Plan Endorsement #24 SP

GROUP #	A24107		
EFFECTIVE DATE	January 1, 2024		
EMPLOYER ID#	84-1653609	PLAN #s	501
NAME OF PLAN	Christian and Missionary Alliance Employee Benefits Plan		
TYPE OF PLAN	Silver HDHP Plan		

The following wording is hereby added to the Plan:

Christian and Missionary Alliance, of Reynoldsburg, Ohio hereby establishes a plan for payment of certain expenses for the benefit of its eligible employees to be known as Christian and Missionary Alliance Employee Benefits Plan. The attached document serves as the summary plan description, plan description and plan document for the Plan.

Christian and Missionary Alliance has caused this Plan to take effect as of 12:01 A.M. Eastern Time on January 1, 2024 at Reynoldsburg, Ohio.

APPROVED AND ATTESTED:

BY David Peppers TITLE Executive Director

DATE 02/26/2024

Christian and Missionary Alliance

One Alliance Place
Reynoldsburg, OH 43068
Phone: (800) 700-2651

Silver HDHP Plan

This booklet describes the Medical benefits for Eligible Employees of **Christian and Missionary Alliance.**

Information Applicable to Plan 501

Employer Identification Number
84-1653609

The Benefits In This Booklet Are Effective
January 1, 2024

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INTRODUCTION

This Plan was established by The Christian and Missionary Alliance for the benefit of Employees who are employed by any denominational Employer that elects to participate in the Plan. Denominational Employers that are eligible to participate in the Plan include the C&MA National Office, a district office or local church, and any agency, supporting organization, or institution officially related to The Christian and Missionary Alliance. This Plan is intended to be a "church plan" within the meaning of section 414(e) of the Internal Revenue Code of 1986, as amended, and section 3(33) of the Employee Retirement Income Security Act of 1974 ("ERISA") and, as such, is exempt from the requirements of ERISA.

This document is a description of Christian and Missionary Alliance Health Care Plan (the Plan). No oral interpretations can change this Plan. The Plan described is designed to protect Plan Participants against certain catastrophic health expenses. This High Definition Health (HDHP) Plan is designed to be used with a Health Savings Accounts (HSA), HSA HDHP.

The Plan Administrator fully intends to maintain this Plan indefinitely. However, it reserves the right to terminate, suspend, discontinue or amend the Plan at any time and for any reason.
Changes in the Plan may occur in any or all parts of the Plan including benefit coverage, Deductibles, maximums, Exclusions, limitations, Definitions, Eligibility and the like.

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

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

The Plan will pay benefits only for the expenses incurred while this coverage is in force. No benefits are payable for expenses incurred before coverage began or after coverage terminated. An expense for a service or supply is incurred on the date the service or supply is furnished.
If the Plan is terminated, amended, or benefits are eliminated, the rights of Covered Persons are limited to Covered Charges incurred before termination, amendment or elimination.

It is the intent of this Plan and the Plan Administrator to comply with all applicable Federal laws and regulations. In the event of non-compliance with any such law or regulation, the Plan Document will be deemed amended to comply with said law or regulation as of its effective date, and the remainder of the Plan Document will remain in full force and effect. Similarly, in the event a law or regulation applicable to this Plan becomes effective after the initial effective date of this Plan Document, said law or regulation will be deemed included in this Plan Document as of its effective date and without the necessity of an amendment to this Plan Document.

KEY INFORMATION

EMPLOYER/COMPANY/PLAN ADMINISTRATOR/ PLAN SPONSOR CONTACT INFORMATION:
Christian and Missionary Alliance
One Alliance Place
Reynoldsburg, OH 43068
Phone: (800) 700-2651

EMPLOYER/COMPANY IDENTIFICATION NUMBER (EIN) AS ASSIGNED BY THE INTERNAL REVENUE SERVICE (IRS):
84-1653609

PLAN NAME:
Christian and Missionary Alliance Employee Benefits Plan

PLAN CONTACT INFORMATION:
Alliance Benefits Team
Christian and Missionary Alliance
One Alliance Place
Reynoldsburg, OH 43068
Phone: (800) 700-2651

PLAN NUMBER:
501

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

GROUP NUMBER:
A24107

SPD EFFECTIVE DATE:
January 1, 2024

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

TYPE OF PLAN:
Medical and Prescription Drugs

NAME, ADDRESS AND TELEPHONE NUMBER OF THE CLAIMS PROCESSOR:

Allied Benefit Systems, LLC
P. O. Box 211651
Eagan, MN 55121
For customer support, please see Your member ID card for the phone number where you can reach Your designated customer support team.

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

The following employees, or classes of employees, or other persons under control of the Plan Sponsor, shall be given access to the protected health information (PHI) to be disclosed:

- Executive Director for Alliance Benefits.
- Staff designated by Executive Director for Alliance Benefits.
- Chief Financial Officer.
- Staff designated by Chief Financial Officer.

ELIGIBILITY:

- Employees who are scheduled to work at least 30 hours per week. Coverage for regular full-time Employees becomes effective on the first day of the month following completion of the Waiting Period, subject to completion of enrollment requirements.
- Regular part-time Employees: Employees designated by the Employer as regular part-time Employees who are scheduled to work at least 20 hours per week. Coverage for regular part-time Employees becomes effective on the first day of the month following completion of the Waiting Period, subject to completion of enrollment requirements.

- Retirees: This Plan does not cover retirees or their Dependents(except in special continuation of coverage circumstances).

- Dependents Including:
  - Dependent Children: Child(ren) from birth to the last day of the month they attain age 26 consisting of natural children, stepchildren, foster children, adopted children, children placed for adoption and children for whom You are the court-appointed legal guardian.

    A child who is physically or mentally incapable of self-support upon attaining age 26 may be continued under the health care benefits, while remaining incapacitated and unmarried, subject to the covered Employee's own coverage continuing in effect. To

continue a child under this provision, the Company must receive proof of incapacity within 31 days after coverage would otherwise terminate. Additional proof will be required from time to time.

- Spouse: This Plan defines “marriage” as a legal union between one man and one woman as husband and wife, legally married in a jurisdiction (domestic or foreign) that recognizes their marriage. Marriage does not include a civil union, domestic partnership or any other similar arrangement.

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

WORKING SPOUSE COVERAGE PROVISION:

No surcharge will be levied if the spouse of an eligible Employee is eligible for coverage through his employer and chooses coverage from this Plan.

ENROLLMENT:

- **Enrollment Waiting Period:**

  Coverage hours and eligibility will be determined by the individual employer. A Waiting Period is the time between the first day of employment as an eligible Employee and the first day of coverage under the Plan unless hired on the first day of the month, then coverage begins on that day.

  An Employee's status as a full-time or part-time Employee will be determined on the basis of the average number of hours worked during an initial or standard measurement period, as applicable, as established by the Plan in accordance with applicable law. The Employee's eligibility (or lack of eligibility) for Plan coverage on the basis of his or her full-time or part-time status will extend through the stability period established by the Plan in accordance with applicable law. In calculating the average hours worked, the Plan will count hours paid and hours for which the Employee is entitled to payment (such as paid holidays, vacation, pay, etc.). An Employee's status as a full-time or part-time Employee will be determined on the basis of the Employer's standard employment practices.

  Contact your Human Resources Department for additional information.

- **Open Enrollment Period:**

  Each year, a period of time may be designated as an Open Enrollment period. Except for Special Enrollment or Late Enrollment, if applicable, it is only during this period that an Employee or Dependent who did not enroll during their initial eligibility period may enroll in

a Plan. It is also only during this period that an Employee who is currently covered under one Plan may switch to another. Coverage will become effective on the date specified by Your Employer.

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

TERMINATION OF COVERAGE:

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

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

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

IMPORTANT NETWORK CONTACT INFORMATION:

Function	Network Name	Claims Filing Information	Phone Number	URL
PPO Network	First Health Network	Electronic: Payer ID #37308 Paper: Allied Benefit Systems, LLC P. O. Box 211651 Eagan, MN 55121	1-800-226-5116	www.myfirsthealth.com

PRE-CERTIFICATION PROGRAM

Your Plan also includes a **pre-certification program**. The toll-free number You must use for pre-certification is shown on Your member ID card. **Failure to follow the guidelines listed below will subject Your benefits to a penalty for non-compliance as discussed in this section and referenced in the schedule of covered services and provisions.**

The following service require pre-certification:

- Inpatient Hospital admissions.
- Durable Medical Equipment exceeding $1,000.
- Infusion therapy.
- Genetic testing.
- Oncology Treatment
    - Chemotherapy (Including oral)
    - Radiation Therapy
    - Oncology and transplant related injections, infusions and treatment (e.g., CAR-T, endocrine and immunotherapy), excluding supportive drugs (e.g., antiemetic and antihistamine)

If Your Physician recommends any service listed above, please follow these steps:

1. Notify Your Physician that You participate in a pre-certification program. Please note that this applies even if this Plan is the secondary payer under Coordination of Benefits.

2. You or Your Physician must call the number shown on Your member ID card 2 weeks before or, if less than 2 weeks, as soon as scheduled for an elective Hospital admission. Note: For exceptions, please refer to the section of this document entitled "Compliance Regulations," and see the subheading "Statement of Rights Under the Newborns' and Mothers' Health Protection Act".

3. If You have an emergency admission, pre-certification is required within 48 hours or the next business day following admission.

The following information will be needed to pre-certify:

Regarding Patient:	**Regarding Employee:**
Name	Name
Address	Address
Telephone #	Telephone #
Date of Birth	Date of Birth

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

4. A nurse may call Your Physician to review a proposed Inpatient admission or other listed service. If admission is necessary, an assigned length of stay will be determined. If additional days are later thought to be necessary, these additional days must also be pre-certified.

5. When You or Your Physician call to pre-certify an Inpatient admission or other listed service, the call will be logged so that:

   a. The facility can verify that pre-certification has been done and can track expected length of stay.

   b. The Claims Processor can verify that the pre-certification requirements have been met when the claim is received for processing.

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

PENALTY FOR NON-COMPLIANCE:

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

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

PRE-NOTIFICATION

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

Procedures for which pre-notification is recommended are:

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

SCHEDULE OF COVERED SERVICES AND PROVISIONS

I. MEDICAL CARE BENEFITS:

COVERED SERVICES and PROVISIONS	In-Network	Out-of-Network
Calendar Year Deductible *(taken before benefits are payable unless waived)* *Note: There is no limit to the amount that an individual may apply towards the Family Deductible. However, note that the entire Family Deductible amount must be met before any benefits are payable for any individual in the family (except for preventive care services benefits as specifically stated herein).*	$2,000.00 per person $4,000.00 per family	$4,000.00 per person $12,000.00 per family
Coinsurance	80%	50%
Deductible Carry-Over	N/A	
Out-of-Pocket Maximum per Calendar Year *(*medical and Rx co-pays Co-Insurance and Deductibles count towards the Out-of-Pocket Maximum) *After amount is reached, 100% level of benefits applies for that* Calendar Year. The following expenses do not apply to and are not affected by the Out-of-Pocket Maximum: • "Non-compliance penalty" (for failure to abide by pre-certification requirements). • Any out-of-pocket expenses that are for non-covered services or for services that are in excess of any Plan maximum or limit. *This is an embedded Out-of-Pocket Maximum, meaning each covered family member only needs to satisfy his or her individual Out-of-Pocket Maximum, not the entire family Out-of-Pocket maximum, prior to receiving Plan benefits paid at 100%. The balance of the family Out-of-Pocket Maximum can be satisfied by one member or a combination of remaining family members.*	$6,300.00 per person $12,600.00 per family	$12,600.00 per person $37,800.00 per family
Calendar Year Benefit Maximum	Unlimited	
Precertification Penalty for Non-Compliance: Certain benefits are subject to a $500.00 penalty per occurrence ***(in addition to Deductible)*** for failure to follow the Pre-Certification Program provisions. Please refer to Pre-Certification Program section for additional information.	Allied Care 1-800-892-1893	
Claims Filing Limit	All charges, and corresponding requested documentation, must be submitted within 1 year(s) of the date incurred.	
Coordination of Benefits	If it is determined that this Plan is the secondary payer, benefits will be adjusted and reduced (standard). Benefits payable from both plans shall not exceed 100% of the eligible U&C charges.	
In-network and out-of-network Deductibles and Out-of-Pocket Maximums are tracked separately, such that Covered Services applied to one will not apply to the other.		

II. PRESCRIPTION DRUG BENEFIT:

COVERED SERVICES and PROVISIONS	In-Network	Out-of-Network
Your Prescription Drug Benefit is administered by MedOne. For prescription drug questions please call 1-888-884-6331 or visit www.medone-rx.com.		
If member requests brand only when a generic is available, the member will be charged the generic co-pay plus the cost difference between the brand and generic medication. The amount of this cost difference does not apply to the Deductibles or Out-of-Pocket Maximums.		
Prescription Drug Card Benefit (up to 30-day supply per prescription through participating pharmacies).	15%/generic, 15%/brand, 25%/Non-preferred brand (per prescription). After Deductible	
Mail-Order Drug Benefit (up to 90-day supply per prescription through mail order) *except where prohibited by state or federal law.*	10%/generic, 10%/brand, 25%/Non-preferred brand (per prescription). After Deductible.	
Mail-Order/Extended Retail Pharmacy Requirement	Optional	
Specialty Drug Benefit *(up to 30-day supply per prescription, includes certain injectable medications) except where prohibited by state or federal law.* *You must contact Vivio if you are refilling or getting a new prescription for a specialty medication at 800-470-4034.*	Please contact Vivio for all Specialty Inquiries	
FDA approval does not automatically constitute plan coverage. Pre-approval studies for medications for specialty and orphan conditions do not always involve scientific rigor required of medications for more common conditions. Phil Long Dealerships follow MedOne's specialty inclusion list, which provides the framework to appropriately determine the safety and efficacy of specialty and orphan products required to be considered covered products.		
Note: Certain prescriptions shall be covered at 100%, and no co-pay will apply as per Federal Regulations		

III. PREVENTIVE CARE SERVICES:

COVERED SERVICES and PROVISIONS ***Note:*** *Generally, for in-network charges billed on a Form CMS-1500 exceeding $5,000, payment will be limited to the Medicare fee schedule. Some exceptions may apply. See the Out-of-Network Benefits section of this SPD for more information.*	**In-Network**	**Out-of-Network**
Preventive Care Services - (*must be billed with a routine diagnosis).* This plan includes coverage for physical exams, immunizations, tests, labs, x-rays, pap smears and analysis, PSA test, bone density tests (for women age 60 and older, every 5 Calendar Year *This benefit also covers all referenced within the Recommendations of the United States Preventive Service Task Force, Recommendations of the Advisory Committee On Immunization Practices (ACIP) that have been adopted by the Director of the Centers for Disease Control and Prevention and appear on the Immunization Schedules of the Centers for Disease Control and Prevention, the Comprehensive Guidelines Supported by the Health Resources and Services Administration (HRSA), as well as referenced in the Guidelines for Women's Preventative Services adopted by the United States Department of Health and Human Services, based on recommendations by the Institute of Medicine.* This benefit specifically does not cover executive physicals, heart scans, full body scans, CAT scans, MRIs, PET or other similar tests.	100% Deductible waived.	50% After Deductible
Preventive Care Services – Enhanced - (*must be billed with a routine diagnosis).* • Mammograms (including 3D), once every year (age 40 or older) • Choice between a sigmoidoscopy or a colonoscopy once every 5 years (age 45 or older)	100% Deductible waived.	50% After Deductible
Family history benefit *Any age or visit limit maximums will not apply when family history is the only diagnosis billed for routine tests. This benefit is limited to the services referenced within the Recommendations of the United States Preventive Service Task Force, as well as referenced in the Guidelines for Women's Preventative Services adopted by the United States Department of Health and Human Services, based on recommendations by the Institute of Medicine*.	100% Deductible waived.	50% After Deductible
Family Planning - Permanent Procedures for Women *Includes:* • *Sterilization.*	100% Deductible waived.	50% After Deductible
Breast Pumps and Supplies (Includes one breast pump per pregnancy, and certain covered supplies purchased through a retail supplier).	100% Deductible waived.	100% Deductible waived.

IV. Physician Services:

COVERED SERVICES and PROVISIONS		
Note: *Generally, for in-network charges billed on a Form CMS-1500 exceeding $5,000, payment will be limited to the Medicare fee schedule. Some exceptions may apply. See the Out-of-Network Benefits section of this SPD for more information.*	**In-Network**	**Out-of-Network**
Note: For surgical assistance provided by an assistant surgeon (when Medically Necessary), Covered Services of the assistant surgeon are limited to 20% of the Plan's allowance for the surgeon.		
Virtual Physician charges	Paid same as any other service according to type of service and provider.	
Mental/Nervous and Substance Use Disorders Physician Office Visits- *exam charge only*	90% After Deductible	Paid same as in-network (subject to the in-network Deductible and in-network Out-of-Pocket)
Physician Office Visits – *exam charge only* *Allied considers the following doctors as primary care physicians, all others would be specialists:* • *General Practice.* • *Family Practice.* • *OB/Gyn.* • *Internal Medicine.* • *Osteopaths.* • *Pediatricians.* • *Physician Assistants* • *Nurse Practitioners*	90% After Deductible	50% After Deductible
Urgent Care - *includes facility fees and all other services done during the urgent care visit.*	85% After Deductible	50% After Deductible
Specialist Office Visits – *exam charge only*	80% After Deductible	50% After Deductible
Surgery Incurred at a Physician's Office	80% After Deductible	50% After Deductible
Other Physician Services Incurred at a Physician's Office Visit *Does not include labs, x-rays or imaging; please see Section V for additional benefit coverage information.*	80% After Deductible	50% After Deductible
Emergency Room Physician Care	Please refer to Emergency Room Services benefit in Section VI.	
Physical and Occupational Therapy *All services rendered by physical therapists/occupational therapists are limited to a combined maximum of* 60 *visits for office and Outpatient facility services, per Covered Person per* Calendar Year. *However, this* Calendar Year *visit maximum does not apply to covered therapy services for autism.*	80% After Deductible	50% After Deductible
Speech Therapy *Limited to a maximum of* 60 *visits for office and Outpatient facility services, per Covered Person per* Calendar Year. *However, this* Calendar Year *visit maximum does not apply to covered therapy services for autism.*	80% After Deductible	50% After Deductible

IV. Physician Services:

COVERED SERVICES and PROVISIONS ***Note:*** *Generally, for in-network charges billed on a Form CMS-1500 exceeding $5,000, payment will be limited to the Medicare fee schedule. Some exceptions may apply. See the Out-of-Network Benefits section of this SPD for more information.*	**In-Network**	**Out-of-Network**
Note: For surgical assistance provided by an assistant surgeon (when Medically Necessary), Covered Services of the assistant surgeon are limited to 20% of the Plan's allowance for the surgeon.		
All Care Rendered by a Chiropractor and Massage therapy. *All services are limited to a combined maximum of* 20 *visits per Covered Person per* Calendar Year*, regardless of the place of service or services provided. Does not include labs and x-rays please see Section V for additional benefit coverage information.*	80% After Deductible	Paid same as in-network (subject to the in-network Deductible and in-network Out-of-Pocket)
Anesthesia and its Administration *(Inpatient/Outpatient)*	80% After Deductible	50% After Deductible
Allergy Injections, Serum, and Administration.	80% After Deductible	50% After Deductible
Other Physician Services *Does not include Outpatient/Independent Laboratory/Office labs, x-rays and imaging please see Section V for additional benefit coverage information.*	80% After Deductible	50% After Deductible
If a referral is made to a non-network Physician or non-network specialist/facility by a network Physician (due to Medically Necessary services not being available In-Network).	N/A	Paid same as In Network.
Non-Network Physician Services Received at a Network Hospital If services are performed by a non-network Physician/specialist, who is requested or required by that network Hospital, the charges will be covered as if rendered by a network Physician/specialist.	N/A	Paid same as In-Network.

V. OUTPATIENT/OFFICE (PHYSICIAN'S OFFICE AND FACILITY) LABORATORY/RADIOLOGY/PATHOLOGY SERVICES, INCLUDING ADMINISTRATION AND MRI, PET, AND CT SCANS:

COVERED SERVICES and PROVISIONS ***Note:*** *Generally, for in-network charges billed on a Form CMS-1500 exceeding $5,000, payment will be limited to the Medicare fee schedule. Some exceptions may apply. See the Out-of-Network Benefits section of this SPD for more information.*	**In-Network**	**Out-of-Network**
Outpatient/Office/Independent Laboratory Diagnostic Tests, Radiology and Pathology Administration and Interpretation Services *Does not include above services performed in conjunction with the following:* • *Emergency Room Services.* • *Urgent Care Services* *Does not include MRI, PET or CT scans.*	80% After Deductible	50% After Deductible
Outpatient/Office Imaging Services (MRI, PET, and CT scans) *Does not include above services performed in conjunction with the following:* • *Urgent Care Services*	80% After Deductible	50% After Deductible

VI. FACILITY SERVICES:

COVERED SERVICES and PROVISIONS		
	In-Network	**Out-of-Network**
Emergency Room Services Note: See the "Out-of-Network Benefits" section for more information regarding out of network Emergency Room Services.	80% After Deductible	Paid Same as In-network
Inpatient Hospital Services *Coverage is limited to:* • *Room and board not to exceed the semi-private room rate.* • *Necessary services and supplies including an intensive care unit and a cardiac care unit.* • *If admitted through the Hospital emergency room, this benefit will be covered at the in-network level. Notice and consent rules may apply to certain post-stabilization items and services. See Emergency Room Services in the "Definitions" section.* *Note: Room and board subject to the payment of semi-private room rate, unless the Hospital only has private rooms.* *Note: for in-network Inpatient Hospital charges exceeding $10,000, payment will be limited to the Medicare DRG Reimbursement Rate.*	80% After Deductible	50% After Deductible
Ambulatory Surgical Facility Charges for Outpatient Surgical Procedures *Note: for in-network Ambulatory Surgical Center charges exceeding $2,500, payment will be limited to the Medicare ASC Reimbursement Rate.*	80% After Deductible	50% After Deductible
Outpatient Hospital Facility Charges *Note: for in-network Outpatient Hospital charges exceeding $2,500, payment will be limited to Medicare APC Reimbursement Rate.*	80% After Deductible	50% After Deductible
Renal Dialysis *Note: For charges due to renal dialysis, payment by this Plan will not exceed 100% of the Medicare allowance for such incurred expenses.*	100% After Deductible	Paid the same as in-network
Urgent Care Services – facility fees	Please refer to Urgent Care Services benefit in Section IV.	

VII. MENTAL HEALTH AND SUBSTANCE USE SERVICES:

COVERED SERVICES and PROVISIONS		
	In-Network	**Out-of-Network**
BEHAVIOR HEALTH BENEFIT (Mental/Nervous/Substance Use Disorders)		
Outpatient Treatment for Mental/Nervous and Substance Use Disorders *Please see the definitions of Physician and Hospital for further detail.*	80% After Deductible	Paid same as in-network (subject to the in-network Deductible and in-network Out-of-Pocket)
Inpatient Treatment for Mental/Nervous and Substance Use Disorders	80% After Deductible	Paid same as in-network (subject to the in-network Deductible and in-network Out-of-Pocket)

VIII. ADDITIONAL COVERED SERVICES:

COVERED SERVICES and PROVISIONS ***Note:*** *Generally, for in-network charges billed on a Form CMS-1500 exceeding $5,000, payment will be limited to the Medicare fee schedule. Some exceptions may apply. See the Out-of-Network Benefits section of this SPD for more information.*	**In-Network**	**Out-of-Network**
Autism Spectrum Disorders For those diagnosed with this disorder, the following treatments are covered: • Psychiatric and Psychological care, meaning direct, consultative, or diagnostic services provided by a licensed psychiatrist or psychologist. • Habilitative or rehabilitative care, meaning professional, counseling, and guidance services and treatment programs, including applied behavior analysis, that are intended to develop, maintain, and restore the functioning of an individual. Autism spectrum disorders means pervasive developmental disorders as defined in the most recent edition of the Diagnostic and Statistical Manual of Mental Disorders, including autism, Asperger's disorder, and pervasive developmental disorder not otherwise specified.	90% After Deductible	Paid same as in-network (subject to the in-network Deductible and in-network Out-of-Pocket)
Hearing Aids and the fitting thereof- *Limited a maximum payment of $750 per hearing impaired ear every* 24 months.	80% After Deductible	50% After Deductible
Hearing Exams- *Limited to one exam per person every 24 months ages 22 and over. Hearing screenings from birth through age 21 are covered under the Preventive Care benefit.*	80% After Deductible	50% After Deductible

IX. OTHER COVERED SERVICES:

COVERED SERVICES and PROVISIONS ***Note:*** *Generally, for in-network charges billed on a Form CMS-1500 exceeding $5,000, payment will be limited to the Medicare fee schedule. Some exceptions may apply. See the Out-of-Network Benefits section of this SPD for more information.*	In-Network	Out-of-Network
Note: The following benefits are subject to the applicable co-insurance level unless they are included in a separate category listed in this Schedule of Covered Services and Provisions.		
Abortion 41-H2-Statement-on-Sanctity-of-Human-Life-3-15-22.pdf (cmalliance.org)	Not Covered	Not Covered
Acupuncture - *All services are limited to a maximum of* 20 *visits per Covered Person per* Calendar Year.	80% After Deductible	50% After Deductible
Assisted Reproduction	Not Covered	Not Covered
Casts, Splints, Trusses and Braces	80% After Deductible	50% After Deductible
Contact Lenses or Glasses Following Cataract Surgery *Limited to first pair of either contact lenses or glasses following cataract surgery for initial replacement of natural lenses.*	80% After Deductible	50% After Deductible
Dental Treatment *when rendered by a Physician, dentist or oral surgeon for* ***a*** **fractured jaw** *or for* **accidental Injuries to natural teeth within 6 months** *after the accident (replacement or repair of a denture not covered) removal of* **total bony impacted teeth** *charges for* **medical care, services** *and* **supplies** *furnished by a Hospital during Medically Necessary confinement in connection with* dental treatment.	80% After Deductible	50% After Deductible
Durable Medical Equipment *Includes:* • *Cost to purchase or rent up to purchase price.* • *Insulin pump, glucose monitors and other diabetic supplies when Medically Necessary and not covered though Your prescription drug vendor.* • *Equipment for administration of oxygen.* • *Equipment repair or replacement.*	80% After Deductible	50% After Deductible
Family Planning - Permanent Procedures for Men *Includes:* • *Sterilization.* ○ *Male vasectomy.*	80% After Deductible	50% After Deductible
Foot Orthotics *Limited to 1 set of inserts every Calendar Year, as prescribed by a Physician or specialist.*	80% After Deductible	50% After Deductible
Gender Affirming Surgery (including any associated labs and x-rays)	Not Covered	Not Covered
Growth hormones *(must be Medically Necessary)*	80% After Deductible	50% After Deductible

IX. OTHER COVERED SERVICES:

COVERED SERVICES and PROVISIONS ***Note:*** *Generally, for in-network charges billed on a Form CMS-1500 exceeding $5,000, payment will be limited to the Medicare fee schedule. Some exceptions may apply. See the Out-of-Network Benefits section of this SPD for more information.*	In-Network	Out-of-Network
Home Health Care *Limited to a maximum of* 40 *home care visits per Covered Person per* Calendar Year. *Each 4 hours of service by a home health aide in a 24-hour period will be considered 1 home health visit.* *One visit by any other provider of services will be counted as 1 visit.*	80% After Deductible	50% After Deductible
Hospice Care- *Limited to a maximum of 180 days per Lifetime* *Includes all necessary services for the patient if prescribed by a Physician, and the patient's life expectancy is 6 months or less.*	80% After Deductible	50% After Deductible
Infertility Testing *Limited to Covered Services necessary to diagnose this condition only.* *This benefit does not cover charges in connection with the promotion of conception (see Assisted Reproduction benefit for details). Infertility means the inability to conceive a child, or the inability to sustain a successful pregnancy.*	Paid same as any other service according to type of service, provider and place of service.	
Infusion therapy and Injections The first dose of in-network infusion therapy may be given at the Physician's facility of choice, including Outpatient Hospitals, free-standing facilities and home care. Any subsequent dose may also be given at the Physician's facility of choice, but only when clinically appropriate and at a lower cost than other sites of administration. *For* in-network *infusion therapy charges exceeding $1,500 (including, but not limited to, chemotherapy), payment by this Plan will not exceed 100% of the Medicare allowance for such incurred expenses. (Infusion therapy encompasses intravenous and/or intramuscular injections, as well as drugs administered through other non-oral routes, such as epidural routes). Note Self-administered injections, topical solutions and oral specialty medications are not covered under this Plan.*	80% After Deductible	50% After Deductible
Marital Counseling	80% After Deductible	Paid the same as in-network. (Subject to the in-network deductible and Out-of-Pocket maximum)
Mastectomy Related Treatment *Includes charges in accordance with the provisions detailed under the definition of "Reconstructive Breast Surgery."*	80% After Deductible	50% After Deductible
Nutritional Counseling, regardless of underlying covered condition	80% After Deductible	50% After Deductible

IX. OTHER COVERED SERVICES:

COVERED SERVICES and PROVISIONS ***Note:*** *Generally, for in-network charges billed on a Form CMS-1500 exceeding $5,000, payment will be limited to the Medicare fee schedule. Some exceptions may apply. See the Out-of-Network Benefits section of this SPD for more information.*	In-Network	Out-of-Network
Obesity surgery and Non-surgical obesity treatment *Obesity surgery limited to* 1 *surgical procedure per Covered Person per* Per Lifetime *Non-surgical obesity treatment limited to $*5000 *Maximum paid per Covered Person per* Per Lifetime. Benefit does not apply unless Covered Person: • Has attempted weight loss in the past without successful long-term weight reduction and • Meets either a physician-supervised nutrition and exercise program or a multidisciplinary surgical preparatory regimen. Benefit does not apply unless the *Adult* Covered Person: • Has a body mass index (BMI) exceeding 40 *or* • Has a BMI greater than 35 in conjunction with any of the following severe co-morbidities: o Clinically significant obstructive sleep apnea (i.e., patient meets the criteria for treatment of obstructive sleep apnea) or o Coronary heart disease *or* o Medically refractory hypertension (blood pressure greater than 140 mmHg systolic and/or 90 mmHg diastolic despite optimal medical management) *or* o Type 2 diabetes mellitus.	80% After Deductible	50% After Deductible
Organ or Tissue Transplant– **Christian and Missionary Alliance Maintains a Separate Organ Transplant Policy Which is Always Primary**	Please contact Optum at 800-367-4436.	
Organ or Tissue Transplant Procedures – **For cornea, skin, or cartilage transplants:** *The Covered Person, who is the transplant recipient, must receive 2 opinions with regard to the need for transplant surgery. The opinions must be in writing by board-certified specialists in the involved field of surgery. The specialists must certify that alternative procedures, services or courses of treatment would not be effective in the treatment of the condition.*	80% After Deductible	50% After Deductible
For all other Organ and Tissue Transplants: *For specific details on all elements of this coverage, please refer to the Transplants section.*	Coverage and Benefit Level based upon place and type of service.	Not Covered.
Orthopedic Shoes	Not Covered	Not Covered
Prescription Drugs *if not available through the Prescription Drug Benefit. Must be Medically Necessary.*	80% After Deductible	50% After Deductible
Private Duty Nursing Services - *Includes services of a registered professional nurse (R.N.) or a licensed practical nurse (L.P.N.), when Medically Necessary, other than one who ordinarily resides in Your home, or who is a member of the immediate family.* *Limited to a maximum of* 40 *visits (one per day) per Covered Person per* Calendar Year.	80% After Deductible	50% After Deductible

IX. OTHER COVERED SERVICES:

COVERED SERVICES and PROVISIONS ***Note:*** *Generally, for in-network charges billed on a Form CMS-1500 exceeding $5,000, payment will be limited to the Medicare fee schedule. Some exceptions may apply. See the Out-of-Network Benefits section of this SPD for more information.*	**In-Network**	**Out-of-Network**
Professional Ambulance Service *Transportation from the city or town in which the Covered Person becomes disabled, to and from the nearest Hospital qualified to provide treatment for the accidental bodily Injury or disease.* Note: See the "Out-of-Network Benefits" section for more information regarding out of network Air Ambulance services	80% After Deductible	Paid the same as in-network. (Subject to the in-network deductible and Out-of-Pocket maximum)
Prosthetic Medical Appliances (including Artificial Limbs, Eyes and Larynx) *Limited to charges for the purchase, maintenance, or repair of internal and external permanent or temporary aids and supports for defective body parts.*	80% After Deductible	50% After Deductible
Routine Newborn Nursery Care *(including circumcision)*	80% After Deductible	50% After Deductible
Services/Items for Covered Persons Residing Outside the PPO Network Area	*N/A*	*Paid same as any other in-network service according to type of service, provider and place of service.*
Skilled Nursing Facility *Includes Extended Care Facility.* *Limited to* 60 *days per Covered Person per* Calendar Year. *Limited to the usual charge of the facility for semi-private care, including room and board and all other services.*	80% After Deductible	50% After Deductible
Sleep Studies (*home)*	80% After Deductible	50% After Deductible

IX. OTHER COVERED SERVICES:

COVERED SERVICES and PROVISIONS ***Note:*** *Generally, for in-network charges billed on a Form CMS-1500 exceeding $5,000, payment will be limited to the Medicare fee schedule. Some exceptions may apply. See the Out-of-Network Benefits section of this SPD for more information.*	In-Network	Out-of-Network
Sleep Studies ***(In-lab, facility)*** *In order to be eligible, the following criteria must be met:* • *Excessive daytime sleepiness* • *Epworth sleepiness scale ≥ 10* • *Witnessed snoring* *Along with one of the following comorbid conditions:* • *Chronic obstructive pulmonary disease* • *Neuromuscular disease* • *Stroke* • *Epilepsy* • *Congestive heart failure* • *BMI > 45* • *Periodic limb movement disorder* • *Narcolepsy* • *Central or complex sleep apnea*	80% After Deductible	50% After Deductible
TMJ *(Temporomandibular Joint Dysfunction) diagnostic and non-surgical procedures- Limited to $1500 Maximum paid per Covered Person per Calendar Year. Benefit does not include charges for orthodontic services or surgical services for TMJ.*	80% After Deductible	50% After Deductible
Wigs *for hair loss resulting from the treatment of cancer. Limited to one wig per Covered Person every Calendar Year.*	80% After Deductible	50% After Deductible
Please Refer to the Pre-Certification Program and Exclusions sections for additional coverage details.		

EXCLUSIONS

No payment will be made under this Plan for expenses incurred by a Covered Person based on the below exclusions *(unless specifically stated within the Schedule of Covered Services and Provisions*):

1. for or in connection with an Injury or Illness for which the Employee or Dependent is entitled to benefits under any Workers' Compensation, Occupational Disease, or similar law;
2. for care and treatment of an Injury or Illness arising out of, or in the course of, any employment for wage or profit;
3. in a Hospital owned or operated by the United States Government or for services or supplies furnished by or for any other government unless payment is legally required;
4. for charges which the Covered Person is not legally required to pay or for charges which would not have been made if no coverage had existed;
5. which are not Reasonable and/or in excess of Usual and Customary Charges (depending on contract provisions, this limitation may not apply to charges from network providers or non-network providers who are utilized as a result of requests or requirements of network providers) unless otherwise set forth in the "Out-of-Network Benefits" section;
6. which are for care or treatment which is not Medically Necessary;
7. for custodial care (Expenses incurred to assist a person in daily living activities are considered costs for custodial care. Costs for medical maintenance services and supplies in connection with custodial care due to age, mental or physical conditions, are not covered if such care cannot reasonably be expected to improve a medical condition.);
8. due to accidental bodily Injury or Illness resulting from participation in an insurrection or riot, or participation in the commission of an assault or felony;
9. for purchase or rental of personal comfort items or supplies of common use; for purchase or rental of blood pressure kits, exercise cycles, air purifiers, air conditioners, water purifiers, hypo-allergenic pillows, mattresses or waterbeds, escalators, elevators, saunas, steam rooms and/or swimming pools;
10. for non-medical expenses such as preparing medical reports, itemized bills or charges for mailing;
11. for training, educational instructions or materials, even if they are performed or prescribed by a Physician;
12. for legal fees and expenses incurred in obtaining medical treatment;
13. for genetic testing and counseling (except as may be specifically stated as covered elsewhere in this document) unless Medically Necessary;

14. for Friday and Saturday admissions unless due to a Medical Emergency or if surgery is scheduled within the 24 hour period immediately following admission;
15. for treatment by a Physician, Registered Nurse (R.N.), Licensed Practical Nurse (L.P.N) if the Physician or nurse is related by blood, marriage, or by legal adoption to either the Covered Person or a spouse, or ordinarily resides with the Covered Person;
16. for any expense in excess of any maximum or limit as stated elsewhere in this document;
17. for failure to provide any additional documentation or information as may be requested pursuant to the "Procedures For Filing Claims" section of this Plan;
18. for charges for travel or accommodations, whether or not recommended by a Physician, unless specifically stated as covered;
19. for charges incurred before coverage was effective or after it was terminated;
20. for charges incurred as a result of radioactive contamination or the hazardous properties of nuclear material;
21. except as stated in the Schedule of Covered Services and Provisions, 1) for treatment of or to the teeth, the nerves or roots of the teeth, and 2) for the repair or replacement of a denture,
22. for research studies not reasonably necessary to the treatment of an Illness or Injury;
23. This Exclusion is intentionally left blank;
24. This Exclusion is intentionally left blank;
25. for treatment for sexual dysfunction or inadequacy; for sex changes, services or treatment for non-congenital transsexualism, gender dysphoria or sexual reassignment or change. This Exclusion includes medication, implants, hormone therapy, surgery, medical psychiatric treatment;
26. for vitamins (except prescription pre-natal and pediatric vitamins); for over-the-counter drugs regardless of being prescribed by a Physician, unless required by federal law;
27. for routine foot care such as removal of corns, calluses or toenails, except in the treatment of a peripheral-vascular disease when recommended by a medical doctor or doctor of osteopathy;
28. for splints or braces for non-medical purposes (i.e., supports worn primarily during participation in sports or similar physical activities;
29. for any form of medication or treatment not prescribed in relation to an Injury, Illness or pregnancy, unless stated as covered elsewhere in this document;
30. for growth hormones unless Medically Necessary;
31. on account of any declared or undeclared act of war;
32. for charges in connection with Cosmetic Surgery/Treatment, except to correct deformities

resulting from Injuries sustained in an accident; or due to an Illness such as breast cancer (including all services mandated by federal provisions related to mastectomy treatment – see definition of "Reconstructive Breast Surgery Coverage");

33. This Exclusion is intentionally left blank;
34. for expenses incurred for cryo-preservation and storage of sperm, eggs and embryos;
35. for charges incurred outside the United States if travel to such a location was for the primary purpose of obtaining medical services, drugs or supplies;
36. for special education services (unless specifically referenced in the Schedule of Covered Services);
37. for experimental or investigational services or, for treatment not deemed clinically acceptable by (1) the National Institute of Health; or (2) the FDA; or (3) the Centers for Medicare and Medicaid Services (CMS); or (4) the AMA; or a similar national medical organization of the United States;
38. for routine eye examinations, unless required by federal law; for eyeglasses or contact lenses, or the fitting of eyeglasses or contact lenses, except as stated in the Schedule of Covered Services and Provisions for any procedure, treatment or exam in connection with refractive disorders for eye surgery such as radial keratotomy;
39. This Exclusion is intentionally left blank;
40. This Exclusion is intentionally left blank;
41. for instruction or activities for weight reduction or weight control, including charges for vitamins, diet supplements, or physical fitness programs even if the services are performed or prescribed by a Physician (except as referenced in the Schedule of Covered Services);
42. This Exclusion is intentionally left blank;
43. This Exclusion is intentionally left blank;
44. for surgical reversal of elective sterilizations;
45. abortions;
46. for chelation (metallic ion) therapy, except as approved by the Food and Drug Administration;
47. for "nicotine patches" or other forms of anti-smoking medication (except as stated in the "Prescription Drug Benefit");
48. for care and treatment for hair loss including wigs, hair transplants, hair implants or any drug that promises hair growth, whether or not prescribed by a Physician except for wigs after chemotherapy;
49. for any service for assisted reproduction (including in vitro fertilization, uterine embryo lavage, embryo transfer, artificial insemination, gamete intrafallopian tube transfer, zygote

intrafallopian tube transfer, and low tubal ovum transfer); however, diagnosis and treatment of medical conditions (such as endometriosis) that may contribute to the condition of infertility are covered;

50. for services and supplies received from a medical or dental department maintained by or on behalf of an employer, a mutual benefit association, trustee or similar person or group;
51. This Exclusion is intentionally left blank;
52. This Exclusion is intentionally left blank;
53. This Exclusion is intentionally left blank;
54. for expenses for injuries incurred in the commission of a criminal act involving the use of alcohol or illegal drugs;
55. This Exclusion is intentionally left blank;
56. This Exclusion is intentionally left blank;
57. This Exclusion is intentionally left blank;
58. This Exclusion is intentionally left blank;
59. for charges due to renal dialysis, payment by this Plan will not exceed 100% of the Medicare allowance for such incurred expenses (except as specifically stated in the Out-of-Network Benefits section);
60. for in-network Inpatient Hospital charges exceeding $10,000, payment will be limited to the Medicare DRG Reimbursement Rate. If a Medicare DRG Reimbursement Rate is not available, then reimbursement will be limited to the Rate of the next closest Hospital;
61. for in-network Outpatient Hospital charges exceeding $2,500, payment will be limited to the Medicare APC Reimbursement Rate. If a Medicare APC Reimbursement Rate is not available, then reimbursement will be limited to the Rate of the next closest Hospital;
62. for in-network Ambulatory Surgical Center charges exceeding $2,500, payment will be limited to the Medicare ASC reimbursement fee schedule;
63. for in-network ambulance (ground and air) charges exceeding $2,500, payment by this Plan will not exceed 100% of the Medicare allowance for such incurred expenses (except as specifically stated in the Out-of-Network Benefits section). Charges include those which relate to 1) transportation and 2) medical supplies used during transport, including those for BLS (basic life support) only services and ALS (advanced life support) services/supplies.
64. for in-network charges billed on a Form CMS-1500 exceeding $5,000, payment will be limited to the Medicare fee schedule (except as specifically stated in the Out-of-Network Benefits section).

65. in-network infusion therapy charges exceeding $1,500 (including, but not limited to, chemotherapy), payment by this Plan will not exceed 100% of the Medicare allowance for such incurred expenses (except as specifically stated in the Out-of-Network Benefits section). Infusion therapy encompasses intravenous and/or intramuscular injections, as well as drugs administered through other non-oral routes, such as epidural routes.
66. for provider charges claimed as a result of purported lost discounts;
67. for charges for oral nutrition including infant formula;
68. for court ordered services, for otherwise covered services ordered by a court or other tribunal as part of Your or Your Dependents sentence;
69. for cellular therapy, which is the transfer of whole, live cells (modified or unmodified) to produce an immune or other biological response. Cellular therapy includes but is not limited to, cellular immunotherapies and cancer vaccines.
70. For gene Therapy, which is the use of genetic material to modify or manipulate the expression of gene or alters the biological properties of living cells for therapeutic use;
71. for family planning temporary procedures, including but not limited to injections, implants, and intrauterine contraceptives including administration, insertion, and removal other than depo-provera and medroxyprogesterone injections.
72. for charges for prescription drugs for contraceptive purposes other than those listed on the preventive drug list; for contraceptives for all abortifacient purposes.

DEFINITIONS

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

AIR AMBULANCE

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

AMBULATORY SURGICAL CENTER

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

ANCILLARY SERVICES

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

ASC REIMBURSEMENT FEE SCHEDULE

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

CALENDAR YEAR

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

CASE MANAGEMENT PROGRAM

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

If, at any point in the progress of a given medical situation, after having considered the opinions of the Covered Person (and/or his legally responsible representatives), the Covered Person's

Physician and/or other medical authorities, the Plan Administrator determines that the benefits of this Plan may be best utilized through the implementation of a Case Management Program, the Plan reserves the right to require that further benefits be provided only under the administration of such a program.

CLAIMS PROCESSOR

The entity providing consulting services to the Company in connection with the operation of the Plan and performing other functions, including processing of claims. The Claims Processor is Allied Benefit Systems, LLC, P. O. Box 909786-60690, Chicago, IL 60690. Should be P.O Box 211651 Eagan, MN 55121.

COMPANY

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

COSMETIC SURGERY/TREATMENT

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

COVERED PERSON / PLAN PARTICIPANT

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

COVERED SERVICES

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

DEDUCTIBLE/CO-INSURANCE

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

DEPENDENTS

Spouse of the Employee.

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

A child who is physically or mentally incapable of self-support upon attaining age 26 may be continued under the health care benefits, while remaining incapacitated and unmarried, subject to the covered Employee's own coverage continuing in effect. To continue a child under this provision, the Company must receive proof of incapacity within 31 days after coverage would otherwise terminate. Additional proof will be required from time to time.

DOMESTIC PARTNER

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

ELECTIVE SURGICAL PROCEDURE

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

EMERGENCY ROOM SERVICES

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

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

- The patient is able to receive the notice and provide consent, as determined by the attending emergency Physician or treating provider using appropriate medical judgment, and to provide informed consent under such section, in accordance with applicable state law.
- The provider or facility satisfies any additional requirements or prohibitions as may be imposed under state law.

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

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

EMPLOYEE

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

EMPLOYER

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

ENROLLMENT DATE

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

ESSENTIAL HEALTH BENEFITS

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

EXTENDED CARE FACILITY

An institution (or a distinct part of an institution) which: (a) provides for Inpatients (1) 24-hour nursing care and related services for patients who require medical or nursing care, or (2) service for the rehabilitation of injured or sick persons; (b) has policies developed with the advice of (and subject to review by) professional personnel to cover nursing care and related services; (c) has a Physician, a registered professional nurse or a medical staff responsible for the execution of such policies; (d) requires that every patient be under the care of a Physician and makes a Physician

available to furnish medical care in case of emergency; (e) maintains clinical records on all patients and has appropriate methods for dispensing drugs and biologicals; (f) has at least one registered professional nurse employed full time; (g) provides for periodic review by a group of Physicians to examine the need for admissions, adequacy of care, duration of stay and medical necessity of continuing confinement of patients; (h) is licensed pursuant to law, or is approved by appropriate authority as qualifying for licensing and is also approved by Medicare; (i) is not primarily a place for the elderly, a place for rest, or a place for custodial or educational care.

FAMILY DEDUCTIBLE

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

GENDER NEUTRAL WORDING

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

GENETIC INFORMATION

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

HOME HEALTH CARE AGENCY

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

HOSPICE

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

HOSPITAL

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

In addition, the term "Hospital" shall mean, as defined by Medicare, a Psychiatric Hospital, which is qualified to participate in and is eligible to receive payments under and in accordance with the provisions of Medicare; or, which meets the following requirements; (a) is licensed by the jurisdiction in which it operates; and (b) is accredited by the Joint Commission on the Accreditation of Healthcare Organizations.

HOSPITAL INTENSIVE CARE/CARDIAC CARE UNIT

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

HOSPITAL SEMI-PRIVATE

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

ILLNESS

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

INJURY

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

INPATIENT

A Covered Person shall be considered to be an "Inpatient" if he is treated at a Hospital and is confined for 23 or more consecutive hours. The term "Inpatient" shall also apply to those situations where "partial hospitalization" (defined as an on-going period of treatment involving full use of Hospital facilities excepting only room and board service) is recommended by the patient's Physician as an alternative to Hospital confinement.

LATE ENROLLMENT

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

LIFETIME

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

MEDICAL EMERGENCY

A **"**Medical Emergency**"** is defined as a medical condition, including a Mental/Nervous or Substance Use Disorder, manifesting itself by acute symptoms of sufficient severity (including severe pain) so that a prudent layperson, who possesses an average knowledge of health and medicine, could reasonably expect the absence of immediate medical attention to result in 1) a condition placing the health of the individual (or, with respect to a pregnant woman, the health of the woman or her unborn child) in serious jeopardy; 2) serious impairment to bodily functions; or 3) serious dysfunction of any bodily organ or part.

MEDICALLY NECESSARY

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

MEDICARE DRG OR APC REIMBURSEMENT RATE

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

MENTAL/NERVOUS AND SUBSTANCE USE DISORDER SERVICES
Services for diagnoses that are listed in the Diagnostic and Statistical Manual of Mental Disorders published by the American Psychiatric Association that is current as of the date services are rendered.

NAMED FIDUCIARY

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

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

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

OPEN ENROLLMENT

Each year, a period of time may be designated as an Open Enrollment period. Except for Special Enrollment or Late Enrollment, if applicable, it is only during this period that an Employee or Dependent who did not enroll during their initial eligibility period may enroll in a Plan. It is also only during this period that an Employee who is currently covered under one Plan may switch to another. Coverage will become effective on the date specified by Your Employer. See the Key Information section at the beginning of this document for applicability, as well as Your Employer for details.

OUT-OF-NETWORK RATE

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

OUT-OF-POCKET MAXIMUM

The "Out-of-Pocket Maximum" is the total amount of co-pays, co-insurance and deductibles for which the Covered Person or covered family is responsible during the course of a Calendar Year. These amounts are shown in the "Schedule of Covered Services and Provisions," along with

expenses not applicable towards the Out-of-Pocket maximum. Once this amount has been reached, 100% level of benefits applies for the remainder of that Calendar Year.

OUTPATIENT

A Covered Person shall be considered to be an "Outpatient" if he is treated at a Hospital and is confined less than 23 consecutive hours.

PHYSICIAN

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

PLACEMENT FOR ADOPTION

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

PLAN

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

PLAN ADMINISTRATOR

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

PLAN YEAR

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

QUALIFIED MEDICAL CHILD SUPPORT ORDER

A legal order requiring the coverage of specified child(ren) under an individual's medical plan benefits. If Your employer determines that a separated or divorced spouse or any state child support or Medicaid agency has obtained a legal QMCSO, and Your current plan offers dependent

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

REASONABLE/REASONABLENESS

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

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

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

RECOGNIZED AMOUNT

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

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

RECONSTRUCTIVE BREAST SURGERY COVERAGE

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

RETIREE

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

SECOND SURGICAL OPINION

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

SPECIAL ENROLLMENT

An enrollment which takes place during the 30-day period following the date of the event which triggers the Special Enrollment period. See "Eligibility" section for details.

USUAL AND CUSTOMARY

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

be Usual and Customary, the charge must be in compliance with the Plan Administrator's policies and procedures relating to billing practices for unbundling or multiple procedures.

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

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

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

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

WAITING PERIOD

The period of time before an individual is eligible to be covered under the terms of a group health plan. Any period before a Late Enrollment, Open Enrollment or Special Enrollment is not a Waiting Period.

YOU, YOUR, YOURSELF

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

ELIGIBILITY

WHO IS ELIGIBLE

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

NON-DISCRIMINATION

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

EMPLOYEE COVERAGE

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

DEPENDENT COVERAGE

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

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

INDIVIDUAL EFFECTIVE DATE

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

1. All Employees, who are eligible Employees, shall be covered on the day they become eligible, as discussed in the Key Information section at the beginning of this document.
2. Dependents shall be covered simultaneously with Employees covering them as Dependents.
3. Coverage for a spouse will begin from the date of marriage. Coverage for a newborn birth child will begin from the date of birth. Coverage for a child placed under legal guardianship, an adopted child or a child placed for adoption with the Employee will

begin from the date of Placement for Adoption. Coverage for a stepchild or foster child will begin from the date the child meets the definition of "Dependent." With respect to a spouse, the spouse must be formally enrolled and appropriate coverage arranged within 30 days from date of marriage. With respect to a newborn birth child, the child must be formally enrolled and appropriate coverage arranged within 60 days from birth. With respect to a child placed under legal guardianship, an adopted child or child placed for adoption, the child must be formally enrolled and appropriate coverage arranged within 60 days from the date of Placement For Adoption. With respect to a stepchild or a foster child, the child must be formally enrolled and appropriate coverage arranged within 30 days from the date that the child meets the definition of "Dependent."

OPEN ENROLLMENT

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

LATE ENROLLMENT

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

SPECIAL ENROLLMENT

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

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

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

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

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

Under Special Enrollment, the Employee must request enrollment, in writing within 30 days after the exhaustion of COBRA, or termination of the other coverage (other than Medicaid or Children's Health Insurance, see below), or the date of the marriage, birth, adoption or placement for adoption. If eligible, enrollment in the Plan, in cases of marriage, birth or adoption/Placement for Adoption, will be effective as of the date of the event; otherwise, coverage will be available no later than the first day of the first month beginning after the completed request for enrollment is received.

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

TERMINATION OF COVERAGE

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

EMPLOYER POLICIES AND PROCEDURES

Except as required under the Americans with Disabilities Act, the Family and Medical Leave Act, or the Uniformed Services Employment and Reemployment Rights Act, the Employer's policies and procedures regarding waiting periods, continuation of coverage or reinstatement of coverage shall apply during the following situations: Employer certified disability, layoff, reinstatement, or hire. Whether an Employee averages the requisite hours of service to be eligible for coverage shall be determined in accordance with the policies and procedures of the Employer.

Leave of Absence. A defined and approved leave of absence period is authorized and extended to an Employee for time away from job responsibilities up to a maximum of 90 days. An Employer should have a process and written documentation in place for any approved length of an Employee's leave of absence and up to a maximum of 90 days for benefit purposes. Benefits under the Plan may not be offered during a leave of absence for more than 90 days. An unpaid or paid leave of absence period must be reported by the Employer to the Plan Administrator within 30 days of change in status for further determination of benefits. If the leave of absence is due to a serious health condition, the Employer must notify the Plan Administrator immediately for review and for possible eligibility of long-term disability benefits. If the Employee is no longer eligible to continue benefits under their Employer, extended coverage will be offered as outlined in the Continuation Coverage section of this document.

Rehiring a Terminated Employee. A terminated Employee who is rehired will be treated as a new hire and be required to satisfy all Eligibility and Enrollment requirements to the extent permitted by terms of the Plan and applicable law.

INDIVIDUALS PARTICIPATING IN APPROVED CLINICAL TRIALS

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

The following definitions are applicable under this provision:

Qualified Individual

A Covered Person who meets the following conditions:

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

B. Either:

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

Approved Clinical Trial

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

- Federally funded trials. The study or investigation is approved or funded (which may include funding through in-kind contributions) by one or more of the following:
    1. The National Institutes of Health.
    2. The Centers for Disease Control and Prevention.
    3. The Agency for Health Care Research and Quality.

4. The Centers for Medicare & Medicaid Services.
5. A cooperative group or center of any of the entities described in clauses 1 through 4 above or the Department of Defense or the Department of Veterans Affairs.
6. A qualified non-governmental research entity identified in the guidelines issued by the National Institutes of Health for center support grants.
7. Any of the following entities in clauses 7a. through 7c. below if the following conditions are met: the study or investigation has been reviewed and approved through a system of peer review that the Secretary of Health and Human Services determines to be comparable to the system of peer review of studies and investigations used by the National Institutes of Health, and assures unbiased review of the highest scientific standards by qualified individuals who have no interest in the outcome of the review.
    a. The Department of Veterans Affairs.
    b. The Department of Defense.
    c. The Department of Energy.

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

Routine Patient Costs

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

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

Life-Threatening Disease or Condition

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

NETWORK BENEFITS

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

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

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

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

OUT-OF-NETWORK BENEFITS

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

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

- *Emergency Room Services*.

- *Air Ambulance*.

- *Non-Emergency Care* when provided by a non-network provider at certain in-network facilities (i.e., a Hospital, a Hospital Outpatient department, a critical access Hospital, an Ambulatory Surgical Center, and any other facility specified by the Secretary of HHS) for the categories of service listed below,:

    - Ancillary Services (see the Definitions section);
    - Non-Ancillary Services, if the non-network provider has not given proper notice and You've not given proper consent;

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

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

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

If You believe You have been wrongly billed, You may contact the No Surprises Help Desk at 1-

800-985-3059 from 8 am to 8 pm EST, 7 days a week, to submit Your question or a complaint. You can also submit a complaint online at: https://www.cms.gov/nosurprises/consumers/complaints-about-medical-billing.

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

PROCEDURES FOR FILING CLAIMS

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

KEY POINTS TO REMEMBER

The claims filing address You must use for filing all medical claims is shown on Your ID card.

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

Providers will normally file Your (Dependents) claim with Your health Plan, however You are ultimately responsible to ensure Your (Dependents) claim has been filled accordingly.

Always retain a copy of the bill for Your records.

MISCELLANEOUS CLAIMS FILING CONSIDERATIONS

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

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

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

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

Always retain a copy of the bill for Your records.

THIS PLAN AND MEDICARE

Medicare will pay primary, secondary or last to the extent stated in federal law. If a Plan Participant is Medicare entitled this Plan will base its payment upon benefits that would have been paid by Medicare under Parts A and B regardless of whether or not the person was enrolled under any of these parts. The Plan Administrator will make this determination based on the information available through CMS. If CMS does not provide sufficient information to determine the amount Medicare would pay, the Plan Administrator will make reasonable assumptions based on published Medicare fee schedules.

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

GENERAL PROVISIONS

ADMINISTRATION OF THE PLAN

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

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

APPEALING A CLAIM

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

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

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

CLAIMS PROCEDURES

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

The Claims Processor will notify you of an Adverse Benefit Determination within 30 days after receipt of the claim. However, in certain cases an extension of up to 15 days may be utilized if the Claims Processor determines that the extension is necessary due to matters beyond the

control of the Plan and you are notified prior to the expiration of the initial 30 day period of the circumstances requiring the extension of time and the date by which the Claims Processor expects to render a decision. If such an extension is necessary due to your failure to submit the information necessary to decide the claim, the notice of extension shall specifically describe the required information, and you shall be given at least 45 days within which to provide the specified information. A notice of Adverse Benefit Determination will include the following:

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

  https://secured.insurance.ohio.gov/ConsumServ/ConServComments.asp.

FIRST LEVEL APPEALS PROCEDURE

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

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

- Upon written request, the identification of medical or vocational experts whose advice was obtained on behalf of the Plan in connection with your Adverse Benefit Determination, without regard to whether the advice was relied upon in making the benefit determination.

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

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

614-644-2673, and the website is:
https://secured.insurance.ohio.gov/ConsumServ/ConServComments.asp.

SECOND LEVEL APPEALS PROCEDURE (MEDICAL CLAIMS ONLY)

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

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

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

In making a decision, the Plan Administrator will:

- Not give deference to the initial claim determination.

- Not allow the same person who made the initial decision (or any subordinate of that person) to decide the appeal.

    - Consult with a health care professional on any appeal that involves the exercise of medical judgment. The health care professional will have training or experience in a field of medicine appropriate to the questions raised on appeal. The professional will not be the same person consulted in connection with the original denial or any subordinate of that person. The Plan Administrator will identify the professionals consulted upon written request.

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

Your appeal will be determined on its own merits at each stage of review, and the decision on your appeal will not be considered as setting any precedent or creating any future liability with

respect to you or any other Covered Person. If for any reason the Plan Administrator fails to act within these time frames, the appeal will be deemed to be denied.

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

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

If the Plan denies Your second level appeal, in whole or in part, and You choose to bring a civil action, such action must be filed within 365 days of the date of the Plan's denial of Your second level appeal. This 365 day time period, however, will be temporarily suspended to the extent You are entitled to file a third level (external) appeal (see below) and do in fact file such an appeal. Under such circumstances, this 365 day time period will be suspended from the date You submit a request for a third level (external) appeal that is both complete and eligible until the date of the decision of the Independent Review Organization or Superintendent, as applicable (see below).

THIRD LEVEL (EXTERNAL) APPEALS PROCEDURE

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

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

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

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

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

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

Following receipt of a request for external review, the Claims Processor, on behalf of the Plan Administrator, must review the request to determine whether it is complete, including whether you have exhausted the Plan's first and second level appeal processes. If complete, and reviewable by an IRO, the Superintendent shall assign an IRO from the list of organizations maintained by the Superintendent to conduct the external review. The Superintendent shall notify the Claims Processor of the name of the assigned IRO. The Claims Processor shall then notify you in writing of the acceptance of the third level review. Depending on the type of request for external review, this notice will include the name and contact information for either the assigned IRO or Superintendent (whichever is applicable) for the purpose of submitting additional documentation. The notice will also include a statement that you may submit in writing to either the IRO or Superintendent (whichever is applicable) within ten business days following the date of receipt of the notice, any additional information that should be considered when conducting

the third level review. (If the request for an external review is not complete, the Claims Processor shall inform you in writing, and include what information is needed to make the request complete. If the Plan Administrator denies a request for an external review on the basis that the Final Internal Adverse Benefit Determination is not eligible for an external review, the Claims Processor shall notify you in writing the reason for the denial, and that the denial may be appealed to the Superintendent.)

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

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

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

- Your medical records;
- The attending health care professional's recommendation;
    - Reports from appropriate health care professionals and other documents submitted by the Plan Administrator or Claims Processor, you or your treating provider;
    - The terms of the Plan to ensure that the IRO's decision is not contrary to these terms;
    - Appropriate practice guidelines, including evidence-based standards and other

guidelines developed by the Federal government, national or professional medical societies, boards and associations;

- Any applicable clinical review criteria developed and used by the Claims Processor or Plan Administrator; and
- The opinion of the IRO's clinical reviewer(s) after considering the other sources referenced above.

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

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

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

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

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

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

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

- A description of your condition;

- A description of the indicators relevant to determining whether there is sufficient evidence to demonstrate that the recommended or requested therapy is more likely than not to be more beneficial to you than standard therapies, and that the adverse risks of the requested therapy would not be substantially greater than those of available standard health care services;

- A description and analysis of any medical or scientific evidence considered in reaching the opinion;

- A description and analysis of any evidence-based standard considered; and

- Information on whether the reviewer's rationale for the opinion is based on whether the requested health care service has been approved by the federal Food and Drug Administration, if applicable for the condition, and whether medical or scientific evidence, or evidence-based standards, demonstrate that the expected benefits of the requested services are more likely than not to be beneficial to you than any available standard services, and that the adverse risks of the services would not be substantially greater than those of available standard services.

If there are multiple clinical reviewers, and the majority of the reviewers recommend the service should not be covered, the IRO will uphold the Final Internal Adverse Benefit Determination. If the majority of clinical reviewers recommend the service should be covered, the IRO will reverse the Final Internal Adverse Benefit Determination. If the reviewers are evenly split as to whether the Final Internal Adverse Benefit Determination should be reversed or upheld, the IRO shall

obtain the opinion of an additional clinical reviewer in order for the IRO to make a decision based on the opinions of a majority of the clinical reviewers. The additional clinical reviewer selected shall use the same information to reach an opinion as the clinical reviewers who have already submitted their opinions. The selection of the additional clinical reviewer shall not extend the time within which the assigned IRO is required to make a decision.

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

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

ASSIGNMENT OF BENEFITS

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

CLAIM AUDIT

Once a written claim for benefits is received, the Plan Administrator, at its discretion, may elect to have such claim reviewed or audited for accuracy, Reasonableness and/or the Usual and Customary nature of charges as part of the adjudication process. This process may include, but

not be limited to, identifying charges for items/services that may not be covered or may not have been delivered, duplicate charges and charges beyond the Reasonable and/or Usual and Customary guidelines as determined by the Plan Administrator.

COMPLIANCE

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

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

Same as Employer.

CONTRIBUTIONS

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

FUNDING

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

LIENS

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

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

NO WAIVER

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

PLAN IS NOT A CONTRACT

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

PLAN AMENDMENT, MODIFICATION OR TERMINATION

The Company reserves the right to amend, modify, revoke or terminate the Plan, in whole or in part, at any time and such amendment, modification, revocation or termination of the Plan shall be made by a written Plan endorsement signed by an authorized representative of the Company. Any such changes to the Plan, which affect participants, will be communicated to such participants by the Plan Administrator. Upon termination of the Plan, the rights of participants to benefits are limited to claims incurred and due up to the date of termination.

PROHIBITION ON RESCISSION

The Plan cannot rescind coverage except in the case of fraud or an intentional misrepresentation of a material fact. A rescission is a cancellation or discontinuance of coverage that has retroactive effect, unless it is attributable to a failure to pay timely required premiums or contributions towards the cost of coverage. The Plan must provide 30 calendar days advance notice to an individual before coverage may be rescinded.

REIMBURSEMENT AND SUBROGATION PROVISIONS

PAYMENT CONDITION

The Plan, in its sole discretion, may elect to conditionally advance payment of benefits in those situations where an Illness, Injury, or disability is caused in whole or in part by, or results from the acts or omissions of, a Covered Person 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 no-fault, uninsured motorist, underinsured motorist, medical payment provisions, third party assets, third party insurance, and/or grantor(s) of a third party (collectively “Coverage”).

However, such payment of benefits by the Plan shall be made only if the Covered Person first provides a reimbursement agreement in writing. Notwithstanding the foregoing, payment of any claim in the absence of a signed reimbursement agreement shall not invalidate the obligation of the Covered Person to otherwise reimburse the Plan.

The Covered Person (including his attorney, and/or legal guardian of a covered 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 the full extent of payment from any one or combination of first and third party sources in trust, without disruption except for reimbursement to the Plan or the Plan's assignee. By accepting benefits, the Covered Person agrees the Plan shall have an equitable lien on any funds received by the Covered Person and/or his attorney from any source and said funds shall be held in trust until such time as the obligations under this provision are fully satisfied. The Covered Person agrees to include the Plan's name as a co-payee on any and all settlement drafts. Further, by accepting benefits, the Covered Person understands that any recovery obtained pursuant to this section is an asset of the Plan to the extent of the amount of benefits paid by the Plan and that the Covered Person shall be a trustee over those Plan assets.

In the event a Covered Person settles, recovers, or is reimbursed by any Coverage, the Covered Person agrees to reimburse the Plan for all benefits paid or that will be paid by the Plan on behalf of the Covered Person. If the Covered Person fails to reimburse the Plan out of any judgment or settlement received, the Covered Person will be responsible for any and all expenses (fees and costs) associated with the Plan's attempt to recover such money.

If there is more than one party responsible for charges paid by the Plan, or who may be responsible for charges paid by the Plan, the Plan will not be required to select a particular party from whom reimbursement is due. Furthermore, unallocated settlement funds meant to compensate multiple injured parties of which the Covered Person is only one, 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 Covered Person agrees to assign to the Plan the right to subrogate and pursue any and all claims, causes of action or rights that may arise against any person, corporation and/or entity and to any Coverage to which the Covered Person is entitled, regardless of how classified or characterized, at the Plan's discretion.

If a Covered Person receives or becomes entitled to receive benefits, an automatic equitable lien attaches in favor of the Plan to any claim, which any Covered Person may have against any Coverage and/or party causing the Illness, Injury or disability to the extent of such conditional payment by the Plan plus reasonable costs of collection. The Covered Person is obligated to notify the Plan or its authorized representative of any settlement prior to finalization of the settlement, execution of a release, or receipt of applicable funds. The Covered Person is also obligated to hold any and all funds so received in trust on the Plan's behalf and function as a trustee as applied 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 Covered Person commence a proceeding or pursue a claim against any party or Coverage for the recovery of all damages to the full extent of the value of any such benefits or conditional payments advanced by the Plan.

If the Covered Person fails to file a claim or pursue damages against:

a) the responsible party, its insurer, or any other source on behalf of that party;

b) any first party insurance through medical payment coverage, personal injury protection, no-fault coverage, uninsured or underinsured motorist coverage;

c) any policy of insurance from any insurance company or guarantor of a third party;

d) worker's compensation or other liability insurance company; or

e) any other source, including but not limited to crime victim restitution funds, any medical, disability or other benefit payments, and school insurance coverage;

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

RIGHT OF REIMBURSEMENT

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

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.

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

These rights of subrogation and reimbursement shall apply without regard to whether any separate written acknowledgment of these rights is required by the Plan and signed by the Covered Person.

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 sickness, injury, disease or disability.

COVERED PERSON IS A TRUSTEE OVER PLAN ASSETS

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

a) 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;

b) instruct his/her attorney to ensure that the Plan and/or its authorized representative is included as a payee on all settlement drafts;

c) in circumstances where the Covered Person is not represented by an attorney, instruct the insurance company or any third party from whom the Covered Person obtains a settlement, judgment or other source of coverage to include the Plan or its authorized representative as a payee on the settlement draft; and,

d) 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 Covered Person disputes his/her obligation to the Plan under this section, the Covered Person or any of his/her 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 attorney's fees, for which he/she exercises control, in an account segregated from his/her general accounts or general assets until such time as the dispute is resolved.

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

SEPARATION OF FUNDS

Benefits paid by the Plan, funds recovered by the Covered Person, and funds held in trust over which the Plan has an equitable lien exist separately from the property and estate of the Covered Person(s), such that the death of the Covered Person, or filing of bankruptcy by the Covered Person(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 Covered Person dies as a result of his 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.

OBLIGATIONS

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

a) to cooperate with the Plan, or any representatives of the Plan, in protecting its rights, including discovery, attending depositions, and/or cooperating in trial to preserve the Plan's rights;

b) to provide the Plan with pertinent information regarding the Illness, Injury, or disability, including accident reports, settlement information and any other requested additional information;

c) to take such action and execute such documents as the Plan may require to facilitate enforcement of its subrogation and reimbursement rights, including providing to the Plan an executed reimbursement agreement;

d) to do nothing to prejudice the Plan's rights of subrogation and reimbursement;

e) to promptly reimburse the Plan when a recovery through settlement, judgment, award or other payment is received; and

f) to not settle or release, without the prior consent of the Plan, any claim to the extent that the Covered Person may have against any responsible party or Coverage.

If the Covered Person and/or his attorney fails to reimburse the Plan for all benefits paid or to be paid, as a result of said injury or condition, out of any proceeds, judgment or settlement received, the Covered Person will be responsible for any and all expenses (whether fees or costs) associated with the Plan's attempt to recover such money from the Covered Person.

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

OFFSET

Failure by the Covered Person and/or his attorney to comply with any of these requirements may, at the Plan's discretion, result in a forfeiture of payment by the Plan of medical benefits, and any funds, or payments due under this Plan on behalf of the Covered Person may be withheld until the Covered Person satisfies his obligation.

MINOR STATUS

In the event the Covered Person is a minor as that term is defined by applicable law, the minor's parents or court-appointed guardian shall cooperate in any and all actions by the Plan to seek and obtain requisite court approval to bind the minor and his 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.

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.

RIGHT TO RECEIVE AND RELEASE NECESSARY INFORMATION

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

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

RIGHTS OF RECOVERY

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

SEVERABILITY

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

SUBMISSION OF CLAIM

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

SUMMARY OF MATERIAL MODIFICATIONS

Covered Persons shall be furnished summary descriptions of material modifications in the terms of this Plan and changes in the information required to be included in the Summary Plan Description pertaining to this Plan not later than 210 days after the end of the Plan Year in which the change is adopted. However, in the case of any modification or change that is a material reduction in Covered Services or benefits provided under the Plan, Covered Persons will be furnished a summary of such modification or change not later than 60 days after the adoption of the modification or change, unless the Employer provides summaries of modifications or changes at regular intervals of not more than 90 days.

SUMMARY PLAN DESCRIPTION

The Company will issue to each Employee under the Plan, a document that shall summarize the benefits to which the person is entitled, to whom the benefits are payable, and the provisions of the Plan principally affecting the Employee. This document is intended to satisfy the requirement for both a Summary Plan Description and Plan Description

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SYSTEM FOR PROCESSING CLAIMS

Claims will be processed on the following basis: 1) first, any non-covered services or services in excess of Plan provisions will be subtracted from billed charges; 2) then, Reasonable and/or Usual

and Customary limitations will be applied (if applicable); 3) then, any reduction authorized by agreements with provider networks will be applied to charges from network providers; and 4) then, any Deductible/Co-Insurance or uncollected co-pays will be deducted from the remaining eligible amount prior to payment.

TYPE OF ADMINISTRATION

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

COORDINATION OF BENEFITS (COB)

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

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

1. If a plan does not have a provision for the coordination of benefits, its benefits are payable before this Plan.
2. If a plan covers a person other than as a Dependent, its benefits are payable before this Plan. This includes Medicare covering a person other than as a Dependent (e.g. a retired Employee) and any Medicare Supplement Plan. However, in all instances, federal regulations regarding Medicare as a secondary payer will apply.
3. If a plan covers an active Employee, its benefits are payable before this Plan. This order of determination does not supersede No. 2 above.
4. If an individual is covered as a Dependent under 2 separate plans, the benefits are payable first under the Employee's plan having the earliest birthday in a Calendar Year. However, if the Dependent is a child whose parents are separated or divorced, the "birthday rule" does not apply. The following order to determination will apply:
   If the parent with custody has not remarried:
   a) The plan of the parent with custody is primary.
   b) The plan of the parent without custody is secondary.
   If the parent with custody has remarried:
   a) The plan of the parent with custody is primary.
   b) The plan of the stepparent with custody is secondary.
   c) The plan of the parent without custody is tertiary (third).
   There may be a court decree that makes one parent financially responsible for the health care expenses incurred by the child. If a plan covers the child as a Dependent of that parent, its benefits are payable before those of a plan that covers the child as a Dependent of the parent without financial responsibility.
5. If a plan covers an individual who is also allowed to be covered by this Plan pursuant to COBRA continuation coverage, its benefits are payable before this Plan.
6. If items 1, 2, 3, 4 or 5 do not apply, the benefits of a plan that has covered the person for the longest period of time will be payable before those of the other plan.

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

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

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

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

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

COMPLIANCE REGULATIONS

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

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

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

SOURCE OF INJURY RESTRICTIONS

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

WELLNESS VS. RISK FACTORS

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

FAMILY MEDICAL LEAVE ACT (FMLA)

The following applies to companies with 50 or more employees

If the Covered Person is entitled to, and elects to take, a family or medical leave solely under the terms of the Family and Medical Leave Act of 1993 (FMLA), the Covered Person and his covered

Dependents shall continue to be covered under this Plan while the Covered Person is absent from work on an FMLA leave as if there were no interruption of active employment. Provided the applicable premium is paid, such coverage will continue until the earlier of the expiration of such leave or the date notice is given to the Company that the Covered Person does not intend to return to work at the end of the FMLA leave.

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

MILITARY LEAVES

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

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

GENETIC INFORMATION

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

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

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

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

CONTINUATION COVERAGE

WHEREAS, The Christian and Missionary Alliance (C&MA) Benefit Board has approved a plan of employee health benefits (referred to as the "Health Plan," or "Plan" in this section);

WHEREAS, the benefits under the Plan are made available to the Employees of The Christian and Missionary Alliance (referred to as "Participating Employers") that have been accepted into membership in or affiliation with the C&MA;

WHEREAS, the Plan desires that coverage under the medical, dental, and vision benefits of the Plan (together referred to as the "The Health Plan") be temporarily continued for eligible employees and their dependents in the event of employment termination and certain other events;

NOW, THEREFORE, the following Continuation Coverage is hereby adopted to govern the terms of and conditions upon which the Health Plan Benefits will be continued for eligible employees and their dependents following circumstances that would normally result in termination of those Health Plan Benefits:

(1) Continuation Coverage is a continuation of Plan coverage when coverage would otherwise end because of a life event known as a qualifying event. Specific qualifying events are listed later in this section. After a qualifying event, Continuation Coverage shall be offered to the Employee and qualified Dependents participating in the Plan. Except as otherwise provided by a Participating Employer with respect to its employees or as otherwise stated in this section, qualified beneficiaries who elect Continuation Coverage must pay for that coverage.

(2) Plan benefits of an enrolled Employee that commences Short-Term Disability benefits or begins a leave of absence under the Family and Medical Leave Act, or any other leave of absence approved by the Plan, will continue on the same basis as if the Employee was actively employed (except that the individual's contribution may be on an after-tax basis). This will be applicable for the duration of the individual's Short-Term Disability absence or under an approved leave of absence not to exceed 90 days. If an Employee does not return to active employment following a period of Short-Term Disability or expiration of an approved leave of absence, the individual's employment will be considered as terminated for purposes of this Continuation Coverage (whether or not commencing Long-Term Disability benefits), and remaining eligible months of continuation coverage under this Plan will be available as applicable for coverage in effect immediately prior to employment termination.

(3) The Spouse of an Employee will become a qualified beneficiary if the Spouse loses any Plan coverage due to the qualifying event of the Employee's death.

(4) If an Employee has been on this Plan for any length of time, C&MA will offer a minimum of one month Continuation Coverage (even if the Employee was on the Plan less than one month).

C&MA will offer one month of Continuation Coverage for every month the Employee was on the plan as an active employee, up to a maximum of 12 months Continuation Coverage if they have been on the Plan as an active Employee for 12 months or more.

When Continuation Coverage Is Available. Continuation Coverage for the Plan will be offered to qualified beneficiaries only after the Plan Administrator (or its designee) has been notified according to Plan procedures that a qualifying event has occurred. When the qualifying event is the end of employment, the Participating Employer must provide written notice within 30 days of the qualifying event.

If an Employee age 65 or over:

- loses eligibility for the C&MA Plan, either through termination or reduction in hours, continuation of coverage will be offered to any Dependents who are under age 65; or

- leaves the C&MA Plan while still eligible (i.e., drops the plan due to Medicare eligibility), continuation coverage will be offered to any dependent who is under 65.

How Continuation Coverage Is Provided. Except as provided in the "Election Period" discussion, below, once the Plan Administrator receives notice that a qualifying event has occurred, Continuation Coverage will be offered to Employee and qualified Dependents.

Continuation Coverage is a temporary continuation of coverage. Continuation Coverage lasts for up to a maximum of 12 months. In the case of death of a Spouse, Continuation Coverage lasts for up to a maximum of 18 months. The maximum period will not be extended if one or more additional qualifying events described above subsequently occurs during the Continuation Coverage period.

Election Period. Once the Plan Administrator (or its designee) is notified of a qualifying event, the Plan's Continuation Coverage Administrator will notify the employee of the right to elect Continued Coverage and provide an election form to complete and return. The Employee will

have election rights, and elections must be submitted in writing within 30 days of the later of:

(1) The date coverage terminates because of the qualifying event, or

(2) The date the notification and election form is mailed to the qualified.

Election forms that are mailed must be postmarked within the 30-day election period, and submissions of election forms by facsimile or email must bear a transmittal date within the 30-day election period.

Type of Coverage. Continuation Coverage can only be elected for Plan benefits in which the qualified beneficiary is enrolled at the time of the qualifying event. At annual enrollment, the qualifying beneficiary already on Continuation Coverage may elect to change or add any Plan coverage options with the types of coverage in which they are then enrolled (for example, qualifying beneficiaries under one medical option may elect a different medical option. If the Plan benefits change for active Employees, such changes shall apply to anyone with Continuation Coverage, unless otherwise determined by the Plan Administrator.

Cost of Coverage and Payment. Continuation Coverage is subject to payment by the qualified beneficiaries in the amount determined by the Plan Administrator and set forth in the election notice. Generally, the payment amounts required for each Plan benefit will be a function of the contributions charged with respect to active Employees in similar circumstances. The contributions are charged on an after-tax basis and will be increased by an additional monthly fee for purposes of covering administrative costs.

Continuation Coverage shall be paid for in monthly installments. The first payment will be retroactive to the date of the loss of coverage due to the qualifying event and will be due no later than 30 days after the later of:

(1) The date coverage terminates because of the qualifying event, or

(2) The date the notification and election form is mailed to the qualified beneficiary.

Payments are collected electronically within the first three business days of the month for that month of coverage. Coverage is effective once the initial payment is received. Once payment is received, the participant may re-file claims that may have been denied between the initial benefits termination and the election and payment for Continued Coverage.

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

ISSUED PURSUANT TO

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

1. Disclosure of Summary Health Information to the Plan Sponsor

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

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

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

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

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

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

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

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

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

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

g. Make available the information required to provide an accounting of disclosures

in accordance with Section 164.528 of the Privacy Standards (45 CFR 164.528);

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

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

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

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

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

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

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

3. Disclosure of Certain Enrollment Information to the Plan Sponsor

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

4. Other Disclosures and Uses of PHI

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

NOTICE OF PRIVACY PRACTICES

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

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

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

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

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

THE PLAN'S RESPONSIBILITIES

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

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

Genetic information shall be treated as health information pursuant to the Health Insurance Portability and Accountability Act. The use or disclosure by the Plan of protected health information that is genetic information about an individual for underwriting purposes under the

Plan shall not be a permitted use or disclosure.

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

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

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

PERMISSIBLE USES AND DISCLOSURES OF PHI

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

TREATMENT, PAYMENT AND HEALTH CARE OPERATIONS

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

TREATMENT

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

PAYMENT

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

HEALTH CARE OPERATIONS

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

POTENTIAL IMPACT OF STATE LAW

The HIPAA Privacy Regulations generally do not "preempt" (or take precedence over) state privacy or other applicable laws that provide individuals greater privacy protections. As a result, to the extent state law applies, the privacy laws of a particular state, or other federal laws, rather than the HIPAA Privacy Regulations, might impose a privacy standard under which the Plan will be required to operate. For example, where such laws have been enacted, the Plan will follow more stringent state privacy laws that relate to uses and disclosures of PHI concerning HIV or AIDS, mental health, substance abuse/chemical dependency, genetic testing, reproductive rights, etc.

OTHER PERMISSIBLE USES AND DISCLOSURES OF PHI

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

REQUIRED BY LAW

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

PUBLIC HEALTH ACTIVITIES

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

HEALTH OVERSIGHT ACTIVITIES

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

government benefit programs; (3) other government regulatory programs and (4) compliance with civil rights laws.

ABUSE OR NEGLECT

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

LEGAL PROCEEDINGS

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

LAW ENFORCEMENT

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

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

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

RESEARCH

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

TO PREVENT A SERIOUS THREAT TO HEALTH OR SAFETY

Consistent with applicable federal and state laws, the Plan may disclose PHI if there is

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

MILITARY ACTIVITY AND NATIONAL SECURITY, PROTECTIVE SERVICES

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

INMATES

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

WORKERS' COMPENSATION

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

EMERGENCY SITUATIONS

The Plan may disclose PHI of a Covered Person in an emergency situation, or if the Covered Person is incapacitated or not present, to a family member, close personal friend, authorized disaster relief agency, or any other person previously identified by the Covered Person. The Plan will use professional judgment and experience to determine if the disclosure is in the best interests of the Covered Person. If the disclosure is in the best interest of the Covered Person, the Plan will disclose only the PHI that is directly relevant to the person's involvement in the care of the Covered Person.

FUNDRAISING ACTIVITIES

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

GROUP HEALTH PLAN DISCLOSURES

The Plan may disclose the PHI of a Covered Person to a sponsor of the group health plan

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

UNDERWRITING PURPOSES

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

OTHERS INVOLVED IN YOUR HEALTH CARE

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

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

REQUIRED DISCLOSURES OF PHI

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

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

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

DISCLOSURES TO COVERED PERSONS

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

The Plan will disclose a Covered Person's PHI to an individual who has been designated by that Covered Person as his personal representative and who has qualified for such

designation in accordance with relevant state law. However, before the Plan will disclose PHI to such a person, the Covered Person must submit a written notice of his designation, along with the documentation that supports his qualification (such as a power of attorney).

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

BUSINESS ASSOCIATES

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

OTHER COVERED ENTITIES

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

PLAN SPONSOR

The Plan may disclose PHI to the Plan Sponsor of the group health plan for purposes of plan administration or pursuant to an authorization request signed by the Covered Person. Also, the Plan may use or disclose "summary health information" to the Plan Sponsor for obtaining premium bids or modifying, amending or terminating the group health plan. Summary health information summarizes the claims history, claims expenses

or types of claims experienced by individuals for whom a Plan Sponsor has provided health benefits under a group health plan and from which identifying information has been deleted in accordance with the HIPAA Privacy Rule.

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

SALE OF PHI

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

MARKETING

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

PSYCHOTHERAPY NOTES

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

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

A COVERED PERSON'S RIGHTS

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

RIGHT TO REQUEST A RESTRICTION

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

A Covered Person may request a restriction by contacting the person(s) or office identified under Plan Contact Information in the Key Information section at the beginning of this

document. It is important that the Covered Person directs his request for restriction to this individual or office so that the Plan can begin to process Your request. Requests sent to individuals or offices other than the one indicated might delay processing the request.

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

RIGHT TO REQUEST CONFIDENTIAL COMMUNICATIONS

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

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

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

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

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

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

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

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

RIGHT TO INSPECT AND COPY

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

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

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

RIGHT TO AMEND

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

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

RIGHT OF AN ACCOUNTING

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

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

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

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

RIGHT TO A COPY OF THIS NOTICE

The Covered Person has the right to request a copy of this Notice at any time by contacting the person(s) or office identified under Plan Contact Information in the Key Information

section at the beginning of this document. If You receive this Notice on the Plan's website or by electronic mail, You also are entitled to request a paper copy of this Notice.

COMPLAINTS

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

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

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

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

1. DEFINITIONS

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

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

2. PLAN SPONSOR OBLIGATIONS

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

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

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

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

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

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

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

e. Plan Sponsor shall make its internal practices, books, and records relating to its compliance with the Security Standards to the Secretary of the U.S. Department of Health and Human Services ("HHS"), or any other officer or employee of HHS to

whom the authority involved has been delegated, for purposes of determining compliance by the Plan with the Security Standards.

Plan Endorsement #24 SP

GROUP #	A24107		
EFFECTIVE DATE	January 1, 2024		
EMPLOYER ID#	84-1653609	PLAN #s	501
NAME OF PLAN	Christian and Missionary Alliance Employee Benefits Plan		
TYPE OF PLAN	Bronze Plan		

The following wording is hereby added to the Plan:

Christian and Missionary Alliance, of Reynoldsburg, Ohio hereby establishes a plan for payment of certain expenses for the benefit of its eligible employees to be known as Christian and Missionary Alliance Employee Benefits Plan. The attached document serves as the summary plan description, plan description and plan document for the Plan.

Christian and Missionary Alliance has caused this Plan to take effect as of 12:01 A.M. Eastern Time on January 1, 2024 at Reynoldsburg, Ohio.

APPROVED AND ATTESTED:

BY David Peppers TITLE Executive Director

DATE 02/26/2024

Christian and Missionary Alliance

One Alliance Place
Reynoldsburg, OH 43068
Phone: (800) 700-2651

Bronze Plan

This booklet describes the Medical benefits for Eligible Employees of **Christian and Missionary Alliance.**

Information Applicable to Plan 501

Employer Identification Number
84-1653609

The Benefits In This Booklet Are Effective
January 1, 2024

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INTRODUCTION

This Plan was established by The Christian and Missionary Alliance for the benefit of Employees who are employed by any denominational Employer that elects to participate in the Plan. Denominational Employers that are eligible to participate in the Plan include the C&MA National Office, a district office or local church, and any agency, supporting organization, or institution officially related to The Christian and Missionary Alliance. This Plan is intended to be a "church plan" within the meaning of section 414(e) of the Internal Revenue Code of 1986, as amended, and section 3(33) of the Employee Retirement Income Security Act of 1974 ("ERISA") and, as such, is exempt from the requirements of ERISA.

This document is a description of Christian and Missionary Alliance Health Care Plan (the Plan). No oral interpretations can change this Plan. The Plan described is designed to protect Plan Participants against certain catastrophic health expenses. This High Definition Health (HDHP) Plan is designed to be used with a Health Savings Accounts (HSA), HSA HDHP.

The Plan Administrator fully intends to maintain this Plan indefinitely. However, it reserves the right to terminate, suspend, discontinue or amend the Plan at any time and for any reason.
Changes in the Plan may occur in any or all parts of the Plan including benefit coverage, Deductibles, maximums, Exclusions, limitations, Definitions, Eligibility and the like.

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

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

The Plan will pay benefits only for the expenses incurred while this coverage is in force. No benefits are payable for expenses incurred before coverage began or after coverage terminated. An expense for a service or supply is incurred on the date the service or supply is furnished.
If the Plan is terminated, amended, or benefits are eliminated, the rights of Covered Persons are limited to Covered Charges incurred before termination, amendment or elimination.

It is the intent of this Plan and the Plan Administrator to comply with all applicable Federal laws and regulations. In the event of non-compliance with any such law or regulation, the Plan Document will be deemed amended to comply with said law or regulation as of its effective date, and the remainder of the Plan Document will remain in full force and effect. Similarly, in the event a law or regulation applicable to this Plan becomes effective after the initial effective date of this Plan Document, said law or regulation will be deemed included in this Plan Document as of its effective date and without the necessity of an amendment to this Plan Document.

KEY INFORMATION

EMPLOYER/COMPANY/PLAN ADMINISTRATOR/ PLAN SPONSOR CONTACT INFORMATION:
Christian and Missionary Alliance
One Alliance Place
Reynoldsburg, OH 43068
Phone: (800) 700-2651

EMPLOYER/COMPANY IDENTIFICATION NUMBER (EIN) AS ASSIGNED BY THE INTERNAL REVENUE SERVICE (IRS):
84-1653609

PLAN NAME:
Christian and Missionary Alliance Employee Benefits Plan

PLAN CONTACT INFORMATION:
Alliance Benefits Team
Christian and Missionary Alliance
One Alliance Place
Reynoldsburg, OH 43068
Phone: (800) 700-2651

PLAN NUMBER:
501

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

GROUP NUMBER:
A24107

SPD EFFECTIVE DATE:
January 1, 2024

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

TYPE OF PLAN:
Medical and Prescription Drugs

NAME, ADDRESS AND TELEPHONE NUMBER OF THE CLAIMS PROCESSOR:

Allied Benefit Systems, LLC
P. O. Box 211651
Eagan, MN 55121
For customer support, please see Your member ID card for the phone number where you can reach Your designated customer support team.

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

The following employees, or classes of employees, or other persons under control of the Plan Sponsor, shall be given access to the protected health information (PHI) to be disclosed:

- Executive Director for Alliance Benefits.
- Staff designated by Executive Director for Alliance Benefits.
- Chief Financial Officer.
- Staff designated by Chief Financial Officer.

ELIGIBILITY:

- Employees who are scheduled to work at least 30 hours per week. Coverage for regular full-time Employees becomes effective on the first day of the month following completion of the Waiting Period, subject to completion of enrollment requirements.
- Regular part-time Employees: Employees designated by the Employer as regular part-time Employees who are scheduled to work at least 20 hours per week. Coverage for regular part-time Employees becomes effective on the first day of the month following completion of the Waiting Period, subject to completion of enrollment requirements.

- Retirees: This Plan does not cover retirees or their Dependents(except in special continuation of coverage circumstances).

- Dependents Including:
  - Dependent Children: Child(ren) from birth to the last day of the month they attain age 26 consisting of natural children, stepchildren, foster children, adopted children, children placed for adoption and children for whom You are the court-appointed legal guardian.

    A child who is physically or mentally incapable of self-support upon attaining age 26 may be continued under the health care benefits, while remaining incapacitated and unmarried, subject to the covered Employee's own coverage continuing in effect. To

continue a child under this provision, the Company must receive proof of incapacity within 31 days after coverage would otherwise terminate. Additional proof will be required from time to time.

- Spouse: This Plan defines “marriage” as a legal union between one man and one woman as husband and wife, legally married in a jurisdiction (domestic or foreign) that recognizes their marriage. Marriage does not include a civil union, domestic partnership or any other similar arrangement.

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

WORKING SPOUSE COVERAGE PROVISION:

No surcharge will be levied if the spouse of an eligible Employee is eligible for coverage through his employer and chooses coverage from this Plan.

ENROLLMENT:

- **Enrollment Waiting Period:**

  Coverage hours and eligibility will be determined by the individual employer. A Waiting Period is the time between the first day of employment as an eligible Employee and the first day of coverage under the Plan unless hired on the first day of the month, then coverage begins on that day.

  An Employee's status as a full-time or part-time Employee will be determined on the basis of the average number of hours worked during an initial or standard measurement period, as applicable, as established by the Plan in accordance with applicable law. The Employee's eligibility (or lack of eligibility) for Plan coverage on the basis of his or her full-time or part-time status will extend through the stability period established by the Plan in accordance with applicable law. In calculating the average hours worked, the Plan will count hours paid and hours for which the Employee is entitled to payment (such as paid holidays, vacation, pay, etc.). An Employee's status as a full-time or part-time Employee will be determined on the basis of the Employer's standard employment practices.

  Contact your Human Resources Department for additional information.

- **Open Enrollment Period:**

  Each year, a period of time may be designated as an Open Enrollment period. Except for Special Enrollment or Late Enrollment, if applicable, it is only during this period that an

Employee or Dependent who did not enroll during their initial eligibility period may enroll in a Plan. It is also only during this period that an Employee who is currently covered under one Plan may switch to another. Coverage will become effective on the date specified by Your Employer.

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

TERMINATION OF COVERAGE:

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

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

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

IMPORTANT NETWORK CONTACT INFORMATION:

Function	Network Name	Claims Filing Information	Phone Number	URL
PPO Network	First Health Network	Electronic: Payer ID #37308 Paper: Allied Benefit Systems, LLC P. O. Box 211651 Eagan, MN 55121	1-800-226-5116	www.myfirsthealth.com

PRE-CERTIFICATION PROGRAM

Your Plan also includes a **pre-certification program**. The toll-free number You must use for pre-certification is shown on Your member ID card. **Failure to follow the guidelines listed below will subject Your benefits to a penalty for non-compliance as discussed in this section and referenced in the schedule of covered services and provisions.**

The following service require pre-certification:

- Inpatient Hospital admissions.
- Durable Medical Equipment exceeding $1,000.
- Infusion therapy.
- Genetic testing.
- Oncology Treatment
    - Chemotherapy (Including oral)
    - Radiation Therapy
    - Oncology and transplant related injections, infusions and treatment (e.g., CAR-T, endocrine and immunotherapy), excluding supportive drugs (e.g., antiemetic and antihistamine)

If Your Physician recommends any service listed above, please follow these steps:

1. Notify Your Physician that You participate in a pre-certification program. Please note that this applies even if this Plan is the secondary payer under Coordination of Benefits.

2. You or Your Physician must call the number shown on Your member ID card 2 weeks before or, if less than 2 weeks, as soon as scheduled for an elective Hospital admission. Note: For exceptions, please refer to the section of this document entitled "Compliance Regulations," and see the subheading "Statement of Rights Under the Newborns' and Mothers' Health Protection Act".

3. If You have an emergency admission, pre-certification is required within 48 hours or the next business day following admission.

The following information will be needed to pre-certify:

Regarding Patient:	**Regarding Employee:**
Name	Name
Address	Address
Telephone #	Telephone #
Date of Birth	Date of Birth

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

4. A nurse may call Your Physician to review a proposed Inpatient admission or other listed service. If admission is necessary, an assigned length of stay will be determined. If additional days are later thought to be necessary, these additional days must also be pre-certified.

5. When You or Your Physician call to pre-certify an Inpatient admission or other listed service, the call will be logged so that:

   a. The facility can verify that pre-certification has been done and can track expected length of stay.

   b. The Claims Processor can verify that the pre-certification requirements have been met when the claim is received for processing.

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

PENALTY FOR NON-COMPLIANCE:

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

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

PRE-NOTIFICATION

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

Procedures for which pre-notification is recommended are:

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

SCHEDULE OF COVERED SERVICES AND PROVISIONS

I. MEDICAL CARE BENEFITS:

COVERED SERVICES and PROVISIONS	In-Network	Out-of-Network
Calendar Year Deductible *(taken before benefits are payable unless waived)* *This is an embedded Deductible, meaning each covered family member only needs to satisfy his or her individual Deductible, not the entire Family Deductible, prior to receiving plan benefits. The balance of the Family Deductible can be satisfied by one member or a combination of remaining family members.*	$7,000.00 per person $14,000.00 per family	$14,000.00 per person $28,000.00 per family
Coinsurance	80%	50%
Deductible Carry-Over	N/A	
Out-of-Pocket Maximum per Calendar Year *(*medical and Rx co-pays Co-Insurance and Deductibles count towards the Out-of-Pocket Maximum) *After amount is reached, 100% level of benefits applies for that* Calendar Year. The following expenses do not apply to and are not affected by the Out-of-Pocket Maximum: • "Non-compliance penalty" (for failure to abide by pre-certification requirements). • Any out-of-pocket expenses that are for non-covered services or for services that are in excess of any Plan maximum or limit. *This is an embedded Out-of-Pocket Maximum, meaning each covered family member only needs to satisfy his or her individual Out-of-Pocket Maximum, not the entire family Out-of-Pocket maximum, prior to receiving Plan benefits paid at 100%. The balance of the family Out-of-Pocket Maximum can be satisfied by one member or a combination of remaining family members.*	$8,050.00 per person $16,100.00 per family	$16,100.00 per person $32,200.00 per family
Calendar Year Benefit Maximum	Unlimited	
Precertification Penalty for Non-Compliance: Certain benefits are subject to a $500.00 penalty per occurrence ***(in addition to Deductible)*** for failure to follow the Pre-Certification Program provisions. Please refer to Pre-Certification Program section for additional information.	Allied Care 1-800-892-1893	
Claims Filing Limit	All charges, and corresponding requested documentation, must be submitted within 1 year(s) of the date incurred.	
Coordination of Benefits	If it is determined that this Plan is the secondary payer, benefits will be adjusted and reduced (standard). Benefits payable from both plans shall not exceed 100% of the eligible U&C charges.	
In-network and out-of-network Deductibles and Out-of-Pocket Maximums are tracked separately, such that Covered Services applied to one will not apply to the other.		

II. PRESCRIPTION DRUG BENEFIT:

COVERED SERVICES and PROVISIONS	In-Network	Out-of-Network
Your Prescription Drug Benefit is administered by MedOne. For prescription drug questions please call 1-888-884-6331 or visit www.medone-rx.com.		
If member requests brand only when a generic is available, the member will be charged the generic co-pay plus the cost difference between the brand and generic medication. The amount of this cost difference does not apply to the Deductibles or Out-of-Pocket Maximums.		
Prescription Drug Card Benefit (up to 30-day supply per prescription through participating pharmacies).	15%/generic, 15%/brand, 25%/Non-preferred brand (per prescription). After Deductible	
Mail-Order Drug Benefit (up to 90-day supply per prescription through mail order) *except where prohibited by state or federal law.*	10% /generic, 10%/brand, 25%/Non-preferred brand (per prescription). After Deductible.	
Mail-Order/Extended Retail Pharmacy Requirement	Optional	
Specialty Drug Benefit *(up to 30-day supply per prescription, includes certain injectable medications) except where prohibited by state or federal law.* *You must contact Vivio if you are refilling or getting a new prescription for a specialty medication at 800-470-4034.*	Please contact Vivio for all Specialty Inquiries	
FDA approval does not automatically constitute plan coverage. Pre-approval studies for medications for specialty and orphan conditions do not always involve scientific rigor required of medications for more common conditions. Phil Long Dealerships follow MedOne's specialty inclusion list, which provides the framework to appropriately determine the safety and efficacy of specialty and orphan products required to be considered covered products.		
Note: Certain prescriptions shall be covered at 100%, and no co-pay will apply as per Federal Regulations		

III. PREVENTIVE CARE SERVICES:

COVERED SERVICES and PROVISIONS ***Note:*** *Generally, for in-network charges billed on a Form CMS-1500 exceeding $5,000, payment will be limited to the Medicare fee schedule. Some exceptions may apply. See the Out-of-Network Benefits section of this SPD for more information.*	**In-Network**	**Out-of-Network**
Preventive Care Services - (*must be billed with a routine diagnosis).* This plan includes coverage for physical exams, immunizations, tests, labs, x-rays, pap smears and analysis, PSA test, bone density tests (for women age 60 and older, every 5 Calendar Year *This benefit also covers all referenced within the Recommendations of the United States Preventive Service Task Force, Recommendations of the Advisory Committee On Immunization Practices (ACIP) that have been adopted by the Director of the Centers for Disease Control and Prevention and appear on the Immunization Schedules of the Centers for Disease Control and Prevention, the Comprehensive Guidelines Supported by the Health Resources and Services Administration (HRSA), as well as referenced in the Guidelines for Women's Preventative Services adopted by the United States Department of Health and Human Services, based on recommendations by the Institute of Medicine.* This benefit specifically does not cover executive physicals, heart scans, full body scans, CAT scans, MRIs, PET or other similar tests.	100% Deductible waived.	50% After Deductible
Preventive Care Services – Enhanced - (*must be billed with a routine diagnosis).* • Mammograms (including 3D), once every year (age 40 or older) • Choice between a sigmoidoscopy or a colonoscopy once every 5 years (age 45 or older)	100% Deductible waived.	50% After Deductible
Family history benefit *Any age or visit limit maximums will not apply when family history is the only diagnosis billed for routine tests. This benefit is limited to the services referenced within the Recommendations of the United States Preventive Service Task Force, as well as referenced in the Guidelines for Women's Preventative Services adopted by the United States Department of Health and Human Services, based on recommendations by the Institute of Medicine*.	100% Deductible waived.	50% After Deductible
Family Planning - Permanent Procedures for Women *Includes:* • *Sterilization.*	100% Deductible waived.	50% After Deductible
Breast Pumps and Supplies (Includes one breast pump per pregnancy, and certain covered supplies purchased through a retail supplier).	100% Deductible waived.	100% Deductible waived.

IV. Physician Services:

COVERED SERVICES and PROVISIONS		
Note: *Generally, for in-network charges billed on a Form CMS-1500 exceeding $5,000, payment will be limited to the Medicare fee schedule. Some exceptions may apply. See the Out-of-Network Benefits section of this SPD for more information.*	**In-Network**	**Out-of-Network**
Note: For surgical assistance provided by an assistant surgeon (when Medically Necessary), Covered Services of the assistant surgeon are limited to 20% of the Plan's allowance for the surgeon.		
Virtual Physician charges	Paid same as any other service according to type of service and provider.	
Mental/Nervous and Substance Use Disorders Physician Office Visits- *exam charge only*	90% After Deductible	Paid same as in-network (subject to the in-network Deductible and in-network Out-of-Pocket)
Physician Office Visits – *exam charge only* *Allied considers the following doctors as primary care physicians, all others would be specialists:* • *General Practice.* • *Family Practice.* • *OB/Gyn.* • *Internal Medicine.* • *Osteopaths.* • *Pediatricians.* • *Physician Assistants* • *Nurse Practitioners*	90% After Deductible	50% After Deductible
Urgent Care - *includes facility fees and all other services done during the urgent care visit.*	85% After Deductible	50% After Deductible
Specialist Office Visits – *exam charge only*	80% After Deductible	50% After Deductible
Surgery Incurred at a Physician's Office	80% After Deductible	50% After Deductible
Other Physician Services Incurred at a Physician's Office Visit *Does not include labs, x-rays or imaging; please see Section V for additional benefit coverage information.*	80% After Deductible	50% After Deductible
Emergency Room Physician Care	Please refer to Emergency Room Services benefit in Section VI.	
Physical and Occupational Therapy *All services rendered by physical therapists/occupational therapists are limited to a combined maximum of* 60 *visits for office and Outpatient facility services, per Covered Person per* Calendar Year. *However, this* Calendar Year *visit maximum does not apply to covered therapy services for autism.*	80% After Deductible	50% After Deductible
Speech Therapy *Limited to a maximum of* 60 *visits for office and Outpatient facility services, per Covered Person per* Calendar Year. *However, this* Calendar Year *visit maximum does not apply to covered therapy services for autism.*	80% After Deductible	50% After Deductible

IV. Physician Services:

COVERED SERVICES and PROVISIONS ***Note:*** *Generally, for in-network charges billed on a Form CMS-1500 exceeding $5,000, payment will be limited to the Medicare fee schedule. Some exceptions may apply. See the Out-of-Network Benefits section of this SPD for more information.*	**In-Network**	**Out-of-Network**
Note: For surgical assistance provided by an assistant surgeon (when Medically Necessary), Covered Services of the assistant surgeon are limited to 20% of the Plan's allowance for the surgeon.		
All Care Rendered by a Chiropractor and Massage therapy. *All services are limited to a combined maximum of* 20 *visits per Covered Person per* Calendar Year*, regardless of the place of service or services provided. Does not include labs and x-rays please see Section V for additional benefit coverage information.*	80% After Deductible	Paid same as in-network (subject to the in-network Deductible and in-network Out-of-Pocket)
Anesthesia and its Administration *(Inpatient/Outpatient)*	80% After Deductible	50% After Deductible
Allergy Injections, Serum, and Administration.	80% After Deductible	50% After Deductible
Other Physician Services *Does not include Outpatient/Independent Laboratory/Office labs, x-rays and imaging please see Section V for additional benefit coverage information.*	80% After Deductible	50% After Deductible
If a referral is made to a non-network Physician or non-network specialist/facility by a network Physician (due to Medically Necessary services not being available In-Network).	N/A	Paid same as In Network.
Non-Network Physician Services Received at a Network Hospital If services are performed by a non-network Physician/specialist, who is requested or required by that network Hospital, the charges will be covered as if rendered by a network Physician/specialist.	N/A	Paid same as In-Network.

V. OUTPATIENT/OFFICE (PHYSICIAN'S OFFICE AND FACILITY) LABORATORY/RADIOLOGY/PATHOLOGY SERVICES, INCLUDING ADMINISTRATION AND MRI, PET, AND CT SCANS:

COVERED SERVICES and PROVISIONS ***Note:*** *Generally, for in-network charges billed on a Form CMS-1500 exceeding $5,000, payment will be limited to the Medicare fee schedule. Some exceptions may apply. See the Out-of-Network Benefits section of this SPD for more information.*	**In-Network**	**Out-of-Network**
Outpatient/Office/Independent Laboratory Diagnostic Tests, Radiology and Pathology Administration and Interpretation Services *Does not include above services performed in conjunction with the following:* • *Emergency Room Services.* • *Urgent Care Services* *Does not include MRI, PET or CT scans.*	80% After Deductible	50% After Deductible
Outpatient/Office Imaging Services (MRI, PET, and CT scans) *Does not include above services performed in conjunction with the following:* • *Urgent Care Services*	80% After Deductible	50% After Deductible

VI. FACILITY SERVICES:

COVERED SERVICES and PROVISIONS		
	In-Network	**Out-of-Network**
Emergency Room Services Note: See the "Out-of-Network Benefits" section for more information regarding out of network Emergency Room Services.	80% After Deductible	Paid Same as In-network
Inpatient Hospital Services *Coverage is limited to:* • *Room and board not to exceed the semi-private room rate.* • *Necessary services and supplies including an intensive care unit and a cardiac care unit.* • *If admitted through the Hospital emergency room, this benefit will be covered at the in-network level. Notice and consent rules may apply to certain post-stabilization items and services. See Emergency Room Services in the "Definitions" section.* *Note: Room and board subject to the payment of semi-private room rate, unless the Hospital only has private rooms.* *Note: for in-network Inpatient Hospital charges exceeding $10,000, payment will be limited to the Medicare DRG Reimbursement Rate.*	80% After Deductible	50% After Deductible
Ambulatory Surgical Facility Charges for Outpatient Surgical Procedures *Note: for in-network Ambulatory Surgical Center charges exceeding $2,500, payment will be limited to the Medicare ASC Reimbursement Rate.*	80% After Deductible	50% After Deductible
Outpatient Hospital Facility Charges *Note: for in-network Outpatient Hospital charges exceeding $2,500, payment will be limited to Medicare APC Reimbursement Rate.*	80% After Deductible	50% After Deductible
Renal Dialysis *Note: For charges due to renal dialysis, payment by this Plan will not exceed 100% of the Medicare allowance for such incurred expenses.*	100% After Deductible	Paid the same as in-network
Urgent Care Services – facility fees	Please refer to Urgent Care Services benefit in Section IV.	

VII. MENTAL HEALTH AND SUBSTANCE USE SERVICES:

COVERED SERVICES and PROVISIONS		
	In-Network	**Out-of-Network**
BEHAVIOR HEALTH BENEFIT (Mental/Nervous/Substance Use Disorders)		
Outpatient Treatment for Mental/Nervous and Substance Use Disorders *Please see the definitions of Physician and Hospital for further detail.*	80% After Deductible	Paid same as in-network (subject to the in-network Deductible and in-network Out-of-Pocket)
Inpatient Treatment for Mental/Nervous and Substance Use Disorders	80% After Deductible	Paid same as in-network (subject to the in-network Deductible and in-network Out-of-Pocket)

VIII. ADDITIONAL COVERED SERVICES:

COVERED SERVICES and PROVISIONS ***Note:*** *Generally, for in-network charges billed on a Form CMS-1500 exceeding $5,000, payment will be limited to the Medicare fee schedule. Some exceptions may apply. See the Out-of-Network Benefits section of this SPD for more information.*	**In-Network**	**Out-of-Network**
Autism Spectrum Disorders For those diagnosed with this disorder, the following treatments are covered: • Psychiatric and Psychological care, meaning direct, consultative, or diagnostic services provided by a licensed psychiatrist or psychologist. • Habilitative or rehabilitative care, meaning professional, counseling, and guidance services and treatment programs, including applied behavior analysis, that are intended to develop, maintain, and restore the functioning of an individual. Autism spectrum disorders means pervasive developmental disorders as defined in the most recent edition of the Diagnostic and Statistical Manual of Mental Disorders, including autism, Asperger's disorder, and pervasive developmental disorder not otherwise specified.	90% After Deductible	Paid same as in-network (subject to the in-network Deductible and in-network Out-of-Pocket)
Hearing Aids and the fitting thereof- *Limited a maximum payment of $750 per hearing impaired ear every* 24 months.	80% After Deductible	50% After Deductible
Hearing Exams- *Limited to one exam per person every 24 months ages 22 and over. Hearing screenings from birth through age 21 are covered under the Preventive Care benefit.*	80% After Deductible	50% After Deductible

IX. OTHER COVERED SERVICES:

COVERED SERVICES and PROVISIONS ***Note:*** *Generally, for in-network charges billed on a Form CMS-1500 exceeding $5,000, payment will be limited to the Medicare fee schedule. Some exceptions may apply. See the Out-of-Network Benefits section of this SPD for more information.*	In-Network	Out-of-Network
Note: The following benefits are subject to the applicable co-insurance level unless they are included in a separate category listed in this Schedule of Covered Services and Provisions.		
Abortion 41-H2-Statement-on-Sanctity-of-Human-Life-3-15-22.pdf (cmalliance.org)	Not Covered	Not Covered
Acupuncture - *All services are limited to a maximum of* 20 *visits per Covered Person per* Calendar Year.	80% After Deductible	50% After Deductible
Assisted Reproduction	Not Covered	Not Covered
Casts, Splints, Trusses and Braces	80% After Deductible	50% After Deductible
Contact Lenses or Glasses Following Cataract Surgery *Limited to first pair of either contact lenses or glasses following cataract surgery for initial replacement of natural lenses.*	80% After Deductible	50% After Deductible
Dental Treatment *when rendered by a Physician, dentist or oral surgeon for* ***a*** **fractured jaw** *or for* **accidental Injuries to natural teeth within 6 months** *after the accident (replacement or repair of a denture not covered) removal of* **total bony impacted teeth** *charges for* **medical care, services** *and* **supplies** *furnished by a Hospital during Medically Necessary confinement in connection with* dental treatment.	80% After Deductible	50% After Deductible
Durable Medical Equipment *Includes:* • *Cost to purchase or rent up to purchase price.* • *Insulin pump, glucose monitors and other diabetic supplies when Medically Necessary and not covered though Your prescription drug vendor.* • *Equipment for administration of oxygen.* • *Equipment repair or replacement.*	80% After Deductible	50% After Deductible
Family Planning - Permanent Procedures for Men *Includes:* • *Sterilization.* ○ *Male vasectomy.*	80% After Deductible	50% After Deductible
Foot Orthotics *Limited to 1 set of inserts every Calendar Year, as prescribed by a Physician or specialist.*	80% After Deductible	50% After Deductible
Gender Affirming Surgery (including any associated labs and x-rays)	Not Covered	Not Covered
Growth hormones *(must be Medically Necessary)*	80% After Deductible	50% After Deductible

IX. OTHER COVERED SERVICES:

COVERED SERVICES and PROVISIONS ***Note:*** *Generally, for in-network charges billed on a Form CMS-1500 exceeding $5,000, payment will be limited to the Medicare fee schedule. Some exceptions may apply. See the Out-of-Network Benefits section of this SPD for more information.*	In-Network	Out-of-Network
Home Health Care *Limited to a maximum of* 40 *home care visits per Covered Person per* Calendar Year. *Each 4 hours of service by a home health aide in a 24-hour period will be considered 1 home health visit.* *One visit by any other provider of services will be counted as 1 visit.*	80% After Deductible	50% After Deductible
Hospice Care- *Limited to a maximum of 180 days per Lifetime* *Includes all necessary services for the patient if prescribed by a Physician, and the patient's life expectancy is 6 months or less.*	80% After Deductible	50% After Deductible
Infertility Testing *Limited to Covered Services necessary to diagnose this condition only.* *This benefit does not cover charges in connection with the promotion of conception (see Assisted Reproduction benefit for details). Infertility means the inability to conceive a child, or the inability to sustain a successful pregnancy.*	Paid same as any other service according to type of service, provider and place of service.	
Infusion therapy and Injections The first dose of in-network infusion therapy may be given at the Physician's facility of choice, including Outpatient Hospitals, free-standing facilities and home care. Any subsequent dose may also be given at the Physician's facility of choice, but only when clinically appropriate and at a lower cost than other sites of administration. *For* in-network *infusion therapy charges exceeding $1,500 (including, but not limited to, chemotherapy), payment by this Plan will not exceed 100% of the Medicare allowance for such incurred expenses. (Infusion therapy encompasses intravenous and/or intramuscular injections, as well as drugs administered through other non-oral routes, such as epidural routes). Note Self-administered injections, topical solutions and oral specialty medications are not covered under this Plan.*	80% After Deductible	50% After Deductible
Marital Counseling	80% After Deductible	Paid the same as in-network. (Subject to the in-network deductible and Out-of-Pocket maximum)
Mastectomy Related Treatment *Includes charges in accordance with the provisions detailed under the definition of "Reconstructive Breast Surgery."*	80% After Deductible	50% After Deductible
Nutritional Counseling, regardless of underlying covered condition	80% After Deductible	50% After Deductible

IX. OTHER COVERED SERVICES:

COVERED SERVICES and PROVISIONS ***Note:*** *Generally, for in-network charges billed on a Form CMS-1500 exceeding $5,000, payment will be limited to the Medicare fee schedule. Some exceptions may apply. See the Out-of-Network Benefits section of this SPD for more information.*	In-Network	Out-of-Network
Obesity surgery and Non-surgical obesity treatment *Obesity surgery limited to* 1 *surgical procedure per Covered Person per* Per Lifetime *Non-surgical obesity treatment limited to $*5000 *Maximum paid per Covered Person per* Per Lifetime. Benefit does not apply unless Covered Person: • Has attempted weight loss in the past without successful long-term weight reduction and • Meets either a physician-supervised nutrition and exercise program or a multidisciplinary surgical preparatory regimen. Benefit does not apply unless the *Adult* Covered Person: • Has a body mass index (BMI) exceeding 40 *or* • Has a BMI greater than 35 in conjunction with any of the following severe co-morbidities: o Clinically significant obstructive sleep apnea (i.e., patient meets the criteria for treatment of obstructive sleep apnea) or o Coronary heart disease *or* o Medically refractory hypertension (blood pressure greater than 140 mmHg systolic and/or 90 mmHg diastolic despite optimal medical management) *or* o Type 2 diabetes mellitus.	80% After Deductible	50% After Deductible
Organ or Tissue Transplant– **Christian and Missionary Alliance Maintains a Separate Organ Transplant Policy Which is Always Primary**	Please contact Optum at 800-367-4436.	
Organ or Tissue Transplant Procedures – **For cornea, skin, or cartilage transplants:** *The Covered Person, who is the transplant recipient, must receive 2 opinions with regard to the need for transplant surgery. The opinions must be in writing by board-certified specialists in the involved field of surgery. The specialists must certify that alternative procedures, services or courses of treatment would not be effective in the treatment of the condition.*	80% After Deductible	50% After Deductible
For all other Organ and Tissue Transplants: *For specific details on all elements of this coverage, please refer to the Transplants section.*	Coverage and Benefit Level based upon place and type of service.	Not Covered.
Orthopedic Shoes	Not Covered	Not Covered
Prescription Drugs *if not available through the Prescription Drug Benefit. Must be Medically Necessary.*	80% After Deductible	50% After Deductible
Private Duty Nursing Services - *Includes services of a registered professional nurse (R.N.) or a licensed practical nurse (L.P.N.), when Medically Necessary, other than one who ordinarily resides in Your home, or who is a member of the immediate family.* *Limited to a maximum of* 40 *visits (one per day) per Covered Person per* Calendar Year.	80% After Deductible	50% After Deductible

IX. OTHER COVERED SERVICES:

COVERED SERVICES and PROVISIONS ***Note:*** *Generally, for in-network charges billed on a Form CMS-1500 exceeding $5,000, payment will be limited to the Medicare fee schedule. Some exceptions may apply. See the Out-of-Network Benefits section of this SPD for more information.*	In-Network	Out-of-Network
Professional Ambulance Service *Transportation from the city or town in which the Covered Person becomes disabled, to and from the nearest Hospital qualified to provide treatment for the accidental bodily Injury or disease.* Note: See the "Out-of-Network Benefits" section for more information regarding out of network Air Ambulance services	80% After Deductible	Paid the same as in-network. (Subject to the in-network deductible and Out-of-Pocket maximum)
Prosthetic Medical Appliances (including Artificial Limbs, Eyes and Larynx) *Limited to charges for the purchase, maintenance, or repair of internal and external permanent or temporary aids and supports for defective body parts.*	80% After Deductible	50% After Deductible
Routine Newborn Nursery Care *(including circumcision)*	80% After Deductible	50% After Deductible
Services/Items for Covered Persons Residing Outside the PPO Network Area	*N/A*	*Paid same as any other in-network service according to type of service, provider and place of service.*
Skilled Nursing Facility *Includes Extended Care Facility.* *Limited to* 60 *days per Covered Person per* Calendar Year. *Limited to the usual charge of the facility for semi-private care, including room and board and all other services.*	80% After Deductible	50% After Deductible
Sleep Studies (*home)*	80% After Deductible	50% After Deductible

IX. OTHER COVERED SERVICES:

COVERED SERVICES and PROVISIONS ***Note:*** *Generally, for in-network charges billed on a Form CMS-1500 exceeding $5,000, payment will be limited to the Medicare fee schedule. Some exceptions may apply. See the Out-of-Network Benefits section of this SPD for more information.*	In-Network	Out-of-Network
Sleep Studies ***(In-lab, facility)*** *In order to be eligible, the following criteria must be met:* • *Excessive daytime sleepiness* • *Epworth sleepiness scale ≥ 10* • *Witnessed snoring* *Along with one of the following comorbid conditions:* • *Chronic obstructive pulmonary disease* • *Neuromuscular disease* • *Stroke* • *Epilepsy* • *Congestive heart failure* • *BMI > 45* • *Periodic limb movement disorder* • *Narcolepsy* • *Central or complex sleep apnea*	80% After Deductible	50% After Deductible
TMJ *(Temporomandibular Joint Dysfunction) diagnostic and non-surgical procedures- Limited to $1500 Maximum paid per Covered Person per Calendar Year. Benefit does not include charges for orthodontic services or surgical services for TMJ.*	80% After Deductible	50% After Deductible
Wigs *for hair loss resulting from the treatment of cancer. Limited to one wig per Covered Person every Calendar Year.*	80% After Deductible	50% After Deductible
Please Refer to the Pre-Certification Program and Exclusions sections for additional coverage details.		

EXCLUSIONS

No payment will be made under this Plan for expenses incurred by a Covered Person based on the below exclusions *(unless specifically stated within the Schedule of Covered Services and Provisions*):

1. for or in connection with an Injury or Illness for which the Employee or Dependent is entitled to benefits under any Workers' Compensation, Occupational Disease, or similar law;
2. for care and treatment of an Injury or Illness arising out of, or in the course of, any employment for wage or profit;
3. in a Hospital owned or operated by the United States Government or for services or supplies furnished by or for any other government unless payment is legally required;
4. for charges which the Covered Person is not legally required to pay or for charges which would not have been made if no coverage had existed;
5. which are not Reasonable and/or in excess of Usual and Customary Charges (depending on contract provisions, this limitation may not apply to charges from network providers or non-network providers who are utilized as a result of requests or requirements of network providers) unless otherwise set forth in the "Out-of-Network Benefits" section;
6. which are for care or treatment which is not Medically Necessary;
7. for custodial care (Expenses incurred to assist a person in daily living activities are considered costs for custodial care. Costs for medical maintenance services and supplies in connection with custodial care due to age, mental or physical conditions, are not covered if such care cannot reasonably be expected to improve a medical condition.);
8. due to accidental bodily Injury or Illness resulting from participation in an insurrection or riot, or participation in the commission of an assault or felony;
9. for purchase or rental of personal comfort items or supplies of common use; for purchase or rental of blood pressure kits, exercise cycles, air purifiers, air conditioners, water purifiers, hypo-allergenic pillows, mattresses or waterbeds, escalators, elevators, saunas, steam rooms and/or swimming pools;
10. for non-medical expenses such as preparing medical reports, itemized bills or charges for mailing;
11. for training, educational instructions or materials, even if they are performed or prescribed by a Physician;
12. for legal fees and expenses incurred in obtaining medical treatment;
13. for genetic testing and counseling (except as may be specifically stated as covered elsewhere in this document) unless Medically Necessary;

14. for Friday and Saturday admissions unless due to a Medical Emergency or if surgery is scheduled within the 24 hour period immediately following admission;
15. for treatment by a Physician, Registered Nurse (R.N.), Licensed Practical Nurse (L.P.N) if the Physician or nurse is related by blood, marriage, or by legal adoption to either the Covered Person or a spouse, or ordinarily resides with the Covered Person;
16. for any expense in excess of any maximum or limit as stated elsewhere in this document;
17. for failure to provide any additional documentation or information as may be requested pursuant to the "Procedures For Filing Claims" section of this Plan;
18. for charges for travel or accommodations, whether or not recommended by a Physician, unless specifically stated as covered;
19. for charges incurred before coverage was effective or after it was terminated;
20. for charges incurred as a result of radioactive contamination or the hazardous properties of nuclear material;
21. except as stated in the Schedule of Covered Services and Provisions, 1) for treatment of or to the teeth, the nerves or roots of the teeth, and 2) for the repair or replacement of a denture,
22. for research studies not reasonably necessary to the treatment of an Illness or Injury;
23. This Exclusion is intentionally left blank;
24. This Exclusion is intentionally left blank;
25. for treatment for sexual dysfunction or inadequacy; for sex changes, services or treatment for non-congenital transsexualism, gender dysphoria or sexual reassignment or change. This Exclusion includes medication, implants, hormone therapy, surgery, medical psychiatric treatment;
26. for vitamins (except prescription pre-natal and pediatric vitamins); for over-the-counter drugs regardless of being prescribed by a Physician, unless required by federal law;
27. for routine foot care such as removal of corns, calluses or toenails, except in the treatment of a peripheral-vascular disease when recommended by a medical doctor or doctor of osteopathy;
28. for splints or braces for non-medical purposes (i.e., supports worn primarily during participation in sports or similar physical activities;
29. for any form of medication or treatment not prescribed in relation to an Injury, Illness or pregnancy, unless stated as covered elsewhere in this document;
30. for growth hormones unless Medically Necessary;
31. on account of any declared or undeclared act of war;
32. for charges in connection with Cosmetic Surgery/Treatment, except to correct deformities

resulting from Injuries sustained in an accident; or due to an Illness such as breast cancer (including all services mandated by federal provisions related to mastectomy treatment – see definition of "Reconstructive Breast Surgery Coverage");

33. This Exclusion is intentionally left blank;
34. for expenses incurred for cryo-preservation and storage of sperm, eggs and embryos;
35. for charges incurred outside the United States if travel to such a location was for the primary purpose of obtaining medical services, drugs or supplies;
36. for special education services (unless specifically referenced in the Schedule of Covered Services);
37. for experimental or investigational services or, for treatment not deemed clinically acceptable by (1) the National Institute of Health; or (2) the FDA; or (3) the Centers for Medicare and Medicaid Services (CMS); or (4) the AMA; or a similar national medical organization of the United States;
38. for routine eye examinations, unless required by federal law; for eyeglasses or contact lenses, or the fitting of eyeglasses or contact lenses, except as stated in the Schedule of Covered Services and Provisions for any procedure, treatment or exam in connection with refractive disorders for eye surgery such as radial keratotomy;
39. This Exclusion is intentionally left blank;
40. This Exclusion is intentionally left blank;
41. for instruction or activities for weight reduction or weight control, including charges for vitamins, diet supplements, or physical fitness programs even if the services are performed or prescribed by a Physician (except as referenced in the Schedule of Covered Services);
42. This Exclusion is intentionally left blank;
43. This Exclusion is intentionally left blank;
44. for surgical reversal of elective sterilizations;
45. abortions;
46. for chelation (metallic ion) therapy, except as approved by the Food and Drug Administration;
47. for "nicotine patches" or other forms of anti-smoking medication (except as stated in the "Prescription Drug Benefit");
48. for care and treatment for hair loss including wigs, hair transplants, hair implants or any drug that promises hair growth, whether or not prescribed by a Physician except for wigs after chemotherapy;
49. for any service for assisted reproduction (including in vitro fertilization, uterine embryo lavage, embryo transfer, artificial insemination, gamete intrafallopian tube transfer, zygote

intrafallopian tube transfer, and low tubal ovum transfer); however, diagnosis and treatment of medical conditions (such as endometriosis) that may contribute to the condition of infertility are covered;

50. for services and supplies received from a medical or dental department maintained by or on behalf of an employer, a mutual benefit association, trustee or similar person or group;
51. This Exclusion is intentionally left blank;
52. This Exclusion is intentionally left blank;
53. This Exclusion is intentionally left blank;
54. for expenses for injuries incurred in the commission of a criminal act involving the use of alcohol or illegal drugs;
55. This Exclusion is intentionally left blank;
56. This Exclusion is intentionally left blank;
57. This Exclusion is intentionally left blank;
58. This Exclusion is intentionally left blank;
59. for charges due to renal dialysis, payment by this Plan will not exceed 100% of the Medicare allowance for such incurred expenses (except as specifically stated in the Out-of-Network Benefits section);
60. for in-network Inpatient Hospital charges exceeding $10,000, payment will be limited to the Medicare DRG Reimbursement Rate. If a Medicare DRG Reimbursement Rate is not available, then reimbursement will be limited to the Rate of the next closest Hospital;
61. for in-network Outpatient Hospital charges exceeding $2,500, payment will be limited to the Medicare APC Reimbursement Rate. If a Medicare APC Reimbursement Rate is not available, then reimbursement will be limited to the Rate of the next closest Hospital;
62. for in-network Ambulatory Surgical Center charges exceeding $2,500, payment will be limited to the Medicare ASC reimbursement fee schedule;
63. for in-network ambulance (ground and air) charges exceeding $2,500, payment by this Plan will not exceed 100% of the Medicare allowance for such incurred expenses (except as specifically stated in the Out-of-Network Benefits section). Charges include those which relate to 1) transportation and 2) medical supplies used during transport, including those for BLS (basic life support) only services and ALS (advanced life support) services/supplies.
64. for in-network charges billed on a Form CMS-1500 exceeding $5,000, payment will be limited to the Medicare fee schedule (except as specifically stated in the Out-of-Network Benefits section).

65. in-network infusion therapy charges exceeding $1,500 (including, but not limited to, chemotherapy), payment by this Plan will not exceed 100% of the Medicare allowance for such incurred expenses (except as specifically stated in the Out-of-Network Benefits section). Infusion therapy encompasses intravenous and/or intramuscular injections, as well as drugs administered through other non-oral routes, such as epidural routes.
66. for provider charges claimed as a result of purported lost discounts;
67. for charges for oral nutrition including infant formula;
68. for court ordered services, for otherwise covered services ordered by a court or other tribunal as part of Your or Your Dependents sentence;
69. for cellular therapy, which is the transfer of whole, live cells (modified or unmodified) to produce an immune or other biological response. Cellular therapy includes but is not limited to, cellular immunotherapies and cancer vaccines.
70. For gene Therapy, which is the use of genetic material to modify or manipulate the expression of gene or alters the biological properties of living cells for therapeutic use;
71. for family planning temporary procedures, including but not limited to injections, implants, and intrauterine contraceptives including administration, insertion, and removal other than depo-provera and medroxyprogesterone injections.
72. for charges for prescription drugs for contraceptive purposes other than those listed on the preventive drug list; for contraceptives for all abortifacient purposes.

DEFINITIONS

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

AIR AMBULANCE

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

AMBULATORY SURGICAL CENTER

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

ANCILLARY SERVICES

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

ASC REIMBURSEMENT FEE SCHEDULE

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

CALENDAR YEAR

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

CASE MANAGEMENT PROGRAM

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

If, at any point in the progress of a given medical situation, after having considered the opinions of the Covered Person (and/or his legally responsible representatives), the Covered Person's

Physician and/or other medical authorities, the Plan Administrator determines that the benefits of this Plan may be best utilized through the implementation of a Case Management Program, the Plan reserves the right to require that further benefits be provided only under the administration of such a program.

CLAIMS PROCESSOR

The entity providing consulting services to the Company in connection with the operation of the Plan and performing other functions, including processing of claims. The Claims Processor is Allied Benefit Systems, LLC, P. O. Box 909786-60690, Chicago, IL 60690. Should be P.O Box 211651 Eagan, MN 55121.

COMPANY

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

COSMETIC SURGERY/TREATMENT

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

COVERED PERSON / PLAN PARTICIPANT

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

COVERED SERVICES

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

DEDUCTIBLE/CO-INSURANCE

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

DEPENDENTS

Spouse of the Employee.

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

A child who is physically or mentally incapable of self-support upon attaining age 26 may be continued under the health care benefits, while remaining incapacitated and unmarried, subject to the covered Employee's own coverage continuing in effect. To continue a child under this provision, the Company must receive proof of incapacity within 31 days after coverage would otherwise terminate. Additional proof will be required from time to time.

ELECTIVE SURGICAL PROCEDURE

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

EMERGENCY ROOM SERVICES

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

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

applicable state law.

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

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

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

EMPLOYEE

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

EMPLOYER

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

ENROLLMENT DATE

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

ESSENTIAL HEALTH BENEFITS

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

EXTENDED CARE FACILITY

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

Physicians to examine the need for admissions, adequacy of care, duration of stay and medical necessity of continuing confinement of patients; (h) is licensed pursuant to law, or is approved by appropriate authority as qualifying for licensing and is also approved by Medicare; (i) is not primarily a place for the elderly, a place for rest, or a place for custodial or educational care.

FAMILY DEDUCTIBLE

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

GENDER NEUTRAL WORDING

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

GENETIC INFORMATION

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

HOME HEALTH CARE AGENCY

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

HOSPICE

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

HOSPITAL

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

In addition, the term "Hospital" shall mean, as defined by Medicare, a Psychiatric Hospital, which is qualified to participate in and is eligible to receive payments under and in accordance with the provisions of Medicare; or, which meets the following requirements; (a) is licensed by the jurisdiction in which it operates; and (b) is accredited by the Joint Commission on the Accreditation of Healthcare Organizations.

HOSPITAL INTENSIVE CARE/CARDIAC CARE UNIT

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

HOSPITAL SEMI-PRIVATE

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

ILLNESS

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

INJURY

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

INPATIENT

A Covered Person shall be considered to be an "Inpatient" if he is treated at a Hospital and is confined for 23 or more consecutive hours. The term "Inpatient" shall also apply to those situations where "partial hospitalization" (defined as an on-going period of treatment involving full use of Hospital facilities excepting only room and board service) is recommended by the patient's Physician as an alternative to Hospital confinement.

LATE ENROLLMENT

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

LIFETIME

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

MEDICAL EMERGENCY

A **"**Medical Emergency**"** is defined as a medical condition, including a Mental/Nervous or Substance Use Disorder, manifesting itself by acute symptoms of sufficient severity (including severe pain) so that a prudent layperson, who possesses an average knowledge of health and medicine, could reasonably expect the absence of immediate medical attention to result in 1) a condition placing the health of the individual (or, with respect to a pregnant woman, the health of the woman or her unborn child) in serious jeopardy; 2) serious impairment to bodily functions; or 3) serious dysfunction of any bodily organ or part.

MEDICALLY NECESSARY

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

MEDICARE DRG OR APC REIMBURSEMENT RATE

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

MENTAL/NERVOUS AND SUBSTANCE USE DISORDER SERVICES

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

NAMED FIDUCIARY

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

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

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

OPEN ENROLLMENT

Each year, a period of time may be designated as an Open Enrollment period. Except for Special Enrollment or Late Enrollment, if applicable, it is only during this period that an Employee or Dependent who did not enroll during their initial eligibility period may enroll in a Plan. It is also only during this period that an Employee who is currently covered under one Plan may switch to another. Coverage will become effective on the date specified by Your Employer. See the Key Information section at the beginning of this document for applicability, as well as Your Employer for details.

OUT-OF-NETWORK RATE

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

OUT-OF-POCKET MAXIMUM

The "Out-of-Pocket Maximum" is the total amount of co-pays, co-insurance and deductibles for which the Covered Person or covered family is responsible during the course of a Calendar Year.

These amounts are shown in the "Schedule of Covered Services and Provisions," along with expenses not applicable towards the Out-of-Pocket maximum. Once this amount has been reached, 100% level of benefits applies for the remainder of that Calendar Year.

OUTPATIENT

A Covered Person shall be considered to be an "Outpatient" if he is treated at a Hospital and is confined less than 23 consecutive hours.

PHYSICIAN

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

PLACEMENT FOR ADOPTION

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

PLAN

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

PLAN ADMINISTRATOR

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

PLAN YEAR

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

QUALIFIED MEDICAL CHILD SUPPORT ORDER

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

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

REASONABLE/REASONABLENESS

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

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

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

RECOGNIZED AMOUNT

For purposes of Covered Services that are subject to balance billing protections (see the "Out-of-Network Benefits" section for more details), the Recognized Amount is the amount used to calculate the Covered Person's cost share for such services. The Recognized Amount is typically the lesser of the billed charge or the qualifying payment amount. The methodology for

determining the qualifying payment amount is set by federal regulations at 29 CFR 2590.716-6, and is adjusted from time to time*.

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

RECONSTRUCTIVE BREAST SURGERY COVERAGE

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

RETIREE

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

SECOND SURGICAL OPINION

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

SPECIAL ENROLLMENT

An enrollment which takes place during the 30-day period following the date of the event which triggers the Special Enrollment period. See "Eligibility" section for details.

USUAL AND CUSTOMARY

"Usual and Customary" (U&C) shall mean Covered Services which are identified by the Plan Administrator, taking into consideration the charge(s) which the provider most frequently bills the majority of patients for the service or supply, the cost to the provider for providing the service or supply, the prevailing range of charges billed in the same "area" by providers of similar training and experience for the service or supply, and/or the Medicare reimbursement rates. The term(s)

"same geographic locale" and/or "area" shall be defined as a metropolitan area, county, or such greater area as is necessary to obtain a representative cross-section of providers, persons or organizations rendering such treatment, service, or supply for which a specific charge is made. To be Usual and Customary, the charge must be in compliance with the Plan Administrator's policies and procedures relating to billing practices for unbundling or multiple procedures.

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

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

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

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

WAITING PERIOD

The period of time before an individual is eligible to be covered under the terms of a group health plan. Any period before a Late Enrollment, Open Enrollment or Special Enrollment is not a Waiting Period.

YOU, YOUR, YOURSELF

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

ELIGIBILITY

WHO IS ELIGIBLE

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

NON-DISCRIMINATION

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

EMPLOYEE COVERAGE

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

DEPENDENT COVERAGE

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

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

INDIVIDUAL EFFECTIVE DATE

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

1. All Employees, who are eligible Employees, shall be covered on the day they become eligible, as discussed in the Key Information section at the beginning of this document.
2. Dependents shall be covered simultaneously with Employees covering them as Dependents.
3. Coverage for a spouse will begin from the date of marriage. Coverage for a newborn birth child will begin from the date of birth. Coverage for a child placed under legal guardianship, an adopted child or a child placed for adoption with the Employee will

begin from the date of Placement for Adoption. Coverage for a stepchild or foster child will begin from the date the child meets the definition of "Dependent." With respect to a spouse, the spouse must be formally enrolled and appropriate coverage arranged within 30 days from date of marriage. With respect to a newborn birth child, the child must be formally enrolled and appropriate coverage arranged within 60 days from birth. With respect to a child placed under legal guardianship, an adopted child or child placed for adoption, the child must be formally enrolled and appropriate coverage arranged within 60 days from the date of Placement For Adoption. With respect to a stepchild or a foster child, the child must be formally enrolled and appropriate coverage arranged within 30 days from the date that the child meets the definition of "Dependent."

OPEN ENROLLMENT

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

LATE ENROLLMENT

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

SPECIAL ENROLLMENT

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

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

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

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

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

Under Special Enrollment, the Employee must request enrollment, in writing within 30 days after the exhaustion of COBRA, or termination of the other coverage (other than Medicaid or Children's Health Insurance, see below), or the date of the marriage, birth, adoption or placement for adoption. If eligible, enrollment in the Plan, in cases of marriage, birth or adoption/Placement for Adoption, will be effective as of the date of the event; otherwise, coverage will be available no later than the first day of the first month beginning after the completed request for enrollment is received.

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

TERMINATION OF COVERAGE

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

EMPLOYER POLICIES AND PROCEDURES

Except as required under the Americans with Disabilities Act, the Family and Medical Leave Act, or the Uniformed Services Employment and Reemployment Rights Act, the Employer's policies and procedures regarding waiting periods, continuation of coverage or reinstatement of coverage shall apply during the following situations: Employer certified disability, layoff, reinstatement, or hire. Whether an Employee averages the requisite hours of service to be eligible for coverage shall be determined in accordance with the policies and procedures of the Employer.

Leave of Absence. A defined and approved leave of absence period is authorized and extended to an Employee for time away from job responsibilities up to a maximum of 90 days. An Employer should have a process and written documentation in place for any approved length of an Employee's leave of absence and up to a maximum of 90 days for benefit purposes. Benefits under the Plan may not be offered during a leave of absence for more than 90 days. An unpaid or paid leave of absence period must be reported by the Employer to the Plan Administrator within 30 days of change in status for further determination of benefits. If the leave of absence is due to a serious health condition, the Employer must notify the Plan Administrator immediately for review and for possible eligibility of long-term disability benefits. If the Employee is no longer eligible to continue benefits under their Employer, extended coverage will be offered as outlined in the Continuation Coverage section of this document.

Rehiring a Terminated Employee. A terminated Employee who is rehired will be treated as a new hire and be required to satisfy all Eligibility and Enrollment requirements to the extent permitted by terms of the Plan and applicable law.

INDIVIDUALS PARTICIPATING IN APPROVED CLINICAL TRIALS

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

The following definitions are applicable under this provision:

Qualified Individual

A Covered Person who meets the following conditions:

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

B. Either:

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

Approved Clinical Trial

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

- Federally funded trials. The study or investigation is approved or funded (which may include funding through in-kind contributions) by one or more of the following:
    1. The National Institutes of Health.
    2. The Centers for Disease Control and Prevention.
    3. The Agency for Health Care Research and Quality.

4. The Centers for Medicare & Medicaid Services.
5. A cooperative group or center of any of the entities described in clauses 1 through 4 above or the Department of Defense or the Department of Veterans Affairs.
6. A qualified non-governmental research entity identified in the guidelines issued by the National Institutes of Health for center support grants.
7. Any of the following entities in clauses 7a. through 7c. below if the following conditions are met: the study or investigation has been reviewed and approved through a system of peer review that the Secretary of Health and Human Services determines to be comparable to the system of peer review of studies and investigations used by the National Institutes of Health, and assures unbiased review of the highest scientific standards by qualified individuals who have no interest in the outcome of the review.
    a. The Department of Veterans Affairs.
    b. The Department of Defense.
    c. The Department of Energy.

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

Routine Patient Costs

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

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

Life-Threatening Disease or Condition

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

NETWORK BENEFITS

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

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

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

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

OUT-OF-NETWORK BENEFITS

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

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

- *Emergency Room Services*.

- *Air Ambulance*.

- *Non-Emergency Care* when provided by a non-network provider at certain in-network facilities (i.e., a Hospital, a Hospital Outpatient department, a critical access Hospital, an Ambulatory Surgical Center, and any other facility specified by the Secretary of HHS) for the categories of service listed below,:

    - Ancillary Services (see the Definitions section);
    - Non-Ancillary Services, if the non-network provider has not given proper notice and You've not given proper consent;

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

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

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

If You believe You have been wrongly billed, You may contact the No Surprises Help Desk at 1-

800-985-3059 from 8 am to 8 pm EST, 7 days a week, to submit Your question or a complaint. You can also submit a complaint online at: https://www.cms.gov/nosurprises/consumers/complaints-about-medical-billing.

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

PROCEDURES FOR FILING CLAIMS

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

KEY POINTS TO REMEMBER

The claims filing address You must use for filing all medical claims is shown on Your ID card.

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

Providers will normally file Your (Dependents) claim with Your health Plan, however You are ultimately responsible to ensure Your (Dependents) claim has been filled accordingly.

Always retain a copy of the bill for Your records.

MISCELLANEOUS CLAIMS FILING CONSIDERATIONS

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

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

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

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

Always retain a copy of the bill for Your records.

THIS PLAN AND MEDICARE

Medicare will pay primary, secondary or last to the extent stated in federal law. If a Plan Participant is Medicare entitled this Plan will base its payment upon benefits that would have been paid by Medicare under Parts A and B regardless of whether or not the person was enrolled under any of these parts. The Plan Administrator will make this determination based on the information available through CMS. If CMS does not provide sufficient information to determine the amount Medicare would pay, the Plan Administrator will make reasonable assumptions based on published Medicare fee schedules.

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

GENERAL PROVISIONS

ADMINISTRATION OF THE PLAN

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

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

APPEALING A CLAIM

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

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

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

CLAIMS PROCEDURES

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

The Claims Processor will notify you of an Adverse Benefit Determination within 30 days after receipt of the claim. However, in certain cases an extension of up to 15 days may be utilized if the Claims Processor determines that the extension is necessary due to matters beyond the

control of the Plan and you are notified prior to the expiration of the initial 30 day period of the circumstances requiring the extension of time and the date by which the Claims Processor expects to render a decision. If such an extension is necessary due to your failure to submit the information necessary to decide the claim, the notice of extension shall specifically describe the required information, and you shall be given at least 45 days within which to provide the specified information. A notice of Adverse Benefit Determination will include the following:

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

  https://secured.insurance.ohio.gov/ConsumServ/ConServComments.asp.

FIRST LEVEL APPEALS PROCEDURE

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

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

- Upon written request, the identification of medical or vocational experts whose advice was obtained on behalf of the Plan in connection with your Adverse Benefit Determination, without regard to whether the advice was relied upon in making the benefit determination.

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

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

614-644-2673, and the website is:
https://secured.insurance.ohio.gov/ConsumServ/ConServComments.asp.

SECOND LEVEL APPEALS PROCEDURE (MEDICAL CLAIMS ONLY)

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

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

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

In making a decision, the Plan Administrator will:

- Not give deference to the initial claim determination.

- Not allow the same person who made the initial decision (or any subordinate of that person) to decide the appeal.

    - Consult with a health care professional on any appeal that involves the exercise of medical judgment. The health care professional will have training or experience in a field of medicine appropriate to the questions raised on appeal. The professional will not be the same person consulted in connection with the original denial or any subordinate of that person. The Plan Administrator will identify the professionals consulted upon written request.

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

Your appeal will be determined on its own merits at each stage of review, and the decision on your appeal will not be considered as setting any precedent or creating any future liability with

respect to you or any other Covered Person. If for any reason the Plan Administrator fails to act within these time frames, the appeal will be deemed to be denied.

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

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

If the Plan denies Your second level appeal, in whole or in part, and You choose to bring a civil action, such action must be filed within 365 days of the date of the Plan's denial of Your second level appeal. This 365 day time period, however, will be temporarily suspended to the extent You are entitled to file a third level (external) appeal (see below) and do in fact file such an appeal. Under such circumstances, this 365 day time period will be suspended from the date You submit a request for a third level (external) appeal that is both complete and eligible until the date of the decision of the Independent Review Organization or Superintendent, as applicable (see below).

THIRD LEVEL (EXTERNAL) APPEALS PROCEDURE

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

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

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

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

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

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

Following receipt of a request for external review, the Claims Processor, on behalf of the Plan Administrator, must review the request to determine whether it is complete, including whether you have exhausted the Plan's first and second level appeal processes. If complete, and reviewable by an IRO, the Superintendent shall assign an IRO from the list of organizations maintained by the Superintendent to conduct the external review. The Superintendent shall notify the Claims Processor of the name of the assigned IRO. The Claims Processor shall then notify you in writing of the acceptance of the third level review. Depending on the type of request for external review, this notice will include the name and contact information for either the assigned IRO or Superintendent (whichever is applicable) for the purpose of submitting additional documentation. The notice will also include a statement that you may submit in writing to either the IRO or Superintendent (whichever is applicable) within ten business days following the date of receipt of the notice, any additional information that should be considered when conducting

the third level review. (If the request for an external review is not complete, the Claims Processor shall inform you in writing, and include what information is needed to make the request complete. If the Plan Administrator denies a request for an external review on the basis that the Final Internal Adverse Benefit Determination is not eligible for an external review, the Claims Processor shall notify you in writing the reason for the denial, and that the denial may be appealed to the Superintendent.)

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

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

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

- Your medical records;
- The attending health care professional's recommendation;
    - Reports from appropriate health care professionals and other documents submitted by the Plan Administrator or Claims Processor, you or your treating provider;
    - The terms of the Plan to ensure that the IRO's decision is not contrary to these terms;
    - Appropriate practice guidelines, including evidence-based standards and other

guidelines developed by the Federal government, national or professional medical societies, boards and associations;

- Any applicable clinical review criteria developed and used by the Claims Processor or Plan Administrator; and
- The opinion of the IRO's clinical reviewer(s) after considering the other sources referenced above.

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

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

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

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

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

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

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

- A description of your condition;

- A description of the indicators relevant to determining whether there is sufficient evidence to demonstrate that the recommended or requested therapy is more likely than not to be more beneficial to you than standard therapies, and that the adverse risks of the requested therapy would not be substantially greater than those of available standard health care services;

- A description and analysis of any medical or scientific evidence considered in reaching the opinion;

- A description and analysis of any evidence-based standard considered; and

- Information on whether the reviewer's rationale for the opinion is based on whether the requested health care service has been approved by the federal Food and Drug Administration, if applicable for the condition, and whether medical or scientific evidence, or evidence-based standards, demonstrate that the expected benefits of the requested services are more likely than not to be beneficial to you than any available standard services, and that the adverse risks of the services would not be substantially greater than those of available standard services.

If there are multiple clinical reviewers, and the majority of the reviewers recommend the service should not be covered, the IRO will uphold the Final Internal Adverse Benefit Determination. If the majority of clinical reviewers recommend the service should be covered, the IRO will reverse the Final Internal Adverse Benefit Determination. If the reviewers are evenly split as to whether the Final Internal Adverse Benefit Determination should be reversed or upheld, the IRO shall

obtain the opinion of an additional clinical reviewer in order for the IRO to make a decision based on the opinions of a majority of the clinical reviewers. The additional clinical reviewer selected shall use the same information to reach an opinion as the clinical reviewers who have already submitted their opinions. The selection of the additional clinical reviewer shall not extend the time within which the assigned IRO is required to make a decision.

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

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

ASSIGNMENT OF BENEFITS

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

CLAIM AUDIT

Once a written claim for benefits is received, the Plan Administrator, at its discretion, may elect to have such claim reviewed or audited for accuracy, Reasonableness and/or the Usual and Customary nature of charges as part of the adjudication process. This process may include, but

not be limited to, identifying charges for items/services that may not be covered or may not have been delivered, duplicate charges and charges beyond the Reasonable and/or Usual and Customary guidelines as determined by the Plan Administrator.

COMPLIANCE

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

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

Same as Employer.

CONTRIBUTIONS

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

FUNDING

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

LIENS

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

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

NO WAIVER

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

PLAN IS NOT A CONTRACT

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

PLAN AMENDMENT, MODIFICATION OR TERMINATION

The Company reserves the right to amend, modify, revoke or terminate the Plan, in whole or in part, at any time and such amendment, modification, revocation or termination of the Plan shall be made by a written Plan endorsement signed by an authorized representative of the Company. Any such changes to the Plan, which affect participants, will be communicated to such participants by the Plan Administrator. Upon termination of the Plan, the rights of participants to benefits are limited to claims incurred and due up to the date of termination.

PROHIBITION ON RESCISSION

The Plan cannot rescind coverage except in the case of fraud or an intentional misrepresentation of a material fact. A rescission is a cancellation or discontinuance of coverage that has retroactive effect, unless it is attributable to a failure to pay timely required premiums or contributions towards the cost of coverage. The Plan must provide 30 calendar days advance notice to an individual before coverage may be rescinded.

REIMBURSEMENT AND SUBROGATION PROVISIONS

PAYMENT CONDITION

The Plan, in its sole discretion, may elect to conditionally advance payment of benefits in those situations where an Illness, Injury, or disability is caused in whole or in part by, or results from the acts or omissions of, a Covered Person 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 no-fault, uninsured motorist, underinsured motorist, medical payment provisions, third party assets, third party insurance, and/or grantor(s) of a third party (collectively “Coverage”).

However, such payment of benefits by the Plan shall be made only if the Covered Person first provides a reimbursement agreement in writing. Notwithstanding the foregoing, payment of any claim in the absence of a signed reimbursement agreement shall not invalidate the obligation of the Covered Person to otherwise reimburse the Plan.

The Covered Person (including his attorney, and/or legal guardian of a covered 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 the full extent of payment from any one or combination of first and third party sources in trust, without disruption except for reimbursement to the Plan or the Plan's assignee. By accepting benefits, the Covered Person agrees the Plan shall have an equitable lien on any funds received by the Covered Person and/or his attorney from any source and said funds shall be held in trust until such time as the obligations under this provision are fully satisfied. The Covered Person agrees to include the Plan's name as a co-payee on any and all settlement drafts. Further, by accepting benefits, the Covered Person understands that any recovery obtained pursuant to this section is an asset of the Plan to the extent of the amount of benefits paid by the Plan and that the Covered Person shall be a trustee over those Plan assets.

In the event a Covered Person settles, recovers, or is reimbursed by any Coverage, the Covered Person agrees to reimburse the Plan for all benefits paid or that will be paid by the Plan on behalf of the Covered Person. If the Covered Person fails to reimburse the Plan out of any judgment or settlement received, the Covered Person will be responsible for any and all expenses (fees and costs) associated with the Plan's attempt to recover such money.

If there is more than one party responsible for charges paid by the Plan, or who may be responsible for charges paid by the Plan, the Plan will not be required to select a particular party from whom reimbursement is due. Furthermore, unallocated settlement funds meant to compensate multiple injured parties of which the Covered Person is only one, 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 Covered Person agrees to assign to the Plan the right to subrogate and pursue any and all claims, causes of action or rights that may arise against any person, corporation and/or entity and to any Coverage to which the Covered Person is entitled, regardless of how classified or characterized, at the Plan's discretion.

If a Covered Person receives or becomes entitled to receive benefits, an automatic equitable lien attaches in favor of the Plan to any claim, which any Covered Person may have against any Coverage and/or party causing the Illness, Injury or disability to the extent of such conditional payment by the Plan plus reasonable costs of collection. The Covered Person is obligated to notify the Plan or its authorized representative of any settlement prior to finalization of the settlement, execution of a release, or receipt of applicable funds. The Covered Person is also obligated to hold any and all funds so received in trust on the Plan's behalf and function as a trustee as applied 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 Covered Person commence a proceeding or pursue a claim against any party or Coverage for the recovery of all damages to the full extent of the value of any such benefits or conditional payments advanced by the Plan.

If the Covered Person fails to file a claim or pursue damages against:

a) the responsible party, its insurer, or any other source on behalf of that party;

b) any first party insurance through medical payment coverage, personal injury protection, no-fault coverage, uninsured or underinsured motorist coverage;

c) any policy of insurance from any insurance company or guarantor of a third party;

d) worker's compensation or other liability insurance company; or

e) any other source, including but not limited to crime victim restitution funds, any medical, disability or other benefit payments, and school insurance coverage;

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

RIGHT OF REIMBURSEMENT

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

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.

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

These rights of subrogation and reimbursement shall apply without regard to whether any separate written acknowledgment of these rights is required by the Plan and signed by the Covered Person.

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 sickness, injury, disease or disability.

COVERED PERSON IS A TRUSTEE OVER PLAN ASSETS

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

a) 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;

b) instruct his/her attorney to ensure that the Plan and/or its authorized representative is included as a payee on all settlement drafts;

c) in circumstances where the Covered Person is not represented by an attorney, instruct the insurance company or any third party from whom the Covered Person obtains a settlement, judgment or other source of coverage to include the Plan or its authorized representative as a payee on the settlement draft; and,

d) 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 Covered Person disputes his/her obligation to the Plan under this section, the Covered Person or any of his/her 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 attorney's fees, for which he/she exercises control, in an account segregated from his/her general accounts or general assets until such time as the dispute is resolved.

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

SEPARATION OF FUNDS

Benefits paid by the Plan, funds recovered by the Covered Person, and funds held in trust over which the Plan has an equitable lien exist separately from the property and estate of the Covered Person(s), such that the death of the Covered Person, or filing of bankruptcy by the Covered Person(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 Covered Person dies as a result of his 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.

OBLIGATIONS

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

a) to cooperate with the Plan, or any representatives of the Plan, in protecting its rights, including discovery, attending depositions, and/or cooperating in trial to preserve the Plan's rights;

b) to provide the Plan with pertinent information regarding the Illness, Injury, or disability, including accident reports, settlement information and any other requested additional information;

c) to take such action and execute such documents as the Plan may require to facilitate enforcement of its subrogation and reimbursement rights, including providing to the Plan an executed reimbursement agreement;

d) to do nothing to prejudice the Plan's rights of subrogation and reimbursement;

e) to promptly reimburse the Plan when a recovery through settlement, judgment, award or other payment is received; and

f) to not settle or release, without the prior consent of the Plan, any claim to the extent that the Covered Person may have against any responsible party or Coverage.

If the Covered Person and/or his attorney fails to reimburse the Plan for all benefits paid or to be paid, as a result of said injury or condition, out of any proceeds, judgment or settlement received, the Covered Person will be responsible for any and all expenses (whether fees or costs) associated with the Plan's attempt to recover such money from the Covered Person.

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

OFFSET

Failure by the Covered Person and/or his attorney to comply with any of these requirements may, at the Plan's discretion, result in a forfeiture of payment by the Plan of medical benefits, and any funds, or payments due under this Plan on behalf of the Covered Person may be withheld until the Covered Person satisfies his obligation.

MINOR STATUS

In the event the Covered Person is a minor as that term is defined by applicable law, the minor's parents or court-appointed guardian shall cooperate in any and all actions by the Plan to seek and obtain requisite court approval to bind the minor and his 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.

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.

RIGHT TO RECEIVE AND RELEASE NECESSARY INFORMATION

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

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

RIGHTS OF RECOVERY

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

SEVERABILITY

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

SUBMISSION OF CLAIM

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

SUMMARY OF MATERIAL MODIFICATIONS

Covered Persons shall be furnished summary descriptions of material modifications in the terms of this Plan and changes in the information required to be included in the Summary Plan Description pertaining to this Plan not later than 210 days after the end of the Plan Year in which the change is adopted. However, in the case of any modification or change that is a material reduction in Covered Services or benefits provided under the Plan, Covered Persons will be furnished a summary of such modification or change not later than 60 days after the adoption of the modification or change, unless the Employer provides summaries of modifications or changes at regular intervals of not more than 90 days.

SUMMARY PLAN DESCRIPTION

The Company will issue to each Employee under the Plan, a document that shall summarize the benefits to which the person is entitled, to whom the benefits are payable, and the provisions of the Plan principally affecting the Employee. This document is intended to satisfy the requirement for both a Summary Plan Description and Plan Description

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SYSTEM FOR PROCESSING CLAIMS

Claims will be processed on the following basis: 1) first, any non-covered services or services in excess of Plan provisions will be subtracted from billed charges; 2) then, Reasonable and/or Usual

and Customary limitations will be applied (if applicable); 3) then, any reduction authorized by agreements with provider networks will be applied to charges from network providers; and 4) then, any Deductible/Co-Insurance or uncollected co-pays will be deducted from the remaining eligible amount prior to payment.

TYPE OF ADMINISTRATION

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

COORDINATION OF BENEFITS (COB)

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

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

1. If a plan does not have a provision for the coordination of benefits, its benefits are payable before this Plan.
2. If a plan covers a person other than as a Dependent, its benefits are payable before this Plan. This includes Medicare covering a person other than as a Dependent (e.g. a retired Employee) and any Medicare Supplement Plan. However, in all instances, federal regulations regarding Medicare as a secondary payer will apply.
3. If a plan covers an active Employee, its benefits are payable before this Plan. This order of determination does not supersede No. 2 above.
4. If an individual is covered as a Dependent under 2 separate plans, the benefits are payable first under the Employee's plan having the earliest birthday in a Calendar Year. However, if the Dependent is a child whose parents are separated or divorced, the "birthday rule" does not apply. The following order to determination will apply:
   If the parent with custody has not remarried:
   a) The plan of the parent with custody is primary.
   b) The plan of the parent without custody is secondary.
   If the parent with custody has remarried:
   a) The plan of the parent with custody is primary.
   b) The plan of the stepparent with custody is secondary.
   c) The plan of the parent without custody is tertiary (third).
   There may be a court decree that makes one parent financially responsible for the health care expenses incurred by the child. If a plan covers the child as a Dependent of that parent, its benefits are payable before those of a plan that covers the child as a Dependent of the parent without financial responsibility.
5. If a plan covers an individual who is also allowed to be covered by this Plan pursuant to COBRA continuation coverage, its benefits are payable before this Plan.
6. If items 1, 2, 3, 4 or 5 do not apply, the benefits of a plan that has covered the person for the longest period of time will be payable before those of the other plan.

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

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

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

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

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

COMPLIANCE REGULATIONS

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

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

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

SOURCE OF INJURY RESTRICTIONS

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

WELLNESS VS. RISK FACTORS

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

FAMILY MEDICAL LEAVE ACT (FMLA)

The following applies to companies with 50 or more employees

If the Covered Person is entitled to, and elects to take, a family or medical leave solely under the terms of the Family and Medical Leave Act of 1993 (FMLA), the Covered Person and his covered

Dependents shall continue to be covered under this Plan while the Covered Person is absent from work on an FMLA leave as if there were no interruption of active employment. Provided the applicable premium is paid, such coverage will continue until the earlier of the expiration of such leave or the date notice is given to the Company that the Covered Person does not intend to return to work at the end of the FMLA leave.

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

MILITARY LEAVES

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

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

GENETIC INFORMATION

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

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

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

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

CONTINUATION COVERAGE

WHEREAS, The Christian and Missionary Alliance (C&MA) Benefit Board has approved a plan of employee health benefits (referred to as the "Health Plan," or "Plan" in this section);

WHEREAS, the benefits under the Plan are made available to the employees of The Christian and Missionary Alliance (referred to as "Participating Employers") that have been accepted into membership in or affiliation with the C&MA;

WHEREAS, the Plan desires that coverage under the medical, dental, and vision benefits of the Plan (together referred to as the "The Health Plan") be temporarily continued for eligible employees and their dependents in the event of employment termination and certain other events;

NOW, THEREFORE, the following Continuation Coverage is hereby adopted to govern the terms of and conditions upon which the Health Plan Benefits will be continued for eligible employees and their dependents following circumstances that would normally result in termination of those Health Plan Benefits:

(1) Continuation Coverage is a continuation of Plan coverage when coverage would otherwise end because of a life event known as a qualifying event. Specific qualifying events are listed later in this section. After a qualifying event, Continuation Coverage shall be offered to the Employee and qualified Dependents participating in the Plan. Except as otherwise provided by a Participating Employer with respect to its employees or as otherwise stated in this section, qualified beneficiaries who elect Continuation Coverage must pay for that coverage.

(2) Plan benefits of an enrolled Employee that commences Short-Term Disability benefits or begins a leave of absence under the Family and Medical Leave Act, or any other leave of absence approved by the Plan, will continue on the same basis as if the Employee was actively employed (except that the individual's contribution may be on an after-tax basis). This will be applicable for the duration of the individual's Short-Term Disability absence or under an approved leave of absence not to exceed 90 days. If an Employee does not return to active employment following a period of Short-Term Disability or expiration of an approved leave of absence, the individual's employment will be considered as terminated for purposes of this Continuation Coverage (whether or not commencing Long-Term Disability benefits), and remaining eligible months of continuation coverage under this Plan will be available as applicable for coverage in effect immediately prior to employment termination.

(3) The Spouse of an Employee will become a qualified beneficiary if the Spouse loses any Plan coverage due to the qualifying event of the Employee's death.

(4) If an Employee has been on this Plan for any length of time, C&MA will offer a minimum of one month Continuation Coverage (even if the Employee was on the Plan less than one month).

C&MA will offer one month of Continuation Coverage for every month the Employee was on the plan as an active employee, up to a maximum of 12 months Continuation Coverage if they have been on the Plan as an active Employee for 12 months or more.

When Continuation Coverage Is Available. Continuation Coverage for the Plan will be offered to qualified beneficiaries only after the Plan Administrator (or its designee) has been notified according to Plan procedures that a qualifying event has occurred. When the qualifying event is the end of employment, the Participating Employer must provide written notice within 30 days of the qualifying event.

If an Employee age 65 or over:

- loses eligibility for the C&MA Plan, either through termination or reduction in hours, continuation of coverage will be offered to any Dependents who are under age 65; or

- leaves the C&MA Plan while still eligible (i.e., drops the plan due to Medicare eligibility), continuation coverage will be offered to any dependent who is under 65.

How Continuation Coverage Is Provided. Except as provided in the "Election Period" discussion, below, once the Plan Administrator receives notice that a qualifying event has occurred, Continuation Coverage will be offered to Employee and qualified Dependents.

Continuation Coverage is a temporary continuation of coverage. Continuation Coverage lasts for up to a maximum of 12 months. In the case of death of a Spouse, Continuation Coverage lasts for up to a maximum of 18 months. The maximum period will not be extended if one or more additional qualifying events described above subsequently occurs during the Continuation Coverage period.

Election Period. Once the Plan Administrator (or its designee) is notified of a qualifying event, the Plan's Continuation Coverage Administrator will notify the employee of the right to elect Continued Coverage and provide an election form to complete and return. The Employee will

have election rights, and elections must be submitted in writing within 30 days of the later of:

(1) The date coverage terminates because of the qualifying event, or

(2) The date the notification and election form is mailed to the qualified.

Election forms that are mailed must be postmarked within the 30-day election period, and submissions of election forms by facsimile or email must bear a transmittal date within the 30-day election period.

Type of Coverage. Continuation Coverage can only be elected for Plan benefits in which the qualified beneficiary is enrolled at the time of the qualifying event. At annual enrollment, the qualifying beneficiary already on Continuation Coverage may elect to change or add any Plan coverage options with the types of coverage in which they are then enrolled (for example, qualifying beneficiaries under one medical option may elect a different medical option. If the Plan benefits change for active Employees, such changes shall apply to anyone with Continuation Coverage, unless otherwise determined by the Plan Administrator.

Cost of Coverage and Payment. Continuation Coverage is subject to payment by the qualified beneficiaries in the amount determined by the Plan Administrator and set forth in the election notice. Generally, the payment amounts required for each Plan benefit will be a function of the contributions charged with respect to active Employees in similar circumstances. The contributions are charged on an after-tax basis and will be increased by an additional monthly fee for purposes of covering administrative costs.

Continuation Coverage shall be paid for in monthly installments. The first payment will be retroactive to the date of the loss of coverage due to the qualifying event and will be due no later than 30 days after the later of:

(1) The date coverage terminates because of the qualifying event, or

(2) The date the notification and election form is mailed to the qualified beneficiary.

Payments are collected electronically within the first three business days of the month for that month of coverage. Coverage is effective once the initial payment is received. Once payment is received, the participant may re-file claims that may have been denied between the initial benefits termination and the election and payment for Continued Coverage.

After the initial payment, participants on Continued Coverage for more than one month are required to make monthly payments thereafter which are due within the first three business days of the calendar month for which the coverage is to be effective, with a 30-day grace period, or at such other times as the Plan Administrator shall require by advance written notice. If the cost or benefits change in the future for active Employees, the changes will also affect those on Continued Coverage except as the Plan Administrator may otherwise determine.

Termination of Continue Coverage. Continuation Coverage automatically ends when the first of the following occurs:

(1) The applicable coverage period of 12 months ends; or 18 months in the case of death of a Spouse, ends;

(2) The end of the month prior to the Employee's 65th birthday;

(3) The participant voluntarily elects to end coverage;

(4) The participant fails to make the required contribution on time;

(5) All or a portion of the Plan benefits are terminated with respect to all or any category of participants that includes those on Continuation Coverage (in which event, notice of termination will be provided at least 60 days in advance of the effective date); or

(6) The participant becomes eligible under another group health plan (as an employee or otherwise) after the election of Continuation Coverage.

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

ISSUED PURSUANT TO

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

1. Disclosure of Summary Health Information to the Plan Sponsor

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

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

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

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

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

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

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

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

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

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

g. Make available the information required to provide an accounting of disclosures

in accordance with Section 164.528 of the Privacy Standards (45 CFR 164.528);

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

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

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

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

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

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

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

3. Disclosure of Certain Enrollment Information to the Plan Sponsor

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

4. Other Disclosures and Uses of PHI

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

NOTICE OF PRIVACY PRACTICES

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

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

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

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

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

THE PLAN'S RESPONSIBILITIES

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

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

Genetic information shall be treated as health information pursuant to the Health Insurance Portability and Accountability Act. The use or disclosure by the Plan of protected health information that is genetic information about an individual for underwriting purposes under the

Plan shall not be a permitted use or disclosure.

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

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

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

PERMISSIBLE USES AND DISCLOSURES OF PHI

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

TREATMENT, PAYMENT AND HEALTH CARE OPERATIONS

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

TREATMENT

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

PAYMENT

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

HEALTH CARE OPERATIONS

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

POTENTIAL IMPACT OF STATE LAW

The HIPAA Privacy Regulations generally do not "preempt" (or take precedence over) state privacy or other applicable laws that provide individuals greater privacy protections. As a result, to the extent state law applies, the privacy laws of a particular state, or other federal laws, rather than the HIPAA Privacy Regulations, might impose a privacy standard under which the Plan will be required to operate. For example, where such laws have been enacted, the Plan will follow more stringent state privacy laws that relate to uses and disclosures of PHI concerning HIV or AIDS, mental health, substance abuse/chemical dependency, genetic testing, reproductive rights, etc.

OTHER PERMISSIBLE USES AND DISCLOSURES OF PHI

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

REQUIRED BY LAW

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

PUBLIC HEALTH ACTIVITIES

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

HEALTH OVERSIGHT ACTIVITIES

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

government benefit programs; (3) other government regulatory programs and (4) compliance with civil rights laws.

ABUSE OR NEGLECT

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

LEGAL PROCEEDINGS

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

LAW ENFORCEMENT

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

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

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

RESEARCH

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

TO PREVENT A SERIOUS THREAT TO HEALTH OR SAFETY

Consistent with applicable federal and state laws, the Plan may disclose PHI if there is

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

MILITARY ACTIVITY AND NATIONAL SECURITY, PROTECTIVE SERVICES

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

INMATES

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

WORKERS' COMPENSATION

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

EMERGENCY SITUATIONS

The Plan may disclose PHI of a Covered Person in an emergency situation, or if the Covered Person is incapacitated or not present, to a family member, close personal friend, authorized disaster relief agency, or any other person previously identified by the Covered Person. The Plan will use professional judgment and experience to determine if the disclosure is in the best interests of the Covered Person. If the disclosure is in the best interest of the Covered Person, the Plan will disclose only the PHI that is directly relevant to the person's involvement in the care of the Covered Person.

FUNDRAISING ACTIVITIES

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

GROUP HEALTH PLAN DISCLOSURES

The Plan may disclose the PHI of a Covered Person to a sponsor of the group health plan

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

UNDERWRITING PURPOSES

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

OTHERS INVOLVED IN YOUR HEALTH CARE

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

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

REQUIRED DISCLOSURES OF PHI

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

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

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

DISCLOSURES TO COVERED PERSONS

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

The Plan will disclose a Covered Person's PHI to an individual who has been designated by that Covered Person as his personal representative and who has qualified for such

designation in accordance with relevant state law. However, before the Plan will disclose PHI to such a person, the Covered Person must submit a written notice of his designation, along with the documentation that supports his qualification (such as a power of attorney).

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

BUSINESS ASSOCIATES

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

OTHER COVERED ENTITIES

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

PLAN SPONSOR

The Plan may disclose PHI to the Plan Sponsor of the group health plan for purposes of plan administration or pursuant to an authorization request signed by the Covered Person. Also, the Plan may use or disclose "summary health information" to the Plan Sponsor for obtaining premium bids or modifying, amending or terminating the group health plan. Summary health information summarizes the claims history, claims expenses

or types of claims experienced by individuals for whom a Plan Sponsor has provided health benefits under a group health plan and from which identifying information has been deleted in accordance with the HIPAA Privacy Rule.

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

SALE OF PHI

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

MARKETING

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

PSYCHOTHERAPY NOTES

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

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

A COVERED PERSON'S RIGHTS

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

RIGHT TO REQUEST A RESTRICTION

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

A Covered Person may request a restriction by contacting the person(s) or office identified under Plan Contact Information in the Key Information section at the beginning of this

document. It is important that the Covered Person directs his request for restriction to this individual or office so that the Plan can begin to process Your request. Requests sent to individuals or offices other than the one indicated might delay processing the request.

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

RIGHT TO REQUEST CONFIDENTIAL COMMUNICATIONS

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

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

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

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

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

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

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

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

RIGHT TO INSPECT AND COPY

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

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

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

RIGHT TO AMEND

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

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

RIGHT OF AN ACCOUNTING

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

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

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

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

RIGHT TO A COPY OF THIS NOTICE

The Covered Person has the right to request a copy of this Notice at any time by contacting the person(s) or office identified under Plan Contact Information in the Key Information

section at the beginning of this document. If You receive this Notice on the Plan's website or by electronic mail, You also are entitled to request a paper copy of this Notice.

COMPLAINTS

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

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

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

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

1. DEFINITIONS

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

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

2. PLAN SPONSOR OBLIGATIONS

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

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

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

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

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

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

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

e. Plan Sponsor shall make its internal practices, books, and records relating to its compliance with the Security Standards to the Secretary of the U.S. Department of Health and Human Services ("HHS"), or any other officer or employee of HHS to

whom the authority involved has been delegated, for purposes of determining compliance by the Plan with the Security Standards.