Plan Document
Self-Funded Group Health Plan #286460-0
Plan Sponsor: GREENVILLE MEATS INC
824 WHITE HORSE RD
GREENVILLE SC 29605
864-277-5570
Plan Effective Date: 01/01/2022

PLAN DOCUMENT

FOR THE

GREENVILLE MEATS INC
EMPLOYEE GROUP HEALTH PLAN ("PLAN")

PLAN DOCUMENT INDEX

PLAN SPONSOR, PLAN EFFECTIVE DATE & PLAN YEAR

Plan Sponsor: GREENVILLE MEATS INC ("Sponsoring Employer")
Plan Effective Date: 01/01/2022 ("Effective Date")
Initial Plan Year: 01/01/2022 - 12/31/2022
Subsequent Plan Years: Commence Each Subsequent: January 01

GROUP HEALTH PLAN ESTABLISHED

Sponsoring Employer hereby establishes the Plan, effective as of the Effective Date stated hereinabove, for the participation and exclusive benefit of its eligible employees ("Employees") and their eligible dependents ("Dependents"). The purpose of the Plan is to provide for the payment or reimbursement of all or a portion of eligible medical expenses. The benefits described herein are available to an Employee or Dependent only if that person is covered under the Plan and all required contributions for such coverage have been received by the Plan. The terms of the Plan are intended to be legally enforceable.

The Plan is a group health plan providing medical expense benefits and is subject to the provisions of the Employee Retirement Income Security Act of 1974 ("ERISA"). This document constitutes the written Plan Document as required under ERISA. This Plan Document supersedes and replaces any and all other plan documents (or amendments) that may have been distributed by the Plan or the Sponsoring Employer. Subject to applicable law, this Plan Document may be amended, changed, canceled, discontinued or terminated by Sponsoring Employer without the consent of any covered Employee or Dependent. None of the terms of the Plan may be modified, nor any forfeiture under it waived, except by an agreement in writing signed by the Sponsoring Employer. The Sponsoring Employer's authority for this purpose cannot be delegated.

Sponsoring Employer is the Plan Sponsor, Plan Administrator, Plan Fiduciary and Plan Trustee for purposes of ERISA. This is a self-insured group health plan, funded by Plan Sponsor contributions (from the Sponsoring Employer's general assets) and Employee contributions (deducted pre-tax from wages). Benefits under the Plan are not insured.

This Plan Document may be examined at the office of the Sponsoring Employer (in its capacity as the Plan Administrator) within 30 days of submitting a written request.

PLAN TERMS & BENEFITS

As the Plan Administrator, Sponsoring Employer has full and final discretionary authority to adopt, interpret and determine the terms and benefits of the Plan. Sponsoring Employer hereby adopts the Summary Plan Description attached hereto as Exhibit A ("Plan SPD") as the terms and benefits of the Plan and incorporates the Plan SPD by reference.

The Plan SPD supersedes and replaces any and all other Summary Plan Descriptions (or amendments) that may have been distributed by the Plan or the Sponsoring Employer. Because the Plan SPD is incorporated into the Plan Document, the Plan SPD may also be amended, changed, canceled, discontinued or terminated by Sponsoring Employer at any time without the consent of any covered Employee or Dependent (subject to applicable law). None of the terms of the Plan SPD may be modified, nor any forfeiture under it waived, except by an agreement in writing signed by the Sponsoring Employer. The Sponsoring Employer's authority for this purpose cannot be delegated.

ADMINISTRATIVE SERVICES DELEGATED

The Sponsoring Employer hereby delegates certain non-fiduciary, ministerial administrative acts, duties and responsibilities of the Plan (Delegated Services) to Allied National, LLC., a licensed third-party administrator (Allied National):

Allied National, LLC

P.O. Box 29187 (enrollment)
P.O. Box 29186 (claims)
Shawnee Mission, KS 66201
(800) 825-7531 or (913) 945-4100
www.alliednational.com

However, the Sponsoring Employer remains the Plan Sponsor, Plan Fiduciary, Plan Administrator and Plan Trustee and is responsible for all coverage determinations and benefit payments. Allied National does not insure the Plan and is not responsible for funding benefit payments.

The Sponsoring Employer, in its capacity as the Plan Administrator, also retains full discretionary authority to interpret and apply all Plan provisions, including, but not limited to, all issues concerning eligibility and determination of benefits in the Plan SPD. Final authority to construe and apply Plan provisions rests exclusively with the Sponsoring Employer. Decisions of the Sponsoring Employer, made in good faith, are final and binding.

CONTRIBUTIONS

1. A covered Employee must pay required contributions for coverage under the Plan as they become due. Failure of a covered Employee to pay any required contribution on time will result in the termination of coverage.
2. The Plan reserves the right to change the contribution rates by giving written notice to covered Employees at least sixty (60) days in advance of the change.
3. If any change or clerical error affects contributions, an equitable adjustment in contributions shall be made on the first of the month next following the date of the change or the discovery of the error. Any contribution adjustment shall be limited to the twelve (12) months immediately preceding the date of determination that the adjustment in contribution should be made.
4. Contributions are payable in advance to the Sponsoring Employer.
5. Sponsoring Employer and Employee contribution amounts are determined by referring to the attached Summary of Contribution sheet.
6. All Plan contributions, whether contributed by the Sponsoring Employer or Employees, shall continue to be applied for the exclusive purposes of providing benefits to Plan participants or defraying Plan expenses, until all such contributions are exhausted.

TERMINATION

TERMINATION OF COVERAGE - EMPLOYEE

The Coverage of an Employee and his Dependents shall automatically terminate on the earliest of the following dates:

1. The date the Plan terminates;
2. The date any Section or Part of the Plan terminates, as respects coverage under that Section or Part;
3. The date the Plan is amended to terminate the eligibility of any class of Employee of which the Employee is a member;
4. The end of the last period for which the last required contribution is paid by the Employee for his coverage;
5. The date the Employee enters the armed forces of any country, state or international organization, other than for reserve duty of 30 days or less;
6. The first of the month that coincides with or next follows the date on which the Employee is no longer eligible;
7. The date the Employee's coverage is terminated because of:
   a. failure to provide any signed release, consent, assignment or other documents requested by the Plan;
   b. failure to fully cooperate with the Plan in the administration of the Plan;
   c. material misrepresentation or fraud on any enrollment form, or in requesting the receipt of benefits under the Plan; or
   d. misuse by the Employee of his identification card;
8. The first of the month that coincides with or next follows the date the Employee's employment is terminated. Termination of employment occurs on the date the Employee is no longer Actively at Work as a member of any class of Employee eligible for coverage under the Plan. Provided, however, that:
   a. coverage may be continued during any period when the Employee is absent from Active Work due to a disability because of Sickness or Bodily Injury which prevents him from performing the duties of his occupation, or during an approved leave of absence or temporary layoff, but not to exceed a period of three (3) months. Successive periods of disability which are separated by less than one month of Active Work are considered a single period of disability for establishing the maximum continuation of coverage period;

b. upon termination of employment, payment by the Sponsoring Employer in lieu of vacation or other severance compensation shall not extend the term of employment;

9. The first of the month that coincides with or next follows the date on which a former Employee's coverage terminates under any continuation law applicable to the Group Health Plan that this Plan replaces; or
10. The date the Employee has received benefits under the Plan up to the Lifetime Maximum Aggregate Benefit.

TERMINATION OF COVERAGE - DEPENDENT

A Dependent's Coverage also terminates on the earliest of the following dates:

1. The date the Plan is amended to terminate the eligibility of any class of Employee eligible for Dependent Coverage of which the Employee is a member;
2. The first of the month that coincides with or next follows the date on which the Employee's Coverage under the Plan terminates;
3. The end of the last period for which the last required contribution is paid by the Employee for the Dependent's Coverage;
4. The first of the month that coincides with or next follows the date on which the Employee ceases to be eligible for Dependent Coverage under the Plan;
5. The date the Plan specifies that the Dependent Coverage of an Employee is terminated because of:
   a. failure to provide any signed release, consent, assignment or other documents requested by the Plan;
   b. failure to fully cooperate with the Plan in the administration of the Plan;
   c. material misrepresentation or fraud on any enrollment form, or in requesting the receipt of benefits under the Plan; or
   d. misuse by the Employee, or his Dependents, of the Employee's identification card;
6. The date the Dependent enters the armed forces of any country, state or international organization, other than for reserve duty of thirty (30) days or less;
7. With respect to an Employee's covered Spouse, the first of the month that coincides with or next follows the date on which the Employee is legally separated or divorced from his Spouse, or the date on which the Employee's Marriage, Same Sex Marriage, Domestic Partnership or Civil Union with his Dependent Spouse is legally annulled or otherwise dissolved;
8. The first of the month that coincides with or next follows the date on which an eligible Dependent Child no longer qualifies as a "Dependent", except that, if, upon attaining any limiting age, a Dependent Child because of Mental or Physical Incapacity, as defined below, is incapable of earning his own living and is chiefly dependent upon the Employee for support and maintenance, coverage for that Dependent Child may be continued if the required contribution is paid by the Employee during the time of incapacity, provided that:
   a. proof, in writing, of the incapacity is given to the Plan within thirty-one (31) days after the date on which the Dependent Child reaches the limiting age;
   b. the Plan will have the right any time during the continuation of coverage under this provision to require proof of the incapacity and to have the Dependent Child examined by Doctors designated by the Plan at any time during the first two (2) years of the continuation but not more often than once each year thereafter; and
   c. this continuation will terminate with the occurrence of any event described in paragraphs 1 through 6 above, and paragraph 9 below.

   Mental or Physical Incapacity means a mental or physical impairment that results in anatomical, physiological or psychological abnormalities as demonstrated by medically acceptable clinical or laboratory diagnostic techniques and which are expected to last for a continuous period of time not less than twelve (12) months; or
9. The date the Dependent has received benefits under the Plan up to the Lifetime Maximum Aggregate Benefit.

TERMINATION OF PLAN

The Plan terminates, in whole or part, on the earliest of the following dates, subject to the terms of the Plan and compliance with applicable law:

1. The date the Sponsoring Employer terminates, suspends or withdraws the Plan, or amends or modifies the Plan with respect to a particular benefit or employee class. The Sponsoring Employer reserves the right at any time to terminate the Plan, subject to due written notice as may be required under applicable law;
2. Three (3) months following the date the following Plan participation levels are no longer maintained, if those participation levels are not reestablished within that three (3) month period:
   a. Participation by a minimum of two (2) eligible Employees; and
   b. Participation by a minimum of 75% of the total number of eligible Employees.
3. If the Plan has contracted with a PPO network, the date that PPO network, or any replacement PPO network, is no longer accessible by covered Employees.

GENERAL PROVISIONS

PLAN IS NOT A CONTRACT
This Plan Document does not give any Employee the right to continued employment with the Sponsoring Employer and does not interfere with the right of the Sponsoring Employer to discharge or otherwise terminate the employment of any Employee. The coverage of an Employee under the Plan (including Dependent coverage, if any) may be rescinded by the Plan for fraud or misrepresentation of material fact by the Employee in his enrollment form or in a claim for benefits.

CONFORMITY WITH LAW
If any provision of the Plan is contrary to any law to which it is subject, that provision is hereby amended to conform thereto.

LEGAL PROCEEDINGS
No action at law or in equity may be brought to recover under the Plan prior to exhaustion of the administrative process described in this Plan Document (including the exhaustion of all appeals) (refer to Claim Processing and Appeal Rights), nor shall any such action be brought at all unless filed within three (3) years of the expiration of the time within which proof of loss is required by the Plan.

EFFECTIVE DATES
No coverage under the Plan shall become effective until notice in writing is given to an Employee by the Plan. Issuance of the attached Plan SPD will be deemed proper notification, provided, however, no form of coverage under the Plan shall be effective unless all contributions are paid as required under the terms of the Plan.

GOVERNING LAW
It is the intention of the Sponsoring Employer to hereby establish a program of benefits constituting an "Employee Welfare Benefit Plan", otherwise called a "Group Health Plan. The Plan is therefore governed by and subject to ERISA, as amended, and all other federal laws regulating Group Health Plans.

NO WAIVER OF RIGHTS
If the Sponsoring Employer, at its discretion, chooses not to enforce a term or condition of the Plan, such a decision does not waive any rights under the Plan to enforce such term or condition in the future.

STATEMENT OF ERISA RIGHTS

As a participant in this self-funded group health Plan, you are entitled to certain rights and protections under the Employee Retirement Income Security Act of 1974 (ERISA). ERISA provides that all Plan participants shall be entitled to:

Receive Information About Your Plan and Benefits
Examine, without charge, at the Plan Administrator's office all documents governing the Plan, including a copy of the latest annual report (Form 5500 Series) filed by the Plan with the U.S. Department of Labor and available at the Public Disclosure Room of the Pension and Welfare Benefit Administration.

Obtain, upon written request to the Plan Administrator, copies of documents governing the operation of the Plan, including copies of the latest annual report (Form 5500 Series). The Plan Administrator may make a reasonable charge for the copies.

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

Continue Group Health Plan Coverage
Continue health care coverage for yourself or your Dependents if there is a loss of coverage under the Plan as a result of a qualifying event. You or your Dependents may have to pay for such coverage. Review this Plan SPD for the rules governing your COBRA continuation coverage rights.

A reduction or elimination of exclusionary periods of coverage for preexisting conditions under the Plan, if you have Creditable Coverage from another plan. You should be provided a certificate of Creditable Coverage, free of charge, from your group health plan or health insurance issuer when you lose coverage under the plan, when you become entitled to elect COBRA continuation coverage, when your COBRA continuation coverage ceases, if you request it before losing coverage, or if you request it up to 24 months after losing coverage. Without evidence of Creditable Coverage, you may be subject to a preexisting condition exclusion for 12 months (18 months for late enrollees) after your enrollment date in your coverage.

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

Enforce Your Rights
If your claim for a welfare benefit is denied or ignored, in whole or in part, you have a right to know why this was done, to obtain copies of documents relating to the decision without charge, and to appeal any denial, all within certain time schedules.

Under ERISA, there are steps you can take to enforce the above rights. For instance, if you request a copy of Plan documents or the latest annual report from the Plan and do not receive them within 30 days, you may file suit in a Federal court. In such a case, the court may require the Plan Administrator to provide the materials and pay you up to $110 a day until you receive the materials, unless the materials were not sent because of reasons beyond the control of the administrator. If you have a claim for benefits which is denied or ignored, in whole or in part, you may file suit in a state or Federal court. In addition, if you disagree with the Plan's decision or lack thereof concerning the qualified status of a domestic relations order or a medical child support order, you may file suit in Federal court. If it should happen that Plan fiduciaries misuse the Plan's money, or if you are discriminated against for asserting your rights, you may seek assistance from the U.S. Department of Labor, or you may file suit in a Federal court. The court will decide who should pay court costs and legal fees. If you are successful, the court may order the person you have sued to pay these costs and fees. If you lose, the court may order you to pay these costs and fees, for example, if it finds your claim is frivolous.

Assistance with Your Questions
If you have any questions about your Plan, you should contact the Plan Administrator. If you have any questions about this statement or about your rights under ERISA, or if you need assistance in obtaining documents from the Plan Administrator, you should contact the nearest office of the Employee Benefits Security Administration, U.S. Department of Labor, listed in your telephone directory or the Division of Technical Assistance and Inquiries, Employee Benefits Security Administration, U.S. Department of Labor, 200 Constitution Avenue N.W., Washington, D.C. 20210. You may also obtain certain publications about your rights and responsibilities under ERISA by calling the publications hotline of the Employee Benefits Security Administration.

CLAIM PROCESSING PROCEDURES AND APPEAL RIGHTS

Your self-funded Group Health Plan (Plan) coverage is provided through an employee welfare benefit plan established by your employer. As a Plan participant, you (and your covered dependant(s)) have certain claim processing and appeal rights under the Employee Retirement Income Security Act of 1974 (as amended) (ERISA).

1. INTRODUCTION

Introduction: Under ERISA and applicable U.S. Department of Labor (DOL) regulations, claimants are entitled to full and fair review of any claims made under the Plan. The procedures described below are intended to comply with ERISA and these DOL regulations by providing reasonable procedures governing the filing of benefit claims, the issuing of benefit decisions and the reasonable notification of the right to appeal adverse benefit determinations.

Purpose: These procedures are furnished as a separate document that accompanies the Plan SPD. These procedures comply with ERISA and the DOL regulations. Consult the SPD for details regarding the benefits provided under the Plan.

2. DEFINITIONS

Plan: The Plan is the Employee Welfare Benefit Plan established by your employer.
Claim: A claim is any request for a Plan benefit or benefits made in accordance with these procedures. A communication regarding benefits that is not made in accordance with these procedures will not be treated as a claim under these procedures.
Claimant: You become a claimant when you make a request for a Plan benefit or benefits in accordance with these procedures.
Incorrectly-Filed Claim: Any request for benefits that is not made in accordance with these procedures is called an incorrectly-filed claim.
Authorized Representative: An Authorized Representative may act on behalf of a claimant with respect to a benefit claim or appeal under these procedures. However, no person (including a treating health care professional) will be recognized until the Plan receives written authorization signed by the claimant. Once an authorized representative is appointed, the Plan shall direct all information, notification, etc. regarding the claim to the authorized representative. The claimant shall be copied on all notifications regarding determinations, unless the claimant provides specific written direction otherwise. *Any reference in these procedures to claimant is intended to include the authorized representative of such claimant appointed in compliance with the above procedures.*
Plan Sponsor/Plan Administrator/Plan Fiduciary/Plan Trustee: Your employer is the Plan Sponsor, Plan Administrator, Plan Fiduciary and Plan Trustee for the Plan. The Plan is self-insured by your employer and benefits are funded by employer and employee contributions. The Plan is not insured by an insurance company and your employer is solely responsible for all benefit payments. Your employer, in its capacity as the Plan Administrator and in light of the purposes for which the Plan was established and is maintained, shall consider and render, in its sole discretion, appropriate eligibility, coverage and benefit determinations. In particular, the Plan Administrator shall have full and sole discretionary authority to interpret all Plan documents and to make all interpretive and factual determinations as to whether any individual is entitled to receive any benefits under the terms of the Plan. Your employer is also responsible for making claim and appeal determinations.
Designated Administrator: Your employer has, by agreement, delegated certain non-fiduciary, ministerial administrative acts, duties and responsibilities of the Plan to Allied National, LLC., a licensed third-party administrator (Allied National). As the designated

administrator, Allied National is authorized to process enrollments, bill and collect contributions, process claims payments, and perform other services, according to the terms of the agreement.

3. HOW TO FILE A CLAIM FOR BENEFITS

General Filing Rules: A claim for benefits is made when a claimant (or authorized representative) submits written Notice and Proof of Loss as required in the Plan SPD to:

Allied National, LLC, Attn: Claims Department, PO Box 29186, Shawnee Mission, KS 66201

A claim will be treated as received by the Plan (a) on the date it is hand delivered to the above address; or (b) on the date that it is deposited in the U.S. Mail for first-class delivery in a properly-stamped envelope containing the above name and address. The postmark on any such envelope will be proof of date of mailing.

Notice and Proof of Loss of a claim shall be filed within 90 calendar days following receipt of medical service, treatment or product to which the claim relates unless (a) it was not reasonably possible to file the claim within such time; and (b) the claim is filed as soon as possible and in no event (except in the case of legal incapacity of the claimant) later than fifteen (15) months after the date of receipt of medical service, treatment or product to which the claim relates.

How Incorrectly-Filed Claims Are Treated: These procedures do not apply to any request for benefits that is not made in accordance with these procedures.

4. DETERMINING BENEFITS

Timeframe: The Plan shall determine benefits for a claim, or request any additional information needed to process an incomplete claim, within a reasonable time, but no later than 30 calendar days after receipt of the claim. The Plan issues only retrospective (post-service) claim determinations.

When Extensions of Time Are Permitted: Nothing prevents the claimant from voluntarily agreeing to extend the above timeframe.

Incomplete Claims: If any information needed to process a claim is missing, the claim shall be treated as an incomplete claim.

How Incomplete Claims Are Treated: If a claim is incomplete, the Plan may deny the claim or request the missing information within the 30-calendar day timeframe described above. If the Plan requests the missing information, it shall do so in writing and include a description of the missing information. The missing information must be provided within 45 calendar days. If the missing information is provided, the Plan shall determine benefits within 15 calendar days of receipt. If the missing information is not provided within the 45 calendar days, benefits may be denied or the claim may be inactivated.

5. NOTIFICATION OF ADVERSE DETERMINATION BY PLAN

Written Notification: Written notification of an adverse determination by the Plan shall be provided to the claimant.

Content of Notification of Adverse Benefit Decision: Written notification provided to the claimant of the Plan's adverse determination on a claim shall include the following, in a manner calculated to be understood by the claimant:

- a statement of the specific reason(s) for the determination;
- reference(s) to the specific Plan provision(s) on which the determination is based;
- a description of any additional material or information necessary to complete the required proof of loss and why such information is necessary;
- a description of the Plan procedures and time limits for appeal of the determination, and the right to obtain information about those procedures and the right to sue in federal court;
- a statement disclosing any internal rule, guidelines, protocol or similar criterion relied on in making the determination; and
- if the determination involves scientific or clinical judgment, disclose an explanation and discussion of the scientific or clinical judgment applying the terms of the Plan to the claimant's medical circumstances.

Definition of Adverse: A determination on a claim is "adverse" if it is a denial, reduction or termination of, or a failure to provide or make payment (in whole or in part) for a benefit, including any such denial, reduction, termination or failure to provide or make payment that is based on a determination of a participant's or beneficiary's eligibility to participate in a plan.

6. YOUR RIGHT TO APPEAL

Your Right to Appeal: A claimant has a right to appeal an adverse determination and to receive a full and fair review under these procedures.

7. HOW TO APPEAL AN ADVERSE BENEFIT DETERMINATION

Claim Inquiries: Please contact Allied National's Customer Service department at **1-800-825-7531** with any questions about the processing of your claim, including coverage and benefit determinations and Claim Reviews.

Internal Claim Review: If you disagree with a coverage or benefit determination, you have the **RIGHT TO APPEAL** that determination by requesting an Internal Claim Review within **180 CALENDAR DAYS** from the date you received the coverage or benefit determination. Only one (1) Internal Claim Review is required per claim. An Internal Claim Review determination acts as a Final Internal Adverse Benefit Determination.

Internal Claim Review Instructions and Procedures:

1. To request an Internal Claim Review, please
   a. State your request for an Internal Claim Review in writing, include your full name, date of birth and certificate number, identify the claim in question, and explain why you disagree with the determination. You may also submit any additional written comments, documents, records or other information relating to the claim.
   b. Sign and date your written request and attach all supporting documentation.
   c. Mail the written request and attachments to the following address, **within the 180-day deadline stated above**:

Allied National, LLC, Attn: Internal Claim Reviews, PO Box 29186, Shawnee Mission, KS 66201

2. Upon request and at no charge, you may have reasonable access (including copies) to the claim file, including all documents, records and information submitted to our office that relate to your claim.
3. The Internal Claim Review will take into account all written comments, documents, records and other information submitted to our office that relate to your claim, including comments, documents, records or other information not previously considered or submitted at the time the claim was processed.
4. Copies of any clinical rationale or review criteria and any new or additional evidence which the Internal Claim Review considers, relies upon or generates will be included with our written determination, free of charge.
5. The Internal Claim Review will be a "fresh" look at your claim, ignoring the appealed determination. It will be conducted by a person not involved in the appealed determination, not currently supervised by someone involved in that determination, and whose terms of employment are not based on the likelihood of upholding that determination.
6. If the appealed determination is based on a medical judgment (in whole or in part), the Internal Claim Review will include consultation with a health care professional, trained and experienced in the medical field relevant to the determination, not involved in the appealed determination, not currently supervised by someone involved in that determination and whose terms of employment are not based on the likelihood of upholding that determination.
7. You, your doctor or your authorized representative may request an Internal Claim Review and you may be represented by a relative, friend, lawyer or other authorized representative.
8. You may present evidence and testimony by submitting written comments, documents, records or other information relating to the claim. Hearings, panel reviews or other formal in-person proceedings are not conducted.
9. Within 5 business days of receiving your written request, our office will mail a written acknowledgement to you.
10. Within 30 calendar days of receiving your written request, our office will mail a written determination to you.

Optional Second Internal Review: If you disagree with the Internal Claim Review, you may go directly to External Review (if available, see below) or request an optional Second Internal Review. A written request for a Second Internal Review must be submitted to our office within 180 CALENDAR DAYS [six (6) months] from the date you received the determination for the initial Internal Claim Review. Please refer to the Internal Claim Review Instructions and Procedures stated above for completing and submitting a written request for a Second Internal Review. Only one (1) Second Internal Review is available per claim. A Second Internal Review is completely voluntary and not required to exhaust your rights of appeal under your health plan coverage.

External Review: You may have a right to External Review of your claim if:

1. You disagree with the Internal Claim Review (or the optional Second Internal Review, if one was requested); and
2. Your claim is eligible for Independent or External Review by an Independent Review Organization (IRO) under applicable federal or state law (including, but not limited to, medical judgment determinations such as medical necessity, appropriateness, health care setting, level of care or effectiveness).

Please refer to the External Review Instructions below for submitting a written request. Only one (1) External Review is available per claim. External Review is provided at no charge to you (some states may charge a small processing fee) and acts as a Final External Review Decision.

External Review Instructions: If External Review is available for your claim, an application packet will be enclosed with the determination for the Internal Claim Review. To request External Review, please follow the instructions contained in the packet and mail the application within 120 CALENDAR DAYS [four (4) months] from the date you received the determination for the Internal Claim Review (or the Second Internal Review, if one was requested).

State Assistance: You also have the right to request assistance from, or to file a complaint with, the Department of Insurance (DOI) or Consumer Services Division (CSD) for your state of residence (or employment), at any time. Please note the following contact information:

CA: CSD, 980 9th St., S. 500, Sacramento, CA 95814, http://www.healthhelp.ca.gov, 888-466-2219, helpline@dmhc.ca.gov
CO: DOI, 1560 Broadway, S. 850, Denver, CO 80202, http://www.dora.state.co.us/insurance, 800-930-3745
GA: CSD, 2 MLK, Jr. Dr., W. Tr., S. 716, Atlanta, GA 30334, http://www.oci.ga.gov/consumerservice/home.aspx, 800-656-2298
IL: CSD, 320 W. Washington St., 4th Fl., Springfield, IL 62727, http://www.insurance.illinois.gov, 877-527-9431
IN: DOI, 311 W. Washington St., S. 300, Indianapolis, IN 46204-2787, http://www.in.gov/idoi, 800-622-4461
IA: CSD, 330 Maple St., Des Moines, IA 50319, http://www.insuranceca.iowa.gov, 877-955-1212
KS: CSD, 420 SW 9th St., Topeka, KS 66612, http://www.ksinsurance.org, 800-432-2484, CAP@ksinsurance.org
MO: CSD, 301 W. High St., Rm. 830, Jefferson City, MO 65101, www.insurance.mo.gov, 800-726-7390
NE: DOI, 941 O St., S. 400, Lincoln, NE 68508-3639, http://www.doi.ne.gov/, 877-564-7323
NV: CSD, 555 E. Washington Ave., S. 4800, Las Vegas, NV 89101, http://www.govcha.state.nv.us, 888-333-1597
OH: DOI, 50 W. Town St., 3rd Fl., S. 300, Columbus, OH 43215, http://www.ohioinsurance.gov/, 800-686-1526

OK: CSD, 3625 NW 56th St, S 100, OK City, OK 73112, http://oid.ok.gov/, 800-522-0071
PA: CSD, 1326 Strawberry Square, Harrisburg, PA 17111, www.insurance.pa.gov, 877-881-6388
TN: CSD, 500 James Robertson Pkwy, DC Tr, 4th Fl, Nashville, TN 37243, www.tn.gov/commerce/insurance, 800-342-4029
TX: CSD, MC 111-1A, 333 Guadalupe, Austin, TX 78714, www.texashealthoptions.com, 855-839-2427, chap@tdi.state.tx.us
VA: CSD, P.O. Box 1157, Richmond, VA 23218, http://www.scc.virginia.gov/boi, 877-310-6560

Plan Assistance: To request assistance from or file a complaint with the Plan, please note the following contact information:

Allied National, LLC, P.O. Box 29186, Shawnee Mission, KS 66201, http://www.alliednational.com/, 800-825-7531

Judicial Review: If you exhaust all administrative rights of appeal under your Group Health Plan, you have the right to bring a civil action under Section 502(a) of ERISA. The time limitations stated in your Plan SPD for bringing legal actions or proceedings apply to any such civil action.

NOTICE OF PRIVACY POLICIES & PRACTICES

EFFECTIVE DATE	**THIS NOTICE DESCRIBES HOW YOUR MEDICAL INFORMATION MAY BE USED AND DISCLOSED AND HOW YOU MAY ACCESS THAT INFORMATION. PLEASE REVIEW IT CAREFULLY.**	COPY AVAILABLE AT
January 1, 2011		www.alliednational.com

Since 1951, Allied National, LLC. (and its affiliates, collectively referred to as "Allied") has adhered to strict client confidentiality policies and practices. Allied is committed not only to providing superior benefit products, administration and service, but to protecting the privacy of its clients. To comply with the Health Insurance Portability and Accountability Act of 1996 (HIPAA) and other privacy laws and regulations, Allied is required to maintain and abide by the following **Privacy Policies and Practices** and to provide its clients with this notice. Please be assured that:

- All health, medical, benefit, employment, business, financial or other personal, non-public or protected health information you disclose to us ("Protected Information") is maintained by Allied in secured hard copy and system files, with restricted access.
- Protected Information remains completely confidential and is disclosed only as is minimally necessary to service your account for benefit administration purposes.
- Allied does not sell Protected Information to any third party, for any reason.
- It is not necessary for you to reply to this notice, or to take any other action, in order for your Protected Information to remain completely secure and confidential.

This notice may be revised within Allied's discretion to comply with applicable law and regulation. Any such revision shall apply to all of your past, present and future Protected Information maintained by Allied, on and after the effective date of that revision or its distribution to you, whichever date is later.

PRIVACY POLICIES AND PRACTICES

I. **Commitment to Client Privacy**

A. Allied values and respects the privacy and confidentiality of its clients, and desires to safeguard, secure and protect Protected Information.

B. Allied recognizes its legal and ethical duty to safeguard, secure and protect Protected Information.

C. Allied shall maintain and abide by strict policies and practices to safeguard, secure and protect Protected Information.

II. **Definitions**

A. Clients: All prospective, current and former individual clients of Allied, who have inquired about, applied for, or obtained benefit products or services from Allied, for personal, family or household purposes, and in doing so have shared or disclosed personal, non-public or protected health information with Allied.

B. Protected Information: All information that personally identifies a Client and is not otherwise available to the public, which may generally include, but is not limited to, name, address, date of birth, social security number, telephone number, credit history, income, assets, investments, debts, marital status, tax filing status, dependent obligations, contributions, benefit coverage and claims, health history, medical treatment, medical information, business information and employment history.

C. Affiliates: All companies or other legal entities, including all individuals employed by those entities, under common control or ownership with Allied National, LLC.

D. Non-Affiliated Third Parties: All companies or other legal entities and individuals <u>not</u> under common control or ownership with Allied National, LLC, including but not limited to:

1. Insurance carriers, benefit plans, preferred provider networks, attorneys, accountants, actuaries and other companies or individuals on contract with or consulting for Allied.
2. Medical information bureaus, government agencies, third parties via court order or subpoena and other industry, regulatory or legally required entities or individuals.
3. Medical providers, agents, prior carriers, prior benefit plans, custodians for medical records and other entities or individuals possessing benefit, medical or health information or documentation of a Client.

4. All other Non-Affiliated Third Parties not included in numbers 1, 2 and 3 above.

III. **Collecting and Disclosing Protected Information**

A. Allied collects and discloses only that Protected Information which is minimally necessary to:

1. Provide or administer the product or service requested by the Client, including underwriting, claims adjudication, case management and investigation;
2. Allow Allied to provide superior products and services;
3. Comply with applicable law and regulation;
4. Respond to a Client inquiry or complaint;
5. Protect and safeguard Protected Information and Allied records;
6. Take any other action authorized and requested by the Client; or
7. Otherwise effect, administer or enforce a Client requested product, service or transaction, or perform any benefit administration function.

B. Allied collects the majority of Protected Information directly from the Client during the application or enrollment process, and then subsequently as requested by the Client to administer benefits or to change or adjust product coverage and/or service.

C. Confidential Information will not be collected from or disclosed to Non-Affiliated Third Parties listed in II. D. 4 above, by Allied, unless authorized and requested by the Client in writing.

D. Confidential Information may be collected from or disclosed to the Non-Affiliated Third Parties listed in II. D. 1, 2 and 3 above, by Allied, without additional authorization from the Client, but only for the purposes described in III. A above.

IV. **Safety and Security of Protected Information**

A. Allied ensures the safety and security of all Protected Information with strict policies and practices.

B. Allied discloses only that Protected Information which is minimally necessary for the purposes described in III. A above.

C. Allied maintains Protected Information in fully secured and restricted hard copy and system files.

D. Allied allows only fully authorized employees access to Protected Information, trained in the proper handling and disclosure of confidential and private information.

E. A strict disciplinary process applies should an employee violate Allied's privacy policies and practices.

F. Protected Information is never disclosed without the Client's prior authorization, other than as described in III. A above.

G. Protected Information is never sold to an Affiliated or Non-Affiliated Third Party, for any reason.

H. Prior to disclosing Protected Information to Non-Affiliated Third Parties for the purposes described in III. A above, Allied requires that third party to adopt and implement similar privacy policies and practices.

I. If Allied or one of the Non-Affiliated Third Parties discovers a breach of PHI privacy or security, Allied will comply with the requirements of the Health Information Technology for Economic and Clinical Health Act of 2009 (HITECH) (and its implementing regulations) and provide notification to all affected individuals, the Health and Human Services Department (HHS) and the media (when required).

V. **Rights and Responsibilities of Clients**

A. It is not necessary for a Client to respond to this notice, or to contact Allied in any manner, to ensure the privacy and confidentiality of his/her Protected Information. Protected Information is safe and secure as stated within this notice.

B. Allied will provide an individual with a copy of this notice, as may be amended, at the time he/she first purchases a product or service from Allied, and at least annually thereafter or at the time of a revision. A Client may request a copy of this notice at any time as directed below.

C. Clients may submit a written request to receive a copy of their Protected Information maintained by Allied, for a reasonable copying fee, except such information or records originating from a medical provider or its custodian, or relevant to a potential or pending legal claim against Allied. The Client's medical provider or attorney should instead be consulted. Written requests must be submitted as directed below.

D. Clients may notify Allied of errors in the Protected Information maintained by Allied, or request restrictions on its use, disclosure or method of delivery, or revoke a prior authorization, or request an accounting of disclosures, by submitting a written request as directed below. Revisions and corrections are within Allied's discretion.

E. A Client may file a complaint with Allied, the U.S. Department of Health and Human Services (Office for Civil Rights, U.S. Department of Health and Human Services, 200 Independence Avenue, S.W., Room 509F HHH Bldg., Washington, D.C. 20201), or his/her state Department of Insurance, if his/her privacy rights are violated. The complaint should be stated in writing and submitted as directed below if addressed to Allied. A Client will not be penalized for filing a complaint.

F. Clients may contact Allied with any questions, concerns, requests or inquiries regarding this notice or the Protected Information maintained by Allied, by writing to this address: Attn: Privacy Official, Allied National, LLC, P.O. Box 29186, Shawnee Mission, KS 66201, or http://www.alliednational.com/, or 1-800-825-7531 (please include your full name, certificate number, date of birth and current address with your mailing).

PLAN ADMINISTRATIVE INFORMATION

Initial Plan Year: Begins 01/01/2022 and continues through 12/31/2022. Records of the

	Initial Plan Year are kept for the same time period.
Subsequent Plan Years:	Begin each January 01 (following the Initial Plan Year) and continue for 12 consecutive months. Records of Subsequent Plan Years are kept for the same time.
Plan Name:	The GREENVILLE MEATS INC Self-Funded Group Health Plan
Employer establishing the Plan (Sponsoring Employer):	GREENVILLE MEATS INC
Plan Sponsor:	Sponsoring Employer
Plan Administrator:	Sponsoring Employer
Plan Fiduciary:	Sponsoring Employer
Named Trustee:	Sponsoring Employer
Agent for Service of Legal Process Service of legal process may be made on a plan trustee (if any) or the Plan Administrator**:**	Sponsoring Employer
Sponsoring Employer's Federal Employer ID #:	571092948
Plan Number:	501
Type of Plan:	Medical Expense
Class(es) of Eligible Employees:	All full-time employees in eligible class(es) effective the first day of the month following 1 months Waiting Period. Full-time employment is determined by the Plan Sponsor.
Eligible Employee Participation:	At least 2, with a minimum of 75% participating
Sponsoring Employer Contribution:	Refer to the attached Summary of Contribution sheet.
Dependent Coverage:	Eligible
Annual Open Enrollment:	The last month of each Plan Year
Enrollment & Claim Administration:	Allied National, LLC P.O. Box 29187 (enrollment) P.O. Box 29186 (claims) Shawnee Mission, KS 66201 *Direct questions about enrollment/claims to:* (800) 825-7531 or (913) 945-4100 www.alliednational.com
Preferred Provider Network:	RBP AND LEGAL ASSIST - ALLIED NATIONAL - GLOBALCARE
Plan Document:	The Plan Document is the final authority for determining benefits under the Plan and may be examined at the office of the Sponsoring Employer (in its capacity as the PlanAdministrator) within 30 days of its receipt of your written request.
Plan SPD:	A full description of the medical expense benefits under the Plan appears in the attached Summary Plan Description, incorporated herein by reference.

EXHIBIT A

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Summary Plan Description
Self-Funded Group Health Plan #286460-0
Plan Sponsor: GREENVILLE MEATS INC
824 WHITE HORSE RD
GREENVILLE SC 29605
864-277-5570
Plan Effective Date: 01/01/2022

All inquiries should be mailed to:
Allied National LLC
P.O. Box 29189 (general)
P.O. Box 29187 (enrollment)
P.O. Box 29186 (claims)
Shawnee Mission, KS 66201

SUMMARY PLAN DESCRIPTION

FOR THE

GREENVILLE MEATS INC EMPLOYEE GROUP HEALTH PLAN

INITIAL PLAN YEAR:
The 12 consecutive month time period, commencing as of **01/01/2022**

SUBSEQUENT PLAN YEARS:
The 12 consecutive month time period, commencing each January 1st

THIS SPD EFFECTIVE:
1/1/2022

IMPORTANT NOTICE

This is a self-funded employee welfare benefit plan. The benefits described in this SPD are self-insured by the Sponsoring Employer. This is not an insured benefit plan. The Sponsoring Employer is solely responsible for all coverage determinations and benefit payments.

SUMMARY PLAN DESCRIPTION INDEX

EFFECTIVE DATE OF COVERAGE

Sponsoring Employer: GREENVILLE MEATS INC

Participating Employee:

Employee's Effective Date of Coverage:

Covered Dependents:

INTRODUCTION

This Summary Plan Description (SPD) contains important information about your benefits under the above-referenced self-funded group health plan (the Plan). The Plan has been established and is maintained by your employer (the Sponsoring Employer) for the participation of its eligible employees (Employees) and their eligible dependents (Dependents). This SPD supersedes and replaces any and all other plan documents, summary plan descriptions or amendments that may have been distributed by the Plan or the Sponsoring Employer.

This SPD is subject to the provisions of the Plan Document.

This SPD contains a summary in English of your Plan rights and benefits. If you have difficulty understanding any part of this SPD, contact your Human Resources Department, or Allied National at 800-825-7531 Monday through Friday 8:00 to 4:30 central time.

Please read this SPD carefully:

- The benefits described herein are available to an Employee or Dependent only if that person is covered under the Plan and all required contributions for such coverage have been received by the Plan.
- The provisions and benefits may be different from your previous health plan coverage.
- Unless the context clearly indicates the contrary, whenever a masculine pronoun is used it includes the feminine and references to the singular include the plural (and vice versa).
- Words that are capitalized are defined in this Introduction or in the Definitions section of this SPD.
- Refer to the Plan Administrative Information below for important information about the Plan.
- The Sponsoring Employer is the Plan Sponsor, Plan Fiduciary, Plan Administrator and Plan Trustee and is responsible for all coverage determinations and benefit payments.

DISCRETIONARY AUTHORITY

The Sponsoring Employer, in its capacity as the Plan Administrator and in light of the purposes for which this Plan was established and is maintained, shall consider and render, in its sole discretion, appropriate eligibility, coverage and benefit determinations. In particular, the Plan Administrator shall have full and sole discretionary authority to interpret all plan documents and to make all interpretive and factual determinations as to whether any individual is entitled to receive any benefits under the terms of this Plan. Any construction of the terms of any plan document and any determination of fact adopted by the Plan Administrator shall be final and legally binding on all parties.

Any interpretation, determination, or other action of the Plan Administrator shall be subject to review only if it is arbitrary or capricious or otherwise an abuse of discretion. Any review of a final decision or action of the Plan Administrator shall be based only on such evidence presented to or considered by the Plan Administrator at the time it made the decision that is the subject of review. Accepting any benefits or making any claim for benefits under this Plan constitutes agreement with and consent to any decisions that the Plan Administrator makes, in its sole discretion, and further constitutes agreement to the CLAIM PROCESSING PROCEDURES AND APPEAL RIGHTS included with this SPD.

FUNDING

Plan benefits for a covered Employee and his covered Dependents (Covered Persons) are funded by both employee contributions (deducted pre-tax from the Employee's wages) and employer contributions (from the Sponsoring Employer's general assets). The Plan Administrator provides a schedule of the applicable contributions during the initial and each subsequent open enrollment period. The enrollment materials contain a payroll deduction authorization.

AMENDMENT AND TERMINATION

Subject to applicable law, the Plan Document may be amended, changed, canceled, discontinued or terminated by written instrument signed by the Plan Sponsor, in accordance with the provisions thereof and without the consent of any Covered Person. The Plan Document may be examined at the office of the Sponsoring Employer (in its capacity as the Plan Administrator) within 30 days of submitting a written request.

DELEGATED ADMINISTRATIVE SERVICES

The Sponsoring Employer has delegated certain non-fiduciary, ministerial administrative acts, duties and responsibilities of the Plan (Delegated Services) to Allied National, LLC, a licensed third-party administrator (Allied National). The Delegated Services include,

but are not limited to, enrolling covered persons, processing claims and determining Plan benefits pursuant to the terms and provisions of the SPD, subject to the Sponsoring Employer's discretionary authority. Therefore, please contact Allied National with all enrollment and claims questions:

Allied National, LLC
P.O. Box 29187 (enrollment)
P.O. Box 29186 (claims)
Shawnee Mission, KS 66201
(800) 825-7531 or (913) 945-4100
www.alliednational.com

However, the Sponsoring Employer remains the Plan Sponsor, Plan Fiduciary, Plan Administrator and Plan Trustee and is responsible for all coverage determinations and benefit payments. Allied National does not insure the Plan and is not responsible for funding benefit payments.

For purposes of providing the Delegated Services, Allied National has contracted with certain business associates. Claims information and other personal health information (PHI) concerning Covered Persons may be transferred or shared among the various business associates. Aggregate data and summary health information, as defined under the Health Insurance Portability and Accountability Act of 1996 (HIPAA), may be used by Allied National and/or the Plan Sponsor to evaluate Plan provisions and performance, including but not limited to, Plan design changes, contribution rates, stop-loss coverage and Plan claim costs. Each business associate will enter into a contract with Allied National to protect all Plan PHI in accordance with HIPAA. A copy of Allied National's Notice of Privacy Practices is included in this SPD.

TOTAL OUT-OF-POCKET AMOUNT

The Total Out-of-Pocket Amount represents the maximum amount of Eligible Expenses that must be paid by a Covered Person each Calendar Year, including Coinsurance, Copayments, and Deductible Amounts. Refer to the definition of that term and the Schedule of Benefits. Your medical providers may bill you directly, or request payment at the time services are rendered, for the applicable Coinsurance, Copayment and/or Deductible Amounts. Benefits under the Plan will be reduced by an amount up to the Total Out-of-Pocket Amount.

OUT-OF-NETWORK PENALTY

If the Plan has contracted with a Managed Care Network (MCN), Covered Persons may receive medical services from participating hospitals and doctors at a discount (MCN Provider). The MCN will be either an Exclusive Provider Organization (EPO) or a Preferred Provider Organization (PPO).

Generally, if you receive medical services **outside** of the MCN, you will be **penalized** as follows:

EPO: If the MCN is an EPO, and you do not use a provider on contract with that EPO (EPO Provider), and/or the medical services are not rendered within that EPO service area (EPO Service Area), no benefits will be payable (all benefits are forfeited).

Or, even if you use an EPO provider and receive the services within the EPO Service Area, a lower benefit may apply (paid at a lower level) if the EPO benefit varies according to the type of provider (i.e., Tier 1, Tier 2, etc.). If this applies, the benefit amount will depend on the tier level of the EPO Provider you use.

PPO: If the MCN is a PPO, and you do not use a provider on contract with that PPO, and/or the medical services are not rendered within that PPO service area, the available benefits will be reduced (paid at a lower level).

Certain exceptions apply. Refer to the Schedule of Benefits in this SPD.

It is your responsibility to confirm that a hospital, doctor or other facility is an MCN Provider (and, for EPO plans, which tier level the provider is assigned to) before receiving medical services. MCN Providers are listed in the EPO or PPO online directory, but contacting the provider directly is the most accurate and reliable method. Please contact Allied National Customer Service at 800-825-7531 for additional assistance.

If the Sponsoring Employer has selected traditional indemnity benefits for your Plan, instead of EPO or PPO benefits, you are free to use any provider without incurring the Out-of-Network Penalty. The designation of a primary care physician is also not required.

Note: Compliance with the above guidelines avoids only the Out-of-Network Penalty. Plan benefits continue to be subject to the Fair & Reasonable Charge limitation, Maximum Allowable Charge limitation, Outpatient Dialysis Treatment Benefit and all other limitations in this SPD.

FAIR & REASONABLE CHARGE LIMITATION
MAXIMUM ALLOWABLE CHARGE LIMITATION
OUTPATIENT DIALYSIS TREATMENT BENEFIT

Plan benefits are subject to the Fair & Reasonable Charge limitation, Maximum Allowable Charge limitation, Outpatient Dialysis Treatment Benefit and all other limitations in this SPD (Plan Limitations). If a provider charges an amount above a Plan Limitation, you may be billed for the excess charge. If this occurs, please contact Allied National Customer Service at 800-825-7531 for assistance in resolving your bill.

MEDICARE COORDINATION

IMPORTANT: Failure to enroll in Medicare may result in significant out-of-pocket expenses. If you are eligible for Medicare, the Plan may pay secondary to Medicare in certain situations (i.e., Medicare pays first). Examples of when Medicare is primary are when the Sponsoring Employer has less than 20 employees and your Medicare eligibility is based on age, or when the Sponsoring Employer has less than 100 employees and your Medicare eligibility is based on disability, or when you have been eligible for Medicare for more than 30 months based on End-Stage Renal Disease (ESRD). If the Covered Person is eligible for Medicare to pay as primary, the Plan will pay secondary to Medicare whether or not he is actually enrolled in Medicare. This means that benefits will still be reduced by the amount Medicare would have paid (under Parts A and B), even if the Covered Person has failed to enroll in Medicare Part A or B. Therefore, if you are eligible for Medicare, you are strongly encouraged to enroll in both Parts A and B of Medicare.

ENROLLMENT PERIODS & PENALTIES

If an Employee or Dependent does not enroll within thirty-one (31) days of first becoming eligible under the Plan, his enrollment will be delayed until the next Special (see below) or Annual Open Enrollment Period (pursuant to the Late Enrollee Penalty) (see below), whichever occurs first.

Late Enrollee Penalty: If an Employee or Dependent does not enroll within thirty-one (31) days of first becoming eligible under the Plan, he will be considered a Late Enrollee and be excluded from coverage under the Plan until the next Annual Open Enrollment Period (or until the next Special Enrollment Period, whichever occurs first).

Special Enrollment Period: If an Employee or Dependent does not enroll within thirty-one (31) days of first becoming eligible under the Plan, he may enroll without the Late Enrollee Penalty (i.e., before the next Annual Open Enrollment Period) if he qualifies for one of the following Special Enrollment Periods:

1. The Employee previously declined coverage, acquires a new Dependent spouse or Child through marriage, birth, adoption or Placement for Adoption, and requests enrollment for he and his Dependent within 31 days of the date he acquired the new Dependent.
2. The Employee previously declined coverage for his Dependent spouse, acquires a new Dependent Child through birth, adoption or Placement for Adoption, and requests enrollment for his Dependent spouse and Child within 31 days of the date he acquired the new Dependent Child.
3. The Employee previously declined coverage for his Dependent Child, acquires a new Dependent spouse or Child through marriage, birth, adoption or Placement for Adoption, and requests enrollment for the Dependent Child and his newly acquired Dependent within 31 days of the date he acquired the new Dependent.
4. The Employee and/or Dependent was covered under Qualifying Existing Coverage at the time he first became eligible for coverage and:
    a. the Employee stated in a waiver of coverage form at the time he first became eligible for coverage under the Plan that Qualifying Existing Coverage was the reason he declined coverage;
    b. the Employee and/or Dependent lost coverage as a result of exhaustion of COBRA continuation coverage, termination of employment or eligibility for coverage, death of the Employee's spouse, the Employee's divorce from his spouse, or termination of Participating Employer contributions toward the coverage; and
    c. the Employee requests coverage for himself and/or his Dependent within 30 days of the date he lost such coverage.
5. With respect to an Employee and his Dependent spouse or Child, the Employee becomes legally required to provide coverage to the Dependent spouse or Child pursuant to a QDRO or QMCSO.
6. With respect to an Employee or any of his Dependents, he becomes eligible for employee contribution assistance under Medicaid or the Children's Health Insurance Program (CHIP), and requests enrollment within 60 days of being determined eligible.

Annual Open Enrollment Period: If an Employee or Dependent does not enroll within thirty-one (31) days of first becoming eligible under the Plan, he may enroll as a Late Enrollee during the next Annual Open Enrollment Period (or during the next Special Enrollment Period, whichever occurs first).

Please contact Allied National Customer Service at 800-825-7531 for assistance in enrolling.

PLAN ADMINISTRATIVE INFORMATION

Initial Plan Year:	Begins 01/01/2022 (same as stop-loss effective date) and continues for any partial first month and then twelve consecutive months. Records of the Initial Plan Year are kept for the same time period.
Subsequent Plan Years:	Begin each January 1 (same as stop-loss renewal date) and continue for 12 consecutive months. Records of Subsequent Plan Years are kept for the same time period.
Plan Name:	The GREENVILLE MEATS INC Self-Funded Group Health Plan
Employer establishing the Plan (Sponsoring Employer):	GREENVILLE MEATS INC 824 WHITE HORSE RD GREENVILLE SC 29605 864-277-5570
Plan Sponsor:	Sponsoring Employer
Plan Administrator:	Sponsoring Employer
Plan Fiduciary:	Sponsoring Employer
Named Trustee:	Sponsoring Employer
Agent for Service of Legal Process Service of legal process may be made on a plan trustee (if any) or the Plan Administrator**:**	Sponsoring Employer
Sponsoring Employer's Federal Employer ID #:	571092948
Plan Number:	501
Type of Plan:	Medical Expense
Class(es) of Eligible Employees:	All full-time employees in eligible class(es) effective the first day of the month following 1 months Waiting Period. Full-time employment is determined by the Plan Sponsor.
Eligible Employee Participation:	At least 2, with a minimum of 75% participating
Sponsoring Employer Contribution:	Refer to the Summary of Contribution sheet presented during enrollment
Dependent Coverage:	Eligible
Annual Open Enrollment:	The last month of each Plan Year
Enrollment & Claim Administration:	Allied National, LLC P.O. Box 29187 (enrollment) P.O. Box 29186 (claims) Shawnee Mission, KS 66201 *Direct questions about enrollment/claims to:* (800) 825-7531 or (913) 945-4100 www.alliednational.com
Managed Care Network:	RBP AND LEGAL ASSIST-ALLIED NATIONAL - GLOBALCARE
Plan Document:	A full description of the medical expense benefits under the Plan appears in this SPD, which summarizes the official Plan Document. The Plan Document is the final authority for determining benefits under the Plan and may be examined at the office of the Sponsoring Employer (in its capacity as the Plan Administrator) within 30 days of its receipt of your written request.

STATEMENT OF ERISA RIGHTS

As a participant in this self-funded group health plan, you are entitled to certain rights and protections under the Employee Retirement Income Security Act of 1974 (ERISA). ERISA provides that all plan participants shall be entitled to:

Receive Information About Your Plan and Benefits
Examine, without charge, at the Plan Administrator's office all documents governing the plan, including a copy of the latest annual report (Form 5500 Series) filed by the plan with the U.S. Department of Labor and available at the Public Disclosure Room of the Pension and Welfare Benefit Administration.

Obtain, upon written request to the Plan Administrator, copies of documents governing the operation of the plan, including copies of the latest annual report (Form 5500 Series). The Plan Administrator may make a reasonable charge for the copies.

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

Continue Group Health Plan Coverage
Continue health care coverage for yourself or your Dependents if there is a loss of coverage under the Plan as a result of a qualifying event. You or your Dependents may have to pay for such coverage. Review this SPD for the rules governing your COBRA continuation coverage rights.

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

Enforce Your Rights
If your claim for a welfare benefit is denied or ignored, in whole or in part, you have a right to know why this was done, to obtain copies of documents relating to the decision without charge, and to appeal any denial, all within certain time schedules.

Under ERISA, there are steps you can take to enforce the above rights. For instance, if you request a copy of plan documents or the latest annual report from the plan and do not receive them within 30 days, you may file suit in a Federal court. In such a case, the court may require the Plan Administrator to provide the materials and pay you up to $110 a day until you receive the materials, unless the materials were not sent because of reasons beyond the control of the Plan Administrator. If you have a claim for benefits which is denied or ignored, in whole or in part, you may file suit in a state or Federal court. In addition, if you disagree with the plan's decision or lack thereof concerning the qualified status of a domestic relations order or a medical child support order, you may file suit in Federal court. If it should happen that plan fiduciaries misuse the plan's money, or if you are discriminated against for asserting your rights, you may seek assistance from the U.S. Department of Labor, or you may file suit in a Federal court. The court will decide who should pay court costs and legal fees. If you are successful, the court may order the person you have sued to pay these costs and fees. If you lose, the court may order you to pay these costs and fees, for example, if it finds your claim is frivolous.

Assistance with Your Questions
If you have any questions about your plan, you should contact the Plan Administrator. If you have any questions about this statement or about your rights under ERISA, or if you need assistance in obtaining documents from the Plan Administrator, you should contact the nearest office of the Employee Benefits Security Administration, U.S. Department of Labor, listed in your telephone directory or the Division of Technical Assistance and Inquiries, Employee Benefits Security Administration, U.S. Department of Labor, 200 Constitution Avenue N.W., Washington, D.C. 20210. You may also obtain certain publications about your rights and responsibilities under ERISA by calling the publications hotline of the Employee Benefits Security Administration.

Section 1 - DEFINITIONS

For the purposes of the Plan, the following terms shall have the meanings set forth below:

ACT Qualified Participant - a Covered Person who is eligible to participate in an Approved Clinical Trial, according to the protocol for that ACT, and either: (a) the Covered Person's Doctor is participating as a medical provider in the ACT and is of the opinion that the Covered Person's participation is medically appropriate; or (b) medical or scientific information is otherwise provided on behalf of the Covered Person, establishing the Covered Person's participation to be medically appropriate.

ACT Routine Patient Costs - Medical services and supplies typically provided to a Covered Person participating in an Approved Clinical Trial, but excluding: (a) the investigational item, device or service itself; (b) services and supplies not included in the direct clinical management of the patient; (c) services and supplies provided only in connection with data collection and analysis; and (c) services and supplies that are not medically necessary.

Active Work or Actively at Work - the active expenditure of time and energy on a Full-Time Basis in the service of and compensated for such service by the Sponsoring Employer. An Employee is also considered to be Actively at Work on each regular non-working day, whether paid or unpaid, provided: he was Actively at Work on his last regularly scheduled working day that immediately preceded the non-working day; his absence on the non-working day is approved by the Sponsoring Employer; and the non-working day is categorized by the Sponsoring Employer as a regularly scheduled non-working day (i.e., weekend or other day off), holiday, vacation day, sick day, or medical or non-medical leave of absence (including disabilities and work-place injuries) or legally required or permitted absence (i.e., jury duty or non-active duty military service).

Activities of Daily Living - daily self-care activities within an individual's place of residence, generally involving functional mobility and personal care such as bathing, dressing and undressing, toileting, continence (bowel and bladder management), meal preparation, eating, self-feeding, transferring (from bed to wheelchair, on or off toilet, etc.), ambulation (walking without an assistive device such as a walker, cane, crutches or wheelchair), personal hygiene and grooming, and changing body position.

Acupuncture - the insertion of needles into the human body by piercing the skin of the body, for the purpose of controlling and regulating the flow and balance of energy in the body to assist in rehabilitation and restoration of previously existing normal bodily functions which were lost or compromised after illness or injury, but only if such treatment results in measurable improvement and is provided by a Health Care Provider acting within the scope of his license or certification.

Ambulatory Patient Services - medical care or treatment provided on an Outpatient basis.

Ambulatory Surgical Center - any public or private establishment: a) with an organized medical staff of Doctors; b) with permanent facilities that are equipped and operated primarily for performing surgical procedures; c) with continuous Doctor services and registered professional nursing services whenever a patient is in the facility; d) which does not provide services or other accommodations for patients to stay overnight; and e) is duly licensed as an Ambulatory Surgical Center by the appropriate state authorities.

Applied Behavior Analysis (ABA) - treatment of an autism spectrum disorder by a behavioral therapist, in the form of designing, implementing and evaluating environmental modifications, by using behavioral stimuli and consequences to produce socially significant improvement in human behavior, including the use of direct observation, measurement and functional analysis of the relations between environment and behavior.

Approved Clinical Trial (ACT) - a phase I, phase II, phase III or phase IV clinical trial conducted in connection with the prevention, detection or treatment of cancer or another life threatening disease or medical condition, which is: (a) federally funded through a variety of entities or departments of the federal government; or (b) conducted in connection with an investigational new drug application under review by the Food and Drug Administration; or (c) exempt from such an investigational new drug application review. For purposes of this definition, "life-threatening condition" is a disease or condition likely to result in death unless the disease or condition is interrupted.

Behavioral Health Treatment - medical treatment for Nervous, Emotional or Mental Disorders and Substance Abuse Disorders (including detoxification).

Bodily Injury - accidental Bodily Injury or Injuries sustained by a Covered Person in any one accident that solely, directly and independently of all other causes results in medical expenses or in a claim for benefits while the Plan is in effect.

Calendar Year - that period commencing at 12:01 A.M. Standard Time at the address of the Sponsoring Employer, January 1 and shall continue until 12:01 A.M. Standard Time at the address of the Sponsoring Employer the next following January 1.

Center of Excellence - a clinically superior program designated a "Center of Excellence" by the U.S. Department of Health and Human Services; the Plan's contracted network for the type of complex medical condition (including organ transplant) under consideration for the Covered Person, that meets standards for quality including the number of procedures performed annually, clinical outcomes and other key quality measures; or any other specialized network contracted by the Plan.

Child – means:

1. Any child described below who has not reached age 26:
    a. a biological child, step child, legally adopted child, or foster child of an Employee or his Spouse;
    b. a child for whom an Employee or his Spouse is a legal guardian (as defined below);
    c. a child for whom an Employee or his Spouse is legally required to provide health benefit coverage pursuant to a QMCSO; or

d. a child (biological, step, foster or legally adopted) of a Dependent Child of an Employee or his Spouse, but only if the Employee or his Spouse is a legal guardian of the child (as defined below).

2. Any child age 26 or older, but only if the child:
   a. is incapable of earning his own living;
   b. is chiefly dependent upon the Employee for support and maintenance because of a Mental or Physical Incapacity (as defined below); and
   c. was enrolled in Group Health Plan coverage which was replaced by coverage under the Plan.

Legal Guardian: The Employee or his Spouse has been appointed the legal guardian of the child by a state or federal court, the child is primarily dependent on the Employee or his Spouse for support (at least 50%), and the child appears as a dependent on the Employee's or his Spouse's federal tax return.

Mental or Physical Incapacity: A mental or physical impairment that results in anatomical, physiological or psychological abnormalities as demonstrated by medically acceptable clinical or laboratory diagnostic techniques and which are expected to last for a continuous period of time not less than twelve (12) months. The Mental or Physical Incapacity must be confirmed in writing by the child's Doctor and the Plan has the right to have the child examined by other Doctors designated by the Plan (but not more often than once each Calendar Year).

Community Health Plan (CHP) Provider – any Doctor, Hospital, Health Care Provider, clinic, or other entity that contracted with the plan to provide Covered Persons with access to medical care and treatment at a discount, within that CHP provider network and on an exclusive basis (i.e., members of a CHP plan). CHP benefits only have one type of provider (i.e., Tier 1).

Chronic Disease Management - medical care or treatment provided for a long-lasting medical condition that can be controlled but not cured.

Civil Union - a legal union other than Marriage or Same Sex Marriage or Domestic Partnership, validly entered into in a state that legally recognizes Civil Unions, by and between two (2) individuals of the same gender, who are at least 18 years of age, and not related by blood closer than that permitted by the Marriage laws of the state of residence of either individual.

Civil Union Party (Party to a Civil Union) - an individual joined in a Civil Union with an Employee.

Coinsurance Percentage - the percentage payable by the Plan for Eligible Expense incurred by a Covered Person in excess of the Deductible or Copay Amount.

Complications of Pregnancy (which are considered to be a Sickness under the Plan) - means: a) conditions requiring Inpatient treatment (when pregnancy is not terminated); b) whose diagnoses are distinct from pregnancy but are adversely affected or caused by pregnancy, such as acute nephritis, nephrosis, cardiac decompensation, missed abortion and similar medical and surgical conditions of comparable severity; and c) non-scheduled or emergency cesarean section, ectopic pregnancy that is terminated, and spontaneous termination of pregnancy that occurs during a period of gestation in which a viable birth, as defined by the World Health Organization, is not possible. Complications of Pregnancy do not include a scheduled cesarean section, complicated or difficult pregnancy with diagnoses such as false labor, occasional spotting, Health Care Provider prescribed rest during the period of pregnancy, morning Sickness, hyperemesis gravidarum, preeclampsia or other similar conditions associated with a difficult pregnancy.

Copayment or Copay - a fixed dollar amount specified in the Schedule of Benefits that is payable by the Covered Person.

Covered Person - an Employee or his Dependent eligible for and covered under the Plan.

Custodial or Convalescence Care - any care that is provided to a Covered Person who is disabled and needs help to support the essential Activities of Daily Living when the Covered Person is not under active and specific medical, surgical, or psychiatric treatment that will reduce the disability to the extent necessary for the person to perform the Activities of Daily Living on his own.

Deductible Amount - the amount specified in the Schedule of Benefits that must be satisfied by each Covered Person each Calendar Year by the application of Eligible Expenses that are subject to the Deductible Amount and actually incurred by the Covered Person before any Eligible Expenses will be payable under the Plan.

Dependent - means:

a. a Covered Employee's eligible Spouse, who is covered under the Plan and is not a member of the armed forces;

b. a Covered Employee's eligible Child, who is covered under the Plan, is not a member of the armed forces and is not eligible as an Employee under the Plan;

If both the Employee and his Spouse are covered as Employees, eligible Children may be covered only as the Dependents of either Employee, but not both.

A Dependent Spouse who also is an eligible Employee may be covered as either an Employee or Dependent but not as both.

Dependent Coverage - coverage under the Plan providing benefits to a Dependent.

Doctor - a physician who is licensed by the proper authorities of the state in which he practices, as either a Medical Doctor (MD) or Doctor of Osteopathic Medicine (DO), and is operating within the scope of that license in rendering or prescribing medical treatment. A Doctor cannot be the Covered Person or a relative of the Covered Person by blood or Marriage (or Same Sex Marriage or Domestic Partnership or Civil Union) and cannot reside in the household of the Covered Person.

Domestic Partner – an individual joined in a Domestic Partnership with an Employee.

Domestic Partnership – a committed, personal and mutually exclusive partnership, other than Marriage or Same Sex Marriage or Civil Union, for the purpose of living together domestically for an indefinite duration, validly entered into in a state that legally recognizes Domestic Partnerships and documented by a legally binding civil contract, by and between two (2) individuals of the same

gender, who are at least 18 years of age, and not related by blood closer than that permitted by the Marriage laws of the state of residence of either individual.

Durable Mechanical Medical Equipment - equipment that is:

a. able to withstand repeated use; and

b. primarily and customarily used to serve a medical purpose; and

c. not generally useful to a person in the absence of Sickness or Bodily Injury.

The Plan has the discretionary authority to identify Durable Mechanical Medical Equipment. The Plan reasonably exercises its discretionary authority in identifying Durable Mechanical Medical Equipment for any claim for Plan benefits.

Eligible Expenses - those expenses incurred as a result of a Covered Person's Bodily Injury or Sickness:

a. which are Medically Necessary and have been recommended and prescribed by a Health Care Provider;

b. which are not in excess of the Maximum Allowable Charge, or any maximum benefit shown in the Schedule of Benefits, or any charges made in the absence of this coverage;

c. which are not excluded from coverage by the Plan;

d. which do not exceed any amounts payable under the Plan; and

e. for which the Covered Person is legally liable.

Expenses are incurred on the date on which the service or supply that gives rise to the expenses is rendered or obtained. The Plan has the discretionary authority to determine Eligible Expenses. The Plan reasonably exercises its discretionary authority in determining Eligible Expenses for any claim for Plan benefits.

Emergency Medical Condition – a condition of recent onset with acute symptoms of sufficient severity, including severe pain, that would lead a prudent layperson acting reasonably and possessing an average knowledge of health and medicine to believe that the absence of immediate medical attention could reasonably be expected to result in: (1) placing the patient's health in jeopardy; or (2) serious impairment of bodily functions, body organs or body parts. The attending Doctor must verify that an Emergency Medical Condition existed.

Emergency Services – medical services provided to a Covered Person in connection with an Emergency Medical Condition, including ambulance transportation, medical screening examinations within the scope of services routinely provided by an emergency room or emergency department of a Hospital, ancillary Hospital services routinely provided to evaluate an Emergency Medical Condition, and such other medical examination and treatment as may be required to medically stabilize the Covered Person. Emergency Services provided by a Non-MCN Provider will be covered at the same benefit and cost sharing level as services provided by an MCN Provider.

Employee - a person directly employed and Actively at Work in the regular business of, and compensated by regular periodic wages for services by, the Sponsoring Employer and who is in a class eligible for benefits under this Plan as designated by the Sponsoring Employer. Leased employees, sole proprietors. partners, corporate directors, limited liability members, and corporate or limited liability stockholders, shareholders and other owners do not qualify as and are not considered to be common-law employees of a Sponsoring Employer. However, such an individual may participate as an Employee if approved by the Sponsoring Employer and Actively at Work and engaged in the regular business of the Sponsoring Employer. A former Employee may also participate as an Employee, if he was covered under the health benefit plan that this coverage replaces as a former employee participant who elected and is still eligible for continuation coverage under any state or federal continuation laws.

Employee Coverage - coverage under the Plan providing benefits with respect to an Employee.

Enrollment Date - the earlier of the first day that a Covered Person is covered under the Plan or the first day of the Waiting Period for that enrollment.

EPO Provider - any Doctor, Hospital, Health Care Provider, clinic, or other entity on contract with an EPO to provide Covered Persons with access to medical care and treatment at a discount, within that EPO's provider network and on an exclusive basis (or a specific Hospital, Health Care Provider, clinic, or other entity that has negotiated a specific fee arrangement directly with the Plan to provide medical care and treatment to Covered Persons at a discount and on an exclusive basis). The MCN for the Plan may elect to categorize EPO Providers according to the type of provider (i.e., primary care vs. specialist, local vs. regional, etc.). If so, the EPO benefit will vary by category and the categories will be identified by tier levels (i.e., Tier 1, Tier 2, etc.).

Essential Health Benefits - benefits covered under the Plan and defined as an "Essential Health Benefit" in the Patient Protection and Affordable Care Act ("PPACA"), including: ambulatory patient services; Emergency Services; Inpatient 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; chronic disease management; Preventive Care Services; and Pediatric services, including oral and vision care.

Exclusive Provider Organization (EPO) – any organization that has contracted with the Plan on an exclusive basis to provide Covered Persons with access to medical care and treatment at a discount, within a specific service area, and through a network of EPO Providers (or a specific EPO Provider that has negotiated a special fee arrangement directly with the Plan, to provide medical care and treatment to Covered Persons at a discount and on an exclusive basis). Benefits are payable only when an EPO Provider is used within the EPO service area. If an EPO Provider is not used, and/or the medical services are not rendered within that EPO service area, no benefits will be payable (all benefits are forfeited). The MCN for the Plan may elect to categorize EPO Providers according

to the type of provider (i.e., primary care vs. specialist, local vs. regional, etc.). If so, the EPO benefit will vary by category and the categories will be identified by tier levels (i.e., Tier 1, Tier 2, etc.).

Experimental Treatment –in the Plan's discretion a treatment, drug, device, procedure, supply or service and related services (or any portion thereof, including the form, administration or dosage) for a particular diagnosis or condition when any **one** of the following exists:

1. the treatment, drug, device, procedure, supply or service is in any clinical trial or a Phase I, II or III trial.
2. the treatment, drug, device, procedure, supply or service is not yet fully approved or recognized (for other than experimental, investigational, research or clinical trial purposes) by the National Cancer Institute (NCI), Food & Drug Administration (FDA), or other pertinent governmental agency or professional organization.
3. the results are not proven through controlled clinical trials with results published in peer-reviewed English language medical journals, to be of greater safety and efficacy than conventional treatment, in both the short and long term.
4. the treatment, drug, device, procedure, supply or service is not generally accepted medical practice in the state where the Covered Person resides or generally accepted throughout the United States as determined in the Plan's discretion, by reference to any one or more of the following: peer-reviewed English-language medical literature, consultation with physicians, authoritative medical compendia, the American Medical Association, or other pertinent professional organizations or governmental agencies.
5. the treatment, drug, device, procedure, supply or service is described as investigational, experimental, a study, or for research or the like in any consent, release or authorization which the Covered Person, or someone acting on his or her behalf, may be required to sign.

The fact that a procedure, service, supply, treatment, drug, or device may be the only hope for survival will not change the fact that it is otherwise investigational, experimental, or for research. The Plan has the discretionary authority to determine Experimental Treatment. The Plan reasonably exercises its discretionary authority in determining Experimental Treatment for any claim for Plan benefits.

Extended Care Facility - an institution, other than a Hospital, operated and licensed pursuant to law, that provides: a) permanent and full-time facilities for the continuous skilled nursing care of three (3) or more sick or injured persons on an Inpatient basis during the convalescent stage of their illnesses or injuries; b) full-time supervision by a Doctor; c) twenty-four (24) hour a day nursing service of one or more Nurses; and d) is not, other than incidentally, a rest home or a home for custodial care or for the aged. Extended Care Facility does not include an institution that primarily engages in the care and treatment of drug addicts or alcoholics.

Fair and Reasonable Charge - to determine the Fair and Reasonable Charge for medical treatment provided to a Covered Person (or any other form of medical care, procedure, drug or supply), the Plan, as determined in the Plan's discretion, consults one (1) or more standard industry sources to calculate, for cases of comparable severity and nature in the same geographical area, the cost of the goods and services reasonably required to produce and deliver such treatment and/or the charge most commonly paid for such treatment. The standard industry sources utilize cost-based formula methodology and/or pricing data (updated semi-annually or more often) to produce replicable and consistent cost and/or pricing parameters.

In calculating the Fair and Reasonable Charge, the Plan may consider such factors as the Plan, in the reasonable exercise of the Plan's discretion, determines are appropriate, including but not limited to:

1. the complexity of medical treatment;
2. the degree of professional skill, experience and training required for a Health Care Provider to perform or provide the medical treatment;
3. the severity or nature of the Bodily Injury or Sickness being treated;
4. the Health Care Provider's adherence or failure to adhere to normal charge practices, as generally accepted by an established United States medical society or other pertinent professional organization or governmental agency as determined by the Plan, including but not limited to billing, itemization, coding, documentation practices and bundling (including restrictions against unbundling such as may occur in multiple procedures, bilateral procedures or when a Doctor is assisting another Doctor);
5. the cost to the Health Care Provider of performing or providing the medical treatment, including reasonable allowance for overhead and profit
6. fee schedules used by third parties such as Medicare or Medicaid, including Medicare Allowable Charge data for Medicare Part B; or
7. hospital cost data as submitted to Medicare, including Medicare Allowable Charge data for Medicare Part A.

The Plan has the discretionary authority to determine the Fair and Reasonable Charge. The Plan reasonably exercises its discretionary authority in determining the Fair and Reasonable Charge for any claim for Plan benefits.

Family - the covered Employee and his covered Dependents.

Food & Drug Administration (FDA) Approved Drug (or FDA-approved) – FDA Approved Drugs are medications that have been approved by the U.S. Food and Drug Administration for use in the United States for longer than six (6) months.

Full-Time Basis - means:

1. For Employees not working on a Variable or Seasonal Schedule: "Full-Time Basis" means working on a non-temporary, regular basis of at least 30 hours per week, on average.
2. For Employees working on a Variable or Seasonal Schedule: "Full-Time Basis" means working as follows:
    a. New Employees: If a New Employee works at least 30 hours per week on average during his Initial Measurement Period, he will be treated as working on a Full-Time Basis during the immediately following Initial Stability Period, regardless of the number of hours actually worked during that Initial Stability Period.
    b. Ongoing Employees: If an Ongoing Employee works at least 30 hours per week on average during a Standard Measurement Period, he will be treated as working on a Full-Time Basis during the immediately following Standard Stability Period, regardless of the number of hours actually worked during that Standard Stability Period.

For purposes of this definition:
"Variable or Seasonal Schedule" means an Employee who does not consistently work at least 30 hours per week, on average, on a non-temporary and regular basis.
"New Employee" means an Employee who has not been employed by the Sponsoring Employer for at least one (1) complete Standard Measurement Period.
"Ongoing Employee" means an Employee who has been employed by the Sponsoring Employer for at least one (1) complete Standard Measurement Period.
"Initial Measurement Period" means the look-back period for New Employees, commencing as of the New Employee's date of hire (or the first of the following month) (or any day in between those dates) (as selected by the Sponsoring Employer) and continuing for at least three (3), but no more than 12 consecutive months (as selected by the Sponsoring Employer).
"Standard Measurement Period" means the look-back period for Ongoing Employees, commencing each calendar year on a date selected by the Sponsoring Employer and continuing for at least three (3), but no more than 12 consecutive months (as selected by the Sponsoring Employer).
"Initial Stability Period" means the look-forward period for New Employees, commencing for a New Employee upon completion of his Initial Measurement Period and continuing for the same duration as the Standard Stability Period.
"Standard Stability Period" means the look-forward period for Ongoing Employees, commencing each calendar year upon completion of the Standard Measurement Period for that calendar year, and continuing for the same duration as the Standard Measurement Period, or six (6) consecutive months, whichever is longer.

Gene Therapy – The therapeutic delivery or transplantation of nucleic acid into a patient's missing or defective cells in order to treat a genetic disorder.

Group Health Plan - an employee welfare benefit plan to the extent it provides medical benefits to employees or their dependents, as defined under the terms of that Group Health Plan, directly or through insurance, reimbursement or otherwise. This Plan is a Group Health Plan.

Habilitative Services and Devices - Medically Necessary health care services and devices provided by a physical therapist, occupational therapist, speech therapist or behavioral therapist, that assist an individual in partially or fully acquiring or developing skills and functioning which had not previously been present and that are necessary to address a health condition, to the maximum extent practical. Such health conditions include autism spectrum disorders and other developmental delays.
Habilitative Services and Devices address the skills and abilities needed for functioning while interacting with an individual's environment. Outpatient short-term rehabilitation, occupational therapy, speech therapy, physical therapy and applied behavior analysis services are covered when the provision of such services can be expected to result in the significant improvement of a Covered Person's condition. The maximum number of visits covered for Habilitative Services per Injury or Sickness will not exceed the number shown in the Schedule of Benefits.
Examples of health care services and devices that are not habilitative services include, but are not limited to, respite care, day care, recreational care, residential treatment, social services, custodial care, or education services of any kind, including, but not limited to, vocational training.
Benefits are payable for Habilitative Services and Devices only when ordered by a Doctor and such therapy is related to the treatment of a Covered Person's condition (in the case of a covered Dependent Child, this includes a medically diagnosed congenital defect).

Health Care Provider- a person licensed or certified by the proper authorities of the state in which he practices, to render or prescribe medical care or treatment, and who is operating within the scope of that license in providing such medical care or treatment to a Covered Person. A Health Care Provider cannot be the Covered Person or a relative of the Covered Person by blood or marriage and cannot reside in the household of the Covered Person.

High Cost Drug Program - Upon eligible member's enrollment, this program combines utilization oversight, Centers of Excellence, drug safety and adherence coaching with cost containment and strategic sourcing solutions. The objective is to help members obtain needed Specialty and/or high cost prescription drugs in a cost effective manner while reducing waste and improving clinical outcomes. Coverage for High Cost Drugs does not begin until six (6) months after the FDA approval date.

Home Health Care Agency - an entity licensed by state or local law operated primarily to provide skilled nursing care and therapeutic services in an individual's home and:

a. which maintains clinical records on each patient;
b. whose services are under the supervision of a Doctor or a licensed graduate registered nurse (RN); and

c. which maintains operational policies established by a professional group including at least one Doctor and one licensed graduate registered nurse (RN).

Home Health Care Plan - a program for continued care and treatment of an individual in his home by a Home Health Care Agency, if established and approved in writing by the individual's attending Doctor. The attending Doctor must also certify that, if such care and treatment under a Home Health Care Plan was not available, the only other medically acceptable treatment of the individual's Bodily Injury or Sickness would be continued confinement in a Hospital.

Hospice - a facility that:

a. is licensed, accredited or approved by the proper authority to provide a Hospice Care Program;

b. admits individuals who:

i. have no reasonable prospect of cure; and

ii. have a life expectancy of six (6) months or less; and

c. provides care by a Hospice Team coordinating its services with the patient's attending Doctor and the patient's Family.

Hospice Care Program - a coordinated program delivered by a Hospice Team at a Hospice, meeting the needs of dying individuals and their families and providing medical, nursing and other health services during illness and bereavement.

Hospice Team - a group of persons composed of a Hospice Doctor, a patient care coordinator (a Doctor or licensed graduate registered nurse (RN)), a licensed graduate registered nurse (RN), a mental health specialist, a social worker, a Chaplain and a lay volunteer.

Hospital - a legally constituted and licensed institution with organized facilities for the care and treatment of sick and injured persons on an Inpatient basis. This includes facilities for diagnosis and surgery under the supervision of a staff of one or more Doctors, that provides twenty-four (24) hour nursing service by licensed graduate registered nurses (RNs) on duty or call. It does not mean Custodial, Convalescent, Residential Treatment, nursing, rest or Extended Care facilities.

Infertility - the inability to conceive a child after one year of unprotected sexual intercourse or the inability to sustain a successful pregnancy.

Inpatient or Inpatient Hospitalization - a Covered Person confined and assigned to a Hospital bed for a period of twenty-three (23) consecutive hours or longer upon the advice of a Doctor for other than Custodial or Convalescent Care.

Intensive Care Unit - that part of a Hospital specifically designed as an Intensive Care Unit. It is permanently equipped and staffed to provide more extensive care for critically ill or injured patients than available in other Hospital rooms or wards. This care includes close observation by trained and qualified personnel primarily assigned to this part of the Hospital. This term shall not include Intermediate Care, Long Term Acute Care or Stepdown Units.

Intermediate Care, Long Term Acute Care (LTAC) or Stepdown Unit - a section, ward or wing within a Hospital or properly accredited free-standing facility which:

a. provides more intensive care than regular room and nursing care;

b. provides less intensive care than in the Intensive Care Unit;

c. may maintain a telemetry monitoring system on all patients;

d. requires a minimum nurse/patient ratio of one to three; and

e. is not a facility maintained for normal post-operative recovery treatment or service.

Laboratory Services - clinical laboratory services provided to a patient upon the order and referral of a Health Care Provider to test or diagnose a specimen taken from that patient.

Late Enrollee - an Employee or Dependent, other than a Special Enrollee, whose enrollment for coverage under the Plan (on forms approved by the Plan) is not received by the Plan Administrator within 31 days of the date he becomes eligible to become covered for coverage under the Plan.

Late Enrollment Period –the Open Enrollment Period immediately following the date an Employee or Dependent becomes eligible as a Late Enrollee. Application must be made during the Open Enrollment Period and received by the Plan Administrator no later than 31 days following the end of the Open Enrollment Period.

Life-Threatening – a condition which, if not immediately interrupted by medical treatment, has a high likelihood of: (1) death, if the end point of the medical treatment is survival; or (2) causing major irreversible morbidity (including: loss of arm, leg, hand or foot; loss of sight or hearing; paralysis; or loss of brain function), if the end point of the medical treatment is survival and/or avoiding that morbidity. The attending Doctor must verify the condition to be life-threatening. The Plan has the discretionary authority to determine if a condition is Life-Threatening. The Plan reasonably exercises its discretionary authority in determining if a condition is Life-Threatening for any claim for Plan benefits.

Managed Care Network (MCN) – any EPO or PPO that has an MCN Contract with the Plan.

Marriage – a personal and consensual legal union, other than Same Sex Marriage or Domestic Partnership or Civil Union, between one (1) man and one (1) woman as husband and wife, validly entered into in a state that legally recognizes traditional marriage between two (2) persons of opposite genders, whether by state statute or common law, who are at least 18 years of age and not related by blood closer than that permitted by the Marriage laws of the state of residence of either individual.

Maternity Care - the care and treatment of Pregnancy, including Complications of Pregnancy and all delivery, Inpatient and Newborn Care for both the mother and newborn child. The Plan may not restrict benefits for any Hospital length of stay in connection with childbirth for the mother or the newborn child to less than 48 hours following a vaginal delivery, or less than 96 hours following a cesarean section (unless the Doctor discharges the mother or newborn earlier, after consultation with the mother). Maternity Care is available to a newborn child only if the newborn qualifies as an eligible Dependent Child under the Plan. Coverage of the newborn is retroactive to the instant the child is born, subject to the newborn qualifying as an eligible Dependent Child under the Plan and timely submission of all required enrollment forms and contributions for that child.

Maximum Allowable Charge - the Maximum Allowable Charge that will be considered as an Eligible Expense for Medically Necessary services and supplies generally furnished for cases of comparable severity and nature in the geographical area in which the services or supplies are furnished will be the lesser of the billed charges, the Fair and Reasonable Charge, the MCN Reimbursement Rate, the maximum benefit under the Plan (if any), or the Medicare Allowable Charge Percentage. The Plan has the discretionary authority to determine the Maximum Allowable Charge. The Plan reasonably exercises its discretionary authority in determining the Maximum Allowable Charge for any claim for Plan benefits.

Total Out-of-Pocket Amount - a fixed dollar amount specified in the Schedule of Benefits that represents the maximum amount of Eligible Expenses that must be paid by a Covered Person each Calendar Year. The Total Out-of-Pocket Amount includes all Coinsurance, Copayments, and Deductible Amounts for Eligible Expenses paid under the major medical coverage and the outpatient prescription drug coverage. All other expenses for which a Covered Person may be responsible are excluded from the definition of Total Out-of-Pocket Amount, including but not limited to Plan contributions, medical expenses that do not qualify as Eligible Expenses, and balance billing by medical providers.

MCN Contract - any CHP, EPO or PPO contract or arrangement with the Plan.

MCN Directory - the EPO or PPO directory furnished through the Sponsoring Employer that lists the EPO or PPO contracted providers. The MCN Directory is updated and distributed at least annually. When applicable, CHP contracted providers are listed in the Schedule of Benefits.

MCN Provider - a Hospital, Health Care Provider, clinic, or other CHP, EPO or PPO contracted entity, which renders medical or surgical services or supplies to a Covered Person, both within the MCN Service Area and pursuant to an MCN Contract. MCN Providers are listed in the MCN Directory.

MCN Reimbursement Rate – The CHP, EPO or PPO discounted rate available to Covered Persons under an MCN Contract.

MCN Service Area - the counties identified by the EPO or PPO in the MCN Directory. When applicable, CHP Facilities and associated providers are identified in the Schedule of benefits.

MCN Services - medical or surgical services or supplies which are payable by the Plan at the MCN Reimbursement Rate, but only if: rendered by a CHP, EPO or PPO contracted provider (pursuant to an MCN Contract); and rendered within the MCN Service Area.

Medically Necessary (Medical Necessity)- any treatment, drug, device, procedure, supply or service that is:

1. rendered under a treatment plan designed by a Health Care Provider and in a setting consistent with the symptoms and/or diagnoses of the patient; and
2. generally accepted by the medical profession as appropriate for the symptoms or diagnoses with regard to standards of good medical practices as depicted by
    a. use in the state where the Covered Person resides or use throughout the United States; or
    b. scientific or medical evidence accepted by a majority of the medical specialty involved, or
    c. classified, recognized, or acknowledged by the American Medical Association or other pertinent professional organization or governmental agency as proven, safe or medically necessary.

In addition, a treatment, drug, procedure, service or supply shall not be considered as Medically Necessary if any of the following applies:

1. is Experimental and/or for research purposes;
2. is provided solely for educational purposes or for the convenience of the patient, the patient's family, the Health Care Provider, the hospital or any other provider;
3. exceeds in scope, duration, or intensity that level of care which is needed to provide safe, adequate, and appropriate diagnosis or treatment and where ongoing treatment is merely for maintenance or preventive care;
4. could have been omitted without adversely affecting the person's condition or the quality of medical care;
5. involves the use of a medical device, drug or substance not formally approved by the United States Food and Drug Administration;
6. involves a service, procedure, supply or drug not approved for reimbursement by the Health Care Financing Administration;
7. can be safely provided to the patient on a more cost effective basis such as Outpatient, by a different medical professional, or pursuant to a more conservative form of treatment.
8. results from error in providing medical care or treatment, if reasonably identifiable and preventable (with or without a finding of provider negligence and/or medical malpractice).

Benefit payment is subject to the determination by the Plan that the treatment, drug, procedure, service or supply is Medically Necessary. Services and supplies are not automatically deemed to be Medically Necessary based solely on the fact they were prescribed, ordered or recommended by a Health Care Provider. The Plan has the discretionary authority to determine Medical Necessity. The Plan reasonably exercises its discretionary authority in determining Medical Necessity for any claim for Plan benefits.

Medicare - the health insurance programs under Title XVIII of the United States Social Security Act of 1965 as amended.

Medicare Allowable Charge - The amount that Medicare considers payment in full for a particular medical service or supply, as listed in the published Medicare fee schedules for Medicare Part A and Medicare Part B.

Medicare Allowable Charge Percentage - the Medicare Allowable Charge multiplied by the percentage stated in the Schedule of Benefits.

Medicare Part A - the insurance program under Medicare that covers Inpatient Hospital care, Inpatient care in a Skilled Nursing Facility and Hospice Care.

Medicare Part B - the insurance program under Medicare that covers Outpatient Hospital services, Doctor services, Home Health Care services, and other medical services not covered by Medicare Part A.

Mental Health Services - medical treatment for Nervous, Emotional or Mental Disorders.

Nervous, Emotional or Mental Disorders - any nervous, emotional and mental disease, illness, syndrome, or dysfunction classified in the *American Psychiatric Association Diagnostic and Statistical Manual of Mental Disorders* on the date care or medical treatment is rendered. This includes, but is not limited to neurosis, psychoneurosis, psychopathy, psychosis, and eating or panic disorder except for mental retardation. It also includes any nervous, emotional or mental disease caused by an organic condition, disease, illness, or syndrome, including organic mental syndrome associated with psychoactive substances (e.g., alcohol, cocaine, opiate, and others).

Newborn Care - Well-baby (prenatal and postnatal) care for a newborn child. Newborn Care is available to a newborn child only if the newborn qualifies as an eligible Dependent Child under the Plan. Coverage of the newborn is retroactive to the instant the child is born, subject to the newborn qualifying as an eligible Dependent Child under the Plan and the timely submission of all required Plan enrollment forms and contributions for that child.

Non-Emergency Complex Medical Condition - any non-emergency health condition reasonably expected: to incur medical expenses in excess of $25,000.00 for its diagnosis and/or treatment; and to benefit from a second medical opinion due to its complexity. Examples include but are not limited to: complex cancer conditions; complex cardiac conditions; complex auto-immune conditions; complex rare diseases; and complex surgeries.

Non-MCN Provider (Non-MCN) - any Hospital, Health Care Provider, clinic, or other entity that does **not** qualify as an MCN Provider, because the medical or surgical services or supplies: are **not** rendered by a CHP, EPO or PPO contracted entity (pursuant to an MCN Contract); and/or **not** rendered within the MCN Service Area.

Non-MCN Service Area - Counties **not** identified by the EPO or PPO in the MCN Directory. CHP Facilities and associated providers **not** identified in the Schedule of benefits.

Non-MCN Services - medical or surgical services or supplies that do **not** qualify as MCN Services, because they: are **not** payable by the Plan at the MCN Reimbursement Rate; and/or are **not** rendered by an MCN Provider; and/or are **not** rendered within the MCN Service Area.

Non-surgical, Outpatient Expense - all Eligible Expenses including, but not limited to, Laboratory Services, X-Rays, Durable Medical Mechanical Equipment, Home Health Care Services, Hospice Care Programs, services for Outpatient Nervous, Emotional or Mental Disorders, Outpatient alcoholism and chemical dependency care and ambulance service. It does not include expenses for Office Visits, Surgical Procedure Expenses and Inpatient facility charges.

Nurse - a licensed graduate registered nurse (RN) or licensed practical nurse (L.P.N.). A Nurse cannot be the Covered Person or a relative of the Covered Person by blood or Marriage (or Same Sex Marriage or Domestic Partnership or Civil Union) and cannot reside in the household of the Covered Person.

Occupational Therapy – treatment of disease by physical agents and methods to assist in rehabilitation and restoration, of previously existing normal bodily functions which were lost or compromised after illness or injury, through a program designed to improve endurance, strength, exercise tolerance, and performance of Activities of Daily Living, but only if such treatment results in measurable improvement and is provided by a Doctor or licensed or registered occupational therapist (O.T.R.). Maintenance therapy or other treatment provided on a routine basis as part of a standard program, and educational training or services designed and adapted to develop a physical function, are not included.

Office Visit Services - non-surgical professional medical services performed in a Health Care Provider's office (including an Urgent Care facility) during one visit to that Health Care Provider, including, but not limited to exams, consultations, diagnostic testing, x-rays, allergy antigen injections, chiropractic treatment, surgical services and Preventive Care Services. After the Office Visit copay, these services are paid at 100% to a total benefit of the dollar amount specified in the Schedule of Benefits (the Office Visit Maximum). Expenses in excess of the Office Visit Maximum, or for diagnostic testing and x-rays not performed in the Health Care Provider's office, are subject to deductible and coinsurance (except for Preventive Care Services and laboratory testing done through Quest Diagnostics, which are paid at 100%). For MCN plans, non-MCN office visits are subject to applicable out-of-network deductible and coinsurance. For plans with annual Office Visit limits, Office Visits in excess of those limits are subject to deductible and coinsurance. For HSA plans, the HSA deductible must be satisfied before this Office Visit benefit becomes available.

Open Enrollment Period – the last month of each Plan Year. Application must be made during the Open Enrollment Period and received by the Plan Administrator no later than 31 days following the end of the Open Enrollment Period.

Orthopedic Manipulation - manipulation involving the spine or any joint to assist in rehabilitation and restoration of previously existing normal bodily functions which were lost or compromised after illness or injury, but only if such treatment results in

measurable improvement and is provided by a Doctor or licensed chiropractor. This includes traction; inversion therapy; hot or cold packs; electrical stimulation therapy; vasopneumatic devices; diathermy; therapeutic exercise; neuromuscular reeducation; gait training; massage therapy; thermography; biofeedback therapy; hydrocollator therapy; passive motion therapy; acupressure; office visits and consultations.

Outpatient - a Covered Person who is receiving Medically Necessary services or supplies upon the advice of a Health Care Provider, acting within the scope of his license or certification and who is not an Inpatient.

Outpatient Visit - treatment of a Covered Person on an Outpatient basis, for a maximum of four (4) hours per visit.

Pediatric Services - Pediatric Vision Care and Preventive Care Services for Children.

Pediatric Vision Care - emergency, preventive and routine vision examinations for a Dependent Child up to age 19, as shown in the Schedule of Benefits, for the purpose of determining the need for corrective lenses, and if needed, to provide a prescription for corrective lenses. One (1) vision examination in any twelve (12) month period is covered, unless more frequent examinations are Medically Necessary as evidenced by appropriate documentation. The vision examination may include, but is not limited to:

1. Case history;
2. External examination of the eye or internal examination of the eye;
3. Opthalmoscopic exam;
4. Determination of refractive status;
5. Binocular distance;
6. Tonometry tests for glaucoma;
7. Gross visual fields and color vision testing; and
8. Summary findings and recommendation for corrective lenses.

Physical Impairment - a medically substantiated chronic condition resulting in the inability of the Covered Person to engage in any substantial gainful employment or activity, if that condition is expected to last for a continuous period of twelve (12) months or more. An impairment exists when a major life activity is substantially limited. Major life activities are defined to include “seeing, hearing, eating, sleeping, walking, standing, lifting, bending, speaking, bathing, learning.” The Plan has the discretionary authority to determine Physical Impairment. The Plan reasonably exercises its discretionary authority in determining Physical Impairment for any claim for Plan benefits.

The Plan has the discretionary authority to determine Physical Impairment. The Plan reasonably exercises its discretionary authority in determining Physical Impairment for any claim for Plan benefits.

Physical Therapy - treatment by: (a) manual manipulation or other physical means; (b) hydrotherapy; (c) heat; (d) physical agents; and (e) biomechanical and neurophysiological principles and devices; used to: 1. relieve pain; 2. restore maximum bodily function; or 3. prevent disability arising from Injury or Sickness. Physical Therapy does not include cardiac rehabilitation.

Placement for Adoption - the assumption and retention of a legal obligation for total or partial support of a Child under 18 years of age by a Covered Employee or his Spouse with whom the Child has been placed in anticipation of the Child’s adoption. Coverage under the Plan is available to an adopted child only if the child qualifies as an eligible Dependent Child under the Plan. Coverage of an adopted child is retroactive to the instant the child is adopted, subject to the adopted child qualifying as an eligible Dependent Child under the Plan and the timely submission of all required Plan enrollment forms and contributions for that child.

Plan - without qualification, means this self-funded employee welfare benefit plan in its entirety, sponsored, established and maintained by the Sponsoring Employer for its Employees and their Dependents, described by this SPD, and herein referred to as the Plan. References herein to the Plan include the Sponsoring Employer, and vice-versa, for purposes of administration and maintenance of the Plan, including required notices and payment of contributions.

Plan Year - the 12 consecutive month time period commencing as of the date designated by the Sponsoring Employer.

Preferred Provider Organization (PPO) - any preferred provider organization that has contracted with the Plan, on a non-exclusive basis, to provide Covered Persons with access to medical care and treatment at a discount, within a specific service area, and through a network of PPO Providers (or any PPO Provider that has negotiated a special fee arrangement with the Plan, to provide medical care and treatment to Covered Persons at a discount and on a non-exclusive basis). Benefits are payable at the MCN Reimbursement Rate only when a PPO Provider is used within the PPO service area.

PPO Provider - any Doctor, Hospital, Health Care Provider, clinic, or other entity on contract with a PPO, on a non-exclusive basis, to provide Covered Persons with access to medical care and treatment at a discount within that PPO's provider network (or a specific Hospital, Health Care Provider, clinic, or other entity that has negotiated a special fee arrangement directly with the Plan to provide medical care and treatment to Covered Persons at a discount and on a non-exclusive basis).

Pregnancy - pregnancy or childbirth, elective cesarean section or elective abortion. Coverage of the newborn child under the Plan is available only if the newborn qualifies as an eligible Dependent Child under the Plan. Coverage of the newborn is retroactive to the instant the child is born, subject to the newborn qualifying as an eligible Dependent Child under the Plan and the timely submission of all required Plan enrollment forms and contributions for that child.

Preventive Care Services - benefits defined as "preventive" in the Patient Protection and Affordable Care Act ("PPACA"), including: Preventive care services rated A or B by the U.S. Preventive Services Taskforce; immunizations recommended by the Advisory Committee on Immunization Practices of the Centers for Disease Control and Prevention; evidence informed preventive care and

screenings for infants, Children and adolescents in comprehensive guidelines supported by the Health Resources and Services Administration; and preventive care and screenings for women in comprehensive guidelines supported by the Health Resources and Services Administration. Please contact our Customer Service department at 1-800-825-7531 for additional information about these services or go to these federal government web sites: http://www.healthcare.gov/center/regulations/prevention.html ; or http://www.ahrq.gov/clinic/uspstfix.htm ; or http://www.cdc.gov/vaccines/recs/acip/ .
Examples of Preventive Care Services include, but are not limited to:

- Periodic health evaluations
- Preventive vision and hearing screening
- Blood pressure, diabetes, and cholesterol tests
- Cancer screenings, including FDA-approved human papillomavirus (HPV) screening test, mammograms and colonoscopies
- Counseling on various topics, including quitting smoking, losing weight, eating healthfully, treating depression, and reducing alcohol use
- Routine immunizations against diseases such as measles, polio, or meningitis
- Flu and pneumonia shots
- Counseling, screening, and immunizations to ensure healthy pregnancies
- Regular well-baby and well-child visits
- Well-woman visits

Preventive Care Services for women also include screening for gestational diabetes; sexually-transmitted infection counseling; human immunodeficiency virus (HIV) screening and counseling; FDA-approved contraception methods for women and contraceptive counseling; breastfeeding support, supplies and counseling; and domestic violence screening and counseling.
Qualified Domestic Relations Order (QDRO) - any judgment, decree or order (including approval of a property settlement agreement), issued pursuant to any state domestic relations law (including community property law) and meeting all QDRO requirements under federal law, that grants child support, alimony or marital property rights to a former Spouse of an Employee, and in addition orders the Employee to provide health benefit coverage for the former Spouse. The Plan has established procedures governing the qualification and processing of QDRO's. A copy of the procedures may be obtained from the Plan Administrator without charge.
Qualified Medical Child Support Order (QMCSO) - any judgment, decree or order issued by any state court or domestic relations magistrate, that orders an Employee or his Spouse to provide health benefit coverage for a Child. To qualify, the order must meet these requirements:

1. The name and last known address of the Employee or his Spouse;
2. The name and last known address of the Child (or state official or political subdivision);
3. A reasonable description of the health benefit coverage to be provided to the Child, or the manner in which such coverage is to be determined; and
4. The period of time to which the order applies.

The Plan has established procedures governing the qualification and processing of QMCSO's. A copy of the procedures may obtained from the Plan Administrator without charge.
Qualifying Existing Coverage - benefits or coverage provided under a Group Health Plan.
Rehabilitative Services and Devices - Medically Necessary health care services and devices provided by a physical therapist, occupational therapist, or speech therapist, that assist an individual in partially or fully recovering or reacquiring skills and functioning lost through Injury or Sickness, to the maximum extent practical. These services and devices address the skills and abilities needed for functioning while interacting with an individual's environment. Outpatient short-term rehabilitation, occupational therapy, speech therapy and physical therapy services are covered when the provision of such services can be expected to result in the significant improvement of a Covered Person’s condition.
Examples of health care services that are <u>not</u> rehabilitative services include, but are not limited to, respite care, day care, recreational care, residential treatment, social services, custodial care, or education services of any kind, including, but not limited to, vocational training.
Benefits are payable for speech, physical and occupational therapy only when ordered by a Doctor and such therapy is related to the treatment or diagnosis of a Covered Person’s Injury or Sickness;
Covered speech, physical and occupational therapy services must begin within [6] [six] months of the following:

a. The date of diagnosis of the Injury or Sickness that caused the need for the therapy;
b. The date the Covered Person is discharged from a Hospital where surgical treatment was rendered; or
c. The date Outpatient surgical care is rendered.

Residential Treatment Facility – a legally constituted and licensed institution with facilities established and organized for the care and treatment of nervous, emotional and mental disorders, including substance abuse on an Inpatient basis. This includes facilities for diagnosis and treatment under the supervision of a staff of one or more Doctors, that provide twenty-four (24) hour nursing service by licensed graduate registered nurses (RNs) on duty or call. Residential Treatment Facility excludes Custodial, Convalescent, Hospital, nursing, rest or Extended Care facilities.

Same Sex Marriage – a personal and consensual legal union, other than Marriage or Domestic Partnership or Civil Union, between two (2) men or two (2) women, as spouses of the same gender, validly entered into in a state that legally recognizes marriage between two (2) persons of the same gender, whether by state statute or common law, who are at least 18 years of age and not related by blood closer than that permitted by the Marriage laws of the state of residence of either individual.

Sickness - disease or illness, from the same or related causes, that results in medical expense or claim for benefits under the Plan. The term "Sickness" includes congenital malformation and Pregnancy. Pregnancy includes Complications of Pregnancy.

Skilled Nursing Care – 24 hour per day nursing services at a Skilled Nursing Facility for an adult Covered Person as a result of Injury or Sickness, but only if: 1) that Covered Person's medical condition no longer requires acute bed care and yet is too unstable for care at an Extended Care Facility, Convalescence Care Facility, Intermediate Care Facility, Outpatient facility or other long-term care facility; and 2) that Covered Person has a defined diagnosis and stable treatment plan.

Skilled Nursing Facility – a free-standing facility or section or wing of a Hospital, operated as part of a Hospital, duly licensed under applicable law as a Skilled Nursing Facility, providing Skilled Nursing Care 24 hours per day, delivered by licensed graduate registered nurses (RN's) or unlicensed personnel supervised by RN's, with such care directed or supervised by one or more Doctors.

Sound and Natural Tooth - a tooth which is totally intact with a root, pulp, and has no more than two surfaces restored and/or decayed, and no missing tooth structure due to fracture.

Special Enrollee - an Employee or Dependent whose enrollment for coverage under the Plan (on forms approved by Us) is not received by Us within 31 days of the date he first becomes eligible to become covered under the Plan, but who subsequently experiences one of the following events and requests enrollment within the required time:

1. The Employee previously declined coverage, acquires a new Dependent spouse or Child through marriage, birth, adoption or Placement for Adoption, and requests enrollment for he and his Dependent within 31 days of the date he acquired the new Dependent.
2. The Employee previously declined coverage for his Dependent spouse, acquires a new Dependent Child through birth, adoption or Placement for Adoption, and requests enrollment for his Dependent spouse and Child within 31 days of the date he acquired the new Dependent Child.
3. The Employee previously declined coverage for his Dependent Child, acquires a new Dependent spouse or Child through marriage, birth, adoption or Placement for Adoption, and requests enrollment for the Dependent Child and his newly acquired Dependent within 31 days of the date he acquired the new Dependent.
4. The Employee and/or Dependent was covered under Qualifying Existing Coverage at the time he first became eligible for coverage and:
    a. the Employee stated in a waiver of coverage form at the time he first became eligible for coverage under the Plan that Qualifying Existing Coverage was the reason he declined coverage;
    b. the Employee and/or Dependent lost coverage as a result of exhaustion of COBRA continuation coverage, termination of employment or eligibility for coverage, death of the Employee's spouse, the Employee's divorce from his spouse, or termination of Participating Employer contributions toward the coverage; and
    c. the Employee requests coverage for himself and/or his Dependent within 30 days of the date he lost such coverage.
5. With respect to an Employee and his Dependent spouse or Child, the Employee becomes legally required to provide coverage to the Dependent spouse or Child pursuant to a QDRO or QMCSO.
6. With respect to an Employee or any of his Dependents, he becomes eligible for employee contribution assistance under Medicaid or the Children's Health Insurance Program (CHIP), and requests enrollment within 60 days of being determined eligible.

Special Enrollment Period – the 31 day period immediately following the date an Employee or Dependent becomes eligible as a Special Enrollee. Application must be received by the Plan Administrator no later than the end of the Special Enrollment Period.

Specialty Prescription Drugs - Specialty drugs are high-cost prescription medications used to treat complex, chronic conditions. It includes all Tier 4 Drugs and typically require special handling, administration or monitoring. It also includes but does not limit to, blood modifiers (e.g. Epogen, Procrit), growth hormones, IGIV, Interferons and select drugs for treating enzyme deficiency, hemophilia and multiple sclerosis.

Speech Therapy – treatment for the loss or impairment of a previously existing level of speech, including examination, evaluation, counseling and testing necessary to diagnose such loss or impairment, provided by a speech pathologist or speech/language pathologist licensed by the applicable state board of healing arts and/or certified by the American Speech-Language and Hearing Association (ASHA), but only if such treatment is: 1) within the scope of that license or certification; 2) provided on an outpatient

basis; 3) expected by a Doctor to result in significant improvement of the Covered Person's speech; and 4) not arranged by or received under any health plan offered by any governmental body or entity, including school districts for their students.

Sponsoring Employer - the individual or entity (including but not limited to all forms of corporations, companies, partnerships, associations, agencies, firms or sole proprietors, whether public, private or government) who sponsors the Plan as an employee welfare benefit plan for its Employees and their Dependents. The Sponsoring Employer is the Plan Sponsor, Plan Administrator, Plan Fiduciary and Plan Trustee for purposes of the Employee Retirement Income Security Act ("ERISA"), Consolidated Omnibus Budget Reconciliation Act ("COBRA"), Health Coverage Portability and Accountability Act ("HIPAA") and the Patient Protection and Affordable Care Act ("PPACA"). Sponsoring Employer also means any affiliates or subsidiaries of the Sponsoring Employer. References herein to the Sponsoring Employer include the Plan, and vice-versa, for purposes of administration and maintenance of the Plan, including required notices and payment of contributions.

Spouse - an Employee's husband or wife by Marriage, or an Employee's spouse of the same gender by Same Sex Marriage, or an Employee's Domestic Partner by Domestic Partnership, or a Party in a Civil Union with an Employee, who is not legally separated or divorced from the Employee, and whose Marriage, Same Sex Marriage, Domestic Partnership or Civil Union with the Employee has not been legally annulled or otherwise dissolved. Spouse also includes an Employee's former Spouse, for whom the Employee is legally required to provide health benefit coverage pursuant to a QDRO.

Substance Use Disorder Services - medical care or treatment (including detoxification) for intoxication, addiction, dependence, abuse or substance withdrawal caused by alcohol or drugs, legal and illegal.

Surgical Procedure Expenses - Eligible Expenses for surgical services including professional charges (including the Doctor component for eligible Pregnancy expense), facility and supply charges for eligible surgical procedures.

Telemedicine – medical care or treatment provided by a Doctor using remote communications including telephone communication or monitoring or internet enable communication or monitoring.

Totally Disabled (Total Disability) - a Covered Employee who is prevented by reason of Bodily Injury or Sickness from engaging in and performing any and every duty pertaining to his employment and is not engaged in any occupation for wages or profit; a Dependent who is prevented by reason of Bodily Injury or Sickness from engaging in the normal activities of a person of like age and sex in good health and is not engaged in any work or occupation for wages or profit. The Plan has the discretionary authority to determine Total Disability. The Plan reasonably exercises its discretionary authority in determining Total Disability for any claim for Plan benefits.

Urgent Care - the delivery of Ambulatory Patient Services on an immediate basis, for the treatment of acute and chronic illness and injury, outside of an Emergency Services room or department at a Hospital.

Waiting Period - the period designated by the Sponsoring Employer that must pass before the Employee is eligible to enroll under the Plan.

Section 2 - ELIGIBILITY

ELIGIBILITY - EMPLOYEE

1. The class(es) of Employees eligible for coverage under the Plan shall be those classes designated by the Sponsoring Employer.
2. An Employee in an eligible class whose employment with the Sponsoring Employer began on or before the date the initial Plan Year commenced, and who has satisfied the Waiting Period (if any) for coverage eligibility, shall be eligible on the date the initial Plan Year commences.
3. An Employee in an eligible class whose employment with the Sponsoring Employer: (a) began on or before the date the initial Plan Year commenced but has **not** yet satisfied the Waiting Period, or (b) begins after the date the initial Plan Year commences and is subject to the Waiting Period, shall become eligible on the first day of the month coinciding with or immediately following the date that he completes his Waiting Period.
4. An Employee in an eligible class whose employment with the Sponsoring Employer begins after the date the initial Plan Year commences and who is **not** subject to a Waiting Period, shall be eligible on the first day of the month coinciding with or immediately following the first day of employment, subject to the **Eligibility-Late Enrollee Provisions**.

ELIGIBILITY - DEPENDENT

1. Each Employee in a class eligible for Dependent coverage under the Plan is eligible for coverage for their Dependents.
2. A Dependent becomes eligible on the later of the following dates:
    a. the date the Employee becomes eligible for coverage as an Employee under the Plan;
    b. the date the Employee first acquires the Dependent through marriage, birth, adoption or Placement for Adoption [Note: Placement for Adoption means the assumption and retention of a legal obligation for total or partial support of a Child under 18 years of age by a Covered Person with whom the Child has been placed in anticipation of the Child's adoption.];

ELIGIBILITY - LATE ENROLLEES

1. A Late Enrollee is an Employee or Dependent who fails to enroll within 31 days of the date he first became eligible, or in the case of a newly acquired Dependent fails to apply for coverage within 31 days from the date of the marriage, birth, adoption or Placement for Adoption, and does not subsequently qualify as a Special Enrollee.
2. A Late Enrollee, whether an Employee (with respect to himself or any of his Dependents) or a Dependent, will not become eligible until the first day of the month of the next Open Enrollment Period (or until the next Special Enrollment Period, whichever occurs first).

ELIGIBILITY - SPECIAL ENROLLEES

We will not consider an Employee (with respect to himself or any of his Dependents) or a Dependent to be a Late Enrollee if he subsequently experiences one of the following events and requests enrollment within the required time:

1. The Employee previously declined coverage, acquires a new Dependent spouse or Child through marriage, birth, adoption or Placement for Adoption, and requests enrollment for he and his Dependent within 31 days of the date he acquired the new Dependent.
2. The Employee previously declined coverage for his Dependent spouse, acquires a new Dependent Child through birth, adoption or Placement for Adoption, and requests enrollment for his Dependent spouse and Child within 31 days of the date he acquired the new Dependent Child.
3. The Employee previously declined coverage for his Dependent Child, acquires a new Dependent spouse or Child through marriage, birth, adoption or Placement for Adoption, and requests enrollment for the Dependent Child and his newly acquired Dependent within 31 days of the date he acquired the new Dependent.
4. The Employee and/or Dependent was covered under Qualifying Existing Coverage at the time he first became eligible for coverage and:
    a. the Employee stated in a waiver of coverage form at the time he first became eligible for coverage under the Plan that Qualifying Existing Coverage was the reason he declined coverage;
    b. the Employee and/or Dependent lost coverage as a result of exhaustion of COBRA continuation coverage, termination of employment or eligibility for coverage, death of the Employee's spouse, the Employee's divorce from his spouse, or termination of Participating Employer contributions toward the coverage; and
    c. the Employee requests coverage for himself and/or his Dependent within 30 days of the date he lost such coverage.
5. With respect to an Employee and his Dependent spouse or Child, the Employee becomes legally required to provide coverage to the Dependent spouse or Child pursuant to a QDRO or QMCSO.
6. With respect to an Employee or any of his Dependents, he becomes eligible for employee contribution assistance under Medicaid or the Children's Health Insurance Program (CHIP), and requests enrollment within 60 days of being determined eligible.

Section 3 - EFFECTIVE DATE OF EMPLOYEE AND DEPENDENT COVERAGE

EFFECTIVE DATE OF COVERAGE - EMPLOYEE

1. Employee coverage shall be effective on the contribution due date that coincides with or next follows the date the Employee's enrollment form is approved by Us, if that enrollment was on the form approved by Us for this purpose and received by Us within 31 days of the date he first became eligible, and We receive all required contributions.
2. If an Employee is not Actively at Work, at his usual place of employment with the Sponsoring Employer on the effective date of his coverage, We will defer the effective date of his coverage until the date immediately following his return to Active Work at his usual place of employment.

EFFECTIVE DATE OF COVERAGE - DEPENDENT

1. Dependent Coverage shall be effective on the date the Employee coverage becomes effective under the Plan, if that Dependent enrollment was on the form approved by Us for this purpose and received by Us within 31 days of the date the Employee first became eligible, and We receive all required contributions.
2. If a Covered Employee does not have Dependent Coverage in effect, and subsequently acquires a Dependent spouse or Child, coverage for the newly acquired Dependent shall be effective on the contribution due date that coincides with or next follows the date the enrollment form for that newly acquired Dependent is approved by Us, if: We receive the enrollment form within 31 days of the date the newly acquired Dependent first became eligible (on the form approved by Us for this purpose); and We receive any required additional contributions.

3. If an Employee has a Dependent Child covered under the Plan, and subsequently acquires an additional Dependent Child other than a newborn or adopted Child, coverage for the newly acquired Dependent Child shall be effective on the contribution due date that coincides with or next follows the date the enrollment form for that newly acquired Dependent Child is approved by Us, if: We receive the enrollment form within 31 days of the date the Child first became eligible (on the form approved by Us for this purpose); and We receive any required additional contributions.
4. If an Employee has a Dependent Child covered under the Policy, and subsequently acquires a newborn or adopted Dependent Child, coverage for the newly acquired newborn or adopted Dependent Child is automatically effective the instant the Child is born, adopted or Placed for Adoption, if: the child qualifies as a Dependent Child under the Plan, we receive the enrollment form within 31 days of the date of the Child's birth, adoption or Placement for Adoption (on the form approved by Us for this purpose), and We receive any required additional contributions. **Important**: The retroactive coverage for a newly acquired newborn or adopted Dependent Child is subject to that child qualifying as a Dependent Child under the Plan and the timely submission of the enrollment form. If we do **not** receive the enrollment form within 31 days of the Child's birth, adoption or Placement for Adoption (on the form approved by Us for this purpose and with any required additional contributions), **all** coverage for that child is forfeited (on and after the date of the Child's birth, adoption or Placement for Adoption) (until the next Open Enrollment Period or Special Enrollment Period, whichever occurs first).

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EFFECTIVE DATE OF COVERAGE - LATE ENROLLEES

Coverage for Late Enrollees, whether an Employee (with respect to himself or any of his Dependents) or a Dependent, shall be effective the first day of the month coinciding with or immediately following the close of the next Open Enrollment Period (or the next Special Enrollment Period, whichever occurs first), if the enrollment form, on a form approved by Us for this purpose, is received by Us within 31 days of the end of that Open Enrollment Period (or Special Enrollment Period, whichever occurs first) and approved by Us, and We receive all required contributions.

EFFECTIVE DATE OF COVERAGE - SPECIAL ENROLLEES

Coverage for Special Enrollees, whether an Employee (with respect to himself or any of his Dependents) or a Dependent, shall be effective as follows:

1. If an Employee previously declined coverage, then acquires a new Dependent through marriage, birth, or adoption or Placement for Adoption and requests enrollment for he and his new Dependent within 31 days of the date he acquired the new Dependent (on the form approved by Us for this purpose), and We receive all required contributions, coverage shall be effective on the contribution due date that coincides with or next follows the date the Employee's enrollment form is approved by Us.
2. If an Employee previously declined coverage for his Dependent spouse, then acquires a new Dependent Child through birth, adoption or Placement for Adoption, and requests enrollment for his Dependent spouse and Child within 31 days of the date he acquired the new Dependent Child (on the form approved by Us for this purpose), and We receive all required contributions, coverage shall be effective on the contribution due date that coincides with or next follows the date the enrollment form for the Dependent spouse and Child is approved by Us.
3. If an Employee previously declined coverage for his Dependent Child, then acquires a new Dependent spouse or Child through marriage, birth, adoption or Placement for Adoption, and requests enrollment for the Dependent Child and his newly acquired Dependent within 31 days of the date he acquired the new Dependent (on the form approved by Us for this purpose), and We receive all required contributions, coverage shall be effective on the contribution due date that coincides with or next follows the date the enrollment form for his Dependent Child and newly acquired Dependent is approved by Us.
4. If an Employee and/or Dependent was covered under Qualifying Existing Coverage at the time he first became eligible for coverage, coverage shall be effective on the contribution due date that coincides with or next follows the date the Employee and/or Dependent enrollment form is approved by Us, if:
    a. the Employee stated in a waiver of coverage form at the time he first became eligible for coverage under the Plan that Qualifying Existing Coverage was the reason he declined coverage;
    b. the Employee and/or Dependent lost coverage as a result of exhaustion of COBRA continuation coverage, termination of employment or eligibility for coverage, death of the Employee's spouse, the Employee's divorce from his spouse, or termination of Sponsoring Employer contributions toward the coverage; and
    c. the Employee requests coverage for himself and/or his Dependent within 30 days of the date he lost such coverage (on the form approved by Us for this purpose) and We receive all required contributions.
5. If an Employee becomes legally required to provide coverage to his Dependent spouse or Child pursuant to a QDRO or QMCSO, coverage shall be effective for the Dependent spouse or Child (and the Employee if not already enrolled) on the contribution due date that coincides with or next follows the date We receive the QDRO or QMCSO, subject to receipt of all required contributions.
6. If an Employee or any of his Dependents becomes eligible for employee contribution assistance under Medicaid or the Children's Health Insurance Program (CHIP), and requests enrollment (on the form approved by Us for this purpose) within

60 days of being determined eligible for such assistance, and We receive all required contributions, coverage shall be effective on the contribution due date that coincides with or next follows the date the enrollment form is approved by Us.

Section 4 - SCHEDULE OF BENEFITS

No Employee shall be covered under the Plan for amounts of coverage for himself or his Dependent other than as provided in this Schedule of Benefits and Section 9 - PART EDMM. For specific benefits, refer to the SPD Face Page.

SCHEDULE OF BENEFITS

(Refer to specific section of SPD for complete explanation of each benefit.)

IMPORTANT NOTICES

Plan benefits are subject to the Fair & Reasonable Charge limitation, Maximum Allowable Charge limitation and all other limitations in this SPD (Plan Limitations). If a provider charges an amount above a Plan Limitation, you may be billed for the excess charge. If this occurs, please contact Allied National Customer Service at 800-825-7531 for assistance in resolving your bill.

The Plan pays benefits based on the lesser of the billed charge, or the Fair and Reasonable Charge, or the maximum benefit under the Plan (if any), or a percentage of the amount that Medicare considers payment in full (Medicare Allowable Charge).

OPTIONAL EMPLOYEE AND DEPENDENT OUTPATIENT PRESCRIPTION BENEFIT

(Important: Enhanced Benefits may be available (subject to availability and eligibility)**.**
Refer to the Health Care Coordination Program in Section 8d - Health Care Coordination)

If the outpatient prescription benefit is elected by the Sponsoring Employer, Covered Persons will receive prescription drug cards from a Prescription Drug Card Service (PDCS). To access the outpatient prescription benefit, the drug card must be presented to a pharmacy participating in the PDCS.

Specialty Prescription Drugs including all Tier 4 Drugs, and all high-cost drugs with an ingredient cost over $1,000.00 per filled prescription are not covered by the PDCS.

Deductibles, Copayments and Coinsurance

Prescribed Over-the Counter (OTC) Drugs[1]	Included
Deductible	None
Copayment	$3.00
Mail Order Copayment	$3.00
Coinsurance	100%[2]
Generic Prescription Drugs	Included
Deductible	None
Copayment (Non-Diabetes[3] Drugs)	$10.00
Copayment (Diabetes[3] Drugs)	$40.00
Mail Order Copayment (Non-Diabetes[3] Drugs)	$10.00
Mail Order Copayment (Diabetes[3] Drugs)	$40.00
Coinsurance	100%[2]
Brand Name Prescription Drugs (Formulary)	Included
Deductible	$00
Copayment (Non-Diabetes[3] Drugs)	$30.00
Copayment (Diabetes[3] Drugs)	$60.00
Mail Order Copayment (Non-Diabetes[3] Drugs)	$60.00
Mail Order Copayment (Diabetes Drugs)	$90.00
Coinsurance	100%[2]
Brand Name Prescription Drugs (Non-Formulary)	Included
Deductible	$00
Copayment (Non-Diabetes[3] Drugs)	$50.00
Copayment (Diabetes[3] Drugs)	$80.00

Mail Order Copayment (Non-Diabetes[3] Drugs) $100.00

Mail Order Copayment (Diabetes[3] Drugs) $130.00

Coinsurance ..... 100%[2]

Specialty Prescription Drugs ..... Not Included

[1] Prescribed OTC Drugs include, but are not limited to, Claritin, Zyrtec and Prilosec.*

[2] Of Maximum Allowable Cost (MAC). MAC means the ceiling price, as established by the PDCS, on the generic equivalent of a brand name drug. If the Covered Person requests a brand name drug, he must pay the difference in price between the requested brand name drug and the MAC, unless a generic equivalent is unavailable, or a brand name drug is specified "Dispense As Written" (DAW) by the Doctor, or is dispensed per the professional judgment of the pharmacist.*

[3] Diabetes Drugs: "Diabetes Drugs" are drugs or medications prescribed to treat Diabetes. Enhanced Benefits for Diabetes Drug Prescriptions are available if an eligible Covered Person elects to participate in a Diabetes Coaching Program through a Preferred Facility. Under the Enhanced Benefits, all eligible Diabetes Drugs are provided free of charge (i.e., the above-noted Deductibles, Copayments and Coinsurance are waived).**

*Drug formularies are established and maintained by the PDCS. For more information, visit the PDCS website listed on the Plan ID card.

Maximum Benefits

Combined Calendar Year Maximum Benefit per Covered Person for OTC and Generic Prescription Drugs ..... Unlimited

Combined Calendar Year Maximum Benefit per Covered Person for
Brand Name (Formulary), Brand Name (Non-Formulary) and Specialty Prescription Subject to Calendar Year Maximum Aggregate Benefit

Maximum Supply Per Prescription Order (other than by mail) ..... 30 days

Maximum Supply Per Prescription Mail Order ..... 90 days

Maximum Benefit for Prescription Drugs purchased outside the United States ..... The amounts payable under the Tourism Prescription Benefit

NOTE: This benefit is subject to all limitations and exclusions in the SPD, including the Pre-Notification Program, DAW and MAC pricing and all limitations and exclusions stated in Section 9, Part EDOP, Paragraphs 2, 3, 3c and 7.

Enhanced Benefits

Variable Copay Program: If available* under the Plan, the out-of-pocket obligation for an eligible Covered Person's prescription drug may be reduced or eliminated by a drug manufacturer's co-payment subsidy.

If you are eligible to receive a manufacturer copay subsidy for a drug, your copay obligation for that drug will be the maximum manufacturer copay subsidy for that drug. **Note: Any manufacturer copay subsidy obtained under the Variable Copay™ Program will not accumulate toward your deductible or out of pocket costs.** If you are not eligible to receive a manufacturer copay subsidy, your copay obligation will be the copay amount listed for the drug in the standard formulary under the plan. **Note: if you are eligible for a manufacturer copay subsidy for a drug but fail to obtain the subsidy, your copay obligation—and the out-of-pocket cost you may be required to pay—will be the maximum manufacturer copay subsidy for that drug.** A detailed schedule of subsidies available through manufacturer copay programs under the Variable Copay™ Program is available at crxspecialty.com or may be accessed free of charge by contacting (877)646-1716.

Manufacturer Free Drug Initiative: If available* under the Plan, the out-of-pocket obligation for an eligible Covered Person's prescription drug may be eliminated by a drug manufacturer's Free Drug Initiative. If you are not eligible for, or if you do not receive a Free Drug Initiative from a manufacturer (or another entity) after applying, your out-of-pocket obligation for a prescription drug will be at the amount listed for the drug in the standard formulary under the plan.

Tourism Prescription Benefit: If available* under the Plan, Mail-Order Prescriptions from Tier 1 Countries (such as Canada, UK, Australia and New Zealand) are provided via mail-order pharmacies for 90-day supplies of brand name drugs (30-day supplies for specialty medications) for $0.00 copays.**

Diabetes Medications: Enhanced Benefits for Diabetes Drug Prescriptions are available if an eligible Covered Person elects to participate in a Diabetes Coaching Program through a Preferred Facility. Under the Enhanced Benefits, all eligible Diabetes Drugs are provided free of charge (i.e., the above-noted Deductibles, Copayments and Coinsurance are waived)**.

Select Generic and Brand Mail Order Program: Eligible medications may be provided free of charge**.

*Discount or No Cost formularies are established and maintained by the PDCS. For more information, visit the PDCS website listed on the Plan ID card.

** Covered Persons enrolled in a qualified HSA high deductible health plan may not be eligible for all Enhanced Benefits, such as waiving the deductible.

OPTIONAL SUPPLEMENTAL ACCIDENT EXPENSE COVERAGE

(Available only if this optional benefit was elected by the Sponsoring Employer)

Maximum Supplemental Accident Benefit per Covered Person per Accident
(not subject to any Copay, Deductible Amounts or Coinsurance) ..... $ 0.00

OUTPATIENT DIALYSIS TREATMENT BENEFIT

Maximum Outpatient Dialysis Treatment Benefit
(subject to all Copays, Deductible Amounts and Coinsurance) ..... 120% of Medicare Allowable Charges

SPECIAL BENEFIT ELECTIONS BY EMPLOYER

Optional HealthChoices Benefit ..... **No**

MAJOR MEDICAL EXPENSE COVERAGE

Eligible Expenses

(Important: Enhanced Benefits may be available, subject to availability and eligibility. Refer to the Health Care Coordination Program in Section 8d – Health Care Coordination)

Eligible Expenses

Maximum Allowable Charges incurred for Medically Necessary services and supplies listed in paragraph 2 of Section 9 - PART EDMM, subject to the definition of Eligible Expenses in Section 1, the Health Care Coordination Program in Section 8d – Health Care Coordination, and the Limitations and Exclusions in paragraph 7 of Section 9 – PART EDMM.

Deductible Amounts

Deductible Amount per Calendar Year per Covered Person* $2500.00
Deductible Amount per Calendar Year per Family* $5000.00
Deductible Waived for Outpatient treatment through Preferred** Facilities for Nervous, Emotional or Mental Disorders or Substance Abuse Disorders (including Detoxification) $0.00
*Deductible, Copayments and Coinsurance do not apply to Preventive Care Services.

Enhanced Benefits

Deductibles, Copays and Coinsurances waived for the following services when received through a Preferred Facility**

- Diabetes, Weight & Hypertension Coaching
- Diabetic Testing Supplies
- Stress, Depression & Anxiety Coaching
- Chronic Pain Coaching
- Second Opinion Review Services
- Telehealth***
- Complex Imaging Including MRI and CT scans***
- Outpatient Laboratory***
- Outpatient Procedures***

** Subject to designation of the program or facility as "Preferred" by the Plan, availability of the program or facility, and the Covered Person's eligibility for and participation in the program or facility.
*** Covered Persons enrolled in a qualified HSA high deductible health plan may not be eligible for all Enhanced Benefits, such as waiving the deductible.

Copayments and Coinsurance Percentages

Coinsurance Percentages are payable by the Plan for Eligible Expense in each Calendar Year after the applicable Copay or Deductible Amount(s) per Covered Person is (are) satisfied. The Copayment is payable by the Covered Person. The Eligible Expense is reduced by the amount of the copayment. The Deductible will be waived for any Eligible Expenses for which a Copayment is specified.

The Sponsoring Employer has selected traditional indemnity benefits for your Plan. Therefore, you are free to use any provider without incurring an out-of-network penalty. The designation of a primary care physician is also not required.

Preventive Services[1]:
Coinsurance.....100%
Office Visit Services[2]:
Copayment per visit.....$30.00
Coinsurance.....100%

Maximum Eligible Benefit: $500
Non-Surgical Outpatient Expense:
Coinsurance.....70%
Surgical Outpatient Expense:
Coinsurance.....70%

Inpatient Admissions:
Coinsurance.....70%
Urgent Care Services:
Copayment per admission[2]*.....$50.00
Coinsurance.....100%
Benefits then payable the same as for Office Visit Services after the Copayment.
Emergency Room Services:
Coinsurance.....70%

[1] Copayments and Coinsurance do not apply to Preventive Care Services.
[2] Copayments and Coinsurance do not apply to Office Visit Services for Preventive Care Services.

Maximum Amount of Total Out-of-Pocket Eligible Expense

If, during the same Calendar Year, a Covered Person incurs: $5000.00 of Out-of-Pocket Eligible Expense, any additional Eligible Expense incurred by the Covered Person in the remainder of the Calendar Year is payable at 100% Coinsurance, subject to any Maximum Benefit shown in the Schedule of Benefits. The Maximum Amount of Total Out-of-Pocket for Eligible Expense is deemed to have been satisfied during any Calendar Year for all persons in a Family once their combined Total Out-of-Pocket Eligible Expense equals two (2) times the individual Total Out-of-Pocket Eligible Expense.

Extended Care Facility

Extended Care Facility.....Not to exceed 60 days during a Calendar Year

Lifetime Maximum Aggregate Benefits

Lifetime Maximum Aggregate Benefit.....Unlimited*

* Except as otherwise indicated in this Schedule of Benefits and Section 9 - PART EDMM.

Maximum Benefits by Expense

Maximum Benefit per Human Organ or Tissue Transplant: .....50% of Eligible Expenses[1]
Maximum Benefit per Covered Human Organ or Tissue Transplant from a Donor..... $10,000.00
If HealthChoices is elected by the Employer as shown above, the Maximum Benefit for Non-Emergency Complex Medical Conditions, Complex Imaging, or Outpatient Procedures .....50% of Eligible Expenses[1]
Calendar Year Maximum Inpatient Days for Hospital Confinement for Nervous, Emotional or Mental Disorders or Substance Abuse Disorders (Including detoxification)* ..... up to 31 days
Calendar Year Maximum Outpatient Visits for Nervous, Emotional or Mental Disorders or Substance Abuse Disorders (Including detoxification)* .....up to 26 visits
Lifetime Maximum Benefit for Hospice Care ..... One benefit period not to exceed 6 months
Calendar Year Maximum Benefit for Home Health Care.....40 Visits, Limited to 1 Visit per Day
Calendar Year Maximum Benefit for Skilled Nursing Facility services .....60 days
Calendar Year Maximum Benefit for Orthopedic Manipulation .....Limited to 20 visits per Calendar Year

Implantable Devices and Durable Mechanical Medical Equipment ..... 150% of Cost
Outpatient Habilitative Services ..... Limited to 40 visits (4 hours each) per Calendar Year
Pregnancy[2] (including complications of pregnancy, voluntary abortion, maternity and well-baby care) ..... benefits payable in the same manner and to the same extent as for any Sickness covered under this Plan
Emergency Air Ambulance Transportation ..... 150% of Cost, up to a Maximum Benefit of $15,000.00 per flight to the nearest qualified Hospital for an Emergency Medical Condition.
Non-Emergency Air Ambulance Transportation ..... 50% of Eligible Expenses for Medically Necessary Non-Emergency Transport, up to a Maximum Benefit of $7,500.00 per flight[1]

[1] Enhanced benefits may be available (subject to availability and eligibility). Refer to the Health Care Coordination Program in Section 8d - Health Care Coordination

[2] If a Covered Person, while covered under the Plan, incurs Eligible Expense as a result of pregnancy, we will pay benefits for the Eligible Expense in the same manner and to the same extent as for any Sickness covered under the Plan. Coverage under this benefit shall be for a minimum of forty-eight (48) hours of Inpatient care following a vaginal delivery and a minimum of ninety-six (96) hours of Inpatient care following a cesarean section for a mother and her newly born child in a Hospital or any other health care facility licensed to provide obstetrical care. A shorter length of Hospital stay may be authorized if it meets with the approval of the attending Doctor after consulting with the mother. Coverage of the newborn child under the Plan is available only if the newborn qualifies as an eligible Dependent Child under the Plan. Coverage of the newborn is retroactive to the instant the child is born, subject to the newborn qualifying as an eligible Dependent Child under the Plan and the timely submission of all required enrollment forms and contributions for that child.

*If the Plan Sponsor employed an average of at least fifty-one (51) employees during the preceding calendar year, Eligible Expenses incurred for Nervous, Emotional or Mental Disorders or Substance Abuse Disorders (Including detoxification) shall be covered the same as any other Sickness.

Medicare Allowable Charge Percentage

The Medicare Allowable Charge multiplied by the following percentages:

Facility services and supplies 150%

Physician services and supplies 125%

Deductible Expense Credit

A credit will be granted for the deductible amount satisfied under the health benefit plan that this Plan replaces, if that amount was satisfied during the 90 days prior to the Effective Date, or during the current Calendar Year, whichever time period is greater.

OPTIONAL OCCUPATIONAL EXPENSE BENEFIT
FOR CORPORATE OFFICERS, OWNERS AND PARTNERS ..... Included

With respect only to a Covered Employee who is also an officer, owner, or partner of the Sponsoring Employer, and subject to all limitations and exclusions in this SPD, the Major Medical Expense benefits provided under the Plan shall be payable for any Eligible Expenses caused by, incurred for, or resulting from Bodily Injury or Sickness which arises out of or in the course of his employment for wage or profit with the Sponsoring Employer.

Section 5 - TERMINATION OF COVERAGE

TERMINATION OF COVERAGE - EMPLOYEE

The Coverage of an Employee and his Dependents shall automatically terminate on the earliest of the following dates:

1. The date the Plan terminates;
2. The date any Section or Part of the Plan terminates, as respects coverage under that Section or Part;
3. The date the Plan is amended to terminate the eligibility of any class of Employee of which the Employee is a member;
4. The end of the last period for which the last required contribution is paid by the Employee for his coverage;
5. The date the Employee enters the armed forces of any country, state or international organization, other than for reserve duty of 30 days or less;
6. The first of the month that coincides with or next follows the date on which the Employee is no longer eligible;
7. The date the Employee's coverage is terminated because of:
    a. failure to provide any signed release, consent, assignment or other documents requested by the Plan;
    b. failure to fully cooperate with the Plan in the administration of the Plan;
    c. material misrepresentation or fraud on any enrollment form, or in requesting the receipt of benefits under the Plan; or
    d. misuse by the Employee of his identification card;

Coverage shall not be rescinded except for fraud or intentional misrepresentation of a material fact.

1. The first of the month that coincides with or next follows the date the Employee's employment is terminated. Termination of employment occurs on the date the Employee is no longer Actively at Work as a member of any class of Employee eligible for coverage under the Plan. Provided, however, that:
    a. coverage may be continued during any period when the Employee is absent from Active Work due to a disability because of Sickness or Bodily Injury which prevents him from performing the duties of his occupation, or during an approved leave of absence or temporary layoff, but not to exceed a period of three (3) months. Successive periods of disability which are separated by less than one month of Active Work are considered a single period of disability for establishing the maximum continuation of coverage period;
    b. upon termination of employment, payment by the Sponsoring Employer in lieu of vacation or other severance compensation shall not extend the term of employment;
2. The first of the month that coincides with or next follows the date on which a former Employee's coverage terminates under any continuation law applicable to the Group Health Plan that this Plan replaces; or
3. The date the Employee has received benefits under the Plan up to the Lifetime Maximum Aggregate Benefit under the Major Medical Expense Coverage. This provision applies only to medical expenses that do not qualify as Essential Health Benefits.

TERMINATION OF COVERAGE - DEPENDENT

A Dependent's Coverage also terminates on the earliest of the following dates:

1. The date the Plan is amended to terminate the eligibility of any class of Employee eligible for Dependent Coverage of which the Employee is a member;
2. The first of the month that coincides with or next follows the date on which the Employee's Coverage under the Plan terminates;
3. The end of the last period for which the last required contribution is paid by the Employee for the Dependent's Coverage;
4. The first of the month that coincides with or next follows the date on which the Employee ceases to be eligible for Dependent Coverage under the Plan;
5. The date the Plan specifies that the Dependent Coverage of an Employee is terminated because of:
    a. failure to provide any signed release, consent, assignment or other documents requested by the Plan;
    b. failure to fully cooperate with the Plan in the administration of the Plan;
    c. material misrepresentation or fraud on any enrollment form, or in requesting the receipt of benefits under the Plan; or
    d. misuse by the Employee, or his Dependents, of the Employee's identification card;

Coverage shall not be rescinded except for fraud or intentional misrepresentation of a material fact.

1. The date the Dependent enters the armed forces of any country, state or international organization, other than for reserve duty of thirty (30) days or less;

2. With respect to an Employee's covered Spouse, the first of the month that coincides with or next follows the date on which the Employee is legally separated or divorced from his Spouse, or the date on which the Employee's Marriage, Same Sex Marriage, Domestic Partnership or Civil Union with his Spouse is legally annulled or otherwise dissolved;

3. The first of the month that coincides with or next follows the date on which an eligible Dependent Child no longer qualifies as a "Dependent", except that, if, upon attaining any limiting age, a Dependent Child because of Mental or Physical Incapacity, as defined below, is incapable of earning his own living and is chiefly dependent upon the Employee for support and maintenance, coverage for that Dependent Child may be continued if the required contribution is paid by the Employee during the time of incapacity, provided that:

    a. proof, in writing, of the incapacity is given to the Plan within thirty-one (31) days after the date on which the Dependent Child reaches the limiting age;

    b. the Plan will have the right any time during the continuation of coverage under this provision to require proof of the incapacity and to have the Dependent Child examined by Doctors designated by the Plan at any time during the first two (2) years of the continuation but not more often than once each year thereafter; and

    c. this continuation will terminate with the occurrence of any event described in paragraphs 1 through 6 above, and paragraph 9 below.

4. Mental or Physical Incapacity means a mental or physical impairment that results in anatomical, physiological or psychological abnormalities as demonstrated by medically acceptable clinical or laboratory diagnostic techniques and which are expected to last for a continuous period of time not less than twelve (12) months; or

5. The date the Dependent has received benefits under the Plan up to the Lifetime Maximum Aggregate Benefit under the Major Medical Expense Coverage. This provision applies only to medical expenses that do not qualify as Essential Health Benefits.

Section 6 - CONTRIBUTIONS

1. A Covered Person must pay required contributions for coverage under the Plan as they become due. Failure of a Covered Person to pay any required contribution on time will result in the termination of coverage.
2. The Plan reserves the right to change the contribution rates by giving written notice to Covered Persons at least sixty (60) days in advance of the change.
3. If any change or clerical error affects contributions, an equitable adjustment in contributions shall be made on the first of the month next following the date of the change or the discovery of the error. Any contribution adjustment shall be limited to the twelve (12) months immediately preceding the date of determination that the adjustment in contribution should be made.
4. Contributions are payable in advance to the Sponsoring Employer.

Section 7 - TERMINATION OF PLAN

The Plan terminates, in whole or part, on the earliest of the following dates, subject to the terms of the Plan and compliance with applicable law:

1. The date the Sponsoring Employer terminates, suspends or withdraws the Plan, or amends or modifies the Plan with respect to a particular benefit or employee class;
2. Three (3) months following the date the following Plan participation levels are no longer maintained, if those participation levels are not reestablished within that three (3) month period:
    a. Participation by a minimum of two (2) eligible Employees; and
    b. Participation by a minimum of 75% of the total number of eligible Employees.
3. The date the MCN network with which the Plan has contracted, or any replacement MCN network, is no longer accessible by Covered Persons.

Section 8 - GENERAL PROVISIONS

PURPOSE

This SPD sets forth the provisions of this Self-Funded Group Health Plan (the Plan), established and maintained by the Sponsoring Employer for the exclusive benefit and participation of its eligible Employees and their eligible Dependents. The purpose of the Plan is to provide for the payment or reimbursement of all or a portion of eligible medical expenses. This SPD supersedes and replaces any and all other plan documents, summary plan descriptions or amendments that may have been distributed by the Plan or the Sponsoring

Employer. The benefits described herein are available to an Employee or Dependent only if that person is covered under the Plan and all required contributions for such coverage have been received by the Plan. This SPD is subject to the provisions of the Plan Document and the terms of the Plan are intended to be legally enforceable.

PLAN INTERPRETATION

The Sponsoring Employer, in its capacity as the Plan Administrator, has full discretionary authority to interpret and apply all Plan provisions, including, but not limited to, all issues concerning eligibility and determination of benefits. The Plan Administrator may contract with an independent third-party administrator (TPA) to process enrollments, adjudicate claims, maintain Plan data, provide health care coordination and perform other Plan connected services. However, final authority to construe and apply Plan provisions rests exclusively with the Plan Administrator. Decisions of the Plan Administrator, made in good faith, are final and binding.

ADMINISTRATIVE SERVICES ONLY

If the Plan Administrator contracts with an independent TPA, the TPA shall provide only ministerial, non-fiduciary administrative services. Any such TPA shall not assume Plan Administrator or other fiduciary obligations and shall not be responsible for any financial risk or obligation of the Plan. The Plan is a self-funded health plan and the Sponsoring Employer assumes all financial risk and obligation thereunder, including payment of benefits for claims.

CONTRIBUTIONS TO THE PLAN

The Sponsoring Employer shall from time to time evaluate the costs of the Plan and determine the amount to be contributed by the Sponsoring Employer (if any) and the amount to be contributed (if any) by each covered Employee. The Plan will notify each covered Employee in writing of any changes.

PLAN IS NOT A CONTRACT

This SPD does not give any Employee the right to continued employment with the Sponsoring Employer and does not interfere with the right of the Sponsoring Employer to discharge or otherwise terminate the employment of any Employee. The coverage of an Employee under the Plan (including Dependent coverage, if any) may be rescinded by the Plan for fraud or misrepresentation of material fact by the Employee in his enrollment form (a copy of which is attached hereto) or in a claim for benefits.

NOTICE AND PROOF OF CLAIM

Written notice of loss upon which a claim for benefits under the Plan may be based must be given to the Plan within thirty (30) days of the date of such loss. Notice given by or on behalf of the claimant to the Plan, with particulars sufficient to identify the Covered Person, is considered to be notice to the Plan. Failure to file notice of claim within 30 days shall not invalidate or reduce any claim if it was not reasonably possible to give notice within that time period and notice is then given as soon as reasonably possible. In no event shall notice be given later than ninety (90) days from the date of the loss, except if the claimant lacks the legal capacity to give notice.

Written proof of loss upon which a claim for benefits under the Plan may be based, covering the occurrence, character and extent of loss, must be furnished to the Plan not later than ninety (90) days after the date of such loss. Proof given by or on behalf of the claimant to the Plan, with particulars sufficient to determine the occurrence, character and extent of loss, is considered to be proof of loss. Failure to file proof of loss within 90 days shall not invalidate or reduce any claim if it was not reasonably possible to submit proof within that time period and written proof is then given as soon as reasonably possible. In no event shall proof of loss be submitted later than six (6) months from the date of the loss, except if the claimant lacks the legal capacity to submit proof.

The Plan, at the Plan's own expense, has the right and opportunity to examine the person whose Bodily Injury or Sickness is the basis of a claim under the Plan when and so often as it may reasonably require during the pendency of such claim.

AUTHORITY, AMENDMENT AND ALTERATION

None of the terms of the Plan may be modified, nor any forfeiture under it waived, except by an agreement in writing signed by the Sponsoring Employer. The Sponsoring Employer's authority for this purpose cannot be delegated. The Plan may be amended or changed at any time by the Sponsoring Employer, subject to applicable law, without the consent of the individual persons covered under the Plan or their beneficiaries, if any. No agent or person, other than as stated above, shall have the authority to change the Plan or otherwise waive any requirements or provisions of the Plan. No change in the Plan shall be valid unless evidenced by endorsement on the Plan or by an amendment to the Plan signed by the Sponsoring Employer.

TERMINATION OF PLAN

The Sponsoring Employer reserves the right at any time to terminate the Plan, subject to due written notice as may be required under applicable law. All Plan contributions, whether contributed by the Sponsoring Employer or Employees, shall continue to be applied for the exclusive purposes of providing benefits to Plan participants or defraying Plan expenses, until all such contributions are exhausted.

TIME OF PAYMENT OF CLAIMS

Any benefits provided in the Plan will be paid within thirty (30) days of due written proof of the loss (or as may be required under applicable law). If any such benefits are payable to the estate of the Covered Person, or if the Covered Person is a minor or is, in the Plan's opinion, legally incapable of giving valid receipt and discharge of any payment, the Plan may, at the Plan's option, pay an amount not exceeding $1,000.00 to any relative by blood or Marriage (or Same Sex Marriage or Domestic Partnership or Civil Union) of the Covered Person or beneficiary, who is considered by the Plan to be equitably entitled thereto. Any payment so made will

constitute a complete discharge of the Plan's obligations to the extent of that payment, and the Plan will not be required to see to the application of the money so paid.

PLAN COVERAGE RECORDS

The Sponsoring Employer shall furnish periodically to the Plan the information relative to Employees becoming covered, changes in amounts of coverage, and terminations of coverage, as the Plan may require to administer the coverage under the Plan. Any of the Sponsoring Employer's records that the Plan believes have a bearing on the coverage under the Plan shall be open for inspection by the Plan at any reasonable time.

The Plan is entitled to obtain such medical records as may reasonably be relevant to treatment, payment and healthcare operations in the administration of benefits under the Plan.

Clerical errors by the Plan will not cause a denial of benefits that should otherwise have been granted, nor will clerical errors grant benefits that should otherwise have been denied.

ASSIGNMENT

Benefits under the Plan are not assignable by any Employee.

No payee under the Plan has any right, except as provided below or as prescribed by law, to assign, alienate, anticipate or commute any payments under the Plan and, no payments are subject to the debts, contracts or engagements of any payee or to any judicial process to levy upon or attach the same for the payment thereof. Any Employee, however, may authorize the Plan to pay benefits directly to the person or institution on whose charges the claim is based. The Plan shall be discharged from all liability to the extent of any payment made in accordance with any authorization.

MISSTATEMENT OF AGE

If the age of any Employee or Dependent has been misstated, there shall be an equitable adjustment of Plan contributions. If the amount of coverage under the Plan for the Employee, in accordance with the terms of the Plan, would be affected by the misstatement of age, the amount of coverage shall be adjusted to the amount to which the Employee would have been entitled at his correct age and the adjustment in Plan contributions shall be based on that adjusted amount of coverage.

CONFORMITY WITH LAW

If any provision of the Plan is contrary to any law to which it is subject, that provision is hereby amended to conform thereto.

LEGAL PROCEEDINGS

No action at law or in equity may be brought to recover under the Plan prior to exhaustion of the administrative process described in this SPD (including the exhaustion of all appeals) (refer to CLAIM PROCESSING PROCEDURES AND APPEAL RIGHTS), nor shall any such action be brought at all unless filed within three (3) years of the expiration of the time within which proof of loss is required by the Plan.

EFFECTIVE DATES

No coverage under the Plan shall become effective until notice in writing is given to an Employee by the Plan. Issuance of this SPD will be deemed proper notification, provided, however, no form of coverage under the Plan shall be effective unless all contributions are paid as required under the terms of the Plan.

OVERPAYMENTS

The Plan will seek recovery of benefit payments the Plan makes erroneously but in good faith. The Plan may offset subsequent benefits that may be payable under the Plan by the amount of the erroneous benefit payment.

GOVERNING LAW

It is the intention of the Sponsoring Employer to hereby establish a program of benefits constituting an "Employee Welfare Benefit Plan", otherwise called a "Group Health Plan", under the Employee Retirement Income Security Act ("ERISA"). The Plan is therefore governed by and subject to ERISA, as amended, and all other federal laws regulating Group Health Plans.

IDENTIFICATION CARD

A Covered Person must present their identification card prior to receiving benefits under the Plan. However, having an identification card creates no right to such benefits or other services. To be entitled to benefits, the cardholder must be currently covered under the Plan with all required contributions paid. A person who incurs medical charges while not covered under the Plan will be responsible for payment of those charges.

NEGLIGENCE OR MALPRACTICE

The Plan does not practice medicine. Any medical treatment, service, supply or medication rendered to any Covered Person is the responsibility of that medical provider. The Plan is not liable for any improper or negligent act, inaction or act of malfeasance or malpractice of any medical provider in rendering such medical treatment, service, supply or medication.

NO WAIVER OF RIGHTS

If the Sponsoring Employer, at its discretion, chooses not to enforce a term or condition of the Plan, such a decision does not waive any rights under the Plan to enforce such term or condition in the future.

OTHER MEDICAL EXPENSE COVERAGE

Each Covered Person shall provide the Plan with information regarding any other medical expense coverage to which such Covered Person may be entitled.

Section 8a - COORDINATION OF BENEFITS

1. APPLICABILITY

a. This Coordination of Benefits ("COB") provision applies to "This Plan" when an Employee or the Employee's covered Dependent has health care coverage under more than one "Plan". "Plan" and "This Plan" are defined below.

b. If this COB provision applies, the order of benefit determination rules should be looked at first. Those rules determine whether the benefits of This Plan are determined before or after those of another Plan. The benefits of This Plan:

i. shall not be reduced when, under the order of benefit determination rules, This Plan determines its benefits before another Plan; but

ii. may be reduced when, under the order of benefit determination rules, another Plan determines its benefits first. The above reduction is described in Section 4, Effect on the Benefits of This Plan.

2. DEFINITIONS

a. A "PLAN" is any of the following which provides benefits or services for, or on account of, medical or dental care or treatment:

i. Group insurance or group-type coverage, whether insured or uninsured (self-funded). This includes prepayment, group practice or individual practice coverage, and medical benefits coverage in group, group-type and individual automobile "no fault" and "traditional fault" type contracts. It does not include student accident-type coverage.

ii. Coverage under a governmental plan or required or provided by law. This does not include a state plan under Medicaid (Title XIX, Grants to States for Medical Assistance Programs, of the United States Social Security Act as amended from time to time). It also does not include any plan when, by law, its benefits are excess of those of any private program or other non-governmental program.

Each contract or other arrangement for coverage under 1) or 2) is a separate Plan. Also, if an arrangement has two parts and COB rule applies only to one of the two, each of the parts is a separate Plan.

b. "THIS PLAN" is the part of the Plan that provides benefits for medical care expenses.

c. "PRIMARY PLAN"/"SECONDARY PLAN". The order of benefit determination rules state whether This Plan is a Primary Plan or Secondary Plan as to another Plan covering the person.

When This Plan is a Primary Plan, its benefits are determined before those of the other Plan and without considering the other Plan's benefits.

When This Plan is a Secondary Plan, its benefits are determined after those of the other Plan and may be reduced because of the other Plan's benefits.

When there are more than two Plans covering the person, This Plan may be a Primary Plan as to one or more other Plans, and may be a Secondary Plan as to a different Plan or Plans.

a. "ALLOWABLE EXPENSE" means a medically necessary, reasonable and customary item of expense for health care, when the item of expense is covered at least in part by one or more Plans covering the person for whom the claim is made.

When a Plan provides benefits in the form of services, the reasonable cash value of each service rendered will be considered both as an Allowable Expense and a benefit paid.

a. "CLAIM DETERMINATION PERIOD" means a Calendar Year. However, it does not include any part of a year during which a person has no coverage under This Plan, or any part of a year before the date this COB provision or a similar provision takes effect.

3. ORDER OF BENEFIT DETERMINATION RULES

a. GENERAL - When there is a basis for a claim under This Plan and another Plan, This Plan is a Secondary Plan which has its benefits determined after those of the other Plan, unless:
   1) the other Plan has rules coordinating its benefits with those of This Plan; and
   2) both those rules and This Plan's rules, in subparagraph b. below, require that This Plan's benefits be determined before those of the other Plan.

b. RULES - This Plan determines its order of benefits using the first of the following rules which applies:
   1) Non-Dependent/Dependent - The benefits of the Plan which covers the person as an Employee, member or subscriber (that is, other than as a Dependent) are determined before those of the Plan which covers the person as a Dependent. However, if the person is also a Medicare beneficiary, and if the rule established under the Social Security Act of 1965, as

amended, makes Medicare secondary to the Plan covering the person as a Dependent of an active Employee, the order of benefit determination is:

i) First, benefits of a Plan covering persons as an Employee, member, or subscriber.
ii) Second, benefits of a Plan of an active worker covering persons as a Dependent.
iii) Third, Medicare benefits.

2) Dependent Child/Parents Not Separated or Divorced (or whose Domestic Partnership or Civil Union is not dissolved or annulled) - Except as stated in subparagraph b.3) below, when This Plan and another Plan cover the same child as a Dependent of different persons, called "parents":
   i) the benefits of the Plan of the parent whose birthday falls earlier in a Calendar Year are determined before those of the Plan of the parent whose birthday falls later in that Calendar Year.
   ii) if both parents have the same birthday, the benefits of the Plan which covered the parent longer are determined before those of the Plan which covered the other parent for a shorter period of time.

   However, if the other Plan does not have the rule described in (i) immediately above, but instead has a rule based upon the gender of the parents, and if, as a result, the Plans do not agree on the order of benefits, the rule in the other Plan will determine the order of benefits.
3) Dependent Child/Separated or Divorced Parents (or whose Domestic Partnership or Civil Union is dissolved or annulled) - if two (2) or more Plans cover a person as a Dependent child of divorced or separated parents (or whose Domestic Partnership or Civil Union is dissolved or annulled), benefits for the child are determined in this order:
   i) first, the Plan of the parent with custody of the child;
   ii) then, the Plan of the Spouse of the parent with custody of the child; and
   iii) finally, the Plan of the parent not having custody of the child.

   However, if the specific terms of a court decree state that one of the parents is responsible for the health care expenses of the child, and the entity obligated to pay or provide the benefits of the Plan of that parent has actual knowledge of those terms, the benefits of that Plan are determined first. This paragraph does not apply with respect to any Claim Determination Period or plan year during which any benefits are actually paid or provided before the entity has that actual knowledge.
4) Active/Inactive Employee - The benefits of a Plan which covers a person as an Employee who is neither laid off nor retired (or as that Employee's Dependent) are determined before those of a Plan which covers that person as a laid off or retired Employee (or as that Employee's Dependent). If the other Plan does not have this rule, and if, as a result, the Plans do not agree on the order of benefits, this rule 4) is ignored.
5) Continuation coverage - If a person whose coverage is provided under a right of continuation pursuant to federal or state law is covered under another Plan, the following will be the order of benefit determination:
   (i) First, the benefits of a Plan covering the person as an Employee, member or subscriber (or as that person's Dependent);
   (ii) Second, the benefits under the continuation coverage. If the other Plan does not have the rule described above, and if, as a result, the Plans do not agree on the order of benefits, this rule is ignored.
6) Longer/Shorter Length of Coverage - If none of the above rules determines the order of benefits, the benefits of the plan which covered an Employee, member or subscriber longer are determined before those of the Plan which covered that person for the shorter time.

4. EFFECT ON THE BENEFITS OF THIS PLAN

a. WHEN THIS SECTION APPLIES - This Section 4 applies when, in accordance with Section 3, Order of Benefit Determination Rules, This Plan is a Secondary Plan as to one or more other Plans. In that event, the benefits of This Plan may be reduced under this section. Such other Plans are referred to as "the other Plans" in b. immediately below.
b. REDUCTION IN THIS PLAN'S BENEFITS - The benefits of This Plan will be reduced when the sum of:
   1) the benefits that would be payable for the Allowable Expenses under This Plan in the absence of the COB provision; and
   2) the benefits that would be payable for the Allowable Expenses under the other Plans in the absence of provisions with a purpose like that of this COB provision, whether or not claim is made;

   exceeds those Allowable Expenses in a Claim Determination Period. In that case, the benefits of This Plan will be reduced so that they and the benefits payable under the other Plans do not total more than those Allowable Expenses.

When the benefits of This Plan are reduced as described above, each benefit is reduced in proportion. It is then charged against any applicable benefit limit of This Plan.

5. RIGHT TO RECEIVE AND RELEASE NEEDED INFORMATION

Certain facts are needed to apply these COB rules. This Plan has the right to decide which facts This Plan needs. This Plan may get needed facts from or give them to any other organization or person. This Plan need not tell, or get the consent of, any person to do this. Each person claiming benefits under This Plan must give This Plan any facts This Plan needs to pay the claim.

6. FACILITY OF PAYMENT

A payment made under another Plan may include an amount which should have been paid under This Plan. If it does, This Plan may pay that amount to the organization which made that payment. That amount will then be treated as though it were a benefit

paid under This Plan. This Plan will not have to pay that amount again. The term "payment made" includes providing benefits in the form of services, in which case "payment made" means reasonable cash value of the benefits provided in the form of services.

7. RIGHT OF RECOVERY

If the amount of the payments made by This Plan is more than This Plan should have paid under this COB provision, This Plan may recover the excess from one or more of:

a. the persons This Plan paid or for whom This Plan has paid;

b. insurance companies; or

c. other organizations.

The "amount of the payments made" includes the reasonable cash value of any benefits provided in the form of services.

8. SMALL CLAIM WAIVER

These COB provisions may not be applied to claims less than fifty dollars ($50.00), but if additional liability is incurred to raise the small claim above fifty dollars ($50.00), the entire liability may be included in the Coordination of Benefits computation.

Section 8b - MEDICARE COORDINATION

Benefits payable under the Plan shall be coordinated with:

1. Any amounts paid under Part A or Part B of Title XVIII of the Social Security Act of 1965 (more commonly known and described as "Medicare") and any amendments thereto; and
2. Any amounts which would have been payable had the Covered Person been eligible for or enrolled in the aforementioned Part A and Part B.

IMPORTANT: Failure to enroll in Medicare may result in significant out-of-pocket expenses. If you are eligible for Medicare, the Plan may pay secondary to Medicare in certain situations (i.e., Medicare pays first). Examples of when Medicare is primary are when the Sponsoring Employer has less than 20 employees and your Medicare eligibility is based on age, or when the Sponsoring Employer has less than 100 employees and your Medicare eligibility is based on disability, or when you have been eligible for Medicare for more than 30 months based on End-Stage Renal Disease (ESRD). If the Covered Person is eligible for Medicare to pay as primary, the Plan will pay secondary to Medicare whether or not he is actually enrolled in Medicare. This means that benefits will still be reduced by the amount Medicare would have paid (under Parts A and B), even if the Covered Person has failed to enroll in Medicare Part A or B. Therefore, if you are eligible for Medicare, you are strongly encouraged to enroll in both Parts A and B of Medicare.

Section 8c - SUBROGATION; RIGHT OF REIMBURSEMENT; ACTS OF THIRD PARTY CLAUSE

SUBROGATION

As a condition to receiving benefits under the Plan, Covered Persons receiving medical benefits agree to transfer in full to the Plan their rights to recover damages for these benefits when the Bodily Injury or Sickness occurs through the act or omission of another person. If a repayment agreement is required to be signed, all rights of recovery are transferred to the Plan regardless of whether it is actually signed. It is only necessary that the Bodily Injury or Sickness occurs through the act of a third party. The Plan's subrogation rights of full recovery may be from any person or business entity, in accordance with applicable law. The Plan may enforce its right of subrogation by requiring the Covered Person to assert a claim to any of the coverages to which he/she may be entitled. The Plan will not pay fees or costs associated with a claim/lawsuit without express written authorization.

RIGHT OF REIMBURSEMENT

As a condition to receiving benefits under the Plan, Covered Persons receiving medical benefits agree to reimburse the Plan in full any such benefits when they are recovered from another person or business entity. If a repayment agreement is required to be signed, the Plan shall be entitled to full reimbursement regardless of whether it is actually signed. The Plan's right of reimbursement may be from funds received from any person or business entity, in accordance with applicable law. The Plan may enforce its right of reimbursement by requiring the Covered Person to assert a claim to any of the coverages to which he/she may be entitled. The Plan will not pay fees or costs associated with any claim/lawsuit without express written consent.

ACTS OF THIRD PARTY CLAUSE

Medical benefits are not payable to or for a Covered Person under the Plan when the Bodily Injury or Sickness of the Covered Person occurs through the act or omission of another person. However, the Plan may elect to advance payment for medical expenses incurred for a Bodily Injury or Sickness caused by the act or omission of a third party. The Covered Person or guardian must sign an agreement to repay the Plan in full any sums advanced for such medical expenses from any judgment or settlement received. The Plan has the right to recover in full the medical expenses advanced regardless of whether that person actually signs any required repayment agreement. It is only necessary that the Bodily Injury or Sickness occurs through the act or omission of a third party. The Plan's right of recovery in full may be from any person or business entity, in accordance with applicable law. The Plan may enforce this provision by requiring the Covered Person to assert a claim to any of the coverages to which he may be entitled. The Plan will not pay fees or costs associated with the claim/lawsuit without express written authorization.

Section 8d - HEALTH CARE COORDINATION

Health Care Coordination is a program conducted by the Plan which:

a. identifies cases involving the Covered Person in a clinical situation with the potential for significant or catastrophic claims; and

b. assesses those cases for the appropriate level of patient care; the setting in which it is received and the necessary services required for an optimal medical outcome.

Under Health Care Coordination, Enhanced Benefits may be available: The Plan may pay incurred Eligible Expenses without application of the Deductible, Copay or Coinsurance when a designated Preferred facility or provider is available and the Covered Person is eligible to receive services. Services or supplies not considered as Eligible Expense under the terms and provisions of the Plan may be allowed as an exception when deemed appropriate and in the best interest of the Covered Person. If approval is granted, payment of benefits under the Plan for those services or supplies shall be on the same basis as if those services or supplies were Eligible Expenses.

NO COVERED PERSON IS REQUIRED TO ACCEPT AN ALTERNATE TREATMENT PLAN RECOMMENDED BY THE HEALTH CARE COORDINATOR.

Enhanced Benefits may also be available under the **Health Care Coordination** program without application of the Deductible, Copay or Coinsurance or as an allowed Eligible Expense if the Covered Person has complied with the Plan's Pre-Notification provision and health care coordination requirements (Section 9, Part EDMM, Paragraph 3)**:

a. If a Covered Person receives a human organ or tissue transplant in a Preferred Center of Excellence.

b. If a Covered Person uses a Preferred air ambulance service for non-emergency transport.

c. Inpatient treatment of Nervous, Emotional or Mental Disorders or Substance Abuse Disorders* if the member enters into and complies with an Outpatient Treatment agreement.

d. If a Covered Person obtains a second medical opinion through a Preferred program, for any diagnosis and/or prescribed treatment for an eligible Non-Emergency Complex Medical Condition.

e. If a Covered Person obtains counseling and guidance through a Preferred program for Safety Monitory for eligible specialty drugs.

f. If a Covered Person utilizes a Preferred Center of Excellence for Non-Emergency Complex Imaging or Outpatient Procedure.

Specialty (tier 4) and all high-cost drugs with an ingredient cost over $1,000.00 per filled prescription are not eligible under the PDCS. However, eligible drugs may be sourced through the High Cost Drug Program.

If no benefits are available through the High Cost Drug Program, the high cost drug will be filled with a standard Copay of 10% of the Maximum Allowable Cost (MAC) up to $200.00 maximum per fill**.

Each Covered Person will need to enroll in the High Cost Drug Program to be eligible for assistance or coverage. Failure to enroll will require the Covered Person to pay the full cost of the drug.

If the Employer has elected the HealthChoices option (as shown on the Schedule of Benefits) the following Enhanced Benefits may also be available**:

a. Preferred Non-Emergency Complex Medical Conditions Program:
   i. If prior to receiving services or treatment a Covered Person fully **completes** a preferred program designed and approved for an eligible Non-Emergency Complex Medical Condition, the Maximum Benefit will increase from 50% to 100% of Eligible Expenses and all other Out-of-Pocket obligations (Deductibles, Coinsurance and Copayments) will be waived.
   ii. If prior to receiving services or treatment, a Covered Person **considers** (or enters into but does not complete) a preferred program designed and approved for an eligible Non-Emergency Complex Medical Condition, the Maximum Benefit will increase from 50% to the same Coinsurance as similar Eligible Expenses.

b. Preferred Center of Excellence for Non-Emergency Complex Imaging or Outpatient Procedures:
   i. If a Covered Person **uses** a preferred Center of Excellence for an eligible non-emergency imaging and/or Outpatient procedure the Maximum Benefit will increase from 50% to 100% of Eligible Expenses and all other Out-of-Pocket obligations (Deductibles, Coinsurance and Copayments) will be waived.
   ii. If a Covered Person **considers** a reasonably located preferred Center of Excellence for an eligible non-emergency imaging and/or Outpatient surgery service the Maximum Benefit will increase from 50% to the same Coinsurance as similar Eligible Expenses.

* If the Plan Sponsor employed an average of at least fifty-one (51) employees during the preceding calendar year, Eligible Expenses incurred for Nervous, Emotional or Mental Disorders or Substance Abuse Disorders (Including detoxification) shall be covered at no less than any other Sickness.

** Covered Persons enrolled in a qualified HSA high deductible health plan may not be eligible for all Enhanced

Benefits, such as waiving the deductible.

Section 9 - BENEFITS

PART EDOP - EMPLOYEE AND DEPENDENT OUTPATIENT PRESCRIPTION DRUG CARD BENEFIT (Optional Coverage)

1. Coverage Clause

If this optional benefit is elected by the Sponsoring Employer, and a Covered Person incurs Outpatient covered prescription drug charges as a result of a covered Bodily Injury or Sickness, the Prescription Drug Card Service (PDCS) will pay, as set forth below, the Coinsurance Percentage specified in the Schedule of Benefits for charges which are in excess of the Copayment per prescription order and Calendar Year Deductible Amount specified in the Schedule of Benefits.

No benefits provided under this Part of the Plan are considered as Eligible Expense under any other Part of the Plan (i.e., no Outpatient drug benefits, prescription or non-prescription, are payable under any other Part).

Payment of any benefits under this Part does not waive, or in any manner whatsoever affect, any of the Employee and Dependent Major Medical Expense Coverage Limitations and Exclusions.

2. Outpatient Covered Prescription Drug Charges

Outpatient covered prescription drug charges are those incurred by a Covered person for Food & Drug Administration (FDA) Approved Drugs which are: lawfully obtainable only upon the written prescription of a Doctor; not excluded in paragraph 7 below of this Part EDOP; and which can be obtained from a licensed pharmacist. Drugs dispensed by a Doctor in an Outpatient setting are covered under this clause, not as a Major Medical Expense (unless provided as part of a surgical procedure. Insulin, syringes and needle (with insulin) qualify as Outpatient covered prescription drug charges, with or without a prescription.

3. Prescription Order and Benefit Payment

a. If the dispensing pharmacy is a member of the PDCS, the Covered Person must show his prescription drug card to the pharmacy and pay the Copayment, Coinsurance and Calendar Year Deductible, as applicable. The pharmacy will then bill PDCS for the balance of the charges.

b. If the dispensing pharmacy is **not** a member of the PDCS or is a Doctor, or if the Covered Person elects not to use his prescription drug card, the Covered Person must fill out a direct reimbursement claim form (available from the PDCS upon request) and submit it to the PDCS, which will then reimburse the Covered Person. In addition to any Copay, Deductible or Coinsurance due, the Covered person will also be responsible for any expense above the normally discounted price charged when using the PDCS.

c. The PDCS also applies the Maximum Allowable Charge limitation for ingredient cost pricing. Consequently, if the Doctor issue a "substitution allowed" prescription for a brand name drug for which a generic equivalent is available, and the pharmacist dispenses the more expensive brand name drug, the Covered Person will be responsible for any expense above the normally discounted price charged for the generic equivalent.

4. Dispensing Limitation

Benefits for covered prescription orders will not exceed the Maximum Benefits shown in the Schedule of Benefits for Outpatient Prescription Drug Card Benefits.

5. Right of Recovery

If a Covered Person's coverage under the Plan terminates for any reason (including termination for non-payment of contributions), the Plan has the right to recover from the Covered Person any Outpatient prescription benefits, to the extent of the number of days, or doses, dispensed beyond that termination date (unless the Covered Person timely elects federal or state continuation).

6. Prescription Orders Subject to Pre-Notification Program

Certain prescribed medications may be subject to the Pre-Notification Program (see paragraph 3 of Section 9 - PART EDMM) and PDCS review prior to dispensing by the pharmacy. Refer to the PDCS formulary for a current list of such medications (accessed via the PDCS website on the Plan ID card). Pre-Notification and the PDCS review may initiated by either the pharmacy or Covered Person.

7. Exclusions

a. Over-the-counter drugs and products, except select drugs listed in Tier 0 obtained with a Doctor's prescription,

b. Fertility agents or drugs for sexual dysfunction;

c. Vitamins (other than pre-natal);

d. Hair loss medications, e.g. Rogaine, Monoxidil;

e. Immunization agents, biological sera, blood or blood plasma;

f. Investigational use or experimental drugs; except that coverage shall not be excluded for a drug used for the treatment of cancer on the grounds that the drug has not been approved by the Federal Food and Drug Administration for the treatment of the specific type of cancer for which the drug has been prescribed, provided that the drug is recognized for treatment of that specific type of cancer in one of the standard reference compendia or in the medical literature;

g. Any charge for administration of injectable insulin;

h. Drugs covered under workers' compensation or similar insurance, or workers' compensation, occupational disease or similar laws;

i. Anorectic drugs for weight control;

j. Medication taken, prescribed or administered while an Inpatient at a Hospital, rest home, sanitarium, Extended Care Facility, Convalescent Hospital, nursing home or similar institution which operates a facility for dispensing pharmaceuticals;

k. Therapeutic devices or appliances, support garments and other non-medicinal substances regardless of intended use;

l. Homeopathic medications;

m. Any drugs purchased outside the United States of America, unless covered under the Tourism Prescription Benefit in the Schedule of Benefits;

n. Medications for complexion or acne if the Covered Person is over 30 years of age; or

o. Any charge for the therapeutic delivery of nucleic acid as a drug or other medication to treat disease, or for any other form of gene or cell therapy, unless specifically covered under the Schedule of Benefits or as set forth in paragraph 2, Eligible Expense of Part EDMM.

p. Specialty (Tier 4) and other high-cost drugs with an ingredient cost over $1,000.00 per filled prescription are not eligible under the PDCS.

PART EDSA - EMPLOYEE AND DEPENDENT SUPPLEMENTAL ACCIDENT EXPENSE COVERAGE (Optional Coverage)

1. Coverage Clause

If this optional benefit is elected by the Sponsoring Employer, and a Covered Person, while covered under this Part EDSA, incurs Eligible Expenses as a result of a covered accidental Bodily Injury, upon receipt of due proof and subject to all provisions of the Plan, the Plan will waive any Copayments, Deductible Amounts or Coinsurance that otherwise would be payable by the Covered Person for all Eligible Expenses incurred for all Bodily Injuries sustained during any one accident, but not to exceed the applicable Maximum Supplemental Accident Expense Benefit specified in the Schedule of Benefits. In no event will benefits be covered under this Supplemental Accident Expense Benefit in addition to Major Medical Expense benefits.

2. Limitations and Exclusions

a. No payment shall be made under this Part EDSA for expenses incurred for any Complications of Pregnancy resulting from such accidental Bodily Injury or Injuries.

b. All Limitations and Exclusions specified in paragraph 7 of Part EDMM below, under this Section 9, apply to this Part EDSA.

PART EDOD - EMPLOYEE AND DEPENDENT OUTPATIENT DIALYSIS TREATMENT BENEFIT

1. Coverage Clause

Subject to all provisions of the Plan, if a Covered Person while covered under this Part EDOD, incurs Eligible Expenses for dialysis treatment on an Outpatient basis (Outpatient Dialysis Treatment), as a result of a covered Bodily Injury or Sickness, the Plan will pay, upon receipt of written proof of loss, the Coinsurance Percentage specified in the Schedule of Benefits of the Eligible Expenses which are in excess of any Copayments and Deductible Amount specified in the Schedule of Benefits, but not to exceed the Maximum Benefit specified in the Schedule of Benefits for Outpatient Dialysis Treatment. In no event will benefits be covered under this Outpatient Dialysis Treatment Benefit in addition to Major Medical Expense benefits.

2. Limitations and Exclusions

All Limitations and Exclusions specified in paragraph 7 of Part EDMM below, under this Section 9, apply to this Part EDOD.

3. Outpatient Dialysis Treatment

Subject to all provisions of the Plan, for the purpose of this Part, the term “Outpatient Dialysis Treatment” means any Medically Necessary procedure, on an Outpatient basis, that removes waste materials from the body, and all related Medically Necessary tests, services and supplies for purposes of treating chronic kidney disease, End Stage Renal Disease (ESRD), kidney transplant, acute renal failure, chronic renal insufficiency, anemia (or other diagnosis) related to renal failure, or any other condition for which dialysis is Medically Necessary on an Outpatient basis, including but not limited to: diagnostic and laboratory tests; injectable and intravenous medications (administered before, during or after dialysis) (including but not limited to Heparin, Epogen and Procrit); dialysis (both hemodialysis and peritoneal dialysis); acute care dialysis; and self-management education.]

4. Medicare Enrollment

IMPORTANT: Failure to enroll in Medicare may result in significant out-of-pocket expenses for Outpatient Dialysis Treatment. If you are eligible for Medicare, the Plan may pay secondary to Medicare in certain situations (i.e., Medicare pays primary or first). Examples of when Medicare is primary are when the Sponsoring Employer has less than 20 employees and your Medicare eligibility is based on age, or when the Sponsoring Employer has less than 100 employees and your Medicare eligibility is based on disability, or when you have been eligible for Medicare for more than 30 months based on End-Stage Renal Disease (ESRD). If Medicare pays primary, the Plan will pay secondary to Medicare whether or not the Covered Person is actually enrolled in Medicare. This means that benefits will still be reduced by the amount Medicare would have paid (under Parts A and B), even if

the Covered Person has failed to enroll in Medicare Part A or B. Therefore, if you are eligible for Medicare, you are strongly encouraged to enroll in both Parts A and B of Medicare.

PART EDMM - EMPLOYEE AND DEPENDENT MAJOR MEDICAL EXPENSE COVERAGE

1. Coverage Clause

Subject to all provisions of the Plan, if a Covered Person while covered under this Part EDMM, incurs Eligible Expenses as a result of a covered Bodily Injury or Sickness, the Plan will pay, upon receipt of proof, the Coinsurance Percentage, specified in the Schedule of Benefits, of the Eligible Expenses which are in excess of any Copayments and Deductible Amount specified in the Schedule of Benefits, but not to exceed the Maximum Benefits specified in the Schedule of Benefits.

2. Eligible Expense (Not to exceed any applicable Coinsurance Percentage or Maximum Benefit specified in the Schedule of Benefits)

Subject to all provisions of the Plan, for the purpose of this Part, the term "Eligible Expense" includes only the Maximum Allowable Charges made for Medically Necessary services and supplies:

a. by a Hospital for medical services and supplies, except that the amount of daily room and board charge, including any nursing charge for Inpatient professional services by a Nurse for an Inpatient, shall not exceed:

   1) the Hospital's average charge for its semi-private rooms or its prorated hourly equivalent if billed as such; or

   2) if the Hospital provides private room only, the average semi-private rate shall be based on charges of Hospitals in the immediate area; or

   3) the maximum daily room and board charge benefits specified in the Schedule of Benefits.

   However, no benefits will be paid for charges made by a Hospital for medical services or supplies in connection with a non-emergency Saturday or Sunday admission when the Covered Person does not undergo surgery on the day immediately following admission to the Hospital.

b. by a Health Care Provider, acting within the scope of his license or certification, for Inpatient and Outpatient professional medical or surgical services, including but not limited to primary care and specialist Office Visit Services, assistant surgeons, second medical opinions and Telemedicine (when billed with a valid CPT code for the service rendered).

c. for professional services by a Nurse, including Inpatient Nursing care (billed by a Hospital in its daily room and board charges) and Outpatient (private-duty) Nursing care (if that care requires the Outpatient professional services of a Nurse, takes place under a Home Health Care Plan, is in lieu of services that would otherwise be required to take place in an acute care setting and the Plan determines that those services are not primarily for Custodial or Convalescence Care, and could not be provided by a person other than a Nurse).

d. by a radiologist or laboratory for diagnosis or treatment, including radiation therapy, chemotherapy, infusion therapy and prostate specific antigen (PSA) testing for men age 50 or older or men whose Doctor determines that early cancer screening is Medically Necessary.

e. for X-ray, radium and radioactive isotope therapy; x-ray examinations and laboratory tests; and imaging (CT/PET Scans, MRIs) (including Outpatient lab and professional services).

f. by an anesthetist, a physical therapist, a licensed acupuncturist, registered occupational therapist or licensed speech and language pathologist.

g. for Medically Necessary ground transportation by a professional ambulance service to or from a Hospital; and Medically Necessary air transportation by a professional ambulance service to the nearest qualified Hospital for an Emergency Medical Condition, subject to the maximum air ambulance benefit in the Schedule of Benefits.

h. for voluntary sterilization and Medically Necessary medical or surgical services for the physical diagnosis or treatment of infertility of a Covered Person, except treatment excluded in Limitations and Exclusions.

i. by Outpatient facilities for professional medical or surgical services or supplies, including but not limited to an Ambulatory Surgical Center.

j. by an Extended Care Facility for room and board accommodations; if:

   1) the amount of daily room and board charge considered as Eligible Expense does not exceed the daily benefit amount in the Schedule of Benefits;

   2) the Covered Person is an Inpatient in that facility on the certification of the attending Doctor that the confinement is Medically Necessary;

   3) the confinement commences immediately following a period of at least three (3) continuous days of Hospital confinement; and

   4) that confinement is for the same covered Bodily Injury or Sickness that was treated during the Covered Person's confinement in the Hospital.

k. by a Doctor or licensed chiropractor or physical therapist for Orthopedic Manipulation.

l. for treatment of a Covered Person with a life expectancy of six (6) months or less in a qualified Hospice Care Program at a Hospice by a Hospice Team. The benefit period commences on the date the Covered Person is admitted on the referral of the attending Doctor to the qualified Hospice Care Program. Eligible Expenses for Hospice Care are the Maximum Allowable Charges made according to a Hospice Care Program, including:

1) Home Health Care services;

2) Inpatient and Outpatient medical and non-medical care;

3) emotional support services to the Covered Person; and

4) bereavement counseling to immediate covered Family members (Spouse, parents and Children) of the Covered Person within the three (3) month period following the death of the Covered Person, not to exceed for the bereavement counseling a Family maximum of three (3) visits.

Benefits for Hospice Care are in lieu of any similar benefits provided under any other Eligible Expense provision of this Part.

m. for treatment of a Covered Person by a Home Health Care Agency under a Home Health Care Plan. Up to four (4) consecutive hours in a twenty-four (24) hour period of Home Health Care services shall be considered as one Home Health Care visit. Eligible Expenses for Home Health Care are the Maximum Allowable Charges made for the following:

1) part-time skilled nursing care;

2) physical therapy;

3) speech therapy;

4) medical supplies, drugs and medicines prescribed by a Doctor;

5) laboratory services by or on behalf of the Hospital, but only to the extent benefits for those services would have been paid under the Plan had the Covered Person remained Hospitalized;

6) occupational therapy; and

7) respiratory therapy.

However, benefits will not be paid for charges made by a Home Health Care Agency for:

1) any charges excluded under paragraph 7., Limitations and Exclusions of this Part;

2) full-time nursing care at home;

3) meals delivered to the home;

4) homemaker services;

5) any services of an individual who ordinarily resides in the Covered Person's home or is a member of the Covered Person's Family; or

6) any transportation services.

Benefits for Home Health Care are in lieu of any similar benefits provided under any other Eligible Expense provision of this Part.

n. by a Hospital and Doctor for human organ transplant or tissue transplant or replacement. However:

1) the only human organ transplants considered to be Eligible Expense are those listed in the Schedule of Benefits and **not** considered Experimental Treatment; and

2) only the following tissue transplant or replacements are considered to be Eligible Expenses: cornea, prosthetic tissue and joints, vein or artery graft, heart valve, and plantable prosthetic lens in connection with cataract.

If the Covered Person receives a covered human organ or tissue transplant, the donor's expenses will be considered to be the Covered Person's expenses even if the donor is also covered under the Plan as an Employee or Dependent. The Plan will pay benefits for the donor's Eligible Expenses to the extent an actual charge is made that is not paid or payable by any other plan covering the donor, but not to exceed the Maximum Benefit specified in the Schedule of Benefits per covered human organ or tissue transplant per donor.

o. for Preventive Care Services.

p. for ACT Routine Patient Costs furnished to an ACT Qualified Participant in an Approved Clinical Trial (on the same basis as for any other covered sickness or injury, without application of maximum benefit limits based on dollar amounts).

q. for any of the following services and supplies to the extent that they do not duplicate charges included under any other Eligible Expense provision of this Part:

1) Federal Drug Administration (FDA) Approved Drugs lawfully obtainable only upon the written prescription of a Doctor and administered while the Covered Person is an Inpatient, provided benefits are payable for the condition for which the drug is prescribed.

2) Blood, blood plasma, oxygen and anesthesia and their administration.

3) The initial artificial limbs or eyes required to replace natural limbs or eyes, lost while covered under this Part.

4) Casts, splints, surgical dressings, trusses, braces, crutches and the rental of wheelchairs, Hospital beds, respirators or other Durable Mechanical Medical Equipment available only on the written prescription of a Doctor for the therapeutic treatment of a covered Bodily Injury or Sickness but the rental shall not exceed the purchase price. When the equipment is purchased instead of rented, a monthly rental equivalent will be determined by dividing the purchase price by 12 with one rental equivalent payment made each calendar month for the balance of the coverage period. However, the total of all payments will not exceed the amount shown in the Schedule of Benefits.

5) The initial eyeglasses or contact lens(es) required as a result of cataract surgery or other vision correction after surgery or Bodily Injury.

6) Ostomy, urological, orthopedic, laryngectomy, prosthetic, orthotic and cochlear implant devices and supplies.

r. for breast reconstruction surgery for a Covered person who is receiving benefits under the Plan in connection with a mastectomy and who elects breast reconstruction in connection with that mastectomy, which shall include:

1) reconstruction of the breast on which the mastectomy has been performed;

2) surgery and reconstruction of the other breast to restore symmetry; and

3) prostheses and physical complications in all stages of mastectomy, including lymphedemas;

in a manner as determined in consultation by the Covered Person with her attending Doctor and subject to copayments, deductibles and coinsurance.

s. for the following equipment, supplies and related services for the treatment of Type I, Type II and gestational diabetes when recommended or prescribed by a Doctor:

1) visual reading and urine testing strips;

2) insulin pumps and medically necessary accessories thereto;

3) insulin infusion devices; and

4) podiatric appliances for prevention of complications associated with diabetes;

and for the following equipment, supplies and related services only if not available through the Outpatient Prescription Drug Card Benefit:

1) blood glucose monitors;

2) blood glucose monitors for the legally blind;

3) test strips for glucose monitors;

4) insulin;

5) injection aids;

6) cartridges for the legally blind;

7) syringes; and

8) oral agents for controlling blood sugar.

t. for diabetes self-management training prescribed by a Doctor, including Medically Necessary medical nutrition therapy relating to diet, caloric intake and diabetes management (excluding programs whose only purpose is weight reduction) only if that therapy is provided by a licensed health care professional with specialized training in diabetes management, including a licensed registered dietitian or a licensed certified nutritionist, and that is limited to the following:

1) visits upon the diagnosis of diabetes;

2) Medically Necessary changes in a Covered Person's self-management based on a Doctor's diagnosis representing a significant change in the Covered Person's symptoms or conditions; and

3) visits for Medically Necessary reeducation or refresher training.

u. for anesthesia and associated facility charges when the mental or physical condition of a Dependent child or mentally handicapped adult requires dental or orthodontic treatment to be rendered under Physician-supervised general anesthesia in a Hospital, Ambulatory Surgical Center or dental office.

v. for the diagnosis and treatment of a metabolic disease or disorder where the Covered Person has been diagnosed by a Doctor with a compromise in the ability to consume nutrition by mouth or to tolerate oral feedings. For nutritional replacement products to be considered as an Eligible Expense the nutritional product(s) must be established as the primary source of nutrition and obtained via a prescription or certificate of Medical Necessity completed by a Doctor.

w. for diagnosis and treatment of nervous, emotional, mental and substance abuse disorders in a Residential Treatment Facility.

x. for the care and treatment of Pregnancy (including Complications of Pregnancy and voluntary abortion), with benefits payable in the same manner and to the same extent as for any other Sickness covered under the Plan, including all Maternity Care, delivery, Inpatient, Newborn Care and well-baby (prenatal and postnatal) care, with **a minimum of forty-eight (48) hours of Inpatient care following a vaginal delivery and a minimum of ninety-six (96) hours of Inpatient care following a cesarean section, for a mother and her newly born child in a Hospital or any other health care facility licensed to provide obstetrical care. A shorter length of Hospital stay may be authorized if it meets with the approval of the attending Doctor after consulting with the mother.** Coverage of the newborn child under the Plan is available only if the newborn qualifies as an eligible Dependent Child under the Plan. Coverage of the **newly born child** is retroactive to the instant the child is born, subject to the newborn qualifying as an eligible Dependent Child under the Plan and timely submission of all required enrollment forms and contributions for that child.

y. for routine eye exams for adults, and Pediatric Vision Care for children.

z. for Emergency Services by a Hospital's emergency room or an Outpatient urgent care facility to treat an Emergency Medical Condition, including Emergency Services arising out of sexual assault or abuse.

aa. for Skilled Nursing Care at a Skilled Nursing Facility.

bb. for Inpatient and Outpatient services for Nervous, Emotional or Mental Disorders and Substance Abuse Disorders (including detoxification), with benefits payable in the same manner and to the same extent as for any other Sickness covered under the Plan, subject to the Maximum Benefits specified in the Schedule of Benefits.

cc. for Outpatient Rehabilitative and Habilitative Services and Devices (including Speech, Occupational and Physical Therapies), subject to the Maximum Benefits specified in the Schedule of Benefits.

dd. Dental services due to Bodily Injury.

ee. for any form of chronic kidney disease, including but not limited to End Stage Renal Disease (ESRD), acute renal failure, chronic renal insufficiency, or anemia (or other diagnosis) related to renal failure, and all Medically Necessary dialysis to treat chronic kidney disease, except dialysis on an Outpatient basis is subject to the Outpatient Dialysis Treatment Benefit (in Part EDOD above of this Section 9) and the Maximum Benefit specified in the Schedule of Benefits for Outpatient Dialysis Treatment.

ff. for nutritional therapy and counseling, including treatment of phenylketonuria.

gg. charge for the therapeutic delivery of nucleic acid as a drug or other medication to treat disease, or for any other form of gene or cell therapy. Any charge for the therapeutic delivery of nucleic acid as a drug or other medication to treat disease, or for any other form of gene or cell therapy, is only an eligible expense if covered through the High Cost Drug Program. When cell or gene therapy is eligible for reimbursement under the high cost drug program, eligible charges for drug or implant costs will not exceed the manufacturer's invoice amount.

3. Pre-Notification Program

The Plan requests Pre-Notification by the Covered Person of all:

a. Proposed Inpatient confinements in any medical facility;

b. Proposed Outpatient Service, or course of services costing $10,000.00 or more (including, but not limited to, surgeries, chemotherapy and radiation therapy);

c. Proposed human organ or tissue transplants or replacements;

d. Pregnancies, within thirty (30) days from the date the Covered Person first obtains diagnosis of an existing pregnancy;

e. Prescription Orders subject to this program (refer to paragraph 6 of Part EDOP above, under this Section 9);

f. Proposed Air Transport;

g. Non-emergency complex imaging, including MRIs and CT Scans; and

h. Tier 4 and other high cost drugs delivered on an Outpatient basis, including, but not limited to, Bone Resorptive Agents, Neuromuscular Blockers, Gonadotropin-Releasing Hormone analogues, Immunomodulators, Asthma and Allergy Monoclonal antibodies, and Viscosupplementation. cell or gene therapy, or any drugs with an ingredient cost over $1,000,00 per filled prescription.

To request Pre-Notification, the Covered Person or the Covered Person’s attending Doctor should notify the Plan at least 7 days in advance of treatment (or at the start of an organ or tissue donor search and selection) or 14 days in advance of treatment for services that are eligible for the Center of Excellence, for a second opinion through a preferred program, or for drugs that are eligible under the High Cost Drug program. Pre-Notification contact information is on the covered Employee's identification card. The Covered Person will be asked to provide:

a. name, address and the telephone number of the attending Doctor;
b. the diagnosis and the proposed surgical procedure (if applicable); and

c. the Covered Person's authorization or, if a minor, authorization on his behalf to release medical information.

Emergency Services should be pre-notified in the same manner as non-emergency services, but the Covered Person or the Covered Person's attending Doctor is asked to contact the Plan within forty-eight (48) hours (or the first business day immediately following an admission which occurs on a holiday, late Friday, Saturday, or Sunday), or as soon as reasonably possible, of the Emergency Service.

PRE-NOTIFICATION IS A **VOLUNTARY** PROGRAM:

- PRE-NOTIFICATION IS NOT REQUIRED FOR APPROVAL OF COVERAGE OR PAYMENT OF BENEFITS.
- PRE-NOTIFICATION SERVES ONLY TO COLLECT INFORMATION FOR THE SOLE PURPOSE OF IDENTIFYING POTENTIALLY CATASTROPHIC CLAIMS.
- PRE-NOTIFICATION DOES NOT PRE-AUTHORIZE OR PRE-CERTIFY COVERAGE OR BENEFITS, OR ACT TO AUTHORIZE HEALTH CARE SERVICES IN ANY MANNER.
- PRE-NOTIFICATION IS NOT A COMPONENT OF UTILIZATION REVIEW, NOR A BENEFIT DETERMINATION IN ADVANCE OF UTILIZATION REVIEW.

Enhanced Benefits: Additional and/or enhanced benefits may be available for a Pre-Notified medical condition. Refer to Section 8d - HEALTHCARE COORDINATION above.

4. Deductible Amount

In the event more than one Covered Person in the same Family (a covered Employee and his covered Dependent(s)) is injured by reason of any one accident, only one such individual Deductible Amount will be applied to all Covered Persons as the result of such accident, regardless of the number of persons involved.

5. Lifetime Maximum Aggregate Benefit (applies only to medical expenses that do not qualify as Essential Health Benefits)

Lifetime Maximum Benefit means the total maximum amount specified in the Schedule of Benefits which will be payable by the Plan for all Eligible Expenses which are incurred by the Covered Person for all Bodily Injuries and all Sickness combined during the Covered Person's lifetime and that do not qualify as Essential Health Benefits. No payment shall be made to, or on behalf of, the Covered Person to the extent that would cause the total amount paid by the Plan to exceed the Lifetime Maximum Aggregate Benefit.

6. Allocation and Apportionment of Benefits

The Plan reserve the right to allocate the Deductible Amount to any Eligible Expenses and to apportion the payment of benefits between the Employee and any person designated by the Employee. Any allocation and apportionment shall be conclusive and binding upon the Employee and all assignees.

7. Limitations and Exclusions

Unless specific exceptions to the following limitations and exclusions are made, no benefits shall be payable under the Plan for any expenses caused by, incurred for, or resulting from:

a. Bodily Injury or Sickness which arises out of or in the course of any employment for wage or profit (except for Covered Persons covered for the Optional Occupational Major Medical Expense Benefit for Corporate Officers, Owners and Partners), nor for a Bodily Injury or Sickness for which the Employee has or had a right to compensation under any workers' compensation insurance or similar insurance, or under any workers' compensation law, occupational disease law or similar law; irrespective of settlement or agreement (out-of-court or court approved) or a judgment or award by a court.

b. Services or supplies for which no charge is made, or for which the Covered Person is not required to pay, or for which a third party (or his insurance coverage) is responsible;

c. War or any act of war (declared or undeclared); civil unrest including riots, hostilities or invasion; injury or illness caused by a nuclear or radioactive accident;

d. Engaging in an illegal occupation; injury sustained while legally intoxicated and operating a motor vehicle, including motorcycles, scooters and ATV's; injury caused by or sustained while under the influence of any illegal or controlled substance (unless prescribed by and taken under the direction of a Doctor); or the commission of, or attempting to commit, an assault, battery or felony;

e. Cosmetic surgery, nor any treatment for ensuing complications; Cosmetic surgery includes but is not limited to:

   1) surgery to the upper and lower eyelid;
   2) augmentation mammoplasty;
   3) full or partial facial lifts;
   4) dermal or chemo abrasion;
   5) scar revision;
   6) otoplasty;

7) lift, stretch or reduction of abdomen, buttocks, thighs or upper arm;

8) silicone injections to any part of the body;

9) circumcision and

10) rhinoplasty;

Cosmetic surgery does **not** include:

1) surgery for a condition resulting from a congenital defect or birth abnormality; and

2) surgery due to Bodily Injury, which occurred while the Covered Person was covered under the Plan (or a newborn child).

f. Reduction mammoplasty that is not Medically Necessary;

g. Elective surgery which is not Medically Necessary, including complications or reconstruction arising therefrom, except for Eligible Expenses incurred by a Covered Person for vasectomies, tubal ligations, hysterectomies and other forms of voluntary sterilization;

h. Prevention or correction of teeth irregularities, including removal of soft tissue impacted teeth and malocclusion of jaws by wire appliances, braces or other mechanical aids, or any other care, repair, removal, replacement or treatment of or to the teeth or any surrounding tissues, except for the excision of partial bony or full bony impacted teeth or of a tumor or cyst, or an incision and drainage of an abscess or cyst or treatment listed as an Eligible Expense in this Part EDMM or the Schedule of Benefits;

i. Treatment or surgery as the result of temporomandibular joint dysfunction;

j. Treatment or surgery as the result of prognathism, retrognathism, microtrognathism, or any treatment or surgery to reposition the maxilla (upper jaw), mandible (lower jaw), or both maxilla and mandible;

k. Penile implant, reconstruction of vasectomy, or reconstruction of tubal ligation;

l. Keratotomies or other surgical procedures to correct refractive errors, or examinations for and the cost of eyeglasses, contact lens(es) or hearing aids, unless listed as an Eligible Expense in this Part EDMM or the Schedule of Benefits;

m. Exogenous or morbid obesity, including but not limited to:

1) weight reduction programs of any type;

2) all surgical procedures for the purpose of or as the result of weight reduction of a Covered Person;

3) all surgical procedures for creation, reconstruction, repair or reversal of gastric or jejunoileal bypass, or as a result thereof;

4) all treatment or surgery to remove redundant or excess tissue as a result of weight loss; and

5) any complications associated with any such treatments or procedures

n. Repair or replacement of artificial limbs or eyes, except if listed as an Eligible Expense in this Part EDMM or the Schedule of Benefits, or:

1) it is the Covered Person's primary prosthetic and used for Activities of Daily Living (not an additional or back-up prosthetic, or secondary prosthetic for a specialized purpose or function such as sports, bathing or similar limited activity);

2) made Medically Necessary as a result of physical bodily change, or natural breakdown of the prosthetic, incurred while the Covered Person was covered under the Plan;

3) the lack of repair or replacement is significantly impacting one or more Activities of Daily Living of the Covered Person;

4) it is recommended and prescribed by a Doctor; and

5) benefits have not previously been paid on behalf of the Covered Person for repair or replacement of any artificial limbs or eyes, while the Covered Person has been covered under the Plan;

o. Inpatient and Outpatient drugs (prescription or non-prescription) which are not directly related to a specific diagnosis, not Medically Necessary, or may be legally obtained without a written prescription by a Doctor, unless listed as an Eligible Expense in this Part EDMM or the Schedule of Benefits;

p. Specialty (Tier 4) and other high-cost drugs with an ingredient cost over $1,000.00 per filled prescription. Drugs may be sourced through the High Cost Drug Program, which your plan has arranged to help you in obtaining financial assistance to get your specialty and/or high cost drugs. You will need to enroll with High Cost Drug Program to be eligible for assistance or coverage.

q. Expenses incurred for preventive care or wellness exams, unless classified as a Preventive Care Service, or provided for in the Schedule of Benefits;

r. Expenses arising from the treatment of a Bodily Injury or Sickness for which the Covered Person is not under the regular care of a Health Care Provider or which are not authorized or prescribed by a Doctor;

s. Services furnished by a Hospital or institution which:

1) does not meet the definition specified in the Plan;

2) is owned or operated by the United States Government, or any agency thereof, or is owned or operated by any State, Province or any other political subdivision, unless there is a legal obligation for the Covered Person to pay in the absence of medical expense coverage;

t. Expenses for treatment, paring or removal of corns, calluses or toenails (other than partial or complete removal of nail roots) except when prescribed by a Doctor who is treating the Covered Person for a metabolic disease, such as diabetes mellitus or a peripheral-vascular disease such as arteriosclerosis; or treatment of the feet by posting or strapping, or range of motion studies, or orthotics;

u. Expenses incurred as the result of attempted suicide or intentionally self-inflicted Bodily Injury or Sickness while sane or insane, except that this exclusion does not apply to any self-inflicted Bodily Injury or Sickness that is the result of a medical condition;

v. Expenses incurred on a date on which the Covered Person is not covered under the Plan; Expenses which are not covered under the Plan; Expenses for treatment of a complication of a medical condition which is not covered under the Plan;

w. Treatment of infertility by any method other than natural intercourse including artificial insemination, in vitro fertilization of an ovum and/or development of an embryo in a laboratory, or use of fertility drugs; except that benefits shall be payable for medical or surgical services which are Medically Necessary for the physical diagnosis or treatment of infertility of a Covered Person, as set forth in paragraph 2, Eligible Expense of this Part EDMM, or classified as a Preventive Care Service;

x. Services received or supplies purchased outside the United States (other than Outpatient prescription medications obtained through the PDCS, if elected as an optional benefit), unless the charges are incurred while traveling on business or for pleasure, provided the procedure or treatment is approved for use in the United States and the claim is submitted in English or with English translation;

y. Any medical care, treatment, procedure, service, supply or drug determined by the Plan to be Experimental Treatment, or not Medically Necessary, or not an Eligible Expense, unless listed as an Eligible Expense in this Part EDMM or the Schedule of Benefits; or any expense in excess of the Fair and Reasonable Charge or Maximum Allowable Charge;

z. Services or supplies which are for maintenance only, including but not limited to such items as: surgical stockings, special bras following breast reconstruction, or supplies for Durable Mechanical Medical Equipment and prosthetics (including but not limited to prosthetic socks and gel liners); or replacement parts or repairs to Durable Mechanical Medical Equipment and prosthetics (including replacement or repairs due to recall by the manufacturer or required by law or regulation), except as provided for in the Schedule of Benefits or as set forth in paragraph 2, Eligible Expense of this Part EDMM;

aa. Custodial or Convalescence Care or nursing or rest or Extended Care or Residential Treatment or similar facilities, except as provided for in the Schedule of Benefits or as set forth in paragraph 2, Eligible Expense of this Part EDMM;

bb. An organ or tissue transplant or replacement, except those organ or tissue transplants or replacements specified under the Schedule of Benefits or as set forth in paragraph 2, Eligible Expense of this Part EDMM; or for or related to transplantation of animal or artificial organs or tissues; or for somatic cell nuclear transfer (SCNT) technologies or stem cell implantation procedures;

cc. Any service or supply in connection with the implant of an artificial organ, including the implant of the artificial organ;

dd. Any organ which is sold rather than donated to the Covered Person;

ee. Any service or supply in connection with autologous bone marrow transplantation for treatment of any disease other than acute lymphocytic leukemia, acute non-lymphocytic leukemia, Hodgkin's disease, non-Hodgkin's lymphoma, neuroblastomas and breast cancer when combined with high dose chemotherapy;

ff. Any service or supply in connection with autotransfusion/transplantation of autologous stem cells for the treatment of leukopenia from any cause;

gg. Any service or supply in connection with identification of an organ donor from a local, state or national listing;

hh. Any services or supplies in connection with cigarette smoking cessation, unless classified as a Preventive Care Service;

ii. Any service which is not documented in the Covered Person's medical file;

jj. Treatment, drugs, or devices for sexual dysfunction;

kk. Hypnotherapy when used to treat conditions that are not recognized as Nervous, Mental or Emotional Disorder by the American Psychiatric Association;

ll. Services and supplies related to narcotic maintenance for narcotic addiction; or

mm. Dialysis on an Outpatient basis, except to the extent covered under the Outpatient Dialysis Treatment Benefit, in Part EDOD above of this Section 9.

nn. Any charge for the therapeutic delivery of nucleic acid as a drug or other medication to treat disease, or for any other form of gene or cell therapy, unless specifically covered under the Schedule of Benefits or as set forth in paragraph 2, Eligible Expense of this Part EDMM. Drugs may be available through the High Cost Drug Program, which your plan has arranged to help you in obtaining financial assistance to get your specialty and/or high cost drugs. You will need to enroll with High Cost Drug Program to be eligible for assistance or coverage.

CLAIM PROCESSING PROCEDURES AND APPEAL RIGHTS

Your self-funded Group Health Plan (Plan) coverage is provided through an employee welfare benefit plan established by your employer. As a Plan participant, you (and your covered dependent(s)) have certain claim processing and appeal rights under the Employee Retirement Income Security Act of 1974 (as amended) (ERISA).

1. INTRODUCTION

Introduction: Under ERISA and applicable U.S. Department of Labor (DOL) regulations, claimants are entitled to full and fair review of any claims made under the Plan. The procedures described below are intended to comply with ERISA and these DOL regulations by providing reasonable procedures governing the filing of benefit claims, the issuing of benefit decisions and the reasonable notification of the right to appeal adverse benefit determinations.

Purpose: These procedures are furnished as a separate document that accompanies the Summary Plan Description (SPD) for your Plan. These procedures comply with ERISA and the DOL regulations. Consult the SPD for details regarding the benefits provided under the Plan.

2. DEFINITIONS

Plan: The Plan is the Employee Welfare Benefit Plan established by your employer.
Claim: A claim is any request for a Plan benefit or benefits made in accordance with these procedures. A communication regarding benefits that is not made in accordance with these procedures will not be treated as a claim under these procedures.
Claimant: You become a claimant when you make a request for a Plan benefit or benefits in accordance with these procedures.
Incorrectly-Filed Claim: Any request for benefits that is not made in accordance with these procedures is called an incorrectly-filed claim.
Authorized Representative: An Authorized Representative may act on behalf of a claimant with respect to a benefit claim or appeal under these procedures. However, no person (including a treating health care professional) will be recognized until the Plan receives written authorization signed by the claimant. Once an authorized representative is appointed, the Plan shall direct all information, notification, etc. regarding the claim to the authorized representative. The claimant shall be copied on all notifications regarding determinations, unless the claimant provides specific written direction otherwise. *Any reference in these procedures to claimant is intended to include the authorized representative of such claimant appointed in compliance with the above procedures.*
Plan Sponsor/Plan Administrator/Plan Fiduciary/Plan Trustee: Your employer is the Plan Sponsor, Plan Administrator, Plan Fiduciary and Plan Trustee for the Plan. The Plan is self-insured by your employer and benefits are funded by employer and employee contributions. The Plan is not insured by an insurance company and your employer is solely responsible for all benefit payments. Your employer, in its capacity as the Plan Administrator and in light of the purposes for which the Plan was established and is maintained, shall consider and render, in its sole discretion, appropriate eligibility, coverage and benefit determinations. In particular, the Plan Administrator shall have full and sole discretionary authority to interpret all Plan documents and to make all interpretive and factual determinations as to whether any individual is entitled to receive any benefits under the terms of the Plan. Your employer is also responsible for making claim and appeal determinations.
Designated Administrator: Your employer has, by agreement, delegated certain non-fiduciary, ministerial administrative acts, duties and responsibilities of the Plan to Allied National, LLC, a licensed third-party administrator (Allied National). As the designated administrator, Allied National is authorized to process enrollments, bill and collect contributions, process claims payments, and perform other services, according to the terms of the agreement.

3. HOW TO FILE A CLAIM FOR BENEFITS

General Filing Rules: A claim for benefits is made when a claimant (or authorized representative) submits written Notice and Proof of Loss as required in the SPD to:

Allied National, LLC, Attn: Claims Department, PO Box 29186, Shawnee Mission, KS 66201 (fax: 913-9454390)

A claim will be treated as received by the Plan (a) on the date it is hand delivered to the above address; (b) on the date that it is deposited in the U.S. Mail for first-class delivery in a properly-stamped envelope containing the above name and address (the postmark on any such envelope will be proof of date of mailing); (c) on the next business day immediately following the date it is faxed using the above fax number; or (d) on the next business day immediately following the date it is electronicly submitted in compliance with HIPAA electronic transaction standards.

Notice of a claim shall be filed within 30 calendar days, and Proof of Loss of a claim shall be filed within 90 calendar days, following receipt of the medical service, treatment or product to which the claim relates. However, if it was not reasonably possible to file notice or proof within those time periods, notice must be filed within 90 calendar days, and Proof of Loss must be filed within six (6) months, following receipt of the medical service, treatment or product (except in the case of legal incapacity of the claimant).

How Incorrectly-Filed Claims Are Treated: These procedures do not apply to any request for benefits that is not made in accordance with these procedures.

4. DETERMINING BENEFITS

Timeframe: The Plan shall determine benefits for a claim, or request any additional information needed to process an incomplete claim, within a reasonable time, but no later than 30 calendar days after receipt of the claim. The Plan issues only retrospective (post-service) claim determinations.

When Extensions of Time Are Permitted: Nothing prevents the claimant from voluntarily agreeing to extend the above timeframe.

Incomplete Claims: If any information needed to process a claim is missing, the claim shall be treated as an incomplete claim.

How Incomplete Claims Are Treated: If a claim is incomplete, the Plan may deny the claim or request the missing information within the 30-calendar day timeframe described above. If the Plan requests the missing information, it shall do so in writing and include a description of the missing information. The missing information must be provided within 45 calendar days. If the missing information is provided, the Plan shall determine benefits within 15 calendar days of receipt. If the missing information is not provided within the 45 calendar days, benefits may be denied or the claim may be inactivated.

5. NOTIFICATION OF ADVERSE DETERMINATION BY PLAN

Written Notification: Written notification of an adverse determination by the Plan shall be provided to the claimant.

Content of Notification of Adverse Benefit Decision: Written notification provided to the claimant of the Plan's adverse determination on a claim shall include the following, in a manner calculated to be understood by the claimant:

- a statement of the specific reason(s) for the determination;
- reference(s) to the specific Plan provision(s) on which the determination is based;
- a description of any additional material or information necessary to complete the required proof of loss and why such information is necessary;
- a description of the Plan procedures and time limits for appeal of the determination, and the right to obtain information about those procedures and the right to sue in federal court;
- a statement disclosing any internal rule, guidelines, protocol or similar criterion relied on in making the determination; and
- if the determination involves scientific or clinical judgment, disclose an explanation and discussion of the scientific or clinical judgment applying the terms of the Plan to the claimant's medical circumstances.

Definition of Adverse: A determination on a claim is "adverse" if it is a denial, reduction or termination of, or a failure to provide or make payment (in whole or in part) for a benefit, including any such denial, reduction, termination or failure to provide or make payment that is based on a determination of a participant's or beneficiary's eligibility to participate in a plan.

6. YOUR RIGHT TO APPEAL

Your Right to Appeal: A claimant has a right to appeal an adverse determination and to receive a full and fair review under these procedures.

7. HOW TO APPEAL AN ADVERSE BENEFIT DETERMINATION

Claim Inquiries: Please contact Allied National's Customer Service department at **1-800-825-7531** with any questions about the processing of your claim, including coverage and benefit determinations and Claim Reviews.

Internal Claim Review: If you disagree with a coverage or benefit determination, you have the **RIGHT TO APPEAL** that determination by requesting an Internal Claim Review within **180 CALENDAR DAYS** from the date you received the coverage or benefit determination. Only one (1) Internal Claim Review is available per claim. An Internal Claim Review determination acts as a Final Internal Adverse Benefit Determination.

Internal Claim Review Instructions and Procedures:

1. To request an Internal Claim Review, please

   a. State your request for an Internal Claim Review in writing, include your full name, date of birth and certificate number, identify the claim in question, and explain why you disagree with the determination. You may also submit any additional written comments, documents, records or other information relating to the claim.

   b. Sign and date your written request and attach all supporting documentation.

   c. Mail the written request and attachments to the following address, **within the 180-day deadline stated above**:

   Allied National, LLC, Attn: Internal Claim Reviews, PO Box 29186, Shawnee Mission, KS 66201

2. Upon request and at no charge, you may have reasonable access (including copies) to the claim file, including all documents, records and information submitted to our office that relate to your claim.

3. The Internal Claim Review will take into account all written comments, documents, records and other information submitted to our office that relate to your claim, including comments, documents, records or other information not previously considered or submitted at the time the claim was processed.

4. Copies of any clinical rationale or review criteria and any new or additional evidence which the Internal Claim Review considers, relies upon or generates will be included with our written determination, free of charge.

5. The Internal Claim Review will be a "fresh" look at your claim, ignoring the appealed determination. It will be conducted by a person not involved in the appealed determination, not currently supervised by someone involved in that determination, and whose terms of employment are not based on the likelihood of upholding that determination.

6. If the appealed determination is based on a medical judgment (in whole or in part), the Internal Claim Review will include consultation with a health care professional, trained and experienced in the medical field relevant to the determination, not involved in the appealed determination, not currently supervised by someone involved in that determination and whose terms of employment are not based on the likelihood of upholding that determination.

7. You, your doctor or your authorized representative may request an Internal Claim Review and you may be represented by a relative, friend, lawyer or other authorized representative.

8. You may present evidence and testimony by submitting written comments, documents, records or other information relating to the claim. Hearings, panel reviews or other formal in-person proceedings are not conducted.

9. Within 5 business days of receiving your written request, our office will mail a written acknowledgement to you.

10. Within 30 calendar days of receiving your written request, our office will mail a written determination to you.

Optional Second Internal Review: If you disagree with the Internal Claim Review, you may go directly to External Review (if available, see below) or request an optional Second Internal Review. A written request for a Second Internal Review must be submitted to our office within 180 CALENDAR DAYS [six (6) months] from the date you received the determination for the initial Internal Claim Review. Please refer to the Internal Claim Review Instructions and Procedures stated above for completing and submitting a written request for a Second Internal Review. Only one (1) Second Internal Review is available per claim. A Second Internal Review is completely voluntary and not required to exhaust your rights of appeal under your health plan coverage.

External Review: You may have a right to External Review of your claim if:

1. You disagree with the Internal Claim Review (or the optional Second Internal Review, if one was requested); and
2. Your claim is eligible for Independent or External Review by an Independent Review Organization (IRO) under applicable law (including, but not limited to, medical judgment determinations such as medical necessity, appropriateness, health care setting, level of care or effectiveness).

Please refer to the External Review Instructions below for submitting a written request. Only one (1) External Review is available per claim. External Review is provided at no charge to you (some states may charge a small processing fee) and acts as a Final External Review Decision.

External Review Instructions: If External Review is available for your claim, an application packet will be enclosed with the determination for the Internal Claim Review. To request External Review, please follow the instructions contained in the packet and mail the application within 120 CALENDAR DAYS [four (4) months] from the date you received the determination for the Internal Claim Review (or the Second Internal Review, if one was requested).

State Assistance: You also have the right to request assistance from, or to file a complaint with, the Department of Insurance (DOI) or Consumer Services Division (CSD) for your state of residence (or employment), at any time. Please note the following contact information:

CA: CSD, 980 9th St., S. 500, Sacramento, CA 95814, http://www.healthhelp.ca.gov, 888-466-2219, helpline@dmhc.ca.gov
CO: DOI, 1560 Broadway, S. 850, Denver, CO 80202, http://www.dora.state.co.us/insurance, 800-930-3745
GA: CSD, 2 MLK, Jr. Dr., W. Tr., S. 716, Atlanta, GA 30334, http://www.oci.ga.gov/consumerservice/home.aspx, 800-656-2298
IL: CSD, 320 W. Washington St., 4th Fl., Springfield, IL 62727, http://www.insurance.illinois.gov, 877-527-9431
IN: DOI, 311 W. Washington St., S. 300, Indianapolis, IN 46204-2787, http://www.in.gov/idoi, 800-622-4461
IA: CSD, 330 Maple St., Des Moines, IA 50319, http://www.insuranceca.iowa.gov, 877-955-1212
KS: CSD, 420 SW 9th St., Topeka, KS 66612, http://www.ksinsurance.org, 800-432-2484, CAP@ksinsurance.org
MO: CSD, 301 W. High St., Rm. 830, Jefferson City, MO 65101, www.insurance.mo.gov, 800-726-7390
NE: DOI, 941 O St., S. 400, Lincoln, NE 68508-3639, http://www.doi.ne.gov/, 877-564-7323
NV: CSD, 555 E. Washington Ave., S. 4800, Las Vegas, NV 89101, http://www.govcha.state.nv.us, 888-333-1597
OH: DOI, 50 W. Town St., 3rd Fl., S. 300, Columbus, OH 43215, http://www.ohioinsurance.gov/, 800-686-1526
OK: CSD, 3625 NW 56th St, S 100, OK City, OK 73112, http://oid.ok.gov/, 800-522-0071
PA: CSD, 1326 Strawberry Square, Harrisburg, PA 17111, www.insurance.pa.gov, 877-881-6388
TN: CSD, 500 James Robertson Pkwy, DC Tr, 4th Fl, Nashville, TN 37243, www.tn.gov/commerce/insurance, 800-342-4029
TX: CSD, MC 111-1A, 333 Guadalupe, Austin, TX 78714, www.texashealthoptions.com, 855-839-2427, chap@tdi.state.tx.us
VA: CSD, P.O. Box 1157, Richmond, VA 23218, http://www.scc.virginia.gov/boi, 877-310-6560

Plan Assistance: To request assistance from or file a complaint with the Plan, please note the following contact information:

Judicial Review: If you exhaust all administrative rights of appeal under your Group Health Plan, you have the right to bring a civil action under Section 502(a) of ERISA. The time limitations stated in your Plan SPD for bringing legal actions or proceedings apply to any such civil action.

CONTINUATION OF GROUP HEALTH PLAN COVERAGE

Your self-funded Group Health Plan (Plan) coverage is provided through an employee welfare benefit plan sponsored by your employer. If your Sponsoring Employer normally employed at least 20 employees on a typical business day during the prior calendar year, and Plan coverage for you (or your dependent(s)) terminates, you (or your dependent(s)) may have a right to continue Plan coverage under the Consolidated Omnibus Budget Reconciliation Act of 1985 (as amended) (COBRA).

I. DEFINITIONS - The following terms whenever used shall have the following meanings:

1) "Group Health Plan" means - an employee welfare benefit plan providing medical care to participants who are beneficiaries directly or through an insurance carrier, reimbursement plan, or otherwise.
2) "Covered Employee" means - an employee eligible for coverage under the Plan and covered in accordance therewith.
3) "Covered Dependent Spouse" means - a Covered Employee's Dependent Spouse, who is eligible for coverage under the Plan and covered in accordance therewith.
4) "Covered Dependent Child" means - a Covered Employee's Dependent Child, who is eligible for coverage under the Plan and covered in accordance therewith.
5) "Medicare" means - Title XVIII of the Social Security Act of 1965, as last amended.
6) "Qualified Employee" means - a Covered Employee who is eligible in the event of an Employee Qualifying Event (as defined below) for continuation of coverage under the Plan. However, in no event will a non-resident alien be considered a Qualified Employee.
7) "Qualified Dependent Spouse" means - a Covered Dependent Spouse who is eligible in the event of a Spouse Qualifying Event (as defined below) for continuation of coverage under the Plan. However, in no event will a non-resident alien be considered a Qualified Dependent Spouse.
8) "Qualified Dependent Child" means - a Covered Dependent Child who is eligible in the event of a Child Qualifying Event (as defined below) for continuation of coverage under the Plan. It also includes a child who is born or placed for adoption with the Covered Employee. However, in no event will a non-resident alien be considered a Qualified Dependent Child.
9) A. "Employee Qualifying Event" means:
    1. the termination of the Covered Employee's employment with the Sponsoring Employer due to any reason other than his gross misconduct; or
    2. the termination of eligibility for coverage under the Plan by reason of being employed by the Sponsoring Employer for less than 30 hours per week.

    B. "Spouse Qualifying Event" means:
    1. the events in A. 1. and A. 2. of this paragraph 8;
    2. the termination of eligibility for coverage under the Plan by reason of death of the Covered Employee;
    3. the termination of eligibility for coverage under the Plan by reason of divorce or legal separation from the Covered Employee (or dissolution or annulment of a Domestic Partnership or Civil Union with the Covered Employee); or
    4. the termination of eligibility for coverage under the Plan when the Covered Employee becomes covered under Medicare.

    C. "Child Qualifying Event" means:
    1. the events indicated in A. 1. and A. 2. of this paragraph 8;
    2. the termination of eligibility for coverage under the Plan by reason of death of the Covered Employee;
    3. the termination of eligibility for coverage under the Plan when the child no longer qualifies as a dependent under the Plan; or
    4. the termination of eligibility for coverage under the Plan when the Covered Employee becomes covered under Medicare.

II. CONTINUATION OF COVERAGE FOR QUALIFIED EMPLOYEES

A Qualified Employee shall have the option to continue his medical expense coverage under the Plan, with respect to himself, his Qualified Dependent Spouse and his Qualified Dependent Children, beyond the date his medical expense coverage would otherwise terminate due to the Employee Qualifying Event, subject to the following conditions:

1) his Sponsoring Employer notifies the Plan Administrator of the Employee Qualifying Event within 30 days of its occurrence;
2) he makes written election to continue his medical expense coverage under the Plan, within 60 days of the date his coverage terminates under the Plan due to the Employee Qualifying Event, or the date he receives notice of the right to make such election from the Plan Administrator, whichever is later; and
3) he pays to the Sponsoring Employer the total amount of medical expense coverage contributions required (as set forth in Section VI. CONTRIBUTIONS), within 45 days of electing continuation (as indicated in number 2 immediately above in this paragraph).

A Qualified Employee will not be denied continuation solely because he is covered under another Group Health Plan or Medicare on the date the Employee Qualifying Event occurs.

If a Qualified Employee timely elects continuation, the right to continue coverage under the Plan shall terminate on the earliest of the following dates:

1) 18 months following the date of the Employee Qualifying Event;
2) 29 months following the date of the Employee Qualifying Event, subject to the following conditions:
   a) the Qualified Employee (or his Qualified Dependent Spouse or Qualified Dependent Child) is determined to be disabled (as defined under the Social Security Act of 1965) at any time within the first 60 days of the continuation coverage; and
   b) the Qualified Employee (or his Qualified Dependent Spouse or Qualified Dependent Child) provides notice to the Plan Administrator of the determination of disability, within 60 days of that disability determination, or the date of the Employee Qualifying Event, or the date coverage would otherwise terminate under the Plan due to the Employee Qualifying Event, or the date the Qualified Employee received this COBRA written notice, whichever is later.
3) with respect to continuation of coverage beyond 18 months pursuant to number 2 immediately above in this paragraph, at the end of the month that begins more than 30 days after the date of a final determination that the Qualified Employee (or his Qualified Dependent Spouse or Qualified Dependent Child) is no longer disabled (as defined under the Social Security Act of 1965).
4) the end of the period for which the last payment for his contributions was made to the Sponsoring Employer when due;
5) the date on which the Plan terminates;
6) the date on which the Sponsoring Employer ceases to sponsor the Plan;
7) the date he becomes covered under Medicare; or
8) the date he becomes covered by any other Group Health Plan that does not contain any exclusion or limitation with respect to any pre-existing health condition of the Qualified Employee. **Refer to Section V, Simultaneous Coverage Under the Plan and Under Another Group Health Plan, of this written notice for conditions applicable when a Qualified Employee is covered under the Plan and, by reason of employment, under another Group Health Plan that contains an exclusion or limitation with respect to pre-existing health conditions of the Qualified Employee.**

III. CONTINUATION OF COVERAGE FOR QUALIFIED DEPENDENT SPOUSES

A Qualified Dependent Spouse shall have the option to continue his medical expense coverage under the Plan, with respect to himself and his Qualified Dependent Children, beyond the date his medical expense coverage would otherwise terminate due to the Spouse Qualifying Event, subject to the following conditions:

1) if the Spouse Qualifying Event is due to divorce, annulment or other legal dissolution of a Marriage, Same Sex Marriage, Domestic Partnership or Civil Union with the Covered Employee, or legal separation from the Covered Employee, he (or the Covered Employee) notifies the Plan Administrator of the Spouse Qualifying Event within 60 days of its occurrence;
2) if the Spouse Qualifying Event is due to any reason other than as set forth in number 1 of this paragraph, the Sponsoring Employer notifies the Plan Administrator of the Spouse Qualifying Event within 30 days of its occurrence;
3) he makes written election to continue his medical expense coverage under the Plan, within 60 days of the date his coverage terminates under the Plan due to the Spouse Qualifying Event, or the date he receives notice of the right to make such election from the Plan Administrator, whichever is later; and
4) he pays to the Sponsoring Employer the total amount of medical expense coverage contributions required (as set forth in Section VI. CONTRIBUTIONS), within 45 days of electing continuation (as indicated in number 3 immediately above in this paragraph).

A Qualified Dependent Spouse will not be denied continuation solely because he is covered under another Group Health Plan or Medicare on the date the Spouse Qualifying Event Occurs.

A Qualified Dependent Spouse is individually entitled to a separate election of this continuation of coverage option.

If a Qualified Dependent Spouse timely elects continuation, the right to continue coverage under the Plan shall terminate on the earliest of the following dates:*

1) 18 months following the date of the Spouse Qualifying Event, if the Spouse Qualifying Event results from the occurrence of an Employee Qualifying Event and the Covered Employee is under age 65;
2) 29 months following the date of the Spouse Qualifying Event, subject to the following conditions:
   a) the Spouse Qualifying Event results from the occurrence of an Employee Qualifying Event;
   b) the Qualified Dependent Spouse (or the Qualified Employee or a Qualified Dependent Child) is determined to be disabled (as defined under the Social Security Act of 1965) at any time within the first 60 days of the continuation coverage; and
   c) the Qualified Dependent Spouse (or the Qualified Employee or a Qualified Dependent Child) provides notice to the Plan Administrator of the determination of disability, within 60 days of that disability determination, or the date of the Spouse Qualifying Event, or the date coverage would otherwise terminate under the Plan due to the Spouse Qualifying Event, or the date the Qualified Employee received this COBRA written notice, whichever is later.
3) with respect to continuation of coverage beyond 18 months pursuant to number 2 immediately above in this paragraph, at the end of the month that begins more than 30 days after the date of a final determination that the Qualified Dependent Spouse (or the Qualified Employee or a Qualified Dependent Child) is no longer disabled (as defined under the Social Security Act of 1965).

4) 36 months following the date of the Spouse Qualifying Event, if the Spouse Qualifying Event results from the occurrence of an Employee Qualifying Event and the Insured Employee is age 65 or over;
5) 36 months following the date of the Spouse Qualifying Event, if the Spouse Qualifying Event does not result from the occurrence of an Employee Qualifying Event;
6) the end of the period for which the last payment for his contributions was made to the Sponsoring Employer when due;
7) the date on which the Plan terminates;
8) the date on which the Sponsoring Employer ceases to sponsor the Plan; or
9) the date he becomes covered by Medicare, or he becomes covered by any other Group Health Plan that does not contain any exclusion or limitation with respect to any pre-existing health condition of the Qualified Dependent Spouse. **Refer to Section V, Simultaneous Coverage Under the Plan and Under Another Group Health Plan, of this written notice for conditions applicable when a Qualified Dependent Spouse is covered under the Plan and by reason of employment under another Group Health Plan that contains an exclusion of limitation with respect to pre-existing health conditions of the Qualified Dependent Spouse.**

***NOTE: The combined maximum period of continued coverage cannot exceed 36 months, even if multiple Qualifying Events are experienced.**

IV. CONTINUATION OF COVERAGE FOR QUALIFIED DEPENDENT CHILDREN

A Qualified Dependent Child shall have the option to continue his medical expense coverage under the Plan, beyond the date his medical expense coverage would otherwise terminate due to the Child Qualifying Event, subject to the following conditions:

1) if the Child Qualifying Event is due to the Qualified Dependent Child no longer qualifying as a dependent under the Plan, he (or the Insured Employee or Dependent Spouse) notifies the Plan Administrator of the Child Qualifying Event within 60 days of its occurrence;
2) if the Child Qualifying Event is due to any reason other than as set forth in number 1 of this paragraph, the Sponsoring Employer notifies the Plan Administrator of the Child Qualifying Event within 30 days of its occurrence;
3) he makes written election to continue his medical expense coverage under the Plan, within 60 days of the date his coverage terminates under the Plan due to the Child Qualifying Event, or the date he receives notice of the right to make such election from the Plan Administrator, whichever is later; and
4) he pays to the Sponsoring Employer the total amount of medical expense coverage contributions required (as set forth in Section VI. CONTRIBUTIONS), within 45 days of electing continuation (as indicated in number 3 immediately above in this paragraph).

A Qualified Dependent Child is individually entitled to a separate election of this continuation of coverage option.

A Qualified Dependent Child will not be denied continuation solely because he is covered under another Group Health Plan or Medicare.

If a Qualified Dependent Child timely elects continuation, the right to continue coverage under the Plan shall terminate on the earliest of the following dates:*

1) 18 months following the date of the Child Qualifying Event, if the Child Qualifying Event results from the occurrence of an Employee Qualifying Event and the Covered Employee is under age 65;
2) 29 months following the date of the Child Qualifying Event, subject to the following conditions:
   a) the Child Qualifying Event results from the occurrence of an Employee Qualifying Event;
   b) the Qualified Dependent Child (or the Qualified Employee or Qualified Dependent Spouse) is determined to be disabled (as defined under the Social Security Act of 1965) at any time within the first 60 days of the continuation coverage; and
   c) the Qualified Dependent Child (or the Qualified Employee or Qualified Dependent Spouse) provides notice to the Plan Administrator of the determination of disability, within 60 days of that disability determination, or the date of the Child Qualifying Event, or the date coverage would otherwise terminate under the Plan due to the Child Qualifying Event, or the date the Qualified Employee received this COBRA written notice, whichever is later.
3) with respect to continuation of coverage beyond 18 months pursuant to number 2 immediately above in this paragraph, at the end of the month that begins more than 30 days after the date of a final determination that the Qualified Dependent Child (or the Qualified Employee or Qualified Dependent Spouse) is no longer disabled (as defined under the Social Security Act of 1965).
4) 36 months following the date of the Child Qualifying Event, if the Child Qualifying Event results from the occurrence of an Employee Qualifying Event and the Covered Employee is age 65 or over;
5) 36 months following the date of the Child Qualifying Event, if the Child Qualifying Event does not result from the occurrence of an Employee Qualifying Event;
6) the end of the period for which the last payment for his contributions was made to the Sponsoring Employer when due;
7) the date on which the Plan terminates;
8) the date on which the Sponsoring Employer ceases to sponsor the Plan; or
9) the date he becomes covered by Medicare, or he becomes covered by any other Group Health Plan that does not contain any exclusion or limitation with respect to any pre-existing health condition of the Qualified Dependent Spouse. **Refer to Section**

V, Simultaneous Coverage Under the Plan and Under Another Group Health Plan, of this written notice for conditions applicable when a Qualified Dependent Spouse is covered under the Plan and by reason of employment under another Group Health Plan that contains an exclusion of limitation with respect to pre-existing health conditions of the Qualified Dependent Spouse.

***NOTE: The combined maximum period of continued coverage cannot exceed 36 months, even if multiple Qualifying Events are experienced.**

V. SIMULTANEOUS COVERAGE UNDER THE PLAN AND UNDER ANOTHER GROUP HEALTH PLAN

A Qualified Employee (with respect to himself and his Qualified Dependent Spouse and Qualified Dependent Children), Qualified Dependent Spouse (with respect to himself and his Qualified Dependent Children), or Qualified Dependent Child, shall be subject to the following conditions when he is covered under the Plan and, by reason of employment, under another Group Health Plan that contains an exclusion or limitation with respect to the qualified person's pre-existing conditions:

1) If such person incurs Eligible Expenses as a result of a health condition deemed to be a pre-existing condition under the definitions and limitations of the other Group Health Plan, upon receipt of proof that the underwriter of the other Group Health Plan denied benefits for such pre-existing condition, the Plan, subject to all Plan provisions, terms, exclusions and limitations, shall pay medical expense coverage benefits for such pre-existing conditions.
2) If such person incurs Eligible Expenses as a result of a health condition, other than a pre-existing condition under the terms of the other Group Health Plan, upon receipt of due proof, the Plan, subject to all Plan provisions, terms, exclusions and limitations, shall pay medical expense coverage benefits for such conditions. The Coordination of Benefits provisions in the Plan shall apply to such benefit payments and when there is a basis for a claim under the Plan and under the other Group Health Plan, the Plan shall be deemed as the secondary plan which has its benefits determined after those of the other Group Health Plan.

Provided, however, that in accordance with the termination of coverage provisions set forth in Sections II, III and IV hereof, continued coverage under the Plan shall terminate on the date the Other Group Health Plan's pre-existing health condition exclusion or limitation is no longer in effect.

VI. CONTRIBUTIONS

The contribution rates for the continuation coverage under the terms and conditions of this written notice shall not exceed 102% of the applicable group contribution rate; **provided, however, that with respect to a Qualified Employee or Qualified Dependent Spouse or Qualified Dependent Child who is considered to be disabled (as defined under the Social Security Act of 1965) within the first 60 days of the continuation coverage, the premium rate shall be 150% for any month after the 18th month of continued coverage. Premium rates shall be based on:**

1) the rating structure of the Sponsoring Employer's Medical Expense Plan;
2) the Qualified Employee's attained age on each contribution due date;
3) with respect to a Qualifying Dependent Spouse, the Qualified Employee's or the Covered Employee's attained age (or the age that would have been attained had such employee survived) on each contribution due date that would be charged if the Qualified Dependent Spouse had remained covered under the Plan as a dependent of the Qualified Employee or the Insured Employee;
4) with respect to a Qualified Dependent Child, the Qualified Employee's or the Covered Employee's attained age (or the age that would have been attained had such employee survived) on each contribution due date that would be charged if the Qualified Dependent Child had remained covered under the Plan as a dependent of the Qualified Employee or the Insured Employee;
5) the benefit structure of the Plan on each contribution due date. If the Sponsoring Employer modifies its Medical Expense Plan, continuation of coverage hereunder for a Qualified Employee, Qualified Dependent Spouse or Qualified Dependent Child will also be modified accordingly; and
6) the rating factors applied by the Sponsoring Employer.

A grace period of 30 days will be allowed for any contribution due. If the Qualified Employee, Qualified Dependent Spouse or Qualified Dependent Child fails to pay such contribution before the expiration of the grace period, his coverage shall lapse as of the contribution due date.

Contributions, if any, by the Sponsoring Employer shall be made in a non-discriminatory manner.

VII. ASSISTANCE

Your employer is the Plan Sponsor, Plan Administrator, Plan Fiduciary and Plan Trustee for the Plan. Your employer has, by agreement, delegated certain non-fiduciary, ministerial administrative acts, duties and responsibilities of the Plan to Allied National, LLC, a licensed third-party administrator (Allied National). Please contact Allied National with any questions about continuation of coverage under the Plan: Allied National, LLC, P.O. Box 29186, Shawnee Mission, KS 66201, or 1-800-825-7531, or http://www.alliednational.com/. You may also contact the Employee Benefits Security Administration (EBSA) of the U.S. Department of Labor. Addresses and phone numbers for regional and district EBSA offices are available at: http://www.dol.gov/ebsa.

WOMEN'S HEALTH AND CANCER RIGHTS

You or a covered Dependent may be entitled to certain Plan benefits under the Women's Health and Cancer Rights Act of 1998 (WHCRA). The following Plan coverage will be provided, in a manner determined in consultation with the attending physician and the patient, to any Covered Person who is receiving benefits in connection with a mastectomy and who elects breast reconstruction in connection with such mastectomy:

(1) all stages of reconstruction of the breast on which the mastectomy has been performed;
(2) surgery and reconstruction of the other breast to produce a symmetrical appearance;
(3) prostheses; and
(4) treatment of physical complications of the mastectomy, including lymphedemas.

Such coverage is subject to annual deductibles and coinsurance provisions as are consistent with those established for other benefits under the Plan.

Your employer is the Plan Sponsor, Plan Administrator, Plan Fiduciary and Plan Trustee for the Plan. Your employer has, by agreement, delegated certain non-fiduciary, ministerial administrative acts, duties and responsibilities of the Plan to Allied National, LLC, a licensed third-party administrator (Allied National). Please contact Allied National with any questions about WHCRA benefits under the Plan: Allied National, LLC, P.O. Box 29186, Shawnee Mission, KS 66201, or 1-800-825-7531, or http://www.alliednational.com/.

UNIFORMED SERVICES RIGHTS

Your self-funded Group Health Plan (Plan) coverage is provided through an employee welfare benefit plan sponsored by your employer. If Plan coverage for you (or your dependent(s)) terminates due to "service" in the "uniformed services", you (or your dependent(s)) may have the following rights under the Uniformed Services Employment and Reemployment Rights Act of 1994 (USERRA):

- To elect to continue your Plan coverage (for you and any covered dependents) for up to 24 months; or
- To have your Plan coverage reinstated upon reemployment (without waiting periods or exclusions, except for service-connected illnesses or injuries).

The above rights are subject to:

- Providing the Plan with reasonable advance written notice of your absence from work due to "service" in the "uniformed services" (unless precluded by military necessity or otherwise impossible or unreasonable under the circumstances);
- If your "service" is for less than 31 days, you will be required to continue to pay the employee contributions for your Plan coverage;
- If your "service" is for more than 30 days, you will be required to pay up to 102% of all contributions for your Plan coverage (both employer and employee contributions);
- Upon completion of your "service", returning to your employment within the time periods stated in USERRA; and
- Not receiving a dishonorable discharge from the military (or other disciplinary action, as stated in USERRA).

"Service" means the performance of duty on a voluntary or involuntary basis in the uniformed services under competent authority, including active duty, active and inactive duty for training, National Guard duty under federal statute, a period for which a person is absent from employment for an examination to determine his or her fitness to perform any of these duties, and a period for which a person is absent from employment to perform certain funeral honors duty. It also includes certain service by intermittent disaster response appointees of the National Disaster Medical System (NDMS).

"Uniformed services" means the Armed Forces, the Army National Guard, and the Air National Guard when an individual is engaged in active duty for training, inactive duty training, or full-time National Guard duty (i.e., pursuant to orders issued under federal law), the commissioned corps of the Public Health Service, and any other category of persons designated by the President in time of war or national emergency.

Your employer is the Plan Sponsor, Plan Administrator, Plan Fiduciary and Plan Trustee for the Plan. Your employer has, by agreement, delegated certain non-fiduciary, ministerial administrative acts, duties and responsibilities of the Plan to Allied National, LLC, a licensed third-party administrator (Allied National). Please contact Allied National with any questions about USERRA rights under the Plan: Allied National, LLC, P.O. Box 29186, Shawnee Mission, KS 66201, or 1-800-825-7531, or http://www.alliednational.com/.

You may also contact The U.S. Department of Labor, Veterans' Employment and Training Service (VETS) at 1-866-487-2365 or http://www.dol.gov/vets and http://www.dol.gov/elaws/userra.htm.

NEWBORNS' AND MOTHERS' MATERNITY RIGHTS

Your self-funded Group Health Plan (Plan) coverage is provided through an employee welfare benefit plan sponsored by your employer.

Under the Newborns' and Mothers' Health Protection Act of 1996 (NMHPA):

1. The Plan may not restrict benefits for any Hospital length of stay in connection with childbirth for the mother or the newborn child to less than 48 hours following a vaginal delivery, or less than 96 hours following a cesarean section (unless the Doctor discharges the mother or newborn earlier, after consultation with the mother);
2. The Plan 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; and
3. The Plan may not require the Doctor to obtain authorization for prescribing a length of stay of up to 48 hours (or 96 hours). (unless required to use certain providers or facilities, or to reduce your out-of-pocket costs).

Coverage of the newborn child under the Plan is available only if the newborn qualifies as an eligible Dependent Child under the Plan. Coverage of the newborn is retroactive to the instant the child is born, subject to the newborn qualifying as an eligible Dependent Child under the Plan and timely submission of all required enrollment forms and contributions for that child

Your employer is the Plan Sponsor, Plan Administrator, Plan Fiduciary and Plan Trustee for the Plan. Your employer has, by agreement, delegated certain non-fiduciary, ministerial administrative acts, duties and responsibilities of the Plan to Allied National, LLC, a licensed third-party administrator (Allied National). Please contact Allied National with any questions about NMHPA benefits under the Plan: Allied National, LLC, P.O. Box 29186, Shawnee Mission, KS 66201, or 1-800-825-7531, or http://www.alliednational.com/.

QUALIFIED MEDICAL CHILD SUPPORT ORDERS

Your self-funded Group Health Plan (Plan) coverage is provided through an employee welfare benefit plan sponsored by your employer.

Under the Employee Retirement Income Security Act of 1974 (as amended) (ERISA), any state court or domestic relations magistrate may issue a judgment, decree or order known as a Qualified Medical Child Support Order (QMCSO). A QMCSO orders a Plan participant (an Employee or his Spouse) to provide health benefit coverage for a Child. To qualify, the order must meet these requirements:

1. The name and last known address of the Employee or his Spouse;
2. The name and last known address of the Child (or state official or political subdivision);
3. A reasonable description of the health benefit coverage to be provided to the Child, or the manner in which such coverage is to be determined; and
4. The period of time to which the order applies.

The Plan has established procedures governing the qualification and processing of QMCSO's:

a. Within ten (10) days of receiving a QMCSO, the Plan notifies both the Plan participant and child.

b. The notice provides the Plan's procedures for determining if a QMCSO is qualified.

c. Within thirty (30) days, the Plan determines if the QMCSO is qualified.

d. If the QMCSO is determined to be deficient, the Plan notifies the Plan participant and child. A corrected QMCSO may then be resubmitted and the Plan has fifteen (15) days to determine whether the resubmitted QMCSO is qualified.

e. If the QMCSO is determined to be qualified, the Plan notifies the Plan participant and child, and enrolls the child.

Your employer is the Plan Sponsor, Plan Administrator, Plan Fiduciary and Plan Trustee for the Plan. Your employer has, by agreement, delegated certain non-fiduciary, ministerial administrative acts, duties and responsibilities of the Plan to Allied National, LLC, a licensed third-party administrator (Allied National). Please contact Allied National with any questions about QMCSO enrollment under the Plan: Allied National, LLC, P.O. Box 29186, Shawnee Mission, KS 66201, or 1-800-825-7531, or http://www.alliednational.com/.

NOTICE OF FAMILY & MEDICAL LEAVE RIGHTS

Your self-funded Group Health Plan (Plan) coverage is provided through an employee welfare benefit plan sponsored by your employer. A Federal law called the Federal Family and Medical Leave Act of 1993 (FMLA) provides continuation and reinstatement rights for Eligible Employees employed by Eligible Employers.

Eligible Employer: Any employer engaged in commerce or in any industry or activity affecting commerce who employs 50 or more employees for each working day during each of 20 or more calendar workweeks in the current or preceding calendar years.

Eligible Employee: An employee who has worked for the Eligible Employer:

1. For at least 12 months;
2. For at least 1,250 hours (approximately 24 hours per week) during the year preceding the start of the leave; and

3. At a work-site where the Eligible Employer employs at least 50 employees within a 75-mile radius.

FMLA Leave: Eligible Employers must allow Eligible Employees up to 12 weeks of unpaid leave during any 12-month period (FMLA Leave) for:

1. Birth of a child of an Eligible Employee and in order to care for the child; or
2. Placement of a child with Eligible Employee for adoption or foster care; or
3. Care (physical or psychological care) of a Spouse , Child, or parent of the Eligible Employee, if they have a "serious health condition"; or
4. A "serious health condition" that makes the Eligible Employee unable to perform the functions of his job.

FMLA Continuation Right: If an Eligible Employee takes FMLA Leave, and elects to continue his coverage under the Plan, the Eligible Employer must maintain the employee's coverage by continuing to pay its share of the contributions.
FMLA Reinstatement Right: If an Eligible Employee takes FMLA Leave, but does not elect to continue his coverage under the Plan, the Eligible Employer must reinstate Plan coverage for the Eligible Employee upon his return, on the same terms as before the FMLA Leave.

Your employer is the Plan Sponsor, Plan Administrator, Plan Fiduciary and Plan Trustee for the Plan. Your employer has, by agreement, delegated certain non-fiduciary, ministerial administrative acts, duties and responsibilities of the Plan to Allied National, LLC, a licensed third-party administrator (Allied National). Requests for FMLA continuation or reinstatement should be directed to Allied National: Allied National, LLC, P.O. Box 29186, Shawnee Mission, KS 66201, or http://www.alliednational.com/, or 1-800-825-7531.

NOTICE OF MEDICARE COORDINATION OF BENEFITS

Your self-funded Group Health Plan (Plan) coverage is provided through an employee welfare benefit plan sponsored by your employer. A Federal law called the Tax Equity and Fiscal Responsibility Act of 1982 (TEFRA) prohibits the Plan from coordinating benefit payments with Title XVIII of the Social Security Act of 1965 (Medicare) if your employer employs 20 or more employees.

Applicable Employers: Any employer engaged in commerce or in any industry or activity affecting commerce who employs 20 or more employees each working day during 20 or more weeks, either in the current or immediately preceding calendar year.

Applicable Employees: An employee employed by an Eligible Employer who is:

1. Covered under the Plan;
2. Entitled to benefits under Part A of Medicare; and
3. Age 65 or older.

Applicable Dependent Spouses: A Spouse of an employee of an Eligible Employer, who is:

1. Covered under the Plan;
2. Entitled to benefits under Part A of Medicare; and
3. Age 65 or older.

Medicare Coordination: With respect to Plan benefits payable on behalf of Applicable Employees and Dependent Spouses, the Plan is prohibited from reducing such benefit payments, if based on amounts payable under Parts A or B of Medicare.

IMPORTANT: Failure to enroll in Medicare may result in significant out-of-pocket expenses. If you are eligible for Medicare, the Plan may pay secondary to Medicare in certain situations (i.e., Medicare pays first). Examples of when Medicare is primary are when the Sponsoring Employer has less than 20 employees and your Medicare eligibility is based on age, or when the Sponsoring Employer has less than 100 employees and your Medicare eligibility is based on disability, or when you have been eligible for Medicare for more than 30 months based on End-Stage Renal Disease (ESRD). If the Covered Person is eligible for Medicare to pay as primary, the Plan will pay secondary to Medicare whether or not he is actually enrolled in Medicare. This means that benefits will still be reduced by the amount Medicare would have paid (under Parts A and B), even if the Covered Person has failed to enroll in Medicare Part A or B. Therefore, if you are eligible for Medicare, you are strongly encouraged to enroll in both Parts A and B of Medicare.

NOTICE OF PRIVACY POLICIES & PRACTICES

EFFECTIVE DATE
January 1, 2011

THIS NOTICE DESCRIBES HOW YOUR MEDICAL INFORMATION MAY BE USED AND DISCLOSED AND HOW YOU MAY ACCESS THAT INFORMATION. PLEASE REVIEW IT CAREFULLY.

COPY AVAILABLE AT
www.alliednational.com

Since 1951, Allied National, LLC (and its affiliates, collectively referred to as "Allied") has adhered to strict client confidentiality policies and practices. Allied is committed not only to providing superior benefit products, administration and service, but to protecting the privacy of its clients. To comply with the Health Insurance Portability and Accountability Act of 1996 (HIPAA) and other privacy laws and regulations, Allied is required to maintain and abide by the following **Privacy Policies and Practices** and to provide its clients with this notice. Please be assured that:

- All health, medical, benefit, employment, business, financial or other personal, non-public or protected health information you disclose to us ("Protected Information") is maintained by Allied in secured hard copy and system files, with restricted access.
- Protected Information remains completely confidential and is disclosed only as is minimally necessary to service your account for benefit administration purposes.
- Allied does not sell Protected Information to any third party, for any reason.
- It is not necessary for you to reply to this notice, or to take any other action, in order for your Protected Information to remain completely secure and confidential.

This notice may be revised within Allied's discretion to comply with applicable law and regulation. Any such revision shall apply to all of your past, present and future Protected Information maintained by Allied, on and after the effective date of that revision or its distribution to you, whichever date is later.

PRIVACY POLICIES AND PRACTICES

I. **Commitment to Client Privacy**

A. Allied values and respects the privacy and confidentiality of its clients, and desires to safeguard, secure and protect Protected Information.

B. Allied recognizes its legal and ethical duty to safeguard, secure and protect Protected Information.

C. Allied shall maintain and abide by strict policies and practices to safeguard, secure and protect Protected Information.

II. **Definitions**

A. Clients: All prospective, current and former individual clients of Allied, who have inquired about, applied for, or obtained benefit products or services from Allied, for personal, family or household purposes, and in doing so have shared or disclosed personal, non-public or protected health information with Allied.

B. Protected Information: All information that personally identifies a Client and is not otherwise available to the public, which may generally include, but is not limited to, name, address, date of birth, social security number, telephone number, credit history, income, assets, investments, debts, marital status, tax filing status, dependent obligations, contributions, benefit coverage and claims, health history, medical treatment, medical information, business information and employment history.

C. Affiliates: All companies or other legal entities, including all individuals employed by those entities, under common control or ownership with Allied National, LLC

D. Non-Affiliated Third Parties: All companies or other legal entities and individuals <u>not</u> under common control or ownership with Allied National, LLC, including but not limited to:

1. Insurance carriers, benefit plans, preferred provider networks, attorneys, accountants, actuaries and other companies or individuals on contract with or consulting for Allied.
2. Medical information bureaus, government agencies, third parties via court order or subpoena and other industry, regulatory or legally required entities or individuals.
3. Medical providers, agents, prior carriers, prior benefit plans, custodians for medical records and other entities or individuals possessing benefit, medical or health information or documentation of a Client.
4. All other Non-Affiliated Third Parties not included in numbers 1, 2 and 3 above.

III. **Collecting and Disclosing Protected Information**

A. Allied collects and discloses only that Protected Information which is minimally necessary to:

1. Provide or administer the product or service requested by the Client, including underwriting, claims adjudication, case management and investigation;

2. Allow Allied to provide superior products and services;

3. Comply with applicable law and regulation;

4. Respond to a Client inquiry or complaint;

5. Protect and safeguard Protected Information and Allied records;

6. Take any other action authorized and requested by the Client; or

7. Otherwise effect, administer or enforce a Client requested product, service or transaction, or perform any benefit administration function.

B. Allied collects the majority of Protected Information directly from the Client during the application or enrollment process, and then subsequently as requested by the Client to administer benefits or to change or adjust product coverage and/or service.

C. Confidential Information will not be collected from or disclosed to Non-Affiliated Third Parties listed in II. D. 4 above, by Allied, unless authorized and requested by the Client in writing.

D. Confidential Information may be collected from or disclosed to the Non-Affiliated Third Parties listed in II. D. 1, 2 and 3 above, by Allied, without additional authorization from the Client, but only for the purposes described in III. A above.

IV. **Safety and Security of Protected Information**

A. Allied ensures the safety and security of all Protected Information with strict policies and practices.

B. Allied discloses only that Protected Information which is minimally necessary for the purposes described in III. A above.

C. Allied maintains Protected Information in fully secured and restricted hard copy and system files.

D. Allied allows only fully authorized employees access to Protected Information, trained in the proper handling and disclosure of confidential and private information.

E. A strict disciplinary process applies should an employee violate Allied's privacy policies and practices.

F. Protected Information is never disclosed without the Client's prior authorization, other than as described in III. A above.

G. Protected Information is never sold to an Affiliated or Non-Affiliated Third Party, for any reason.

H. Prior to disclosing Protected Information to Non-Affiliated Third Parties for the purposes described in III. A above, Allied requires that third party to adopt and implement similar privacy policies and practices.

I. If Allied or one of the Non-Affiliated Third Parties discovers a breach of PHI privacy or security, Allied will comply with the requirements of the Health Information Technology for Economic and Clinical Health Act of 2009 (HITECH) (and its implementing regulations) and provide notification to all affected individuals, the Health and Human Services Department (HHS) and the media (when required).

V. **Rights and Responsibilities of Clients**

A. It is not necessary for a Client to respond to this notice, or to contact Allied in any manner, to ensure the privacy and confidentiality of his/her Protected Information. Protected Information is safe and secure as stated within this notice.

B. Allied will provide an individual with a copy of this notice, as may be amended, at the time he/she first purchases a product or service from Allied, and at least annually thereafter or at the time of a revision. A Client may request a copy of this notice at any time as directed below.

C. Clients may submit a written request to receive a copy of their Protected Information maintained by Allied, for a reasonable copying fee, except such information or records originating from a medical provider or its custodian, or relevant to a potential or pending legal claim against Allied. The Client's medical provider or attorney should instead be consulted. Written requests must be submitted as directed below.

D. Clients may notify Allied of errors in the Protected Information maintained by Allied, or request restrictions on its use, disclosure or method of delivery, or revoke a prior authorization, or request an accounting of disclosures, by submitting a written request as directed below. Revisions and corrections are within Allied's discretion.

E. A Client may file a complaint with Allied, the U.S. Department of Health and Human Services (Office for Civil Rights, U.S. Department of Health and Human Services, 200 Independence Avenue, S.W., Room 509F HHH Bldg., Washington, D.C. 20201), or his/her state Department of Insurance, if his/her privacy rights are violated. The complaint should be stated in writing and submitted as directed below if addressed to Allied. A Client will not be penalized for filing a complaint.

F. Clients may contact Allied with any questions, concerns, requests or inquiries regarding this notice or the Protected Information maintained by Allied, by writing to this address: Attn: Privacy Official, Allied National, LLC, P.O. Box 29186, Shawnee Mission, KS 66201, or http://www.alliednational.com/, or 1-800-825-7531 (please include your full name, certificate number, date of birth and current address with your mailing).

NOTICE OF FREE OR LOW-COST HEALTH COVERAGE

Medicaid and the Children's Health Insurance Program (CHIP)
Offer Free Or Low-Cost Health Coverage To Children And Families

If you are eligible for health coverage from your employer, but are unable to afford the employee contributions, some States have employee contribution assistance programs that can help pay for coverage. These States use funds from their Medicaid or CHIP programs to help people who are eligible for employer sponsored health coverage, but need assistance in paying their employee contributions.

If you or your dependents are already enrolled in Medicaid or CHIP and you live in a State listed below, you can contact your State Medicaid or CHIP office to find out if employee contribution assistance is available.

If you or your dependents are NOT currently enrolled in Medicaid or CHIP, and you think you or any of your dependents might be eligible for either of these programs, you can contact your State Medicaid or CHIP office or dial **1-877-KIDS NOW** or **www.insurekidsnow.gov** to find out how to apply. If you qualify, you can ask the State if it has a program that might help you pay the employee contributions for an employer-sponsored plan.

Once it is determined that you or your dependents are eligible for employee contribution assistance under Medicaid or CHIP, your employer's health plan is required to permit you and your dependents to enroll in the plan – as long as you and your dependents are eligible, but not already enrolled in the employer's plan. This is called a "special enrollment" opportunity, and **you must request coverage within 60 days of being determined eligible for employee contribution assistance**.

If you live in one of the following States, you may be eligible for assistance paying your employer health plan premiums. The following list of States is current as of July 31, 2011. You should contact your State for further information on eligibility –

ALABAMA – Medicaid [Website: http://www.medicaid.alabama.gov; Phone: 1-800-362-1504]
ALASKA – Medicaid [Website: http://health.hss.state.ak.us/dpa/programs/medicaid/; Phone (Outside of Anchorage): 1-888-318-8890; Phone (Anchorage): 907-269-6529]
ARIZONA – CHIP [Website: http://www.azahcccs.gov/applicants/default.aspx; Phone (Outside of Maricopa County): 1-877-764-5437; Phone (Maricopa County): 602-417-5437]
CALIFORNIA – Medicaid [Website: http://www.dhcs.ca.gov/services/Pages/; TPLRD_CAU_cont.aspx; Phone: 1-866-298-8443]
COLORADO – Medicaid and CHIP [Medicaid Website: http://www.colorado.gov/; Medicaid Phone (In state): 1-800-866-3513; Medicaid Phone (Out of state): 1-800-221-3943; CHIP Website: http:// www.CHPplus.org; CHIP Phone: 303-866-3243]
FLORIDA – Medicaid [Website: https://www.flmedicaidtplrecovery.com/; Phone: 1-877-357-3268]
GEORGIA – Medicaid [Website: http://dch.georgia.gov/; Click on Programs, then Medicaid; Phone: 1-800-869-1150]
IDAHO – Medicaid and CHIP [Medicaid Website: www.accesstohealthinsurance.idaho.gov; Medicaid Phone: 1-800-926-2588; CHIP Website: www.medicaid.idaho.gov; CHIP Phone: 1-800-926-2588]
INDIANA – Medicaid [Website: http://www.in.gov/fssa; Phone: 1-800-889-9948]
IOWA – Medicaid [Website: www.dhs.state.ia.us/hipp/; Phone: 1-888-346-9562]
KANSAS – Medicaid [Website: http://www.kdheks.gov/hcf/; Phone: 1-800-792-4884]
KENTUCKY – Medicaid [Website: http://chfs.ky.gov/dms/default.htm; Phone: 1-800-635-2570]
LOUISIANA – Medicaid [Website: http://www.lahipp.dhh.louisiana.gov; Phone: 1-888-695-2447]
MAINE – Medicaid [Website: http://www.maine.gov/dhhs/OIAS/publicassistance/index.html; Phone: 1-800-572-3839]
MASSACHUSETTS – Medicaid and CHIP [Website: http://www.mass.gov/MassHealth; Phone: 1-800-462-1120]
MINNESOTA – Medicaid [Website: http://www.dhs.state.mn.us/ Click on Health Care, then Medical Assistance; Phone (Outside of Twin City area): 800-657-3739; Phone (Twin City area): 651-431-2670]
MISSOURI – Medicaid [Website: http://www.dss.mo.gov/mhd/participants/pages/hipp.htm; Phone: 573-751-2005]
MONTANA – Medicaid [Website: http://medicaidprovider.hhs.mt.gov/clientpages/clientindex.shtml; Phone: 1-800-694-3084]
NEBRASKA – Medicaid [Website: http://www.dhhs.ne.gov/med/medindex.htm; Phone: 1-877-255-3092]
NEVADA – Medicaid [Website: http://dwss.nv.gov/; Phone: 1-800-992-0900]
NEW HAMPSHIRE – Medicaid [Website: www.dhhs.nh.gov/ombp/index.htm; Phone: 603-271-8183]
NEW JERSEY – Medicaid and CHIP [Medicaid Website: http://www.state.nj.us/humanservices/dmahs/clients/medicaid/; Medicaid Phone: 1-800-356-1561; CHIP Website: http://www.njfamilycare.org/index.html; CHIP Phone: 1-800-701-0710]
NEW YORK – Medicaid [Website: http://www.nyhealth.gov/health_care/medicaid/; Phone: 1-800-541-2831]
NORTH CAROLINA – Medicaid [Website: http://www.nc.gov; Phone: 919-855-4100]
NORTH DAKOTA – Medicaid [Website: http://www.nd.gov/dhs/services/medicalserv/medicaid/; Phone: 1-800-755-2604]
OKLAHOMA – Medicaid and CHIP [Website: http://www.insureoklahoma.org; Phone: 1-888-365-3742]
OREGON – Medicaid and CHIP [Website: http://www.oregon.gov/OHA/OPHP/FHIAP/index.shtml; Phone: 1-888-564-9669]
PENNSYLVANIA – Medicaid [Website: http://www.dpw.state.pa.us/hipp; Phone: 1-800-692-7462]
RHODE ISLAND – Medicaid [Website: www.dhs.ri.gov; Phone: 401-462-5300]

SOUTH CAROLINA – Medicaid [Website: http://www.scdhhs.gov; Phone: 1-888-549-0820]
TEXAS – Medicaid [Website: https://www.gethipptexas.com/; Phone: 1-800-440-0493]
UTAH – Medicaid and CHIP[Website: http://health.utah.gov/upp; Phone: 1-866-435-7414]
VERMONT– Medicaid [Website: http://www.greenmountaincare.org/; Phone: 1-800-250-8427]
VIRGINIA – Medicaid and CHIP [Medicaid Website: http://www.dmas.virginia.gov/rcp-HIPP.htm; Medicaid Phone: 1-800-432-5924; CHIP Website: http://www.famis.org/; CHIP Phone: 1-866-873-2647]
WASHINGTON – Medicaid [Website: http://hrsa.dshs.wa.gov/premiumpymt/Apply.shtm; Phone: 1-800-562-3022 ext. 15473]
WEST VIRGINIA – Medicaid [Website: www.dhhr.wv.gov/bms/; Phone: 304-558-1700]
WISCONSIN – Medicaid [Website: http://www.badgercareplus.org/pubs/p-10095.htm; Phone: 1-800-362-3002]
WYOMING – Medicaid [Website: http://www.health.wyo.gov/healthcarefin/index.html; Phone: 307-777-7531]

To see if any more States have added a premium assistance program since July 31, 2011, or for more information on special enrollment rights, you can contact either:

U.S. Department of Labor
Employee Benefits Security Administration
www.dol.gov/ebsa
1-866-444-EBSA (3272)

U.S. Department of Health and Human Services
Centers for Medicare & Medicaid Services
www.cms.hhs.gov
1-877-267-2323, Ext. 61565

MEDICARE PART D

MEDICARE PART D
CREDITABLE COVERAGE NOTICE

Your self-funded Group Health Plan (Plan) coverage is provided through an employee welfare benefit plan sponsored by your employer.

Important Notice from Your Plan About Your Prescription Drug Coverage and Medicare

Please read this notice carefully and keep it where you can find it. This notice has information about your current prescription drug coverage with your Plan and about your options under Medicare's prescription drug coverage. This information can help you decide whether or not you want to join a Medicare drug plan. If you are considering joining, you should compare your current coverage, including which drugs are covered at what cost, with the coverage and costs of the plans offering Medicare prescription drug coverage in your area. Information about where you can get help to make decisions about your prescription drug coverage is at the end of this notice.

There are two important things you need to know about your current coverage and Medicare's prescription drug coverage:

1. Medicare prescription drug coverage became available in 2006 to everyone with Medicare. You can get this coverage if you join a Medicare Prescription Drug Plan or join a Medicare Advantage Plan (like an HMO or PPO) that offers prescription drug coverage. All Medicare drug plans provide at least a standard level of coverage set by Medicare. Some plans may also offer more coverage for a higher monthly premium.
2. Your Plan has determined that the prescription drug coverage it offers is, on average for all plan participants, expected to pay out as much as standard Medicare prescription drug coverage pays and is therefore considered Creditable Coverage. Because your existing coverage is Creditable Coverage, you can keep this coverage and not pay a higher premium (a penalty) if you later decide to join a Medicare drug plan.

When Can You Join A Medicare Drug Plan?

You can join a Medicare drug plan when you first become eligible for Medicare and each year from October 15th to December 7th. However, if you lose your current creditable prescription drug coverage, through no fault of your own, you will also be eligible for a two (2) month Special Enrollment Period (SEP) to join a Medicare drug plan.

What Happens To Your Current Coverage If You Decide to Join A Medicare Drug Plan?

If you decide to join a Medicare drug plan, your current Plan coverage will be affected. If you enroll in Medicare prescription drug coverage, you will be disqualified from participation in any prescription coverage sponsored by your Plan while you are enrolled in the Medicare prescription drug coverage.

If you do decide to join a Medicare drug plan and drop your current coverage, be aware that you and your dependents will be able to get this coverage back during your Plan's annual Open Enrollment Period.

When Will You Pay A Higher Premium (Penalty) To Join A Medicare Drug Plan?

You should also know that if you drop or lose your current Plan coverage and don't join a Medicare drug plan within 63 continuous days after your current coverage ends, you may pay a higher premium (a penalty) to join a Medicare drug plan later.
If you go 63 continuous days or longer without creditable prescription drug coverage, your monthly premium may go up by at least 1% of the Medicare base beneficiary premium per month for every month that you did not have that coverage. For example, if you go

nineteen months without creditable coverage, your premium may consistently be at least 19% higher than the Medicare base beneficiary premium. You may have to pay this higher premium (a penalty) as long as you have Medicare prescription drug coverage. In addition, you may have to wait until the following October to join.

For More Information About This Notice Or Your Current Prescription Drug Coverage:
Your employer is the Plan Sponsor, Plan Administrator, Plan Fiduciary and Plan Trustee for the Plan. Your employer has, by agreement, delegated certain non-fiduciary, ministerial administrative acts, duties and responsibilities of the Plan to Allied National, Inc., a licensed third-party administrator (Allied National). Please contact Allied National with any questions about your prescription drug coverage: Allied National, Inc., P.O. Box 29186, Shawnee Mission, KS 66201, or http://www.alliednational.com/, or 1-800-825-7531.

For More Information About Your Options Under Medicare Prescription Drug Coverage:
More detailed information about Medicare plans that offer prescription drug coverage is in the "Medicare & You" handbook. You'll get a copy of the handbook in the mail every year from Medicare. You may also be contacted directly by Medicare drug plans. For more information about Medicare prescription drug coverage: Visit www.medicare.gov

Also call your State Health Insurance Assistance Program (see the inside back cover of your copy of the "Medicare & You" handbook for their telephone number) for personalized help at 1-800-MEDICARE (1-800-633-4227). TTY users should call 1-877-486-2048.

If you have limited income and resources, extra help paying for Medicare prescription drug coverage is available. For information about this extra help, visit Social Security on the web at www.socialsecurity.gov, or call them at 1-800-772-1213 (TTY 1-800-325-0778).

NOTE: You'll get this notice each year. You will also get it before the next period you can join a Medicare drug plan, and if this coverage through your Plan changes. You also may request a copy of this notice at any time.

Remember: Keep this Creditable Coverage notice. If you decide to join one of the Medicare drug plans, you may be required to provide a copy of this notice when you join to show whether or not you have maintained creditable coverage and, therefore, whether or not you are required to pay a higher premium (a penalty).