws of any State prohibiting assignment of rights which interferes with or compromises in any way the Plan's equitable lien and right to reimbursement. The obligation to reimburse the Plan in full exists regardless of how the judgment or settlement is classified and whether or not the judgment or settlement specifically designates the recovery or a portion of it as including medical, disability, or other expenses and extends until the date upon which the liable party is released from liability. If the Participant's/Participants' recovery is less than the benefits paid, then the Plan is entitled to be paid all of the recovery achieved. Any funds received by the Participant are deemed held in constructive trust and should not be dissipated or disbursed until such time as the Participant's obligation to reimburse the Plan has been satisfied in accordance with these provisions. The Participant is also obligated to hold any and all funds so received in trust on the Plan's behalf and function as a trustee as it applies to those funds until the Plan's rights described herein are honored and the Plan is reimbursed.

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. Additionally, the Participant shall indemnify the Plan against any of the Participant's attorney's fees, costs, or other expenses related to the Participant's recovery for which the Plan becomes responsible by any means other than the Plan's explicit written consent.

The Plan's right of subrogation and reimbursement will not be reduced or affected as a result of any fault or claim on the part of the Participant(s), whether under the doctrines of causation, comparative fault or contributory negligence, or other similar doctrine in law. Accordingly, any lien reduction statutes, which attempt to apply such laws and reduce a subrogating Plan's recovery will not be applicable to the Plan and will not reduce the Plan's reimbursement rights.

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 Participant(s).

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, or disability.

Participant is a Trustee Over Plan Assets

Any Participant who receives benefits and is therefore subject to the terms of this section is hereby deemed a recipient and holder of Plan assets and is therefore deemed a trustee of the Plan solely as it relates to possession of any funds which may be owed to the Plan as a result of any settlement, judgment or recovery through any other means arising from any injury or accident. By virtue of this status, the Participant understands that he or she is required to:

1. 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.
2. Instruct his or her attorney to ensure that the Plan and/or its authorized representative is included as a payee on all settlement drafts.
3. In circumstances where the Participant is not represented by an attorney, instruct the insurance company or any third party from whom the Participant obtains a settlement, judgment or other source of Coverage to include the Plan or its authorized representative as a payee on the settlement draft.
4. 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.

To the extent the Participant disputes this obligation to the Plan under this section, the Participant or any of its agents or representatives is also required to hold any/all settlement funds, including the entire settlement if the settlement is less than the Plan's interests, and without reduction in consideration of attorneys' fees, for which he or she exercises control, in an account segregated from their general accounts or general assets until such time as the dispute is resolved.

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

Release of Liability

The Plan's right to reimbursement extends to any incident related care that is received by the Participant(s) (Incurred) prior to the liable party being released from liability. The Participant's/Participants' obligation to reimburse the Plan is therefore tethered to the date upon which the claims were Incurred, not the date upon which the payment is made by the Plan. In the case of a settlement, the Participant has an obligation to review the "lien" provided by the Plan and reflecting claims paid by the Plan for which it seeks reimbursement, prior to settlement and/or executing a release of any liable or potentially liable third party, and is also obligated to advise the Plan of any incident related care incurred prior to the proposed date of settlement and/or release, which is not listed but has been or will be incurred, and for which the Plan will be asked to pay.

Excess Insurance

Except as outlined in the "Effect on Benefits" provision in regard to any Other Plan, if at the time of Injury, Illness or disability there is available, or potentially available any Coverage (including but not limited to Coverage resulting from a judgment at law or settlements), the benefits under this Plan shall apply only as an excess over such other sources of Coverage, except as otherwise provided for under the Plan's Coordination of Benefits section.

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

1. The responsible party, its insurer, or any other guarantor 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, including any similar coverage under a different name in a particular state.
3. Any policy of insurance from any insurance company or guarantor of a responsible third party, including but not limited to an employer's policy.
4. Workers' compensation or other liability insurance company.
5. Any of the following:

a. Crime victim restitution funds
b. Civil restitution funds
c. No-fault restitution funds such as vaccine injury compensation funds
d. Any medical, applicable disability or other benefit payments
e. School insurance coverage.

Separation of Funds

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

Wrongful Death

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

Obligations

It is the Participant's/Participants' obligation at all times, both prior to and after payment of medical benefits by the Plan:

1. To cooperate with the Plan, or any representatives of the Plan, in protecting its rights, including discovery, attending depositions, and/or cooperating in trial to preserve the Plan's rights.
2. To provide the Plan with pertinent information regarding the Illness, disability, or Injury, including accident reports, settlement information and any other requested additional information.
3. To take such action and execute such documents as the Plan may require to facilitate enforcement of its subrogation and reimbursement rights.
4. To do nothing to prejudice the Plan's rights of subrogation and reimbursement.
5. To promptly reimburse the Plan when a recovery through settlement, judgment, award or other payment is received.
6. To notify the Plan or its authorized representative of any incident related claims or care which may be not identified within the lien (but has been Incurred) and/or reimbursement request submitted by or on behalf of the Plan.
7. To notify the Plan or its authorized representative of any settlement prior to finalization of the settlement.
8. To not settle or release, without the prior consent of the Plan, any claim to the extent that the Participant may have against any responsible party or Coverage.
9. To instruct his or her attorney to ensure that the Plan and/or its authorized representative is included as a payee on any settlement draft.
10. In circumstances where the Participant is not represented by an attorney, instruct the insurance company or any third party from whom the Participant obtains a settlement to include the Plan or its authorized representative as a payee on the settlement draft.
11. To make good faith efforts to prevent disbursement of settlement funds until such time as any dispute between the Plan and Participant over settlement funds is resolved.

If the Participant(s) and/or his or her attorney fails to reimburse the Plan for all benefits paid, to be paid, Incurred, or that will be Incurred, prior to the date of the release of liability from the relevant entity, as a result of said Injury or condition, out of any proceeds, judgment or settlement received, the Participant(s) will be responsible for any and all expenses (whether fees or costs) associated with the Plan's attempt to recover such money from the Participant(s).

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

Offset

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

Minor Status

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

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 with respect to this provision. The Plan Administrator may amend the Plan at any time without notice.

Severability

In the event that any section of this provision is considered invalid or illegal for any reason, said invalidity or illegality shall not affect the remaining sections of this provision and Plan. The section shall be fully severable. The Plan shall be construed and enforced as if such invalid or illegal sections had never been inserted in the Plan..

MISCELLANEOUS PROVISIONS

Clerical Error/Delay

Any clerical error by the Plan Administrator or an agent of the Plan Administrator in keeping pertinent records or a delay in making any changes to such records will not invalidate coverage otherwise validly in force or continue coverage validly terminated. Contributions made in error by Participants due to such clerical error will be returned to the Participant; coverage will not be inappropriately extended. Contributions that were due but not made, in error and due to such clerical error will be owed immediately upon identification of said clerical error. Failure to so remedy amounts owed may result in termination of coverage. Effective Dates, waiting periods, deadlines, rules, and other matters will be established based upon the terms of the Plan, as if no clerical error had occurred. An equitable adjustment of contributions will be made when the error or delay is discovered.

If, an overpayment occurs in a Plan reimbursement amount, the Plan retains a contractual right to the overpayment. The person or institution receiving the overpayment will be required to return the incorrect amount of money. In the case of a Participant, the amount of overpayment may be deducted from future benefits payable.

Conformity With Applicable Laws

Any provision of this Plan that is contrary to any applicable law, equitable principle, regulation or court order (if such a court is of competent jurisdiction) will be interpreted to comply with said law, or, if it cannot be so interpreted, shall be automatically amended to satisfy the law's minimum requirement, including, but not limited to, stated maximums, Exclusions, or statutes of limitations. It is intended that the Plan will conform to the requirements of ERISA, as it applies to Employee welfare plans, as well as any other applicable law.

Fraud

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

If a Participant, or any other entity, submits or attempts to submit a claim for or on behalf of a person who is not a Participant 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 Participant 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 Participant and their entire Family Unit of which the Participant 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 Participant whose coverage is being rescinded will be provided a 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. Participants are advised not to rely on any provision because of the heading.

Pronouns

Unless the context otherwise demands, words importing any gender shall be interpreted to mean any or all genders.

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.

No Waiver or Estoppel

All parts, portions, provisions, conditions, and/or other items addressed by this Plan shall be deemed to be in full force and effect, and not waived, absent an explicit written instrument expressing otherwise; executed by the Plan Administrator. Absent such explicit waiver, there shall be no estoppel against the enforcement of any provision of

this Plan. Failure by any applicable entity to enforce any part of the Plan shall not constitute a waiver, either as it specifically applies to a particular circumstance, or as it applies to the Plan's general administration. If an explicit written waiver is executed, that waiver shall only apply to the matter addressed therein, and shall be interpreted in the most narrow fashion possible.

Plan Contributions

The Plan Administrator 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 Participant.

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 Administrator'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.

Written Notice

Any written notice required under this Plan which, as of the Effective Date, is in conflict with the law of any governmental body or agency which has jurisdiction over this Plan shall be interpreted to conform to the minimum requirements of such law.

Statements

All statements made by the Company or by a Participant will, in the absence of fraud, be considered representations and not warranties, and no statements made for the purpose of obtaining benefits under this document will be used in any contest to avoid or reduce the benefits provided by the document unless contained in a written application for benefits and a copy of the instrument containing such representation is or has been furnished to the Participant.

Any Participant who knowingly and with intent to defraud the Plan, files a statement of claim containing any materially false information, or conceals for the purpose of misleading, information concerning any material fact, commits a fraudulent act. The Participant may be subject to prosecution by the United States Department of Labor. Fraudulently claiming benefits may be punishable by a substantial fine, imprisonment, or both.

Binding Arbitration

NOTE: The Employee is enrolled in a plan provided by the Employer that is subject to ERISA. Any dispute involving an Adverse Benefit Determination must be resolved under ERISA's claims procedure rules, and is not subject to mandatory binding arbitration. The individual may pursue voluntary binding arbitration after he or she has completed an appeal under ERISA. If the individual has any other dispute which does not involve an Adverse Benefit Determination, this Binding Arbitration provision applies.

Any dispute or claim, of whatever nature, arising out of, in connection with, or in relation to this Plan, or breach or rescission thereof, or in relation to care or delivery of care, including any claim based on contract, tort or statute, must be resolved by arbitration if the amount sought exceeds the jurisdictional limit of the small claims court. Any dispute regarding a claim for damages within the jurisdictional limits of the small claims court will be resolved in such court.

The Federal Arbitration Act shall govern the interpretation and enforcement of all proceedings under this Binding Arbitration provision. To the extent that the Federal Arbitration Act is inapplicable, or is held not to require arbitration of a particular claim, State law governing agreements to arbitrate shall apply.

The Participant and the Plan Administrator agree to be bound by this Binding Arbitration provision and acknowledge that they are each giving up their right to a trial by court or jury.

The Participant and the Plan Administrator agree to give up the right to participate in class arbitration against each other. Even if applicable law permits class actions or class arbitrations, the Participant waives any right to pursue, on a class basis, any such controversy or claim against the Plan Administrator and the Plan Administrator waives any right to pursue on a class basis any such controversy or claim against the Participant.

The arbitration findings will be final and binding except to the extent that State or Federal law provides for the judicial review of arbitration proceedings.

The arbitration is begun by the Participant making written demand on the Plan Administrator. The arbitration will be conducted by Judicial Arbitration and Mediation Services ("JAMS") according to its applicable Rules and Procedures. If, for any reason, JAMS is unavailable to conduct the arbitration, the arbitration will be conducted by another neutral arbitration entity, by mutual agreement of the Participant and the Plan Administrator, or by order of the court, if the Participant and the Plan Administrator cannot agree.

The costs of the arbitration will be allocated per the JAMS Policy on Consumer Arbitrations. If the arbitration is not conducted by JAMS, the costs will be shared equally by the parties, except in cases of extreme financial hardship, upon application to the neutral arbitration entity to which the parties have agreed, in which cases, the Plan Administrator will assume all or a portion of the costs of the arbitration.

SCHEDULE OF BENEFITS

General Limits

Payment for any of the expenses listed below is subject to all Plan Exclusions, limitations and provisions. All coverage figures, if applicable, are after the out of pocket Deductible has been satisfied.

See the Care Coordination and Utilization Management section for more information regarding Preauthorization and/or Notification requirements.

Network and Non-Network Provider Arrangement

The Plan contracts with medical Provider Networks to access discounted fees for service for Participants. Hospitals, Physicians and other Providers who have contracted with the medical Provider Networks are called "Network Providers." Those who have not contracted with the Networks are referred to in this Plan as "Non-Network Providers." This arrangement results in the following benefits to Participants:

1. The Plan provides different levels of benefits based on whether the Participants use a Network or Non-Network Provider. Unless one of the exceptions shown below applies, if a Participant elects to receive medical care from the Non-Network Provider, the benefits payable are generally lower than those payable when a Network Provider is used. The following exceptions apply:
    a. In the event a Network Provider refers a Participant to a Non-Network Provider for diagnostic testing, x-rays, laboratory services or anesthesia, then charges of the Non-Network Provider will be paid as though the services were provided by a Network Provider.
    b. The Network Provider level of benefits is payable when a Participant receives Emergency care either out-of-area or at a Non-Network Hospital for an Accident Bodily Injury or Emergency.
2. Except as outlined in "No Surprises Act – Emergency Services and Surprise Bills" below, if the charge billed by a Non-Network Provider for any covered service is higher than the Maximum Allowable Charge determined by the Plan, Participants are responsible for the excess unless the Provider accepts assignment of benefits as consideration in full for services rendered. Since Network Providers have agreed to accept a negotiated discounted fee as full payment for their services, Participants are not responsible for any billed amount that exceeds that fee. The Plan Administrator reserves the right to revoke any previously-given assignment of benefits or to proactively prohibit assignment of benefits to anyone, including any Provider, at its discretion.
3. To receive benefit consideration, Participants may need to submit claims for services provided by Non-Network Providers to the Third Party Administrator. Network Providers have agreed to bill the Plan directly, so that Participants do not have to submit claims themselves.
4. Benefits available to Network Providers are limited such that if a Network Provider advances or submits charges which exceed amounts that are eligible for payment in accordance with the terms of the Plan, or are for services or supplies for which Plan coverage is not available, or are otherwise limited or excluded by the Plan, benefits will be paid in accordance with the terms of the Plan.

Please note affirmation that a treatment, service, or supply is of a type compensable by the Plan is not a guarantee that the particular treatment, service, or supply in question, upon receipt of a Clean Claim and review by the Plan Administrator, will be eligible for payment. Except as otherwise specified in this Plan, determinations for Non-Network providers will be made under the Plan's Claim Review and Audit Program, and covered expenses will be the amount of Allowable Claim Limits.

Balance Billing

In the event that a claim submitted by a Network or Non-Network Provider is subject to a medical bill review or medical chart audit and that some or all of the charges in connection with such claim are repriced because of billing errors and/or overcharges, it is the Plan's position that the Participant should not be responsible for payment of any charges denied as a result of the medical bill review or medical chart audit, and should not be balance billed for the difference between the billed charges and the amount determined to be payable by the Plan Administrator. However, balance billing is legal in many situations, and the Plan has no control over Non-Network Providers that engage in balance billing practices.

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

in balance billing practices, except to the extent that such practices are contrary to the contract governing the relationship between the Plan and the Network Provider.

The Participant is responsible for any applicable payment of Coinsurances, Deductibles, and out-of-pocket maximums and may be billed for any or all of these.

Choice of Providers

The Plan is not intended to disturb the Physician-patient relationship. Each Participant 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 Participant remains the sole prerogative and responsibility of the attending Physician or other health care Provider. The Participant, 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.

Claims Audit

In addition to the Plan's Medical Record Review process, the Plan Administrator may use its discretionary authority to utilize an independent bill review and/or claim audit program or service for a complete claim. While every claim may not be subject to a bill review or audit, the Plan Administrator has the sole discretionary authority for selection of claims subject to review or audit.

The analysis will be employed to identify charges billed in error and/or charges that exceed the Maximum Allowable Charge or services that are not Medically Necessary and may include a patient medical billing records review and/or audit of the patient's medical charts and records.

Upon completion of an analysis, a report will be submitted to the Plan Administrator or its agent to identify the charges deemed in excess of the Maximum Allowable Charge or other applicable provisions, as outlined in this Plan Document.

Despite the existence of any agreement to the contrary, the Plan Administrator has the discretionary authority to reduce any charge to the Maximum Allowable Charge, in accord with the terms of this Plan Document.

Continuity of Care

In the event a Participant is a continuing care patient receiving a course of treatment from a Provider which is In-Network or otherwise has a contractual relationship with the Plan governing such care and that contractual relationship is terminated, not renewed, or otherwise ends for any reason other than the Provider's failure to meet applicable quality standards or for fraud, the Participant shall have the following rights to continuation of care.

The Plan shall notify the Participant in a timely manner, but in no event later than 14 calendar days after termination that the Provider's contractual relationship with the Plan has terminated, and that the Participant has rights to elect continued transitional care from the Provider. If the Participant elects in writing to receive continued transitional care, Plan benefits will apply under the same terms and conditions as would be applicable had the termination not occurred, beginning on the date the Plan's notice of termination is provided and ending 90 days later or when the Participant ceases to be a continuing care patient, whichever is sooner.

For purposes of this provision, "continuing care patient" means an individual who:

1. is undergoing a course of treatment for a serious and complex condition from a specific Provider,
2. is undergoing a course of institutional or Inpatient care from a specific Provider,
3. is scheduled to undergo non-elective surgery from a specific Provider, including receipt of postoperative care with respect to the surgery,
4. is pregnant and undergoing a course of treatment for the Pregnancy from a specific Provider, or
5. is or was determined to be terminally ill and is receiving treatment for such illness from a specific Provider.

Note that during continuation, Plan benefits will be processed as if the termination had not occurred, however, the Provider may be free to pursue the Participant for any amounts above the Plan's benefit amount.

No Surprises Act – Emergency Services and Surprise Bills

For Non-Network claims subject to the No Surprises Act ("NSA"), Participant cost-sharing will be the same amount as would be applied if the claim was provided by a Network Provider and will be calculated as if the Plan's Allowable Expense was the Recognized Amount, regardless of the Plan's actual Maximum Allowable Charge. The NSA prohibits Providers from pursuing Participants for the difference between the Maximum Allowable Charge and the Provider's billed charge for applicable services, with the exception of valid Plan-appointed cost-sharing as outlined above. Any such cost-sharing amounts will accrue toward In-Network Deductibles and out of pocket maximums.

Benefits for claims subject to the NSA will be denied or paid within 30 days of receipt of an initial claim, and if approved will be paid directly to the Provider.

Claims subject to the NSA are those which are submitted for:

1. Emergency Services;
2. Non-emergency services rendered by a Non-Network Provider at a Participating Health Care Facility, provided the Participant has not validly waived the applicability of the NSA; and
3. Covered Non-Network air ambulance services.

MEDICAL SCHEDULE OF BENEFITS - OPEN ACCESS Plan

Benefit Level	Ardent Network (Tier 1)	ADP Network (Tier 2)	Non-Network (Tier 3)	
Annual Deductible Per Calendar Year Excluding The Prescription Benefit Deductible: • Per Person • Per Family **Note: If You Have Family Coverage, Any Combination Of Covered Family Members May Help Meet The Maximum Family Deductible; However, No One Person Will Pay More Than His Or Her Individual Deductible Amount.**	 $500 $1,000	 $1,000 $2,000	 $2,500 $5,000	
Plan Participation Rate, Unless Otherwise Stated Below: • Paid By Plan After Satisfaction Of Deductible	90%	80%	70%	
Annual Total Out-Of-Pocket Maximum: **Note: Medical And Pharmacy Expenses Are Subject To The Same Out-Of-Pocket Maximum.** • Per Person • Per Family **Note: If You Have Family Coverage, Any Combination Of Covered Family Members May Help Meet The Family Out-Of-Pocket Maximum; However, No One Person Will Pay More Than His Or Her Individual Out-Of-Pocket Amount.**	 $2,000 $4,000	 $3,900 $7,800	 $5,400 $10,800	
Ambulance Transportation: • Paid By Plan After Deductible	90%	80%	70%	
Breast Pumps: • Paid By Plan (Deductible Waived)	100%	100%	100%	
Contraceptive Methods And Contraceptive Counseling Approved By The FDA: • Paid By Plan (Deductible Waived)	100%	100%	100%	
Diabetes Education • Paid By Plan After Deductible	90%	80%	70%	
Dialysis • Paid By Plan After Deductible	90% Subject to a maximum of 200% of Medicare allowable rate for treatment in the Access Direct Platinum Network	80% Subject to a maximum of 200% of Medicare allowable rate for treatment in the Access Direct Platinum Network	70%	
Durable Medical Equipment: • Paid By Plan After Deductible	90%	80%	70%	
Urgent Services / Treatment: **Urgent Care:** • Co-pay Per Visit • Paid By Plan (Deductible Waived)	 $0 100%	 $40 100%	 $60 100%	

Walk-In Retail Health Clinics:				
• Co-pay Per Visit (Primary Care)	$25	$40	$60	
• Paid By Plan (Deductible Waived)	100%	100%	100%	
Emergency Room Only:				
• Co-pay Per Visit (Waived If Admitted As Inpatient Within 24 Hours)	$150	$300	$350	
• Paid By Plan (Deductible Waived)	100%	100%	100%	
Emergency Physicians Only:				
• Paid By Plan (Deductible Waived)	100%	100%	100%	
Extended Care Facility Benefits, Such As Skilled Nursing, Convalescent, Or Subacute Facility				
• Maximum Days Per Calendar Year		60 Days		
• Paid By Plan After Deductible	90%	80%	70%	
Hearing Services:				
Exams, Tests:				
• Paid By Plan After Deductible	90%	80%	70%	
Hearing Aids:				
• Maximum Benefit Per Calendar Year		$2,500		
• Paid By Plan After Deductible	90%	80%	70%	
Implantable Hearing Devices:				
• Paid By Plan After Deductible	90%	80%	70%	
Home Health Care Benefits:				
• Maximum Visits Per Calendar Year		100 Visits		
• Paid By Plan After Deductible	90%	80%	70%	
Note: A Home Health Care Visit Will Be Considered A Periodic Visit By A Nurse, Qualified Therapist, Or Qualified Dietician, Or Up To Four Hours Of Home				
Hospice Care Benefits:				
Hospice Services:				
• Paid By Plan After Deductible	90%	80%	70%	
Bereavement Counseling:				
• Paid By Plan After Deductible	90%	80%	70%	
Respite Care:				
• Paid By Plan After Deductible	90%	80%	70%	
Hospital Services:				
Pre-Admission Testing:				
• Paid By Plan After Deductible	90%	80%	70%	
Inpatient Services Only:				
• Paid By Plan After Deductible	90%	80%	70%	
Inpatient Physician Charges Only:				
• Paid By Plan After Deductible	90%	80%	70%	
Outpatient Services Only:				
• Paid By Plan After Deductible	90%	80%	70%	
Outpatient Physician Charges Only:				
• Paid By Plan After Deductible	90%	80%	70%	
Outpatient Advanced Imaging Charges: **All Outpatient Advanced Imaging done within Smith County must be done at UT Health**				

• Paid By Plan After Deductible	90%	80%	70%	
Outpatient Lab And X-Ray Charges Only:				
• Co-pay Per Visit	$25	$35	$75	
• Paid By Plan (Deductible Waived)	100%	100%	100%	
Outpatient Surgery Only:				
• Paid By Plan After Deductible	90%	80%	70%	
Outpatient Surgeon Charges Only:				
• Paid By Plan After Deductible	90%	80%	70%	
Manipulations:				
• Co-pay Per Visit	$30	$45	$60	
• Maximum Visits Per Calendar Year		20 Visits		
• Paid By Plan (Deductible Waived)	100%	100%	100%	
Visit Maximums Are Applied Based On Provider Designation And Procedure Code (If A Provider Bills For A Manipulation And A Therapy On The Same Claim, Only One Visit Will Be Applied To The Manipulation Maximum Based On The Provider's Designation).				
Maternity:				
Routine Prenatal Services:				
• Paid By Plan (Deductible Waived)	100%	100%	100%	
Non-Routine Prenatal Services, Delivery, And Postnatal Care:				
• Paid By Plan After Deductible	90%	80%	70%	
Mental Health, Substance Use Disorder:				
Inpatient Services Only:				
• Paid By Plan After Deductible	90%	80%	70%	
Inpatient Physician Charges Only:				
• Paid By Plan After Deductible	90%	80%	70%	
Residential Services Only:				
• Paid By Plan After Deductible	90%	80%	70%	
Residential Physician Charges Only:				
• Paid By Plan After Deductible	90%	80%	70%	
Outpatient Or Partial Hospitalization Services Only:				
• Paid By Plan After Deductible	90%	80%	70%	
Outpatient Or Partial Hospitalization Physician Charges Only:				
• Paid By Plan After Deductible	90%	80%	70%	
Office Visit:				
• Co-pay Per Visit (Primary Care Physician)	$0	$30	$40	
• Paid By Plan (Deductible Waived)	100%	100%	100%	
Morbid Obesity Treatment:				
• Paid By Plan After Deductible	90%	80%	70%	
Bariatric Surgery:				

• Co-pay	$2,500 (Does Not Apply to Out-Of-Pocket Maximum	Benefit Not Applicable. Benefit Is Limited To Tier 1 Providers	Benefit Not Applicable. Benefit Is Limited To Tier 1 Providers Only.	
• Maximum Benefit Per Lifetime	1 Surgery			
• Paid By Plan After Deductible	100%			
Note: Covered After One Year Of Being Eligible And Enrolled In The Medical Plan.				
Weight Loss Program:				
• Paid By Plan After Deductible	100%	80%	70%	
Diagnostic Services:				
• Paid By Plan After Deductible	100%	80%	70%	
Nutritional Counseling:				
• Paid By Plan After Deductible	100%	80%	70%	
Physician Office Services:				
• Co-pay Per Visit – Primary Care Physician	$0	$30	$40	
• Co-pay Per Visit – Specialist	$0	$45	$60	
• Paid By Plan (Deductible Waived)	100%	100%	100%	
Allergy Injections				
• Paid By Plan (Deductible Waived)	100%	100%	100%	
Allergy Serum:				
• Paid By Plan (Deductible Waived)	100%	100%	100%	
Diagnostic X-Ray And Laboratory:				
• Paid By Plan (Deductible Waived)	100%	100%	100%	
Advanced Office Imaging: **All Outpatient Advanced Imaging done within Smith County must be done at UT Health**				
• Paid By Plan After Deductible	90%	80%	70%	
Preventive / Routine Care Benefits. See Glossary Of Terms For Definition. Benefits Include:				
Preventive/Routine Physical Exams At Appropriate Ages:				
• Paid By Plan (Deductible Waived)	100%	100%	100%	
Immunizations:				
• Paid By Plan (Deductible Waived)	100%	100%	100%	
Preventive / Routine Diagnostic Tests, Lab, And X-Rays At Appropriate Ages:				
• Paid By Plan (Deductible Waived)	100%	100%	100%	
Preventive / Routine Mammograms And Breast				
• Maximum Exams Per Calendar Year			1 Exam	
• Paid By Plan (Deductible Waived)	100%	100%	100%	
3D Mammograms For Preventive Screenings:				

• Maximum Exams Per Calendar Year			1 Exam	
• Paid By Plan (Deductible Waived)	100%	100%	100%	
3D Mammograms For Diagnosis / Treatment Of A Covered Medical Benefit:				
• Maximum Exams Per Calendar Year			1 Exam	
• Paid By Plan After Deductible	90%	80%	70%	
Preventive / Routine Pelvic Exams And Pap Tests:				
• Maximum Exams Per Calendar Year			1 Exam	
• Paid By Plan (Deductible Waived)	100%	100%	100%	
Preventive / Routine PSA Test & Prostate Exams:				
• Maximum Exams Per Calendar Year			1 Exam	
• Paid By Plan (Deductible Waived)	100%	100%	100%	
Preventive / Routine Screenings / Services At Appropriate Ages And Gender:				
• Paid By Plan (Deductible Waived)	100%	100%	100%	
Preventive / Routine Colonoscopies, Sigmoidoscopies, And Similar Routine Surgical Procedures Performed For Preventive Reasons:				
• Paid By Plan (Deductible Waived)	100%	100%	100%	
Preventive / Routine Hearing Exams:				
• Paid By Plan (Deductible Waived)	100%	100%	100%	
Preventive / Routine Counseling For Alcohol Or Substance Use Disorder, Tobacco Use, Obesity, Diet, And Nutrition:				
• Paid By Plan (Deductible Waived)	100%	100%	100%	
In Addition, The Following Preventive / Routine Services Are Covered For Women:				
• Treatment For Gestational Diabetes				
• Papillomavirus DNA Testing*				
• Counseling For Sexually Transmitted Infections (Provided Annually)*				
• Counseling For Human Immune- Deficiency Virus (Provided Annually)*				
• Breastfeeding Support, Supplies, And Counseling				
• Counseling For Interpersonal And Domestic Violence Provided Annually)*				
• Paid By Plan (Deductible Waived)	100%	100%	100%	
***These Services May Also Apply To Men.**				
Expanded Preventive List For Specific Chronic Conditions – Refer To The Covered Medical Benefits Section For Details:				
• Antiresorptive Therapy For Diagnosis Of Osteoporosis And/Or Osteopenia				
• Retinopathy Screening, Glucometer, Hemoglobin A1C Testing For Diagnosis of Diabetes				
• Peak Flow Meter And Inhaled Corticosteroids For Diagnosis Of Asthma				
• International Normalization Ration (INR) Testing For Diagnosis Of Liver Disease And/Or Bleeding				
• Low-Density Lipoprotein (LDL) Testing For Diagnosis of Heart Disease				

• Beta-Blockers For Diagnosis of Congestive Heart Failure • Paid By Plan (Deductible Waived)	100%	100%	100%	
Sterilizations: • Paid By Plan (Deductible Waived)	100%	100%	100%	
Teladoc Services: Note - multiple copays apply when multiple claims are billed on the same date of service				
• Co-pay per Visit – General Medicine			$30	
• Co-pay per Visit – Dermatology			$45	
• Co-pay per Visit – Behavioral Health			$30	
• Paid By Plan After Co-Pay (Deductible Waived)			100%	
Telemedicine Or Telephone Consultations • Co-pay Per Visit – Primary Care • Co-pay Per Visit – Specialty • Paid By Plan (Deductible Waived)	$0 $0 100%	$30 $45 100%	$40 $60 100%	
Therapy Services: OT/PT/ST- Combined 50 Maximum visits per calendar year **Occupational / Physical Outpatient Hospital And Office Therapy:** • Co-pay Per Visit • Paid By Plan (Deductible Waived)	$30 100%	$45 100%	$60 100%	
Speech Outpatient Hospital And Office Therapy: • Co-pay Per Visit • Paid By Plan (Deductible Waived)	$30 100%	$45 100%	$60 100%	
Cardiac Rehab Outpatient Hospital And Office Therapy: • Co-pay Per Visit • Paid By Plan (Deductible Waived)	$20 100%	$30 100%	$40 100%	
Wigs (Cranial Prostheses), Toupees, Or Hairpieces Related To Cancer Treatment And Alopecia Areata: • Maximum Benefit Per Eligible Condition Per Calendar Year	1 Wig (Cranial Prosthesis), Toupee, Or Hairpiece Up To $500			
• Paid By Plan After Deductible	90%	80%	70%	
All Other Covered Expenses: • Paid By Plan After Deductible	90%	80%	70%	

SUMMARY OF BENEFITS

These medical benefits will be payable as shown in the Summary of Benefits or as otherwise outlined in this Plan. Subject to the Plan's provisions, limitations and Exclusions, the following are covered major medical benefits:

Important: Prior authorization may be required before benefits will be considered for payment. Failure to obtain prior authorization may result in a penalty or increased out-of-pocket costs. Refer to the Care Management section of this SPD for a description of these services and prior authorization procedures.

3D Mammograms for the diagnosis and treatment of a covered medical benefit or for preventive screenings as described under the Preventive / Routine Care Benefits

Advanced Imaging. Charges for advanced imaging including: Computed Tomographic (CT) studies, Coronary CT angiography, MRI/MRA, nuclear cardiology, nuclear medicine, and PET scans. Covered Expenses include the readings of these medical tests/scans. These specific imaging procedures within Smith County must be performed at UT Health East Texas to be considered allowable.

Allergy Services. Charges related to the treatment of allergies to include injections, testing and serum.

Air Ambulance (Emergency Only).
Benefits are provided for air ambulance transportation only if the Plan Administrator determines that the Participant's condition, the type of service required for the treatment of the Participant's condition, and the type of facility required to treat the Participant's condition justify the use of air ambulance instead of another means of transport. This Plan will only cover air ambulance transportation when no other method of transportation is appropriate (including emergency ground transport).

This Plan will cover rotary and fixed wing aircraft, excluding all fixed wing charter flights, for air ambulance services.
The determination of whether air ambulance transport for 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.

Ambulance (Emergency Only). Covered Expenses for professional ambulance, including approved available water and rail transportation, to a local Hospital or transfer to the nearest facility having the capability to treat the condition, if the transportation is connected with an Inpatient confinement.

Ambulatory Surgical Center. Services of an Ambulatory Surgical Center for Medically Necessary care provided.

Anesthesia. Anesthesia, anesthesia supplies, and administration of anesthesia by facility staff.

Aquatic Therapy. (See Therapy Services Below.)

Augmentation Communication Devices and related instruction or therapy.

Autism Spectrum Disorders (ASD) Treatment, when Medical Necessity is met.
(ASD includes Autistic Disorder, Asperger's Syndrome, Childhood Disintegrative Disorder, Rett Syndrome and Pervasive Developmental Disorders.)

ASD treatment may include any of the following services: diagnosis and assessment; psychological, psychiatric, and pharmaceutical (medication management) care; speech therapy, occupational therapy, and physical therapy; or Applied Behavioral Analysis (ABA) therapy.
Treatment is prescribed and provided by a licensed healthcare professional practicing within the scope of

his or her license (if ABA therapy, preferably a Board Certified Behavior Analyst, or BCBA).

Treatment is subject to all other Plan provisions as applicable (such as Prescription benefit coverage, behavioral/mental health coverage, and/or coverage of therapy services).

Coverage does not include services or treatment identified elsewhere in the Plan as non-covered or excluded (such as Experimental, Investigational, or Unproven treatment, Custodial Care, nutritional or dietary supplements, or educational services that should be provided through a school district).

Birthing Center. Services of a birthing center for Medically Necessary care provided within the scope of its license.

Breast Pumps and related supplies. Benefits for breast pumps include the cost of purchasing one breast pump per pregnancy in conjunction with childbirth and in accordance with federal preventative guidelines.

Breast Reductions if Medically Necessary.

Breastfeeding Support, Supplies, and Counseling in conjunction with each birth. The Plan also covers comprehensive lactation support and counseling by a trained provider during pregnancy and in the postpartum period, and costs for renting breastfeeding equipment.

Cardiac Pulmonary Rehabilitation when Medically Necessary for Activities of Daily Living (see the Glossary of Terms) and when needed as a result of an Illness or Injury.

Cardiac Rehabilitation programs (when Medically Necessary), if referred by a Physician, for patients who have certain cardiac conditions including, but not limited to, the following:

1. the Covered Person had a heart attack in the last 12 months; or
2. the Covered Person had coronary bypass surgery; or
3. the Covered Person had a stable angina pectoris.
4.

Covered services include:

1. Phase I cardiac rehabilitation, while the Covered Person is an Inpatient.
2. Phase II cardiac rehabilitation, while the Covered Person is in a Physician-supervised Outpatient, monitored, low-intensity exercise program. Services generally will be in a Hospital rehabilitation facility and include monitoring of the Covered Person's heart rate and rhythm, blood pressure, and symptoms by a health professional. Phase II generally begins within 30 days after discharge from the Hospital.

Cataract or Aphakia Surgery as well as surgically implanted conventional intraocular cataract lenses following such a procedure. Multifocal intraocular lenses are not allowable. Eye refractions and one set of contact lenses or glasses (frames and lenses) after cataract surgery are also covered.

Circumcision and related expenses when care and treatment meet the definition of Medical Necessity. Circumcision of newborn males is also covered as stated under nursery and newborn medical benefits.

Cleft Palate and Cleft Lip, including Medically Necessary oral surgery and pre-graft palatal expanders.

Chemotherapy. Charges for chemotherapy, including materials and services of technicians.

Chiropractic Care. Spinal adjustment and manipulation x-rays for manipulation and adjustment and other modalities performed by a Physician or other licensed practitioner, as limited in the Summary of Benefits, as applicable.

Cochlear Implants. Charges for cochlear implants for Participants who are certified as deaf or hearing

impaired by a Provider.

Contraceptives. The charges for all Food and Drug Administration (FDA) approved contraceptives methods, except oral contraceptives, in accordance with Health Resources and Services Administration (HRSA) guidelines. **NOTE:** Oral contraceptives are covered under the Prescription Drug Benefits section. Prescription contraceptives that require that a Physician administer a hormone shot or insert a device will be processed under the Covered Medical Benefits in this SPD.

Cornea Transplants are payable at the percentage listed under "All Other Covered Expenses" on the Schedule of Benefits.

Dental Services—Accident Only. Charges made for a continuous course of dental treatment started within 12 months from the date of the Injury to sound natural teeth. Sound natural teeth are defined as natural teeth that are free of active clinical decay, have at least 50% bony support and are functional in the arch. Inpatient or Outpatient Hospital charges, including professional services for X-rays, laboratory services, and anesthesia while in the Hospital, if Medically Necessary. Removal of all teeth at an Inpatient or Outpatient Hospital or dentist's office if removal of the teeth is part of standard medical treatment that is required before the Covered Person can undergo radiation therapy for a covered medical condition.
Note: No charge will be covered under this Plan for dental and oral Surgical Procedures involving orthodontic care of teeth, periodontal disease, and preparing the mouth for fitting of or continued use of dentures.

Diabetic Education. Charges Incurred for the treatment of diabetes and diabetic self- management education programs, diabetic shoes and nutritional counseling.

Dialysis. Charges for dialysis treatment of acute renal failure or chronic irreversible renal insufficiency for the removal of waste materials from the body, including hemodialysis and peritoneal dialysis. Coverage also includes use of equipment or supplies, unless covered through the Prescription Drug Benefits section. Charges are paid the same for any other Illness. Dialysis charges will be subject to a maximum of 200% of Medicare allowable rate for treatment in the Access Direct Platinum network.

Durable Medical Equipment. The equipment must meet the definition of Durable Medical Equipment in the Glossary of Terms. Examples include, but are not limited to, crutches, wheelchairs, Hospital-type beds, and oxygen equipment.
The equipment must be prescribed by a Physician.
The equipment will be provided on a rental basis when available; however, such equipment may be purchased at the Plan's option. Any amount paid to rent the equipment will be applied toward the purchase price. In no case will the rental cost of Durable Medical Equipment exceed the purchase price of the item.
The Plan will pay benefits for only ONE of the following: a manual wheelchair, motorized wheelchair or motorized scooter, unless necessary due to the growth of the person or if changes to the person's medical condition require a different product, as determined by the Plan.
If the equipment is purchased, benefits may be payable for subsequent repairs excluding batteries, or replacement only if required:

1. due to the growth or development of a Dependent Child;
2. because of a change in the Covered Person's physical condition; or
3. because of deterioration caused from normal wear and tear.
   The repair or replacement must also be recommended by the attending Physician. In all cases, repairs or replacement due to abuse or misuse, as determined by the Plan, are not covered, and replacement is subject to prior approval by the Plan.
4. This Plan covers taxes and shipping and handling charges for Durable Medical Equipment.

Emergency Room Hospital and Physician Services, including Emergency room services for stabilization or initiation of treatment of a medical Emergency condition provided on an Outpatient basis at a Hospital, as shown in the Schedule of Benefits.
Charges will be paid under the applicable diagnostic code. The following services are covered:

1. Room and board.
2. Miscellaneous services, supplies, and treatments provided by an Extended Care Facility, including Inpatient rehabilitation.

Eye Refractions if related to a covered medical condition.

Foot Disorders. Surgical treatment of foot disorders, including associated services, performed by a licensed Physician (excluding routine foot care).

Gender Dysphoria:
Benefits for the treatment of Gender Dysphoria, limited to the following services:

1. Psychotherapy for Gender Dysphoria and associated co-morbid psychiatric diagnoses as described in the Mental Health Benefits section of this SPD.
2. Cross-sex hormone therapy:
    - Cross-sex hormone therapy administered by a medical provider (for example, during an office visit) as described in the Mental Health Benefits section of this SPD.
    - Cross-sex hormone therapy dispensed from a pharmacy as described in the Prescription Drug Benefits section of this SPD.
3. Puberty-suppressing medication injected or implanted by a medical provider in a clinical setting.
4. Laboratory testing to monitor the safety of continuous cross-sex hormone therapy.
5. Travel and Lodging benefits up to $2,000 yearly maximum associated with travel for covered services performed by a network provider to support members with limited provider availability for services in their immediate area.
6. Surgery for the treatment of Gender Dysphoria, including the surgeries listed below as medically appropriate:

    - Clitoroplasty (creation of clitoris)
    - Labiaplasty (creation of labia)
    - Orchiectomy (removal of testicles)
    - Penectomy (removal of penis)
    - Urethroplasty (reconstruction of female urethra)
    - Vaginoplasty (creation of vagina)
    - Bilateral mastectomy or breast reduction
    - Breast augmentation
    - Hysterectomy (removal of uterus)
    - Metoidioplasty (creation of penis, using clitoris)
    - Penile prosthesis
    - Phalloplasty (creation of penis)
    - Salpingo-oophorectomy (removal of fallopian tubes and ovaries)
    - Scrotoplasty (creation of scrotum)
    - Testicular prosthesis
    - Urethroplasty (reconstruction of male urethra)
    - Vaginectomy (removal of vagina)
    - Vulvectomy (removal of vulva)
    - Tracheal shave
    - Voice modification surgery
    - Voice modification therapy

Genital Surgery and Bilateral Mastectomy or Breast Reduction Surgery Documentation Requirements:

The Covered Person must provide documentation of the following for breast surgery:

1. A written psychological assessment from at least one Qualified behavioral health provider experienced in treating Gender Dysphoria. The assessment must document that the Covered

Person meets all of the following criteria:

- The Covered Person has experienced persistent, well-documented Gender Dysphoria.
- The Covered Person has the capacity to make a fully informed decision and to consent to treatment.
- The Covered Person must be 18 years of age or older.

If significant medical or mental health concerns are present, they must be reasonably well controlled.

The Covered Person must provide documentation of the following for genital surgery:

1. A written psychological assessment from at least two Qualified behavioral health providers experienced in treating Gender Dysphoria who have independently assessed the Covered Person. The assessment must document that the Covered Person meets all of the following criteria:

    - The Covered Person has experienced persistent, well-documented Gender Dysphoria.
    - The Covered Person has the capacity to make a fully informed decision and to consent to treatment.
    - The Covered Person must be 18 years of age or older.
    - If significant medical or mental health concerns are present, they must be reasonably well controlled.
    - The Covered Person must complete at least 12 months of successful, continuous, full-time, real-life experience in the desired gender.
    - The Covered Person must complete 12 months of continuous cross-sex hormone therapy appropriate for the desired gender (unless medically contraindicated).

2. The treatment plan must be based on identifiable external sources, including the World Professional Association for Transgender Health (WPATH) standards, and/or evidence-based professional society guidance.

Genetic Counseling based on Medical Necessity.

Genetic Testing for services related to Preventative and Wellness Services as specified by the Affordable Care Act of 2021.or when Medically Necessary (see below).
Genetic testing MUST meet the following requirements:
The test must not be considered Experimental, Investigational, or Unproven. The test must be performed by a CLIA-certified laboratory. The test result must directly impact or influence the disease treatment of the Covered Person. In some cases, testing may be accompanied with pre- test and post-test counseling. Genetic testing must also meet at least one of the following:

1. The patient has current signs and/or symptoms (i.e., the test is being used for diagnostic purposes).
2. Conventional diagnostic procedures are inconclusive.
3. The patient has risk factors or a particular family history that indicates a genetic cause.
4. The patient meets defined criteria that place him or her at high genetic risk for the condition.

Generally, genetic testing is not covered for:

1. Population screening without a personal or family history, with the exception of preconception or prenatal carrier screening for certain conditions, such as cystic fibrosis, Tay-Sachs disease, sickle cell disease, and other hemoglobinopathies
2. Informational purposes alone (e.g., testing of minors for adult-onset conditions and self-referrals or home testing)
3. Experimental, Investigational, or Unproven purposes.

Habilitative Services. These services include:

1. **Applied Behavior Analysis (ABA) Therapy.** Charges for ABA therapy for treatment of Autism Spectrum Disorder (ASD).
2. **Occupational Therapy.** Treatment or services rendered by a registered occupational therapist, under the direct supervision of a Physician, in a home setting or at a facility or Institution whose primary purpose is to provide medical care for an Illness or Injury, or at a free standing outpatient facility.
3. **Physical Therapy.** Treatment or services rendered by a physical therapist, under direct supervision of a Physician, in a home setting or a facility or Institution whose primary purpose is to provide medical care for an Illness or Injury, or at a free standing duly licensed outpatient therapy facility.
4. **Speech-Language Pathology.** Treatment for speech delays and disorders.

See the Summary of Benefits for treatment and/or frequency limitations, as applicable.

Hearing Aids. Charges for hearing aids, which includes examinations for the prescription, fitting, and/or repair of hearing aids and implantable hearing devices.

Home Health Care. Home Health Care services are provided for patients when Medically Necessary, as determined by the Utilization Review Organization.
Prior authorization may be required before receiving services. Please refer to the Care Management section of this SPD for more details. Covered services may include:

1. Home visits instead of visits to the provider's office that do not exceed the maximum allowable under this Plan.
2. Intermittent nurse services. Benefits are paid for only one nurse at any one time, not to exceed 4 hours per 24-hour period.
3. Nutrition counseling provided by or under the supervision of a Qualified dietician or other Qualified Provider, if applicable.
4. Physical, occupational, respiratory, and speech therapy provided by or under the supervision of a Qualified therapist or other Qualified Provider, if applicable.
5. Medical supplies, drugs, laboratory services, or medication prescribed by a Physician.

A Home Health Care Visit is defined as a visit by a nurse providing intermittent nurse services (each visit includes up to a 4-hour consecutive visit in a 24-hour period if Medically Necessary) or a single visit by a Qualified therapist, Qualified dietician, or other Qualified Provider, if applicable.
Exclusions: In addition to the items listed in the General Exclusions section, benefits will NOT be provided for any of the following:

1. Homemaker or housekeeping services.
2. Supportive environment materials such as handrails, ramps, air conditioners, and telephones.
3. Services performed by family members or volunteer workers.
4. "Meals on Wheels" or similar food service.
5. Separate charges for records, reports, or transportation.
6. Expenses for the normal necessities of living, such as food, clothing, and household supplies.
7. Legal and financial counseling services, unless otherwise covered under this Plan.

Hospice Care Services: Treatment given at a Hospice Care facility must be in place of a stay in a Hospital or Extended Care Facility, and may include:

1. **Assessment,** which includes an assessment of the medical and social needs of the Terminally Ill person and a description of the care required to meet those needs.
2. **Inpatient Care** in a facility when needed for pain control and other acute and chronic symptom management, psychological and dietary counseling, physical or occupational therapy, and part- time Home Health Care services.

3. **Outpatient Care,** which provides or arranges for other services related to the Terminal Illness, including the services of a Physician or Qualified physical or occupational therapist or nutrition counseling services provided by or under the supervision of a Qualified dietician.
4. **Respite Care** to provide temporary relief for up to 80 hours of respite care per hospice care period to the family or other caregivers in the case of an Emergency or to provide temporary relief from the daily demands of caring for a Terminally Ill person.
5. **Bereavement Counseling:** services that are received by a Covered Person's Close Relative when directly connected to the Covered Person's death and the charges for which are bundled with other hospice charges. Counseling services must be provided by a Qualified social worker, Qualified pastoral counselor, Qualified psychologist, Qualified psychiatrist, or other Qualified Provider, if applicable. The services must be furnished within twelve months of death.

The Covered Person must be Terminally Ill with an anticipated life expectancy of about six months. However, services are not limited to a maximum of six months if continued Hospice Care is deemed appropriate by the Physician, up to the maximum hospice benefits available under the Plan.

Hospital Based Clinics: Hospital Outpatient Department charges affiliated with physician services in an Ardent hospital-based provider clinic will be covered with no patient responsibility.

Hospital Services (Including Inpatient Services, Surgical Centers, and Inpatient Birthing Centers). The following services are covered:

1. Semi-private room and board. For Network charges, this rate is based on Network re-pricing. For non-Network charges, any charge over a semi-private room charge will be a Covered Expense only if determined by the Plan to be Medically Necessary. If the Hospital has no semi- private rooms, the Plan will allow the private room rate, subject to the Maximum Allowable Charge, or the Negotiated Rate, whichever is applicable.
2. Intensive care unit room and board.
3. Miscellaneous and Ancillary Services.
4. Blood, blood plasma, and plasma expanders, when not available without charge.

Observation in a Hospital room will be considered Inpatient treatment if the duration of the observation status exceeds 72 hours. Observation means the use of appropriate monitoring, diagnostic testing, treatment, and assessment of patient symptoms, signs, laboratory tests, and response to therapy for the purpose of determining whether a patient will require further treatment as an Inpatient or can be discharged from the Hospital setting.

Hospital Services (Outpatient).
Observation in a Hospital room will be considered Outpatient treatment if the duration of the observation status is 72 hours or less. Observation means the use of appropriate monitoring, diagnostic testing, treatment, and assessment of patient symptoms, signs, laboratory tests, and response to therapy for the purpose of determining whether a patient will require further treatment as an Inpatient or can be discharged from the Hospital setting.

Infant Formula administered through a tube as the sole source of nutrition for the Covered Person.

Infertility Treatment to the extent required to treat or correct underlying causes of infertility, when such treatment is Medically Necessary and cures the condition of, alleviates the symptoms of, slows the harm to, or maintains the current health status of the Covered Person.

Infertility Treatment does not include Genetic Testing. (See General Exclusions for details
Laboratory and Pathology Services. Charges for x-rays, diagnostic tests, labs, and pathology services.

Learning Disability: Special education, remedial reading, school system testing, and other rehabilitation treatment for a Learning Disability except for services that should legally be provided by a school.

Manipulations: Manipulations for musculoskeletal conditions when Medically Necessary. Also refer to Maintenance Therapy under the General Exclusions section of this SPD.

Mastectomy. The Federal Women's Health and Cancer Rights Act, signed into law on October 21, 1998, contains coverage requirements for breast cancer patients who elect reconstruction in connection with a Mastectomy. The Federal law requires group health plans that provide Mastectomy coverage to also cover breast reconstruction Surgery and prostheses following Mastectomy.

As required by law, the Participant is being provided this notice to inform him or her about these provisions. The law mandates that individuals receiving benefits for a Medically Necessary Mastectomy will also receive coverage for:

1. Reconstruction of the breast on which the Mastectomy has been performed.
2. Surgery and reconstruction of the other breast to produce a symmetrical appearance.
3. Prostheses and physical complications from all stages of Mastectomy, including lymphedemas.

The reconstruction of the breast will be done in a manner determined in consultation with the attending Physician and the patient.

This coverage will be subject to the same annual Deductible and Coinsurance provisions that currently apply to Mastectomy coverage, and will be provided in consultation with the Participant and his or her attending Physician.

Maternity Benefits for Covered Persons include:

1. Hospital or Birthing Center room and board.
2. Vaginal delivery or Cesarean section.
3. Postnatal care.
4. Medically Necessary diagnostic testing.
5. Abdominal operation for intrauterine pregnancy or miscarriage.
6. Outpatient Birthing Centers.
7. Midwives.

Medical and/or Routine Services Provided in a Foreign Country, except that no coverage is provided if the sole purpose of travel to that country is to obtain medical services and/or supplies

Medical Foods. Medical foods are considered a covered charge if intravenous therapy (IV) or tube feedings are Medically Necessary. Medical foods taken orally are not covered under the Plan, except for PKU formula when Medically Necessary.

Medical Supplies. Dressings, casts, splints, trusses, braces and other Medically Necessary medical supplies, with the exception of dental braces or corrective shoes.

Mental Health and Substance Abuse Benefits. Benefits are available for Inpatient or Outpatient care for mental health and Substance Abuse conditions, including individual and group psychotherapy, psychiatric tests, and expenses related to the Diagnosis when rendered by a covered Provider.
Benefits are available for Residential Treatment Facility, Partial Hospitalization, and Intensive Outpatient Services.

Modifiers or Reducing Modifiers, if Medically Necessary. These terms apply to services and procedures performed on the same day and may be applied to surgical, radiological, and other diagnostic procedures. For a provider participating with a primary or secondary Network, claims will be paid according to the Network contract. These allowances are then processed according to Plan provisions. A global package includes the services that are a necessary part of the procedure. For individual services that are part of a global package, it is customary for the individual services not to be billed separately. A separate charge will

not be allowed under the Plan.

Morbid Obesity Treatment includes only the following treatments if those treatments are determined to be Medically Necessary and be appropriate for an individual's Morbid Obesity condition. Refer to the Glossary of Terms for a definition of Morbid Obesity.

1. Bariatric surgery, including but not limited to:

    - Gastric or intestinal bypasses (Roux-en-Y, biliopancreatic bypass, and biliopancreatic diversion with duodenal switch).
    - Stomach stapling (vertical banded gastroplasty, gastric banding, and gastric stapling).
    - Lap band (laparoscopic adjustable gastric banding).
    - Gastric sleeve procedure (laparoscopic vertical gastrectomy and laparoscopic sleeve gastrectomy).

Eligibility for weight loss surgery is available following one year of being eligible and enrolled in the Plan.

1. Physician-supervised weight loss programs at a medical facility.
2. Charges for diagnostic services.
3. Nutritional counseling by registered dieticians or other Qualified Providers.

This Plan does not cover diet supplements, exercise equipment or any other items listed in the General Exclusions section of this SPD.

Newborn Care. Hospital and Physician nursery care for newborns who are Children of the Employee or spouse and properly enrolled in the Plan, as set forth below.

Benefits will be provided under the Child's coverage, and the Child's own Deductible and Coinsurance provisions will apply:

1. If the newborn is early, experiences illness or remains in hospital for longer than 96 hours;
2. If Dad is on the policy (the plan will coordinate benefits once newborn is added to the Plan).

Routine well-newborn benefits will be provided under the Mom's coverage for the first 96 hours including:

1. Hospital routine care for a newborn during the Child's initial Hospital confinement at birth.
2. Physician services for well-baby examinations during the newborn's initial Hospital confinement at birth:
3. Physician services for circumcision during the newborn's initial Hospital confinement at birth.

Nutritional Counseling. Charges for nutritional counseling for the management of a medical condition (including both physical and mental health conditions).

Occupational Therapy. (See Therapy Services below.)

Oral Surgery includes:

1. Excision of partially or completely impacted teeth.
2. Excision of tumors and cysts of the jaws, cheeks, lips, tongue, roof, and floor of the mouth when such conditions require pathological examinations.
3. Surgical procedures required to correct Accidental injuries of the jaws, cheeks, lips, tongue, roof, and floor of the mouth.
4. Reduction of fractures and dislocations of the jaw.
5. External incision and drainage of cellulitis.
6. Incision of accessory sinuses, salivary glands, or ducts.

7. Excision of exostosis of jaws and hard palate.

Orthotic Appliances, Devices, and Casts, including the exam for required Prescription and fitting, when prescribed to aid in healing, provide support to an extremity, or limit motion to the musculoskeletal system after Injury. These devices can be used for acute Injury or to prevent Injury. Orthotic Appliances and devices include custom molded shoe orthotics, supports, trusses, elastic compression stockings, and braces.

Oxygen and Its Administration.

Pharmacological Medical Case Management (medication management and lab charges).

Physical Therapy. (See Therapy Services below.)

Physician Services. Services of a Physician for Medically Necessary care, including office visits, home visits, Hospital Inpatient care, Hospital Outpatient visits and exams, clinic care and surgical opinion consultations.
Pre-Admission Testing if necessary and consistent with the diagnosis and treatment of the condition for which the Covered Person is being admitted to the Hospital.

Prescription Medications that are administered or dispensed as take-home drugs as part of treatment while in the Hospital or at a medical facility (including claims billed on a claim form from a long-term care facility, assisted living facility, or Skilled Nursing Facility) and that require a Physician's Prescription. Coverage does not include paper (script) claims obtained at a retail pharmacy, which are covered under the Prescription benefit.

Pregnancy Expenses. Expenses attributable to a Pregnancy including non-routine prenatal care. Pregnancy expenses of Dependent Children are covered. Benefits for Pregnancy expenses are paid the same as any other Sickness. **NOTE:** Preventive care charges for Pregnancy are covered under the Preventive Care benefit in the Medical Benefits section.

Under the Newborns' and Mothers' Health Protection Act of 1996, group health plans and health insurance issuers generally may not restrict benefits for any Hospital length of stay in connection with childbirth for the mother or newborn Child to less than 48 hours following a vaginal delivery, or less than 96 hours following a cesarean section. However, Federal law generally does not prohibit the mother's or newborn's attending Provider, after consulting with the mother, from discharging the mother or her newborn earlier than 48 hours (or 96 hours as applicable). In any case, plans and issuers may not, under Federal law, require that a Provider obtain authorization from the Plan or the issuer for prescribing a length of stay not in excess of 48 hours (or 96 hours). In no event will an "attending Provider" include a plan, Hospital, managed care organization, or other issuer.

In accordance with the Summary of Benefits and this section, benefits for the care and treatment of Pregnancy that are covered will be subject to all applicable Plan limitations and maximums (if any), and are payable in the same manner as medical or surgical care of an Illness.

Preventive Care. Charges for Preventive Care services. This Plan intends to comply with the Affordable Care Act's (ACA) requirement to offer In-Network coverage for certain preventive services without cost-sharing.

Benefits mandated through the ACA legislation include Preventive Care such as immunizations, screenings, and other services that are listed as recommended by the United States Preventive Services Task Force (USPSTF), the Health Resources and Services Administration (HRSA), and the Federal Centers for Disease Control (CDC).

See the following websites for more details:

https://www.healthcare.gov/coverage/preventive-care-benefits/;
https://www.uspreventiveservicestaskforce.org/uspstf/recommendation-topics/uspstf-a-and-b-recommendations;
https://www.cdc.gov/vaccines/hcp/acip-recs/index.html;
https://www.aap.org/en/practice-management/care-delivery-approaches/periodicity-schedule/;
https://www.hrsa.gov/womensguidelines/.

NOTE: The Preventive Care services identified through the above links are recommended services. It is up to the Provider and/or Physician of care to determine which services to provide; the Plan Administrator has the authority to determine which services will be covered. Preventive Care services will be covered at 100% for Non-Network Providers if there is no Network Provider who can provide a required preventive service. Benefits include gender-specific Preventive Care services, regardless of the sex the Participant was assigned at birth, his or her gender identity, or his or her recorded gender.

Preventive and Wellness Services for Adults and Children - 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).

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. With respect to infants, Children, and adolescents, evidence-informed Preventive Care and screenings as provided for in the comprehensive guidelines supported by the Health Resources and Services Administration (HRSA).

Women's Preventive Services - 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.
A description of Women's Preventive Services can be found at:
http://www.hrsa.gov/womensguidelines/ or at the websites listed above.

Prosthetic Devices. The initial purchase, fitting, repair and replacement of fitted prosthetic devices (artificial body parts, including limbs, eyes and larynx) that replace body parts. Benefits may be payable for subsequent repairs or replacement only if required:

1. Due to the growth or development of a Dependent Child; or
2. When necessary because of a change in the Covered Person's physical condition; or
3. Because of deterioration caused from normal wear and tear.

The repair or replacement must also be recommended by the attending Physician. In all cases, repairs or replacement due to abuse or misuse, as determined by the Plan, are not covered and replacement is subject to prior approval by the Plan.

Qualifying Clinical Trials as defined below, including routine patient care costs Incurred during participation in a Qualifying Clinical Trial for the treatment of:

1. Cancer or other Life-Threatening Disease or Condition. For purposes of this benefit, a Life-Threatening Disease or Condition is one from which the likelihood of death is probable unless the course of the disease or condition is interrupted.

Benefits include the reasonable and necessary items and services used to prevent, diagnose, and treat complications arising from participation in a Qualifying Clinical Trial.

Benefits are available only when the Covered Person is clinically eligible for participation in the Qualifying Clinical Trial as defined by the researcher.
Routine patient care costs for Qualifying Clinical Trials may include:

1. Covered health services (e.g., Physician charges, lab work, X-rays, professional fees, etc.) for which benefits are typically provided absent a clinical trial;
2. Covered health services required solely for the administration of the Investigational item or service, the clinically appropriate monitoring of the effects of the item or service, or the prevention of complications; and
3. Covered health services needed for reasonable and necessary care arising from the provision of an Investigational item or service.

Routine costs for clinical trials do not include:

1. The Experimental or Investigational service or item as it is typically provided to the patient through the clinical trial.
2. Items and services provided solely to satisfy data collection and analysis needs and that are not used in the direct clinical management of the patient;
3. A service that is clearly consistent with widely accepted and established standards of care for a particular diagnosis; and
4. Items and services provided by the research sponsors free of charge for any person enrolled in the trial.

With respect to cancer or other Life-Threatening Diseases or Conditions, a Qualifying Clinical Trial is a Phase I, Phase II, Phase III, or Phase IV clinical trial that is conducted in relation to the prevention, detection, or treatment of cancer or other Life-Threatening Disease or Condition and that meets any of the following criteria in the bulleted list below.

1. Federally funded trials. The study or investigation is approved or funded (which may include funding through in-kind contributions) by one or more of the following:

    - National Institutes of Health (NIH), including the National Cancer Institute (NCI);
    - Centers for Disease Control and Prevention (CDC);
    - Agency for Healthcare Research and Quality (AHRQ);
    - Centers for Medicare and Medicaid Services (CMS);
    - A cooperative group or center of any of the entities described above or the Department of Defense (DOD) or Veterans Administration (VA);
    - A qualified non-governmental research entity identified in the guidelines issued by the NIH for center support grants; or
    - The Department of Veterans Affairs, the DOD, or the Department of Energy as long as the study or investigation has been reviewed and approved through a system of peer review that is determined by the Secretary of Health and Human Services to meet both of the following criteria:
        - It is comparable to the system of peer review of studies and investigations used by the NIH; and
        - It ensures unbiased review of the highest scientific standards by qualified individuals who have no interest in the outcome of the review.
2. The study or investigation is conducted under an Investigational new drug application reviewed by the U.S. Food and Drug Administration;
3. The study or investigation is a drug trial that is exempt from having such an Investigational new drug application;
4. The clinical trial must have a written protocol that describes a scientifically sound study and have been approved by all relevant Institutional Review Boards (IRBs) before participants are enrolled in the trial. The Plan Sponsor may, at any time, request documentation about the trial; or
5. The subject or purpose of the trial must be the evaluation of an item or service that meets the definition of a covered health service and is not otherwise excluded under the Plan.

Notwithstanding the foregoing, participation in clinical trials will be made available in accordance with the Patient Protection and Affordable Care Act.

Radiation Therapy and Chemotherapy charges.

Radiology and Interpretation charges.

Reconstructive Surgery includes:

1. Surgery following a mastectomy under the Women's Health and Cancer Rights Act (WHCRA). Under the WHCRA, the Covered Person must be receiving benefits in connection with a mastectomy in order to receive benefits for reconstructive treatments. Covered Expenses are reconstructive treatments that include all stages of reconstruction of the breast on which the mastectomy was performed; surgery and reconstruction of the other breast to produce a symmetrical appearance; and prostheses and complications of mastectomies, including lymphedemas.
2. Surgery to restore a bodily function that has been impaired by a congenital Illness or anomaly, or by an Accident, or from an infection or other disease of the involved part.

Respiratory Therapy. (See Therapy Services below.)

Second Surgical Opinions. Charges for second surgical opinions. The Physician providing the second opinion must not be affiliated in any way with the Physician who rendered the first opinion.

Skilled Nursing Facility. Charges made by a Skilled Nursing Facility or a convalescent care facility, up to the limits set forth in the Summary of Benefits, in connection with convalescence from an Illness or Injury (excluding drug addiction, chronic brain syndrome, alcoholism, senility, intellectual disability or other Mental or Nervous Disorders) for which the Participant is confined.

Sleep Therapy. (See Therapy Services below.)

Sleep Disorders if Medically Necessary.

Sleep Studies.

Sterilizations.

Surgery.

1. If bilateral or Multiple Surgical Procedures are performed by one surgeon, benefits will be determined based on the Maximum Allowable Charge that is allowed for the primary procedure; 50% of the Maximum Allowable Charge will be allowed for each additional procedure performed through the same incision; and 70% of Maximum Allowable Charge will be allowed for each additional procedure performed through a separate incision.
2. If multiple unrelated surgical procedures are performed by two more surgeons on separate operative fields, benefits will be based on the Maximum Allowable Charge for each surgeon's primary procedure. If two or more surgeons perform a procedure that is normally performed by one surgeon, benefits for all surgeons will not exceed the Maximum Allowable Charge allowed for that procedure.

Substance Use Disorder Services. (Refer to the Substance Use Disorder Benefits section of this SPD.)

Telemedicine - Telephone or Internet Consultations: Consultations made by a Covered Person to a Physician.

Therapy Services: Therapy must be ordered by a Physician and provided as part of the Covered Person's treatment plan. Services include:

1. **Occupational therapy** by a Qualified occupational therapist (OT) or other Qualified Provider, if applicable.
2. **Physical therapy** by a Qualified physical therapist (PT) or other Qualified Provider, if applicable.
3. **Respiratory therapy** by a Qualified respiratory therapist (RT) or other Qualified Provider, if applicable.
4. **Applied Behavior Analysis (ABA) Therapy.** Charges for ABA Therapy for treatment of Autism Spectrum Disorder (ASD).
5. **Aquatic therapy** by a Qualified physical therapist (PT), Qualified aquatic therapist (AT), or other Qualified Provider, if applicable.
6. **Sleep Therapy** by a Qualified Provider.
7. **Speech therapy** by a Qualified speech therapist (ST), or other Qualified Provider, if applicable, including therapy for stuttering due to a neurological disorder.

The Plan allows coverage for occupational, physical, or speech therapy for Developmental Delays due to Accidents or Illnesses such as Bell's palsy, CVA (stroke), apraxia, cleft palate/lip, recurrent/chronic otitis media, vocal cord nodules, Down's syndrome, and cerebral palsy when performed by a Qualified Provider.

Tobacco Addiction: Preventive / Routine Care as required by applicable law. Physician office visits to obtain Prescriptions only related to addiction to or dependency on nicotine.

Transplant Services. (Refer to Transplant section of this SPD.)

Urgent Care Facility as shown in the Schedule of Benefits of this SPD.

Urinary Drug Screens (UDS).

Walk-In Retail Health Clinics: Charges associated with medical services provided at Walk-In Retail Health Clinics.

Wigs. Charges associated with the initial purchase of a wig after chemotherapy or radiation therapy or alopecia related to a medical condition.

X-Ray Services for covered benefits.

TRANSPLANT BENEFITS

Benefit Plans – OPEN ACCESS

Refer to the Care Management section of this SPD for prior authorization requirements

TRANSPLANT SCHEDULE OF BENEFITS Benefit Plan – OPEN ACCESS PLAN			
Transplant Services At A Designated Transplant Facility: **Transplant Services:** • Paid By Plan After Tier 2 Deductible **Travel And Housing:** • Maximum Benefit Per Transplant • Paid By Plan Travel And Housing At Designated Transplant Facility At Contract Effective Date/Pre-Transplant Evaluation And Up One Year From Date Of Transplant.	80% $10,000 100% (Deductible Waived)		
	Ardent Network	**ADP Network**	**Non-Network**
Transplant Services At A Non-Designated Transplant Facility: **Transplant Services:** • Paid By Plan After Deductible **Travel And Housing:** • Maximum Benefit Per Transplant • Paid By Plan Travel And Housing At Designated Transplant Facility At Contract Effective Date/Pre-Transplant Evaluation And Up One Year From Date Of Transplant.	90% $10,000 100% (Deductible Waived)	80% $10,000 80% After Deductible	No Benefit

This coverage provides You with a choice for transplant care. The Plan provides incentives to You and Your covered Dependents by giving You the option of using a Designated Transplant Facility. While the Plan does not require You to use a Designated Transplant Facility in order to receive benefits You may receive better benefits if You do so. A Designated Transplant Facility is a facility that must meet extensive criteria in the areas of patient outcomes that include patient and graft survival, patient satisfaction, Physician and program experience, program accreditations, and patient and caregiver education.

DEFINITIONS

The following terms are used for the purpose of the Transplant Benefits section of this SPD. Refer to the Glossary of Terms section of this SPD for additional definitions.

Approved Transplant Services means services and supplies for certified transplants when ordered by a Physician. Such services include, but are not limited to, Hospital charges, Physician charges, organ and tissue procurement, tissue typing, and Ancillary Services.

Designated Transplant Facility means a facility that has agreed to provide Approved Transplant Services

to Covered Persons pursuant to an agreement with a transplant provider Network or rental network with which the Plan has a contract.

Non-Designated Transplant Facility means a facility that does not have an agreement with the transplant provider Network with whom the Plan has a contract. This may include a facility that is listed as a participating provider.

Organ and Tissue Acquisition/Procurement means the harvesting, preparation, transportation, and the storage of human organ and tissue that is transplanted to a Covered Person. This includes related medical expenses of a living donor

Stem Cell Transplant includes autologous, allogeneic, and syngeneic transplant of bone marrow and peripheral and cord blood stem cells.

BENEFITS
The Plan will pay for Covered Expenses Incurred by a Covered Person at a Designated or Non- Designated Transplant Facility due to an Illness or Injury, subject to any Deductibles, Plan Participation amounts, maximums, or limits shown on the Schedule of Benefits. Benefits are based on the Maximum Allowable Charge or the Plan's Negotiated Rate.

It will be the Covered Person's responsibility to obtain prior authorization for all transplant-related services. If prior authorization is not obtained, benefits may not be payable for such services. Benefits may also be subject to reduced levels as outlined in individual Plan provisions. The approved transplant and medical criteria for such transplant must be Medically Necessary for the medical condition for which the transplant is recommended. The medical condition must not be an individual Plan exclusion.

COVERED EXPENSES
The Plan will pay for Approved Transplant Services at a Designated or Non-Designated Transplant Facility for Organ and Tissue Acquisition/Procurement and transplantation, if a Covered Person is the recipient.

If a Covered Person requires a transplant, including a bone marrow or Stem Cell Transplant, the cost of Organ and Tissue Acquisition/Procurement from a living human or cadaver will be included as part of the Covered Person's Covered Expenses when the donor's own plan does not provide coverage for Organ and Tissue Acquisition/Procurement. Coverage includes the cost of donor testing, blood typing, and evaluation to determine if the donor is a suitable match.

The Plan will provide donor services for donor-related complications during the transplant period, per the transplant contract, if the recipient is a Covered Person under this Plan.

The Plan will provide donor services at a Non-Designated Transplant Facility for initial acquisition/procurement only, up to the maximum listed on the Schedule of Benefits, if any. Complications, side effects, or injuries are not covered unless the donor is a Covered Person.

Benefits are payable for the following transplant types:

1. Kidney.
2. Kidney/pancreas.
3. Pancreas, if the transplant meets the criteria determined by care management.
4. Liver.
5. Heart.
6. Heart/lung.
7. Lung.
8. Bone marrow or Stem Cell Transplant (allogeneic and autologous) for certain conditions.
9. Small bowel.

SECOND OPINION
The Plan will notify the Covered Person if a second opinion is required at any time during the determination of benefits period. If a Covered Person is denied a transplant procedure by the transplant facility, the Plan will allow him or her to go to a second Designated Transplant Facility for evaluation. If the second facility determines, for any reason, that the Covered Person is an unacceptable candidate for the transplant procedure, benefits will not be paid for further transplant-related services or supplies, even if a third Designated Transplant Facility accepts the Covered Person for the procedure.

ADDITIONAL PROVISIONS (Applies to a Designated Transplant Facility Only)

TRAVEL EXPENSES (Applies to Covered Person who is a recipient)
If the Covered Person lives more than 50 miles from the transplant facility, the Plan will pay for travel and housing related to the transplant, up to the maximum listed on the Schedule of Benefits. Expenses will be paid for the Covered Person and:

1. One or two parents of the Covered Person (if the Covered Person is a Dependent Child, as defined in this Plan); or
2. An adult to accompany the Covered Person.

Covered travel and housing expenses include the following:
1. Transportation to and from the transplant facility, including:
    a. Airfare.
    b. Tolls and parking fees.
    c. Gas/mileage.
2. Lodging at or near the transplant facility, including:
    a. Apartment rental.
    b. Hotel rental.
    c. Applicable tax.

Lodging for purposes of this Plan does not include private residences.

Lodging reimbursement that is greater than $50 per person per day may be subject to IRS codes for taxable income.

Benefits will be payable for up to one year from the date of the transplant while the Covered Person is receiving services at the transplant facility.

TRANSPLANT EXCLUSIONS
In addition to the items listed in the General Exclusions section of this SPD, benefits will NOT be provided for any of the following:

1. Expenses if a Covered Person donates an organ and/or tissue and the recipient is not a Covered Person under this Plan.
2. Expenses for Organ and Tissue Acquisition/Procurement and storage of cord blood, stem cells, or bone marrow, unless the Covered Person has been diagnosed with a condition for which there would be Approved Transplant Services.
3. Expenses for any post-transplant complications of the donor, if the donor is not a Covered Person under this Plan.
4. Transplants considered Experimental, Investigational, or Unproven unless covered under a Qualifying Clinical Trial.
5. Solid organ transplantation, autologous transplant (bone marrow or peripheral stem cell), or allogeneic transplant (bone marrow or peripheral stem cell) for conditions that are not considered to be Medically Necessary and/or are not appropriate, based on the National Comprehensive Cancer Network (NCCN) and/or Transplant Review Guidelines.
6. Expenses related to, or for, the purchase of any organ.

PRESCRIPTION DRUG CARD PROGRAM

Administered by OptumRX

Prescription Drug Benefit – OPEN ACCESS Plan

Prescription Drug Plan	Calendar Year Out-of-Pocket Maximum
Individual	$5,400 Maximum Out-of-Pocket, combined with Medical
Family	$10,800 Maximum Out-of-Pocket, combined with Medical
Covered Prescription Drug Expenses:	**Participating Pharmacy**
Retail Option – 30 Day Supply:	
Preventive Drug (Classified as preventive by HHS)	$0 Copay
Copayment per prescription or refill, for Generic	$15 Copay
Copayment per prescription or refill, for Preferred Brand	20% Copay, Max of $70
Copayment per prescription or refill, for Non-Preferred Brand	30% Copay, Max of $225
Mail Order Option – 90 Day Supply:	
Copayment per prescription or refill, for Generic	$30 Copay
Copayment per prescription or refill, for Preferred Brand	20% Copay, Max of $140
Copayment per prescription or refill, for Non-Preferred Brand	30% Copay, Max of $450
Specialty Drug Option – 30 Day Supply:	
Copayment per prescription or refill	30% Copay, Max of $250

The out-of-pocket maximum is the maximum dollar amount Participants are responsible for paying for covered services during a Calendar Year, including the Copayments. When the individual and/or family out-of-pocket expenses reach the out-of-pocket maximum, the Plan will pay 100% of the Allowable Expenses for the remainder of the Calendar Year.

A Copayment is the flat dollar amount specified in the Summary of Benefits that a Participant is required to pay for certain covered services. Copayments will not apply after the out-of-pocket maximum has been reached.

For all plans, if a generic drug is available and you or your doctor chooses a brand-name drug, you will be responsible for the generic copayment or coinsurance amount PLUS the difference in cost between the brand dispensed and the generic.
Eligible expenses include Prescription Drugs and medicines prescribed in writing by a Physician and dispensed by a licensed participating pharmacist, which are deemed necessary for treatment of an Illness or Injury including but not limited to: insulin; hypodermic needles or syringes, but only when dispensed upon a written prescription of a licensed Physician; diabetic supplies; smoking deterrents; growth hormones; weight loss medications; sexual dysfunction/impotence medication (6 pills per month); and contraceptives (regardless of intended use). Please note Prescription Drugs are subject to the cost- sharing provisions described in the Prescription Drug Schedule of Benefits unless the Prescription Drug qualifies as a Preventive Drug (as described below).

When your prescription 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 may 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.

Expenses for injectables 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. Please refer to the Eligible Medical Expenses and the General Limitations and Exclusions section 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 injectables that are not covered under the Prescription Drug Card Program). 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.

Dispense as Written
The Plan requires pharmacies dispense Generic Drugs when available unless the Physician specifically prescribes a Preferred or Non-Preferred Drug and marks the script "Dispense as Written" (DAW). Should a Covered Person choose a Preferred or Non-Preferred Drug rather than the Generic equivalent when the Physician allowed a Generic Drug to be dispensed, the Covered Person will also be responsible for the cost difference between the Generic and Preferred or Non-Preferred Drug. The cost difference is not covered by the Plan and will not accumulate toward your Out-of-Pocket Maximum.

Specialty Pharmacy Program
Specialty drugs are high cost drugs used to treat chronic diseases, including, but not limited to: HIV/Aids, Rheumatoid Arthritis, Cancer, Hepatitis, Hemophilia, Multiple Sclerosis, and Growth Hormone Deficiency. Specialty drugs must be obtained directly from the specialty pharmacy program and may require prior authorization. For additional information, please contact the Prescription Drug Card Program Administrator.

Brand Name Drug: Means a trade name medication.

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

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

Preferred Drug: 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.

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

Preventive Drug 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 Administrator. Pharmacy Plan Administrator:
OptumRX
6800 W 115th St, Ste 600
Overland Park, Kansas
1.844.783.1405 www.optumrx.com

HEARING AID BENEFITS

This Plan includes a benefit that allows Covered Persons to access discounted hearing aids and related testing and fitting. This benefit is being offered under the Plan by EPIC Hearing Healthcare.

This benefit may be accessed under the Plan by calling EPIC at its toll-free number: 1-866-956-5400. Once contacted, one of EPIC's hearing professionals will coordinate the Covered Person's care and direct him or her to the nearest appropriate provider.

The hearing aid benefit being provided through EPIC consists of discounted hearing aids and related testing and fitting. EPIC discounts may be as much as 50% below manufacturer's suggested retail prices and up to 35% lower than most discount offers. EPIC will require that the Covered Person pay for his or her hearing aids and other services not covered under the Plan out-of-pocket prior to the delivery of services.

In the event that You have questions or complaints about the hearing aid products or services offered under the Plan, contact EPIC directly at its toll-free number or write to: EPIC Hearing Services, 3191 W. Temple Ave. Ste. 200, Pomona, CA 91768.

MENTAL HEALTH and SUBSTANCE USE DISORDER BENEFITS

The Plan will pay for the following Covered Expenses for services authorized by a Physician for the treatment of a Mental Health Disorder, subject to any Deductibles, Co-pays if applicable, Plan Participation amounts, maximums, or limits shown on the Schedule of Benefits of this SPD. Benefits are based on the Maximum Allowable Charge, or the Negotiated Rate.

COVERED BENEFITS

Inpatient Services means services provided at a Hospital or facility accredited by a recognized accrediting body or licensed by the state as an acute care psychiatric, chemical dependency, or dual- diagnosis facility for the treatment of Mental Health Disorders. If outside the United States, the Hospital or facility must be licensed or approved by the foreign government or an accreditation of the licensing body working in that foreign country.

Residential Treatment means a sub-acute facility-based program that is licensed to provide "residential" treatment and delivers 24-hour-per-day, 7-day-per-week assessment and diagnostic services, as well as active behavioral health treatment for mental health conditions. Coverage does not include facilities or programs where therapeutic services are not the primary service being provided (e.g., therapeutic boarding schools, halfway houses, and group homes).

Day Treatment (Partial Hospitalization) means a day treatment program that offers intensive, multidisciplinary services not otherwise offered in an Outpatient setting. The treatment program generally consists of a minimum of 20 hours of scheduled programming extended over a minimum of five days per week. The program is designed to treat patients with serious mental or nervous disorders and offers major diagnostic, psychosocial, and prevocational modalities. Such a program may be a less restrictive alternative to Inpatient treatment.

Outpatient Therapy Services are covered, subject to all of the following:

1. The Covered Person must receive the services in person at a therapeutic medical facility; and
2. The services must be provided by a Qualified Provider.

ADDITIONAL PROVISIONS AND BENEFITS

1. Any diagnosis change after a payment denial will not be considered for benefits unless the Plan is provided with all pertinent records along with the request for the change that justifies the revised diagnosis.

MENTAL HEALTH EXCLUSIONS

In addition to the items listed in the General Exclusions section, benefits will NOT be provided for any of the following:

1. Inpatient charges for the period of time when full, active, Medically Necessary treatment for the Covered Person's condition is not being provided.
2. Bereavement counseling, unless specifically listed as a covered benefit elsewhere in this SPD.
3. Services provided for conflict between the Covered Person and society that is solely related to criminal activity. This exclusion does not apply if the injury in question occurred as the result of being the victim of an act of domestic violence or if it occurred as the direct result of the participant's mental or physical medical condition, even if the condition is not diagnosed before the Injury.
4. Conditions listed in the most recent American Psychiatric Association Diagnostic and Statistical Manual (DSM) or the International Classification of Diseases - Clinical Modification (ICD-CM) manual (most recent revision) in the following categories:
    a. Personality disorders; or
    b. Behavior and impulse control disorders; or
    c. "V" codes (including marriage counseling).
5. Services for biofeedback.

CARE COORDINATION AND UTILIZATION MANAGEMENT

INTRODUCTION

The Plan incorporates a "Care Coordination" process by Quantum Health which leverages resources including but not limited to your employer, the Plan and the Third-Party Administrator, your provider and your community to help you best navigate the healthcare system. This process includes a staff of Care Coordinators who receive notifications regarding most healthcare services sought by Covered Members, and coordinate activities and information flow between the providers.

Care Coordination is intended to help Covered Members obtain quality healthcare and services in the most appropriate setting, help reduce unnecessary medical costs, and ensure early identification of Covered Members with complex medical conditions. The Care Coordinators are available to Covered Members and their providers for information, assistance, and guidance, and can be reached toll-free by calling:

Care Coordinators: 1-(888) 295-9299

It is important to note that clinical reviews are done to determine Plan coverage and are conducted by the clinical staff of Quantum Health.

CARE COORDINATION REQUIREMENTS

In order to receive the highest benefits available in the Plan, Covered Members must follow the Care Coordination process outlined in this section, as well as other provisions in the Plan. In some cases, failure to follow this process can result in significant benefit reductions, penalties or even loss of benefits for specific services.

The Care Coordination process generally includes:

- Use of in-network providers
- Designating a Coordinating Provider (PCP)
- The Care Coordination Process and Utilization Management
    - Preauthorization and Clinical Review
    - Concurrent Utilization Review
    - Personal Care Guide Management

Use of In-Network Providers

The Plan offers a broad network of providers and provides the highest level of benefits when Covered Members utilize "In-Network" providers. These networks will be indicated on your Plan identification card. **Services provided by Out-of-Network providers will not be eligible for the highest benefits**. Specific benefit levels are shown in the Schedule of Benefits.

Designated Coordinating Provider

All Covered Members are asked to designate a coordinating Primary Care Provider (PCP) for each covered member of their family. While such designation is not mandatory, it is strongly recommended. **To ensure highest level of benefits, and the best coordination of your care, all Covered Members are encouraged to designate an In-Network Primary Care Provider (PCP) to be their coordinating Provider.** The Care Coordination process generally begins with

the coordinating Provider who maintains a relationship with the Covered Member, provides general healthcare evaluation, guidance, and management.

Covered Members are encouraged to begin all healthcare events or inquiries with a call or visit to their designated PCP who will guide Covered Members as appropriate. In addition to providing Care Coordination and submitting preauthorization requests, the PCP may also receive notices regarding healthcare services that their designated patients receive under the Plan. This allows the PCP to provide ongoing healthcare guidance.

If you have trouble obtaining access to a PCP, the Care Coordinators will be able to assist you by providing a list of in-network PCPs. Please contact the Care Coordinators by calling:

Care Coordinators: 1-(888) 295-9299

Preauthorization and Clinical Review

To be covered at the highest level of benefit and to ensure complete Care Coordination, the Plan requires that certain care, services, and procedures be preauthorized before they are provided. Preauthorization requests are submitted to the Care Coordinators by a designated PCP, other PCP, specialty provider or other healthcare provider. Your Plan identification card includes instructions and the phone number for them to call. Depending on the request, the Care Coordinators may contact the requesting provider to obtain additional clinical information to support the request for the preauthorization and to ensure that the care, service and/or procedure meet Plan and nationally accepted medical criteria. If a pre-authorization request does not meet Plan and nationally accepted medical criteria, the Covered Member and healthcare provider will be notified, and the Care Coordinators will assist in redirecting care if appropriate.

The following care, services and procedures are subject to preauthorization:

- Inpatient and Skilled Nursing Facility Admissions
- Outpatient Surgeries
- MRI/MRA and PET scans
- Oncology Care and Services (chemotherapy, radiation therapy, clinical trials)
- Genetic Testing
- Dialysis
- Organ, Tissue, and Bone Marrow Transplants
- Home Health Care
- Hospice Care
- Durable Medical Equipment - all rentals and any purchase over $1500.
- Partial Hospitalization and Intensive Outpatient for Mental Health/Substance Use Disorders

All preauthorizations and clinical review services are conducted by Quantum Health. Care Coordinators will assist Covered Members in understanding what services require preauthorization.

For preauthorization, Providers should call the number listed on the Plan identification card.

Concurrent Utilization Review

Quantum Health will regularly monitor an inpatient hospital stay, other institutional admission, or ongoing course of care for any Covered Member, and evaluate the appropriateness of the level of care and if the stay is meeting medical necessity. If necessary, they will examine the possible use of alternate levels of care or facilities. Quantum Health will communicate regularly with attending providers, the utilization management staff and/or discharge planners of such facilities, and the Covered Member and/or family to monitor the Covered Member's progress and anticipate and initiate planning for discharge needs. Such concurrent review, and authorization for Plan coverage of inpatient days, is conducted in accordance with the utilization criteria adopted by the Plan, Quantum Health, and nationally accepted medical criteria.

Personal Care Guide Management

Quantum Health utilizes a primary nurse model for chronic condition as well as acute condition management. This enhanced approach provides one nurse to address clinical needs for all chronic and acute issues. The Personal Care Guide (PCG) nurse will consult with the Covered Member, their family (if requested), the attending Physician, and other members of the Covered Person's treatment team to assist in facilitating/implementing proactive plans of care which provide the most appropriate health care and services in a timely, efficient and cost-effective manner. They assist with benefits, incidental health care issues, becoming healthier, finding resources or an unexpected healthcare journey.

During outreach, the Personal Care Guide will touch on the Covered Member's treatment and perform a physical assessment, perform a medication reconciliation to ensure there are no duplications or interactions, perform a depression screening with subsequent referrals to EAP or in-network providers, as well as focus on the physical and emotional needs of the Covered Member.

The Personal Care Guide will look at the Covered Member's psychosocial needs and social determinants of health. In addition to the depression screening, they will evaluate the Covered Member's financial issues, knowledge deficits, as well as any cultural barriers that may exist. Conversations with the Covered Member would occur at least monthly, if not more frequently, and continue until the Covered Member's health goals and needs are met.

The primary Personal Care Guide nurse will align with the Covered Member and be the single point of contact them, and their family and caregivers, and providers.

The primary Personal Care Guide nurse will:

- Provide comprehensive benefit education/utilization support
- Drive PCP designation and steerage to in-network providers
- Encourage provider involvement
- Deliver pre-certification assistance
- Perform pre-admission, pre-discharge, and post-discharge engagement
- Coordinate for utilization review and discharge planning
- Identify gaps in care and alleviate clinical, financial, and humanistic barriers
- Coordinate second opinions, drive utilization to other third-party vendor tools, and introduce community resources
- Perform behavioral health screening
- Our primary nurse model has three foundational drivers for the changes:

- Humanistic: to help members with acute and chronic needs by assigning a single nurse to the Covered Member and their family as well as a heightened attention to psychosocial issues that can negatively affect health, quality of life and financial outcomes.
- Clinical: identify and prioritize members in need of clinical outreach. Improve adherence to quality measures for preventive health and management of chronic conditions.
- Financial: identify and outreach to members at risk for future high costs while encouraging preventive care and chronic condition management to improve health and reduce costs.

GENERAL PROVISIONS FOR CARE COORDINATION

Authorized Representative

The Covered Member is ultimately responsible for ensuring that all preauthorizations are approved and in place prior to the time of service to receive the highest level of benefits. However, in most cases, the actual preauthorization process will be executed by the Covered Member's Primary Care Provider or other providers. By subscribing to this Plan, the Covered Member authorizes the Plan and its designated service providers (including Quantum Health and the Third Party Administrator, and others) to accept healthcare providers or those providers who otherwise have knowledge of the Covered Member's medical condition, as their authorized representative in matters of Care Coordination, including preauthorization requests. Communications with and notifications to such healthcare providers shall be considered as notification to the Covered Member.

Time of Notice

The preauthorization request should be made to the Care Coordinators within the following timeframe:

- At least **three business days,** before a scheduled (elective) Inpatient admission
- By the next business day after, an emergency Hospital admission
- Upon being identified as a potential organ or tissue transplant recipient
- At least **three business days** before receiving any other services requiring preauthorization

For preauthorization, Providers should call the number listed on the Plan identification card.

Special Note: The Covered Member will not be penalized for failure to obtain preauthorization if a prudent layperson, who possesses an average knowledge of health and medicine, could reasonably expect that the absence of immediate medical attention would jeopardize the life or long-term health of the individual. However, Covered Members who receive care on this basis must contact the Care Coordinators as soon as possible within 24 hours of the first business day after receiving care or Hospital admittance. Care Coordinators will then coordinate with Quantum Health Utilization Management to review services provided within 48 hours of being contacted.

"Emergency" Admissions and procedures

Any Inpatient admission or Outpatient procedure that has not been previously scheduled and cannot be delayed without harming the Covered Member's health is considered an emergency for purposes of the Utilization Management notification.

Maternity Admissions

A notice regarding admissions for childbirth should be submitted to the Care Coordinators in advance, preferably 30 days prior to expected delivery. The Plan and the Care Coordination process complies with all state and federal regulations regarding Utilization Management for maternity admissions. The Plan will not restrict benefits for any hospital stay in connection with childbirth for the mother or newborn child to less than 48 hours following a normal vaginal delivery, or less than 96 hours following a cesarean section, or require preauthorization or authorization for prescribing a length of stay not in excess of these periods. If the mother's or newborn's attending provider, after consulting with the mother, discharges the mother or her newborn earlier than the applicable 48 or 96 hours, the Plan will only consider benefits for the actual length of the stay. The Plan will not set benefit levels or out-of-pocket costs so that any later portion of the 48 or 96-hour stay is treated in a manner less favorable to the mother or newborn than any earlier portion of the stay.

Care Coordination is Not a Guarantee of Payment of Benefits

The Care Coordination process does not provide a guarantee of payment of benefits. Approvals of preauthorizations for procedures, hospitalizations and other services indicate that the medical condition, services, and care settings meet the utilization criteria established by the Plan. The Care Coordination approvals do not indicate that the service is a covered benefit, that the Covered Member is eligible for such benefits, or that other benefit conditions such as co-pay, deductible, co-insurance, or maximums have been satisfied. Final determinations regarding coverage and eligibility for benefits are made by the Plan.

Appeal of Care Coordination Determinations

Covered Members have certain appeal rights regarding adverse determinations in the Care Coordination process, including reduction of benefits and penalties. The appeal process is detailed in the Claims and Appeal Procedures section within this document.

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OTHER FEDERAL PROVISIONS

This Plan complies with, and shall, in any case, be administered in compliance with, the applicable provisions of the:

1. Americans with Disabilities Act, as amended.
2. Pediatric vaccines regulation, whereby an employer will not reduce its coverage for pediatric vaccines below the coverage it provided as of May 1, 1993.
3. TRICARE Prohibition Against Incentives and Nondiscrimination Requirements.

HIPAA PRIVACY

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 Participants. Privacy Standards will be implemented and enforced in the offices of the Employer and Plan Sponsor 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 Participant's PHI, and inform him/her about:

1. The Plan's disclosures and uses of PHI.
2. The Participant's privacy rights with respect to his or her PHI.
3. The Plan's duties with respect to his or her PHI.
4. The Participant'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.

The Plan provides each Participant with a separate Notice of Privacy Practices. This Notice describes how the Plan uses and discloses a Participant's personal health information. It also describes certain rights the Participant has regarding this information. Additional copies of the Plan's Notice of Privacy Practices are available by calling 1-615-296-3378.

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.

Definitions

1. **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.
2. **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.

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. 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).

Primary Uses and Disclosures of PHI

1. Treatment, Payment and Health Care Operations: The Plan has the right to use and disclose a Participant'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 Participant'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 Participant, 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 Participant has coverage through another carrier.

Disclosure of PHI to the Plan Sponsor for Plan Administration Purposes

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

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 Sponsor provides PHI received from the Plan, agree to the same restrictions and conditions that apply to the Plan Sponsor with respect to such PHI.
3. 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.
4. Receive PHI, in the absence of an individual's express authorization, only to carry out Plan administration functions.
5. Not use or disclose genetic information for underwriting purposes.
6. Report to the Plan any PHI use or disclosure that is inconsistent with the uses or disclosures provided for of which the Plan Sponsor becomes aware.
7. Make available PHI in accordance with section 164.524 of the Privacy Standards (45 CFR 164.524).
8. 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).
9. 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).
10. If feasible, return or destroy all PHI received from the Plan that the Plan Sponsor still maintains in any form and retain no copies of such PHI when no longer needed for the purpose for which disclosure was made, except that, if such return or destruction is not feasible, limit further uses and disclosures to those purposes that make the return or destruction of the PHI infeasible.

Required Disclosures of PHI

1. Disclosures to Participants: The Plan is required to disclose to a Participant most of the PHI in a Designated Record Set when the Participant requests access to this information. The Plan will disclose a Participant'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 Participant's personal representative if it has a reasonable belief that the Participant has been, or may be, subjected to domestic violence, abuse, or neglect by such person, it is not in the Participant'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 Participant.

2. Disclosures to the Secretary of the U.S. Department of Health and Human Services: The Plan is required to disclose the Participant'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.

Participant's Rights

The Participant has the following rights regarding PHI about him/her:

1. Request Restrictions: The Participant has the right to request additional restrictions on the use or disclosure of PHI for treatment, payment, or health care operations. The Participant 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 Participant 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 Participant would like to be contacted. The Plan will accommodate all reasonable requests.
3. Right to Receive Notice of Privacy Practices: The Participant 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 Participant 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 Participant 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 Participant of the basis of the disclosure, and certain other information. If the Participant wishes to make a request, please contact the Privacy Officer.
5. Access: The Participant 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 Participant requests copies, he or she may be charged a fee to cover the costs of copying, mailing, and other supplies. If a Participant 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 Participant and the recipient must be clearly identified. The Plan must respond to the Participant's request within 30 days (in some cases, the Plan can request a 30 day extension). In very limited circumstances, the Plan may deny the Participant's request. If the Plan denies the request, the Participant may be entitled to a review of that denial.
6. Amendment: The Participant 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 Participant'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. Other uses and disclosures not described in this section can only be made with authorization from the Participant. The Participant may revoke this authorization at any time.

Questions or Complaints

If the Participant 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 Participant may submit a written complaint to the U.S. Department of Health and Human Services or with the Plan. The Plan will provide the Participant 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 Participant for filing a complaint with the Plan or the U.S. Department of Health and Human Services.

Contact Information

Privacy Officer Contact Information:

Chief Privacy Officer
Ardent Health Services
Phone: 1-615-296-3378

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) and 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) and 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.
5. Establish safeguards for information, including security systems for data processing and storage.
6. Not use or disclose PHI for employment-related actions and decisions or in connection with any other benefit or Employee benefit plan of the Plan Sponsor, except pursuant to an authorization which meets the requirements of the Privacy Standards.
7. Ensure that adequate separation between the Plan and the Plan Sponsor, as required in section 164.504(f)(2)(iii) of the Privacy Standards (45 CFR 164.504(f)(2)(iii)), is established as follows:
    a. The following Employees, or classes of Employees, or other persons under control of the Plan Sponsor, shall be given access to the PHI to be disclosed:
        i. Privacy Officer.
        ii. Director of Employee Benefits.
        iii. Employee Benefits Department employees.
        iv. Information Technology Department.
    b. The access to and use of PHI by the individuals identified above shall be restricted to the plan administration functions that the Plan Sponsor performs for the Plan.

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 Participant. 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 Administrator 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.

Resolution of Noncompliance

In the event that any authorized individual of the Employer's workforce uses or discloses Protected Health Information other than as permitted by the Privacy Standards, the incident shall be reported to the Privacy Officer. The Privacy Officer shall take appropriate action, including:

1. Investigation of the incident to determine whether the breach occurred inadvertently, through negligence, or deliberately; whether there is a pattern of breaches; and the degree of harm caused by the breach.
2. Applying appropriate sanctions against the persons causing the breach, which, depending upon the nature of the breach, may include oral or written reprimand, additional training, or termination of employment.
3. Mitigating any harm caused by the breach, to the extent practicable.
4. Documentation of the incident and all actions taken to resolve the issue and mitigate any damages.
5. Training Employees in privacy protection requirements and appoint a Privacy Officer responsible for such protections.
6. Disclosing the Participant's PHI to the Secretary of the U.S. Department of Health and Health and Human Resources when the Secretary is investigating or determining the Plan's compliance with the HIPAA Privacy Rule.

PARTICIPANT'S RIGHTS

As a Participant in the Plan, the Participant is entitled to certain rights and protections under ERISA. ERISA provides that all Participants are entitled to:

Receive Information About the Plan and Benefits

Examine, without charge, at the Plan Administrator's office and at other specified locations, such as worksites and union halls (if any), all documents governing the Plan, including insurance contracts, collective bargaining agreements (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 and collective bargaining agreements (if any), and copies of the latest annual report (Form 5500 Series) and updated summary plan description. The Administrator may make a reasonable charge for the copies.

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

Continue Group Health Plan Coverage

Continue health care coverage for the Employee and eligible Dependents 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 Plan Document and the documents governing the Plan on the rules governing the Participant's COBRA Continuation Coverage rights.

Prudent Actions by Plan Fiduciaries

In addition to creating rights for Participants, 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 the Participants and beneficiaries. No one, including the Employer, the union (if any), or any other person, 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 Participant's rights under ERISA.

Enforce the Participant's Rights

If a Participant's claim for a welfare benefit is denied or ignored, in whole or in part, the Participant has a right to know why this was done, to obtain copies of documents relating to the decision without charge, and to appeal any denial, all within certain time schedules. Under ERISA, there are steps the Participant can take to enforce the above rights. For instance, if the Participant requests a copy of Plan documents or the latest annual report from the Plan and do not receive them within 30 days, the Participant 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 Participant up to $110 a day until the Participant receives the materials, unless the materials were not sent because of reasons beyond the control of the Plan Administrator. If the Participant has a claim for benefits which is denied or ignored, in whole or in part, the Participant may file suit in a State or Federal court. In addition, if the Participant 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 Participant may file suit in Federal court. If it should happen that Plan fiduciaries misuse the Plan's money, or if the Participant is discriminated against for asserting his or her rights, the Participant may seek assistance from the U.S. Department of Labor, or the Participant may file suit in a Federal court. The court will decide who would pay court costs and legal fees. If the Participant is successful, the court may order the person the Participant sued to pay these costs and fees. If the Participant loses, the court may order the Participant to pay these costs and fees, for example, if it finds the Participant's claim is frivolous.

Assistance with the Participant's Questions

If the Participant has any questions about the Plan, the Participant should contact the Plan Administrator. If the Participant has any questions about this statement or about rights under ERISA, or needs assistance in obtaining documents from the Plan Administrator, the Participant 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 Participant 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.