Mohawk ESV, Inc.
Health and Welfare Benefit Plan
My Medical Neighborhood

Summary Plan Description
Restated: January 1, 2019

Claims Processed by:

8500 Freeport Parkway, Suite 400
Irving TX 75063
Toll Free: 1-866-266-8360

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INTRODUCTION AND PURPOSE; GENERAL PLAN INFORMATION

Introduction and Purpose

The Plan Sponsor has established the Plan for the benefit of eligible Employees and their eligible Dependents, in accordance with the terms and conditions described herein. Plan benefits are funded solely from the general assets of the Plan Sponsor and Employee Contributions.

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

The Plan Administrator is required under ERISA to provide to Participants a Summary Plan Description. The Plan Administrator has adopted this Summary Plan Description as the written description of the Plan to set forth the terms and provisions of the Plan that provide for the payment or reimbursement of all or a portion of certain expenses for eligible benefits. The Summary Plan Description and Plan Document are maintained by the **Benefits Committee of Mohawk ESV, Inc.** (the Plan Administrator) and may be reviewed at any time by any Participant.

General Plan Information

Name of Plan:
Mohawk ESV, Inc. Health and Welfare Benefit Plan

My Medical Neighborhood is a benefit program offered under the Mohawk ESV, Inc. Health and Welfare Benefit Plan. References in this Summary Plan Description to the "Plan" refer to the My Medical Neighborhood benefit program only.

Plan Sponsor:
Mohawk ESV, Inc.
160 South Industrial Boulevard
Calhoun, GA 30701
Phone: 1-706-629-7721

Plan Administrator:
(Named Fiduciary)
Benefits Committee of Mohawk ESV, Inc.
160 South Industrial Boulevard
Calhoun, GA 30701
Phone: 1-706-629-7721

Plan Sponsor ID No. (EIN):
20-1880191

Source of Funding:
Self-Funded

Plan Status:
Non-Grandfathered

Applicable Law:
ERISA

Plan Year:
January 1 through December 31

Plan Number:
501

Plan Type:
Medical

The Mohawk ESV, Inc. Health and Welfare Benefit Plan also provides other benefit programs, including other medical options, which are described in separate summaries.

Third Party Administrator:
WebTPA
8500 Freeport Parkway, Suite 400
Irving, TX 75063
Phone: 1-844-380-4564
Email: helpme@webtpa.com

Prescription Drug Claims Administrator:
Express Scripts
8111 Royal Ridge Pkwy
Irving, TX 75063
Phone: 1-877-887-2879
Website: www.express-scripts.com

Agent for Service of Process:
Mohawk ESV, Inc.
160 South Industrial Boulevard
Calhoun, GA 30701
Phone: 1-706-629-7721

Non-English Language Notice

This Summary Plan Description contains a summary in English of a Participant's plan rights and benefits under the Plan. If a Participant has difficulty understanding any part of this Plan Document, he or she may contact the Benefits Service Center at 1-866-481-4922.

Este documento contiene un resumen en inglés de sus derechos y beneficios bajo el Mohawk ESV, Inc. Health and Welfare Benefit Plan: El Vecindario Medico. Si usted tiene alguna dificultad en comprender cualquier parte de este documento, favor de contactarse con el Centro de Beneficios al 1-866-481-4922.

Legal Entity; Service of Process

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

Not a Contract

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

Applicable Law

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

Discretionary Authority

The Plan Administrator, and any other claims fiduciary with respect to the Plan to the extent that such entity is acting in its fiduciary capacity, shall have sole, full and final discretionary authority to interpret all Plan provisions, including the right to remedy possible ambiguities, inconsistencies and/or omissions in the Plan and related documents; to make determinations in regard to issues relating to eligibility for benefits; to decide disputes that may arise relative to a Participant's rights; and to determine all questions of fact and law arising under the Plan. For prescription drug claims, the Plan Administrator has delegated its fiduciary duties with respect to final internal appeal determinations under the Plan to the Prescription Drug Claims Administrator. The Plan Administrator has retained final authority for medical benefit claim determinations. The Prescription Drug Claims Administrator has the full extent of the Plan Administrator's authority and duties with respect to those responsibilities delegated to it, including full discretionary authority to interpret the Plan; determine eligibility for and the amount of benefits under the Plan; and exercise all of the power and authority contemplated by the Employee Retirement Income Security Act of 1974, as amended, with respect to making final internal appeal determinations under the Plan.

Claims and Appeals

Please see the "Claim Procedures; Payment of Claims" section of this Summary Plan Description for important information about how to make a claim for benefits under the Plan, including the timeframes for submitting a benefit claim or appeal, as well as the applicable deadline for filing a lawsuit.

DEFINITIONS

The following words and phrases shall have the following meanings when used in the Summary Plan Description. **The following definitions are not an indication that charges for particular care, supplies or services are eligible for payment under the Plan, however they may be used to identify ineligible expenses; please refer to the appropriate sections of the Summary Plan Description for that information.**

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

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

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

"Actively At Work" or "Active Employment"
"Actively At Work" or "Active Employment" shall mean on any day the Employee performs in the customary manner all of the regular duties of employment. An Employee will be deemed Actively At Work on each day of a regular paid vacation or on a regular non-working day, provided the covered Employee was Actively At Work on the last preceding regular work day. An Employee shall be deemed Actively At Work if the Employee is absent from work due to a health factor, as defined by HIPAA. An Employee will not be considered under any circumstances Actively At Work if he or she has terminated employment.

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

"Adverse Benefit Determination"
"Adverse Benefit Determination" shall mean any of the following:

1. A denial in benefits.
2. A reduction in benefits.
3. A rescission of coverage, even if the rescission does not impact a current claim for benefits.
4. A termination of benefits.
5. A failure to provide or make payment (in whole or in part) for a benefit, including any such denial, reduction, termination, or failure to provide or make payment that is based on a determination of a Claimant's eligibility to participate in the Plan.
6. A denial, reduction, or termination of, or a failure to provide or make payment (in whole or in part) for, a benefit resulting from the application of any utilization review.
7. A failure to cover an item or service for which benefits are otherwise provided because it is determined to be Experimental or Investigational or not Medically Necessary or appropriate.

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

"Affordable Care Act (ACA)"
The "Affordable Care Act (ACA)" means the health care reform law enacted in March 2010. The law was enacted in two parts: the Patient Protection and Affordable Care Act was signed into law on March 23, 2010

and was amended by the Health Care and Education Reconciliation Act on March 30, 2010. The name "Affordable Care Act" is commonly used to refer to the final, amended version of the law. In this document, the Plan uses the name Affordable Care Act (ACA) to refer to the health care reform law.

"AHA"
"AHA" shall mean the American Hospital Association.

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

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

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

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

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

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

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

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

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

"Cardiac Care Unit"
"Cardiac Care Unit" shall mean a separate, clearly designated service area which is maintained within a Hospital and which meets all the following requirements:

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

"CDC"
"CDC" shall mean Centers for Disease Control and Prevention.

"Child" or "Children"
"Child" or "Children" shall mean the Employee's natural child, stepchild, legally adopted child, foster child, or any other child for whom the Employee has been named legal guardian. The term "Child" will also include an Employee's grandchild who is considered the Employee's dependent for federal income tax purposes. For purposes of this definition, a legally adopted child shall include a child placed in an Employee's physical custody in anticipation of adoption. "Child" shall also mean a covered Employee's child who is an Alternate Recipient under a Qualified Medical Child Support Order, as required by applicable law.

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

"Claim Determination Period"
"Claim Determination Period" shall mean each Calendar Year.

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

"Claims Administrator"
"Claims Administrator" shall mean the entity responsible for determining internal claims and/or appeals under the Plan. For initial claims for benefits under the Plan's medical benefit program, this reference means the Third Party Administrator. For internal appeals under the Plan's medical benefit program, this reference means the Plan Administrator. For prescription drug benefit claims and internal appeals, this reference means the Prescription Drug Claims Administrator. In contrast to the Plan Administrator and the Prescription Drug Claims Administrator, the Third Party Administrator is not a fiduciary of the Plan and does not have final authority to approve or deny benefit payments under the Plan.

"Clean Claim"
A "Clean Claim" is one that can be processed in accordance with the terms of this document without obtaining additional information from the service Provider or a third party. It is a claim which has no defect or impropriety. A defect or impropriety shall include a lack of required sustaining documentation as set forth and in accordance with this document, or a particular circumstance requiring special treatment which prevents timely payment as set forth in this document, and only as permitted by this document, from being made. A Clean Claim does not

include claims under investigation for fraud and abuse or claims under review for Medical Necessity or other coverage criteria, or fees under review for application of the Maximum Allowable Charge, or any other matter that may prevent the charge(s) from being Covered Expenses in accordance with the terms of this document.

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

"CMS"
"CMS" shall mean Centers for Medicare and Medicaid Services.

"COBRA"
"COBRA" shall mean the Consolidated Omnibus Budget Reconciliation Act of 1985, as amended.

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

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

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

"Covered Expense(s)"
"Covered Expense(s)" shall mean a service or supply provided in accordance with the terms of the Plan, whose applicable charge amount does not exceed the Maximum Allowable Charge for an eligible Medically Necessary service, treatment or supply, meant to improve a condition or Participant's health, which is eligible for coverage in accordance with this Plan. When more than one treatment option is available, and one option is no more effective than another, the Covered Expense is the least costly option that is no less effective than any other option.

All treatment is subject to benefit payment maximums shown in the Summary of Benefits and as set forth elsewhere in this document.

"Custodial Care"
"Custodial Care" shall mean care or confinement designated principally for the assistance and maintenance of the Participant, in engaging in the activities of daily living, whether or not totally disabled. This care or confinement could be rendered at home or by persons without professional skills or training. This care may relieve symptoms or pain but is not reasonably expected to improve the underlying medical condition. Custodial Care includes, but is not limited to, assistance in eating, dressing, bathing and using the toilet,

preparation of special diets, supervision of medication which can normally be self-administered, assistance in walking or getting in and out of bed, and all domestic activities.

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

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

"Dependent"
"Dependent" shall mean one or more of the following person(s):

1. An Employee's present spouse, meaning an individual with whom the Employee has established a valid marriage according to State Law, including a common law marriage, not annulled or voided in any way.
2. An Employee's Child who is less than 26 years of age. ***NOTE:*** *Coverage of a Dependent Child will continue until the end of the calendar month he or she turns 26 years of age.*
3. An Employee's Child, regardless of age, who is unmarried and primarily supported by the Employee, was continuously covered as a dependent prior to attaining the limiting age as stated above, and who is incapable of sustaining his or her own living by reason of a mental or physical disability. Such Child must have been mentally or physically incapable of earning his or her own living due to the disabling condition prior to attaining the limiting age as stated above. Written proof of such incapacity and dependency satisfactory to the Plan must be furnished and approved by the Plan within 31 days after the date the Child attains the limiting age as stated above. The Plan may require, at reasonable intervals, subsequent proof satisfactory to the Plan during the next two years after such date. After such two-year period, the Plan may require such proof, but not more often than once each year.

Residents of a country other than the United States shall not be deemed to be "Dependents."

To establish a Dependent relationship, the Plan reserves the right to require documentation satisfactory to the Plan Administrator.

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

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

"Disease"
"Disease" shall mean any disorder which does not arise out of, which is not caused or contributed to by, and which is not a consequence of, any employment or occupation for compensation or profit; however, if evidence satisfactory to the Plan is furnished showing that the individual concerned is covered as an Employee under any workers' compensation law, occupational disease law or any other legislation of similar purpose, or under the maritime doctrine of maintenance, wages, and cure, but that the disorder involved is one not covered under the applicable law or doctrine, then such disorder shall, for the purposes of the Plan, be regarded as a Sickness, Illness or Disease.

"Drug"
"Drug" shall mean a Food and Drug Administration (FDA) approved Drug or medicine that is listed with approval in the *United States Pharmacopeia*, *National Formulary* or *AMA Drug Evaluations* published by the American Medical Association (AMA), that is prescribed for human consumption, and that is required by law to bear the legend: "Caution—Federal Law prohibits dispensing without prescription," or a State restricted drug (any medicinal substance which may be dispensed only by prescription, according to State law), legally obtained and dispensed by a licensed drug dispenser only, according to a written prescription given by a Physician and/or duly licensed Provider. "Drug" shall also mean insulin for purposes of injection.

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

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

"Emergency"
"Emergency" shall mean a situation or medical condition with symptoms of sufficient severity (including severe pain) that the absence of immediate medical attention and treatment would reasonably be expected to result in: (a) serious jeopardy to the health of the individual (or, with respect to a pregnant woman, the woman's unborn child); (b) serious impairment to bodily functions; or (c) serious dysfunction of any bodily organ or part. An Emergency includes, but is not limited to, severe chest pain, poisoning, unconsciousness, and hemorrhage. Other Emergencies and acute conditions may be considered on receipt of proof, satisfactory to the Plan, per the Plan Administrator's discretion, that an Emergency did exist. The Plan may, at its own discretion, request satisfactory proof that an Emergency or acute condition did exist.

"Emergency Medical Condition"
"Emergency Medical Condition" shall mean a medical condition manifesting itself by acute symptoms of sufficient severity (including severe pain) so that a prudent layperson, who possesses an average knowledge of health and medicine, could reasonably expect the absence of immediate medical attention to result in a condition described in clause (i), (ii), or (iii) of section 1867(e)(1)(A) of the Social Security Act (42 U.S.C. 1395dd(e)(1)(A)). In that provision of the Social Security Act, clause (i) refers to placing the health of the individual (or, with respect to a pregnant woman, the health of the woman or her unborn child) in serious jeopardy; clause (ii) refers to serious impairment to bodily functions; and clause (iii) refers to serious dysfunction of any bodily organ or part.

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

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

"Employee"
"Employee" shall mean a person who is classified by the Employer or a Participating Employer as a full-time employee that is regularly scheduled to work at least 30 Hours of Service per week.

You are not an Employee that is eligible to participate in the Plan if you are:

- A leased employee;

- An individual classified by a Participating Employer as an independent contractor, a leased employee, or an employee of a non-participating affiliate, whether or not you are an actual employee of the Participating Employer;
- A union employee, unless otherwise required by a bargaining agreement;
- A nonresident alien that does not receive U.S. source income; or
- Covered by a welfare plan maintained by a foreign affiliate.

"Employer"
"Employer" is Mohawk ESV, Inc.

"ERISA"
"ERISA" shall mean the Employee Retirement Income Security Act of 1974, as amended.

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

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

1. Do not constitute accepted medical practice under the standards of the case and by the standards of a reasonable segment of the medical community or government oversight agencies at the time rendered.
2. Are rendered on a research basis as determined by the United States Food and Drug Administration and the AMA's Council on Medical Specialty Societies.

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

1. If the drug or device cannot be lawfully marketed without approval of the U.S. Food and Drug Administration and approval for marketing has not been given at the time the drug or device is furnished;
2. If reliable evidence shows that the drug, device or medical treatment or procedure is the subject of ongoing Phase I, II, or III clinical trials or under study to determine all of the following:

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

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

Reliable evidence shall mean one or more of the following:

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

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

1. The American Medical Association Drug Evaluations.
2. The American Hospital Formulary Service Drug Information.
3. The United States Pharmacopeia Drug Information.
4. A clinical study or review article in a reviewed professional journal.

Subject to a medical opinion, if no other Food and Drug Administration (FDA) approved treatment is feasible and as a result the Participant faces a life or death medical condition, the Plan Administrator retains discretionary authority to cover the services or treatment.

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

"Family Unit"
"Family Unit" shall mean the Employee and his or her Dependents covered under the Plan.

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

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

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

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

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

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

"Health Savings Account (HSA)"
"Health Savings Account (HSA)" shall mean an account created as part of a High Deductible Health Plan. The money placed in this account can be used to pay for covered health care costs or saved for future health care costs. The account grows interest.

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

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

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

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

"Home Health Care Agency"
"Home Health Care Agency" shall mean an agency or organization which provides a program of Home Health Care and which meets one of the following requirements:

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

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

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

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

"Hospital" shall also have the same meaning, where appropriate in context, set forth in the definition of "Ambulatory Surgical Center."

"HRSA"
"HRSA" shall mean Health Resources and Services Administration.

"Illness"
"Illness" shall have the meaning set forth in the definition of "Disease."

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

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

"Injury"
"Injury" shall mean an Accidental Bodily Injury, which does not arise out of, which is not caused or contributed to by, and which is not a consequence of, any employment or occupation for compensation or profit.

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

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

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

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

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

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

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

"Maximum Allowable Charge" shall mean the benefit payable for a specific coverage item or benefit under this Plan. The Maximum Allowable Charge will be a negotiated rate, if one exists.

If and only if there is no negotiated rate for a given claim, the Plan Administrator will exercise its discretion to determine the Maximum Allowable Charge based on any of the following: Medicare reimbursement rates, Medicare cost data, amounts actually collected by providers in the area for similar services, or average wholesale price (AWP) or manufacturer's retail pricing (MRP). These ancillary factors will take into account generally-accepted billing standards and practices.

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

With respect to Non-Network Emergency Services, the Maximum Allowable Charge will be determined in accordance with the requirements of the ACA.

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

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

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

"Medically Necessary"
"Medically Necessary", "Medical Necessity" and similar language refers to health care services ordered by a Physician exercising prudent clinical judgment provided to a Participant for the purposes of evaluation, Diagnosis or treatment of that Participant's Sickness or Injury. Such services, to be considered Medically Necessary, must be clinically appropriate in terms of type, frequency, extent, site and duration for the Diagnosis or treatment of the Participant's Sickness or Injury. The Medically Necessary setting and level of service is that setting and level of service which, considering the Participant's medical symptoms and conditions, cannot be provided in a less intensive medical setting. Such services, to be considered Medically Necessary must be no more costly than alternative interventions, including no intervention and are at least as likely to produce

equivalent therapeutic or diagnostic results as to the Diagnosis or treatment of the Participant's Sickness or Injury without adversely affecting the Participant's medical condition. The service must meet all of the following requirements:

1. It must not be maintenance therapy or maintenance treatment.
2. Its purpose must be to restore health.
3. It must not be primarily custodial in nature.
4. It must not be a listed item or treatment not allowed for reimbursement by the Centers for Medicare and Medicaid Services (CMS).
5. The Plan reserves the right to incorporate CMS guidelines in effect on the date of treatment as additional criteria for determination of Medical Necessity and/or an Allowable Expense.

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

To be Medically Necessary, all of these criteria must be met. Merely because a Physician or Dentist recommends, approves, or orders certain care does not mean that it is Medically Necessary. The determination of whether a service, supply, or treatment is or is not Medically Necessary may include findings of the American Medical Association and the Plan Administrator's own medical advisors. The Plan Administrator has the discretionary authority to decide whether care or treatment is Medically Necessary.

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

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

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

"Mental or Nervous Disorder"
"Mental or Nervous Disorder" shall mean any Disease or condition, regardless of whether the cause is organic, that is classified as a Mental or Nervous Disorder in the current edition of International Classification of Diseases, published by the U.S. Department of Health and Human Services, is listed in the current edition of Diagnostic and Statistical Manual of Mental Disorders, published by the American Psychiatric Association or other relevant State guideline or applicable sources. The fact that a disorder is listed in any of these sources does not mean that treatment of the disorder is covered by the Plan.

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

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

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

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

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

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

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

"Other Plan"
"Other Plan" shall include, but is not limited to:

1. Any primary payer besides the Plan.
2. Any other group health plan.
3. Any other coverage or policy covering the Participant.
4. Any first party insurance through medical payment coverage, personal injury protection, no-fault coverage, uninsured or underinsured motorist coverage.
5. Any policy of insurance from any insurance company or guarantor of a responsible party.
6. Any policy of insurance from any insurance company or guarantor of a third party.
7. Workers' compensation or other liability insurance company.
8. Any other source, including but not limited to crime victim restitution funds, any medical, disability or other benefit payments, and school insurance coverage.

"Out-of-Area"
"Out-of-Area" shall mean services received by a Participant outside of the normal geographic area supported by the Plan's Network, as determined by the Claims Administrator, at the time each Participant becomes eligible for coverage under this Plan.

"Outpatient"
"Outpatient" shall mean treatment including services, supplies, and medicines provided and used at a Hospital under the direction of a Physician to a person not admitted as a registered bed patient; or services

rendered in a Physician's office, laboratory, or x-ray facility, an Ambulatory Surgical Center, or the patient's home.

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

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

"Participating Employer"
"Participating Employer shall mean an affiliate of the Employer that participates in the Plan. You may contact the Plan Administrator for a complete list of Participating Employers.

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

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

"Plan Year"
"Plan Year" shall mean the 12-month period from January 1 through December 31 of each year.

"Pre-Admission Tests"
"Pre-Admission Tests" shall mean those medical tests and Diagnostic Services completed prior to a scheduled procedure, including Surgery, or scheduled admissions to the Hospital or Inpatient health care facility provided that all of the following requirements are met:

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

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

"Prescription Drug Claims Administrator"
"Prescription Drug Claims Administrator" shall mean Express Scripts, the claims administrator for the portion of the Plan providing prescription drug benefits, which provides customer service and claims and appeals processing and payment services only and does not assume any financial risk or obligation with respect to those claims. The Prescription Drug Claims Administrator has the authority to make final, binding benefit claim decisions in response to all internal appeals of claims for prescription drug benefits under the Plan.

"Preventive Care"
"Preventive Care" shall mean certain Preventive Care services.

To comply with the ACA, and in accordance with the recommendations and guidelines, plans shall provide In-Network coverage for all of the following:

1. Evidence-based items or services rated A or B in the United States Preventive Services Task Force recommendations.
2. Recommendations of the Advisory Committee on Immunization Practices adopted by the Director of the Centers for Disease Control and Prevention.
3. Comprehensive guidelines for infants, children, and adolescents supported by the Health Resources and Services Administration (HRSA).
4. Comprehensive guidelines for women supported by the Health Resources and Services Administration (HRSA).

Copies of the recommendations and guidelines may be found at the following websites:
https://www.healthcare.gov/coverage/preventive-care-benefits/;
https://www.uspreventiveservicestaskforce.org/Page/Name/uspstf-a-and-b-recommendations/;
https://www.cdc.gov/vaccines/hcp/acip-recs/index.html;
https://www.aap.org/en-us/Documents/periodicity_schedule.pdf;
https://www.hrsa.gov/womensguidelines/.

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

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

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

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

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

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

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

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

"Room and Board"
"Room and Board" shall mean a Hospital's charge for any of the following:

1. Room and complete linen service.
2. Dietary service including all meals, special diets, therapeutic diets, required nourishment's, dietary supplements and dietary consultation.
3. All general nursing services including but not limited to coordinating the delivery of care, supervising the performance of other staff members who have delegated member care and member education.
4. Other conditions of occupancy which are Medically Necessary.

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

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

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

"Skilled Nursing Facility"
"Skilled Nursing Facility" shall mean a facility that fully meets all of the following requirements:

1. It is licensed to provide professional nursing services on an Inpatient basis to persons convalescing from Injury or Sickness. The service must be rendered by a Registered Nurse (R.N.) or by a Licensed Practical Nurse (L.P.N.) under the direction of a Registered Nurse. Services to help restore patients to self-care in essential daily living activities must be provided.
2. Its services are provided for compensation and under the full-time supervision of a Physician.
3. It provides 24 hour per day nursing services by licensed nurses, under the direction of a full-time Registered Nurse.
4. It maintains a complete medical record on each patient.
5. It has an effective utilization review plan.
6. It is not, other than incidentally, a place for rest, the aged, drug addicts, alcoholics, mentally disabled, Custodial Care, educational care or care of Mental or Nervous Disorders.
7. It is approved and licensed by Medicare.

"Substance Abuse" and/or "Substance Use Disorder"
"Substance Abuse" and/or "Substance Use Disorder" shall mean any disease or condition that is classified as a Substance Use Disorder as listed in the current edition of the International Classification of Diseases, published by the U.S. Department of Health and Human Services, as listed in the current edition of Diagnostic and Statistical Manual of Mental Disorders, published by the American Psychiatric Association, or other relevant State guideline or applicable sources.

The fact that a disorder is listed in any of the above publications does not mean that treatment of the disorder is covered by the Plan.

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

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

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

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

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

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

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

ELIGIBILITY FOR COVERAGE

Eligibility for Individual Coverage

Each Employee will become eligible for coverage under this Plan with respect to himself or herself on the first day of the month following completion of a Service Waiting Period of 60 days, provided the Employee has begun work for his or her Participating Employer. If the Employee is unable to begin work as scheduled, then his or her coverage will become effective on such later date when the Employee begins work and completes the Service Waiting Period.

Reinstatement of Coverage

An Employee who is laid off and is called back to work within six months of his or her layoff date will have benefits reinstated without being subject to a Service Waiting Period. If an Employee is laid off and then called back more than six months after his or her layoff date, the Employee will need to complete the Plan's Service Waiting Period again before he or she is eligible for Plan benefits.

An Employee who terminates his or her employment voluntarily and has a break in service that is 13 weeks or greater will be treated as a New Hire and subject to a 60-day Service Waiting Period (as described above) before being eligible for benefits. If the break in service is less than 13 weeks, the Employee will be eligible for the Plan without being subject to the Plan's 60-day Service Waiting Period.

If an Employee ceases to be an eligible Employee for reasons other than termination of employment and then returns to eligible Employee status, the Employee's prior service will count toward the Plan's Service Waiting Period, regardless of whether the Employee returns to eligible Employee status within 13 weeks.

Eligibility Dates for Dependent Coverage

Each Employee will become eligible for coverage under this Plan for his or her Dependents on the latest of the following dates:

1. His or her date of eligibility for coverage for himself or herself under the Plan.
2. The first date upon which he or she acquires a Dependent.
3. The date the Dependent is otherwise eligible to enroll in the Plan due to a qualifying status change event, as outlined below.

In no event will any Dependent Child be covered as a Dependent of more than one Employee who is covered under the Plan.

In order for an Employee's Dependent to be covered under the Plan the Employee must be enrolled for coverage under the Plan, and the Employee must timely enroll the Dependent in the Plan (as described below).

Effective Dates of Coverage; Conditions

The coverage for which an individual is eligible under this Plan will become effective on the date specified below, subject to the conditions of this section.

1. Enrollment Application (paper or electronic as applicable). Employee(s) may seek to obtain coverage for themselves and/or Dependents via a form (either paper or electronic as applicable) furnished by the Plan Administrator, in a manner that is satisfactory to the Plan Administrator, and within the time period specified in the enrollment materials (referred to as the Employee's "Initial Enrollment Period"). If coverage is available and appropriate, coverage will become effective after review of the form, and upon the subsequent date such Employee or Dependents are eligible. **Please Note:** The benefit choices that an Employee makes during his or her Initial Enrollment Period will remain in effect for the remainder of the Plan Year and cannot be changed unless the Employee qualifies for a special enrollment period or experiences another qualified life event (as described later in this SPD) and makes new benefit elections.

2. Coverage as Both Employee and Dependent. An eligible Participant may enroll in this Plan either as an Employee or as a Dependent, but not both.
3. Spousal Surcharge. If a covered Employee's spouse is eligible for benefits through another employer and the Employee elects to cover them on the Plan, the covered Employee's spouse will pay an additional $125 per month ($28.85 per week) in medical contributions. A covered Employee currently married to another covered Employee can remain on the Plan without a spousal surcharge.
4. Birth of Dependent Child. A newborn Child of a covered Employee will be considered eligible and will be covered from the moment of birth for Injury or Illness, including the Medically Necessary care and treatment of medically diagnosed congenital defects, birth abnormalities and prematurity, newborn care and Preventive Care **only if written notification to add the Child is received by the Plan Administrator within 31 days following the Child's date of birth**. If written notification to add a newborn Child is received by the Plan Administrator AFTER the 31 day period immediately following the Child's date of birth, the Child is not eligible for the Plan until the next Open Enrollment Period. A newborn Child of a Dependent Child is not eligible for enrollment in this Plan unless the newborn Child is a dependent of the Employee as defined under federal income tax rules.
5. Requirement for Employee Coverage. Coverage for Dependents shall only be available to Dependents of Employees eligible for and enrolled in coverage for him or herself.
6. Dependents of Multiple Employees. If a Dependent may be deemed to be a Dependent of more than one covered Employee, such Dependent shall be deemed to be a Dependent of one such Employee only.
7. Medicaid Coverage. An individual's eligibility for any State Medicaid benefits will not be taken into account by the Plan in determining that individual's eligibility under the Plan.
8. FMLA Leave. Regardless of any requirements set forth in the Plan, the Plan shall at all times comply with FMLA.

NOTE: *It is the responsibility of the enrolled Employee to notify the Plan Administrator of any changes in the Dependent's status. You must provide documentation acceptable to the Plan Administrator to establish an individual's status as an eligible Dependent (i) upon initial enrollment, (ii) when adding a new eligible Dependent, and (iii) upon request from the Plan Administrator. Failure to provide proof is evidence of fraud and material misrepresentation, and could result in a loss of coverage for your Dependents, which may be retroactive to the date as of which the individual become ineligible for Plan coverage, as determined by the Plan Administrator and subject to the Plan's provisions on rescission of coverage.*

You must also notify the Plan Administrator of any status change that would result in a Dependent no longer being eligible for Plan participation (for example, your former Spouse in the event of a divorce). Failure to inform the Plan that a Dependent is no longer eligible for coverage is considered an intentional misrepresentation of material fact entitling the Plan to retroactively cancel the Dependent's coverage. Coverage will end on the date the Dependent is no longer eligible for Plan participation, even if the Plan discovers the Dependent is no longer eligible at a later date.

The Plan will return any Employee contributions made on behalf of an ineligible Dependent and has the right to recover any payments the Plan makes on behalf of an individual who is no longer an eligible Dependent.

Special and Open Enrollment

Federal law requires and the Plan provides so-called "Special Enrollment Periods," during which Employees may enroll in the Plan, even if they declined to enroll during an initial or subsequent eligibility period. The Special Enrollment rules are described in more detail below. Except as specifically provided below under the heading "Additional Special Enrollment Rights," to request special enrollment, you must contact the Benefits Service Center at 1-866-481-4922 within 31 days of your special enrollment event.

Loss of Other Coverage

This Plan will permit an eligible Employee or Dependent (including an Employee's spouse) who is eligible, but not enrolled, to enroll for coverage under the terms of the Plan if each of the following conditions is met:

1. The eligible Employee or Dependent was covered under another group health plan or had other health insurance coverage at the time coverage under this Plan was offered.
2. The eligible Employee or Dependent lost other coverage pursuant to one of the following events:
    a. The eligible Employee or Dependent was under COBRA and the COBRA coverage was exhausted.
    b. The eligible Employee or Dependent was not under COBRA and the other coverage was terminated as a result of loss of eligibility (including as a result of Legal Separation, divorce, loss of Dependent status, death, termination of employment, or reduction in the number of hours worked).
    c. The eligible Employee or Dependent moved out of an HMO service area with no other option available.
    d. The plan is no longer offering benefits to a class of similarly situated individuals.
    e. The benefit package option is no longer being offered and no substitute is available.
    f. The employer contributions were terminated.

3. The eligible Employee or Dependent requests enrollment in the Plan within 31 days after the loss of other coverage described in paragraph 2. For example, if the Employee loses his or her other health coverage on April 22, he or she must notify the Plan Administrator and apply for coverage by close of business on May 23.

For an eligible Employee or Dependent(s) who has met the conditions specified above, coverage under this Plan will be effective no later than the first day of the month following timely receipt of the request for special enrollment.

New Dependent

An Employee or Dependent who is eligible, but not enrolled in this Plan, may be eligible to enroll during a special enrollment period if an Employee acquires a new Dependent as a result of marriage, birth, adoption, or placement for adoption. To be eligible for this special enrollment, the Employee must apply in writing or electronically, as applicable, no later than 31 days after he or she acquires the new Dependent. For example, if the Employee or Employee's spouse gives birth to a baby on June 22, he or she must notify the Plan Administrator and apply for coverage by close of business on July 23. The following conditions apply to any eligible Employee and Dependents:

An Employee or Dependent who is eligible, but not enrolled in this Plan, may enroll during a special enrollment period if one the following occurs:

1. The eligible Employee is a covered Employee under the terms of this Plan but elected not to enroll during a previous enrollment period.
2. An individual has become a Dependent of the eligible Employee through marriage, birth, adoption, or placement for adoption.

If the conditions for special enrollment are satisfied, the coverage of the Dependent and/or Employee enrolled during the Special Enrollment Period will be effective:

1. In the case of marriage, no later than the first day of the month following timely receipt of the request for special enrollment.
2. In the case of a Dependent's birth, as of the date of birth.
3. In the case of a Dependent's adoption or placement for adoption, the date of the adoption or placement for adoption.

Additional Special Enrollment Rights

Employees and Dependents who are eligible but not enrolled are entitled to enroll under one of the following circumstances:

1. The Employee's or Dependent's Medicaid or State Child Health Insurance Plan (i.e. CHIP) coverage has terminated as a result of loss of eligibility and the Employee requests coverage under the Plan within 60 days after the termination.
2. The Employee or Dependent become eligible for a contribution / premium assistance subsidy under Medicaid or a State Child Health Insurance Plan (i.e. CHIP), and the Employee requests coverage under the Plan within 60 days after eligibility is determined.

If the conditions for special enrollment are satisfied, coverage for the Employee and/or his or her Dependent(s) will be effective no later than the first day of the month following timely receipt of the request for special enrollment.

If you have any questions about your special enrollment rights under the Plan, please contact the Benefits Service Center at 1-866-481-4922.

Open Enrollment
Prior to the start of a Plan Year, this Plan has an Open Enrollment Period. Eligible Participants who are not covered under this Plan may enroll for coverage during Open Enrollment Periods. Coverage for Participants enrolling during an Open Enrollment Period will become effective on January 1, as long as all other eligibility requirements have been met. If the other eligibility requirements have not been met, coverage for Participants enrolling during an Open Enrollment Period will become effective as stated in the provision, "Eligibility for Individual Coverage". The elections made by a Participant during an Open Enrollment Period may not be changed during the Plan Year, unless the Participant has a Special Enrollment Period or experiences another qualified change event, as described below.

The terms of the Open Enrollment Period, including duration of the election period, shall be determined by the Plan Administrator and communicated prior to the start of an Open Enrollment Period.

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

Qualified Life Events

This Plan also allows additional changes to enrollment due to change in status and other qualified life events as described below. **If a qualified life event occurs, you must inform the Benefits Service Center at 1-866-481-4922 and make your new benefit election within 31 days after the event (or within 60 days of the event for a loss of coverage under Medicaid).** The change you request must be consistent with your qualified life event, or your request will be denied.

The following events are qualified life events under the Plan:

Change of Status
A change in status is:

- A change in legal marital status (for example, due to marriage, death of a spouse, divorce, annulment or legal separation);
- A change in number of Dependents (for example, due to birth, adoption, placement for adoption, legal guardianship or death of a Dependent);
- A change in employment status of the Employee or a Dependent, such as due to termination or start of employment, strike, lockout, beginning or end of unpaid leave of absence, including under the Family and Medical Leave Act, change in worksite, changing from full-time to part-time or union to non-union, or any similar change resulting in eligibility or ineligibility for coverage; and
- Changes which cause a Dependent to become eligible or ineligible for coverage.

Judgments, Decrees, and Orders
A change in coverage due to and consistent with a judgment, decree, or order resulting from a divorce, legal separation, annulment, or change in legal guardianship that requires health coverage for an Employee's Child under this Plan or requires another individual to provide coverage to the Child.

Medicare or Medicaid Enrollment
An Employee or Dependent may cancel or reduce coverage due to enrollment in Medicare or Medicaid, or enroll or increase coverage due to loss of Medicare or Medicaid eligibility. For a loss of coverage under Medicaid, the Employee will have 60 days to request the change, as described in the "Special and Open Enrollment" section above.

Change in Cost of Coverage
If the cost of benefits increases or decreases during a Plan Year by an insignificant amount (as determined by the Plan Administrator), your contributions for Plan coverage will automatically be changed to reflect the increase or decrease. When the change in cost is significant, an Employee may either increase his or her contributions or elect other medical coverage for which he or she is eligible, either under the Employer's plan or a plan offered by a Dependent's employer.

If a significant overall reduction in coverage is made to the Plan, an Employee may elect another medical benefit option for which he or she is eligible, either under the Employer's plan or a plan offered by a Dependent's employer. If a new medical benefit option is added, or the Employer improves an existing option, an Employee may change his or her election to the new or improved benefit option, if he or she is eligible for that option.

Changes in Coverage Under Another Employer's Plan
An Employee may make a coverage election change that corresponds with a change made under another employer plan (for example the plan of the Employee's spouse) if the other plan:

- Incurs a change such as adding or deleting a benefit option;
- Allows election changes due to qualified life events; or
- This Plan and the other plan have different periods of coverage or open enrollment periods.

Enrollment in Marketplace Plan
If an Employee is eligible to enroll for coverage in a government-sponsored Exchange (Marketplace) during a special or annual enrollment period, the Employee may drop coverage under the Plan, as long as the Employee certifies that the Marketplace coverage will be effective for the Employee and any Dependents dropping coverage no later than the day following the last day of coverage under the Plan.

Qualified Medical Child Support Orders

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

To be considered a Qualified Medical Child Support Order, the Medical Child Support Order must contain the following information:

1. The name and last known mailing address (if any) of the Participant and the name and mailing address of each such Alternate Recipient covered by the order.
2. A reasonable description of the type of coverage to be provided by this Plan to each Alternate Recipient, or the manner in which such type of coverage is to be determined.
3. The period of coverage to which the order applies.
4. The name of this Plan.

A National Medical Support Notice shall be deemed a QMCSO if all of the following requirements are met:

1. It contains the information set forth in the Definitions section in the definition of "National Medical Support Notice."
2. It identifies either the specific type of coverage or all available group health coverage. If the Employer receives a NMSN that does not designate either specific type(s) of coverage or all available coverage, the Employer and the Plan Administrator will assume that all are designated.
3. It informs the Plan Administrator that, if a group health plan has multiple options and the Participant is not enrolled, the issuing agency will make a selection after the NMSN is qualified, and, if the agency does not respond within 20 days, the Child will be enrolled under the Plan's default option (if any).
4. It specifies that the period of coverage may end for the Alternate Recipient(s) only when similarly situated dependents are no longer eligible for coverage under the terms of the Plan, or upon the occurrence of certain specified events.

A NMSN need not be recognized as a QMCSO if it requires the Plan to provide any type or form of benefit, or any option, not otherwise provided to the Participants and eligible Participants without regard to the provisions herein, except to the extent necessary to meet the requirements of a State law relating to Medical Child Support Orders, as described in Social Security Act §1908 (as added by Omnibus Budget Reconciliation Act of 1993 §13822).

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

1. In writing, notify the Participant and each Alternate Recipient covered by such Order (at the address included in the Order) of the receipt of such Order and the Plan's procedures for determining whether the Order qualifies as a QMCSO.
2. Make an administrative determination if the order is a QMCSO and notify the Participant and each affected Alternate Recipient of such determination.

In the instance of any National Medical Support Notice received by this Plan, the Plan Administrator shall perform the following:

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

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

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

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

Acquired Companies

The Plan Administrator may establish different eligibility requirements (for example, waiving the Service Waiting Period or recognizing prior service) with respect to Employees who become employed by a Participating Employer as a result of a corporate transaction.

TERMINATION OF COVERAGE

Termination Dates of Individual Coverage

The coverage of any Employee for himself or herself under this Plan will terminate on the earliest to occur of the following dates:

1. As soon as administratively practicable following the date he or she requests that such coverage be terminated, unless prohibited by law (i.e., when election changes cannot be made due to Internal Revenue Code Section 125 "change in status" guidelines). Please see the "Eligibility for Coverage" section above for more information about mid-year benefit election changes. If coverage is canceled during an Open Enrollment Period, coverage will end on the last day of the current Plan Year. ***NOTE:*** *The Employer offers these benefits in conjunction with a cafeteria plan under Section 125 of the Internal Revenue Code and a voluntary termination must comply with the requirements of the Code and the cafeteria plan*.
2. The date of the expiration of the last period for which the Employee has made a contribution, in the event of his or her failure to make, when due, any contribution for coverage for himself or herself.
3. The day immediately preceding the date on which the Employee is no longer eligible for such coverage under the Plan.
4. The day immediately preceding the date on which the termination of employment occurs.
5. Immediately upon submission of a fraudulent claim or any fraudulent information to the Plan (including enrollment information), by and/or on behalf of an Employee or his or her Dependent, or upon the Employee or his or her Dependent gaining knowledge of the submission, as determined by the Plan Administrator in its discretion, consistent with applicable laws and/or rules regarding such rescission.
6. The date upon which the Plan is terminated.

Termination Dates of Dependent Coverage

The coverage for any Dependents of any Employee who are covered under the Plan will terminate on the earliest to occur of the following dates:

1. Upon the discontinuance of coverage for Dependents under the Plan.
2. The date of termination of the Employee's coverage for himself or herself under the Plan.
3. The date of the expiration of the last period for which the Employee has made a contribution, in the event of his or her failure to make, when due, any contribution for coverage for Dependents.
4. In the case of a Child age 26 or older for whom coverage is being continued due to mental or physical inability to earn his or her own living, the earliest to occur of:
    a. Cessation of such disability or inability.
    b. Failure to provide any required proof of continuous disability or inability or to submit to any required examination.
    c. Upon the Child's no longer being dependent on the Employee for his or her support or marriage.
5. The day immediately preceding the date such person is no longer a Dependent, except as may be provided for in paragraph 6 of this section.
6. The last day of the month in which such person ceases to be a Dependent Child because they reach age 26.
7. For a Dependent Child whose coverage is required pursuant to a QMCSO, the day coverage is no longer required under the terms of the order or this Plan, if the termination results in a qualifying change event (as described above) and the Employee timely requests to terminate such coverage.
8. Immediately upon submission of a fraudulent claim or any fraudulent information to the Plan (including enrollment information), by and/or on behalf of an Employee or his or her Dependent, or upon the Employee or his or her Dependent gaining knowledge of the submission, as determined by the Plan Administrator in its discretion, consistent with applicable laws and/or rules regarding such rescission.
9. As soon as administratively practicable following a request to terminate the Dependent's coverage due to a qualifying life event (other than the Dependent's loss of eligibility under the Plan, as described in paraphs 5 and 6 above).
10. The last day of the current Plan Year, if the Dependent's coverage is terminated during an Open Enrollment Period.

11. The date upon which the Plan is terminated.

NOTE: *The Employer offers these benefits in conjunction with a cafeteria plan under Section 125 of the Internal Revenue Code and a voluntary termination must comply with the requirements of the Code and the cafeteria plan.*

CONTINUATION OF COVERAGE

Employer Continuation Coverage

Eligible Participants may seek to continue coverage upon the occurrence of any Leave of Absence (not meeting the definition of a FMLA Leave); coverage will continue for 90 days.

The above noted leave runs concurrently with FMLA, USERRA or any State-mandated family or medical leave, and/or any other applicable leaves of absence. At the end of the period(s) listed above, the Participant's coverage will be deemed to have terminated for purposes of Continuation of Coverage under COBRA.

Participants should review their Participating Employer's Leave of Absence Policy and consult with the Plan Administrator before taking a Leave of Absence.

Continuation During Family and Medical Leave Act (FMLA) Leave

Regardless of the established leave policies mentioned above, the Plan shall at all times comply with FMLA. It is the intention of the Plan Administrator to provide these benefits only to the extent required by applicable law and not to grant greater rights than those so required. During a FMLA Leave, coverage will be maintained in accordance with the same Plan conditions as coverage would otherwise be provided if the covered Employee had been a continuously active employee during the entire leave period. If Plan coverage lapses during the FMLA Leave, coverage will be reinstated for the person(s) who had coverage under the Plan when the FMLA Leave began, upon the Employee's return to work at the conclusion of the FMLA Leave.

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

Participants should review their Participating Employer's Leave of Absence Policy for information concerning their eligibility for FMLA and consult with the Plan Administrator before taking a Leave of Absence.

Continuation During USERRA

Participants who are absent from employment because they are in the Uniformed Services may elect to continue their coverage under this Plan for up to 24 months. To continue coverage, Participants must comply with the terms of the Plan, including election during the Plan's annual enrollment period, and pay their contributions, if any. In addition, USERRA also requires that, regardless of whether a Participant elected to continue his or her coverage under the Plan, his or her coverage and his or her Dependents' coverage be reinstated immediately upon his or her return to employment, so long as he or she meets certain requirements contained in USERRA. Participants should contact the Plan Administrator for information concerning their eligibility for USERRA and any requirements of the Plan.

The period of coverage available to you and your Dependents under USERRA runs concurrently with any continuation coverage available under COBRA (as described below). Eligibility for TRICARE or active duty military coverage will not terminate eligibility for USERRA continuation coverage.

Continuation During COBRA – Introduction

The right to this form of continued coverage was created by a Federal law, under the Consolidated Omnibus Budget Reconciliation Act of 1985, as amended ("COBRA"). COBRA Continuation Coverage can become available to Employees when they otherwise would lose their group health coverage. It also can become available to other members of the Employee's family who are covered under the Plan when they otherwise would lose their group health coverage. Under the Plan, Qualified Beneficiaries that elect COBRA Continuation Coverage must pay the entire cost of the coverage, including a reasonable administration fee. There are several ways COBRA continuation coverage will terminate, including the failure of the Participant or their covered Dependents to make timely payment of contributions or premiums..

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

COBRA Continuation Coverage

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

Qualifying Events

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

An Employee, who is properly enrolled in this Plan and is a covered Participant, will become a Qualified Beneficiary if he or she loses his or her coverage under the Plan because either one of the following Qualifying Events happens:

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

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

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

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

1. The parent-covered Employee dies.
2. The parent-covered Employee's hours of employment are reduced.
3. The parent-covered Employee's employment ends for any reason other than his or her gross misconduct.
4. The parent-covered Employee becomes entitled to and elects Medicare benefits (Part A, Part B, or both).
5. The parents become divorced or legally separated.
6. The Child stops being eligible for coverage under the Plan as a Dependent Child.

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

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

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

Each of the notifications listed above must be made in writing. Notice must be made by submitting the appropriate form and mailing it by U.S. First Class Mail or hand delivery to the COBRA Administrator. These forms are available, without charge, from the COBRA Administrator.

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

Notification must be received by the COBRA Administrator. The COBRA Administrator is:

TaxSaver Plan
P.O. Box 609002
Dallas, TX 75360
Phone: 1-800-328-4337
Website/Email: csr@taxsaverplan.com

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

Deadline For Providing the Notice
For the initial Qualifying Events described above and all second Qualifying Events, notice must be furnished within 60 days of the latest occurring event set forth below:

1. The date upon which the Qualifying Event occurs.
2. The date upon which the Qualified Beneficiary loses (or would lose) Plan coverage due to a Qualifying Event.

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

1. The date of the disability determination by the SSA.
2. The date on which a Qualifying Event occurs.
3. The date on which the Qualified Beneficiary loses (or would lose) coverage under the Plan as a result of the Qualifying Event.

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

For a change in disability status described above, the notice must be furnished by the date that is 30 days after the date of the final determination by the SSA that the Qualified Beneficiary is no longer disabled.

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

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

Required Contents of the Notice
The notice by or on behalf of the Qualified Beneficiary to the COBRA Administrator must contain the following information:

1. Name and address of the covered Employee or former Employee.
2. Name of the Plan.
3. A description (including the date) of (i) the initial or second Qualifying Event (for example, divorce Legal Separation, cessation of Dependent status, entitlement to Medicare by the covered Employee or former Employee, death of the covered Employee or former Employee), (ii) the disability of a Qualified Beneficiary or loss of disability status, or (iii) other coverage for which a Qualified Beneficiary has become eligible.
    a. In the case of a Qualifying Event that is divorce or Legal Separation, name(s) and address(es) of spouse and Dependent Child or Children covered under the Plan, date of divorce or Legal Separation, and a copy of the decree of divorce or Legal Separation.
    b. In the case of Medicare entitlement of the covered Employee or former Employee or a Qualified Beneficiary, date of entitlement, and name(s) and address(es) of spouse and Dependent Child or Children covered under the Plan.
    c. In the case of a Qualifying Event that is a Dependent Child's cessation of Dependent status under the Plan, name and address of the Child, reason the Child ceased to be an eligible Dependent (for example, attained limiting age).
    d. In the case of a second Qualifying Event that is the death of the covered Employee or former Employee, the date of death, and name(s) and address(es) of spouse and Dependent Child or Children covered under the Plan.
    e. In the case of a disability of a Qualified Beneficiary, name and address of the disabled Qualified Beneficiary, name(s) and address(es) of other family members covered under the Plan, the date the disability began, the date of the SSA's determination, and a copy of the SSA's determination.

f. In the case of a loss of disability status, name and address of the Qualified Beneficiary who is no longer disabled, name(s) and address(es) of other family members covered under the Plan, the date the disability ended and the date of the SSA's determination.

4. Identification of the Qualified Beneficiaries (by name or by status).
5. A certification that the information is true and correct, a signature and date.

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

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

Electing COBRA Continuation Coverage

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

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

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

Duration of COBRA Continuation Coverage

The maximum time period shown below shall dictate for how long COBRA Continuation Coverage will be available. The maximum time period for coverage is based on the type of the Qualifying Event and the status of the Qualified Beneficiary. Multiple Qualifying Events that may be combined under COBRA will not continue coverage for more than 36 months.

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

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

Otherwise, when the Qualifying Event is the end of employment (for reasons other than gross misconduct) or reduction of the covered Employee's hours of employment, COBRA Continuation Coverage generally lasts for only up to a total of 18 months.

There are two ways in which a period of COBRA Continuation Coverage due to the covered Employee's termination of employment or reduction of hours (including COBRA Continuation Coverage during a disability extension period as described below) can be extended.

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

Second Qualifying Event Extension of COBRA Continuation Coverage
If an Employee's family experiences another Qualifying Event while receiving 18 months of COBRA Continuation Coverage, Dependents may receive up to 18 additional months of COBRA Continuation Coverage, for a maximum of 36 months, if notice of the second Qualifying Event is provided to the COBRA Administrator in accordance with the procedures set forth herein. This extension may be applicable to the Employee's death, Medicare Parts A and/or B eligibility, divorce or Legal Separation, or a loss of Dependent status under the terms of the Plan if the event would have also caused the spouse or Dependent Child to lose coverage under the Plan regardless of whether the first Qualifying Event had occurred.

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

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

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

Trade Reform Act of 2002 and Trade Preferences Extension Act of 2015
The Trade Preferences Extension Act of 2015 has extended certain provisions of the Trade Reform Act of 2002, which created a special COBRA right applicable to certain employees who have been terminated or

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

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

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

Other Coverage Options
Instead of enrolling in COBRA Continuation Coverage, there may be other coverage options for Participants through the Health Insurance Marketplace, Medicaid, or other group health plan coverage options (such as a spouse's plan) through what is called a "special enrollment period." Some of these options may cost less than COBRA Continuation Coverage. Participants can learn more about many of these options at www.healthcare.gov.

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

TaxSaver Plan
P.O. Box 609002
Dallas, TX 75360
Phone: 1-800-328-4337
Website/Email: csr@taxsaverplan.com

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

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

GENERAL LIMITATIONS AND EXCLUSIONS

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

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

Air travel as a crew member. That are incurred by the Participant solely due to the Participant's air travel as a crew member.

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

Alcohol. Involving a Participant who has taken part in any activity made illegal due to the use of alcohol or a state of intoxication. This Exclusion does not apply if the Injury (a) resulted from being the victim of an act of domestic violence, or (b) resulted from a documented medical condition (including both physical and mental health conditions).

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

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

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

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

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

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

Experimental. That are Experimental or Investigational.

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

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

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

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

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

Illegal Drugs or Medications. That are services, supplies, care or treatment to a Participant for Injury or Sickness Incurred while the Participant was voluntarily taking or was under the influence of any controlled substance, drug, hallucinogen or narcotic not administered on the advice of a Physician, even if the cause of the Illness or Injury is not related to the use of the controlled substance, drug, hallucinogen or narcotic. This Exclusion does not apply if the Injury (a) resulted from being the victim of an act of domestic violence, or (b) resulted from a documented medical condition (including both physical and mental health conditions).

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

Massage Therapy.

Medical Necessity. That are not Medically Necessary and/or arise from services and/or supplies that are not Medically Necessary.

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

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

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

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

Non-Prescription Drugs. For drugs for use outside of a Hospital or other Inpatient facility that can be purchased over-the-counter and without a Physician's written prescription. This does not apply to the extent the non-prescription drug must be covered under Preventive Care, subject to the Affordable Care Act.

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

Not Specified As Covered. That are not specified as covered under any provision of this Plan.

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

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

Personal Injury Insurance. That are in connection with an automobile accident for which benefits payable hereunder are, or would be otherwise covered by, mandatory no-fault automobile insurance or any other similar type of personal injury insurance required by state or federal law, without regard to whether or not the Participant actually had such mandatory coverage. This Exclusion does not apply if the Injured person is a passenger in a non-family owned vehicle or a pedestrian.

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

Prohibited by Law. That are to the extent that payment under this Plan is prohibited by law.

Provider Error. That are required as a result of unreasonable Provider error.

Self-Inflicted. That are incurred due to an intentionally self-inflicted Injury or Illness, not definitively (a) arising from being the victim of an act of domestic violence, or (b) resulting from a documented medical condition (including both physical and mental health conditions).

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

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

Vehicle Accident. For treatment of any Injury where it is determined that a Participant was involved in a motorcycle Accident or automobile Accident while in violation of traffic laws other than an infraction, or while intoxicated above the legal limit, or while under the influence of hallucinogen or a substance causing intoxication. This Exclusion does not apply: (a) to Participants who were passengers on public transportation, ride for hire or livery services or (b) when a seatbelt or helmet is not required by law. This Exclusion also does not apply if the Injury (a) resulted from being the victim of an act of domestic violence, or (b) resulted from a documented medical condition (including both physical and mental health conditions).

Voluntary Acts. That are incurred due to the voluntary taking of a prescription drug in a manner other than as prescribed by a Physician; any other federally- or state-regulated substance in an unlawful manner; non-prescription medicine, in a manner other than as indicated in the printed instructions; poison; or the voluntary inhaling of gas (unless due to occupational accident). This Exclusion does not apply if the Injury (a) resulted from being the victim of an act of domestic violence, or (b) resulted from a documented medical condition (including both physical and mental health conditions).

War/Riot. That Incurred as a result of war or any act of war, whether declared or undeclared, or any act of aggression by any country, including rebellion or riot.

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

PLAN ADMINISTRATION

The Plan Administrator has been granted the authority to administer the Plan. The Plan Administrator has retained the services of the Third Party Administrator and the Prescription Drug Claims Administrator to provide certain claims processing and other technical services. The Plan Administrator has also delegated its fiduciary duties with respect to final internal appeal determinations under the Plan for prescription drug benefit claims to the Prescription Drug Claims Administrator. Subject to the responsibilities delegated to the Third Party Administrator and the Prescription Drug Claims Administrator, the Plan Administrator reserves the unilateral right and power to administer and to interpret, construe and construct the terms and provisions of the Plan, including without limitation, correcting any error or defect, supplying any omission, reconciling any inconsistency and making factual determinations. The Plan Administrator has the necessary discretionary authority and control to require deferential judicial review. Therefore, the Plan Administrator's exercise of discretion in its interpretation of the Plan's written terms and its findings of fact in its role as the medical benefit program's claims fiduciary will not be overturned unless a court determines they are arbitrary and capricious.

The Plan Administrator has delegated its fiduciary duties with respect to final internal appeal determinations under the Plan for prescription drug benefit claims to the Prescription Drug Claims Administrator. The Prescription Drug Claims Administrator has the full extent of the Plan Administrator's authority and duties with respect to those responsibilities delegated to it, including full discretionary authority to interpret the Plan; determine eligibility for and the amount of benefits under the Plan; and exercise all of the power and authority contemplated by the Employee Retirement Income Security Act of 1974, as amended, with respect to making final internal appeal determinations under the Plan. The Prescription Drug Claims Administrator has the necessary discretionary authority and control to require deferential judicial review. Therefore, the Prescription Drug Claims Administrator's exercise of discretion in its interpretation of the Plan's written terms and its findings of fact in its role as the prescription drug benefit program's claims fiduciary will not be overturned unless a court determines they are arbitrary and capricious.

Plan Administrator

The Plan is administered by the Plan Administrator within the purview of ERISA and in accordance with these provisions.

The Plan Administrator may delegate to one or more individuals or entities part or all of its discretionary authority under the Plan.

The Plan shall be administered by the Plan Administrator, in accordance with its terms. Policies, interpretations, practices, and procedures are established and maintained by the Plan Administrator and its delegates. It is the express intent of this Plan that the Plan Administrator shall have maximum legal discretionary authority to construe and interpret the terms and provisions of the Plan, to make all interpretive and factual determinations as to whether any individual is eligible and entitled to receive any benefit under the terms of this Plan, to decide disputes which may arise with respect to a Participant's rights, and to decide questions of Plan interpretation and those of fact relating to the Plan. As discussed above, the Plan Administrator has delegated its fiduciary duties with respect to final internal appeal determinations under the Plan for prescription drug benefit claims to the Prescription Drug Claims Administrator. Therefore, the final benefit decisions of the Prescription Drug Claims Administrator will be final and binding on all interested parties. In cases where coverage is disputed, benefits will be paid under this Plan only if the Plan Administrator (for medical benefit claims) or Prescription Drug Claims Administrator (for prescription drug benefit claims), in its discretion, determines that the Participant is entitled to them.

Amending and Terminating the Plan

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

If the Plan is terminated, the rights of the Plan Participants are limited to expenses Incurred before termination. In connection with the termination, the Plan Administrator may establish a deadline by which all Claims must be submitted for consideration. Benefits will be paid only for Covered Expenses Incurred prior to the termination date and submitted in accordance with the rules established by the Plan Administrator. Upon termination, any Plan assets will be used to pay outstanding claims and all expenses of Plan termination. As it relates to distribution of assets upon termination of the Plan, any contributions paid by Participants will be used for the exclusive purpose of providing benefits and defraying reasonable expenses related to Plan administration, and will not inure to the benefit of the Employer.

Misuse of Identification Card

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

CLAIM PROCEDURES; PAYMENT OF CLAIMS

Introduction

In accordance with applicable law, the Plan will allow an authorized representative to act on a Claimant's behalf in pursuing or appealing a benefit claim. Please see the "Appointment of Authorized Representative" section below for important information about how to designate an authorized representative.

Claims must be filed with the appropriate Claims Administrator within 365 days of the date charges for the service(s) and/or supplies were Incurred. Claims filed later than that date shall be denied. Benefits are based upon the Plan's provisions at the time the charges were Incurred.

The availability of health benefit payments is dependent upon Claimants complying with the following:

Health Claims

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

Claims for Prescription Drug Benefits. The Plan Administrator has delegated to the Prescription Drug Claims Administrator the discretionary authority to perform a full and fair review, as required by ERISA, of each prescription drug benefit claim denial which has been appealed by a Claimant or his duly authorized representative and to make final internal appeal determinations under the Plan. The Prescription Drug Claims Administrator has the full extent of the Plan Administrator's authority and duties with respect to those responsibilities delegated to it and therefore has the necessary discretionary authority and control to require deferential judicial review. The exercise of discretion by the Prescription Drug Claims Administrator in its interpretation of the Plan's written terms and its findings of fact in its role as the Plan's claims fiduciary will not be overturned unless a court determines they are arbitrary and capricious.

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

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

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

independent external review. Only certain types of claims are eligible for external review. The external review procedures, including a description of the types of claims that are eligible for external review, are described below.

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

A Claimant must exhaust all of the Plan's internal claim and appeal procedures (as described below) before he or she can file a lawsuit. If a lawsuit is brought, it must be filed within one year after completion (or deemed exhaustion) of the Plan's claim and appeal procedures. A lawsuit that is not filed by this deadline will be subject to automatic dismissal.

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

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

   Urgent care or Emergency medical services or admissions will not require notice to the Plan prior to the receipt of care. Furthermore, if in the opinion of a Physician with knowledge of the Claimant's medical condition, pre-determination of payability by the Plan prior to the receipt of medical care (a Pre-service Claim) would result in a delay adequate to jeopardize the life or health of the Claimant, hinder the Claimant's ability to regain maximum function (compared to treatment without delay), or subject the Claimant to severe pain that cannot be adequately managed without the care or treatment that is the subject of the claim, said claim may be deemed to be a "Pre-service Urgent Care Claim." In such circumstances, the Claimant is urged to obtain the applicable care without delay, and communicate with the Plan regarding their claim(s) as soon as reasonably possible.

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

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

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

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

When Claims Must Be Filed

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

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

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

1. The date of service.
2. The name, address, telephone number and tax identification number of the Provider of the services or supplies.
3. The place where the services were rendered.
4. The Diagnosis and procedure codes.
5. The amount of charges, which reflect any applicable PPO re-pricing, if any.
6. The name of the Plan.
7. The name of the covered Employee.
8. The name of the patient.

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

Claims for medical benefits under the Plan must be submitted to:

WebTPA
8500 Freeport Parkway, Suite 400
Irving, TX 75063
Phone: 1-844-380-4564
Website/Email: helpme@webtpa.com

Claims for prescription drug benefits under the Plan must be submitted to:

Express Scripts
Attn: Commercial Claims
P. O. Box 14711
Lexington, KY 40512-4711
Fax: 608-741-5475
Urgent Requests: 1-888-848-4452; "option 2"

Special Note

The Plan uses MedTrak RX regarding prescription fills for two specific conditions: Hepatitis C and Inflammatory Conditions such as Rheumatoid Arthritis. Participants who are new users to these therapies need to contact MedTrak at 800-771-4648 to have their prescriptions filled.

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

Incorrectly Filed Claims
These claims procedures do not apply to any request for benefits that is not made in accordance with these claims procedures, except that (a) in the case of an incorrectly filed Pre-service Claim, the Claimant will be notified as soon as possible but no later than 5 days following receipt by the Claims Administrator of the incorrectly filed claim; and (b) in the case of an incorrectly filed Urgent Care Claim, the Claimant will be notified as soon as possible but no later than 24 hours following receipt by the Claims Administrator of the incorrectly filed claim. The notice will explain that the request is not a properly filed claim and describe the proper procedures for filing a claim. The notice may be oral unless written notice is specifically requested by the Claimant.

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

1. Pre-service Urgent Care Claims:

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

2. Pre-service Non-urgent Care Claims:
    a. If the Claimant has provided all of the information needed to process the claim, in a reasonable period of time appropriate to the medical circumstances, but not later than 15 days after receipt of the claim, unless an extension has been requested, then prior to the end of the 15 day extension period.
    a. If an extension is needed because the Claimant has not provided all of the information needed to process the claim, then the Claimant will be notified as to what specific information is needed as soon as possible and will be given at least 45 days from receipt of the notice to provide the specified information. The Claimant will be notified of a determination of benefits in a reasonable period of time appropriate to the medical circumstances, either prior to the end of the extension period (if additional information was requested during the initial processing period), which will be tolled as provided in paragraph 6 below, or by the date agreed to by the Claims Administrator and the Claimant (if additional information was requested during the extension period).

3. Concurrent Claims:

    a. Plan Notice of Reduction or Termination. If the Claims Administrator is notifying the Claimant of a reduction or termination of a course of treatment (other than by Plan amendment or termination), notification will occur before the end of such period of time or number of treatments. The Claimant will be notified sufficiently in advance of the reduction or termination to allow the Claimant to appeal and obtain a determination on review of that Adverse Benefit

Determination before the benefit is reduced or terminated. This rule does not apply if benefits are reduced or eliminated due to plan amendment or termination. A similar process applies for claims based on a rescission of coverage for fraud or misrepresentation.

b. Request by Claimant Involving Urgent Care. If the Claims Administrator receives a request from a Claimant to extend the course of treatment beyond the period of time or number of treatments involving urgent care, notification will occur as soon as possible, taking into account the medical exigencies, but not later than 24 hours after receipt of the claim, as long as the Claimant makes the request at least 24 hours prior to the expiration of the prescribed period of time or number of treatments. If the Claimant submits the request with less than 24 hours prior to the expiration of the prescribed period of time or number of treatments, the request will be treated as a claim involving urgent care and decided within the urgent care timeframe.

c. Request by Claimant Involving Non-urgent Care. If the Claims Administrator receives a request from the Claimant for a claim not involving urgent care, the request will be treated as a new benefit claim and decided within the timeframe appropriate to the type of claim (either as a Pre-service Non-urgent claim or a Post-service claim).

d. Request by Claimant Involving Rescission. A rescission of coverage is treated as an Adverse Benefit Determination (whether or not the rescission has an adverse effect on any particular benefit at that time). A rescission is a retroactive cancellation of coverage, other than for failure to pay premiums. With respect to rescissions, the Plan will provide at least 30 days advance written notice before coverage is rescinded.

4. Post-service Claims:

a. If the Claimant has provided all of the information needed to process the claim, in a reasonable period of time, but not later than 30 days after receipt of the claim, unless an extension has been requested, then prior to the end of the 15 day extension period.

b. If such an extension is necessary due to a failure of the Claimant to submit the information necessary to decide the claim, the notice of extension shall specifically describe the required information, and the Claimant shall be afforded at least 45 days from receipt of the notice within which to provide the specified information.

c. If the Claimant has not provided all of the information needed to process the claim and additional information is requested during the initial processing period, then the Claimant will be notified of a determination of benefits prior to the end of the extension period, unless additional information is requested during the extension period (which will be tolled as provided in paragraph 6 below), then the Claimant will be notified of the determination by a date agreed to by the Claims Administrator and the Claimant.

5. Extensions:

a. Pre-service Urgent Care Claims. No extensions are available in connection with Pre-service urgent care claims.

b. Pre-service Non-urgent Care Claims. This period may be extended by the Plan for up to 15 days, provided that the Claims Administrator both determines that such an extension is necessary due to matters beyond the control of the Plan and notifies the Claimant, prior to the expiration of the initial 15 day processing period, of the circumstances requiring the extension of time and the date by which the Plan expects to render a decision.

c. Post service Claims. This period may be extended by the Plan for up to 15 days, provided that the Claims Administrator both determines that such an extension is necessary due to matters beyond the control of the Plan and notifies the Claimant, prior to the expiration of the initial 30 day processing period, of the circumstances requiring the extension of time and the date by which the Plan expects to render a decision.

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

Plan. If a Pre-Service (non-urgent care) or Post-service Claim is incomplete, the timeframe for deciding the claim will be suspended from the date the extension notice is sent to the Claimant until the date the missing necessary information is provided to the Plan. If the requested information is provided, the Claims Administrator will decide the claim within the extended period specified in the extension notice. If the requested information is not provided within the time specified, the claim may be decided without that information.

Notification of an Adverse Benefit Determination

The Claims Administrator shall provide a Claimant with a notice, either in writing or electronically (or, in the case of pre-service urgent care claims, by telephone, facsimile or similar method, with written or electronic notice following within three days), containing the following information:

1. Information sufficient to allow the Claimant to identify the claim involved (including date of service, the health care Provider, the claim amount, if applicable, and a statement describing the availability, upon request, of the Diagnosis code and its corresponding meaning, and the treatment code and its corresponding meaning).
2. A reference to the specific portion(s) of the Plan document upon which a denial is based.
3. Specific reason(s) for a denial, including the denial code and its corresponding meaning, and a description of the Plan's standard, if any, that was used in denying the claim.
4. A description of any additional information necessary for the Claimant to perfect the claim and an explanation of why such information is necessary.
5. A description of the Plan's review procedures and the time limits applicable to the procedures, including a statement of the Claimant's right to bring a civil action under Section 502(a) of ERISA following an Adverse Benefit Determination on final review.
6. A statement that the Claimant is entitled to receive, upon request and free of charge, reasonable access to, and copies of, all documents, records and other information relevant to the Claimant's claim for benefits.
7. Upon request, the identity of any medical or vocational experts consulted in connection with a claim, even if the Plan did not rely upon their advice (or a statement that the identity of the expert will be provided, upon request).
8. Any rule, guideline, protocol or similar criterion that was relied upon in making the determination (or a statement that it was relied upon and that a copy will be provided to the Claimant, free of charge, upon request).
9. In the case of denials based upon a medical judgment (such as whether the treatment is Medically Necessary or Experimental), either an explanation of the scientific or clinical judgment for the determination, applying the terms of the Plan to the Claimant's medical circumstances, or a statement that such explanation will be provided to the Claimant, free of charge, upon request.
10. In a claim involving urgent care, a description of the Plan's expedited review process.

Appeal of Adverse Benefit Determinations

Full and Fair Review of All Claims

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

1. A 180 day timeframe following receipt of a notification of an initial Adverse Benefit Determination within which to appeal the determination. **The Plan will not accept appeals filed after a 180 day timeframe.**
2. The opportunity to submit written comments, documents, records, and other information relating to the claim for benefits.
3. The opportunity to review the Claim file and to present evidence and written testimony as part of the internal claims and appeals process.

4. A review that does not afford deference to the previous Adverse Benefit Determination and that is conducted by an appropriate named fiduciary of the Plan, who shall be neither the individual who made the Adverse Benefit Determination that is the subject of the appeal, nor the subordinate of such individual.
5. A review that takes into account all comments, documents, records, and other information submitted by the Claimant relating to the claim, without regard to whether such information was submitted or considered in the prior benefit determination.
6. That, in deciding an appeal of any Adverse Benefit Determination that is based in whole or in part upon a medical judgment, the Plan fiduciary shall consult with a health care professional who has appropriate training and experience in the field of medicine involved in the medical judgment, who is neither an individual who was consulted in connection with the Adverse Benefit Determination that is the subject of the appeal, nor the subordinate of any such individual.
7. Upon request, the identity of medical or vocational experts whose advice was obtained on behalf of the Plan in connection with a claim, even if the Plan did not rely upon their advice.
8. That a Claimant will be provided, free of charge: (a) reasonable access to, and copies of, all documents, records, and other information relevant to the Claimant's claim in possession of the Plan; (b) information regarding any voluntary appeals procedures offered by the Plan; (c) information regarding the Plan's external review process; (d) any internal rule, guideline, protocol or other similar criterion relied upon, considered or generated in making the adverse determination; and (e) an explanation of the scientific or clinical judgment for the determination, applying the terms of the Plan to the Claimant's medical circumstances.
9. That a Claimant will be provided, free of charge, and sufficiently in advance of the date that the notice of Final Internal Adverse Benefit Determination is required, with new or additional evidence considered, relied upon, or generated by the Plan in connection with the Claim, as well as any new or additional rationale for a denial at the internal appeals stage, and a reasonable opportunity for the Claimant to respond to such new evidence or rationale.

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

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

For Pre-service medical benefit Claims:

WebTPA
8500 Freeport Parkway, Suite 400
Irving, TX 75063
Phone: 1-844-380-4564

For Pre-service prescription drug benefit Claims:

Express Scripts
Phone: 1-877-887-2879

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

For Post-service medical benefit Claims:

WebTPA
8500 Freeport Parkway, Suite 400
Irving, TX 75063
Phone: 1-844-380-4564

Post-service Claims for prescription drug benefits under the Plan must be submitted to:

Express Scripts
Attn: Commercial Claims
P. O. Box 14711
Lexington, KY 40512-4711
Fax: 608-741-5475

Special Note
The Plan now uses MedTrak RX regarding prescription fills for two specific conditions: Hepatitis C and Inflammatory Conditions such as Rheumatoid Arthritis. Participants who are new users to these therapies need to contact MedTrak at 800-771-4648 to have their prescriptions filled.

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

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

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

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

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

1. Pre-service Urgent Care Claims: As soon as possible, taking into account the medical exigencies, but not later than 72 hours after receipt of the appeal.
2. Pre-service Non-urgent Care Claims: Within a reasonable period of time appropriate to the medical circumstances, but not later than 30 days after receipt of the appeal.
3. Concurrent Claims: The response will be made in the appropriate time period based upon the type of claim: Pre-service Urgent, Pre-service Non-urgent or Post-service.
4. Post-service Claims: Within a reasonable period of time, but not later than 60 days after receipt of the appeal.

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

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

1. Information sufficient to allow the Claimant to identify the claim involved (including date of service, the health care Provider, the claim amount, if applicable, and a statement describing the availability, upon

request, of the Diagnosis code and its corresponding meaning, and the treatment code and its corresponding meaning).

2. Specific reason(s) for a denial, including the denial code and its corresponding meaning, and a description of the Plan's standard, if any, that was used in denying the claim, and a discussion of the decision.
3. A reference to the specific portion(s) of the Plan on which the denial is based.
4. The identity of any medical or vocational experts consulted in connection with a claim, even if the Plan did not rely upon their advice (or a statement that the identity of the expert will be provided, upon request).
5. A statement that the Claimant is entitled to receive, upon request and free of charge, reasonable access to, and copies of, all documents, records, and other information relevant to the Claimant's claim for benefits.
6. Any rule, guideline, protocol or similar criterion that was relied upon, considered, or generated in making the determination will be provided free of charge. If this is not practical, a statement will be included that such a rule, guideline, protocol or similar criterion was relied upon in making the determination and a copy will be provided to the Claimant, free of charge, upon request.
7. A description of available internal appeals and external review processes, including information regarding how to initiate an appeal or external review.
8. A statement of the Participant's right to bring a civil action under section 502(a) of ERISA following an Adverse Benefit Determination on final review.
9. In the case of denials based upon a medical judgment (such as whether the treatment is Medically Necessary or Experimental), either an explanation of the scientific or clinical judgment for the determination, applying the terms of the Plan to the Claimant's medical circumstances, will be provided. If this is not practical, a statement will be included that such explanation will be provided to the Claimant, free of charge, upon request.
10. Information about the availability of, and contact information for, an applicable office of health insurance consumer assistance or ombudsman established under applicable federal law to assist Participants with the internal claims and appeals and external review processes.

If notification of an Adverse Benefit Determination for an Urgent Care Claim is provided orally, written notification will be provided not later than three days after the oral notice.

Furnishing Documents in the Event of an Adverse Determination

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

Decision on Review

The decision by the Plan Administrator (for medical benefit claims) or Prescription Drug Claims Administrator (for prescription drug benefit claims) on review will be final, binding and conclusive and will be afforded the maximum deference permitted by law. All claim review procedures provided for in the Plan must be exhausted before any legal action is brought.

External Review Process

The Plan's external review process does not apply to a denial, reduction, termination, or a failure to provide payment for a benefit based on a determination that a Claimant or beneficiary fails to meet the requirements for eligibility under the terms of the Plan (except where the claim relates to a rescission of coverage).

Except for certain urgent care claims, as described in the "Expedited external review" section below, you may not file a request for external review until you have exhausted the Plan's internal claim and appeal procedures (as described above). The Plan's external review process is voluntary, which means Claimants are not required to file a request for external review in order to exhaust the Plan's claim and appeal procedures.

The Plan's external review process, in accordance with the current Affordable Care Act regulations, applies only to:

1. Any eligible Adverse Benefit Determination (including a Final Internal Adverse Benefit Determination) by a plan or issuer that involves medical judgment (including, but not limited to, those based on the plan's or issuer's requirements for Medical Necessity, appropriateness, health care setting, level of care, or effectiveness of a covered benefit; or its determination that a treatment is Experimental or Investigational), as determined by the external reviewer.
2. A rescission of coverage (whether or not the rescission has any effect on any particular benefit at that time).

Standard external review

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

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

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

    a. The Claimant is or was covered under the Plan at the time the health care item or service was requested or, in the case of a retrospective review, was covered under the Plan at the time the health care item or service was provided.
    b. The Adverse Benefit Determination does not relate to the Claimant's failure to meet the requirements for eligibility under the terms of the Plan (e.g., worker classification or similar determination), except when the claim relates to a rescission of coverage.
    c. The Claimant has exhausted the Plan's internal appeal process because the Plan has failed to follow its internal claim and appeal procedures.
    d. The Claimant has provided all the information and forms required to process an external review. Within one business day after completion of the preliminary review, the Plan will issue a notification in writing to the Claimant. If the request is complete but not eligible for external review, such notification will include the reasons for its ineligibility and contact information for the Employee Benefits Security Administration (toll-free number 866-444-EBSA (3272)). If the request is not complete, such notification will describe the information or materials needed to make the request complete and the Plan will allow a Claimant to perfect the request for external review within the four-month filing period or within the 48 hour period following the receipt of the notification, whichever is later.

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

4. Reversal of Plan's decision. Upon receipt of a notice of a final external review decision reversing the Final Internal Adverse Benefit Determination, the Plan will provide coverage or payment for the claim

without delay, regardless of whether the Plan intends to seek judicial review of the external review decision and unless or until there is a judicial decision otherwise.

Expedited external review

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

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

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

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

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

Limitation of Action

A Claimant cannot bring any legal action against the Plan for any reason unless he or she first completes all steps in the internal claim and appeal process described in this section. **After completing that process, if he or she wants to bring a legal action against the Plan he or she must do so within one year of his or her completion (or deemed exhaustion) of the Plan's claim and appeal procedures (including external review, if the Claimant choses to complete the voluntary external review process) or he or she will lose any rights to bring such an action against the Plan.** A Claimant will only be deemed to have exhausted the Plan's claim and appeal procedures if the Plan fails to follow its internal claim and appeal procedures with respect to the Claimant's claim.

Any action arising out of or in connection with the Plan may only be brought or filed in Federal District Court for the Northern District of Georgia, Atlanta Division.

Appointment of Authorized Representative

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

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

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

Autopsy

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

Payment of Benefits

Where benefit payments are allowable in accordance with the terms of this Plan, payment shall be made in U.S. Dollars (unless otherwise agreed upon by the Plan Administrator). Payment may be made, in the Plan Administrator's discretion, directly to a Provider, but in any instance may alternatively be made to the Claimant, on whose behalf payment is made and who is the recipient of the services for which payment is being made. The payment of benefits directly to a Provider, if any, will be done as a convenience to the Participant and will not constitute an assignment of rights, benefits, causes of action, or any other interest under the Plan or a waiver of the Plan's anti-assignment provision (as described below). Should the Claimant be deceased, payment shall be made to the Claimant's heir, assign, agent or estate (in accordance with written instructions), or, if there is no such arrangement and in the Plan Administrator's discretion, the institute and/or Provider who provided the care and/or supplies for which payment is to be made.

No Assignments Permitted

No right, benefit, cause of action arising after the denial of benefits, or any other interest under the Plan shall be subject to alienation, sale, transfer, assignment, pledge, or encumbrance or charge, voluntary or involuntary, by operation of law or otherwise, and any attempt at such transaction(s) shall be void. A Participant may not assign his or her rights, benefits, causes of action arising after the denial of benefits, or any other interest under this Plan to a Provider or any other individual or entity. The Plan Administrator may, however, in its discretion, pay a Provider directly for services rendered to a Participant. The payment of benefits directly to a Provider, if any, will be done as a convenience to the Participant and will not constitute an assignment of rights, benefits, causes of action, or any other interest under the Plan or a waiver of this anti-assignment provision.

Non U.S. Providers

A Provider of medical care, supplies, or services, whose primary facility, principal place of business or address for payment is located outside the United States shall be deemed to be a "Non U.S. Provider." Claims for medical care, supplies, or services provided by a Non U.S. Provider and/or that are rendered outside the United States of America, may be deemed to be payable under the Plan by the Plan Administrator, subject to all Plan Exclusions, limitations, maximums and other provisions. The Claimant is responsible for making all payments to Non U.S. Providers, and is solely responsible for subsequent submission of proof of payment to the Plan. Only upon receipt of such proof of payment, and any other documentation needed by the Claims Administrator to process the claims in accordance with the terms of the Plan, shall reimbursement by the Plan

to the Claimant be made. If payment was made by the Claimant in U.S. currency (American dollars), the maximum reimbursable amount by the Plan to the Claimant shall be that amount. If payment was made by the Claimant using any currency other than U.S. currency (American dollars), the Plan shall utilize an exchange rate in effect on the Incurred date as established by a recognized and licensed entity authorized to so establish said exchange rates. The Non U.S. Provider shall be subject to, and shall act in compliance with, all U.S. and other applicable licensing requirements; and claims for benefits must be submitted to the Plan in English.

Recovery of Payments

Occasionally, benefits are paid more than once, are paid based upon improper billing or a misstatement in a proof of loss or enrollment information, are not paid according to the Plan's terms, conditions, limitations or Exclusions, or should otherwise not have been paid by the Plan. As such this Plan may pay benefits that are later found to be greater than the Maximum Allowable Charge. In this case, this Plan may recover the amount of the overpayment from the source to which it was paid, primary payers, or from the party on whose behalf the charge(s) were paid. As such, whenever the Plan pays benefits exceeding the amount of benefits payable under the terms of the Plan, the Plan Administrator has the right to recover any such erroneous payment directly from the person or entity who received such payment and/or from other payers and/or the Claimant or Dependent on whose behalf such payment was made.

A Claimant, Dependent, Provider, another benefit plan, insurer, or any other person or entity who receives a payment exceeding the amount of benefits payable under the terms of the Plan or on whose behalf such payment was made, shall return or refund the amount of such erroneous payment to the Plan within 30 days of discovery or demand. The Plan Administrator shall have no obligation to secure payment for the expense for which the erroneous payment was made or to which it was applied.

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

Providers and any other person or entity accepting payment from the Plan, in consideration of services rendered, payments and/or rights, agrees to be bound by the terms of this Plan and agree to submit claims for reimbursement in strict accordance with their State's health care practice acts, ICD or CPT standards, Medicare guidelines, HCPCS standards, or other standards approved by the Plan Administrator. Any payments made on claims for reimbursement not in accordance with the above provisions shall be repaid to the Plan within 30 days of discovery or demand or incur prejudgment interest of 1.5% per month. If the Plan must bring an action against a Claimant, Provider or other person or entity to enforce the provisions of this section, then that Claimant, Provider or other person or entity agrees to pay the Plan's attorneys' fees and costs, regardless of the action's outcome.

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

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

1. In error.
2. Pursuant to a misstatement contained in a proof of loss or a fraudulent act.

3. Pursuant to a misstatement made to obtain coverage under this Plan.
4. With respect to an ineligible person.
5. In anticipation of obtaining a recovery if a Claimant fails to comply with the Plan's Third Party Recovery, Subrogation and Reimbursement provisions.
6. Pursuant to a claim for which benefits are recoverable under any policy or act of law providing for coverage for occupational injury or disease to the extent that such benefits are recovered. This provision (6) shall not be deemed to require the Plan to pay benefits under this Plan in any such instance.

The deduction may be made against any claim for benefits under this Plan by a Claimant or by any of his covered Dependents if such payment is made with respect to the Claimant or any person covered or asserting coverage as a Dependent of the Claimant.

Medicaid Coverage

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

COORDINATION OF BENEFITS

Coordination of the Benefit Plans

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

Benefits Subject to This Provision

The following shall apply to the entirety of the Plan and all benefits described therein.

Excess Insurance

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

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

1. Any primary payer besides the Plan.
2. Any first party insurance through medical payment coverage, personal injury protection, no-fault coverage, uninsured or underinsured motorist coverage.
3. Any policy of insurance from any insurance company or guarantor of a third party.
4. Workers' compensation or other liability insurance company.
5. Any other source, including but not limited to crime victim restitution funds, any medical, disability or other benefit payments, and school insurance coverage.

Vehicle Limitation

When medical payments are available under any vehicle insurance, the Plan shall pay excess benefits only, without reimbursement for vehicle plan and/or policy deductibles. This Plan shall always be considered secondary to such plans and/or policies. This applies to all forms of medical payments under vehicle plans and/or policies regardless of its name, title or classification.

Effect on Benefits

Application to Benefit Determinations

The plan that pays first according to the rules in the provision entitled "Order of Benefit Determination" will pay as if there were no Other Plan involved. The secondary and subsequent plans will pay the balance due up to 100% of the total Allowable Expenses. When there is a conflict in the rules, this Plan will never pay more than 50% of Allowable Expenses when paying secondary. Benefits will be coordinated on the basis of a Claim Determination Period.

When medical payments are available under automobile insurance, this Plan will pay excess benefits up to 100% of the total Allowable Expenses. Automobile Deductibles will not be reimbursed. This Plan will always be considered the secondary carrier regardless of the individual's election under personal injury protection (PIP) coverage with the automobile insurance carrier.

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

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

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

1. A plan without a coordinating provision will always be the primary plan.
2. The benefits of a plan which covers the person on whose expenses claim is based, other than as a dependent, shall be determined before the benefits of a plan which covers such person as a dependent.
3. If the person for whom claim is made is a dependent child covered under both parents' plans, the plan covering the parent whose birthday (month and day of birth, not year) falls earlier in the year will be primary, except:
    a. When the parents were never married, are separated, or are divorced, the benefits of a plan which covers the child as a dependent of the parent with custody will be determined before the benefits of a plan which covers the child as a dependent of the parent without custody.
    b. When the parents are divorced and the parent with custody of the child has remarried, the benefits of a plan which covers the child as a dependent of the parent with custody shall be determined before the benefits of a plan which covers that child as a dependent of the stepparent, and the benefits of a plan which covers that child as a dependent of the stepparent will be determined before the benefits of a plan which covers that child as a dependent of the parent without custody.

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

4. When the rules above do not establish an order of benefit determination, the benefits of a plan which has covered the person on whose expenses claim is based for the longer period of time shall be determined before the benefits of a plan which has covered such person the shorter period of time.
5. To the extent required by Federal and State regulations, this Plan will pay before any Medicare, Tricare, Medicaid, State child health benefits or other applicable State health benefits program.

Right to Receive and Release Necessary Information

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

Facility of Payment

A payment made under any Other Plan may include an amount that should have been paid under this Plan. The Plan Administrator may, in its sole discretion, pay any organizations making such other payments any amounts it shall determine to be warranted in order to satisfy the intent of this provision. Any such amount paid under this provision shall be deemed to be benefits paid under this Plan. The Plan will not have to pay such amount again and this Plan shall be fully discharged from liability.

Right of Recovery

In accordance with the Recovery of Payments provision, whenever payments have been made by this Plan with respect to Allowable Expenses in a total amount, at any time, in excess of the maximum amount of payment necessary at that time to satisfy the intent of this Coordination of Benefits section, the Plan shall have the right to recover such payments, to the extent of such excess, from any one or more of the following as this Plan shall determine: any person to or with respect to whom such payments were made, or such person's legal representative, any insurance companies, or any other individuals or organizations which the Plan

determines are responsible for payment of such Allowable Expenses, and any future benefits payable to the Participant or his or her Dependents. Please see the Recovery of Payments provision above for more details.

MEDICARE

Applicable to Active Employees and Their Spouses Ages 65 and Over

An active Employee and his or her spouse (ages 65 and over) may, at the option of such Employee, elect or reject coverage under this Plan. If such Employee elects coverage under this Plan, the benefits of this Plan shall be determined before any benefits provided by Medicare. If coverage under this Plan is rejected by such Employee, benefits listed herein will not be payable even as secondary coverage to Medicare.

Applicable to All Other Participants Eligible for Medicare Benefits

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

Applicable to Medicare Services Furnished to End Stage Renal Disease ("ESRD") Participants Who Are Covered Under This Plan

If any Participant is eligible for Medicare benefits because of ESRD, the benefits of the Plan will be determined before Medicare benefits for the first 30 months of Medicare entitlement, unless applicable Federal law provides to the contrary, in which event the benefits of the Plan will be determined in accordance with such law.

THIRD PARTY RECOVERY, SUBROGATION AND REIMBURSEMENT

Payment Condition

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

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

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

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

Subrogation

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

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

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

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

1. The responsible party, its insurer, or any other source on behalf of that party.
2. Any first party insurance through medical payment coverage, personal injury protection, no-fault coverage, uninsured or underinsured motorist coverage.
3. Any policy of insurance from any insurance company or guarantor of a third party.
4. Workers' compensation or other liability insurance company.
5. Any other source, including but not limited to crime victim restitution funds, any medical, disability or other benefit payments, and school insurance coverage.

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

Right of Reimbursement

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

No court costs, experts' fees, attorneys' fees, filing fees, or other costs or expenses of litigation may be deducted from the Plan's recovery without the prior, express written consent of the Plan.

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

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

This provision shall not limit any other remedies of the Plan provided by law. These rights of subrogation and reimbursement shall apply without regard to the location of the event that led to or caused the applicable Sickness, Injury, Disease or disability.

Participant is a Trustee Over Plan Assets

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

1. Notify the Plan or its authorized representative of any settlement prior to finalization of the settlement, execution of a release, or receipt of applicable funds.
2. Instruct his or her attorney to ensure that the Plan and/or its authorized representative is included as a payee on all settlement drafts.
3. In circumstances where the Participant is not represented by an attorney, instruct the insurance company or any third party from whom the Participant obtains a settlement, judgment or other source of Coverage to include the Plan or its authorized representative as a payee on the settlement draft.
4. Hold any and all funds so received in trust, on the Plan's behalf, and function as a trustee as it applies to those funds, until the Plan's rights described herein are honored and the Plan is reimbursed.

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

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

Excess Insurance

If at the time of Injury, Sickness, Disease or disability there is available, or potentially available any Coverage (including but not limited to Coverage resulting from a judgment at law or settlements), the benefits under this Plan shall apply only as an excess over such other sources of Coverage, except as otherwise provided for under the Plan's Coordination of Benefits section.

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

1. The responsible party, its insurer, or any other source on behalf of that party.
2. Any first party insurance through medical payment coverage, personal injury protection, no-fault coverage, uninsured or underinsured motorist coverage.
3. Any policy of insurance from any insurance company or guarantor of a third party.
4. Workers' compensation or other liability insurance company.
5. Any other source, including but not limited to crime victim restitution funds, any medical, disability or other benefit payments, and school insurance coverage.

Separation of Funds

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

Wrongful Death

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

Obligations

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

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

2. To provide the Plan with pertinent information regarding the Sickness, Disease, disability, or Injury, including accident reports, settlement information and any other requested additional information.
3. To take such action and execute such documents as the Plan may require to facilitate enforcement of its subrogation and reimbursement rights.
4. To do nothing to prejudice the Plan's rights of subrogation and reimbursement.
5. To promptly reimburse the Plan when a recovery through settlement, judgment, award or other payment is received.
6. To notify the Plan or its authorized representative of any settlement prior to finalization of the settlement.
7. To not settle or release, without the prior consent of the Plan, any claim to the extent that the Participant may have against any responsible party or Coverage.
8. To instruct his/her attorney to ensure that the Plan and/or its authorized representative is included as a payee on any settlement draft.
9. In circumstances where the Participant is not represented by an attorney, instruct the insurance company or any third party from whom the Participant obtains a settlement to include the Plan or its authorized representative as a payee on the settlement draft.
10. To make good faith efforts to prevent disbursement of settlement funds until such time as any dispute between the Plan and Participant over settlement funds is resolved.

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

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

Offset

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

Minor Status

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

If the minor's parents or court-appointed guardian fail to take such action, the Plan shall have no obligation to advance payment of medical benefits on behalf of the minor. Any court costs or legal fees associated with obtaining such approval shall be paid by the minor's parents or court-appointed guardian.

Language Interpretation

The Plan Administrator has sole, full and final discretionary authority to construe and interpret the language of this provision, to determine all questions of fact and law arising under this provision, and to administer the Plan's subrogation and reimbursement rights; provided, however that to the extent the Plan Administrator has delegated its responsibilities with respect to this provision to a Plan service provider, the Plan service provider has the full extent of the Plan Administrator's authority and duties with respect to the responsibilities delegated to it. The Plan Administrator may amend the Plan, including these provisions, at any time.

Severability

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

MISCELLANEOUS PROVISIONS

Clerical Error/Delay

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

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

Fraud

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

If a Participant, or any other entity, submits or attempts to submit a claim for or on behalf of a person who is not a Participant of the Plan; submits a claim for services or supplies not rendered; provides false or misleading information in connection with enrollment in the Plan; or provides any false or misleading information to the Plan as it relates to any element of its administration; that shall be deemed to be fraud. If a Participant is aware of any instance of fraud, and fails to bring that fraud to the Plan Administrator's attention, that shall also be deemed to be fraud. Fraud will result in immediate termination of all coverage under this Plan for the Participant and their entire Family Unit of which the Participant is a member.

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

Headings

The headings used in this Summary Plan Description are used for convenience of reference only. Participants are advised not to rely on any provision because of the heading.

Word Usage

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

No Waiver or Estoppel

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

waiver, either as it specifically applies to a particular circumstance, or as it applies to the Plan's general administration. If an explicit written waiver is executed, that waiver shall only apply to the matter addressed therein, and shall be interpreted in the most narrow fashion possible.

Plan Funding

The benefits provided under the Plan will be paid, to the extent permitted under ERISA and the Internal Revenue Code, from the general assets of the Participating Employers and Employee contributions. Nothing in the Plan will be construed to require a Participating Employer to maintain any fund for its own contributions or segregate any amount which it is obligated to contribute for the benefit of any Participant, and no Participant or other person will have any claim against, right to, or security or other interest in, any fund, account, or asset of a Participating Employer from which any payment under the Plan may be made.

The Plan Administrator shall, from time to time, determine the amount to be contributed by each Participant for coverage under the Plan. These Participant contributions will be communicated to eligible Employees each year in the Plan's enrollment materials.

Right to Receive and Release Information

The Plan Administrator may, without notice to or consent of any person, release to or obtain any information from any insurance company or other organization or person any information regarding coverage, expenses, and benefits which the Plan Administrator, at its sole discretion, considers necessary to determine and apply the provisions and benefits of this Plan. In so acting, the Plan Administrator shall be free from any liability that may arise with regard to such action. Any Participant claiming benefits under this Plan shall furnish to the Plan Administrator (or its delegate) such information as requested and as may be necessary to implement this provision.

Right of Recovery

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

SUMMARY OF BENEFITS

General Limits

Payment for any of the expenses listed below is subject to all Plan Exclusions, limitations and provisions. All coverage figures, if applicable, are after the out of pocket Deductible has been satisfied. Benefits for Pregnancy expenses, which are covered for Employee and spouse only, are paid the same as any other Sickness.

See the Utilization Management section for more information regarding Pre-Certification and/or Notification requirements.

In-Network and Non-Network Provider Arrangement

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

This arrangement results in the following:

1. The Plan provides different levels of benefits based on whether the Participants use an In-Network or Non-Network Provider. Unless one of the exceptions shown below applies, if a Participant elects to receive medical care from the Non-Network Provider, the benefits payable are generally lower than those payable when an In-Network Provider is used. The following exceptions apply:
    a. The In-Network Provider level of benefits is payable for any Participant who does not have access to an In-Network Provider within 25 miles of their home.
    b. The In-Network Provider level of benefits is payable when a Participant receives Emergency care either Out-of-Area or at a Non-Network Hospital for an Accident Bodily Injury or Emergency.

2. If the charge billed by a Non-Network Provider for any covered service is higher than the Maximum Allowable Charge determined by the Plan, Participants are responsible for the excess. Since In-Network Providers have agreed to accept a negotiated discounted fee as full payment for their services, Participants are not responsible for any billed amount that exceeds that fee.

3. To receive benefit consideration, Participants must submit claims for services provided by Non-Network Providers to the Claims Administrator. In-Network Providers have agreed to bill the Plan directly, so that Participants do not have to submit claims themselves.

4. Benefits available to In-Network Providers are limited such that if an In-Network Provider advances or submits charges which exceed amounts that are eligible for payment in accordance with the terms of the Plan, or are for services or supplies for which Plan coverage is not available, or are otherwise limited or excluded by the Plan, benefits will be paid in accordance with the terms of the Plan.

5. Services rendered at an In-Network facility by a Non-Network Provider will be subject to a Medicare allowable rate as indicated below. The Plan Administrator may exercise its discretion to allow a greater percentage.

Radiology	170% of Medicare reimbursement rates presently utilized by CMS*
Anesthesia	225% of Medicare reimbursement rates presently utilized by CMS*
Pathology	125% of Medicare reimbursement rates presently utilized by CMS*
Emergency Room Physician	150% of Medicare reimbursement rates presently utilized by CMS*
Hospitalist	130% of Medicare reimbursement rates presently utilized by CMS*

**** For Radiology, Anesthesia, Pathology, Emergency Room Physician, and Hospitalist services provided at an In-Network facility, the Plan will pay the lesser of the allowable rate listed above or the negotiated rate accepted by the Plan's In-Network Providers for the same services. Non-Medicare codes will be paid at 40% of the Provider's billed charges.***

Please note affirmation that a treatment, service, or supply is of a type compensable by the Plan is not a guarantee that the particular treatment, service, or supply in question, upon receipt of a Clean Claim and review by the Claims Administrator, will be eligible for payment.

Claims and Appeals

Please see the "Claim Procedures; Payment of Claims" section of this Summary Plan Description for important information about how to make a claim for benefits under the Plan, including the timeframes for submitting a benefit claim or appeal, as well as the applicable deadline for filing a lawsuit.

Balance Billing

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

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

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

Choice of Providers

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

Preferred Provider Information

This Plan contains provisions under which a Participant may receive more benefits by using certain Providers. These Providers are individuals and entities that have contracted with a Provider Network to provide services to Participants at pre-negotiated rates. The In-Network Providers are merely independent contractors; neither the Plan nor the Plan Administrator make any warranty as to the quality of care that may be rendered by any In-Network Provider.

The In-Network Provider list changes frequently; therefore, it is recommended that a Participant verify with the Provider that the Provider is still an In-Network Provider before receiving services. A complete list of

participating network physicians, hospitals, and other health care professionals for the Plan is available from the Third Party Administrator's website (located at http://mohawk.webtpa.com).

Claims Audit

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

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

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

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

Summary of Benefits - Medical

The following benefits are per Participant per Calendar Year. All benefits are subject to the Maximum Allowable Charge.

	In Network My Medical Neighborhood (MMN)	In-Network outside of MMN area-Aetna	Out-of-Network	Limits
Deductible *(NOTE: Medical and Prescription Drug benefit expenses are subject to the same Deductible)* Deductibles do not cross accumulate between in-network and out-of-network				
Individual	$1,650	$1,650	$3,300	
Family Unit	$3,300	$3,300	$6,600	
Maximum Out-of-Pocket *(NOTE: Medical and Prescription Drug benefit expenses are subject to the same Maximum Out-of-Pocket)* OOP maximums do not cross accumulate between in-network and out-of-network tiers				
Individual	$5,000	$5,000	Unlimited	
Family Unit	$13,000	$13,000	Unlimited	
Individual "Embedded Out-of-Pocket"	$6,500	$6,500	N/A	
All charges used to apply toward an "individual" out-of-pocket maximum amount will be applied toward the "family" out-of-pocket maximum amount shown in the Summary of Benefits. No individual In-Network out-of-pocket maximums will exceed the Network Individual Embedded Out-of-Pocket amount for that Calendar Year.				

The following table identifies what does and does not apply toward the Network and Non-Network Out-of-Pocket Maximums:

Plan Features	Applies to the Network Out-of-Pocket Maximum?	Applies to the Non-Network Out-of-Pocket Maximum?
Payments toward the annual Deductible	Yes	Yes
Copayments	Yes	Yes
Charges for non-covered services	No	No
The amounts of any Pre-Certification penalties	No	No
Charges that exceed Allowable Expenses	No	No

Covered Medical Expenses	In-Network My Medical Neighborhood (MMN)	In-Network outside MMN area- Aetna	Out-of-Network	Limits
Allergy Services				
Office Visit	$35 copayment after deductible	$35 copayment after deductible	$35 copayment after deductible	
Injections	$35 copayment after deductible	$35 copayment after deductible	$35 copayment after deductible	
Serum	$35 copayment after deductible	$35 copayment after deductible	$35 copayment after deductible	
Ambulance	80% after deductible	80% after deductible	80% after deductible	Non-emergent services are not covered
Ambulatory Surgical Center	80% after deductible	80% after deductible	50% after deductible	
Anesthesia	80% after deductible	80% after deductible	50% after deductible	
Bariatric Surgery Charges for obesity surgery will not accumulate to plan out of pocket maximum	80% after deductible	80% after deductible	Not Covered	Lifetime Maximum: $10,000
Birthing Center	80% after deductible	80% after deductible	50% after deductible	
Blood & Plasma	80% after deductible	80% after deductible	50% after deductible	
Breast Pump	100%	100%	100%	Includes the rental of one breast pump per birth as prescribed by a physician. Includes related supplies.
Chemotherapy	80% after deductible	80% after deductible	50% after deductible	
Chiropractic Care	$35 copayment after deductible	$35 copayment after deductible	$35 copayment after deductible	12 visits per calendar year
Clinical Trials (Patient Costs)	80% after deductible	80% after deductible	50% after deductible	
Cochlear Implants	80% after deductible	80% after deductible	50% after deductible	When medically necessary
Durable Medical Equipment	80% after deductible	80% after deductible	50% after deductible	
Elective Female Sterilization (If outpatient, covered as a preventive benefit; If	100%	100%	50%	

Covered Medical Expenses	In-Network My Medical Neighborhood (MMN)	In-Network outside MMN area-Aetna	Out-of-Network	Limits
inpatient, subject to deductible.)				
Foot Care	80% after deductible	80% after deductible	50% after deductible	$1,000 calendar year max
Glaucoma, Cataract Surgery and Lenses (one set)	80% after deductible	80% after deductible	50% after deductible	
Habilitative Services Occupational Therapy Physical Therapy Speech-Language Pathology Applied Behavior Analysis (ABA) Therapy Office visit Facility Setting, Lab, X-rays or other services	 $35 copayment after deductible 80% after deductible	 $35 copayment after deductible 80% after deductible	 $35 copayment after deductible 50% after deductible	30 visits each for occupational therapy and speech-language pathology per year. Physical therapy limited to 60 days per calendar year. Services only covered to restore normal functioning.
Benchmark Physical Therapy Locations: Miles-DVD HLC Tuesday & Thursday: 1-5 p.m. Friday: 8 a.m.-Noon Green Street HLC (Dalton) Monday, Tuesday and Thursday: 8 a.m.-Noon Scheduling: 844-895-4439 Alternate #: 800-578-1104	$20 charge per day – payroll deduction only			
Hearing Aids	Not Covered	Not Covered	Not Covered	
Home Health Care	80% after deductible	80% after deductible	50% after deductible	120 days per year max, 16 hours per day
Hospice Care Inpatient	80% after deductible	80% after deductible	50% after deductible	Life expectancy 6 months or less

Covered Medical Expenses	In-Network My Medical Neighborhood (MMN)	In-Network outside MMN area- Aetna	Out-of-Network	Limits
Outpatient	80% after deductible	80% after deductible	50% after deductible	
Family Bereavement Counseling	80% after deductible	80% after deductible	50% after deductible	
Hospital Inpatient Treatment Outpatient Treatment	 80% after deductible 80% after deductible	 80% after deductible 80% after deductible	 50% after deductible 50% after deductible	All private rooms reduced to Semi-Private
Infertility Treatment Infertility Treatment Coverage will be provided for the following services: • Testing and treatment services performed in connection with an underlying medical condition. • Testing performed specifically to determine the cause of infertility. • Treatment and/or procedures performed specifically to restore fertility (e.g. procedures to correct an infertility condition).	80% after deductible	80% after deductible	50% after deductible	Artificial Insemination Surgical Treatment: Limited to procedures for the correction of infertility Services only covered to restore normal function.
Male Sterilization	80% after deductible	80% after deductible	50% after deductible	Reversals of male sterilization not covered.
Mental Health and Substance Abuse Expenses Residential Treatment Facility Partial Hospitalization Intensive Outpatient Services	80% after deductible	80% after deductible	50% after deductible	
Newborn Care	80% after deductible	80% after deductible	50% after deductible	

Covered Medical Expenses	In-Network My Medical Neighborhood (MMN)	In-Network outside MMN area- Aetna	Out-of-Network	Limits
Outpatient Diagnostic X-ray and Lab	80% after deductible	80% after deductible	50% after deductible	CAT and PET Scans are limited to $2,000 per scan. MRIs and MRA's are limited to $2,300 per scan. Per scan maximum applies to physician office, outpatient free standing imaging center and outpatient imaging department at a hospital (non-ER location-non-urgent care) does not apply to inpatient or emergency room.
Outpatient Emergency Services - Emergency Room (Refer to definition of "Emergency Services" in this document)"				
Emergency	80% after deductible	80% after deductible	80% after deductible	
Non-Emergency	80% after deductible	80% after deductible	50% after deductible	
Physician Services Certain specialty drugs such as injectable must be filled through the Pharmacy plan				
Office Visit	$35 copayment after deductible	$35 copayment after deductible	$35 copayment after deductible	
Lab, X-rays & Surgery	80% after deductible	80% after deductible	50% after deductible	

Covered Medical Expenses	In-Network My Medical Neighborhood (MMN)	In-Network outside MMN area- Aetna	Out-of-Network	Limits
Urgent Care Facility Visit Office Visit including lab, X-rays or other services performed at the time of the office visit	$25 copayment after deductible	$25 copayment after deductible	$25 copayment after deductible	
Telehealth (AMWELL ONLY) 844 SEE-DOCS Mohawk.amwell.com Virtual HLC locations in NWGA, Industrial Park, Green Street Scheduling line: 877-365-0015	$20 per acute care visit	$20 per acute care visit	Not Covered	
Healthy Life Center	$20 per acute care visit before deductible is met. After deductible is met 80% per acute care visit.			
Pregnancy Expenses Routine Prenatal Services Non-Routine Prenatal Services, Delivery and Postnatal Care	80% after deductible	80% after deductible	50% after deductible	Applies to employees and spouses only. Dependent child covered for complications only. One 2D sonogram per pregnancy allowed, all others must be medically necessary

Covered Medical Expenses	In-Network My Medical Neighborhood (MMN)	In-Network outside MMN area- Aetna	Out-of-Network	Limits
Preventive Care Well Adult Care Routine Physical Exam Colonoscopies-*must be over age 50, unless Medically Necessary* Mammograms - *must be over age 40, unless Medically Necessary* Pap Smears Routine Immunizations Well Child Care Exam	100%	100%	100%	$225 payment maximum per Mammogram occurrence (Technical Component Only) ($200 prior to May 1, 2018) $285 payment maximum per 3D mammogram (Technical Component Only) Preventive and diagnostic colonoscopies are limited to $2,250 payment maximum
Private Duty Nursing	Not Covered	Not Covered	Not Covered	
Prostate Exam	100%	100%	100%	
Prosthetics, Orthotics, Supplies and Surgical Dressings	80% after deductible	80% after deductible	50% after deductible	Excluded orthotics are prefabricated foot orthoses, orthosis shoes, and primarily for improved athletic performance or sports participation
Radiation Therapy	80% after deductible	80% after deductible	50% after deductible	
Second Surgical Opinions	80% after deductible	80% after deductible	50% after deductible	
Skilled Nursing Facility	80% after deductible	80% after deductible	50% after deductible	
Surgery	80% after deductible	80% after deductible	50% after deductible	
Temporomandibular Joint Disorder (TMJ)	80% after deductible	80% after deductible	50% after deductible	

Covered Medical Expenses	In-Network My Medical Neighborhood (MMN)	In-Network outside MMN area- Aetna	Out-of-Network	Limits
Therapy Services Cardiac Therapy Cognitive Therapy Occupational Therapy Physical Therapy Speech Therapy Autism Spectrum Disorder Treatment				60 days per calendar year for physical therapy. All others 30 visits per year.
Office visit	$35 copayment after deductible	$35 copayment after deductible	$35 copayment after deductible	
Facility Setting, Lab, X-rays or other services	80% after deductible	80% after deductible	50% after deductible	
Transplants				Life Source must be used for Transplants to be covered
Recipient Expenses	100%	Not Covered	Not Covered	
Donor Expenses	100%	Not Covered	Not Covered	

MEDICAL BENEFITS

Medical Benefits

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

Allergy Services. Charges related to the treatment of allergies.

Ambulance. Transportation by professional ambulance, including approved available air and train transportation (excluding chartered air flights), to a local Hospital or transfer to the nearest facility having the capability to treat the condition, if the transportation is connected with an Inpatient confinement.

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

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

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

Blood/Blood Derivatives. Charges for blood and blood plasma (if not replaced by or for the patient), including blood processing and administration services. The Plan shall also cover processing, storage, and administrative services for autologous blood (a patient's own blood) when a Participant is scheduled for Surgery that can be reasonably expected to require blood.

Cataracts. Cataract surgery and one set of lenses (contacts or frame-type).

Chemotherapy. Charges for chemotherapy.

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

Cochlear Implants. Charges for cochlear implants for Participants who are certified as deaf or hearing impaired by a Provider.

Contraceptives. The charges for all Food and Drug Administration (FDA) approved contraceptives methods, except oral contraceptives, in accordance with Health Resources and Services Administration (HRSA) guidelines. ***NOTE:*** *Oral contraceptives are covered under the Prescription Drug Benefits section of this Summary Plan Description.*

Dental Services—Accident Only. Charges made for a continuous course of dental treatment started within 12 months from the date of the Injury to sound natural teeth. Sound natural teeth are defined as natural teeth that are free of active clinical decay, have at least 50% bony support and are functional in the arch.

Note: *No charge will be covered under this Plan for dental and oral Surgical Procedures involving orthodontic care of teeth, periodontal disease, and preparing the mouth for fitting of or continued use of dentures*

Diabetic Education. Services and supplies used in Outpatient diabetes self-management programs are covered under this Plan when they are provided by a Physician.

Diagnostic Tests; Examinations. Charges for x-rays, microscopic tests, laboratory tests, esophagoscopy, gastroscopy, proctosigmoidoscopy, colonoscopy and other diagnostic tests and procedures.

Dialysis. Charges for dialysis.

Durable Medical Equipment. Charges for rental, up to the purchase price, of Durable Medical Equipment, including glucose home monitors for insulin dependent diabetics. At its option, and with its advance written approval, the Plan may cover the purchase of such items when it is less costly and more practical than rental. The Plan does not pay for any of the following:

1. Any purchases without its advance written approval.
2. Replacements or repairs.
3. The rental or purchase of items which do not fully meet the definition of “Durable Medical Equipment."

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

Genetic Counseling or Testing. In addition to coverage specified under Preventive Care, benefits are available for prenatal genetic testing for inherited susceptibility to a medical condition and counseling related to family history or test results to determine the physical characteristics of an unborn child.

Glaucoma. Treatment of glaucoma.

Habilitative Services. These services include:

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

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

Home Health Care. Charges for Home Health Care services and supplies are covered only for care and treatment of an Illness or Injury when Hospital or Skilled Nursing Facility confinement would otherwise be required. The Diagnosis, care, and treatment must be certified by the attending Physician and be contained in a home health care plan. Charges by a Home Health Care Agency for any of the following:

1. Registered Nurses or Licensed Practical Nurses.
2. Certified home health aides under the direct supervision of a Registered Nurse.
3. Registered therapist performing physical, occupational or speech therapy.
4. Physician calls in the office, home, clinic or outpatient department.
5. Services, Drugs and medical supplies which are Medically Necessary for the treatment of the Participant that would have been provided in the Hospital, but not including Custodial Care.
6. Rental of Durable Medical Equipment or the purchase of this equipment if economically justified, whichever is less.

NOTE: *Transportation services are not covered under this benefit.*

Hospice Care. Charges relating to Hospice Care, provided the Participant has a life expectancy of six months or less, subject to the maximums, if any, stated in the Summary of Benefits. Covered Hospice expenses are limited to:

1. Room and Board for confinement in a Hospice.

2. Ancillary charges furnished by the Hospice while the patient is confined therein, including rental of Durable Medical Equipment which is used solely for treating an Injury or Sickness.
3. Medical supplies, Drugs and medicines prescribed by the attending Physician, but only to the extent such items are necessary for pain control and management of the terminal condition.
4. Physician services and nursing care by a Registered Nurse, Licensed Practical Nurse or a Licensed Vocational Nurse (L.V.N.).
5. Home health aide services.
6. Home care furnished by a Hospital or Home Health Care Agency, under the direction of a Hospice, including Custodial Care if it is provided during a regular visit by a Registered Nurse, a Licensed Practical Nurse or a home health aide.
7. Medical social services by licensed or trained social workers, Psychologists or counselors.
8. Nutrition services provided by a licensed dietitian.
9. Respite care.
10. Bereavement counseling, which is a supportive service provided by the Hospice team to Participants in the deceased's Family Unit after the death of the terminally ill person, to assist the Participants in adjusting to the death. Benefits will be payable if the following requirements are met:

    a. On the date immediately before his or her death, the terminally ill person was in a Hospice Care Program and a Participant under the Plan.
    b. Charges for such services are Incurred by the Participants within six months of the terminally ill person's death.

The Hospice Care program must be renewed in writing by the attending Physician every 30 days. Hospice Care ceases if the terminal Illness enters remission.

Hospital. Charges made by a Hospital for:

1. Inpatient Treatment
    a. Daily semi private Room and Board charges.
    b. Intensive Care Unit (ICU) and Cardiac Care Unit (CCU) Room and Board charges.
    c. General nursing services.
    d. Medically Necessary services and supplies furnished by the Hospital, other than Room and Board.
2. Outpatient Treatment
    a. Emergency room.
    b. Treatment for chronic conditions.
    c. Physical therapy treatments.
    d. Hemodialysis.
    e. X ray, laboratory and linear therapy.

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

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

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

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

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

Medical Supplies. Dressings, casts, splints, trusses, braces and other Medically Necessary medical supplies, with the exception of dental braces or corrective shoes, but including syringes for diabetic and allergy Diagnosis, and lancets and chemstrips for diabetics.

Mental Health and Substance Abuse Benefits. Benefits are available for Inpatient or outpatient care for mental health and Substance Abuse conditions, including individual and group psychotherapy, psychiatric tests, and expenses related to the Diagnosis when rendered by a covered provider.

Benefits are available for Residential Treatment Facility, Partial Hospitalization, and Intensive Outpatient Services.

Midwife Services. Benefits for midwife services performed by a certified nurse midwife (CNM) who is licensed as such and acting within the scope of his/her license. This Plan will not provide benefits for lay midwives or other individuals who become midwives by virtue of their experience in performing deliveries.

Newborn Care. Hospital and Physician nursery care for newborns who are natural Children of the Employee or spouse, provided the Child has been timely and properly enrolled in the Plan, as set forth in the "Eligibility for Coverage" section above. Benefits will be provided under the Child's coverage, and the Child's own Deductible and Coinsurance provisions will apply:

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

NOTE: *The Plan will cover Hospital and Physician nursery care for an ill newborn as any other medical condition, provided the newborn is timely and properly enrolled in the Plan, as described in the "Eligibility for Coverage" section above. These benefits are provided under the baby's coverage.*

Nicotine Addiction. Nicotine withdrawal programs, facilities, Drugs or supplies.

Nursing Services. Services of a Registered Nurse or Licensed Practical Nurse.

Oral Surgery. Oral surgery in relation to the bone, including tumors, cysts and growths not related to the teeth, and extraction of soft tissue impacted teeth by a Physician or Dentist. Removal of bony impacted wisdom teeth is covered.

Pathology Services. Charges for pathology services.

Physician Services. Services of a Physician for Medically Necessary care, including office visits, home visits, Hospital Inpatient care, Hospital outpatient visits and exams, clinic care and surgical opinion consultations.

Pregnancy Expenses. Expenses attributable to a Pregnancy. Pregnancy expenses of Dependent Children are not covered. Coverage may be available for expenses related to certain complications of Pregnancy. Benefits for Pregnancy expenses are paid the same as any other Sickness. ***NOTE:*** *Preventive care charges for Pregnancy are covered under the Preventive Care benefit in the Medical Benefits section.*

Under the Newborns' and Mothers' Health Protection Act of 1996, group health plans and health insurance issuers generally may not restrict benefits for any Hospital length of stay in connection with childbirth for the

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

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

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

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

See the following websites for more details:

https://www.healthcare.gov/coverage/preventive-care-benefits/;
https://www.uspreventiveservicestaskforce.org/Page/Name/uspstf-a-and-b-recommendations/;
https://www.cdc.gov/vaccines/hcp/acip-recs/index.html;
https://www.aap.org/en-us/Documents/periodicity_schedule.pdf; https://www.hrsa.gov/womensguidelines/.

NOTE: *The Preventive Care services identified through the above links are recommended services. It is up to the Provider and/or Physician of care to determine which services to provide; the Plan Administrator has the authority to determine which services will be covered. Preventive Care services will be covered at 100%. Benefits include gender-specific Preventive Care services, regardless of the sex the Participant was assigned at birth, his or her gender identity, or his or her recorded gender.*

Preventive and Wellness Services for Adults and Children - In compliance with section (2713) of the Affordable Care Act, benefits are available for evidence-based items or services that have in effect a rating of "A" or "B" in the current recommendations of the United States Preventive Services Task Force (USPSTF).

Immunizations that have in effect a recommendation from the Advisory Committee on Immunization Practices (ACIP) of the Centers for Disease Control and Prevention (CDC) with respect to the individual involved. With respect to infants, Children, and adolescents, evidence-informed Preventive Care and screenings as provided for in the comprehensive guidelines supported by the Health Resources and Services Administration (HRSA).

Women's Preventive Services - With respect to women, such additional Preventive Care and screenings as provided for in comprehensive guidelines supported by the Health Resources and Services Administration (HRSA) not otherwise addressed by the recommendations of the United States Preventive Service Task Force (USPSTF), which will be commonly known as HRSA's Women's Preventive Services Required Health Plan Coverage Guidelines. The HRSA has added the following eight categories of women's services to the list of mandatory preventive services:

1. Well-woman visits.
2. Gestational diabetes screening.
3. Human papillomavirus (HPV) Deoxyribonucleic Acid (DNA) testing.
4. Sexually transmitted infection counseling.
5. Human Immunodeficiency Virus (HIV) screening and counseling.
6. Food and Drug Administration (FDA)-approved contraception methods and contraceptive counseling.

7. Breastfeeding support, supplies and counseling.
8. Domestic violence screening and counseling.

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

Private Duty Nursing. Private duty nursing (outpatient only).

Prosthetics, Orthotics, Supplies and Surgical Dressings. Prosthetic devices (other than dental) to replace all or part of an absent body organ or part, including replacement due to natural growth or pathological change, but not including charges for repair or maintenance. Orthotic devices, but excluding orthopedic shoes and other supportive devices for the feet, such as prefabricated foot orthoses, orthosis shoes, and those primarily for improved athletic performance or sports participation.

Radiation Therapy. Charges for radiation therapy and treatment.

Routine Patient Costs for Participation in an Approved Clinical Trial. Charges for any Medically Necessary services, for which benefits are provided by the Plan, when a Participant is participating in a phase I, II, III or IV clinical trial, conducted in relation to the prevention, detection or treatment of a life-threatening Disease or condition, as defined under the ACA, provided:

1. The clinical trial is approved by any of the following:

    a. The Centers for Disease Control and Prevention of the U.S. Department of Health and Human Services.
    b. The National Institute of Health.
    c. The U.S. Food and Drug Administration.
    d. The U.S. Department of Defense.
    e. The U.S. Department of Veterans Affairs.
    f. An institutional review board of an institution that has an agreement with the Office for Human Research Protections of the U.S. Department of Health and Human Services.

2. The research Institution conducting the Approved Clinical Trial and each health professional providing routine patient care through the Institution, agree to accept reimbursement at the applicable Allowable Expense, as payment in full for routine patient care provided in connection with the Approved Clinical Trial.

Coverage will not be provided for:

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

Skilled Nursing Facility. Charges made by a Skilled Nursing Facility or a convalescent care facility, up to the limits set forth in the Summary of Benefits, in connection with convalescence from an Illness or Injury (excluding drug addiction, chronic brain syndrome, alcoholism, senility, intellectual disability or other Mental or Nervous Disorders) for which the Participant is confined.

Sterilization for Men. Charges for male sterilization procedures. Benefits for all Food and Drug Administration (FDA) approved charges related to sterilization procedures for women are covered under Preventive Care, to the extent required by the Affordable Care Act (ACA).

Surgery. Surgical operations and procedures, unless otherwise specifically excluded under the Plan, and limited as follows:

1. Multiple procedures adding significant time or complexity will be allowed at:
    a. One hundred percent (100%) of the Maximum Allowable Charge for the first or major procedure.
    b. Fifty percent (50%) of the Maximum Allowable Charge for the secondary and subsequent procedures.
    c. Bilateral procedures which add significant time or complexity, which are provided at the same operative session, will be allowed at one hundred percent (100%) of the Maximum Allowable Charge for the major procedure, and fifty percent (50%) of the Maximum Allowable Charge for the secondary or lesser procedure.
2. Charges made for services rendered by an assistant surgeon will be allowed at twenty percent (20%) of the Maximum Allowable Charge for the type of Surgery performed.
3. No benefit will be payable for incidental procedures, such as appendectomy during an abdominal Surgery, performed during a single operative session.

Surgical Treatment of Jaw. Surgical treatment of Diseases, Injuries, fractures and dislocations of the jaw by a Physician or Dentist.

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

Therapy Services. Services for individual therapy are covered on an Inpatient or outpatient basis. They are services or supplies used for the treatment of an Illness or Injury and include:

1. **Cardiac Therapy.** Charges for cardiac therapy.
2. **Cognitive Therapy.** Charges for cognitive therapy.
3. **Occupational Therapy.** Rehabilitation treatment or services rendered by a registered occupational therapist, under the direct supervision of a Physician, in a home setting or at a facility or Institution whose primary purpose is to provide medical care for an Illness or Injury, or at a free standing outpatient facility.
4. **Physical Therapy.** Rehabilitation treatment or services rendered by a physical therapist, under direct supervision of a Physician, in a home setting or a facility or Institution whose primary purpose is to provide medical care for an Illness or Injury, or at a free standing duly licensed outpatient therapy facility.
5. **Speech Therapy.** Speech therapy, for Rehabilitation purposes, by a Physician or qualified speech therapist, when needed due to a Sickness or Injury (other than a functional Nervous Disorder) or due to Surgery performed as the result of a Sickness or Injury, excluding speech therapy services that are educational in any part or due to articulation disorders, tongue thrust, stuttering, lisping, abnormal speech development, changing an accent, dyslexia, hearing loss which is not medically documented or similar disorders.
6. **Autism Spectrum Disorder Treatment.** Charges for treatment of Autism Spectrum Disorder.

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

Transplants.
Once it has been determined that you or one of your eligible Dependents may require an organ or tissue transplant, you or your Physician must call the Cigna LifeSOURCE Transplant Case Manager. The transplant

case manager will coordinate your care before, during and after the transplant. In addition, you must follow any precertification requirements.

The Plan covers donation-related services for actual or potential donors, whether or not they are Participants, as long as the transplant recipient is a Participant. The Plan will cover these costs, provided such costs are not covered in whole or in part by any other source other than the donor's family or estate. This includes, but is not limited to, other insurance, including self-funded medical plans, grants, foundations, and government programs. If a Participant is donating the organ to a person who is not a Participant under this Plan, benefits are not available under this Plan.

Wigs. Charges associated with the initial purchase of a wig after chemotherapy.

Medical Exclusions

Some health care services are not covered by the Plan. In addition to the General Exclusions set forth in the General Limitations and Exclusion section, these include, but are not limited to, any charge for care, supplies, or services, which are:

Abortion. Incurred directly or indirectly as the result of an abortion except when the life of the mother is endangered by the continued Pregnancy.

Acupuncture. Relating directly or indirectly to acupuncture.

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

Biofeedback. For biofeedback.

Dental Care. For normal dental care benefits, including any dental, gum treatments, or oral surgery, except as otherwise specifically provided herein.

Detoxification. Treatment solely for detoxification or primarily for maintenance care is not considered effective treatment. Detoxification is care aimed primarily at overcoming the effects of a specific drinking or drug episode. Maintenance care consists of the providing of an alcohol-free or drug-free environment.

Education or Training Program. Performed by a Physician or other Provider enrolled in an education or training program when such services are related to the education or training program, except as specifically provided herein.

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

Eye Refractions. For eye refractions, eyeglasses, contact lenses, or the vision examination for prescribing or fitting eyeglasses or contact lenses (except for aphakic patients, and soft lenses or sclera shells intended for use in the treatment of Disease or Injury).

Hearing Aids. For hearing aids or examinations for the prescription, fitting, and/or repair of hearing aids.

Impregnation and Infertility Treatment. Following charges related to Impregnation and Infertility Treatment: infertility drugs; in vitro fertilization; gamete intrafallopian transfer (GIFT); zygote intrafallopian transfer (ZIFT) and variations of these procedures; infertility services when the infertility is caused by or related to voluntary sterilization; donor charges and services; cryopreservation of donor sperm and eggs; and any experimental, investigational or unproven infertility procedures or therapies. Services are only covered to restore normal function.

Nutritional Supplements. For nutritional supplements, except for infant formula needed for the treatment of inborn errors of metabolism, and except as specified under Preventive Care.

Obesity. Related to the care and treatment of obesity

Organ Transplants. Related to donation of a human organ or tissue, except as specifically provided.

Orthopedic Shoes. For orthopedic shoes, unless they are an integral part of a leg brace and the cost is included in the orthotist's charge, and other supportive devices for the feet.

Personal Convenience Items. For equipment that does not meet the definition of Durable Medical Equipment, including air conditioners, humidifiers and exercise equipment, whether or not recommended by a Physician.

Pregnancy of a Dependent Child. Incurred by an eligible Dependent Child, including, but not limited to, pre-natal, delivery and post-natal care unless specifically provided as a covered benefit elsewhere in this Plan. Complications from the Pregnancy of a Dependent Child are not excluded. ***NOTE:*** *Preventive care charges for Pregnancy are covered under the Preventive Care benefit in the Medical Benefits section.*

Radial Keratotomy. For radial keratotomy or other plastic surgeries on the cornea in lieu of eyeglasses.

Routine Physical Examinations. For routine or periodic physical examinations, related x-ray and laboratory expenses, and nutritional supplements, except as provided in the Summary of Benefits.

Sexual Dysfunction. For any treatment of a sexual dysfunction, including but not limited to sexual counseling or therapy, implants and hormonal therapy.

Sterilization Reversal. For sterilization procedure reversal.

Travel. For travel, whether or not recommended by a Physician, except as specifically provided herein.

Vitamins. For vitamins.

UTILIZATION MANAGEMENT

Failure to comply with Utilization Management will result in a higher cost to Participants. "Utilization Management" includes Hospital pre-admission certification, continued stay review, length of stay determination and discharge planning. These programs are designed to ensure that Medically Necessary, high quality patient care is provided and enables maximum benefits under the Plan.

Claims and Appeals

Please see the "Claim Procedures; Payment of Claims" section of this Summary Plan Description for important information about how to make a claim for benefits under the Plan, including the timeframes for submitting a benefit claim or appeal, as well as the applicable deadline for filing a lawsuit.

Services that Require Pre-Certification

The following services will require Pre-Certification (or reimbursement from the Plan may be reduced):

Inpatient services

- Inpatient Hospital Services (Medical and Surgical)
- Acute rehabilitation admissions
- Inpatient hospice admissions
- Long term acute care (LTAC) facility admissions
- Skilled nursing facility admissions
- Observation stays over 23 hours

Outpatient

- Private-duty nursing
- Physical/Occupational/Speech Therapy
- Cardiac Rehab
- Sleep Studies
- Radiation Therapy
- Day Rehab
- Genetic testing
- Hospitalization connected to dental procedures

Procedures

- Bronchial thermoplasty
- Carticel (ACI), osteochondral allograft, and autograft transplantations
- Obesity surgery
- Uvulopalatopharyngoplasty (UPPP), including laser-assisted
- Back surgery
- Knee surgery
- Orthognathic surgery

Reconstructive procedures/surgeries and potentially cosmetic procedures

- Blepharoplasty/ptosis repair
- Bone graft, genioplasty, and mentoplasty
- Breast: reconstruction, reduction, augmentation, mammoplasty, mastopexy, insertion and removal of breast implants
- Canthopexy/canthoplasty
- Cervicoplasty
- Chemical peels
- Dermabrasion
- Excision of excessive skin and/or subcutaneous tissue
- Genetically and bio-engineered skin substitutes for wound care
- Hair transplant

- Injectable dermal fillers
- Keloid removal
- Lipectomy, liposuction, or any other excess fat-removal procedure
- Otoplasty
- Rhinoplasty
- Rhytidectomy
- Scar revision
- Skin closures including:
  - Skin grafts
  - Skin flaps
  - Tissue grafts
- Surgery for varicose veins, including perforators and sclerotherapy

Any procedure, device, or service that may potentially be considered experimental or investigational including:

- New emerging technology/procedures, as well as existing technology and procedures applied for new uses and treatments

Elective (nonemergency) ground, air, and sea ambulance transportation
Outpatient injectables, including but not limited to chemo.

- Certain specialty drugs such as injectibles, must be filled through the PBM

Radiology

- PET scans/MRI's/Nuclear Scans /MRA's

Home-care services (including infusion therapy in the home)
Orthoses/Prosthetics/ including:

- Custom ankle-foot orthoses
- Custom knee-ankle-foot orthoses
- Custom knee braces
- Custom limb prosthetics including accessories/components

Durable medical equipment (DME) – Over $1,000

Hyperbaric oxygen therapy

Proton beam therapy

Transplant with the exception of corneal transplants (Cigna LIFESOURCE is the vendor for transplants)

Behavioral health services requiring precertification/authorization

This applies only to services covered under the member's benefits plan.

1. Inpatient admissions
2. Residential treatment center (RTC) admissions
3. Partial hospitalization programs (PHPs)
4. Intensive outpatient programs (IOPs)
5. Psychological testing
6. Neuropsychological testing
7. Psychiatric home care services
8. Outpatient detoxification
9. ABA therapy

(Please note that some services listed above may not be covered services under the plan)

Remember that although the Plan will automatically pre-certify a maternity length of stay that is 48 hours or less for a vaginal delivery or 96 hours for a cesarean delivery, it is important that the Participant has his or her Physician call to obtain Pre-Certification in case there is a need to have a longer stay.

Pre-Certification does not verify eligibility for benefits nor guarantee benefit payments under the Plan. It is the Participant's responsibility to verify that the above services have been pre-certified as outlined below.

Pre-Certification Procedures and Contact Information
The Inpatient Utilization Management Service is simple and easy for Participants to use. Whenever a Participant is advised that Inpatient Hospital care is needed, it is the Participant's responsibility to call the pre-certification department at its toll free number, which is 1-844-380-4564. The review process will continue, as outlined below, until the Participant is discharged from the Hospital.

Urgent Care or Emergency Admissions:
If a Participant needs medical care for a condition which could seriously jeopardize his or her life, obtain such care without delay, and communicate with the Plan as soon as reasonably possible.

If a Participant must be admitted on an Emergency basis, the Participant should follow the Physician's instructions carefully and contact the pre-certification department as follows:

1. For Emergency admissions after business hours on Friday, on a weekend or over a holiday weekend, a call to the pre-certification department must be made within 72 hours after the admission date, but no later than the first business day following the Emergency admission, by or on behalf of the covered patient.
2. For Emergency admissions on a weekday, a call to the pre-certification department must be made within 24 hours after the admission date.

If a medical service is provided in response to an Emergency situation or urgent care scenario, prior approval from the Plan is not required. The Plan will require notice within 72 hours after the admission date, but no later than the first business day following the Emergency admission, by or on behalf of the covered patient. Such a claim shall then be deemed to be a Post-service Claim.

Non-Emergency Admissions:

For Inpatient Hospital stays that are scheduled in advance, a call to the pre-certification department should be completed as soon as possible before actual services are rendered. Once the pre-certification call is received, it will be routed to an appropriate review specialist who will create an on-line patient file. The review specialist will contact the Participant's attending Physician to obtain information and to discuss the specifics of the admission request. If appropriate, alternative care will be explored with the Physician.

If, after assessing procedure necessity, the need for an Inpatient confinement is confirmed, the review specialist will determine the intensity of management required and will remain in contact with the Physician or Hospital during the confinement.

If, at any time during the review process, Medical Necessity cannot be validated, the review specialist will refer the episode to a board certified Physician advisor who will immediately contact the attending Physician to negotiate an appropriate treatment plan. At the end of the Hospital confinement, the review specialist is also available to assist with discharge planning and will work closely with the attending Physician and Hospital to ensure that medically appropriate arrangements are made.

Pre-Certification Penalty
The program requires the support and cooperation of each Participant. If a Participant follows the instructions and procedures, he or she will receive the normal Plan benefits for the services. However, if a Participant fails to notify the pre-certification department of any services listed in the provision entitled "Pre-Certification

Procedures and Contact Information," allowed charges will be reduced by $500. The Participant will be responsible for payment of the part of the charge that is not paid by the Plan.

Alternate Course of Treatment
Certain types of conditions, such as spinal cord Injuries, cancer, AIDS or premature births, may require long term, or perhaps lifetime, care. The claims selected will be evaluated as to present course of treatment and alternate care possibilities.

Pre-Surgical Approval
The Plan recommends that a pre-determination of benefits be obtained prior to the following Surgical Procedures, since they are usually Cosmetic Surgery or not Medically Necessary. These procedures include, but are not limited to:

1. Abdominoplasty.
2. Blepharoplasty.
3. Breast reduction or enlargement.
4. Dermabrasion.
5. Facial or nasal reconstruction.
6. Gastric bypass.
7. Lipectomy.
8. Penile implant.
9. Scar revision.
10. Sex alteration.
11. Any Experimental or research procedures which are not generally accepted medical practice.

Because of the broad range of Surgical Procedures available and under development, if a Participant is scheduled to undergo any questionable procedure, he or she should contact the Third Party Administrator for further information. Pre-surgical approval is not a guarantee of coverage.

PRESCRIPTION DRUG BENEFITS

Prescription Drug Plan	Out-of-Pocket Maximum, per Calendar Year
Individual	Included in Medical Out of Pocket Maximum
Family	

Participating pharmacies ("Participating Pharmacies") have contracted with the Prescription Drug Claims Administrator to charge Participants reduced fees for covered Drugs. Express Scripts is the Prescription Drug Claims Administrator for the Plan. Participants will be issued an identification card to use at the pharmacy at time of purchase. Participants will be held fully responsible for the consequences of attempting to use any pharmacy identification card after termination of coverage. No reimbursement will be made when a Drug is purchased from a non-Participating Pharmacy or when the identification card is not used.

The Mail Order Option is available for maintenance medications (those that are taken for long periods of time, such as Drugs sometimes prescribed for heart Disease, high blood pressure, asthma, etc.). Because of its volume buying, Express Scripts, the mail order pharmacy, is able to offer Participants significant savings on their prescriptions.

Covered Prescription Drug Expenses:	Participating Pharmacy	Non-Participating Pharmacy
Pharmacy/Retail Option (up to a 30-day supply):		
Coinsurance, per prescription or refill, for generic	80% after Deductible*	Not Covered
Coinsurance, per prescription or refill, for brand name brands[1]	80% after Deductible*	Not Covered
Coverage of maintenance medication is limited to 2 fills at retail, then mail order is required, or a penalty of 100% of the discounted cost will be assessed		
Certain drugs are eligible for Walmart's $4 generic drug program for little or no out of pocket cost. Visit www.walmart.com and search "$4 drug list."		
No charge for qualified preventive medications.		
If the ingredient cost for the prescription is $1,000 or more, the participant's coinsurance amount will not exceed $100 per 30-day supply ($300 per 90 day supply).		
Mail Order Option (up to a 90-day supply):		
Coinsurance, per prescription or refill, for generic	80% after Deductible**	Not Covered
Coinsurance, per prescription or refill, for brand name brands[1]	80% after Deductible**	Not Covered
Coinsurance, per prescription or refill, for non-formulary name brands	80% after Deductible**	Not Covered
***** If the ingredient cost for the prescription is $1,500 or more, the participant's coinsurance amount will not exceed $100 per 30-day supply ($300 per 90-day supply).***		

[1] Participant will also be required to pay the cost difference between name brand and generic forms, unless prescription is not manufactured in generic form or Physician has indicated "dispense as written" or similar indication.

Specialty Pharmacy:
$100 per specialty prescription as defined by Express Scripts. Some specialty medications are not covered on the Express Scripts drug list. In most cases, if you fill a prescription for one of these drugs, you will pay the full retail price. If you're currently using one of the excluded medications, please discuss with your doctor about changing to one of the preferred alternatives. See the "Specialty Drug Exclusion List" at mymohawkbenefits.com or refer to your ID card for more information.

Special Note

The Plan uses MedTrak RX regarding prescription fills for two specific conditions: Hepatitis C and Inflammatory Conditions such as Rheumatoid Arthritis.

If you currently receive your prescriptions for these conditions from Express Scripts, you will continue to use them as your pharmacy provider. If you are a new user or new to these therapies, you need to contact MedTrak at 800-771-4648 to have your prescription filled.

Payments made on behalf of copay assistance programs for specialty drugs will not count towards member deductibles and out-of-pocket maximums. They may appear to be applied at the time the prescription is processed; however, after the program submits payment on a members' behalf, the dollars paid by the program will be reversed from member / family deductibles and out-of-pocket maximums.

The Plan follows a drug Formulary in determining payment and covered drugs. The amount you pay for your prescription depends, in part, on whether a Formulary or non-Formulary drug is obtained. The Plan's Formulary with Express Scripts is subject to change. To avoid paying full price, please check express-scripts.com/covered to review the Plan's Formulary to ensure medications are covered. Additional information is also available at mymohawkbenefits.com.

Covered Expenses

The following are covered under the Plan:

Compounded Prescriptions. All compounded prescriptions containing at least one prescription ingredient in a therapeutic quantity. All National Drug Codes (NDCs) within the compound must be a covered expense under the Plan.

Contraceptives. All Food and Drug Administration (FDA)-approved contraceptives Drugs, in accordance with the Health Resources and Services Administration (HRSA) guidelines.

Diabetes. Insulins, insulin syringes and needles, diabetic supplies – legend, diabetic supplies – over the counter, and glucose test strips, when prescribed by a Physician.

Immunologicals. Charges for immunologicals (vaccines).

Injectables. A charge for injectables.

Legend Drugs (drugs that require a prescription).

1. Class V Drugs.
2. Diabetic Supplies.
3. Diagnostics.
4. Legend Drugs with over-the-counter equivalents.
5. Pre-natal vitamins.
6. Vitamins.

Required by Law. All Drugs prescribed by a Physician that require a prescription either by Federal or State law, except injectables (other than insulin) and the Drugs excluded below.

Smoking Deterrents. A charge for Drugs or aids for smoking cessation, including, but not limited to, nicotine gum and smoking cessation patches, to the extent required by the Affordable Care Act (ACA).

Limitations

The benefits set forth in this section will be limited to:

Dosages.

1. With respect to the Pharmacy Option, any one prescription is limited to a 30 day supply.
2. With respect to the Mail Order Option, any one prescription is limited to a 90 day supply.

Refills.

1. Refills only up to the number of times specified by a Physician.
2. Refills up to one year from the date of order by a Physician.

Exclusions

In addition to the General Limitations and Exclusions section, the following are not covered by the Plan:

Administration. Any charge for the administration of a covered Drug.

Anorexiants. Anorexiants (weight loss Drugs).

Anti-Aging Products. Drugs intended to affect the structure or function of the skin that cannot be purchased over-the-counter.

Consumed Where Dispensed. Any Drug or medicine that is consumed or administered at the place where it is dispensed.

Experimental Drugs. Experimental Drugs and medicines, even though a charge is made to the Participant.

Fertility Agents. Charges for fertility agents.

Growth Hormones. Charges for growth hormones.

Immunizations. Immunization agents or biological sera.

Impotency. A charge for impotency medication, including Viagra

Institutional Medication. A Drug or medicine that is to be taken by a Participant, in whole or in part, while confined in an Institution, including any Institution that has a facility for dispensing Drugs and medicines on its premises.

Investigational Use Drugs. A Drug or medicine labeled “Caution – limited by Federal law to Investigational use.”

Non-Insulin Syringes/Needles. Charges for non-insulin syringes and needles.

HIPAA PRIVACY

MOHAWK ESV, INC. HEALTH AND WELFARE BENEFIT PLAN
MY MEDICAL NEIGHBORHOOD

NOTICE OF PRIVACY PRACTICES
January 1, 2019

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

If you have any questions about this Notice, please contact Mohawk's privacy official, the Privacy Officer, who can be contacted at Mohawk Industries, 160 South Industrial Boulevard, Calhoun, GA 30701, or by phone at (866) 481-4922.

Who Will Follow This Notice

This Notice describes the medical privacy practices of the My Medical Neighborhood medical benefit option offered under the Mohawk ESV, Inc. Health and Welfare Benefit Plan (the "Plan"). We are giving you this Notice to inform you of these rights and to comply with a federal law called the Health Insurance Portability and Accountability Act of 1996. This law is also known as "HIPAA."

Our Pledge Regarding Medical Information

We understand that medical information about you and your health is personal, and we are committed to protecting that information. As part of that protection, we have created a record of your health care claims under the Plan. This Notice applies to all of the medical records the Plan maintains about you. Your personal doctor or personal health care provider may have different policies or notices regarding the uses and disclosures of your medical information which may have been created by that doctor or health care provider. In addition, some health benefits offered under the Mohawk ESV, Inc. Health and Welfare Benefit Plan are provided through insurance where Mohawk does not have access to protected health information. If you are enrolled in any insured group health benefit program sponsored by Mohawk, you will receive a separate privacy notice from the insurer. Please note that the group health benefit programs offered under the Mohawk ESV, Inc. Health and Welfare Benefit Plan are part of an organized health care arrangement because they are all sponsored by Mohawk. This means that the benefit programs may share your protected health information with each other, as needed, for the purposes of payment and health care operations.

This Notice tells you about the ways in which the Plan may use or disclose medical information about you. It also describes the Plan's privacy obligations to you and your rights regarding the use and disclosure of your medical information.

The Plan is required by HIPAA to:

- make sure that medical information that identifies you is kept private;
- give you this Notice of its legal duties and privacy practices with respect to medical information about you; and
- follow the terms of this Notice until it is changed. If it is changed, you will receive a copy of the new Notice as long as the Plan keeps personalized health information about you.

In addition to HIPAA, special protections under state or other federal laws may apply to the use and disclosure of your protected health information. The Plan will comply with these state or federal laws where they are more protective of your privacy, but only to the extent these laws are not superseded by federal preemption.

How the Plan May Use and Disclose Medical Information About You

The following categories describe different ways that the Plan uses and discloses medical information about you. For each category of uses or disclosures, we will explain what we mean and present some examples. Obviously, we cannot list every possible use or disclosure which exists, but we will try to list the important ones. All of the ways the Plan is permitted to use and disclose information will fall within one of the categories.

Your Treatment. The first way the Plan may use or disclose medical information about you is to help you with medical treatment or services. The Plan may disclose medical information about you to providers, including doctors, nurses, technicians, medical students, or other hospital personnel who are involved in taking care of you. For example, the Plan might disclose information about your prior prescriptions to a pharmacist to determine if a new prescription could cause health problems because it conflicts with prior prescriptions.

Payment of Your Claims. The Plan may use or disclose medical information about you to determine if you are eligible for Plan benefits, to pay for treatment or services you receive from health care providers, to determine benefit responsibility under the Plan, or to coordinate Plan coverage with other plans. For example, the Plan may tell your health care providers about your medical history to determine if a particular treatment is experimental, investigational, or medically necessary, or to determine if the Plan will cover the treatment. The Plan may also share medical information with a utilization review or precertification service provider. In addition, the Plan may share medical information with another organization to help determine if a claim should be paid or if another person or Plan should be responsible for the claim.

Health Care Operations. The Plan may use or disclose medical information about you for other Plan health care operations. These uses and disclosures are necessary to run the Plan. For example, the Plan may use medical information to conduct quality assessment or improvement activities; to determine the cost of premiums or conduct activities relating to Plan coverage; to submit claims for stop-loss coverage; to conduct or arrange for medical review, legal services, audit services, or fraud and abuse detection programs; and to predict the cost of future claims or manage costs. The Plan's health care operations also include case management and coordination of care, for example, in connection with the Plan's wellness or disease management programs. However, federal law prohibits the Plan from using or disclosing protected health information that is genetic information (e.g., family medical history) for underwriting purposes, which include eligibility determinations, calculating premiums, and any other activities related to the creation, renewal, or replacement of a health insurance contract or health benefits.

Business Associates. The Plan may hire third parties that may need your medical information to perform certain services on behalf of the Plan. These third parties are "Business Associates" of the Plan. Business Associates must protect any protected health information they receive from, or create and maintain on behalf of, the Plan. For example, the Plan may hire a third-party administrator to process claims, an auditor to review how an insurer or third-party administrator is processing claims, or an insurance agent to assess coverages and help with claim problems. In addition to performing services for the Plan, Business Associates may use protected health information for their own management and legal responsibilities and for purposes of aggregating data for Plan health care operations.

Health Information Exchange. As permitted by law, the Plan may participate in Health Information Exchanges ("HIEs") to provide or receive medical information for activities described in this Notice (*i.e.*, treatment, payment, and health care operations purposes). HIEs are organizations where participating health care providers or other health care entities can provide or receive information from each other related to your care.

As Required By Law. The Plan will disclose medical information about you when required to do so by federal, state or local law. For example, the Plan may disclose medical information when required by national security laws or public health disclosure laws.

To Avert a Serious Threat to Health or Safety. The Plan may use or disclose medical information about you when necessary to prevent a serious threat to your health or safety, or to the health and safety of the public or another person. Any disclosure, however, would only be to someone able to help prevent the threat. For example, the Plan may disclose medical information about you in a proceeding concerning the license of a doctor or nurse.

Special Situations

Disclosure to Mohawk or other Mohawk Benefit Programs. The group health plans maintained by Mohawk are part of an organized health care arrangement because they are all sponsored by Mohawk. This means that the plans may share your PHI with each other, as needed, for the purposes of payment and health care operations. In addition, for the purpose of administering the Plan, we may disclose your protected health information to certain designated employees of Mohawk who are responsible for administering the Plan. However, those employees are permitted to use or disclose your information only as necessary to perform Plan administration functions or as otherwise required by HIPAA, unless you have authorized further disclosures. Before your protected health information can be used by or disclosed to these Mohawk employees, Mohawk must certify that it has: (1) amended the Plan documents to explain how your information will be protected, (2) identified the Mohawk employees who need your information to carry out their duties to administer the Plan, and (3) separated the work of these employees from the rest of the workforce so that Mohawk cannot use your protected health information for employment-related purposes or to administer other non-group health benefit plans. Your protected health information cannot be used for employment purposes without your specific authorization.

The Plan may also disclose information to Mohawk that summarizes the claims experience of Plan participants as a group, but without identifying specific individuals, to get new benefit insurance or to change or terminate the Plan. For example, if Mohawk wants to consider adding or changing organ transplant benefits, it may receive this summary health information to assess the costs of those services. The Plan may also disclose limited health information to Mohawk in connection with the enrollment or disenrollment of individuals into or out of the Plan.

Disclosures to Provide You With Information. The Plan or its agents may contact you to remind you about appointments or provide information about treatment alternatives or other health-related benefits and services that may be of interest to you.

Organ and Tissue Donation. If you are an organ donor, the Plan may release your medical information to organizations that handle organ procurement or organ, eye or tissue transplants, or to an organ donation bank to help with organ or tissue donation.

Military and Veterans. If you are a member of the armed forces, the Plan may release medical information about you as required by the military. The Plan may also release medical information about foreign military personnel to the appropriate foreign military authority.

Workers' Compensation. The Plan may release medical information about you for workers' compensation or similar programs. These programs provide benefits for work-related injuries or illness.

Public Health Risks. The Plan may disclose medical information about you for public health purposes. This includes disclosures:

- to prevent or control disease, injury or disability;
- to report births and deaths;

- to report child abuse or neglect;
- to report reactions to medications or problems with products;
- to notify people of recalls of products they may be using;
- to notify a person who may have been exposed to a disease or may be at risk for contracting or spreading a disease or condition; or
- to notify the appropriate government authority if the Plan believes a patient has been the victim of abuse, neglect or domestic violence. The Plan will only make this disclosure if you agree or if required or authorized by law.

Health Oversight Activities. The Plan may disclose medical information to a government health agency for activities authorized by law. These activities include, for example, audits, investigations, inspections, and licensing. These activities are necessary for the government to monitor the health care system, government programs, and to comply with civil rights laws.

Lawsuits and Disputes. If you are involved in a lawsuit or a dispute, the Plan may disclose medical information about you in response to a court or administrative order. The Plan may also disclose medical information about you in response to a subpoena, discovery request, or other lawful demand by someone else involved in the dispute, but only if efforts have been made to tell you about the request or to obtain an order protecting the information requested.

Law Enforcement. The Plan may release medical information if asked to do so by a law enforcement official:

- in response to a court order, subpoena, warrant, summons or similar court papers;
- to identify or locate a suspect, fugitive, material witness, or missing person;
- about the victim of a crime even if, under certain limited circumstances, the Plan is unable to obtain your agreement;
- about a death the Plan believes may be the result of criminal conduct;
- about criminal conduct at a hospital; or
- in emergency circumstances to report a crime or the location of a crime or crime victims, or the identity, description or location of the person who committed the crime.

Coroners, Medical Examiners and Funeral Directors. The Plan may release medical information to a coroner or medical examiner. This may be necessary, for example, to identify someone who has died or to determine the cause of death. The Plan may also release medical information about individuals to funeral directors as necessary to carry out their duties.

National Security and Intelligence Activities. The Plan may release medical information about you to authorized federal officials for intelligence, counterintelligence, and other security activities authorized by law.

Inmates. If you are an inmate of a correctional institution or under the custody of a law enforcement official, the Plan may release medical information about you to the correctional institution or law enforcement official. This release may be necessary (1) for the institution to provide you with health care; (2) to protect your health and safety or the health and safety of others; or (3) for the safety and security of the correctional institution.

Your Rights Regarding Medical Information About You

You have the following rights regarding medical information the Plan maintains about you:

Right to Inspect and Copy. You have the right to inspect and copy medical information that may be used to make decisions about your Plan benefits. To do so, you must submit your request in writing to Mohawk Industries, Attn: Privacy Officer, 160 South Industrial Boulevard, Calhoun, GA 30701.

The Plan may deny your request to inspect and copy your information in certain circumstances. In most cases, if you are denied access to medical information, you may request that the denial be reviewed.

Right to Amend. If you feel that medical information the Plan has about you is incorrect or incomplete, you may ask the Plan to amend the information. You have the right to request an amendment of your information as long as the information is kept by or for the Plan.

To request an amendment, your request must be made in writing and submitted to Mohawk Industries, Attn: Privacy Officer, 160 South Industrial Boulevard, Calhoun, GA 30701. In addition, you must provide a reason that supports your request.

The Plan may deny your request for an amendment if it is not in writing or does not include a reason to support the request. In addition, the Plan may deny your request if you ask to amend information that:

- is not part of the medical information kept by or for the Plan;
- was not created by the Plan, unless the person or entity that created the information is no longer available to make the amendment;
- is not part of the information which you would be permitted to inspect and copy; or
- is accurate and complete.

Right to an Accounting of Disclosures. You have the right to request an accounting of the prior disclosures of your health information if the disclosure was made for any purpose other than treatment, payment, or health care operations.

To request this list or accounting of disclosures, you must submit your request in writing to Mohawk Industries, Attn: Privacy Officer, 160 South Industrial Boulevard, Calhoun, GA 30701. Your request must state a time period which may not be longer than six years. Your request should indicate in what form you want the list (for example, paper or electronic). The first list you request within a 12-month period will be free. For additional lists, the Plan may charge you for the costs of providing the list. The Plan will notify you of the cost involved, and you may choose to withdraw or modify your request at that time before any costs are incurred.

Right to Request Restrictions. You have the right to request a restriction or limitation on medical information the Plan uses or discloses about you for treatment, payment or health care operations. You also have the right to request a limit on the medical information the Plan discloses about you to someone who is involved in your care or the payment for your care, such as a family member or friend. For example, you could ask that the Plan not use or disclose information about a surgery you had. The Plan, however, does not have to agree to your requested restriction. You may also request that your health care provider not disclose your medical information related to a health care item or service to the Plan if you have paid the item or service out-of-pocket in full. Please note that if your health care provider does not disclose the item or service to the Plan, the amount you paid for the item or service will not count toward your annual deductible or any out-of-pocket maximums under the Plan. The provider may also charge you the out-of-network rate for the item or service.

To request restrictions, you must make your request in writing to Mohawk Industries, Attn: Privacy Officer, 160 South Industrial Boulevard, Calhoun, GA 30701. In your request, you must tell the Plan (1) what information

you want to limit; (2) whether you want to limit the Plan's use or disclosure or this information, or both; and (3) to whom you want the restriction to apply, for example, you don't want information disclosed to your spouse.

Right to Request Confidential Communications. You have the right to request that the Plan communicate with you about medical matters in a certain way or at a certain location. For example, you can ask that the Plan only contact you at work or by mail.

To request confidential communications, you must make your request in writing to Mohawk Industries, Attn: Privacy Officer, 160 South Industrial Boulevard, Calhoun, GA 30701. The Plan will not ask you the reason for your request, and will accommodate all reasonable requests. Your request must specify how or where you wish to be contacted.

Right to Receive Notification. You have a right to receive notification of a breach of your unsecured protected health information.

Right to a Paper Copy of This Notice. You have the right to a paper copy of this Notice. You may ask the Plan to give you a copy of this Notice at any time. Even if you have agreed to receive this Notice electronically, you are still entitled to a paper copy of this Notice. To obtain a paper copy of this Notice, contact the Privacy Officer, Mohawk Industries, 160 South Industrial Boulevard, Calhoun, GA 30701.

Medical Information Not Covered by This Notice

This Notice does not cover (1) health information that does not identify you and with respect to which there is no reasonable basis to believe that the information could be used to identify you; or (2) health information that Mohawk can have under applicable law (e.g., the Family and Medical Leave Act, the Americans with Disabilities Act, workers' compensation laws, federal and state occupational health and safety laws, and other state and federal laws), or that Mohawk properly can get for employment-related purposes through sources other than the Plan and that is kept as part of your employment records (e.g., pre-employment physicals, drug testing, fitness for duty examinations, etc.).

Changes to This Notice

The Plan reserves the right to change this Notice in the future, and to make the revised or changed Notice effective for medical information the Plan already has about you as well as any information it receives in the future. You will receive a copy of the changed Notice in the same manner that you received this Notice. The Notice will contain the effective date on the top of the first page.

Complaints

If you believe your privacy rights have been violated, you may file a complaint with the Plan or with the Secretary of the United States Department of Health and Human Services. To file a complaint with the Plan, contact the Privacy Officer, Mohawk Industries, 160 South Industrial Boulevard, Calhoun, GA 30701. All complaints must be submitted in writing. You will not be retaliated against for filing a complaint.

Other Uses of Medical Information

Other uses and disclosures of medical information not covered by this Notice will be made only with your written permission. This written permission is called an "Authorization." For example, the Plan will not use or disclose your protected health information without your written permission for (1) uses and disclosures for marketing purposes, (2) uses and disclosures that constitute the sale of protected health information, (3) most uses and disclosures of psychotherapy notes, and (4) any other uses and disclosures not described in this notice. If you provide the Plan with an Authorization to use or disclose medical information about you, you may revoke that Authorization, in writing, at any time. If you revoke your Authorization, the Plan will no longer use or disclose medical information about you for the reasons covered by your written Authorization. You

understand that the Plan is unable to take back any disclosures it has already made with your Authorization, and that the Plan is required by law to retain records of the care that it has provided to you.

PARTICIPANT'S RIGHTS

As a Participant in the Plan, the Participant is entitled to certain rights and protections under ERISA. ERISA provides that all Participants are entitled to:

Receive Information About the Plan and Benefits

Examine, without charge, at the Plan Administrator's office and at other specified locations, such as worksites and union halls (if any), all documents governing the Plan, including insurance contracts, collective bargaining agreements (if any), and copies of the latest annual report (Form 5500 Series) filed by the Plan with the U.S. Department of Labor and available at the Public Disclosure Room of the Employee Benefits Security Administration.

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

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

Continue Group Health Plan Coverage

Continue health care coverage for the Employee and eligible Dependents if there is a loss of coverage under the Plan as a result of a Qualifying Event. The Employee or eligible Dependents must pay for such coverage. Review this Summary Plan Description and the documents governing the Plan on the rules governing the Participant's COBRA Continuation Coverage rights.

Prudent Actions by Plan Fiduciaries

In addition to creating rights for Participants, ERISA imposes duties upon the people who are responsible for the operation of the Plan. The people who operate the Plan, called "fiduciaries" of the Plan, have a duty to do so prudently and in the interest of the Participants and beneficiaries. No one, including the Employer, the union (if any), or any other person, may fire the Employee or otherwise discriminate against the Employee in any way to prevent the Employee from obtaining a welfare benefit or exercising the Participant's rights under ERISA.

Enforce the Participant's Rights

If a Participant's claim for a welfare benefit is denied or ignored, in whole or in part, the Participant has a right to know why this was done, to obtain copies of documents relating to the decision without charge, and to appeal any denial, all within certain time schedules, as described in the "Claims Procedures; Payment of Claims" section of this Summary Plan Description. Under ERISA, there are steps the Participant can take to enforce the above rights. For instance, if the Participant requests a copy of Plan documents or the latest annual report from the Plan and does not receive them within 30 days, the Participant may file suit in a Federal court. In such a case, the court may require the Plan Administrator to provide the materials and pay the Participant up to $110 a day until the Participant receives the materials, unless the materials were not sent because of reasons beyond the control of the Plan Administrator. If the Participant has a claim for benefits which is denied or ignored, in whole or in part, the Participant may file suit in a State or Federal court, but only after he or she has exhausted (or is deemed to have exhausted) the Plan's internal claim and appeal procedures. The Participant must file the claim before the expiration of the Plan's limitations period, as described in the "Claims Procedures; Payment of Claims" section above, or the claim will be dismissed. In addition, if the Participant disagrees with the Plan's decision or lack thereof concerning the qualified status of a Medical Child Support Order, the Participant may file suit in Federal court. If it should happen that Plan fiduciaries misuse the Plan's money, or if the Participant is discriminated against for asserting his or her rights, the Participant may seek assistance from the U.S. Department of Labor, or the Participant may file suit in a Federal court. The court will decide who would pay court costs and legal fees. If the Participant is successful, the court may order the

person the Participant sued to pay these costs and fees. If the Participant loses, the court may order the Participant to pay these costs and fees, for example, if it finds the Participant's claim is frivolous.

Any action arising out of or in connection with the Plan may only be brought or filed in Federal District Court for the Northern District of Georgia, Atlanta Division.

Assistance with the Participant's Questions

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