SUMMARY PLAN DESCRIPTION
Prepared for

MEDICAL EMPLOYEE HEALTH AND WELFARE BENEFIT PLAN

Effective January 1, 2023

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SECTION 1: INTRODUCTION

1.1 Description

Your employer (the "Plan Administrator" or "Plan Sponsor") maintains this employee health and welfare benefit plan ("Plan") to provide benefits to its eligible employees and eligible dependents. This Summary Plan Description ("SPD") describes the Plan. The Summary Plan Description is not the Plan Document ("PD"). The Plan Document sets forth the rules and features of the Plan, while the SPD merely relays those rules and features in summary form. In no event is the SPD meant to or intended to replace or amend the Plan.

1.2 Effective Date

This Plan was established by the Plan Sponsor effective as indicated in attached Appendix B ("Effective Date").

1.3 Purpose

The purpose of this document is to serve as the SPD which is required by the Employee Retirement Income Security Act of 1974, 29 U.S.C. et seq. ("ERISA")[1]. This document gives you an overview of the Plan and assures that the ERISA requirements regarding the SPD have been met. This document is not a contract of employment between you and your Plan Sponsor and does not give or grant you the right to be retained in the service of your Plan Sponsor.

This SPD supersedes all previous Summary Plan Descriptions. Although the purpose of this document is to summarize the more significant provisions of the Plan, the Plan Document will prevail in the event of any inconsistency between this SPD and the Plan Document.

In this SPD you will find information about eligibility, benefits, and employee/employer contributions for each plan. You are eligible to participate in this Plan if you meet the eligibility requirements described herein.

1.4 Spanish Assistance

This document contains a summary in English of your rights and benefits under your Plan Sponsor welfare plan. If you have difficulty understanding any part of this SPD, contact the Plan Administrator at 1-866-340-7181for assistance.

[1] https://www.law.cornell.edu/uscode/text/29/chapter-XXV-18

SECTION 2: IMPORTANT INFORMATION*

PLAN NAME	**MEDICAL EMPLOYEE HEALTH AND WELFARE BENEFIT PLAN**
PLAN NUMBER	This Plan has been designated by the sponsor as its plan number 501.
TYPE OF PLAN	Health and welfare benefit plan providing group medical benefits.
FUNDING METHOD	Self-insured. The Third-Party Administrator provides certain administrative services for the self-insured coverage. These services include claims payment and other administrative services under an administrative services contract with Plan Sponsor, but they do not assume any financial risk or obligation with respect to claims or benefits under the coverages.
PLAN YEAR	See Plan Year definition on next page.
OPEN ENROLMENT PERIOD	The 30-day period immediately preceding the start date of each Plan Year.
Service of legal process may also be made upon the Plan Administrator.	
THIRD PARTY ADMINISTRATOR	The Loomis Company 850 N Park Road Wyomissing, PA 19610 866-340-7181 www.loomisco.com
NETWORK	PHCS Prac and Anc Network www.multiplan.com/phcspracanc 1-877-952-7427
MEDICAL BENEFITS, CLAIMS & QUESTIONS	The Loomis Company 866-340-7181 www.loomisco.com
PHARMACY BENEFITS, CLAIMS & QUESTIONS	CapRx 844-622-7797 https://www.cap-rx.com
Please have your Identification Card available when you call. ***For additional Important Information please refer to Appendix B.**	

PLAN YEAR DEFINITION:

The 12-month period beginning January 1, April 1, July 1, or October 1 and ending December 31, March 31, June 30, or September 30, respectively.

When the Original Plan Effective Date is a date other than January 1, April 1, July 1, or October 1, the Plan shall utilize an initial short plan year from the Original Plan Effective Date as follows:

Original Plan Effective Date	Initial Short Plan Year Ends	Next Plan Year Begins	Next Plan Year Ends
February 1	December 31	January 1	December 31
March 1	December 31	January 1	December 31
May 1	March 31	April 1	March 31
June1	March 31	April 1	March 31
August 1	June 30	July 1	June 30
September 1	June 30	July 1	June 30
November 1	September 30	October 1	September 30
December 1	September 30	October 1	September 30

*Regardless of the Plan Year selected, the plan's deductibles, out of pocket maximums and limits on number of services/visits allowed will all be administered on a calendar year basis.

SECTION 3: ELIGIBILITY AND PARTICIPATION

3.1 Eligibility

The Plan provides benefit coverage to eligible employees in the Plan and their enrolled eligible dependents. Eligible individuals generally fall into one of two categories:

A. Employees or equity holders of the Plan Sponsor

This Plan is available to eligible employees and equity holders (and their eligible dependents). Equity holders, including but not limited to those persons with status in the group as Members, Partners, Owners, or a similar designation, are considered "employees" for the sole purpose of being classified as "eligible plan participants."

Eligible employees must satisfy the requirements listed below to be eligible to enroll in the Plan:

1) Employment relationship

Employees must have an employer-employee relationship with the Plan Sponsor.

Leased Employees, contract employees, independent contractors, or other workers who provide services for compensation to the Employer will not be considered employees with an employment relationship and are not eligible for participation in this Plan. In the event they are subsequently determined to be common law employees for any purpose, including without limitation, for wage, labor or tax purposes by the Internal Revenue Service, the Department of Labor or any other Federal or state agency, administrative body, or court, then any such determination shall be applied prospectively.

An employment relationship exists on the first day that the employee reports to work.

2) Full time employee status (except as otherwise set forth in Appendix B)

Only employees with full-time status are eligible to participate in the Plan. The number of hours necessary to be considered a full-time eligible employee for medical coverage under the Plan is 30 or more hours of service per week on average for a calendar month. The monthly equivalent of 30 hours of service per week is 130 hours of service for a calendar month and 1560 hours of service for a year.

To the extent required by PPACA for certain companies with 50 or more full-time

employees, the number of hours of service required to obtain full-time status for group medical coverage purposes will be determined in accordance with certain measurement rules adopted by the Plan Sponsor for all employees (including variable hour and seasonal employees, if such classes exist within the Plan Sponsor). Determination of full-time employee status will be made by the Plan Sponsor, in its sole and absolute discretion, in accordance with the Plan and the applicable Employer Shared Responsibility provisions of PPACA and its accompanying regulations. This eligibility information is described in Appendix B and is also available upon request to the Plan Sponsor.

If the Plan Sponsor utilizes the measurement rules under the ''look-back'' method as permitted by PPACA and its accompanying regulations, each employee's hours of service in a prior period (called the ''measurement period'') will be calculated to determine the status of the Employee during a future period (called the ''stability period''). The Plan Sponsor may also utilize an additional time period (called the ''administrative period''), between the measurement period and the stability period, to complete administrative functions such as determining which employees are eligible for coverage and enrolling employees in coverage. Employees whose hours are variable or otherwise uncertain at their start dates (e.g., ''variable hour'' or ''seasonal'' employees") will not initially be eligible for coverage during the applicable measurement period. If it is determined during the measurement period (and any associated administrative period, if applicable) that such employees are full-time, they will be offered coverage during their subsequent stability period.

Newly hired employees who are reasonably expected to be credited with at least thirty (30) hours of service per week on average, in the view of the Plan Sponsor, may be designated as having full-time status on their start date and eligible for coverage under this Plan, subject to any applicable waiting period.

Job descriptions may state explicitly the status of a newly hired employee as full-time or non-full time, (meaning part time or seasonal). These job descriptions will control the newly hired employee's status as designated by the Plan Sponsor. Workers deemed to be full time via job description, including salaried workers who are not paid on an hourly basis, will be designated full time employees irrespective of any measurement method adopted by the Plan Sponsor.

If the Plan Sponsor is subject to certain mandatory benefits wage statutes, such as 41 U.S.C. § 351 et seq. (the "McNamara-O'Hara Service Contract Act of 1965"), 40 U.S.C. § 3141 et seq. (the "Davis Bacon Act"), N.Y.C. Admin. Code § 6-134 (the "Fair Wage for New Yorkers Act), S.F. Admin. Code § 14.1 et seq. (the "San Francisco Health Care Security Ordinance"), or similar law, may create a grid of benefits on which to measure

compliance with these laws. The grid will contain class levels which contain different levels or varieties of benefits per class, based on the accrual of benefits wage by each employee. The Plan Sponsor shall make assumption that any class level on which this Plan is provided, according to the associated benefits grid, is providing the Plan to an eligible individual. This eligible individual may or may not be considered full time by the standards of this Section, but nonetheless the individual will be considered eligible under this Plan.

3) Waiting period

Eligible employees must complete a waiting period before they receive benefits under the Plan. The Plan's waiting period, if any, is set forth in Appendix B. No eligible employee may enroll in this Plan until the eligible employee has satisfied the applicable waiting period which is measured from the first date upon which the employee is otherwise eligible to participate in this plan.

If a Plan participant experiences a break in service (including a termination of employment) and later returns to active employment within 13 weeks, the waiting period will not apply. If the employee had not satisfied the waiting period before the break in service and he returns to active service within 13 weeks, he will be given credit for the period of time previously credited toward satisfaction of the waiting period on the first day an hour of service is credited following the break in service. Otherwise, Plan participants who return from a break in service (including termination of employment) after more than 13 weeks has elapsed since without an hour of service credited must satisfy the eligibility and waiting period requirements of the Plan as any newly hired employee.

B. Dependents

This Plan permits an eligible employee to apply for coverage for his/her dependents, under certain conditions. To become an eligible dependent who may receive benefits under this Plan, the following requirements must be satisfied:

1) In General

a. Only Dependents of Eligible Employees or equity holders enrolled in the Plan may be eligible for enrollment in this Plan.

b. An eligible employee must apply for a dependent's enrollment in the Plan by completing either a dependent application form or the dependent section of an Employee/Equity Holder Application Form.

2) Spouse

   a. If an employee or equity holder is eligible for the plan, so is their spouse.

3) Child

   a. A dependent may qualify as a child through the end of the month in which the dependent turns twenty-six (26) years of age and falls into one of the categories specified below:

      i. A natural child of an eligible plan participant

      ii. A legally adopted child or a child who has been placed for adoption with an eligible plan participant

      iii. A stepchild of an eligible plan participant who meets the definition of child of the eligible plan participant's spouse under the categories of this section

      iv. A dependent for whom an eligible plan participant has been appointed as legal guardian by a court

      v. Any other dependent for whom an eligible plan participant is legally required to provide support, including but not limited to health care benefits

4) Other Dependent

   Such other dependent, if any, to the extent permitted by the Plan as described in Appendix B.

3.2 Enrollment Process

If you are an Eligible Employee, you may enroll in coverage once you meet the requirements for enrollment. The Plan Sponsor will establish enrollment procedures for coverage under the Plan and will prescribe the form and/or manner of enrollment that must be completed by a prescribed deadline prior to commencement of coverage under the Plan.

If you are enrolled, or enrolling, in coverage under the Plan you may enroll your eligible spouse and dependents for the same coverage -- if and to the extent such coverage is available to spouses and dependents, and they meet the eligibility requirements set forth in the Plan. Upon request, you must provide proof of your spouse’s or dependents’ eligibility for coverage.

Coverage begins only upon both successful enrollment within the time and manner specified by the Plan Administrator and timely payment of any required employee contribution.

The following opportunities to enroll, as well as to change or cancel your enrollment, are available under this Plan:

A. Initial Eligibility Enrollment

Enrollment process must be completed by newly eligible employees before the end of their Waiting Period. During this period, you (and your eligible spouse/dependents) may enroll.

B. Open Enrollment

Each year, an open enrollment will be held for all eligible employees and their dependents. Please refer to Section 2 for details. You (and your eligible spouse/dependents) may enroll, or change or cancel your enrollment, during this period.

C. Special Enrollment

You (and your eligible spouse/dependents) may enroll, or change or cancel your enrollment, if you become eligible for a "special enrollment period" based on the following:

1) Loss of Other Coverage – an eligible employee or dependent who is eligible, but not enrolled in this Plan, may enroll during a thirty-one (31) day special enrollment period if there is a loss of other group health plan or health insurance coverage.

2) Acquisition of New Dependent - an eligible employee or dependent who is eligible, but not enrolled in this Plan, may enroll during a thirty-one (31) day special enrollment period if a person becomes a dependent of the eligible employee through marriage, birth, adoption, or placement for adoption.

3) Medicaid and State Child Health Insurance Programs - an eligible employee or dependent who is eligible, but not enrolled in this Plan, may enroll during a sixty (60) day special enrollment period if:

    a. The eligible employee or dependent is covered under a Medicaid plan under Title XIX of the Social Security Act or a State Child Health Insurance Program (CHIP), and coverage of the employee or dependent terminated due to loss of eligibility for such coverage, or

    b. The eligible employee or dependent becomes eligible for government assistance for payment of employee contributions to this Plan through a

Medicaid or CHIP plan.

All special enrollment periods discussed herein begin immediately following the occurrence (i.e. loss of other coverage, acquisition of new dependent, termination of or eligibility for Medicaid or CHIP) which created the special enrollment right.

This Plan intends to comply with all applicable law regarding HIPAA Special Enrollment requirements. If any information presented in this document differs from actual HIPAA Special Enrollment requirements, the Plan reserves the right to administer Special Enrollments in accordance with such actual HIPAA Special Enrollment requirements.

D. Mid-Year Enrollment Changes

Your election to enroll (or not enroll) in Plan coverage through your Plan Sponsor's Section 125 cafeteria plan is generally irrevocable for the duration of the plan year. However, in certain limited circumstances, you may be eligible to later change your election to enroll for, cancel or change coverage for yourself and/or your eligible dependents before the end of the Plan Year if you experience certain events listed in the Section 125 cafeteria plan document. Federal law provides that your change in election must be on account of, correspond to and be consistent with the event. Please note there are several conditions and/or limitations that may apply. Please contact the Plan Sponsor if you have any questions or believe that you may qualify for an election change before the end of the Plan Year.

3.3 Causes for Termination of Coverage

Your coverage under this Plan may cease for any of the following reasons:

A. You become ineligible for coverage under the terms of the Plan.

B. Your election(s) under the Plan expires or is terminated.

C. You fail to make the required premiums or other payments in a timely manner.

D. You fail to comply with the rules and regulations of this Plan.

E. You commit a fraud or material misrepresentation against this Plan.

F. The Plan is amended or terminated causing your coverage to be reduced or eliminated.

Except to the extent coverage is continued as required by COBRA, or other applicable law, coverage for a covered spouse or dependent will cease on the same date your coverage ceases or, if earlier, on either the date the individual ceases to be an eligible dependent for any reason, or the date dependent coverage under the Plan is discontinued.

SECTION 4: FUNDING AND CONTRIBUTIONS

4.1 Funding Method

The Plan Sponsor shall fund the Plan in a manner consistent with the provisions of the Internal Revenue Code, ERISA, and such other laws and regulations as shall be applicable to the end that the Plan shall be funded on a lawful and sound basis; but, to the extent permitted by governing law, the Plan Administrator shall be free to determine the manner and means of funding the Plan.

4.2 Self-Insured Benefits

This Plan is self-insured, meaning no insurance company guarantees the benefits provided by this Plan or pays claims. Instead, this Plan is funded by the Plan Sponsor, who may or may not elect to obtain reinsurance for this self-funding arrangement. Any procurement of reinsurance by the Plan Sponsor shall not constitute a delegation of Plan Sponsor's obligation to pay claims under this self-insured Plan, irrespective of the level of reinsurance procured.

4.3 Plan Design and Contributions

The Plan Administrator shall set, and from time to time reevaluate, the benefit design, funding method, and funding amount of the Plan and may require that you contribute all or part of the costs of these required monthly contributions. The amount of Participant contributions is announced prior to the beginning of each Plan Year and may vary depending on the coverage selected. Please consult your Plan Sponsor for details.

The Plan Sponsor shall allocate all contributions made to the Plan, from whatever source, in its sole and absolute discretion, to fund, administer and operate the Plan. Subject to Section 8 of this SPD:

1-Plan Sponsor contributions, if any, shall be allocated in the following order. First, to the funding of claims payments under the Plan. Then, second, to the payment of reinsurance premium. Then, third, to the payment of the administrative expenses of the Plan.

2- Plan participant contributions, if any, shall be allocated in the following order. First, to the payment of administrative expenses of the Plan. Then, second, to the payment of reinsurance premium. Then, third, to the funding of claims payments under the Plan.

SECTION 5: PLAN ADMINISTRATION

5.1 Plan Administrator

The Plan Administrator has complete discretionary authority with regard to the operation, administration and interpretation of the Plan. Any determination by the Plan Administrator relating to the Plan shall be final, binding, and conclusive. The Plan Sponsor may appoint a Plan Administrator to administer the Plan. Absent such an appointment, Plan Sponsor shall serve as Plan Administrator.

5.2 Duties of the Plan Administrator

A. Administer the Plan in accordance with its terms;

B. Determine all questions of eligibility, status and coverage under the Plan;

C. Interpret the Plan, including the authority to construe possible ambiguities, inconsistencies, omissions and disputed terms;

D. Make factual findings;

E. Decide disputes which may arise relative to a Participant's rights and/or availability of benefits;

F. Prescribe procedures for filing a claim for benefits, to review claim denials and appeals relating to them and to uphold or reverse such denials;

G. Keep and maintain the Plan documents and all other records pertaining to the Plan;

H. Appoint and supervise a claims administrator to pay claims;

I. Perform all necessary reporting as required by ERISA or the IRC;

J. Establish and communicate procedures to determine whether a Medical Child Support Order is a QMCSO;

K. Perform each and every function necessary for or related to the Plan's administration.

SECTION 6: BENEFITS

Refer to Appendix A, for full details of the covered services.

SECTION 7: CLAIMS AND APPEALS

This section covers how a Plan Participant may make a claim for benefits offered under this Plan, how those claims will be processed, what it means to experience an adverse benefits determination, how to appeal a claim, and more.

This section follows the standards set forth by ERISA, regarding the Plan's duties to process claims fairly, competently, and expeditiously for benefits. Any section contrary to this goal is considered void by this Plan and has no effect.

In general, for benefits covered by this Plan accessed in network by the Plan Participant, the claims administration will take place without any further required action by the Plan Participant, as the ability to make claims for benefits is assignable from Plan Participant to the network provider. When a claim is denied because it is not covered by this Plan, further action on behalf of the Plan Participant may occur to gain reconsideration of the claim.

7.1 Benefits Review

The benefits and medical services covered by this Plan may be routinely examined to ensure that these benefits are recommended by the federal government, safe for the Plan Participant, effective at treating the conditions said benefits and services are prescribed to treat, and of value to the Plan Participant.

As a result of these studies, benefits and medical services covered by this Plan may change to better reflect the best care available to the Plan Participant under the terms of and coverages offered by this Plan.

Plan Participants are encouraged to share in this process with questions, concerns, and suggestions regarding the terms and coverages offered by this Plan.

7.2 Identification Card

Each Plan Participant will receive an Identification Card, which grants them access to benefits offered by this Plan as well as a resource for questions, concerns, and issues the Plan Participants may experience.

The Identification Card will signify to medical service providers that the Plan Participant seeking benefits offered by this Plan are bona fide Plan Participants in this Plan. Thus, demonstration of this Identification Card to medical service providers by the Plan Participants is of crucial importance when accessing benefits under this Plan.

The Identification Card will contain at least the following information:

A. The Plan Participant's Name

B. Any Dependent Plan Participant's or the Employee Plan Participant who enrolled with the Plan Participant

C. Status as an Identification Card

D. A Group Identification Number

E. Any deductible and OOP maximum limits applicable to the Plan -- both in network and out of network.

F. A telephone number and website address through which Plan Participants and covered dependents may obtain consumer assistance information.

Upon demonstration of an Identification Card to a medical services provider located in network, the medical services provider will likely then handle the remainder of the initial claims process on behalf of the Plan Participant. This process will include the medical services provider making a claim for benefits under the terms of this Plan on behalf of the Plan Participant. The Plan Sponsor, or a third party delegated this duty by the Plan Sponsor, will then process the claim. As necessary, the Plan Sponsor or said third party delegated this duty by the Plan Sponsor will notify the Plan Participant of any further obligations the Plan Participant may have to either make a co-payment, the level of the Plan Participant's deductible, or any applicable coinsurance provisions of this Plan.

Assuming approval of the claim, the medical services provider will be paid by the Plan Sponsor, or a third party delegated this duty by the Plan Sponsor. The level of payment shall reflect the rules and regulations of this Plan and may not cover the entire cost of the medical services provided to the Plan Participant as a result. The level of payment may be an estimate of the cost of coverage based on information received by the Plan Sponsor or a third party delegated this duty by the Plan Sponsor.

In case of a lost Identification Card, Plan Participants may receive a new card by contacting the Plan Sponsor or a third party delegated this task by the Plan Sponsor.

7.3 Filing a Claim

By accessing medical services from a medical services provider located in network, a Plan Participant begins the initial claims filing process. At this point, the Plan Participant need not take further action on the filing of the claim unless notified otherwise by the Plan Sponsor or a third party delegated this duty by the Plan Sponsor.

The medical services provider must file the claim on behalf of the Plan Participant after rendering medical services with the Plan Sponsor or a third party delegated this duty by the Plan Sponsor. The receiving party will then process the claim and determine whether this Plan covers the medical service(s) performed. Upon an adverse benefits determination, see infra-Section 7.7. Upon approval of the claim, see infra-Section 7.5.

A. Depending on the medical services provided to the Plan Participant, the classification of the claim may differ according to federal law. Different classifications of claims require different claims procedures. The following represent different classifications of claims under federal law:

1) Pre-Service Claims: A "pre-service claim" is a claim for a benefit under the Plan where the Plan conditions receipt of the benefit, in whole or in part, on approval of the benefit in advance of obtaining medical care.

   A "pre-service urgent care claim" is any claim for medical care or treatment with respect to which the application of the time periods for making non-urgent care determinations could seriously jeopardize the life or health of the Plan Participant or the Plan Participant's ability to regain maximum function, or, in the opinion of a physician with knowledge of the Plan Participant's medical condition, would subject the Plan Participant to severe pain that cannot be adequately managed without the care or treatment that is the subject of the claim.

   It is important to remember that, if a Plan Participant needs medical care for a condition which could seriously jeopardize his life, there is no need to contact the Plan for prior approval. The Plan Participant should obtain such care without delay.

   Further, if the Plan does not require the Plan Participant to obtain approval of a specific medical service prior to getting treatment, then there is no pre-service claim. The Plan Participant simply follows the Plan's procedures with respect to any notice which may be required after receipt of treatment, and files the claim as a post-service claim.

2) Concurrent Claims: A "concurrent claim" arises when the Plan has approved an on-going course of treatment to be provided over a period of time or number of treatments, and either:

   a. The Plan Administrator determines that the course of treatment should be reduced or terminated; or

   b. The Plan Participant requests extension of the course of treatment beyond that which the Plan Administrator has approved.

   Since the Plan does not require the Plan Participant to obtain approval of a medical services in an urgent care situation prior to getting treatment, then there is no need to contact the Plan Administrator to request an extension of a course of treatment in an urgent care situation. The Plan Participant simply follows the Plan's procedures with respect to any notice which may be required after receipt of treatment, and files the claim as a post-service claim.

3) Post-Service Claims: A "post-service claim" is a claim for a benefit under the Plan after the services have been rendered.

B. While Plan Participants generally need not file a claim on their own behalf, if a Plan Participant receives a bill or charge for medical services, the Plan Participant should file a claim with the Plan Sponsor, or a third party delegated this duty by the Plan Sponsor for said bill or charge. The deadline for such claim submission is one (1) year plus ninety (90) days.

Plan Participants may file a claim by contacting the Plan Sponsor or a third party delegated this duty by the Plan Sponsor. A claims form will be sent to the Plan Participant within fifteen (15) days of receipt of this request. Proof of claim must be supplied by the Plan Participant to achieve approval of the claim.

C. Note that some benefits offered by this Plan may not be available in network. By accessing out of network services, the Plan Participant may see a higher monetary obligation than for in network services. Out of network medical service providers may charge the Plan Participant instead of filing a claim with this Plan. However, many out of network medical services providers will file a claim as if they were in network medical services providers, meaning the only difference with such claims will be the monetary obligations owed by the Plan Participant.

D. Both in network and out of network medical services providers may refuse certain medical services, refuse to continue certain medical services, or reduce/amend the medical services desired by the Plan Participant at their discretion. Your Plan Sponsor does not interfere in medical treatment decisions of this nature. In such case, the Plan Participant may proceed with the medical service(s) at issue, receive a bill or charge, and file a post-service claim.

E. Both in network and out of network medical services providers may charge different rates for different medical services. By charging different rates, the Plan Participant's monetary obligations regarding such medical services may be different among medical service providers, as well as this Plan's monetary obligations.

7.4 Reference Based Pricing Model

Reference-based pricing (RBP) is a healthcare cost containment model that limits what a group health plan will pay for certain high-cost services, including hospital and outpatient facility charges. This plan does not utilize a network for any facilities. All services performed in a medical facility (for example, a hospital as opposed to a primary care physician's office) will be subject to Reference Based Pricing reimbursements based on a multiple of the Medicare Reimbursement Rate. Plan Participants have the following options to access facilities services:

1. **Finding Providers that Accept RBP.** When you are having a service performed that is subject to referenced based pricing, you must call the number on your ID card and speak with an Advocate. The Advocate will work with you and the providers in your geographic area to find providers that will accept referenced based pricing, otherwise known as a usual and customary rate, at the rates the plan reimburses at. The Advocates will take the lead in this process and will keep you informed throughout the process. It is ultimately your decision as to which provider you use, but the provider you choose could have an impact on the amount you pay instead of the plan for the service you receive. See the next section for more details on the impact on the amount you might have to pay. If you have questions on whether a service is subject to reference-based pricing/at a facility, please call our service department for more information.

2. **Using Higher Cost Providers.** If you choose to have the services performed at a provider that

charges more than the usual and customary rate from a different provider the Advocate was able to reach agreement with for the services you need, the provider you selected may issue a "balance bill," which represents the difference in the usual and customary rate and the amount charged by that provider. You will be responsible for paying that difference, plus any applicable deductibles, copays, or coinsurance. The amounts you pay in this scenario, other than any applicable deductibles, copays, or coinsurance, are not limited by or considered part of your out-of-pocket maximum or deductible and will not count toward you meeting your out-of-pocket maximum or deductible for the plan year.

7.5 Payment of a Claim

When a medical services provider submits a claim on behalf of a Plan Participant, this Plan will directly deal with the medical services provider to render payment for approved claims. Approved claims will be paid at an in-network level to in-network medical services providers and at an out of network level to out of network medical services providers.

If the Plan Participant is billed or charged instead, the Plan Participant must submit a post-service claim to the Plan Sponsor, or a third party delegated this duty by the Plan Sponsor for said bill or charge. The deadline for such claim submission is one (1) year plus ninety (90) days. If the medical service(s) provider has not been paid on the bill or charge and this Plan approves the claim, this Plan may pay either the Plan Participant or the medical services provider, at this Plan's discretion. If the medical services provider has been paid on the bill or charge by the Plan Participant and this Plan approves the claim, this Plan will reimburse the Plan Participant.

Payment by this Plan satisfies any obligations this Plan has with regard to the medical services rendered. The Plan Participant is responsible for the difference in the cost of the medical service(s) rendered and the amount paid by this Plan.

Payment will be rendered by this Plan within thirty (30) days of approval of the submitted claim. Processing times for claims depend on the classification of the claim and are regulated by federal law. This Plan follows those deadlines and hereby incorporates them into this plan by reference.

Besides potential monetary obligations to medical services providers, Plan Participants may have monetary obligations to this Plan as a result of certain medical services including but not limited to premiums, co-payments, and coinsurance.

After a determination on a claim, if negative, an explanation of this decision will be sent by the Plan Sponsor, or a third party delegated this duty by the Plan Sponsor to the Plan Participant claimant. This form may include information about the medical service(s) rendered, the terms of this Plan regarding such service(s), monetary obligations of the Plan Participant claimant, or further information regarding an adverse benefits determination.

7.6 Coordination of Benefits

If a Plan Participant is enrolled in and receiving benefits from more than one health plan,

including at least this Plan, some overlap of coverages is probable. Thus, to properly coordinate which plan will cover which claims and in what order, this Coordinated of Benefits section outlines when benefits of this Plan apply in case of multiple health plans.

Under no circumstances are the benefits offered by this Plan increased under the terms of this section. Benefits offered by this Plan may decrease as a result of Coordination of Benefits, however.

When this section applies, it applies before any other determinations on claims are made.

A. The following types of health plans may or may not be considered by this section, as classified below:
    1) A Plan is any one of the following arrangements which provide medical or dental health benefits which will coordinate with this Plan:
        a. Group, blanket, or franchise insurance;
        b. A group health plan;
        c. Group or group-type arrangements via Health Maintenance Organization(s) or a similarly structured organization(s);
        d. A labor union, multiemployer, or other similarly structured employee organization plan;
        e. A governmental plan to which the Plan Sponsor makes contributions or payroll deductions, or a governmental plan required by law;
        f. Medical services covered by individual, group, or group-type automobile type contracts, whether no-fault or fault;
        g. Medicare or a similarly structured plan; and
        h. Any other group health arrangement.
    2) A Plan is not any one of the following arrangements which provide medical or dental health benefits which will coordinate with This Plan:
        a. Individual insurance contracts;
        b. Individual subscriber contracts;
        c. Individual Health Maintenance Organization coverage or similarly structured organization coverage;
        d. Individual public assistance programs;
        e. Indemnity benefit plans; and
        f. Catastrophic coverage plans.

3) This Plan refers to your Plan Sponsor Benefit Plan. Other plan is any other plan that is not this Plan.

4) The Primary Plan is the plan which applies before a Secondary Plan or beyond plan for the purpose of covering coordinated benefits.

5) The Secondary Plan is the plan which applies after a Primary Plan for the purpose of covering coordinated benefits.

B. The rules below dictate whether this Plan has primacy over other Plan(s). If this Plan has primacy, then other Plan(s) are not considered for the purpose of calculating benefits. If this Plan does not have primacy over other Plan, all other Plan(s) with primacy over This Plan will first be considered for the purpose of calculating benefits.

C. Under this section, an allowable expense is a benefit covered by at least this Plan and one other Plan which is medically necessary on behalf of the Plan Participant. Only the reasonable cash value of such benefits is considered an allowable expense. The excess of upgraded services compared to customary services is generally not considered unless the upgraded service is considered medically necessary.

The Plan Participant is required to submit information to the Plan Sponsor, or a third party delegated this duty by the Plan Sponsor on other Plans.

D. Any reference to a claims determination period in this section refers to the lesser of a Plan Year under this Plan or the time during a given Plan Year of this Plan in which the Plan Participant is enrolled and receiving benefits from this Plan which contains this Coordination of Benefits within its Plan Document.

E. Plan Primacy will be determined for this Plan by the following provisions:

1) A plan which covers a Plan Participant as an employee/primary insured will have primacy over a plan which covers a Plan Participant as a dependent except in under the following circumstance:

a. The Plan Participant is also a Medicare beneficiary, and

b. The Social Security Act of 1965, as amended, dictates that This Plan takes primacy over the Medicare plan. In such circumstances, the order of primacy will be:

i. The plan covering the Plan Participant as a dependent.

ii. Medicare.

iii. Any other Secondary Plans.

2) A plan which covers a dependent child of married parents will have primacy over another plan under the following circumstances:

a. The plan which covers the mother (as an employee if the parents are covered by both plans). If both parents at issue are of the same gender, the biological

parent's/legal custodian's plan has primacy. If both parents at issue are of the same gender and neither are biological parents and both are legal custodians, the plan which has insured one of the parents longer has primacy. If this provision differs from the other Plan's provision on this matter, the other Plan's provision will be given effect unless the other Plan contains a similar clause as this statement.

3) A plan which covers a dependent child of unmarried parents will have primacy over another plan under the following circumstances:
   a. The plan of the custodial parent has primacy.

   b. The plan of the spouse of the custodial parent is next considered.

   c. The plan of the parent without custody is next considered.

   The rules of this section may be changed by a valid court order from a court of sufficient jurisdiction to convey such rights so long as the parent affected has actual knowledge of the court's decision.

4) Plans which cover an employee actively at work have primacy over plans which cover an employee not actively at work unless the other Plan does not have a provision to this effect and assumes Primary Plan status.

5) If no other rule in this section is available to determine primacy, then primacy shall be determined by the plan on which the Plan Participant has been enrolled for a longer period of time. For purposes of this determination, tacking of time spent on a prior plan is permissible if the Plan Participant terminated coverage of the prior plan within twenty-four (24) hours of joining the new plan.

   Start of coverage does not include an amendment of a plan's benefits, a change in the Plan Administrator or other third party, or a change in plan classification. Instead, the first day of coverage (or as close to that day as reasonably determinable) under the plan is the date from which the period of coverage will be measured.

6) If other plan takes an aggressive position, such as only offering coverage in excess to other plan benefits or only assuming Secondary Plan status, the other plan shall be deemed a non- complying plan. Non-complying plans are coordinated with as follows:

   a. When this plan is the primary plan, this plan will proceed without consideration of the non- complying plan.

   b. When this Plan is the Secondary Plan, this Plan will pay benefits only to the amount required as a Secondary Plan, based on the benefits offered by the Primary Non-Complying Plan. If the Primary Non-Complying Plan does not make known its level of benefits for the purpose of this determination, this Plan reserves the right to assume similar coverage as that of This Plan and proceed accordingly unless such information on the Primary Non-Complying Plan is made known to this Plan at a later date before satisfaction of obligations under this Plan occurs.

c. If the Non-Complying plan reduces benefits such that a shortfall is caused for the Plan Participant which would have been avoided had the Non-Complying Plan acted as the Primary Plan, and the following subrogation rules are permitted, this Plan will pay the difference up to the amount this Plan would have paid as the Primary Plan. However, This Plan will assume all subrogation rights of the Plan Participant against the Non-Complying Plan. The excess paid by this Plan is without prejudice it may have against the Non- Complying Plan without such subrogation.

F. When this Plan is determined to be the Secondary Plan, benefits are affected as follows:

1) Benefits of this Plan will be reduced when the sum of the following exceeds the allowable expenses in a claim's determination period such that the benefits paid by this Plan do not exceed the allowable expenses:

a. The value of the benefits that would be paid by this Plan for allowable expenses without a Coordination of Benefits provision.

b. The value of the benefits that would be paid by the other Plan for allowable expenses, assuming a similar absence of a Coordination of Benefits provision.

Benefits hereby reduced are done so proportionally and charged against the terms of this Plan.

G. This Plan reserves the right to determine whether sufficient information has been presented to it for the purpose of making a determination under the terms of this Coordination of Benefits section. This Plan may request further information and refuse to grant certain interpretations under this section without receipt of said information.

H. If other plan pays an excess of the benefit in error, then part of the payment made by this Plan may be submitted to the other Plan as a reimbursement for said error in the exact amount of the discrepancy which should have been paid by this Plan. Payment may be made by any legal means, including services rendered. Such reimbursements, along with any other benefits paid by this Plan under such circumstances in accordance with the terms of this Plan are considered full satisfaction of the obligations of this Plan.

I. If this Plan pays an excess of the benefit in error, including the reasonable cash value for services rendered, then this Plan may recover that excess from the following parties in the order they are listed:

1) The person receiving payment or on whose behalf payment was made,

2) Insurance companies, or

3) Other organizations.

7.7 Adverse Benefits Determinations

Adverse benefits determinations are determinations by the Plan Sponsor, or a third party delegated this duty by the Plan Sponsor that a given claim for medical service(s) rendered is not

covered by this Plan and should therefore be denied. Adverse benefits determinations may occur prospectively or retrospectively, depending on the classification of the claim under review. As this Plan is denying the claim, no payment of the claim will occur under Section 7.5. No Coordination of Benefits will occur under Section 7.6.

An adverse benefit determination is defined as a denial, reduction, or termination of, or a failure to provide or make a payment for a claim that is based on:

- A determination of an individual's eligibility to participate in a plan or health insurance coverage;
- A determination that a benefit is not a covered benefit;
- The imposition of a source-of-injury exclusion, PPO provider network exclusion, or other limitation on otherwise covered benefits; or
- A determination that a benefit is Experimental, investigational, or not Medically Necessary or appropriate.

Although it is not a claim for benefits, the definition of an adverse benefit determination also includes a rescission of coverage under the Plan. A rescission of coverage is defined as a cancellation or discontinuance of coverage that has retroactive effect, except to the extent it is attributable to a failure to timely pay required premiums or contributions towards the cost of coverage.

Adverse benefits determinations do not occur if the Plan Participant has no monetary obligation with respect to a post-service or for past services on a concurrent service claim.

Appeals procedures may be commenced at the discretion of the Plan Participant claimant. For more information on appeals procedures is available, see infra-Section 7.8. Until resolution of such appeals, the benefits determination will not be considered adverse.

7.8 Appealing an Adverse Benefit Determination

J. Full and Fair Review of All Claims

In cases where a claim for benefits is denied, in whole or in part, and the Plan Participant believes the claim has been denied wrongly, the Plan Participant may appeal the denial and review pertinent documents. The claims procedures of this Plan provide a Plan Participant with a reasonable opportunity for a full and fair review of a claim and adverse benefit determination. The Plan provides for two levels of internal appeals.

K. First Internal Appeal Level

1) Requirements for First Internal Appeal

The Plan Participant must file the first internal appeal in writing within 180 days following receipt of the notice of an adverse benefit determination. It shall be the

responsibility of the Plan Participant to submit proof that the claim for benefits is covered and payable under the provisions of the Plan.

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

2) Timing of Notification of Benefit Determination on First Internal Appeal

The Plan Administrator shall notify the Plan Participant of the Plan's benefit determination on review within the following timeframes:

a. Pre-service Non-Urgent Care Claims: Within a reasonable period of time appropriate to the medical circumstances, but not later than 15 days after receipt of the appeal.

b. Concurrent Claims: The response will be made in the appropriate time period based upon the type of claim – pre-service non-urgent or post-service.

c. Post-service Claims: Within a reasonable period of time, but not later than 30 days after receipt of the appeal.

d. 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.

3) Second Internal Appeal Level

a. Requirements for Second Internal Appeal: Upon receipt of notice of the Plan's adverse decision regarding the first appeal, the Plan Participant has 60 days to file a second appeal of the denial of benefits. The Plan Participant again is entitled to a "full and fair review" of any denial made at the first appeal, which means the Plan Participant has the same rights during the second appeal as he or she had during the first appeal.

b. Timing of Notification of Benefit Determination on Second Internal Appeal: The Plan Administrator shall notify the Plan Participant of the Plan's benefit determination on review within the following timeframes:

i. Pre-service Non-Urgent Care Claims: Within a reasonable period of time appropriate to the medical circumstances, but not later than 15 days after receipt of the second appeal.

ii. Concurrent Claims: The response will be made in the appropriate time period based upon the type of claim – pre-service non-urgent or post-service.

iii. Post-service Claims: Within a reasonable period of time, but not later than 30 days after receipt of the second appeal.

iv. Calculating Time Periods: The period of time within which the Plan's determination is required to be made shall begin at the time the second 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.

c. Decision on Second Internal Appeal: If, for any reason, the Plan Participant does not receive a written response to the appeal within the appropriate time period set forth above, the Plan Participant may assume that the appeal has been denied. If the Plan Participant does not elect to file a request for an external review, the decision by the Plan Administrator or other appropriate named fiduciary of the Plan on review of the second internal appeal will be final, binding, and conclusive and will be afforded the maximum deference permitted by law. All internal and external review procedures provided for in the Plan must be exhausted before any legal action is brought. Any legal action for the recovery of any benefits must be commenced within one year after the Plan's claim review procedures have been exhausted.

4) External Review of Adverse Benefit Determinations

When the internal appeals procedures have been exhausted, the Plan Participant may elect to have an additional and final opportunity for a review of an adverse benefit determination (including a final internal adverse benefit determination) by an independent review organization (IRO). The IRO will be accredited by URAC or a similar nationally recognized accrediting organization for the purpose of conducting an independent and unbiased review.

The request for an external review must be filed by the Plan Participant within four months following the Plan Participant's receipt of the notice of adverse benefit determination or final internal adverse benefit determination. However, if the Plan fails to strictly adhere to all the requirements of the internal claims and appeals process with respect to a claim, the Plan Participant will be deemed to have exhausted the internal claims and appeals process, and the Plan Participant may initiate an external review and pursue any available remedies under applicable law, such as judicial review.

The Plan's external review process applies to any adverse benefit determination or final internal adverse benefit determination on appeal, except that a denial, reduction, termination, or a failure to provide payment for a benefit based on a determination that a claimant fails to meet the requirements for eligibility under the terms of the Plan is not eligible for the external review process.

There are two types of external reviews; standard and expedited. An external review is a standard external review unless the timing required to perform a standard external review involves circumstances that would seriously jeopardize the life or health of the Plan Participant or would jeopardize the Plan Participant'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 Plan Participant received emergency services but has not yet been discharged from the facility. In such cases, the Plan will consider the external review to be an expedited review.

The IRO will provide written notice to the Plan Participant and the Plan of the final external review decision within 45 days following receipt of the request for review. The IRO must provide notice of the final external review decision as expeditiously as the Plan Participant'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.

An external review decision is binding on the Plan as well as the Plan Participant, except to the extent other remedies are available under State or Federal law.

All internal and external claim review procedures provided for in the Plan must be exhausted before any legal action is brought. Any legal action for the recovery of any benefits must be commenced within one year after the Plan's claim review procedures have been exhausted.

7.9 Appointment of Authorized Representative

A Plan Participant is permitted to appoint an authorized representative to act on his behalf with respect to a benefit claim or appeal of a denial. An assignment of benefits by a Plan Participant to a provider will not constitute appointment of that provider as an authorized representative. To appoint such a representative, the Plan Participant must complete a form which can be obtained from the Plan Administrator or the TPA. However, in connection with a claim involving urgent care, the Plan will permit a health care professional with knowledge of the Plan Participant's medical condition to act as the Plan Participant's authorized representative without completion of this form. In the event a Plan Participant designates an authorized representative, all future communications from the Plan will be with the representative, rather than the Plan Participant, unless the Plan Participant directs the Plan Administrator, in writing, to the contrary.

SECTION 8: AMENDMENT AND TERMINATION

8.1 In General

The Plan Sponsor expects to maintain this Plan indefinitely, but the Plan may be amended, terminated, or suspended in writing by the Plan Sponsor with respect to all or any class of employees, in whole or in part, at any time and for any reason. Any claims or expenses incurred before the date of any Plan amendment or termination will be paid in accordance with the Plan terms in effect at the time the claim or expense was incurred; provided the claim is filed with the Plan in accordance with the applicable claims' procedures and within the applicable time limits for filing such claims. No vested rights of any nature are provided under the Plan.

Notice of amendments or termination of coverage will be sent to all Plan Participants by the Plan Sponsor or a third party delegated this task by the Plan Sponsor in accordance with applicable law.

SECTION 9: STATEMENT OF ERISA RIGHTS

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

9.1 Received Information About Your Plan and Benefits

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

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

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

9.2 Continue Group Health Plan Coverage

Continue health care coverage for yourself, Spouse or Dependents if there is a loss of coverage under the Plan as a result of a Qualifying Event. You or your Dependents may have to pay for such coverage. Review this SPD and the documents governing the Plan on the rules governing your COBRA Continuation Coverage rights.

9.3 Prudent Actions by Plan Fiduciaries

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

9.4 Enforcement Your Rights

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

Under ERISA, there are steps you can take to enforce the above rights. For instance, if you request a copy of plan documents or the latest annual report from the Plan and do not receive them within thirty (30) days, you may file a suit in a federal court. In such a case, the court may require the Plan Administrator to provide the materials and pay you up to one hundred and ten dollars ($110) a day until you receive the materials, unless the materials were not sent because of reasons beyond the control of the Plan Administrator.

If you have a claim for benefits which is denied or ignored, in whole or in part, you may file suit in a state or Federal court. In addition, if you disagree with the Plan's decision or lack thereof concerning the qualified status of a medical child support order, you may file a suit in Federal court. If it should happen that Plan fiduciaries misuse the Plan's money, or if you are discriminated against for asserting your rights, you may seek assistance from the U.S. Department of Labor, or you may file suit in a federal court. The court will decide who should pay court costs and legal fees. If you are successful, the court may order the person you have sued to pay these costs and fees. If you lose, the court may order you to pay these costs and fees, for example, if it finds the claim is frivolous.

Exhaustion of Administrative Procedures Required. To the fullest extent permitted under applicable law, the right to maintain a court action is subject to the Plan's requirements that administrative procedures be completed first. This is called exhaustion of administrative remedies. Failure to exhaust administrative procedures may preclude you from bringing an action in court.

9.5 Assistance with Questions

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

SECTION 10: COBRA CONTINUATION RIGHTS

The right to COBRA continuation coverage was created by a federal law, the Consolidated Omnibus Budget Reconciliation Act of 1985 (COBRA). When applicable, COBRA Continuation Coverage can become available to Plan Participants when they otherwise would lose their group health coverage. It also can become available to other members of the Participant's family who are covered under the Plan when they otherwise would lose their group health coverage. The entire cost (plus a reasonable administration fee) must be paid by the participant. Coverage will end in certain instances, including if the Participant or their covered Dependents fail to make timely payment of contributions or premiums.

For additional information regarding your rights to COBRA continuation coverage, refer to the Continuation Coverage Rights described more fully in the federally mandated Initial COBRA Notice, separately provided from this SPD when applicable.

A. COBRA Continuation of coverage allows a continuation of Plan coverage when said coverage would otherwise terminate due to the occurrence of a "Qualifying Event." A "Qualifying Event" is one of the followings:

    1) Termination from employment, unless termination is for gross misconduct

    2) Reduction in hours

    3) Death of Plan Participant entails that the employee's dependent may continue under this Section

    4) Divorce or legal separation of a Plan Participant

    5) The Plan Participant's becoming entitled to Medicare

    6) A dependent child's ceasing to be a dependent under this Plan. Coverage may continue for the dependent

    Unless specifically stated otherwise, coverage may continue for the Plan Participant and his or her dependents.

    Individuals must be participating in and covered by this Plan on the day before the Qualifying Event to be eligible for COBRA Continuation of coverage.

    A child new to the family via birth or legal adoption/custody agreement from a court with sufficient jurisdiction to grant such rights during a period of COBRA continuation of coverage will remain eligible for COBRA continuation of coverage for the remaining period of coverage even if the Plan Participant terminates coverage following the birth or legal adoption/custody

agreement from a court of sufficient jurisdiction to grant such rights.

B. Plan Participants must inform the Plan Administrator in writing within sixty (60) days of a divorce or legal separation or when a dependent child loses dependent status under this Plan. Failure to provide adequate, timely, and written notification will result in the forfeiture of COBRA continuation of coverage.

   The Plan Sponsor must notify the Plan Administrator, or the third party delegated this task by the Plan Sponsor, of a Plan Participant's death, termination from employment, reduction in hours, or entitlement to Medicare within thirty (30) days.

   Upon proper notification, the Plan Administrator, or the third party delegated this task by the Plan Sponsor, will notify applicable Plan Participants of their COBRA continuation of coverage rights. Upon notification of rights, an individual eligible for COBRA continuation of coverage has sixty (60) days to elect coverage. If coverage would end at a date after notification is received, the sixty (60) day period does not begin until the date coverage would have been terminated. Failure to elect coverage within this period will result in termination of COBRA continuation of coverage rights.

C. If, upon notification of a Qualifying Event, the Plan Administrator, or a third party delegated this task by the Plan Sponsor, determines that a Plan Participant is not eligible or entitled to COBRA continuation of coverage, the Plan Administrator, or a third party delegated this task by the Plan Sponsor, will provide an explanation as to why the individual is not entitled to COBRA continuation of coverage to said Plan Participant.

D. For all Qualifying Events except termination of employment or reduction in hours, the maximum period of COBRA continuation of coverage is thirty-six (36) months. For a termination of employment or reduction in hours, the maximum period of COBRA continuation of coverage is eighteen (18) months. The period begins on the date of the Qualifying Event.

   However, if a qualifying individual is disabled (as determined under the Social Security Act) at the time of termination or reduction in hours or becomes disabled at any time during the first sixty (60) days of COBRA continuation of coverage, COBRA continuation of coverage for the qualifying individual and any non-disabled eligible dependents who are also entitled to COBRA continuation of coverage may be extended to twenty-nine (29) months provided the qualifying individual or dependent, if applicable, notifies the Plan Administrator, or a third party delegated this task by the Plan Sponsor, in writing within the eighteen (18) month continuation coverage period and within sixty (60) days after receiving notification of determination of disability.

   If a second Qualifying Event occurs during the period of COBRA continuation of coverage

resulting from a termination of employment or reduction in hours, the maximum period of coverage will be computed from the date of the first Qualifying Event but will be extended to the full thirty-six (36) months if required by the subsequent Qualifying Event.

If the qualifying individual is a dependent spouse or child whose Qualifying Event is the termination of employment or reduction in hours and the Plan Participant becomes entitled to Medicare within eighteen (18) months before such qualifying event, the qualifying individual's maximum period of continuation coverage is the longer of thirty-six (36) months from the date of said Medicare entitlement or the otherwise applicable maximum period of coverage.

E. The cost of COBRA continuation of coverage is determined by the Plan Administrator, who may delegate this duty to a third party, and paid by the qualifying individual. If the qualifying individual is not disabled, the contribution cannot exceed one hundred two percent (102%) of this Plan's cost of providing coverage. The cost of coverage during a period of extended COBRA continuation of coverage due to a disability cannot exceed one hundred fifty percent (150%) of this Plan's cost of coverage.

Contributions for coverage for "initial month(s)" are due by the forty-fifth (45th) day after electing continuation coverage. The "initial month(s)" are any month that ends on or before the forty-fifth (45th) day after the qualifying individual elects continuation of coverage. All other contributions are due on the first (1st) of the month for which coverage is sought, subject to a thirty (30) day grace period. Contributions are established by the Plan Administrator and may change when necessary due to Plan modifications. The cost of continuation of coverage is computed from the date coverage would normally end due to the Qualifying Event.

Failure to make the first payment within forty-five (45) days or any subsequent payment within thirty (30) days of the established due date will result in the permanent cancellation of COBRA continuation of coverage.

F. COBRA continuation of coverage ends on the earliest of:

1) The date the maximum continuation of coverage periods expires.

2) The date your Plan Sponsor no longer offers this Plan/terminated this Plan.

3) The first (1st) day for which timely payment of COBRA continuation of coverage costs are not paid to this Plan.

4) The date the qualifying individual becomes covered -- after electing COBRA continuation coverage -- under another group health plan (as an employee or otherwise) that does not impose any pre-existing condition limitation for a pre-existing condition of the qualifying

individual (note: such preexisting condition limitations are no longer permitted under PPACA).

5) The date the qualifying individual becomes entitled to coverage under Medicare (under Part A, Part B, or both) after electing COBRA continuation coverage

6) The first day of the month that begins more than thirty (30) days after the qualifying individual who was entitled to a twenty-nine (29) month maximum continuation period is subject to a final determination under the Social Security Act that he or she is no longer disabled.

G. If continuation coverage for a qualifying individual terminates before the expiration of the maximum period of continuation coverage, the Plan Administrator, or a third party delegated this task by the Plan Sponsor, will provide notice to the individual of the reason that the continuation of coverage terminated and the date of termination. Notice will be provided as soon as practicable following the Plan Administrator's, or a third party delegated this task by the Plan Sponsor, determination regarding termination of the continuation of coverage.

H. This Plan intends to comply with all applicable law regarding COBRA continuation of coverage. If the information presented in this SPD differs from actual COBRA requirements, the Plan reserves the right to administer COBRA in accordance with such actual COBRA requirements, or not administer COBRA if inapplicable.

SECTION 11: HIPAA PRIVACY PRACTICES

11.1 HIPAA Privacy Practices

The Plan will comply with the Standards for Privacy of Individually Identifiable Health Information (i.e., the "Privacy Rule") set forth by the U.S. Department of Health and Human Services ("HHS") pursuant to the Health Insurance Portability and Accountability Act of 1996 ("HIPAA").

The Plan is required by law to:

A. Ensure that the Protected Health Information ("PHI") is kept private, except as such information is required or permitted to be disclosed by law;

B. Describe the Plans' legal duties and privacy practices with respect to your PHI;

C. Abide the terms of this section; and

D. Inform you in the event of a breach of your unsecured PHI.

Refer to Appendix C: Notice of HIPAA Privacy Practices, for additional details.

11.2 Plan Participant's Rights

A. The Participant has the right to request additional restrictions on the use or disclosure of PHI.

B. The Participant has the right to request that he/she receive communications regarding PHI in a certain manner or at a certain location.

C. The Participant is entitled to receive a paper copy of the Plan's Notice of Privacy Practices at any time.

D. The Participant has the right to request an accounting of disclosures the Plan has made of his/her PHI.

E. The Participant has the right to request the opportunity to look at or get copies of PHI maintained by the Plan about him/her in certain records maintained by the Plan.

F. The Participant has the right to request that the Plan change or amend his/her PHI.

11.3 Breach

The Plan will notify you (in the manner required by law) of any use or disclosure of PHI not permitted by HIPAA which compromises the privacy or security of PHI.

SECTION 12: MISCELLANEOUS

12.1 Prior Authorization

You may need prior authorization from the Plan Administrator for some eligible health services. You are responsible for obtaining prior authorization for those benefits that require it. You do not need prior authorization from the Plan or from any other person (including a primary care provider) in order to obtain access to obstetrical or gynecological care from a health care professional in our network who specializes in obstetrics or gynecology. The health care professional, however, may be required to comply with certain procedures, including obtaining prior authorization for certain services, following a pre-approved treatment plan, or procedures for making referrals.

12.2 Subrogation Rights

You consent that the Plan will have a right of subrogation to recover amounts paid to Plan Participants for illnesses and/or injuries caused by third parties which the Plan covers. Plan Participants have an obligation to notify the Plan if circumstances occur which cause a subrogation right to arise.

12.3 Qualified Medical Child Support Orders ("QMCSO")

In certain circumstances you may be able to enroll a child in the Plan if the Plan receives a Qualified Medical Child Support Order. You may obtain a copy of the QMCSO procedures from the Plan Administrator, free of charge.

12.4 Continuity of Care

If a health provider or facility experiences a change in network status due to the expiration or nonrenewal of the network contract between the Plan, certain continuity of care protections applies to a Plan Participant who meets the definition of a "continuing care patient" and is furnished items or services by the provider or facility that are covered by the Plan. Continuity of care may last until the earlier of 90-days following the date the Plan's notice is furnished to the individual, or the date the individual is no longer a continuing care patient of the provider or facility.

In the event this takes place, the Plan will timely notify each individual who is a continuing care patient of the termination of network status and their right to elect transitional care from the provider.

The Plan will give each continuing care patient an opportunity to inform the Plan of their need for transitional care from the provider and will permit the continuing care patient to elect to

continue receiving Plan benefits under the same terms and conditions that would have applied had the termination not occurred, with respect to the course of treatment furnished by the provider or facility.

Continuing care patients are, with respect to a provider or facility, at least one of the following:

A. Undergoing treatment from the provider or facility for a serious and complex condition, defined as:

1) In the case of an acute illness, a condition that is serious enough to require specialized medical treatment to avoid the reasonable possibility of death or permanent harm.

2) In the case of a chronic illness or condition, a condition that is:

a. Life-threatening, degenerative, potentially disabling, or congenital; and
b. Requires specialized medical care over a prolonged period of time.

B. Undergoing a course of institutional or inpatient care from the provider or facility.

C. Scheduled to undergo nonelective surgery from the provider or facility, including receipt of postoperative care from such provider or facility with respect to such a surgery.

D. Pregnant and undergoing treatment for pregnancy from the provider or facility.

E. Terminally ill and receiving treatment for such illness from the provider or facility.

12.5 Provider Directories/Listings

Provider directories/listings for the applicable health provider networks utilized by the Plan will be made available on a public website of the Plan Sponsor, or a third party delegated by the Plan Sponsor, that lists the name, address, specialty, telephone number, and digital contact information for each provider that directly or indirectly participates in the network. Paper copies will be made available, upon request, free of charge.

Requests for network provider information may be made by telephone or through the internet, or other electronic means. In the case of a request by telephone, a response will be provided within one business day and will include a written response provided in print or electronically, as the Plan Participant requests.

The Plan Sponsor, or a third party delegated by the Plan Sponsor, will verify the accuracy of provider information at least every 90 days and will make any changes to the directory within 2 business days of receiving such updated provider information. If there is a network directory

error and services are provided by an out-of-network provider believed to be in-network due to the error, the in-network deductible and out-of-pocket maximum will apply, and any cost-sharing amount will be no higher than the in-network amount that would have applied.

12.6 Cost Comparison Tool

To the extent required by applicable law, the Plan Sponsor, or a third party delegated by the Plan Sponsor, will make available to covered individuals (or an authorized representative) personalized enrollee cost-sharing information, including, when applicable, in-network rates for covered health care items and services through an internet-based self-service tool and in paper form upon request.

12.7 Surprise Billing

Recent federal law now protects against surprise billing in some circumstances. Surprise billing – an unexpected balance bill -- can happen when you can't control who is involved in your care—like when you have an emergency or when you schedule a visit at an in-network facility but are unexpectedly treated by an out-of-network provider. Please refer to Appendix D for an important notice regarding Rights and Protections Against Surprise Medical Bills.

SECTION 13: REQUIRED NOTICES

13.1 Mental Health Parity and Addiction Equity Act ("MHPAEA")

Pursuant to the Mental Health Parity and Addiction Equity Act of 2008, this Plan applies its terms uniformly and enforces parity between covered health care benefits and covered mental health and substance disorder benefits relating to financial cost-sharing restrictions and treatment-duration limitations.

13.2 Genetic Information Non-Discrimination Act ("GINA")

This Act makes it illegal for group health plans to deny coverage or charge a higher rate or premium to an otherwise healthy individual found to have a potential genetic condition or genetic predisposition towards a disease or disorder.

13.3 Newborns and Mothers' Health Protection Act ("NMHPA")

Federal law dictates that this Plan may not restrict benefits for any hospital length of stay in connection with childbirth for the mother or newborn child to less than forty-eight (48) hours following a vaginal delivery, or less than ninety-six (96) hours following a delivery by 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 forty-eight (48) hours (or ninety-six (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 forty-eight (48) hours (or ninety-six (96) hours as applicable).

13.4 Women's Health and Cancer Rights Act of 1998 ("WHCRA")

In the case of a participant or beneficiary who is receiving benefits under the Plan in connection with a mastectomy and who elects breast reconstruction, coverage under the Pn will be provided in a manner determined in consultation with the attending physician and the patient, for:

- Reconstruction of the breast on which the mastectomy was performed;
- Surgery and reconstruction of the other breast to produce a symmetrical appearance; and
- Prostheses and treatment of physical complications at all stages of the mastectomy, including lymphedemas.

Under WHCRA, coverage of breast reconstruction benefits may be subject only to deductibles

and coinsurance limitations consistent with those established for other benefits under the Plan.

13.5 Family and Medical Leave Act of 1993 ("FMLA")

The Family and Medical Leave Act (FMLA) is a federal law that provides eligible employees of covered employers with unpaid, job-protected leave for specified family and medical reasons. Eligible employees may take up to 12 workweeks of leave in a 12-month period for one or more of the following reasons:

A. The birth of an employee's child and in order to care for the child;

B. The placement of a child with the employee for adoption or foster care;

C. To care for a spouse, child or parent of the employee where such relative has a serious health condition;

D. The employee's own serious health condition that makes him/her unable to perform the functions of his or her job;

E. The employee has a qualifying exigency arising because the employee's spouse, son, daughter, or parent is on active duty or has been notified of an impending call or order to active duty in the Armed Forces (including the National Guard and Reserves).

13.6 Uniformed Services Employment and Reemployment Rights Act of 1994 ("USERRA")

A Plan Participant who is ordered to active military service is (and the Participant's Eligible Dependent) considered to have experienced a COBRA qualifying event. The affected persons have the right to elect continuation of coverage under either USERRA or COBRA (except that COBRA applies to employer-sponsored group health plans with 20 or more employees, while USERRA applies to all employers).

APPENDIX A. SCHEDULE OF BENEFITS

Refer to Schedule of Benefits provided here with.

APPENDIX B. ADDITIONAL IMPORTANT INFORMATION

Refer to Additional Important Information provided here with.

APPENDIX C. NOTICE OF HIPAA PRIVACY PRACTICES

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

This Notice of Privacy Practices (the "Notice") describes the legal obligations of the Plan and your legal rights regarding your protected health information health by the Plan under the Health Insurance Portability and Accountability Act of 1996 (HIPAA) and the Health Information Technology for Economic and Clinical Health Act (HITECH Act). Among other things, this Notice describes how your protected health information may be used or disclosed to carry out treatment, payment, or health care operations, or for any other purposes that are permitted or required by law.

We are required to provide this Notices of Privacy Practices to you pursuant to HIPAA.

The HIPAA Privacy Rule protects only certain medical information known as "protected health information." Generally, protected health information is health information, including demographic information, collected from you or created or received by a health care provider, a health care clearinghouse, a health plan, or your Plan Sponsor on behalf of a group health plan, from which it is possible to individually identify you and that relates to:

- your past, present, or future physical or mental health or condition;
- the provision of health care to you; or
- the past, present, or future payment for the provision of health care to you.

If you have any questions about this Notice or about our privacy practices, please contact the Plan Administrator.

Effective Date

This Notice if effective the date listed on Page 1 of the SPD.

Our Responsibilities

We are required by law to:

- maintain the privacy of your protected health information;
- provide you with certain rights with respect to your protected health information;
- provide you with a copy of this Notice of your legal duties and privacy practices with respect to your protected health information; and
- follow the terms of the Notice that is currently in effect.

We reserve the right to change the terms of this Notice and to make new provisions regarding your protected health information that we maintain, as allowed, or required by law. If we make any material change to this Notice, we will provide you with a copy of our revised Notice of Privacy Practice electronically or by mail, depending on whether you have agreed to receive electronic communication from the Plan.

How We May Use and Disclose Your Protected Health Information

Under the law, we may use or disclose your protected health information under certain circumstances without your permission. The following categories describe the different ways that we may use and disclose your protected health information. For each category of uses or disclosures we will explain what we mean and present some examples. Not every use or disclosure in a category will be listed. However, all of the ways we are permitted to use and disclose information will fall within one of the categories.

For Treatment. We may use or disclose your protected health information to facilitate medical treatment or services by providers. We 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, we might disclose information about your prior prescriptions to a pharmacist to determine if prior prescriptions contraindicate a pending prescription.

For Payment. We may use or disclose your protected health information to determine your eligibility for Plan benefits, to facilitate payment for the treatment and services you receive from health care providers, to determine benefit responsibility under the Plan, or to coordinate Plan coverage. For example, we may tell your health care provider about your medical history to determine whether a particular treatment is experimental, investigational, or medically necessary, or to determine whether the Plan will cover the treatment. We may also share your protected health information with a utilization review or precertification service provider. Likewise, we may share your protected health information with another entity to assist with the adjudication or subrogation of health claims or to another health plan to coordinate benefit payments.

For Health Care Operations. We may use and disclose your protected health information for other Plan operations. These uses and disclosures are necessary to run the Plan. For example, we may use medical information in connection with conducting quality assessment and improvement activities; underwriting, premium rating, and other activities relating to Plan coverage; submitting claims for stop-loss coverage; conducting or arranging for medical review, legal services, audit services, and fraud and abuse detection programs; business planning and development such as cost management; and business management and general Plan administrative activities. However, we will not use your genetic information for underwriting purposes.

Treatment Alternatives or Health-Related Benefits and Services. We may use and disclose your protected health information to send you information about treatment alternatives or other health-related benefits and services that might be of interest to you.

To Business Associates. We may contract with individuals or entities known as Business Associates to perform various functions on our behalf or to provide certain types of services. In order to perform these functions or to provide these services, Business Associates will receive, create, maintain, transmit, use, and/or disclose your protected health information, but only after they agree in writing with us to implement appropriate safeguards regarding your protected health information. For example, we may disclose your protected health information to a Business Associate to process your claims for Plan benefits or to provide support services, such as utilization

management, pharmacy benefit management, or subrogation, but only after the Business Associate enters into a Business Associate contract with us.

As Required by Law. We will disclose your protected health information when required to do so by federal, state, or local law. For example, we may disclose your protected health information when required by national security laws or public health disclosure laws.

To Avert a Serious Threat to Health or Safety. We may use and disclose your protected health information when necessary to prevent a serious threat to your health and safety, or 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, we may disclose your protected health information in a proceeding regarding the licensure of a physician.

To Plan Sponsors. For the purpose of administering the plan, we may disclose to certain employees of the Plan Sponsor protected health information. However, those employees will only use or disclose that information as necessary to perform plan administration functions or as otherwise required by HIPAA, unless you have authorized further disclosures. Your protected health information cannot be used for employment purposes without your specific authorization.

Special Situations

In addition to the above, the following categories describe other possible ways that we may use and disclose your protected health information without your specific authorization. For each category of uses or disclosures, we will explain what we mean and present some examples. Not every use or disclosure in a category will be listed. However, all of the ways we are permitted to use and disclose information will fall within one of the categories.

Organ and Tissue Donation. If you are an organ donor, we may release your protected health information after your death to organizations that handle organ procurement or organ, eye, or tissue transplantation or to an organ donation bank, as necessary to facilitate organ or tissue donation and transplantation.

Military. If you are a member of the armed forces, we may release your protected health information as required by military command authorities. We may also release protected health information about foreign military personnel to the appropriate foreign military authority.

Workers' Compensation. We may release your protected health information for workers' compensation or similar programs, but only as authorized by, and to the extent necessary to comply with, laws relating to workers' compensation and similar programs that provide benefits for work-related injuries or illness

Public Health Risks. We may disclosure your protected health information for public health activities. These activities generally include the following:

- 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;
- to notify the appropriate government authority if we believe that a patient has been the victim of abuse, neglect, or domestic violence. We will only make this disclosure if you agree, or when required or authorized by law.

Health Oversight Activities. We may disclose your protected health information to a health oversight agency for activities authorized by law. These oversight activities include, for example, audits, investigations, inspections, and licensure. These activities are necessary for the government to monitor the health care system, government programs, and compliance with civil rights laws.

Lawsuits and Disputes. If you are involved in a lawsuit or a dispute, we may disclose your protected health information in response to a court or administrative order. We may also disclose your protected health information in response to a subpoena, discovery request, or other lawful process by someone involved in a legal dispute, but only if efforts have been made to tell you about the request or to obtain a court or administrative order protecting the information requested.

Law Enforcement. We may disclose your protected health information if asked to do so by a law-enforcement official –

- in response to a court order, subpoena, warrant, summons, or similar process;
- to identify or locate a suspect, fugitive, material witness, or missing person;
- about the victim of a crime if, under certain limited circumstances, we are unable to obtain the victim's agreement;
- about a death that we believe may be the result of criminal conduct; and
- about criminal conduct.

Coroners, Medical Examiners, and Funeral Directors. We may release protected health information to a coroner or medical examiner. This may be necessary, for example, to identify a deceased person or determine the cause of death. We may also release medical information about patients to funeral directors, as necessary to carry out their duties.

National Security and Intelligence Activities. We may release your protected health information to authorized federal officials for intelligence, counterintelligence, and other national security activities authorized by law.

Inmates. If you are an inmate of a correctional institution or are in the custody of a law-enforcement official, we may disclose your protected health information to the correctional institution or law-enforcement official, if 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.

Research. We may disclose your protected health information to researchers when:

- the individual identifiers have been removed; or

- when an institutional review board or privacy board has reviewed the research proposal and established protocols to ensure the privacy of the requested information and approves the research.

Required Disclosures

The following is a description of disclosures of your protected health information we are required to make.

Government Audits. We are required to disclose your protected health information to the Secretary of the United States Department of Health and Human Services when the Secretary is investigating or determining our compliance with the HIPAA privacy rule.

Disclosures to You. When you request, we are required to disclose to you the portion of your protected health information that contains medical records, billing records, and any other records used to make decisions regarding your health care benefits. We are also required, when requested, to provide you with an accounting of most disclosures of your protected health information if the disclosure was for reasons other than for payment, treatment, or health care operations, and if the protected health information was not disclosed pursuant to your individual authorization.

Other Disclosures

Personal Representatives. We will disclose your protected health information to individuals authorized by you, or to an individual designated as your personal representative, attorney-in-fact, etc., so long as you provide us with a written notice/authorization and any supporting documents. Note: Under the HIPAA privacy rule, we do not have to disclose information to a personal representative if we have a reasonable belief that:

- you have been, or may be, subject to domestic violence, abuse, or neglect by such person; or
- treating such person as your personal representative could endanger you; and
- in the exercise of professional judgment, it is not in your best interest to treat the person as your personal representative.

Spouses and other Family Members. With only limited exceptions, we will send all mail to the employee. This includes mail relating to the employee's spouse and other family members who are covered under the Plan and includes mail with information on the use of Plan benefits by the employee's spouse and other family members and information on the denial of any Plan benefits to the employee's spouse and other family members. If a person covered under the Plan has requested Restrictions or Confidential Communications, and if we have agreed to the request, we will send mail as provided by the request for Restrictions or Confidential Communications.

Authorizations. Other uses or disclosures of your protected health information not described above will only be made with your written authorization. For example, in general and subject to specific conditions, we will not use or disclose your psychiatric notes; we will not use or disclose your protected health information for marketing; and we will not sell your protected health information, unless you give us a written authorization. You may revoke written authorizations at any time, so long as the revocation is in writing. Once we receive your written revocation, it will only be effective for future uses and disclosures. It will not be effective for any information that may have been used or disclosed in reliance upon the written authorization and prior to receiving your written revocation.

Your Rights

You have the following rights with respect to your protected health information:

Right to Inspect and Copy. You have the right to inspect and copy certain protected health information that may be used to make decisions about your Plan benefits. If the information you request is maintained electronically, and you request an electronic copy, we will provide a copy in the electronic form and format you request, if the information can be readily produced in that form and format; if the information cannot be readily produced in that form and format, we will work with you to come to an agreement on form and format. If we cannot agree on an electronic form and format, we will provide you with a paper copy.

To inspect and copy your protected health information, you must submit your request in writing to the Plan Administrator. If you request a copy of the information, we may charge a reasonable fee for the costs of copying, mailing, or other supplies associated with your request.

We may deny your request to inspect and copy in certain very limited circumstances. If you are denied access to your medical information, you may request that the denial be reviewed by submitting a written request to the Plan.

Right to Amend. If you feel that the protected health information, we have about you is incorrect or incomplete, you may ask us to amend the information. You have the right to request an amendment for 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 the Plan Administrator. In addition, you must provide a reason that supports your request.

We 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, we may deny your request if you ask us to amend information that:

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

If we deny your request, you have the right to file a statement of disagreement with us and any future disclosures of the disputed information will include your statement.

Right to an Accounting of Disclosures. You have the right to request an "accounting" of certain disclosures of your protected health information. The accounting will not include (1) disclosures for purposes of treatment, payment, or health care operations; (2) disclosures made to you; (3) disclosures made pursuant to your authorization; (4) disclosures made to friends or family in your presence or because of an emergency; (5) disclosures for national security purposes; and (6) disclosures incidental to otherwise permissible disclosures.

To request this list or accounting of disclosures, you must submit your request in writing to the Plan Administrator. Your request must state the time period you want the accounting to cover, which may not be longer than six years before the date of the request. 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 provided free of charge. For additional lists, we may charge you for the costs of providing the list. We 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 your protected health information that we use or disclose for treatment, payment, or healthcare operations. You also have the right to request a limit on your protected health information that we disclose 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 we not use or disclose information about a surgery that you had.

Except as provided in the next paragraph, we are not required to agree to your request. However, if we do agree to the request, we will honor the restriction until you revoke it or we notify you.

We will comply with any restriction request if (1) except as otherwise required by law, the disclosure is to a health plan for purposes of carrying out payment or health care operations (and is not for purposes of carrying out treatment); and (2) the protected health information pertains solely to a health care item or service for which the health care provider involved has been paid in full by you or another person.

To request restrictions, you must make your request in writing to the Plan Administrator. In your request, you must tell us (1) what information you want to limit; (2) whether you want to limit our use, disclosure, or both; and (3) to whom you want the limits to apply – for example, disclosures to your spouse.

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

To request confidential communications, you must make your request in writing to the Plan Administrator. We will not ask you the reason for your request. Your request must specify how or where you wish to be contacted. We will accommodate all reasonable requests.

Right to Be Notified of a Breach. You have the right to be notified in the event that we (or a Business Associate) discover a breach of 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 us 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 Plan Administrator.

Complaints

If you believe that your privacy rights have been violated, you may file a complaint with the Plan Administrator or with the Office for Civil Rights of the United States Department of Health and Human Services; see information at its website: www.hhs.gov. All complaints must be submitted in writing.

You will not be penalized, or in any other way retaliated against, for filing a complaint with the Office for Civil Rights or with us.

APPENDIX D. RIGHTS AND PROTECTIONS AGAINST SURPRISE MEDICAL BILLS

Your Rights and Protections Against Surprise Medical Bills

When you get emergency care or are treated by an out-of-network provider at an in-network hospital or ambulatory surgical center, you are protected from balance billing. In these cases, you shouldn't be charged more than your plan's copayments, coinsurance and/or deductible.

What is "balance billing" (sometimes called "surprise billing")?

When you see a doctor or other health care provider, you may owe certain out-of-pocket costs, like a copayment, coinsurance, or deductible. You may have additional costs or have to pay the entire bill if you see a provider or visit a health care facility that isn't in your health plan's network.

"Out-of-network" means providers and facilities that haven't signed a contract with your health plan to provide services. Out-of-network providers may be allowed to bill you for the difference between what your plan pays, and the full amount charged for a service. This is called "**balance billing**", when a provider bills you for the balance remaining on the bill that your plan doesn't cover. This amount is the difference between the actual billed amount and the allowed amount. For example, if the provider's charge is $200 and the allowed amount is $110, the provider may bill you for the remaining $90, depending on if the provider in-network or out of network. This happens most often when you see an out-of-network provider (non-preferred provider0 or have a claim subject to referenced based pricing where an agreement on the fees for the services was not agreed to in advance with the provider. An in-network provider (preferred provider) may not balance bill you for the covered services. This amount is likely more than in-network costs for the same service and might not count toward your plan's deductible or annual out-of-pocket limit.

"Surprise billing" is an unexpected balance bill. This can happen when you can't control who is involved in your care—like when you have an emergency or when you schedule a visit at an in- network facility but are unexpectedly treated by an out-of-network provider. Surprise medical bills could cost thousands of dollars depending on the procedure or service.

You're protected from balance billing for:

Emergency services.

If you have an emergency medical condition and get emergency services from an out-of- network provider or facility, the most they can bill you is your plan's in-network cost-sharing amount (such as copayments, coinsurance, and deductibles). You **can't** be balance billed for these emergency services. This includes services you may get after you're in stable condition unless you give written consent and give up your protections not to be balanced billed for these post-stabilization services.

Certain services at an in-network hospital or ambulatory surgical center.

When you get services from an in-network hospital or ambulatory surgical center, certain providers there may be out-of-network. In these cases, the most those providers can bill you is your plan's in-network cost-sharing amount. This applies to emergency medicine, anesthesia, pathology, radiology, laboratory, neonatology, assistant surgeon, hospitalist, or intensivist services. These providers **can't** balance bill you and may **not** ask you to give up your protections not to be balance billed.

If you get other types of services at these in-network facilities, out-of-network providers **can't** balance bill you, unless you give written consent and give up your protections.

You're never required to give up your protections from balance billing. You also aren't required to get out-of-network care. You can choose a provider or facility in your plan's network.

When balance billing isn't allowed, you also have these protections:

- You're only responsible for paying your share of the cost (like the copayments, coinsurance, and deductible that you would pay if the provider or facility was in-network). Your health plan will pay any additional costs to out-of-network providers and facilities directly.

- Generally, your health plan must:
    - Cover emergency services without requiring you to get approval for services in advance (also known as "prior authorization").
    - Cover emergency services by out-of-network providers.
    - Base what you owe the provider or facility (cost-sharing) on what it would pay an in-network provider or facility and show that amount in your explanation of benefits.
    - Count any amount you pay for emergency services or out-of-network services toward your in-network deductible and out-of-pocket limit.

If you think you've been wrongly billed, contact your plan administrator for more information on your rights. *The federal phone number for information and complaints is: 1-800-985-3059*].

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