School District of Spring Valley
Medical and Prescription Drug Benefit Plan

Plan Document and Summary Plan Description
Effective: July 01, 2023

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ARTICLE I - ESTABLISHMENT OF THE PLAN: ADOPTION OF THE PLAN DOCUMENT AND SUMMARY PLAN DESCRIPTION

THIS PLAN DOCUMENT AND SUMMARY PLAN DESCRIPTION ("Plan Document"), made by **School District of Spring Valley** (the Company" or the "Plan Sponsor") as of July 01, 2023, hereby sets forth the provisions of the School District of Spring Valley Medical and Prescription Drug Benefit Plan (the "Plan"). Any wording which may be contrary to Federal Laws or Statutes is hereby understood to meet the standards set forth in such. Also, any changes in Federal Laws or Statutes which could affect the Plan are also automatically a part of the Plan, if required. This Plan includes a High Deductible Health Plan (HDHP) option, which is intended to meet all Internal Revenue Service (IRS) regulations of a Health Savings Account (HSA)-qualified HDHP.

1.01 Effective Date

The Plan Document is effective as of the date first set forth above, and each amendment is effective as of the date set forth therein (the "Effective Date").

1.02 Adoption of the Plan Document

The Plan Sponsor, as the settlor of the Plan, hereby adopts this Plan Document as the written description of the Plan. This Plan Document represents both the Plan Document and the Summary Plan Description. This Plan Document amends and replaces any prior statement of the health care coverage contained in the Plan or any predecessor to the Plan.

IN WITNESS WHEREOF, the Plan Sponsor has caused this Plan Document to be executed.

School District of Spring Valley

By: _____

Name: John Groh

Title: Superintendent

Date: 12.14.23

ARTICLE II - INTRODUCTION AND PURPOSE; GENERAL PLAN INFORMATION

2.01 Introduction and Purpose

The Plan Sponsor has established the Plan for the benefit of eligible Employees, in accordance with the terms and conditions described herein. Plan benefits are self-funded through a benefit fund established by the Plan Sponsor with contributions from Participants and/or the Plan Sponsor. The Plan's benefits and administration expenses are paid directly from the Employer's general assets. Participants in the Plan may be required to contribute toward their benefits. Contributions received from Participants are used to cover Plan costs and are expended immediately.

The Plan Sponsor's purpose in establishing the Plan is to help offset, for eligible Employees, the economic effects arising from a non-occupational injury or illness. To accomplish this purpose, the Plan Sponsor must be cognizant of the necessity of containing health care costs through effective plan design, and of abiding by the terms of the Plan Document, to allow the Plan Sponsor to allocate the resources available to help those individuals participating in the Plan to the maximum feasible extent.

The purpose of this Plan Document is to set forth the terms and provisions of the Plan that provide for the payment or reimbursement of all or a portion of certain expenses for eligible benefits. The Plan Document is maintained by **School District of Spring Valley** and may be inspected at any time during normal working hours by any Participant.

2.02 General Plan Information

Name of Plan:
School District of Spring Valley Medical and Prescription Drug Benefit Plan

Plan Sponsor:
School District of Spring Valley
S1450 County Rd CC
Spring Valley WI 54767
Phone: 1-715-778-5551
Website: www.springvalley.k12.wi.us

Plan Administrator:
(Named Fiduciary)
School District of Spring Valley
S1450 County Rd CC
Spring Valley WI 54767
Phone: 1-715-778-5551
Website: www.springvalley.k12.wi.us

Plan Sponsor ID No. (EIN):
39-6004579

Source of Funding:
Self-Funded

Plan Status:
Non-Grandfathered

Applicable Law:
Federal and State of Wisconsin

Plan Year:
July 1 through June 30

Plan Type:
Medical
Prescription Drug

Third Party Administrator:
Prairie States Enterprises, Inc.

Mailing Address:
P.O. Box 23
Sheboygan, WI 53082-0023

Street Address:
615 Pennsylvania Ave
Sheboygan, WI 53082-0023

Phone: 800-615-7020
Local Phone: 920-451-7020
Fax: 920-451-7023
Website: www.prairieontheweb.com

Prescription Drug Plan Administrator:
Liviniti
Phone: 1-800-710-9341
Website: www.liviniti.com

Utilization Review Manager:
Prairie States Enterprises, Inc.
615 Pennsylvania Ave
Sheboygan WI 53081
Phone: 1-800-615-7020
Website/Email: www.prairieontheweb.com

Participating Employer(s):
Phone: 1-715-778-5551

Agent for Service of Process:
School District of Spring Valley
S1450 County Rd CC
Spring Valley WI 54767
Phone: 1-715-778-5551
Website: www.springvalley.k12.wi.us

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

2.03 Non-English Language Notice

This Plan Document contains a summary in English of a Participant's plan rights and benefits under the Plan. If a Participant has difficulty understanding any part of this Plan Document, he or she may contact the Plan Administrator at the contact information above.

2.04 Legal Entity; Service of Process

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

2.05 Not a Contract

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

2.06 Non-Discrimination

No eligibility rules or variations in contribution amounts will be imposed based on an eligible Employee's and his or her Dependent's/Dependents' health status, medical condition, claims experience, receipt of health care, medical history, genetic information, evidence of insurability, disability, or any other health status related factor. Coverage under this Plan is provided regardless of an eligible Employee's and his or her Dependent's/Dependents' race, color, national origin, disability, age, sex, gender identity or sexual orientation. Variations in the administration, processes or benefits of this Plan that are based on clinically indicated reasonable medical management practices, or are part of permitted wellness incentives, disincentives and/or other programs do not constitute discrimination.

2.07 Applicable Law

This Plan is a governmental (sponsored) plan and as such it is exempt from the requirements of the Employee Retirement Income Security Act of 1974 (also known as ERISA), which is a Federal law regulating Employee welfare and pension plans. The Participants' rights in the Plan are governed by the plan documents and applicable State law and regulations.

2.08 Discretionary Authority

To the extent allowed by law, the Plan Administrator shall have sole, full and final discretionary authority to interpret all Plan provisions, including the right to remedy possible ambiguities, inconsistencies and/or omissions in the Plan and related documents; to make determinations in regards to issues relating to eligibility for benefits; to decide disputes that may arise relative to a Participant's rights; and to determine all questions of fact and law arising under the Plan.

ARTICLE III - DEFINITIONS

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

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

"Accident"
"Accident" shall mean a sudden and unforeseen event, or a deliberate act resulting in unforeseen consequences.

"Accidental Bodily Injury" or "Accidental Injury"
"Accidental Bodily Injury" or "Accidental Injury" shall mean an Injury sustained as the result of an Accident, due to an outside traumatic event, or due to exposure to the elements.

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

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

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

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

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

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

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

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

"Alternate Recipient"
"Alternate Recipient" shall mean any Child of a Participant who is recognized under a Medical Child Support Order as having a right to enrollment under this Plan as the Participant's eligible Dependent. For purposes of the benefits provided under this Plan, an Alternate Recipient shall be treated as an eligible Dependent.

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

"Ambulatory Surgical Center"
"Ambulatory Surgical Center" shall mean any public or private State licensed and approved (whenever required by law) establishment with an organized medical staff of Physicians, with permanent facilities that are equipped and operated primarily for the purpose of performing Surgical Procedures, with continuous Physician services and registered professional nursing service whenever a patient is in the facility, and which does not provide service or other accommodations for patients to stay overnight.

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

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

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

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

"Autism Spectrum Disorder(s)"
"Autism Spectrum Disorder(s)" shall mean any of the pervasive developmental disorders defined by the most recent edition of the Diagnostic and Statistical Manual of Mental Disorders (DSM), or its successor, including Autistic Disorder, Asperger's disorder and Pervasive Development Disorders Not Otherwise Specified (PDDNOS).

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

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

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

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

"Center(s) of Excellence"
"Center(s) of Excellence" shall mean medical care facilities that have met stringent criteria for quality care in the specialized procedures of organ transplantation. These centers have the greatest experience in performing transplant procedures and the best survival rates. The Plan Administrator shall determine what Network Centers of Excellence are to be used.

Any Participant in need of an organ transplant may contact the Third-Party Administrator to initiate the Pre-Certification process resulting in a referral to a Center of Excellence. The Third-Party Administrator acts as the primary liaison with the Centers of Excellence, patient and attending Physician for all transplant admissions taking place at a Center of Excellence.

If a Participant chooses not to use a Center of Excellence, the payment for services will be limited to what would have been the cost at the nearest Centers of Excellence.

Additional information about this option, as well as a list of Centers of Excellence, will be given to covered Employees and updated as requested.

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

"Child" and/or "Children"
"Child" and/or "Children" shall mean, in addition to the Employee's own blood descendant of the first degree or lawfully adopted Child, a Child placed with a covered Employee in anticipation of adoption, a covered Employee's Child who is an Alternate Recipient under a Qualified Medical Child Support Order as required by the Federal Omnibus Budget Reconciliation Act of 1993, any stepchild, an "eligible foster child," which is defined as an individual placed with the Employee by an authorized placement agency or by judgment, decree or other order of a court of competent jurisdiction or any other Child for whom the Employee has obtained legal guardianship. A "legal guardian" is a person recognized by a court of law as having the duty of taking care of the person and managing the property and rights of a minor child.

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

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

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

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

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

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

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

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

"Coinsurance"
"Coinsurance" shall mean a specific percentage amount of the Maximum Allowable Charge, set forth in the Summary of Benefits, for which the Participant is responsible after the deduction of a Deductible or Copayment, if applicable.

"Complementary and Alternative Medicine (CAM)"
"Complementary and Alternative Medicine (CAM)" shall mean any charge for holistic medicine or other programs with an objective to provide complete personal fulfillment. Including, but not limited to: rolfing, colon therapy, homeopathy, reiki, or visualization sessions.

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

"Cosmetic Surgery"
"Cosmetic Surgery" shall mean any Surgery, service, Drug or supply designed to improve the appearance of an individual by alteration of a physical characteristic which is within the broad range of normal but which may be considered unpleasing or unsightly, except when necessitated by an Injury.

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

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

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

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

"Dentist"
"Dentist" shall mean an individual holding a D.D.S. or D.M.D. degree, licensed to practice dentistry in the jurisdiction where such services are provided.

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

1. An Employee's present spouse, married within the parameters set by applicable law, and thereby possessing a valid marriage license, not annulled or voided in any way. A Dependent spouse shall therefore not be one whom is divorced or Legally Separated from the Employee and/or considered a Domestic Partner.
2. An Employee's Child who is less than 26 years of age. ***NOTE:*** *Coverage for a Dependent Child will continue until the end of the calendar month he or she turns 26 years of age*.
3. An Employee's Child, regardless of age, who was continuously covered prior to attaining the limiting age as stated in the numbers above, who is mentally or physically incapable of sustaining his or her own living. Such Child must have been mentally or physically incapable of earning his or her own living prior to attaining the limiting age as stated in the numbers above. Written proof of such incapacity and dependency satisfactory to the Plan must be furnished and approved by the Plan within 31 days after the date the Child attains the limiting age as stated in the numbers above. The deadline for submission of written proof of incapacity and dependency is 31 days following the original eligibility date for a new or re-enrolling Employee. The Plan may require, at reasonable

intervals, subsequent proof satisfactory to the Plan during the next two years after such date. After such two-year period, the Plan may require such proof, but not more often than once each year.

An Employee's spouse who is a resident of a country other than the United States shall not be deemed to be a "Dependent."

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

"Developmental Delay"
"Developmental delay" refers only to children between the ages of zero (0) and eight (8) years. It is a primary area of exceptionality when the cause of a child's developmental lag is unknown.

Developmental delay is defined as a condition which represents a significant delay in the process of development. It does not refer to a condition in which the child is slightly or momentarily lagging in development. The presence of developmental delay is an indication that the process of development is significantly affected, and that without special intervention it is likely that the child's ability to attain normal developmental milestones and educational performance at school would be jeopardized. Normal development falls within a range and children whose maturation falls outside this range could be provided with special education supports. More precisely these children have skills deficits including specific delays in language, perception, meta-cognition, and social, emotional and/or motor development.

"Diagnosis"
"Diagnosis" shall mean the act or process of identifying or determining the nature and cause of an Illness or Injury through evaluation of patient history, examination, and review of laboratory data. Diagnosis shall also mean the findings resulting from such act or process.

"Diagnostic Service"
"Diagnostic Service" shall mean a test or procedure performed for specified symptoms to detect or to monitor an Illness. It must be ordered by a Physician or other professional Provider.

"Drug"
"Drug" shall mean insulin and prescription legend drugs. A prescription legend drug is a Federal legend drug (any medicinal substance which bears the legend: "Caution: Federal law prohibits dispensing without a prescription") or a State restricted drug (any medicinal substance which may be dispensed only by prescription, according to State law) and which, in either case, is legally obtained from a licensed drug dispenser only upon a prescription of a currently licensed Physician.

"Durable Medical Equipment"
"Durable Medical Equipment" shall mean equipment which meets all of the following requirements:

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

"Embedded Deductible"
An "Embedded Deductible" means each covered family member only needs to satisfy his or her individual deductible, not the entire family deductible, prior to receiving plan benefits.

"Emergency"
"Emergency" shall mean a situation where necessary treatment is required as the result of a sudden and severe medical event or acute condition. An Emergency includes poisoning, shock, and hemorrhage. Other Emergencies and acute conditions may be considered on receipt of proof, satisfactory to the Plan per the

Plan Administrator's discretion, that an Emergency did exist. The Plan may, at its own discretion, request satisfactory proof that an Emergency or acute condition did exist.

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

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

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

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

"Employee"
"Employee" shall mean a person who is employed by the Employer on a full-time basis and regularly scheduled to work an average of at least 30 hours per week (i.e., Non-Variable Hour Employee) or a Variable Hour Employee who has averaged at least 30 hours per week or 130 hours per month for a complete Measurement Period and is currently in a Stability Period, as determined by the Plan Sponsor. An Employee will remain eligible throughout the Stability Period regardless of a change in employment status (including, but not limited to, a reduction in hours) provided the individual continues to be an employee in accordance with the Patient Protection and Affordable Care Act (as amended).

The following definitions are associated with the Code Section 4980H (Employer Shared Responsibility) as enacted under the Affordable Care Act:

> **Administrative Period** shall mean a period of time selected by the Employer beginning immediately following the end of the Measurement Period and ending immediately before the start of the associated Stability Period. This period of time is used by the Employer to determine if Variable Hour Employees and/or Ongoing Employees are eligible for coverage and, if so, to make an offer of coverage. The Administrative Period also includes the period between a new Employee's start date and the beginning of the Initial Measurement Period,

if the Initial Measurement Period does not begin on the employee's start date. An Administrative Period may not exceed 90 days.

Full-Time Employee or Full-Time Employment shall mean with respect to a calendar month, an Employee who is employed an average of at least 30 hours per week with the Employer.

Hour of Service shall mean each hour for which an Employee is paid, or entitled to payment, for the performance of duties for the employer; and each hour for which an Employee is paid, or entitled to payment by the employer for a period of time during which no duties are performed due to vacation, holiday, Illness, incapacity (including disability), layoff, jury duty, military duty or leave of absence.

Measurement Period shall mean a period of time selected by the Employer during which Variable Hour Employee's and/or Ongoing Employee's Hours of Service are tracked to determine your employment status for benefit purposes.

Initial Measurement Period - for a newly hired Variable Hour Employee, this Measurement Period will start from the date of hire and ends after 12 consecutive months of service.

Standard Measurement Period - for Ongoing Employees, this Measurement Period will start on May 1st each year and will last for 12 consecutive months.

New Employee shall mean an Employee who has not been employed for at least one complete Standard Measurement Period, or who is treated as a New Employee following a period during which the Employee was credited with zero Hours of Service.

Non-Variable Hour Employee shall mean an Employee reasonably expected at the time of hire to work 30 hours per week.

Ongoing Employee shall mean an Employee who has been employed by the Employer for at least one complete Measurement Period.

Stability Period shall mean a period selected by the Employer that immediately follows, and is associated with, a Standard Measurement Period or an Initial Measurement Period (and, if elected by the Employer, the Administrative Period associated with that Standard Measurement Period or Initial Measurement Period), and is used by the Employer as part of the Look-back Measurement Method. The Stability Period is 12 period in which the Variable Hour Employee's and/or Ongoing Employee's eligibility status is fixed.

Variable Hour Employee shall mean an Employee, based on the facts and circumstances at the Employee's start date, whose reasonable expectation of average hours per week cannot be determined.

"Employer"
"Employer" is School District of Spring Valley.

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

The determination of which benefits provided under the plan are Essential Health Benefits shall be made in accordance with the benchmark plan of the State of Utah as permitted by the Departments of Labor, Treasury, and Health and Human Services.

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

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

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

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

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

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

3. If reliable evidence shows that the consensus among experts regarding the drug, device, or medical treatment or procedure is that further studies or clinical trials are necessary to determine all of the following:

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

Reliable evidence shall mean one or more of the following:

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

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

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

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

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

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

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

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

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

"FMLA Leave"
"FMLA Leave" shall mean a Leave of Absence, which the Company is required to extend to an Employee under the provisions of the FMLA.

"Genetic Test(ing)"
"Genetic Test(ing)" shall mean a test to examine the genetic information contained inside a person's cells, called deoxyribonucleic acid (DNA), to determine if that person has or will develop a certain Disease or could pass a Disease to his or her offspring. Genetic tests also determine whether or not couples are at a higher risk than the general population for having a child affected with a genetic disorder.

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

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

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

"High Deductible Health Plan (HDHP)"
"High Deductible Health Plan" shall mean a health plan which has to meet specific federal rules. Participants in a High Deductible Health Plan may be able to put money into a Health Savings Account or health reimbursement arrangement to help pay for health care. The plan Deductible applicable for such plans is generally higher than that of a standard health plan.

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

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

1. The institutionalization of the individual would otherwise have been required if Home Health Care was not provided.
2. The Home Health Care is the result of an Illness or Injury.

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

1. Is approved as a Home Health Care Agency under Medicare.
2. Is established and operated in accordance with the applicable laws in the jurisdiction in which it is located and, where licensing is required, has been licensed and approved by the regulatory authority having the responsibility for licensing.
3. Meets all of the following requirements:

    a. It is an agency which holds itself forth to the public as having the primary purpose of providing a Home Health Care delivery system bringing supportive services to the home.
    b. It has a full-time administrator.
    c. It maintains written records of services provided to the patient.
    d. Its staff includes at least one Registered Nurse (R.N.) or it has nursing care by a Registered Nurse (R.N.) available.
    e. Its employees are bonded and it provides malpractice insurance.

"Hospital"
"Hospital" shall mean an Institution that meets all of the following requirements:

1. It provides medical and surgical facilities for the treatment and care of Injured or Sick persons on an Inpatient basis.
2. It is under the supervision of a staff of Physicians.
3. It provides 24 hour a day nursing service by Registered Nurses.
4. It is duly licensed as a Hospital, except that this requirement will not apply in the case of a State tax supported Institution.
5. It is not, other than incidentally, a place for rest, a place for the aged, a nursing home or a custodial or training type Institution, or an Institution which is supported in whole or in part by a Federal government fund.
6. It is accredited by the Joint Commission on Accreditation of Hospitals sponsored by the AMA and the AHA.

The requirement of surgical facilities shall not apply to a Hospital specializing in the care and treatment of mentally ill patients, provided such Institution is accredited as such a facility by the Joint Commission on Accreditation of Hospitals sponsored by the AMA and the AHA.

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

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

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

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

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

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

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

"Inpatient"
"Inpatient" shall mean any person who, while confined to a Hospital, is assigned to a bed in any department of the Hospital other than its outpatient department and for whom a charge for Room and Board is made by the Hospital.

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

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

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

"Leave of Absence"
"Leave of Absence" shall mean a Leave of Absence of an Employee that has been approved by his or her Participating Employer, as provided for in the Participating Employer's rules, policies, procedures and practices.

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

"Mastectomy"
"Mastectomy" shall mean the surgical removal of all or part of a breast.

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

For claims subject to the No Surprises Act (see "No Surprises Act – Emergency Services and Surprises Bills" within the section "Summary of Benefits,") if no negotiated rate exists, the Maximum Allowable Charge will be:

- An amount determined by an applicable all-payer model agreement; or
- If no such amount exists, an amount determined by applicable state law; or
- If neither such amount exists, an amount deemed payable by a Certified IDR Entity or a court of competent jurisdiction, if applicable.

If none of the above factors is applicable, the Plan Administrator will exercise its discretion to determine the Maximum Allowable Charge based on any of the following: Medicare reimbursement rates, Medicare cost data, amounts actually collected by Providers in the area for similar services, or average wholesale price (AWP) or manufacturer's retail pricing (MRP). These ancillary factors will take into account generally-accepted billing standards and practices.

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

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

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

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

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

1. Its purpose must be to restore health.
2. It must not be primarily custodial in nature.
3. It is ordered by a Physician for the Diagnosis or treatment of a Sickness or Injury.
4. The Plan reserves the right to incorporate CMS guidelines in effect on the date of treatment as additional criteria for determination of Medical Necessity and/or a Covered Expense.

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

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

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

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

3. The Drug is otherwise Medically Necessary to treat the specific condition, including life threatening conditions or chronic and seriously debilitating conditions.

“Medicare”
“Medicare” shall mean the program of health care for the aged established by Title XVIII of the Social Security Act of 1965, as amended.

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

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

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

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

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

“Non-Embedded Deductible”
A “Non-Embedded Deductible” means for Family coverage, the entire Family Annual Deductible must be met before co- pay or Coinsurance is applied for any individual family member.

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

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

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

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

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

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

"Out-of-Pocket" or "Out-of-Pocket Maximum"
"Out-of-Pocket" or "Out-of-Pocket Maximum" shall mean a dollar amount paid by the Participant which includes Deductible amounts, Coinsurance amounts. It does not include penalties for failure to obtain Pre-Certification, amounts in excess of the Maximum Allowable Charge, and charges for non-covered services. If a Family Unit is on the plan, the overall family Out-of-Pocket limit must be met.

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

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

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

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

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

"Physician"
"Physician" shall mean a Doctor of Medicine (M.D.), Doctor of Osteopathy (D.O.), Doctor of Dental Surgery (D.D.S.), Doctor of Podiatry (D.P.M.), Doctor of Chiropractic (D.C.), Psychologist (Ph.D.), psychiatrist or midwife.

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

"Pre-Admission Tests"
"Pre-Admission Tests" shall mean those Diagnostic Services done prior to a scheduled Surgery, provided that all of the following requirements are met:

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

"Pregnancy"
"Pregnancy" shall mean carrying a child, resulting childbirth, miscarriage and/or non-elective abortion. The Plan considers Pregnancy as a Sickness for the purpose of determining benefits.

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

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

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

Copies of the recommendations and guidelines may be found at the following websites:
https://www.healthcare.gov/coverage/preventive-care-benefits/;
https://www.uspreventiveservicestaskforce.org/uspstf/recommendation-topics/uspstf-a-and-b-recommendations;
https://www.cdc.gov/vaccines/hcp/acip-recs/index.html;
https://www.aap.org/en-us/Documents/periodicity_schedule.pdf;
https://www.hrsa.gov/womensguidelines/.
For more information, Participants may contact the Plan Administrator / Employer.

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

"Prior to Effective Date" or "After Termination Date"
"Prior to Effective Date" or "After Termination Date" are dates occurring before a Participant gains eligibility from the Plan, or dates occurring after a Participant loses eligibility from the Plan (unless continuation of benefits applies).

“Primary Care Physician (PCP)”
“Primary Care Physician” shall mean family practitioners, general practitioners, internists, OBGYNs, pediatricians, and office-based nurse practitioners, physician’s assistants, licensed professional counselors, licensed certified professional counselors, certified chemical dependency counselors, or licensed clinical social workers.

“Privacy Standards”
“Privacy Standards” shall mean the applicable standards for the privacy of individually identifiable health information, pursuant to HIPAA.

“Provider”
“Provider” shall mean a Physician, a licensed speech or occupational therapist, licensed professional physical therapist, physiotherapist, audiologist, speech language pathologist, licensed professional counselor, certified nurse practitioner, certified psychiatric/mental health clinical nurse, or other practitioner or facility defined or listed herein, or approved by the Plan Administrator. All facilities must meet the standards as set forth within the applicable definitions of the Plan as it relates to the relevant provider type.

“Psychiatric Hospital”
“Psychiatric Hospital” shall mean an Institution constituted, licensed, and operated as set forth in the laws that apply to Hospitals, which meets all of the following requirements:

1. It is primarily engaged in providing psychiatric services for the Diagnosis and treatment of mentally ill persons either by, or under the supervision of, a Physician.
2. It maintains clinical records on all patients and keeps records as needed to determine the degree and intensity of treatment provided.
3. It is licensed as a Psychiatric Hospital.
4. It requires that every patient be under the care of a Physician.
5. It provides 24 hour a day nursing service.

The term Psychiatric Hospital does not include an Institution, or that part of an Institution, used mainly for nursing care, rest care, convalescent care, care of the aged, Custodial Care or educational care.

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

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

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

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

“Rehabilitation Hospital”
“Rehabilitation Hospital” shall mean an Institution which mainly provides therapeutic and restorative services to Sick or Injured people. It is recognized as such if:

1. It carries out its stated purpose under all relevant Federal, State and local laws.
2. It is accredited for its stated purpose by either the Joint Commission on Accreditation of Hospitals or the Commission on Accreditation for Rehabilitation Facilities.
3. It is approved for its stated purpose by Medicare.

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

“Retrospective Review”
“Retrospective Review” shall mean a determination by the Utilization Review Manager that medical services performed either Inpatient or Outpatient met criteria for Medical Necessity.

“Room and Board”
“Room and Board” shall mean a Hospital’s charge for any of the following:

1. Room and linen service.
2. Dietary service, including meals, special diets and nourishment.
3. General nursing service.
4. Other conditions of occupancy which are Medically Necessary.

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

“Service Waiting Period”
“Service Waiting Period” shall mean an interval of time during which the Employee is in the continuous, Active Employment of his or her Participating Employer.

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

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

“Specialty Drug(s)”
“Specialty Drug(s)” shall mean high-cost prescription medications used to treat complex, chronic conditions including, but not limited to, cancer, rheumatoid arthritis and multiple sclerosis. Specialty Drugs often require special handling (like refrigeration during shipping) and administration (such as injection or infusion). Please contact the Prescription Drug Plan Administrator to determine specific drug coverage.

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

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

“Substance Abuse Treatment Center”
“Substance Abuse Treatment Center” shall mean an Institution which provides a program for the treatment of Substance Abuse monitored by a Physician. This Institution must meet one or more of the following requirements:

1. Affiliated with a Hospital under a contractual agreement with an established system for patient referral.
2. Accredited as such a facility by the Joint Commission on Accreditation of Hospitals.
3. Licensed, certified or approved as an alcohol or Substance Abuse treatment program or center by a State agency having legal authority to do so.

“Surgery”
“Surgery” is performed for the purpose of structurally altering the human body by incision or destruction of tissues and is part of the practice of medicine.

Surgery also is the diagnostic or therapeutic treatment of conditions or Disease processes by any instruments causing localized alteration or transportation of live human tissue, which include lasers, ultrasound, ionizing radiation, scalpels, probes, and needles. The tissue can be cut, burned, vaporized, frozen, probed and manipulated, or otherwise altered by any mechanical means. All of these surgical procedures are invasive, including those that are performed with lasers, and the risks of any surgical intervention are not eliminated by using a light knife or laser in place of a metal knife or scalpel.

Cryotherapy, cyberknife radiotherapy, and robotic radio surgery, a non-invasive alternative to Surgery for the treatment of cancerous and non-cancerous tumors is also considered Surgery.

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

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

“Uniformed Services”
“Uniformed Services” shall mean the Armed Forces, the Army National Guard and the Air National Guard, when engaged in active duty for training, inactive duty training, or full-time National Guard duty, the

commissioned corps of the Public Health Service, and any other category of persons designated by the President of the United States in time of war or Emergency.

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

"Utilization Review Manager"
"Utilization Review Manager" shall mean a team of medical care professionals selected to conduct pre-certification review, emergency admission review, continued stay review, discharge planning, patient consultation, and case management. For more information, see the Utilization Management section of this document.

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

ARTICLE IV - ELIGIBILITY FOR COVERAGE

4.01 Eligibility for Individual Coverage

Each Non-Variable Hour Employee will become eligible for coverage under this Plan with respect to himself or herself on the first of the month following the start date of employment.

Each Variable Hour Employee who has averaged the requisite Hours of Service, as defined herein, will become eligible for coverage under this Plan with respect to himself or herself upon completion of a complete Measurement Period. Coverage shall begin on the first day of the Stability Period, as defined herein.

Each Employee who was covered under the Prior Plan, if any, will be eligible on the Effective Date of this Plan. Any Service Waiting Period or portion thereof satisfied under the Prior Plan, if any, will be applied toward satisfaction of the Service Waiting Period of this Plan.

If an Employee meets the eligibility requirements during a Measurement Period, then the Employee will remain eligible throughout the entire Stability Period that follows, regardless of a change in employment status (including, but not limited to, a reduction in hours) provided the individual continues to be an Employee in accordance with the Affordable Care Act (as amended). However, there is an **exception** to this rule. Please see the requirements for this exception in the Change in Employment Status Exception section below.

Change in Employment Status Exception

There is a special treasury rule under 26 CFR 54.4980H-3(f)(2) that provides for the following:

If an Employee who has had minimum value coverage continuously offered to them, and that Employee's employment status changes within a Stability Period, then the Employee may become ineligible for coverage within that Stability Period if the following are met:

1. The Employee was offered minimum value coverage by the first day of the calendar month following the Employee's initial three full calendar months of employment through the calendar month in which the change in employment status occurs;

2. The Employee changes employment status such that, if the Employee had begun employment in the new position or status, the Employee would have reasonably been expected not to be employed on average at least thirty hours of service per week (i.e., changes from full-time to part-time);

3. The Employee actually averages less than thirty hours of service per week for each of the three full calendar months following the change in employment status.

If the above applies, the monthly measurement method can be utilized to determine full-time status on the first day of the fourth full calendar month following the calendar month in which the Employee experiences a change in employment status (even if the Employer does not apply the monthly measurement method to the other Employees in the same category of employees).

The Employer may continue to apply the monthly measurement method through the end of the first full Measurement Period (and any associated Administrative Period) that would have applied had the Employee remained under the applicable look-back measurement method. If the Employee is not averaging at least thirty hours during any of those given months, the Employee would not be eligible for coverage during those months.

NOTE: *For the three full calendar months between the Employee's change in employment status and the application of the monthly measurement method, the Employee's full-time Employee status is determined based on the Employee's status during the applicable Stability Period(s).*

4.01A Reinstatement of Coverage

A covered Employee who is terminated and rehired will be treated as a New Employee upon rehire only if the Employee was not credited with an Hour of Service with the Employer (or any member of the controlled or affiliated group) for a period of at least 26 consecutive weeks immediately preceding the date of rehire or, if less, a period of consecutive weeks that exceeds the greater of (a) four weeks, or (b) the number of weeks of the Employee's immediately preceding period of employment.

A Variable Hour Employee who is terminated and rehired will be treated as a continuing Employee upon rehire only if the Employee break in service did not exceed 26 weeks and the Employee was a covered Employee immediately prior to termination.

Upon return, coverage will be reinstated first of the month following the date of rehire, so long as all other eligibility criteria are satisfied.

4.01B Eligibility for Retiree Coverage

A person is eligible for Retiree coverage from the first day that he or she meets one of the following requirements:

1. Is a retired Employee of the Employer, enrolled in coverage and retired prior to July 1, 2023.
2. Is an Active Employee who is eligible for retirement under the Plan, having a minimum of two consecutive years of employment and is age 55 and over, but not Medicare Eligible. Spouses and Dependents of a Retiree are also eligible provided they meet the requirements stated in the section entitled "Eligibility for Dependent Coverage."

Retirees are eligible for coverage until Medicare eligibility.

Retiree coverage will be paid for by the Retiree. Rates will be the total COBRA rate.

4.02 Eligibility Dates for Dependent Coverage

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

1. His or her date of eligibility for coverage for himself or herself under the Plan.
2. The date coverage for his or her Dependents first becomes available under any amendment to the Plan, if such coverage was not provided under the Plan on the Effective Date of the Plan.
3. The first date upon which he or she acquires a Dependent.
4. If applicable, for a Dependent Child, the date the Dependent Child becomes eligible due to a qualifying status change event, as outlined in the Section 125 plan.

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

In order for an Employee's Dependent to be covered under the Plan the Employee must be enrolled for coverage under the Plan.

4.03 Effective Dates of Coverage; Conditions

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

1. Enrollment Application (paper or electronic as applicable). Coverage for an Employee or his or her Dependents must be requested by the Employee on a form (either paper or electronic as applicable) furnished by the Plan Administrator and will become effective on the date such Employee or Dependents are eligible, provided the Employee has enrolled for such coverage on a form satisfactory to the Plan Administrator within the 31-day period immediately following the date of eligibility.

2. Birth of Dependent Child. A newborn Child of a covered Employee will be considered eligible and will be covered from the moment of birth for a period of 60 days only. Except as provided in "Newly Acquired Dependents," below, for coverage to continue beyond this period, the Employee must submit a written application to the Plan to enroll the Child within the limited 60-day period (i.e., period from the moment of birth). The application must also be accompanied by any required contribution, ongoing, as the case may be. A newborn Child of a Dependent Child is not eligible for this Plan unless the newborn Child meets the definition of an eligible Dependent.
3. Newly Acquired Dependents. If while an Employee is enrolled for coverage, that Employee acquires a Dependent, coverage for the newly acquired Dependent shall be effective on the date the Dependent becomes eligible only if the existing coverage extends to Dependents and written application is made within 60 days. If coverage for Dependents has not already been secured by the Employee, a written application must be made to the Plan within 60 days of the date of the newly acquired Dependent's initial eligibility, and any required contributions must be made if enrollment is otherwise approved by the Plan Administrator.
4. Requirement for Employee Coverage. No coverage for Dependents of an Employee will become effective unless the Employee is, or simultaneously becomes, eligible for coverage for themselves under the Plan.
5. Coverage as Both Employee and Dependent. No person may be simultaneously covered under this Plan as both an Employee and a Dependent.
6. Medicaid Coverage. An individual's eligibility for any State Medicaid benefits will not be taken into account by the Plan in determining that individual's eligibility under the Plan.
7. FMLA Leave. Regardless of any requirements set forth in the Plan, the Plan shall at all times comply with FMLA.

4.04 Special and Open Enrollment

The Plan provides special enrollment periods that allow Employee's to enroll in the Plan, even if they declined enrollment during an initial or subsequent eligibility period.

4.04A Loss of Other Coverage

If an Employee declined enrollment for himself or herself or his or her Dependents (including his or her spouse) because of other health coverage, he or she may enroll for coverage for himself or herself and/or his or her Dependents if the other health coverage is lost. The Employee must make written application for special enrollment within 31 days of the date the other health coverage was lost. For example, if the Employee loses his or her other health coverage on September 15, he or she must notify the Plan Administrator and apply for coverage by close of business on October 16.

The following conditions apply to any eligible Employee and Dependents:

An Employee may enroll during this special enrollment period if the following requirements are met:

1. If the Employee is eligible for coverage under the terms of this Plan.
2. The Employee is not currently enrolled under the Plan.
3. When enrollment was previously offered, the Employee declined because of coverage under another group health plan or health insurance coverage. The Employee must have provided a written statement that other health coverage was the reason for declining enrollment under this Plan.
4. If the other coverage was terminated due to loss of eligibility for the coverage (including due to Legal Separation, divorce, death, termination of employment, or reduction in the number of hours), or because employer contributions for the coverage were terminated.

The Employee is not eligible for this special enrollment right if:

1. The other coverage was COBRA Continuation Coverage and the Employee did not exhaust the maximum time available to him or her for that COBRA coverage.

2. The other coverage was lost due to non-payment of requisite contribution / premium or for cause (such as making a fraudulent claim or an intentional misrepresentation of a material fact in connection with the Other Plan).

If the conditions for a loss of other coverage special enrollment are satisfied, coverage for the Employee and/or his or her Dependent(s) will be effective at 12:01 A.M. on the first day following the loss of other coverage.

4.04B New Dependent

If an Employee acquires a new Dependent as a result of marriage, legal guardianship, a foster child being placed with the Employee, birth, adoption, or placement for adoption, he or she may be able to enroll himself or herself and his or her Dependents during a special enrollment period. The Employee must make written or electronic application, as applicable, for special enrollment no later than 31 days after he or she acquires the new Dependent. For example, if the Employee is married on September 15, he or she must notify the Plan Administrator and apply for coverage by close of business on October 16.

The following conditions apply to any eligible Employee and Dependents:

An Employee may enroll himself or herself and/or his or her eligible Dependents during this special enrollment period if both of the following conditions are met:

1. The Employee is eligible for coverage under the terms of this Plan.
2. The Employee has acquired a new Dependent through marriage, legal guardianship, a foster child being placed with the Employee, birth, adoption, or placement for adoption.

If the conditions for a new Dependent special enrollment are satisfied, coverage for the Employee and his or her Dependent(s) will be effective at 12:01 A.M. for the following events:

1. For a marriage, on the date of the marriage.
2. For a legal guardianship, on the date on which such Child is placed in the covered Employee's home pursuant to a court order appointing the covered Employee as legal guardian for the Child.
3. In the case of a foster child being placed with the Employee, on the date on which such Child is placed with the Employee by an authorized placement agency or by judgment, decree or other order of a court of competent jurisdiction.
4. For a birth, on the date of birth.
5. For an adoption or placement for adoption, on the date of the adoption or placement for adoption.

4.04C Additional Special Enrollment Rights

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

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

If the conditions for additional special enrollment rights are satisfied, coverage for the Employee and/or his or her Dependent(s) will be effective at 12:01 A.M. on the first day following the above-described additional special enrollment events.

4.04D Open Enrollment

Participants may enroll for coverage during Open Enrollment Periods. Coverage for Participants enrolling during an Open Enrollment Period will become effective on July 1, as long as all other eligibility

requirements have been met. If the other eligibility requirements have not been met, coverage for Participants enrolling during an Open Enrollment Period will become effective as stated in the provision, "Eligibility for Individual Coverage".

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

4.04E Relation to Section 125 Cafeteria Plan
This Plan may also allow additional changes to enrollment due to change in status events under the employer's Section 125 Cafeteria Plan. Refer to the employer's Section 125 Cafeteria Plan for more information.

4.04F Qualified Change in Status
An Employee may change an election with regard to coverage under this Plan after the initial eligibility period and outside an open enrollment period following a qualified change in status as permitted under the Internal Revenue Code (IRC) of 1986, as amended. The following list includes the permitted election changes under IRC § 125. For the applicable permitted election changes please refer to the applicable Cafeteria Plan Document.

1. Marriage, legal separation, annulment, or divorce of the Employee.
2. Birth, adoption or placement for adoption of a child.
3. Death of the Employee's Dependent.
4. An Employee's or Dependent's commencement of or return from an unpaid Leave of Absence.
5. Reduction or increase in hours of employment by the Employee or by the Dependent (including a switch from part-time to full-time employment status or vice-versa, a strike, or a lockout).
6. A significant change in the cost of dependent care.
7. A change in Dependent care Providers.
8. A Dependent care Provider's cessation of business.
9. A change in worksite of the Employee or Dependent.
10. The entitlement to Medicare or Medicaid or the loss of coverage under Medicare or Medicaid by the Employee or Dependent.
11. If the Employee or Dependent becomes eligible for COBRA continuation coverage under the Plan, the Employee may elect to increase his or her contributions to the Medical Flexible Spending Account, Dependent Care Flexible Spending Account, and Premium Only Plan.
12. A reduction in an Employee's hours to fewer than 30 hours per week without regard to whether the change causes a loss of eligibility under this Plan if the Employee intends to enroll in another plan that provides Minimum Essential Coverage (MEC) as defined under the Affordable Care Act.
13. An Employee's intention to enroll in a Qualified Health Plan through a Health Insurance Marketplace ("Marketplace") due to eligibility for a Special Enrollment Period (e.g., marriage, birth of child) or during the Marketplace annual open enrollment period, where the Employee revokes coverage under this Plan, provided coverage under the Qualified Health Plan begins on the day immediately following the loss of coverage under this Plan.
14. Other qualified changes in status as may be permitted under the Internal Revenue Code of 1986, as amended.

A change to an election under this section may be to enroll for coverage, terminate coverage or change coverage level under this Plan, provided the election change is consistent with the qualifying change in family or employment status.

To make an election change under this section, the Employee must submit a completed enrollment form to the Plan Administrator, with documentation of the qualifying change in family or employment status, within 30 days of the applicable change.

4.05 Qualified Medical Child Support Orders
The Plan Administrator shall enroll for immediate coverage under this Plan any Alternate Recipient who is the subject of a Medical Child Support Order that is a "Qualified Medical Child Support Order" ("QMCSO"),

not including an ex-stepchild or ex-stepchildren, if such an individual is not already covered by the Plan as an eligible Dependent, once the Plan Administrator has determined that such order meets the standards for qualification set forth below.

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

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

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

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

However, such an order need not be recognized as "qualified" if it requires the Plan to provide any type or form of benefit, or any option, not otherwise provided to the Participants and Eligible Participants without regard to this section, except to the extent necessary to meet the requirements of a State law relating to Medical Child Support Orders, as described in Social Security Act §1908 (as added by Omnibus Budget Reconciliation Act of 1993 §13822).

Upon receiving a Medical Child Support Order, the Plan Administrator shall, as soon as administratively possible, perform the following:

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

Upon receiving a National Medical Support Notice, the Plan Administrator shall perform the following:

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

To give effect to this requirement, the Plan Administrator shall perform the following:

1. Establish reasonable, written procedures for determining the qualified status of a Medical Child Support Order or National Medical Support Notice.
2. Permit any Alternate Recipient to designate a representative for receipt of copies of the notices that are sent to the Alternate Recipient with respect to the Order.

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

4.06 Acquired Companies

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

4.07 Genetic Information Nondiscrimination Act ("GINA")

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

The term "genetic information" means, with respect to any individual, information about any of the following:

1. Such individual's Genetic Tests.
2. The Genetic Tests of family members of such individual.
3. The manifestation of a Disease or disorder in family members of such individual.

The term "genetic information" includes participating in clinical research involving genetic services. Genetic Tests would include analysis of human DNA, RNA, chromosomes, proteins, or metabolites that detect genotypes, mutations, or chromosomal changes. Genetic information is a form of Protected Health Information (PHI) as defined by and in accordance with the Health Insurance Portability and Accountability Act of 1996 (HIPAA), and is subject to applicable Privacy and Security Standards.

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

GINA will not prohibit a health care Provider who is treating an individual from requesting that the patient undergo Genetic Testing. The rules permit the Plan to obtain Genetic Test results and use them to make claims payment determinations when it is necessary to do so to determine whether the treatment provided to the patient was medically advisable and/or necessary.

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

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

Genetic Testing or collect genetic information either prior to or in connection with enrollment or for underwriting purposes.

ARTICLE V - TERMINATION OF COVERAGE

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

1. The date of termination of the Plan.
2. The last day of the month in, or with respect to which, he or she requests that such coverage be terminated, provided such request is made on or before such date and provided that there is a qualifying event, unless prohibited by law (i.e., when election changes cannot be made due to Internal Revenue Code Section 125 "change in status" guidelines). ***NOTE:*** *The Employer offers these benefits in conjunction with a cafeteria plan under Section 125 of the Internal Revenue Code and a voluntary termination must comply with the requirements of the Code and the cafeteria plan*.
3. The last day of the month for which the Employee has made a contribution, in the event of his or her failure to make, when due, any contribution for coverage for himself or herself to which he or she has agreed in writing.
4. The last day of the month in which the Employee ceases to be eligible for such coverage under the Plan.
5. The last day of the month in which the termination of employment occurs.
6. The last day of the month following the end of the Stability Period for Variable Hour Employees, if the Employee failed to qualify during the previous Measurement Period.
7. Immediately after an Employee or his or her Dependent submits, or has knowledge of the submission of, a fraudulent claim or any fraudulent information to the Plan, including enrollment information.

5.01A Termination Dates of Retiree Coverage
The coverage of any Retiree who is covered under the Plan will terminate on the earliest to occur of the following dates:

1. The date of termination of the Plan.
2. The date of death of the covered Retiree.
3. The date of the expiration of the last period for which the Retiree has made a contribution, in the event of his or her failure to make, when due, any contribution for coverage for himself or herself to which he or she has agreed in writing.
4. The date the covered Retiree becomes eligible for Medicare coverage or becomes eligible for coverage under another Employer's health plan.

5.02 Termination Dates of Dependent Coverage
The coverage for any Dependents of any Employee who are covered under the Plan will terminate on the latest to occur of the following dates:

1. The date of termination of the Plan.
2. The last day of the month upon the discontinuance of coverage for Dependents under the Plan.
3. The last day of the month of the Employee's coverage for himself or herself under the Plan.
4. The date of the expiration of the last period for which the Employee has made a contribution, in the event of his or her failure to make, when due, any contribution for coverage for Dependents to which he or she has agreed in writing.
5. In the case of a Child age 26 or older for whom coverage is being continued due to mental or physical inability to earn his or her own living, the earliest to occur of:
    a. Cessation of such inability.
    b. Failure to furnish any required proof of the uninterrupted continuance of such inability or to submit to any required examination.
    c. Upon the Child's no longer being dependent on the Employee for his or her support.
6. The last day of the month immediately preceding the date such person ceases to be a Dependent.

7. The last day of the month in which such person ceases to be a Dependent Child, as defined herein, except as may be provided for in other areas of this section or within this document.
8. Immediately after an Employee or his or her Dependent submits, or has knowledge of the submission of, a fraudulent claim or any fraudulent information to the Plan, including enrollment information.

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

ARTICLE VI - CONTINUATION OF COVERAGE

6.01 Employer Continuation Coverage
However, if an Employee is not working on a full-time basis as a result of an Employer approved Disability leave, he or she will continue to be eligible to receive full-time Employee coverage under the Plan subject to the following:

1. not beyond 90 days after the date coverage would have normally terminated;
2. premium must be paid by the first of each month;
3. unless the Employee returns to full-time work prior to or immediately following the approved Disability leave, the Employee will become eligible for COBRA.

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

6.02 Continuation During Family and Medical Leave Act (FMLA) Leave
The Plan shall at all times comply with FMLA. During any leave taken under FMLA, the Employee will maintain coverage under this Plan on the same conditions as coverage would have been provided if the covered Employee had been continuously employed during the entire leave period.

6.02A Leave Entitlements
Eligible employees who work for a covered employer can take up to 12 weeks of unpaid, job-protected leave in a 12-month period for the following reasons:

- The birth of a child or placement of a child for adoption or foster care with the eligible employee(s).
- To bond with a child (leave must be taken within 1 year of the child's birth or placement) with the eligible employee(s).
- To care for the employee's spouse, child, or parent who has a qualifying serious health condition.
- For the employee's own qualifying serious health condition that makes the employee unable to perform the employee's job.
- For qualifying exigencies related to the foreign deployment of a military member who is the employee's spouse, child, or parent.

Spouses employed by the same employer are jointly entitled to a combined total of 12 workweeks of FMLA leave for the birth and care of the newborn child, for placement of a child for adoption or foster care, and to care for a parent who has a serious health condition. Leave for birth and care or placement for adoption or foster care must conclude within 12 months of the birth or placement.

An eligible employee who is a covered service member's spouse, child, parent, or next of kin may also take up to 26 weeks of FMLA leave in a single 12-month period to care for the service member with a serious injury or illness.

An employee does not need to use leave in one block. When it is medically necessary or otherwise permitted, employees may take leave intermittently or on a reduced schedule.

Employees may choose, or an employer may require, use of accrued paid leave while taking FMLA leave. If an employee substitutes accrued paid leave for FMLA leave, the employee must comply with the employer's normal paid leave policies.

6.02B Benefits and Protections
While employees are on FMLA leave, employers must continue health insurance coverage as if the employees were not on leave. Upon return from FMLA leave, most employees must be restored to the

same job or one nearly identical to it with equivalent pay, benefits, and other employment terms and conditions.

An employer may not interfere with an individual's FMLA rights or retaliate against someone for using or trying to use FMLA leave, opposing any practice made unlawful by the FMLA, or being involved in any proceeding under or related to the FMLA.

6.02C Eligibility Requirements
An employee who works for a covered employer must meet three criteria in order to be eligible for FMLA leave. The employee must meet all of the following requirements:

- Have worked for the employer for at least 12 months.
- Have at least 1,250 hours of service in the 12 months before taking leave. *
- Work at a location where the employer has at least 50 employees within 75 miles of the employee's worksite.

*Special "hours of service" requirements apply to airline flight crew employees.

6.02D Requesting Leave
Generally, employees must give 30-days' advance notice of the need for FMLA leave. If it is not possible to give 30-days' notice, an employee must notify the employer as soon as possible and, generally, follow the employer's usual procedures.

Employees do not have to share a medical diagnosis, but must provide enough information to the employer so it can determine if the leave qualifies for FMLA protection. Sufficient information could include informing an employer that the employee is or will be unable to perform his or her job functions, that a family member cannot perform daily activities, or that hospitalization or continuing medical treatment is necessary. Employees must inform the employer if the need for leave is for a reason for which FMLA leave was previously taken or certified.

Employers can require a certification or periodic recertification supporting the need for leave. If the employer determines that the certification is incomplete, it must provide a written notice indicating what additional information is required.

6.02E Employer Responsibilities
Once an employer becomes aware that an employee's need for leave is for a reason that may qualify under the FMLA, the employer must notify the employee if he or she is eligible for FMLA leave and, if eligible, must also provide a notice of rights and responsibilities under the FMLA. If the employee is not eligible, the employer must provide a reason for ineligibility.

Employers must notify its employees if leave will be designated as FMLA leave, and if so, how much leave will be designated as FMLA leave.

6.02F Enforcement
Employees may file a complaint with the U.S. Department of Labor, Wage and Hour Division, or may bring a private lawsuit against an employer.

The FMLA does not affect any federal or state law prohibiting discrimination or supersede any state or local law or collective bargaining agreement that provides greater family or medical leave rights.

For additional information or to file a complaint:
1-866-4-USWAGE
(1-866-487-9243) TTY: 1-877-889-5627
https://www.dol.gov/whd/
U.S. Department of Labor Wage and Hour Division

6.03 Continuation During USERRA

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

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

6.04 Continuation During COBRA – Introduction

The right to this form of continued coverage was created by a Federal law, under the Consolidated Omnibus Budget Reconciliation Act of 1985, as amended ("COBRA"). COBRA Continuation Coverage can become available to Participants when they otherwise would lose their group health coverage. It also can become available to other members of the Participant's family who are covered under the Plan when they otherwise would lose their group health coverage. The entire cost (plus a reasonable administration fee) must be paid by the person. Coverage will end in certain instances, including if the Participant or their covered Dependents fail to make timely payment of contributions or premiums. Participants should check with their Employer to see if COBRA applies to them and/or their covered Dependents.

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

6.04A COBRA Continuation Coverage

"COBRA Continuation Coverage" is a continuation of Plan coverage when coverage otherwise would end because of a life event known as a "Qualifying Event". Life insurance, accidental death and dismemberment benefits and weekly income or long-term disability benefits (if a part of the Employer's plan) are not considered for continuation under COBRA.

6.04B Qualifying Events

A qualifying event is any of those listed below if the Plan provided that the Participant would lose coverage (i.e., cease to be covered under the same terms and conditions as in effect immediately before the qualifying event) in the absence of COBRA continuation coverage. After a Qualifying Event, COBRA Continuation Coverage must be offered to each person who is a "Qualified Participant". The Employee, the Employee's spouse, and the Employee's Dependent Children could become Qualified Participants if coverage under the Plan is lost because of the Qualifying Event.

A covered Employee (meaning an Employee covered under the Plan) will become a Qualified Participant if he or she loses his or her coverage under the Plan because either one of the following Qualifying Events happens:

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

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

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

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

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

If a proceeding in bankruptcy is filed with respect to the Company, and that bankruptcy results in the loss of coverage of any retired Employee, spouse, surviving spouse, and Dependent Children covered under the Plan, such member will become a Qualified Participant with respect to the bankruptcy.

6.04C Employer Notice of Qualifying Events

When the Qualifying Event is the end of employment (for reasons other than gross misconduct), reduction of hours of employment, death of the covered Employee, commencement of a proceeding in bankruptcy with respect to the Employer, or the covered Employee's becoming entitled to Medicare benefits (under Part A, Part B, or both), the Employer must notify the COBRA Administrator of the Qualifying Event.

6.04D Employee Notice of Qualifying Events

Each covered Employee or Qualified Participant is responsible for providing the COBRA Administrator with the following notices, in writing, either by U.S. First Class Mail or hand delivery:

1. Notice of the occurrence of a Qualifying Event that is a divorce or Legal Separation of a covered Employee (or former Employee) from his or her spouse.
2. Notice of the occurrence of a Qualifying Event that is an individual's ceasing to be eligible as a Dependent Child under the terms of the Plan.
3. Notice of the occurrence of a second Qualifying Event after a Qualified Participant has become entitled to COBRA Continuation Coverage with a maximum duration of 18 (or 29) months.
4. Notice that a Qualified Participant entitled to receive COBRA Continuation Coverage with a maximum duration of 18 months has been determined by the Social Security Administration ("SSA") to be disabled at any time during the first 60 days of COBRA Continuation Coverage.
5. Notice that a Qualified Participant, with respect to whom a notice described above has been provided, has subsequently been determined by the SSA to no longer be disabled.

The COBRA Administrator is:

Prairie States Enterprises, Inc.

Mailing Address:
P.O. Box 23
Sheboygan, WI 53082-0023

Street Address:

615 Pennsylvania Ave
Sheboygan, WI 53082-0023

Phone: 800-615-7020
Local Phone: 920-451-7020
Fax: 920-451-7023
Website: www.prairieontheweb.com

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

6.04E Deadline for providing the notice
For Qualifying Events described above, the notice must be furnished by the date that is 60 days after the latest of:

1. The date on which the relevant Qualifying Event occurs.
2. The date on which the Qualified Participant loses (or would lose) coverage under the Plan as a result of the Qualifying Event.
3. The date on which the Qualified Participant is informed, through the furnishing of the Plan's SPD or the general notice, of both the responsibility to provide the notice and the Plan's procedures for providing such notice to the COBRA Administrator.

For the disability determination described above, the notice must be furnished by the date that is 60 days after the latest of:

1. The date of the disability determination by the SSA.
2. The date on which a Qualifying Event occurs.
3. The date on which the Qualified Participant loses (or would lose) coverage under the Plan as a result of the Qualifying Event.
4. The date on which the Qualified Participant is informed, through the furnishing of the Plan's SPD or the general notice, of both the responsibility to provide the notice and the Plan's procedures for providing such notice to the COBRA Administrator.

In any event, this notice must be furnished before the end of the first 18 months of COBRA Continuation Coverage.

For a change in disability status described above, the notice must be furnished by the date that is 30 days after the later of:

1. The date of the final determination by the SSA that the Qualified Participant is no longer disabled.
2. The date on which the Qualified Participant is informed, through the furnishing of the Plan's SPD or the general notice, of both the responsibility to provide the notice and the Plan's procedures for providing such notice to the COBRA Administrator.

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

6.04F Who Can Provide the Notice
Any individual who is the covered Employee (or former Employee), a Qualified Participant with respect to the Qualifying Event, or any representative acting on behalf of the covered Employee (or former Employee) or Qualified Participant, may provide the notice, and the provision of notice by one individual shall satisfy

any responsibility to provide notice on behalf of all related Qualified Participants with respect to the Qualifying Event.

6.04G Required Contents of the Notice
The notice must contain the following information:

1. Name and address of the covered Employee or former Employee.
2. Identification of the initial Qualifying Event and its date of occurrence, if the person is already receiving COBRA Continuation Coverage and wishes to extend the maximum coverage period.
3. A description of the Qualifying Event (for example, divorce, Legal Separation, cessation of Dependent status, entitlement to Medicare by the covered Employee or former Employee, death of the covered Employee or former Employee, disability of a Qualified Participant or loss of disability status).
4. In the case of a Qualifying Event that is divorce or Legal Separation, name(s) and address(es) of spouse and Dependent Child or Children covered under the Plan, date of divorce or Legal Separation, and a copy of the decree of divorce or Legal Separation.
5. In the case of a Qualifying Event that is Medicare entitlement of the covered Employee or former Employee, date of entitlement, and name(s) and address(es) of spouse and Child or Children covered under the Plan.
6. In the case of a Qualifying Event that is a Dependent Child's cessation of Dependent status under the Plan, name and address of the Child, reason the Child ceased to be an eligible Dependent (for example, attained limiting age).
7. In the case of a Qualifying Event that is the death of the covered Employee or former Employee, the date of death, and name(s) and address(es) of spouse and Dependent Child or Children covered under the Plan.
8. In the case of a Qualifying Event that is disability of a Qualified Participant, name and address of the disabled Qualified Participant, name(s) and address(es) of other family members covered under the Plan, the date the disability began, the date of the SSA's determination, and a copy of the SSA's determination.
9. In the case of a Qualifying Event that is loss of disability status, name and address of the Qualified Participant who is no longer disabled, name(s) and address(es) of other family members covered under the Plan, the date the disability ended and the date of the SSA's determination.
10. A certification that the information is true and correct, a signature and date.

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

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

6.04H Electing COBRA Continuation Coverage
Complete instructions on how to elect COBRA Continuation Coverage will be provided by the COBRA Administrator within 14 days of receiving the notice of the Qualifying Event. The individual then has 60 days in which to elect COBRA Continuation Coverage. The 60-day period is measured from the later of the date coverage terminates or the date of the notice containing the instructions. If COBRA Continuation Coverage is not elected in that 60-day period, then the right to elect it ceases.

Each Qualified Participant will have an independent right to elect COBRA Continuation Coverage. Covered Employees may elect COBRA Continuation Coverage on behalf of their spouses, and parents may elect COBRA Continuation Coverage on behalf of their Children.

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

6.04I Waiver Before the End of the Election Period

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

6.04J Duration of COBRA Continuation Coverage

COBRA Continuation Coverage will be available up to the maximum time period shown below. Generally, multiple Qualifying Events which may be combined under COBRA will not continue coverage for more than 36 months beyond the date of the original Qualifying Event. When the Qualifying Event is "entitlement to Medicare," the 36-month continuation period is measured from the date of the original Qualifying Event. For all other Qualifying Events, the continuation period is measured from the date of the Qualifying Event, not the date of loss of coverage.

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

When the Qualifying Event is the end of employment or reduction of the covered Employee's hours of employment, and the covered Employee became entitled to Medicare benefits less than 18 months before the Qualifying Event, COBRA Continuation Coverage for Qualified Participants other than the covered Employee lasts until 36 months after the date of Medicare entitlement. For example, if a covered Employee becomes entitled to Medicare eight months before the date on which his or her employment terminates, COBRA Continuation Coverage for his or her spouse and Children can last up to 36 months after the date of Medicare entitlement, which is equal to 28 months after the date of the Qualifying Event (36 months minus eight months).

Otherwise, when the Qualifying Event is the end of employment (for reasons other than gross misconduct) or reduction of the covered Employee's hours of employment, COBRA Continuation Coverage generally lasts for only up to a total of 18 months. There are two ways in which this 18-month period of COBRA Continuation Coverage can be extended.

6.04K Disability Extension of COBRA Continuation Coverage

If an Employee or anyone in an Employee's family covered under the Plan is determined by the SSA to be disabled and the Employee notifies the COBRA Administrator as set forth above, the Employee and his or her entire family may be entitled to receive up to an additional 11 months of COBRA Continuation Coverage, for a total maximum of 29 months. The disability would have to have started at some time before the 60th day of COBRA Continuation Coverage and must last at least until the end of the 18-month period of COBRA Continuation Coverage. An extra fee will be charged for this extended COBRA Continuation Coverage.

6.04L Second Qualifying Event Extension of COBRA Continuation Coverage

If an Employee's family experiences another Qualifying Event while receiving 18 months of COBRA Continuation Coverage, the spouse and Dependent Children in the family can get up to 18 additional months of COBRA Continuation Coverage, for a maximum of 36 months, if notice of the second Qualifying

Event properly is given to the Plan as set forth above. This extension may be available to the spouse and any Dependent Children receiving COBRA Continuation Coverage if the covered Employee or former Employee dies, becomes entitled to Medicare benefits (under Part A, Part B, or both), or gets divorced or Legally Separated, or if the Dependent Child stops being eligible under the Plan as a Dependent Child, but only if the event would have caused the spouse or Dependent Child to lose coverage under the Plan had the first Qualifying Event not occurred.

6.04M Shorter Duration of COBRA Continuation Coverage

It is not necessary that COBRA Continuation Coverage be in effect for the maximum period of time, as set forth herein. COBRA Continuation Coverage will terminate immediately, unless otherwise noted, upon the occurrence of any of the following events:

- Contributions are not paid in full on a timely basis,
- The Plan Sponsor ceases to maintain any group health plan,
- The Qualified Beneficiary begins coverage under another group health plan after electing continuation coverage,
- The Qualified Beneficiary enrolls in Medicare Part A or B after electing continuation coverage (except as stated under COBRA's special bankruptcy rules),
- The Qualified Beneficiary engages in fraud or other conduct that would justify termination of coverage of a similarly situated participant or beneficiary not receiving continuation coverage, or
- If covered under an 11-month disability extension, there is a final determination that the Qualified Beneficiary is no longer disabled for Social Security Purposes (coverage shall terminate on the first day of the month at least 30 days after the determination is made that the Qualified Beneficiary is no longer disabled).

If COBRA Continuation Coverage is terminated early, the Plan will provide the Qualified Beneficiary with an early termination notice.

Employee Notice of Other Enrollment

If the Qualified Beneficiary becomes enrolled in Medicare or under another group health plan after electing COBRA Continuation Coverage, the Qualified Beneficiary must notify the COBRA Administrator in writing immediately.

6.04N Contribution and/or Premium Requirements

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

6.04O Additional Information

Additional information about the Plan and COBRA Continuation Coverage is available from the COBRA Administrator who is:

Prairie States Enterprises, Inc.

Mailing Address:
P.O. Box 23
Sheboygan, WI 53082-0023

Street Address:
615 Pennsylvania Ave
Sheboygan, WI 53082-0023

Phone: 800-615-7020
Local Phone: 920-451-7020
Fax: 920-451-7023
Website: www.prairieontheweb.com

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

6.04P Current Addresses
In order to protect the rights of the Employee's family, the Employee should keep the COBRA Administrator (who is identified above) informed of any changes in the addresses of family members.

ARTICLE VII - SUMMARY OF BENEFITS

7.01 General Limits

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

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

7.01A Network and Non-Network Provider Arrangement

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

1. The Plan provides different levels of benefits based on whether the Participants use a Network or Non-Network Provider. Unless one of the exceptions shown below applies, if a Participant elects to receive medical care from the Non-Network Provider, the benefits payable are generally lower than those payable when a Network Provider is used. The following exceptions apply:

    a. Services at a Network facility rendered by a Non-Network ancillary Provider (radiology, anesthesiology, pathology) will be paid at the In-Network Level.
    b. For Participants who are traveling outside of the country for business or leisure, benefits will be paid at the In-Network Level.

2. Except as outlined in “No Surprises Act – Emergency Services and Surprise Bills” below, if the charge billed by a Non-Network Provider for any covered service is higher than the Maximum Allowable Charge determined by the Plan, Participants are responsible for the excess unless the Provider accepts assignment of benefits as consideration in full for services rendered. Since Network Providers have agreed to accept a negotiated discounted fee as full payment for their services, Participants are not responsible for any billed amount that exceeds that fee. The Plan Administrator reserves the right to revoke any previously-given assignment of benefits or to proactively prohibit assignment of benefits to anyone, including any Provider, at its discretion.

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

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

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

If a Participant receives information with respect to an item or service from the Plan, its representative, or a database maintained by the Plan or its representative indicating that a particular Provider is an In-Network Provider and the Participant receives such item or service in reliance on that information, the Participant’s Coinsurance, Copayment, Deductible, and Out-of-Pocket Maximum will be calculated as if the Provider had been In-Network despite that information proving inaccurate.

7.02 Balance Billing

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

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

The Participant is responsible for any applicable payment of Coinsurances, Deductibles, and Out-of-Pocket Maximums and may be billed for any or all of these.

7.03 Choice of Providers

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

7.04 Preferred Provider Information

The Network Providers are merely independent contractors; neither the Plan nor the Plan Administrator make any warranty as to the quality of care that may be rendered by any Network Provider.

A current list of Network Providers is available, without charge, through the Third-Party Administrator's website (located at www.prairieontheweb.com). If the Participant does not have access to a computer at his or her home, he or she may access this website at his or her place of employment. If the Participant has any questions about how to do this, he or she should contact the Human Resources Department. The Network Provider list changes frequently; therefore, it is recommended that a Participant verify with the Provider that the Provider is still a Network Provider before receiving services. Please refer to the Participant identification card for the PPO website address.

7.05 Claims Audit

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

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

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

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

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

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

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

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

Note that during continuation, although Plan benefits will be processed as if the termination had not occurred and the law requires the Provider to continue to accept the previously-contracted amount, the contract itself will have terminated, and thus the Plan may be unable to protect the Participant if the Provider pursues a balance bill.

7.07 Transition of Care. If a Participant is under the care of a Non-Network Provider at the time of joining the Plan, there are a limited number of medical conditions that may qualify for transition of care. If transitional care is appropriate, specific treatment by a Non-Network Provider may be covered at the Network level of benefits for a limited period of time not exceeding 90 days. The Third-Party Administrator will review and approve or deny such requests.

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

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

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

- Emergency Services;

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

7.09 Summary of Medical Benefits

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

	IN-NETWORK	OUT-OF-NETWORK
Deductible		
Individual Family Unit (Non-Embedded)	$1,500 $3,000	$1,500 $3,000
Total Maximum Out-of-Pocket*		
Individual Family Unit (Non-Embedded)	$1,500 $3,000	$1,750 $3,500
TOTAL MAXIMUM OUT OF POCKET AMOUNT, PER PLAN YEAR includes: • Deductible • Coinsurance		
After the Deductible has been satisfied, Covered Expenses will be paid at 100 percent or 80 percent until the maximum Out-of-Pocket expense amount is met. Covered Expenses from In-Network Providers will be paid at 100 percent. Covered Expenses from all Out-of-Network Providers will be paid at 80 percent. Once the maximum Out-of-Pocket expense amount is met, the Plan will then pay 100 percent of all Covered Expenses. The Deductible and Total Maximum Out-of-Pocket amounts do cross satisfy for In and Out of Network.		
The following charges do not apply toward the annual maximum out of pocket and are never paid at 100%. • Cost containment penalties • Employee Premiums • Ineligible Charges • Balance Billing • Amounts over the Maximum Allowable Charge • Health care this plan doesn't cover		

Covered Medical Expenses	IN-NETWORK	OUT-OF-NETWORK	Limits
Allergy Services and Allergy injection in office	100% Coinsurance after Deductible	80% Coinsurance after Deductible	
Ambulance (Air) Ambulance (Ground/Water)	100% Coinsurance after Deductible	100% Coinsurance after In-Network Deductible	
Autism	Benefit level will depend on type of covered service	Benefit level will depend on type of covered service	
Chemotherapy / Radiation Therapy	100% Coinsurance after Deductible	80% Coinsurance after Deductible	Pre-Certification is required.

Covered Medical Expenses	IN-NETWORK	OUT-OF-NETWORK	Limits
			If you don't receive pre-certification, benefits will be reduced by $250.
Chiropractic Care	100% Coinsurance after Deductible	80% Coinsurance after Deductible	Includes office visit, x-rays, manipulations and supportive care. Maintenance Care is **not** covered by the Plan. Limited to maximum of 25 visits per member per Plan Year
Colonoscopy • **Diagnostic** • **Screening**	100% Coinsurance after Deductible 100%, no Deductible Cologuard covered at 100%. Limited to one (1) every three (3) plan years. If the Cologuard comes back requiring the Member to have a Colonoscopy, the Plan will pay for one (1) follow-up Colonoscopy at the 100%	80% Coinsurance after Deductible 80% Coinsurance after Deductible Cologuard covered at 100%. Limited to one (1) every three (3) plan years. If the Cologuard comes back requiring the Member to have a Colonoscopy, the Plan will pay for one (1) follow-up Colonoscopy at the 100%	ACA age guidelines will be followed
Dental Services – Accidental Injury	100% Coinsurance after Deductible	80% Coinsurance after Deductible	
Diabetic Equipment and Supplies **Diabetic Education**	100% Coinsurance after Deductible	80% Coinsurance after Deductible	

Covered Medical Expenses	IN-NETWORK	OUT-OF-NETWORK	Limits
Diagnostic Services ***(Outpatient X-ray, Imaging, Labs)***			
• Lab Services, Bloodwork and X-Rays	100% Coinsurance after Deductible	80% Coinsurance after Deductible	Pre-Certification is required for PET scans. If you don't receive pre-certification, benefits will be reduced by $250.
• MRI, PET & CT Scans	100% Coinsurance after Deductible	80% Coinsurance after Deductible	
• Ultrasounds, EKG and Echocardiograms	100% Coinsurance after Deductible	80% Coinsurance after Deductible	
Dialysis	100% Coinsurance after Deductible	80% Coinsurance after Deductible	Pre-Certification is required. If you don't receive pre-certification, benefits will be reduced by $250.
Durable Medical Equipment (DME) (Received from a Supplier) • Durable Medical Equipment • Orthotics (Custom Molded Only) • Prosthetics • Medical and Surgical Supplies	100% Coinsurance after Deductible	80% Coinsurance after Deductible	Pre-Certification is required for ALL rentals and equipment purchases over $500. If you don't receive pre-certification, benefits will be reduced by $250. Custom molded limited to one (1) pair every three (3) years Compression socks: Limited to 3 pairs per Plan Year
• Breast Pumps	100% per ACA	100% per ACA	Mastectomy Bras: Limited to 2 per Plan Year Purchase over the internet or Retail will be allowed.
Glaucoma, Cataract Surgery and Lenses	100% Coinsurance after Deductible	80% Coinsurance after Deductible	Pre-Certification is required. If you don't receive pre-certification, benefits will be reduced by $250. One (1) pair of lenses after cataract surgery will be covered.

Covered Medical Expenses	IN-NETWORK	OUT-OF-NETWORK	Limits
Habilitative Services	100% Coinsurance after Deductible	80% Coinsurance after Deductible	Pre-Certification is required for all Therapy Services.
Hearing Aids & Cochlear Implants	100% Coinsurance after Deductible	80% Coinsurance after Deductible	Limited to one (1) per hearing impaired ear every 36 months. Hearing Aids and/or Cochlear Coverage are only covered for Children through the age of 18.
Home Health Care • Home Care Visits • Home Dialysis • Home Infusion Therapy • Other Home Care Services/Supplies	100% Coinsurance after Deductible	80% Coinsurance after Deductible	Limited to 40 visits per plan year. Pre-Certification required for Home Infusion Services. If you don't receive pre-certification, benefits will be reduced by $250.
Hospice Care • Home Care • Inpatient Hospice	100% Coinsurance after Deductible	80% Coinsurance after Deductible	
Hospital (Inpatient Services) • Hospital/Acute Care Facility • Physician/Surgeon	100% Coinsurance after Deductible 100% Coinsurance after Deductible	80% Coinsurance after Deductible 80% Coinsurance after Deductible	Pre-Certification is required. If you don't receive pre-certification, benefits will be reduced by $250.
Infertility Diagnostic Testing	100% Coinsurance after Deductible	80% Coinsurance after Deductible	No coverage for treatment of infertility
Mammograms including 3D (Outpatient) • Diagnostic mammograms • Routine Mammograms	100% Coinsurance after Deductible 100% Deductible waived.	80% Coinsurance after Deductible 80% Coinsurance after Deductible	ACA guidelines will be followed
Maternity & Reproductive Health Services • Office Visits			Pre-Certification is required if maternity length of stay is greater than 48 hours for vaginal delivery or 96 hours for a cesarean delivery.

Covered Medical Expenses	IN-NETWORK	OUT-OF-NETWORK	Limits
• Maternity Visits (Global fee for the ObGyn's prenatal, postnatal, and delivery services) • Inpatient Services	100% Coinsurance after Deductible	80% Coinsurance after Deductible	If you don't receive pre-certification, benefits will be reduced by $250. Dependent Pregnancy is covered
Mental Health & Substance Abuse Expenses			
• Inpatient Facility Services	100% Coinsurance after Deductible	80% Coinsurance after Deductible	
• Residential Treatment Center Services	100% Coinsurance after Deductible	80% Coinsurance after Deductible	
• Inpatient Provider Services (Doctor and other professional Providers)	100% Coinsurance after Deductible	80% Coinsurance after Deductible	
• Outpatient Facility Services (Partial Hospitalization Program / Intensive Outpatient Program)	100% Coinsurance after Deductible	80% Coinsurance after Deductible	Pre-Certification is required for inpatient stays. If you don't receive pre-certification, benefits will be reduced by $250.
• Outpatient Provider Services in an Outpatient Facility (e.g., Doctor and other professional Providers in a Partial Hospitalization Program / Intensive Outpatient Program)	100% Coinsurance after Deductible	80% Coinsurance after Deductible	
• Office Visits (Including Online Visits and Intensive In-Home Behavioral Health Programs)	100% Coinsurance after Deductible	80% Coinsurance after Deductible	

Covered Medical Expenses	IN-NETWORK	OUT-OF-NETWORK	Limits
Oral Surgery	100% Coinsurance after Deductible	80% Coinsurance after Deductible	Pre-Certification is required. If you don't receive pre-certification, benefits will be reduced by $250.
Outpatient Emergency Services • Emergency Room Facility Charge • Emergency Room Doctor Charge • Other Facility Charges (including diagnostic x-ray and lab services, medical supplies)	100% Coinsurance after Deductible	100% Coinsurance after In-Network Deductible	Notification must be obtained within 48 hours following admission or on the first business day following weekend or holiday admission.
Outpatient Surgery Facility Services • Facility Surgery Charge • Physician/surgeon fees	100% Coinsurance after Deductible	80% Coinsurance after Deductible	Pre-Certification is required. If you don't receive pre-certification, benefits will be reduced by $250.
Physician Services – Office Visits • Primary Care Office Visit, including Convenience Care Office Visit • Specialist Office Visit	100% Coinsurance after Deductible 100% Coinsurance after Deductible	80% Coinsurance after Deductible 80% Coinsurance after Deductible	
Preventive Care – Well Adults Care • Routine Physical Exam • Routine Colonoscopy • Routine Mammograms (1 Mammogram per plan year is allowed) • Pap Smears • Routine Immunizations • Routine PSA	100% per ACA	80% Coinsurance after Deductible	ACA guidelines will be followed

Covered Medical Expenses	IN-NETWORK	OUT-OF-NETWORK	Limits
Preventive Care – Well Child Care • Exam • Immunizations	100% per ACA	80% Coinsurance after Deductible	
Prosthetics, Orthotics, Supplies & Surgical Dressings	See "Durable Medical Equipment (DME) and Medical Devices, Orthotics, Prosthetics, Medical and Surgical Supplies.	See "Durable Medical Equipment (DME) and Medical Devices, Orthotics, Prosthetics, Medical and Surgical Supplies.	
Skilled Nursing Facility Rehabilitation Nursing Home	100% Coinsurance after Deductible	80% Coinsurance after Deductible	Skilled nursing is limited to 60 visits per confinement.
Sterilization • Woman • For men	100% per ACA 100% Coinsurance after Deductible	80% Coinsurance after Deductible 80% Coinsurance after Deductible	Pre-Certification is required for Outpatient surgeries. If you don't receive pre-certification, benefits will be reduced by $250.
Surgery (Physicians Services) • Inpatient • Outpatient	100% Coinsurance after Deductible 100% Coinsurance after Deductible	80% Coinsurance after Deductible 80% Coinsurance after Deductible	Pre-Certification is required for Inpatient and Outpatient surgeries. If you don't receive pre-certification, benefits will be reduced by $250.
Telemedicine • Primary Care Physician • Specialist Care Physician	100% Coinsurance after Deductible 100% Coinsurance after Deductible	Not Covered Not Covered	
Therapy Services • Applied Behavior Analysis (ABA) • Cardiac Rehabilitation Therapy • Habilitation Therapy	100% Coinsurance after Deductible	80% Coinsurance after Deductible	Pre-Certification is required for all Therapy Services. If you don't receive pre-certification, benefits will be reduced by $250. No limits on autism spectrum disorder therapies.

Covered Medical Expenses	IN-NETWORK	OUT-OF-NETWORK	Limits
• Occupational Therapy • Physical Therapy • Pulmonary Therapy • Speech Therapy			
Temporomandibular Joint Disorder (TMJ)	Benefits are relative to covered services performed	Benefits are relative to covered services performed	Limited to $2,500 limit per member per lifetime
Transplants	See separate Organ Transplant Carve-out policy	See separate Organ Transplant Carve-out policy	Pre-Certification is required for Inpatient and Outpatient surgeries. If you don't receive pre-certification, benefits will be reduced by $250. See separate Organ Transplant Carve-out policy
Urgent Care	100% Coinsurance after Deductible	80% Coinsurance after Deductible	Notification must be obtained within 48 hours following admission or on the first business day following weekend or holiday admission.
Wigs	100% Coinsurance after Deductible	80% Coinsurance after Deductible	Limited to a maximum of $900 per episode/diagnosis After Chemotherapy / Radiation / other medical treatment, covered disease or accident that cause hair loss.
All Other Covered Services not specifically mentioned	100% Coinsurance after Deductible	80% Coinsurance after Deductible	

Any amounts paid or reimbursed by a third party, including but not limited to: point of service rebates, manufacturer coupons, manufacturer debit cards or other forms of direct reimbursement to a member for a product or service, will not apply as an Out-of-Pocket expense, to the extent permitted under state and federal law.

7.10 Summary of Benefits - Prescription Drug

The following benefits are per Participant:

Covered Prescription Drug Expenses:	Network	Non-Network	Limits
RETAIL & MAIL PHARMACY BENEFIT			
Tier 1 - Generic Drugs	**Retail:** 100% Coinsurance after Deductible **Mail Order:** 100% Coinsurance after Deductible	Not Covered	Covers up to 90-day supply (retail prescription & mail-order prescription)
Tier 2 - Preferred (Formulary) Brand Drugs	**Retail:** 100% Coinsurance after Deductible **Mail Order:** 100% Coinsurance after Deductible	Not Covered	
Tier 3 - Non-Preferred (Non-Formulary) Brand Drugs	**Retail:** 100% Coinsurance after Deductible **Mail Order:** 100% Coinsurance after Deductible	Not Covered	
SPECIALTY DRUG BENEFIT			
Specialty Prescription Drugs	100% Coinsurance after Deductible	Not Covered	All specialty medications are limited up to 30-day supply, specialty formulary & specialty network only.

ARTICLE VIII - MEDICAL BENEFITS

8.01 Medical Benefits

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

1. **3D Mammography.**

2. **Advanced Imaging.** Charges for advanced imaging including: Computed Tomographic (CT) studies, Coronary CT angiography, MRI/MRA, nuclear cardiology, nuclear medicine, and PET scans. Covered Expenses include the readings of these medical tests/scans.

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

   This Plan will cover rotary and fixed wing aircraft, excluding all fixed wing charter flights, for air ambulance services.

   Only charges Incurred for the first trip to a Hospital, or from one Hospital to another Hospital shall be included.

   The determination of whether air ambulance transport for a service, supply, or treatment is or is not Medically Necessary may include findings of the American Medical Association and the Plan Administrator's own medical advisors. The Plan Administrator has the discretionary authority to decide whether care or treatment is Medically Necessary.

4. **Allergy Services.** Charges related to the treatment of allergies.

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

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

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

8. **Autism Spectrum Disorder Services.** The following definitions apply for purposes of Autism Spectrum Disorders:

   a. "Intensive level services" shall mean evidence-based behavioral therapies that are designed to help an individual with Autism Spectrum Disorder overcome the cognitive, social and behavioral deficits associated with that disorder. Intensive level services may include evidence-based speech therapy and occupational therapy provided by a qualified therapist when such therapy is based on, or related to, an individual's therapeutic goals and skills, and is concomitant with evidence-based behavioral therapy.
   b. "Non-intensive level services" shall mean evidence-based therapy that occurs after the completion of treatment for Intensive level services and that is designed to sustain and maximize gains made during treatment with intensive level services or, for an individual

who has not and will not receive intensive level services, evidence-based therapy that will improve the individual's condition.

Intensive Level Services

NOTE: Benefits for intensive-level services begin after the enrolled Dependent Child turns two years of age but prior to turning nine years of age.

a. Benefits are provided for evidence-based behavioral intensive level therapy for a Participant with a verified Diagnosis of Autism Spectrum Disorder, the majority of which shall be provided to the Dependent Child when the parent or legal guardian is present and engaged. The prescribed therapy must be consistent with all of the following requirements:

    i. Based upon a treatment plan developed by an individual who at least meets the requirements of a qualified intensive level provider or a qualified intensive level professional that includes at least 20 hours per week over a six-month period of time of evidence-based behavioral intensive therapy, treatment and services with specific cognitive, social, communicative, self-care, or behavioral goals that are clearly defined, directly observed and continually measured and that address the characteristics of Autism Spectrum Disorders. Treatment plans shall require that the Dependent Child be present and engaged in the intervention.
    ii. Implemented by qualified providers, qualified professional, qualified therapists or qualified paraprofessionals.
    iii. Provided in an environment most conducive to achieving the goals of the Dependent Child's treatment plan.
    iv. Included training and consultation, participation in team meeting and active involvement of the Dependent Child's family and treatment team for implementation of the therapeutic goals developed by the team.
    v. The Dependent Child is directly observed by the qualified intensive level provider or qualified intensive level professional at least once every two months.
    vi. Beginning after the Dependent Child is two years of age and before the Dependent Child is nine years of age.

b. Intensive level services will be covered for up to four cumulative years. The Plan may credit against any previous intensive level services the Dependent Child received against the required four years of intensive level services regardless of payer. The Plan may also require documentation including medical records and treatment plans to verify any evidence-based behavioral therapy the Participant received for Autism Spectrum Disorders that was provided to the Dependent Child prior to attaining nine years of age. Evidence-based behavioral therapy that was provided to the Dependent Child for an average of 20 or more hours per week over a continuous six-month period is considered to be intensive-level services.
c. Travel time for qualified providers, supervising providers, professionals, therapists, paraprofessionals or behavioral analysts is not included when calculating the number of hours of care provided per week.
d. The Plan requires that progress be assessed and documented throughout the course of treatment. The Plan may request and review the Dependent Child's treatment plan and the summary of progress on a periodic basis.
e. The Plan will cover services from a qualified therapist when services are rendered concomitant with intensive level evidence-based behavioral therapy and all of the following apply:

    i. The qualified therapist provides evidence-based therapy to a Dependent Child who has a primary Diagnosis of an Autism Spectrum Disorder.
    ii. The Dependent Child is actively receiving behavioral services from a qualified intensive level provider or qualified intensive level professional.

iii. The qualified therapist develops and implements a treatment plan consistent with their license and this section.

Non-Intensive Level Services
Non-intensive level services will be covered for a Dependent Child with a verified Diagnosis of Autism Spectrum Disorder for non-intensive level services that are evidence-based and are provided to a Dependent Child by a qualified provider, qualified professional, qualified therapist or qualified paraprofessional in either of the following conditions:

a. After the completion of intensive level services and designed to sustain and maximize gains made during intensive level services treatment.
b. To a Dependent Child who has not and will not receive intensive level services but for whom non-intensive level services will improve the Dependent Child's condition.

Benefits will be provided for evidence-based therapy that is consistent with all of the following requirements:

a. Based upon a treatment plan developed by an individual who minimally meets the requirements as a qualified provider, qualified professional or qualified therapist that includes evidence-based specific therapy goals that are clearly defined, directly observed and continually measured and that address the characteristics of Autism Spectrum Disorders. Treatment plans shall require that the Dependent Child be present and engaged in the intervention.
b. Implemented by qualified providers, qualified professionals, qualified therapist or qualified paraprofessionals.
c. Provided in an environment most conducive to achieving the goal of the Dependent Child's treatment plan.
d. Included training and consultation, participation in team meetings and active involvement of the Dependent Child's family in order to implement the therapeutic goals developed by the team.
e. Non-intensive level services may include direct or consultative services when provided by qualified providers, qualified supervising providers, qualified professionals, qualified paraprofessionals, or qualified therapists.
f. The Plan requires that progress be assessed and documented throughout the course of treatment. The Plan may request and review the Dependent Child's treatment plan and the summary of progress on a periodic basis.
g. Travel time for qualified providers, qualified supervising providers, qualified professional, qualified therapists, qualified paraprofessionals or qualified behavioral analysts is not included when calculating the number of hours of care provided per week.

Intensive level and non-intensive level services include but are not limited to speech, occupational and behavioral therapies.

The following services are not covered under the Autism Spectrum Disorders:

a. Acupuncture.
b. Animal-based therapy including hippotherapy.
c. Auditory integration training.
d. Chelation therapy.
e. Child care fees.
f. Cranial sacral therapy.
g. Custodial or respite care.
h. Hyperbaric oxygen therapy.
i. Special diets or supplements.
j. Pharmaceuticals and Durable Medical Equipment.

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

10. **Blood and Plasma.** Blood transfusions, plasma and blood derivatives and charges for whole blood not donated or replaced by a blood bank.

11. **Cardiac Rehabilitation.** Charges for Phase III and IV Cardiac Rehabilitation Therapy.

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

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

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

15. **Cochlear Implants.** Charges for cochlear implants for Dependent Children limited to one (1) implant per ear every 36 months up to the age of 18.

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

17. **COVID-19 (2019 Novel Coronavirus).** Covered Expenses associated with testing for COVID-19 include the following:

    COVID-19 (i.e., Coronavirus) diagnostic testing and treatments will be subject to plan deductibles, co-pays and/or coinsurance. This includes items and services furnished during health care provider office visits (including virtual visits), urgent care center visits and emergency room visits that result in an order for or administration of a COVID-19 diagnostic test or treatment, to the extent that those items and services are necessary for the administration of the test or treatment, or for purposes of determining the need for the test or treatment.

    Coverage for COVID-19 Vaccinations:

    - COVID-19 vaccinations will be covered at 100% if administered by a Network Provider.
    - COVID-19 vaccinations administered by a Non- Network provider will be subject to deductibles, co-pays and/or coinsurance

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

    Oral surgery performed by a Doctor of Dental Surgery (D.D.S.) or a Doctor of Medical Dentistry (D.M.D.) in connection with services that is covered by this Plan; for example, removal of impacted wisdom teeth.

    Hospital and Ambulatory Surgical Center charges, including Anesthesia charges, if you must receive dental care in one of these setting you have a chronic Disability or medical condition that requires Hospitalization or general Anesthesia for dental care.

In addition to the Plan covering extraction of natural teeth, charges for the following services due to the extraction/replacement of natural teeth:

a. the initial replacement of the extracted natural teeth;
b. the replacement of previously existing fixed bridgework if replacement is required due to the extraction of one or more natural teeth that are:
    (i) adjacent to the fixed bridgework, or
    (ii) abutment teeth supporting the existing bridgework.
c. the replacement of previously existing partial removable dentures:
    (i) if replacement is required due to the extraction of one or more natural teeth, and
    (ii) the existing partial denture is no longer serviceable and cannot be made serviceable.

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

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

20. **Dialysis.** Charges for dialysis therapy and treatment shall be covered as follows:

    Outpatient Renal Dialysis Services - The member's first 40 renal dialysis visits, cumulative and not subject to annual reset are paid at the applicable deductible and coinsurance listed in the Schedule of Benefits of the allowable amount. Charges that exceed this amount are not a Covered Service and are not eligible for reimbursement under the Plan. Visits for both network providers and non-network providers are a Covered Service and eligible for reimbursement under the Plan during the member's first 40 visits, subject to the limitations described above.
    The Plan does not utilize or access any network for additional visits beyond the first 40 renal dialysis visits. Charges for additional visits are a Covered Service only up to 150% of the national Medicare allowable amount, adjusted for the geographic wage index. Charges that exceed this amount are not a Covered Service and are not eligible for reimbursement under the Plan.

    Medicare Part B Reimbursement - If you or your covered dependent has End-Stage Renal Disease ("ESRD"), the Plan's medical programs primary status applies during the first 30 months of dialysis, or the first 30 months of treatment in connection with a transplant. Thereafter, Medicare generally becomes the primary payer of benefits.

    The Medicare Secondary Payer statute requires the Plan to identify members in the Plan, including eligible dependents, which are eligible for Medicare, including those eligible based on ESRD. To ensure the correct coordination of claims payments, members are required to provide the Plan the basis for their eligibility to Medicare (age, ESRD, or disability) and the effective date of Medicare Part A and Part B.

    During the period where the Plan has primary status, Medicare Part B monthly premiums for covered members and their dependents that have become entitled, including dually entitled, to Medicare based on ESRD, will be covered by the Plan. Reimbursement for monies withheld by Medicare from Social Security, Railroad Retirement, or Office of Personnel Management payments will be made at the end of each calendar quarter.

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

a. Any purchases without its advance written approval.
b. Replacements or repairs, unless Medically Necessary. *NOTE: The plan covers repair and replacement of Durable Medical Equipment when Medically Necessary due to a physiological change to the patient, due to normal wear and tear of an item or the existing equipment is damaged and cannot be made serviceable.*
c. The rental or purchase of items which do not fully meet the definition of "Durable Medical Equipment".

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

23. **Genetic Testing.** The charges for Genetic Testing, if Medically Necessary and indicated under nationally accepted guidelines. Refer to the Genetic Information Nondiscrimination Act of 2008 (GINA) subsection for information regarding the prohibition of discriminating on the basis of genetic information.

24. **Glaucoma.** Treatment of glaucoma.

25. **Habilitative Services.** These services include: *The following services are covered per the State Mandated benefits for the treatment of Autism only:*

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

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

26. **Hearing Aids.** Charges for hearing aids, which includes examinations for the prescription, fitting, and/or repair of hearing aids. Limited to one (1) per hearing impaired ear every 36 months for dependents up to age 18.

27. **Home Health Care.** Charges for Home Health Care services and supplies are covered only for care and treatment of an Illness or Injury when Hospital or Skilled Nursing Facility confinement would otherwise be required. The Diagnosis, care, and treatment must be certified by the attending Physician and be contained in a home health care plan. Charges by a Home Health Care Agency for any of the following:
    1. Registered Nurses or Licensed Practical Nurses.
    2. Certified home health aides under the direct supervision of a Registered Nurse.
    3. Registered therapist performing physical, occupational or speech therapy.
    4. Physician calls in the office, home, clinic or outpatient department.
    5. Services, Drugs and medical supplies which are Medically Necessary for the treatment of the Participant that would have been provided in the Hospital, but not including Custodial Care.
       NOTE*: Home infusion therapy does not apply to the home health care maximum.*
    6. Rental of Durable Medical Equipment or the purchase of this equipment if economically justified, whichever is less.

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

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

    a. Room and Board for confinement in a Hospice for symptoms management.
    b. Ancillary charges furnished by the Hospice while the patient is confined therein, including rental of Durable Medical Equipment which is used solely for treating an Injury or Sickness.
    c. Medical supplies, Drugs and medicines prescribed by the attending Physician, but only to the extent such items are necessary for pain control and management of the terminal condition.
    d. Physician services and nursing care by a Registered Nurse, Licensed Practical Nurse or a Licensed Vocational Nurse (L.V.N.).
    e. Home health aide services.
    f. Home care furnished by a Hospital or Home Health Care Agency, under the direction of a Hospice, including Custodial Care if it is provided during a regular visit by a Registered Nurse, a Licensed Practical Nurse or a home health aide.
    g. Medical social services by licensed or trained social workers, Psychologists or counselors.
    h. Nutrition services provided by a licensed dietitian.
    i. Respite care.

    Hospice Care ceases if the Terminal Illness enters remission.

29. **Hospital.** Charges made by a Hospital for:

    1. Inpatient Treatment

        1. Daily semi private Room and Board charges.
        2. Intensive Care Unit (ICU) and Cardiac Care Unit (CCU) Room and Board charges.
        3. General nursing services.
        4. Medically Necessary services and supplies furnished by the Hospital, other than Room and Board.

    2. Outpatient Treatment

        1. Emergency room.
        2. Treatment for chronic conditions.
        3. Physical therapy treatments.
        4. Hemodialysis.
        5. X-ray, laboratory and linear therapy.

30. **Hospital Admission.** Charges for hospital admission on Friday, Saturday or Sunday only if the admission is an emergency situation, or Surgery is scheduled within 24 hours. If neither situation applies, hospital expenses will be payable commencing on the date of actual Surgery.

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

32. **Implantable Hearing Devices.** For services or supplies in connection with implantable hearing devices, including, but not limited to, cochlear implants and exams for their fitting. Covered for Dependent Children up to age 18.

33. **Laboratory and Pathology Services.** Charges for x-rays, diagnostic tests, labs, and pathology services.

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

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

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

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

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

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

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

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

    Benefits are available for, but not limited to, Residential Treatment Facility, Partial Hospitalization, and Intensive Outpatient Services.

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

39. **Newborn Care.** Hospital and Physician nursery care for newborns who are natural Children of the Employee or spouse and properly enrolled in the Plan, as set forth below. Benefits will be provided under the Child's coverage, and the Child's own Deductible and Coinsurance provisions will apply:

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

        1. The initial newborn examination and a second examination performed prior to discharge from the Hospital.
        2. Circumcision.

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

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

41. **Nutritional Counseling.** Charges for nutritional counseling for the management of a medical condition that has a specific diagnostic criteria that can be verified. The nutritional counseling must be prescribed by a Physician.

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

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

44. **Pregnancy Expenses.** Dependent Children are eligible for coverage for any expenses in connection with Pregnancy. Covered Expenses for treatment, services or supplies for a surrogate mother or any Pregnancy for a Participant's service as a surrogate mother.

    Benefits are payable in the same manner as for medical or surgical care of an Illness, shown in the "Summary of Benefits" and this section, and subject to the same maximums (if any).

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

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

    See the following websites for more details:
    https://www.healthcare.gov/coverage/preventive-care-benefits/;
    https://www.uspreventiveservicestaskforce.org/uspstf/recommendation-topics/uspstf-a-and-b-recommendations;
    https://www.cdc.gov/vaccines/hcp/acip-recs/index.html;
    https://www.aap.org/en-us/Documents/periodicity_schedule.pdf;
    https://www.hrsa.gov/womensguidelines/.

    NOTE: *The Preventive Care services identified through the above links are recommended services. It is up to the Provider and/or Physician of care to determine which services to provide; the Plan Administrator has the authority to determine which services will be covered. Preventive Care services will be covered at 100% for Non-Network Providers if there is no Network Provider who can provide a required preventive service.*

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

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

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

a. Well-woman visits.
b. Gestational diabetes screening.
c. Human papillomavirus (HPV) Deoxyribonucleic Acid (DNA) testing.
d. Sexually transmitted infection counseling.
e. Human Immunodeficiency Virus (HIV) screening and counseling.
f. Food and Drug Administration (FDA)-approved contraception methods and contraceptive counseling.
g. Breastfeeding support, supplies and counseling.
h. Domestic violence screening and counseling.

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

46. **Prosthetics, Orthotics, Supplies and Surgical Dressings.** Prosthetic devices (other than dental) to replace all or part of an absent body organ or part, including replacement due to natural growth or pathological change, but not including charges for repair or maintenance. Custom Molded Orthotic Devices, but excluding orthopedic shoes and other supportive devices for the feet.

47. **Radiation Therapy.** Charges for radiation and dialysis therapy and treatment.

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

    a. The clinical trial is approved by:

        i. The Centers for Disease Control and Prevention of the U.S. Department of Health and Human Services.
        ii. The National Institute of Health.
        iii. The U.S. Food and Drug Administration.
        iv. The U.S. Department of Defense.
        v. The U.S. Department of Veterans Affairs.
        vi. An Institutional review board of an Institution that has an agreement with the Office for Human Research Protections of the U.S. Department of Health and Human Services.

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

49. **Second Surgical Opinions.** Charges for second surgical opinions.

50. **Skilled Nursing Facility.** Charges made by a skilled nursing facility or a convalescent care facility, as defined in the Plan, up to the limits set forth in the Summary of Benefits, in connection with convalescence from an Illness or Injury for which the Participant is confined. For information on Inpatient medical benefits for mental health or Substance Use Disorders, please refer to the "Mental Health and Substance Abuse Benefits" in the Medical Benefits section above.

51. **Stabilization.** Charges for Inpatient care before a Participant's condition is stabilized. When care is provided in a Non-Network Hospital or by a Non-Network Provider, charges for Inpatient care through stabilization will be payable at the Network Hospital Coinsurance level, if the care is approved by Medical Management. When care is provided in an Out-of-Area Hospital, charges for Inpatient care through stabilization will be payable at the Network Coinsurance level.

52. **Sterilization for Men.** Charges for male sterilization procedures.

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

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

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

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

56. **Telemedicine.** The charges for telemedicine including but not limited to: virtual ICU or virtual primary care services.

57. **Temporomandibular Joint Disorder.** Charges for the Diagnosis and treatment of, or in connection with, temporomandibular joint disorders, myofascial pain dysfunction or orthognathic treatment. If a Physician or Dentist recommends treatment for or in connection with temporomandibular joint disorders, myofascial pain dysfunction or orthognathic treatment, a Participant must submit the treatment plan, including x-rays and study models, for pre-determination of benefits under the Plan. The pre-determination of benefits is required before any course of treatment is begun. The Plan Administrator will determine if the treatment is a Covered Expense and will notify the Participant. If treatment is begun before the pre-determination of benefits, no benefits are payable under the Plan.

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

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

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

59. **Transplants.** (See Separate Organ Transplant Policy for Benefits) Services and supplies in connection with Medically Necessary non-Experimental transplant procedures, except as provided by United HealthCare Insurance Company (UHIC) Transplant Benefit Policy, subject to the following conditions:

    1. a concurring opinion must be obtained prior to undergoing any transplant procedure. This mandatory opinion must concur with the attending Physician's findings regarding the Medical Necessity of such procedure. The Physician rendering this concurring opinion must be qualified to render such a service either through experience, specialist training, education, or such similar criteria, and must not be affiliated in any way with the Physician who will be performing the actual surgery.
    2. if the donor is covered under this Plan, eligible medical expenses Incurred by the donor will be considered eligible. If the donor is not covered under this Plan, reference provision (5).
    3. if the recipient is covered under this Plan, eligible medical expenses Incurred by the recipient will be considered eligible.
    4. if both the donor and the recipient and covered under this Plan, eligible medical expenses Incurred by each person will be treated separately for each person.
    5. the Maximum Allowable Charge of securing an organ from the designated live donor, a cadaver or tissue bank, including the surgeon's fees, anesthesiology, radiology and pathology fees for the removal of the organ, and a Hospital's charge for storage or transportation of the organ will be considered eligible.

    Transplant coverage is limited to those transplants that are medically recognized and are non-Experimental/Investigational in nature.

    The Plan will also cover benefits for lodging and transportation. Limited to a daily maximum of $300 with a combined maximum of $15,000 for lodging and transportation.

60. **Vehicle Accident.** For injuries sustained in a vehicle accident where it was determined the Participant wasn't wearing a seat belt or helmet.

61. **Wigs.** Charges associated with wigs, artificial hair pieces, human or artificial hair transplants, or any Drug, prescription or otherwise, used to eliminate baldness after chemotherapy or radiation therapy. Limited to $2,500 per Diagnosis.

8.02 Medical Exclusions

Some health care services are not covered by the Plan. These include, but are not limited to, any charge for care, supplies, or services, which are:

1. **Abortion.** For or related to an abortion, except where the life of the mother is endangered by the continued Pregnancy, or if the Pregnancy is the result of rape or incest.

2. **Acupuncture.** Relating directly or indirectly to acupuncture.

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

4. **Alcohol.** Involving a Participant who has taken part in any activity made illegal either due to the use of alcohol or a state of intoxication. Expenses will be covered for Injured Participants other than the person partaking in an activity made illegal due to the use of alcohol or a state of intoxication, and expenses may be covered for Substance Abuse treatment as specified in this Plan, if applicable. This Exclusion does not apply if the Injury (a) resulted from being the victim of an act of domestic violence, or (b) resulted from a documented medical condition (including both physical and mental health conditions).

5. **Biofeedback.** For biofeedback.

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

7. **Chelation Therapy.** For charges for chelation therapy, except as treatment of heavy metal poisoning.

8. **Complementary and Alternative Medicine (CAM).** Charges for complementary and alternative medicine (CAM), including but not limited to, Massage Therapy and Meditation.

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

10. **Confined Persons.** Received while incarcerated in a federal, state or local penal institution or services required while in custody of federal, state or local enforcement authorities, including under the Huber law, if and when applicable. In addition, all mandated psychological services or treatment are not covered, unless such treatment is deemed Medically Necessary. The term "mandated" applies to any service or treatment ordered by a court, probation department, parole board, or similar authority. In relation to this Exclusion, any costs incurred for the following will not be covered:

    a. Court-ordered appearances for hearings or proceedings.
    b. Preparation of special medical reports.
    c. Non-medical Drug screening.

11. **Consultations.** For consultations, charges for failure to keep a scheduled visit, or charges for completion of a claim form, except as provided under the Telemedicine benefit.

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

13. **Counseling.** For charges for religious, marital, family, financial, or legal counseling, unless specifically covered herein.

14. **Court Ordered Services.** That are ordered by a court, unless determined by the Plan Administrator, in its discretion, to otherwise be appropriate and covered. Including examinations or counseling for licenses.

15. **Custodial Care.** For custodial Care, domiciliary care or rest cures, or Home Health Care except as specifically provided herein.

16. **Deductible Applicable.** That are not payable due to the application of any specified Deductible provisions contained herein.

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

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

19. **Developmental Delays/Recreational/Educational Therapy.** Expenses and services in connection with:

    a. developmental delay
    b. recreational and educational therapy
    c. learning disabilities
    d. behavior modification therapy
    e. non-medical self-care or self-help training including any diagnostic testing
    f. music therapy
    g. health club memberships

    This exclusion will not apply to expenses related to the diabetic self-management education programs, the initial diagnosis and testing of developmental delays or if the developmental delay is caused by an Illness, disease, Injury or surgery and any pervasive development disorder not otherwise specified.

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

21. **Error.** That are required to treat injuries that are sustained or an Illness that is contracted, including infections and complications, while the Participant was under, and due to, the care of a Provider

wherein such Illness, Injury, infection or complication is not reasonably expected to occur. This Exclusion will apply to expenses directly or indirectly resulting from the circumstances of the course of treatment that, in the opinion of the Plan Administrator, in its sole discretion, unreasonably gave rise to the expense.

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

23. **Excess.** That are not payable under the Plan due to application of any Plan maximum or limit or because the charges are in excess of the Maximum Allowable Charge based upon the Plan Administrator's determination as set forth by and within the terms of this document.

24. **Exercise Programs.** For charges for exercise programs for treatment of any condition, except as specified herein. No benefits are covered for health clubs, aerobic and strength conditioning.

25. **Experimental.** That are Experimental or Investigational.

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

27. **Foot Care.** For charges for routine, palliative or cosmetic foot care, including, but not limited to: treatment of weak, unstable, flat, strained or unbalanced feet; subluxations of the foot; treatment of corns or calluses; non-surgical care of toenails.

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

29. **Government.** That are expenses to the extent paid, or which the Participant is entitled to have paid or obtain without cost, in accordance with the laws or regulations of any government.

30. **Government-Operated Facilities.**

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

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

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

32. **Hypnosis.** Related to the use of hypnosis.

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

34. **Illegal Drugs or Medications.** That are services, supplies, care or treatment to a Participant for Injury or Sickness Incurred while the Participant was voluntarily taking or being under the influence of any controlled substance, drug, hallucinogen or narcotic not administered on the advice of a Physician. Expenses will be covered for Injured Participants other than the person using controlled substances and expenses will be covered for Substance Abuse treatment as specified in this Plan. This Exclusion does not apply if the Injury (a) resulted from being the victim of an act of domestic violence, or (b) resulted from a documented medical condition (including both physical and mental health conditions).

35. **Impregnation and Infertility Treatment.** Following charges related to Impregnation and Infertility Treatment: artificial insemination, fertility Drugs, G.I.F.T. (Gamete Intrafallopian Transfer), impotency Drugs such as Viagra™, in-vitro fertilization, donor eggs, collection or purchase of donor semen (sperm) or oocytes (eggs), freezing of sperm, oocytes, or embryos, or any type of artificial impregnation procedure, whether or not such procedure is successful.

36. **Incurred by Other Persons.** For expenses actually Incurred by other persons.

37. **Long Term Care.** For Long Term Care.

38. **Maintenance Therapy.** Charges for maintenance therapy of any type when the individual has reached the maximum level of improvement.

39. **Marijuana.** For marijuana or marijuana-derived substances or compounds (like THC/CBD oil), even if the Participant has a prescription and marijuana is legal under the laws of the state in which he or she lives.

40. **Medical Necessity.** That are not Medically Necessary.

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

42. **Negligence.** For Injuries resulting from negligence, misfeasance, malfeasance, nonfeasance or malpractice on the part of any licensed Physician.

43. **No Legal Obligation.** That are provided to a Participant for which the Provider of a service customarily makes no direct charge, or for which the Participant is not legally obligated to pay, or for which no charges would be made in the absence of this coverage, including but not limited to fees, care, supplies, or services for which a person, company or any other entity except the Participant or this benefit plan, may be liable for necessitating the fees, care, supplies, or services.

44. **Non-Prescription Drugs.** That are for drugs for use outside of a Hospital or other Inpatient facility that can be purchased over-the-counter and without a Physician's written prescription. Drugs for which there is a non-prescription equivalent available. This does not apply to the extent the non-prescription drug must be covered under Preventive Care, subject to the Affordable Care Act and FFCRA, as amended.

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

46. **Not Actually Rendered.** That are not actually rendered.

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

48. **Not Specifically Covered.** That are not specifically covered under this Plan.

49. **Nutritional Supplements.** For nutritional supplements, except as specified under Preventive Care.

50. **Obesity.** Charges for bariatric surgery, including but not limited to, gastric bypass, stapling and intestinal bypass, and lap band surgery, including reversals related to both obesity and Class III obesity (if body mass index (BMI) is equal to or greater than 40.0 kg/m²). For non-Class III obesity, related to care and treatment of obesity, weight loss or dietary control. This Exclusion does not apply to obesity screening and counseling that are covered under the Preventive Care benefit.

51. **Occupational.** For any condition, Illness, Injury or complication thereof arising out any employment for wage or profit, when the Participant is entitled to coverage mandated by Workers' Compensation or similar law, whether or not such coverage is in force or a claim has been made.

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

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

54. **Osseous Surgery.** For osseous surgery.

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

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

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

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

59. **Private Duty Nursing.** For private duty nursing, except as may be covered under Home Health Care or Hospice.

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

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

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

63. **Repair of Purchased Equipment.** For maintenance and repairs needed due to misuse or abuse of purchased equipment.

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

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

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

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

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

66. **Sexual Dysfunction.** For any treatment of a sexual dysfunction, including but not limited to sexual counseling or therapy, implants and hormonal therapy, except of dysfunction due to organic disease or gender dysphoria, unless otherwise specified by the Plan.

67. **Sterilization Reversal.** For sterilization procedure reversal.

68. **Structural Changes.** For charges for structural changes to a house or vehicle.

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

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

71. **Unreasonable.** That are required to treat Illness or Injuries arising from and due to error(s) caused at any point in the course of treatment by any Provider, including, but not limited to, a Physician or Hospital, wherein such Illness, Injury, infection or complication is not reasonably expected to occur. This Exclusion will apply to expenses directly or indirectly resulting from circumstances that, in the opinion of the Plan Administrator in its sole discretion, gave rise to the expense, whether or not they were directly or indirectly caused by the treating Provider, and are not generally foreseeable or expected amongst professionals practicing the same or similar type(s) of medicine as the treating Provider whose error caused the loss(es).

72. **Vision Care.** Expenses for the following:

a. For eye refractions, eyeglasses, contact lenses, or the vision examination for prescribing or fitting eyeglasses or contact lenses (except for aphakic patients, and soft lenses or sclera shells intended for use in the treatment of Illness or Injury).
b. For radial keratotomy or other plastic surgeries on the cornea in lieu of eyeglasses.
c. Vision therapy (orthoptics) and supplies.
d. Orthokeratology lenses for reshaping the cornea of the eye to improve vision.

73. **Vitamins.** For charges for nonprescription drugs, such as vitamins, cosmetic dietary aids, and nutritional supplements.

74. **War.** That Incurred as a result of war or any act of war, whether declared or undeclared, or any act of aggression, when the Participant is a member of the armed forces of any country, or during service by a Participant in the armed forces of any country. This exclusion does not apply to any Participant who is not a member of the armed forces, and does not apply to victims of any act of war or aggression.

ARTICLE IX - UTILIZATION MANAGEMENT

"Utilization Management" consists of several components to assist Participants in staying well: providing optimal management of chronic conditions, support, and service coordination during times of acute or new onset of a medical condition. The scope of the program includes Hospital admission certification, continued stay review, length of stay determination, discharge planning Retrospective Review, and case management. These programs are designed to ensure that Medically Necessary, high quality patient care is provided and enables maximum benefits under the Plan. In order to maximize Plan reimbursements, please read the following provisions carefully.

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

1. Hospitalization > 23 hour stay.
2. Transplant Candidacy Evaluation and Transplant (organ and/or tissue).
3. Skilled Nursing & Rehab Facilities.
4. Cardiac & Pulmonary Rehab
5. Chemotherapy.
6. Clinical Trials.
7. Diagnostic Testing: PET scans.
8. Dialysis.
9. Durable Medical Equipment (DME) - All rentals. Purchases over $500.
10. Epidural steroid injections/Facet injections.
11. Genetic Testing.
12. Home Health Care/Outpatient Infusion Services.
13. Inpatient and Outpatient Surgeries.
14. Therapy services:

    a. Applied Behavior Analysis (ABA) therapy.
    b. Cardiac therapy.
    c. Cognitive therapy.
    d. Occupational therapy.
    e. Physical therapy.
    f. Respiration therapy.
    g. Speech therapy.
    h. Vision therapy.

15. Radiation Therapy.
16. Varicose Vein Treatment.
17. Participation in an Approved Clinical Trial

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

The Pre-Certification process is limited to determining the Medical Necessity of the procedure. This does not verify eligibility for benefits nor guarantee benefit payments under the Plan. It is the Participant's responsibility to verify that the above services have been pre-certified as outlined below.

9.01A Pre-Certification Procedures and Contact Information
Utilization Management Service is simple and easy for Participants to use. Whenever a Participant is advised that any of the above care is needed, it is the Participant's responsibility to call the pre-certification department at its toll-free number, which is 1-800-615-7020.

The review process will continue, as outlined below, until the completion of the treatment plan and/or the Participant's discharge from the Hospital.

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

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

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

The Plan does not require the Participant to obtain approval of a medical service prior to getting treatment for an urgent care or Emergency situation, so there are no "Pre-service Urgent Care Claims" under the Plan. The 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.

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

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

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

Outpatient Services:
A Participant is required to contact the pre-certification department when the Physician requests certain outpatient procedures and services. The Summary of Benefits indicates which outpatient procedures and services require Pre-Certification.

9.01B Pre-Certification Penalty
The program requires the support and cooperation of each Participant. If a Participant follows the instructions and procedures, he or she will receive the normal Plan benefits for the services. However, if a Participant fails to notify the pre-certification department of any services listed in the section entitled "Services that Requires Pre-Certification" allowed charges will be reduced by $250. The Participant will be responsible for payment of the part of the charge that is not paid by the Plan.

NOTE: *If a Participant's admission or service is determined to not be Medically Necessary, he or she may pursue an appeal by following the provisions described in the Claims Procedures; Payment of Claims*

section of this document. The Participant and Provider will be informed of any denial or non-certification in writing.

9.01C Retrospective Review. The Plan allows a review of the Medical Necessity of the health care services provided on an Emergency basis, after they have been provided. Retroactive Pre-Certification is allowed for medical non-Emergency care situations up to 90 days after the date of service without a penalty.

9.01D Alternate Course of Treatment

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

If the Plan Administrator should determine that an alternate, less expensive, course of treatment is appropriate, and if the attending Physician agrees to the alternate course of treatment, all Medically Necessary expenses stated in the treatment plan will be eligible for payment under the Plan, subject to the applicable benefit maximum(s) set forth in this Plan, even if these expenses normally would not be eligible for payment under the Plan. In the event the Participant and the attending Physician select a more expensive course of treatment, coverage under the Plan will be based upon the charge allowed for the alternate, less expensive, course of treatment.

9.01E Pre-Admission Testing

If a Participant is to be admitted to a Hospital for non-Emergency Surgery or treatment, one set of laboratory tests and x-ray examinations performed on an Outpatient basis within seven days prior to such Hospital admission will be paid, after the Deductible, as outlined in the Summary of Benefits, provided that the following conditions are met:

1. The tests are related to the performance of the scheduled Surgery or treatment.
2. The tests have been ordered by a Physician after a condition requiring Surgery or treatment has been diagnosed and Hospital admission has been requested by the Physician and confirmed by the Hospital.
3. The Participant is subsequently admitted to the Hospital, or confinement is cancelled or postponed because a Hospital bed is unavailable or if, after the tests are reviewed, the Physician determines that the confinement is unnecessary.
4. The tests are performed in the Hospital where the confinement will take place and accepted in lieu of duplicate tests rendered during confinement.

9.01F Second Surgical Opinion

If a Physician recommends Surgery for a Participant, the Participant may request a second opinion as to whether or not the Surgery is Medically Necessary.

When a second opinion is requested, the Plan will pay of the Maximum Allowable Charge Incurred for that opinion along with laboratory, x-ray and other Medically Necessary services ordered by the second Physician after application of the Deductible. Second opinions for Cosmetic Surgery, normal obstetrical delivery and Surgeries that require only local anesthesia are not covered. If the second opinion does not concur with the first, the Plan will pay for a third opinion as outlined above. The second or third opinion must be given within 90 days of the first.

In all cases where a second opinion is requested, the original recommendation for Surgery must have been obtained from a Physician licensed in the medical specialty under which the recommended Surgery falls. The Physician consulted for the second opinion must be licensed in the same medical specialty and may not be a partner of or in association with the original Physician.

9.01G Case Management

Case management is a preemptive coordination of a Participant's care in cases where the medical condition is or is expected to be serious, chronic, or when the cost of treatment is expected to be significant. This

program provides for a case manager who monitors Participants and explores, discusses and recommends coordinated and/or alternate types of appropriate Medically Necessary care. Case management is a voluntary service. There are no reductions of benefits or penalties if the patient and family choose not to participate. Each treatment plan is individually tailored to a specific patient and should not be seen as appropriate or recommended for any other patient, even one with the same Diagnosis.

ARTICLE X - PRESCRIPTION DRUG BENEFITS

Covered Prescription Drug Expenses:	Network	Non-Network	Limits
RETAIL & MAIL PHARMACY BENEFIT			
Tier 1 - Generic Drugs	**Retail:** 100% Coinsurance after Deductible **Mail Order:** 100% Coinsurance after Deductible	Not Covered	Covers up to 90-day supply (retail prescription & mail-order prescription)
Tier 2 - Preferred (Formulary) Brand Drugs	**Retail:** 100% Coinsurance after Deductible **Mail Order:** 100% Coinsurance after Deductible	Not Covered	
Tier 3 - Non-Preferred (Non-Formulary) Brand Drugs	**Retail:** 100% Coinsurance after Deductible **Mail Order:** 100% Coinsurance after Deductible	Not Covered	
SPECIALTY DRUG BENEFIT			
Specialty Prescription Drugs	100% Coinsurance after Deductible	Not Covered	All specialty medications are limited up to 30-day supply, specialty formulary & specialty network only.

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

The Mail Order Option is available for maintenance medications (those that are taken for long periods of time, such as Drugs sometimes prescribed for heart disease, high blood pressure, asthma, etc.). Because

of the volume buying, Southern Scripts, the mail order pharmacy, is able to offer Participants significant savings on their prescriptions.

The Coinsurance amounts/Deductible amounts are applied to each charge and are shown on the Summary of Benefits, above.

RxCompass Program

The Plan has adopted the RxCompass Program to help members address the issues of high-cost medications by providing multiple solutions for sourcing drugs, through the RxCompass pathways. RxCompass will utilize a drug exclusion list whereby the specified drugs will be excluded from the primary plan. If your drug is an excluded medication outreach from an RxCompass Care Navigator will be initiated. The Care Navigator team has been established to assist you in the entire process of securing certain high-cost medications through an RxCompass drug savings pathways. Your Care Navigator will work directly with you and your physician to help determine the best option for securing your medication.

Additional information on the RxCompass program is available at myrxcompass.com and pricing.myrxcompass.com or may be accessed free of charge by contacting RxCompass at (833)-652-8379 or carenavigator@myrxcompass.com.

Value of Drug Manufacturer Assistance

Any amounts paid toward Participant responsibility which were paid or reimbursed by manufacturer assistance programs, copay cards, or similar patient assistance programs from a third party do not accrue toward the Deductible or annual Out-of-Pocket Maximum when the Drug in question is a specialty drug and there is a medically appropriate generic available.

10.01 Covered Expenses
Please contact the Plan Administrator or Pharmacy Benefit Manager for a complete list of covered benefits.

10.02 Limitations
Please contact the Plan Administrator or Pharmacy Benefit Manager for a complete list of limitations.

10.03 Exclusions
Please contact the Plan Administrator or Pharmacy Benefit Manager for a complete list of excluded benefits.

ARTICLE XI - PLAN ADMINISTRATION

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

11.01 Plan Administrator

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

The Plan Administrator shall administer this Plan in accordance with its terms and establish its policies, interpretations, practices, and procedures. It is the express intent of this Plan that the Plan Administrator shall have maximum legal discretionary authority to construe and interpret the terms and provisions of the Plan, to make determinations regarding issues which relate to eligibility for benefits (including the determination of what services, supplies, care and treatments are Experimental), to decide disputes which may arise relative to a Participant's rights, and to decide questions of Plan interpretation and those of fact relating to the Plan. The decisions of the Plan Administrator as to the facts related to any claim for benefits and the meaning and intent of any provision of the Plan, or its application to any claim, shall receive the maximum deference provided by law and will be final and binding on all interested parties. Benefits under this Plan will be paid only if the Plan Administrator decides, in its discretion, that the Participant is entitled to them.

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

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

11.02 Duties of the Plan Administrator

The duties of the Plan Administrator include the following:

1. To administer the Plan in accordance with its terms.
2. To determine all questions of eligibility, status and coverage under the Plan.
3. To interpret the Plan, including the authority to construe possible ambiguities, inconsistencies, omissions and disputed terms.
4. To make factual findings.
5. To decide disputes which may arise relative to a Participant's rights and/or availability of benefits.
6. To prescribe procedures for filing a claim for benefits, to review claim denials and appeals relating to them and to uphold or reverse such denials.
7. To keep and maintain the Plan documents and all other records pertaining to the Plan.
8. To appoint and supervise a Third-Party Administrator to pay claims.

9. To establish and communicate procedures to determine whether a Medical Child Support Order is a QMCSO.
10. To delegate to any person or entity such powers, duties and responsibilities as it deems appropriate.
11. To perform each and every function necessary for or related to the Plan's administration.

11.03 Amending and Terminating the Plan

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

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

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

11.04 Summary of Material Modification (SMM)

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

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

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

11.05 Summary of Material Reduction (SMR)

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

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

any Employee covered by the Plan who would reasonably expect to receive a summary through other means within the next 90 days.

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

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

11.06 Misuse of Identification Card

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

ARTICLE XII - CLAIM PROCEDURES; PAYMENT OF CLAIMS

12.01 Introduction
The procedures outlined below must be followed by Participants to obtain payment of health benefits under this Plan.

12.02 Health Claims
All claims and questions regarding health claims should be directed to the Third-Party Administrator. The Plan Administrator shall be ultimately and finally responsible for adjudicating such claims and for providing full and fair review of the decision on such claims in accordance with the following provisions, and applicable law. Benefits under the Plan will be paid only if the Plan Administrator decides in its discretion that the Participant is entitled to them. The responsibility to process claims in accordance with the Plan Document may be delegated to the Third-Party Administrator; provided, however, that the Third-Party Administrator is not a fiduciary of the Plan and does not have the authority to make decisions involving the use of discretion.

Each Participant claiming benefits under the Plan shall be responsible for supplying, at such times and in such manner as the Plan Administrator in its sole discretion may require, written proof that the expenses were Incurred or that the benefit is covered under the Plan. If the Plan Administrator in its sole discretion shall determine that the Participant has not Incurred a Covered Expense or that the benefit is not covered under the Plan, or if the Participant shall fail to furnish such proof as is requested, no benefits shall be payable under the Plan.

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

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

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

Benefits will be payable to a Participant, or to a Provider that has accepted an assignment of benefits as consideration in full for services rendered.

According to Federal regulations which apply to the Plan, there are four types of claims: Pre-service (Urgent and Non-urgent), Concurrent Care and Post service. However, as noted below, because of this Plan's design, there are no Pre-service Urgent Care Claims which may be filed with the Plan.

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. However, if the Plan does not require the Participant to obtain approval of a medical service prior to getting treatment, then there is no "Pre-service Claim." The 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.

   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 Participant or the Participant's ability to regain maximum function, or, in the opinion of a Physician with knowledge of the Participant's medical condition, would subject the Participant to severe pain that cannot be adequately managed without the care or treatment that is the subject of the claim.

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

The Plan does not require the Participant to obtain approval of any urgent care or Emergency medical services or admissions prior to getting treatment for an urgent care or Emergency situation, so there are no "Pre-service Urgent Care Claims" under the Plan. The 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.

Pre-admission certification of a non-Emergency Hospital admission is a "claim" only to the extent of the determination made – that the type of procedure or condition warrants Inpatient confinement for a certain number of days. The rules regarding Pre-service Claims will apply to that determination only. Once a Participant has the treatment in question, the claim for benefits relating to that treatment will be treated 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 determines that the course of treatment should be reduced or terminated.
    b. The Participant requests extension of the course of treatment beyond that which the Plan has approved.

   If the Plan does not require the Participant to obtain approval of a medical service prior to getting treatment, then there is no need to contact the Plan Administrator to request an extension of a course of treatment. The 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.

12.02A When Claims Must Be Filed

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

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

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

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

7. The name of the covered Employee.
8. The name of the patient.

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

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

12.02B Timing of Claim Decisions

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

1. Pre-service Urgent Care Claims:

    a. If the Participant has provided all of the necessary information, as soon as possible, taking into account the medical exigencies, but not later than 72 hours after receipt of the claim.
    b. If the Participant has not provided all of the information needed to process the claim, then the Participant will be notified as to what specific information is needed as soon as possible, but not later than 24 hours after receipt of the claim.
    c. The Participant will be notified of a determination of benefits as soon as possible, but not later than 48 hours, taking into account the medical exigencies, after the earliest of:

        i. The Plan's receipt of the specified information.
        ii. The end of the period afforded the Participant to provide the information.

    d. If there is an Adverse Benefit Determination, a request for an expedited appeal may be submitted orally or in writing by the Participant. All necessary information, including the Plan's benefit determination on review, may be transmitted between the Plan and the Participant by telephone, facsimile, or other similarly expeditious method. Alternatively, the Participant may request an expedited review under the external review process.

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

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

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

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

c. Request by Participant Involving Non-urgent Care. If the Plan Administrator receives a request from the Participant to extend the course of treatment beyond the period of time or number of treatments that is a claim not involving urgent care, the request will be treated as a new benefit claim and decided within the timeframe appropriate to the type of claim (either as a Pre-service Non-urgent claim or a post-service claim).

d. Request by Participant Involving Rescission. With respect to rescissions, the following timetable applies:

   i. Notification to Participant - 30 Days
   ii. Notification of Adverse Benefit Determination on appeal - 30 Days

4. Post-service Claims:
   a. If the Participant has provided all of the information needed to process the claim, in a reasonable period of time, but not later than 30 days after receipt of the claim, unless an extension has been requested, then prior to the end of the 15-day extension period.
   b. If such an extension is necessary due to a failure of the Participant to submit the information necessary to decide the claim, the notice of extension shall specifically describe the required information, and the Participant shall be afforded at least 45 days from receipt of the notice within which to provide the specified information.
   c. If the Participant has not provided all of the information needed to process the claim and additional information is requested during the initial processing period, then the Participant will be notified of a determination of benefits prior to the end of the extension period, unless additional information is requested during the extension period, then the Participant will be notified of the determination by a date agreed to by the Plan Administrator and the Participant.
5. Extensions:
   a. Pre-service Urgent Care Claims. No extensions are available in connection with Pre-service urgent care claims.
   b. Pre-service Non-urgent Care Claims. This period may be extended by the Plan for up to 15 days, provided that the Plan Administrator both determines that such an extension is necessary due to matters beyond the control of the Plan and notifies the Participant, prior to the expiration of the initial 15-day processing period, of the circumstances requiring the extension of time and the date by which the Plan expects to render a decision.
   c. Post-service Claims. This period may be extended by the Plan for up to 15 days, provided that the Plan Administrator both determines that such an extension is necessary due to matters beyond the control of the Plan and notifies the Participant, prior to the expiration of the initial 30-day processing period, of the circumstances requiring the extension of time and the date by which the Plan expects to render a decision.
6. Calculating Time Periods. The period of time within which a benefit determination is required to be made shall begin at the time a claim is deemed to be filed in accordance with the procedures of the Plan.

12.02C Notification of an Adverse Benefit Determination

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

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

12.03 Appeal of Adverse Benefit Determinations

12.03A Full and Fair Review of All Claims

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

1. A 180-day timeframe following receipt of a notification of an initial Adverse Benefit Determination within which to appeal the determination. The Plan will not accept appeals filed after a 180-day timeframe.
2. Participants the opportunity to submit written comments, documents, records, and other information relating to the claim for benefits.
3. Participants the opportunity to review the Claim file and to present evidence and testimony as part of the internal claims and appeals process.
4. For a review that does not afford deference to the previous Adverse Benefit Determination and that is conducted by an appropriate named fiduciary of the Plan, who shall be neither the individual who made the Adverse Benefit Determination that is the subject of the appeal, nor the subordinate of such individual.
5. For a review that takes into account all comments, documents, records, and other information submitted by the Participant relating to the claim, without regard to whether such information was submitted or considered in the prior benefit determination.
6. That, in deciding an appeal of any Adverse Benefit Determination that is based in whole or in part upon a medical judgment, the Plan fiduciary shall consult with a health care professional who has appropriate training and experience in the field of medicine involved in the medical judgment, who

is neither an individual who was consulted in connection with the Adverse Benefit Determination that is the subject of the appeal, nor the subordinate of any such individual.

7. Upon request, the identity of medical or vocational experts whose advice was obtained on behalf of the Plan in connection with a claim, even if the Plan did not rely upon their advice.
8. If applicable, a discussion of the basis for disagreeing with the disability determination made by either (a) the Social Security Administration; or (b) an independent medical expert that has conducted a full medical review of the Claimant if presented by the Claimant in support of the claim.
9. That a Participant will be provided, free of charge: (a) reasonable access to, and copies of, all documents, records, and other information relevant to the Participant's claim in possession of the Plan Administrator or Third Party Administrator; (b) information regarding any voluntary appeals procedures offered by the Plan; (c) information regarding the Participant's right to an external review process; (d) any internal rule, guideline, protocol or other similar criterion relied upon, considered or generated in making the adverse determination; and (e) an explanation of the scientific or clinical judgment for the determination, applying the terms of the Plan to the Participant's medical circumstances.
10. That a Participant will be provided, free of charge, and sufficiently in advance of the date that the notice of Final Internal Adverse Benefit Determination is required, with new or additional evidence considered, relied upon, or generated by the Plan in connection with the Claim, as well as any new or additional rationale for a denial at the internal appeals stage, and a reasonable opportunity for the Participant to respond to such new evidence or rationale.

12.03B Requirements for First Level Appeal

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

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

Prairie States Enterprises, Inc.
P.O. Box 23
615 Pennsylvania Ave
Sheboygan, WI 53082-0023

Phone: 800-615-7020
Local Phone: 920-451-7020
Fax: 920-451-7023
Website: www.prairieontheweb.com

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

Prairie States Enterprises, Inc.
P.O. Box 23
615 Pennsylvania Ave
Sheboygan, WI 53082-0023

Phone: 800-615-7020
Local Phone: 920-451-7020
Fax: 920-451-7023
Website: www.prairieontheweb.com

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

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

12.03C Timing of Notification of Benefit Determination on Review

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

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

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

12.03D Manner and Content of Notification of Adverse Benefit Determination on Review

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

1. Information sufficient to allow the Participant to identify the claim involved (including date of service, the health care Provider, the claim amount, if applicable, and a statement describing the availability, upon request, of the Diagnosis code and its corresponding meaning, and the treatment code and its corresponding meaning).
2. A reference to the specific portion(s) of the plan provisions upon which a denial is based.
3. Specific reason(s) for a denial, including the denial code and its corresponding meaning, and a description of the Plan's standard, if any, that was used in denying the claim, and a discussion of the decision.
4. A description of any additional information necessary for the Participant to perfect the claim and an explanation of why such information is necessary.
5. A description of available internal appeals and external review processes, including information regarding how to initiate an appeal.
6. A description of the Plan's review procedures and the time limits applicable to the procedures.
7. Upon request, the identity of any medical or vocational experts consulted in connection with a claim, even if the Plan did not rely upon their advice (or a statement that the identity of the expert will be provided, upon request).
8. Any rule, guideline, protocol or similar criterion that was relied upon, considered, or generated in making the determination will be provided free of charge. If this is not practical, a statement will be included that such a rule, guideline, protocol or similar criterion was relied upon in making the determination and a copy will be provided to the Participant, free of charge, upon request.
9. In the case of denials based upon a medical judgment (such as whether the treatment is Medically Necessary or Experimental), either an explanation of the scientific or clinical judgment for the determination, applying the terms of the Plan to the Participant's medical circumstances, will be

provided. If this is not practical, a statement will be included that such explanation will be provided to the Participant, free of charge upon request.

10. Information about the availability of, and contact information for, an applicable office of health insurance consumer assistance or ombudsman established under applicable federal law to assist Participants with the internal claims and appeals and external review processes.
11. The following statement: “You and your Plan may have other voluntary alternative dispute resolution options, such as mediation. One way to find out what may be available is to contact your local U.S. Department of Labor Office and your State insurance regulatory agency.”

12.03E Furnishing Documents in the Event of an Adverse Determination

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

12.03F Decision on Review

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

12.03G Deemed Exhaustion of Internal Claims Procedures and De Minimis

Exception to the Deemed Exhaustion Rule

A Participant will not be required to exhaust the internal claims and appeals procedures described above if the Plan fails to adhere to the claims procedures requirements. In such an instance, a Participant may proceed immediately to the external review program or make a claim in court. However, the internal claim and appeals procedures will not be deemed exhausted (meaning the Participant must adhere to them before participating in the external review program or bringing a claim in court) in the event of a de minimis violation that does not cause, and is not likely to cause, prejudice or harm to the Participant as long as the Plan Administrator demonstrates that the violation was for good cause or due to matters beyond the control of the Plan, the violation occurred in the context of an ongoing, good faith exchange of information between the Plan and the Participant, and the violation is not reflective of a pattern or practice of non-compliance.

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

12.03H External Review Process

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

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

1. Any eligible Adverse Benefit Determination (including a Final Internal Adverse Benefit Determination) by a plan or issuer that involves medical judgment (including, but not limited to, those based on the plan's or issuer's requirements for Medical Necessity, appropriateness, health care setting, level of care, or effectiveness of a covered benefit; its determination that a treatment is Experimental or Investigational; its determination whether a Claimant or beneficiary is entitled to

a reasonable alternative standard for a reward under a wellness program; its determination whether a plan or issuer is complying with the nonquantitative treatment limitation provisions of Code section 9812 and § 54.9812-1, which generally require, among other things, parity in the application of medical management techniques), as determined by the external reviewer.

2. An Adverse Benefit Determination that involves consideration of whether the Plan is complying with the surprise billing and cost-sharing protections set forth in the No Surprises Act.
3. A rescission of coverage (whether or not the rescission has any effect on any particular benefit at that time).

Standard external review

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

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

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

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

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

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

Expedited external review

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

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

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

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

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

12.04 Appointment of Authorized Representative

A Participant is permitted to appoint an authorized representative to act on his or her behalf with respect to a benefit claim or appeal of a denial. An assignment of benefits by a Participant to a Provider will not constitute appointment of that Provider as an authorized representative. To appoint such a representative, the Participant must complete a form which can be obtained from the Plan Administrator or the Third-Party Administrator. However, in connection with a claim involving Urgent Care, the Plan will permit a health care professional with knowledge of the Participant's medical condition to act as the Participant's authorized representative without completion of this form. In the event a Participant designates an authorized

representative, all future communications from the Plan will be with the representative, rather than the Participant, unless the Participant directs the Plan Administrator, in writing, to the contrary.

12.05 Autopsy
The Plan reserves the right to have an autopsy performed upon any deceased Participant whose condition, Sickness, or Injury is the basis of a claim. This right may be exercised only where not prohibited by law.

12.06 Payment of Benefits
All benefits under this Plan are payable, in U.S. Dollars, to the covered Employee whose Sickness or Injury, or whose covered Dependent's Sickness or Injury, is the basis of a claim. In the event of the death or incapacity of a covered Employee and in the absence of written evidence to this Plan of the qualification of a guardian for his or her estate, this Plan may, in its sole discretion, make any and all such payments to the individual or Institution which, in the opinion of this Plan, is or was providing the care and support of such Employee.

12.06A Assignments
For this purpose, the term "Assignment of Benefits" (or "AOB") is defined as an arrangement whereby a Participant of the Plan, at the discretion of the Plan Administrator, assigns its right to seek and receive payment of eligible Plan benefits, less Deductible, Copayments and Coinsurance amounts, to a medical Provider. If a Provider accepts said arrangement, the Provider's rights to receive Plan benefits are equal to those of the Participant, and are limited by the terms of this Plan Document. A Provider that accepts this arrangement indicates acceptance of an AOB and Deductibles, Copayments, and Coinsurance amounts, as consideration in full for treatment rendered.

The Plan Administrator may revoke an AOB at its discretion and treat the Participant of the Plan as the sole beneficiary. Benefits for medical expenses covered under this Plan may be assigned by a Participant to the Provider as consideration in full for services rendered; however, if those benefits are paid directly to the Participant, the Plan will be deemed to have fulfilled its obligations with respect to such benefits. The Plan will not be responsible for determining whether any such assignment is valid. Payment of benefits which have been assigned may be made directly to the assignee unless a written request not to honor the assignment, signed by the Participant, has been received before the proof of loss is submitted, or the Plan Administrator – at its discretion – revokes the assignment.

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

12.06B Non-U.S. Providers
Medical expenses for care, supplies, or services which are rendered by a Provider whose principal place of business or address for payment is located outside the United States (a "Non-U.S. Provider") are payable under the Plan, subject to all Plan Exclusions, limitations, maximums and other provisions, under the following conditions:

1. Benefits may not be assigned to a Non-U.S. Provider.
2. The Participant is responsible for making all payments to Non-U.S. Providers, and submitting receipts to the Plan for reimbursement.
3. Benefit payments will be determined by the Plan based upon the exchange rate in effect on the Incurred Date.
4. The Non-U.S. Provider shall be subject to, and in compliance with, all U.S. and other applicable licensing requirements.
5. Claims for benefits must be submitted to the Plan in English.
6. Claims from Non-U.S. providers shall be covered at the In-Network benefit level.

12.06C Recovery of Payments

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

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

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

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

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

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

1. In error.
2. Pursuant to a misstatement contained in a proof of loss or a fraudulent act.
3. Pursuant to a misstatement made to obtain coverage under this Plan within two years after the date such coverage commences.
4. With respect to an ineligible person.

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

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

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

12.06D Medicaid Coverage

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

12.06E Limitation of Action

A Participant cannot bring any legal action against the Plan for a claim of benefits until 90 days after all appeal processes have been exhausted. After 90 days, if the Participant wants to bring a legal action against the Plan, he or she must do so within 3 years of the date he or she is notified of the final decision on the final appeal or he or she will lose any rights to bring such an action against the Plan.

ARTICLE XIII - COORDINATION OF BENEFITS

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

Standard Coordination of Benefits
The plan that pays first according to the rules will pay as if there were no other plan involved. The secondary and subsequent plans will pay the balance due up to 100% of the total allowable charges**.**

13.02 Benefits Subject to This Provision
The following only applies to the medical benefits of the Plan.

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

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

1. The responsible party, its insurer, or any other source on behalf of that party.
2. Any first party insurance through medical payment coverage, personal injury protection, no-fault coverage, uninsured or underinsured motorist coverage.
3. Any policy of insurance from any insurance company or guarantor of a third party, including but not limited to an employer's policy.
4. Workers' compensation or other liability insurance company.
5. Any other source of coverage, including, but not limited to, the following:
    - Crime victim restitution funds
    - Civil restitution funds
    - No-fault restitution funds such as vaccine injury compensation funds
    - Any medical, applicable disability or other benefit payments
    - School insurance coverage

13.04 Vehicle Limitation
When medical payments are available under any vehicle insurance, the Plan shall pay excess benefits only, without reimbursement for vehicle plan and/or policy deductibles. This Plan shall always be considered secondary to such plans and/or policies and will exclude benefits subject to the Exclusions in this Plan up to the maximum amount available to the Participant under applicable state law, regardless of a Participant's election of lesser coverage amount. This applies to all forms of medical payments under vehicle plans and/or policies regardless of their names, titles, or classifications.

13.05 Effect on Benefits

13.05A Application to Benefit Determinations
The plan that pays first according to the rules in the section entitled "Order of Benefit Determination" will pay as if there were no Other Plan involved. The secondary and subsequent plans will pay the balance due up to 100% of the total Covered Expenses. Sometimes this calculation will result in no additional amount paid. When there is a conflict in the rules, this Plan will never pay more than 50% of Covered Expenses when paying secondary. Benefits will be coordinated on the basis of a Claim Determination Period.

When medical payments are available under automobile insurance, this Plan will pay excess benefits only, without reimbursement for automobile plan deductibles. This Plan will always be considered secondary

regardless of the individual's election under personal injury protection (PIP) coverage with the automobile insurance carrier regarding priority of payment.

When some "Other Plan" provides benefits in the form of services (rather than cash payments), the Plan Administrator shall assess the value of said benefit(s) and determine the reasonable cash value of the service or services rendered, by determining the amount that would be payable in accordance with the terms of the Plan.

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

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

13.05B Order of Benefit Determination

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

1. A plan without a coordinating provision will always be the primary plan.
2. The benefits of a plan which covers the person on whose expenses a claim is based, other than as a dependent, shall be determined before the benefits of a plan which covers such person as a dependent.
3. If the person for whom claim is made is a dependent child covered under both parents' plans, the plan covering the parent whose birthday (month and day of birth, not year) falls earlier in the year will be primary, except:

    a. When the parents were never married, are separated, or are divorced, the benefits of a plan which covers the child as a dependent of the parent with custody will be determined before the benefits of a plan which covers the child as a dependent of the parent without custody.
    b. When the parents are divorced and the parent with custody of the child has remarried, the benefits of a plan which covers the child as a dependent of the parent with custody shall be determined before the benefits of a plan which covers that child as a dependent of the stepparent, and the benefits of a plan which covers that child as a dependent of the stepparent will be determined before the benefits of a plan which covers that child as a dependent of the parent without custody.

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

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

13.06 Right to Receive and Release Necessary Information

For the purpose of determining the applicability of and implementing the terms of this provision or any provision of similar purpose of any Other Plan, this Plan may, without the consent of or notice to any person, release to or obtain from any insurance company, or other organization or individual, any information with

respect to any person, which the Plan deems to be necessary for such purposes. Any person claiming benefits under this Plan shall furnish to the Plan such information as may be necessary to implement this provision.

13.07 Facility of Payment

Whenever payments which should have been made under this Plan in accordance with this provision have been made under any Other Plans, the Plan Administrator may, in its sole discretion, pay any organizations making such other payments any amounts it shall determine to be warranted in order to satisfy the intent of this provision, and amounts so paid shall be deemed to be benefits paid under this Plan and, to the extent of such payments, this Plan shall be fully discharged from liability.

13.08 Right of Recovery

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

ARTICLE XIV - MEDICARE

14.01 Applicable to Active Employees and Their Spouses Ages 65 and Over
An Active Employee and his or her spouse (ages 65 and over) may, at the option of such Employee, elect or reject coverage under this Plan. If such Employee elect's coverage under this Plan, the benefits of this Plan shall be determined before any benefits provided by Medicare. If coverage under this Plan is rejected by such Employee, benefits listed herein will not be payable even as secondary coverage to Medicare.

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

14.03 Applicable to Medicare Services Furnished to End Stage Renal Disease ("ESRD") Participants Who Are Covered Under This Plan
If any Participant is enrolled in Medicare coverage because of ESRD, the benefits of the Plan will be determined before Medicare benefits for the first 30 months of the Participant's Medicare entitlement, regardless of the date of enrollment, unless applicable Federal law provides to the contrary, in which event the benefits of the Plan will be determined in accordance with such law.

ARTICLE XV - THIRD PARTY RECOVERY, SUBROGATION AND REIMBURSEMENT

15.01 Payment Condition

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

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

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

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

15.02 Subrogation

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

If a Participant(s) receives or becomes entitled to receive benefits, an automatic equitable lien attaches in favor of the Plan to any claim, which any Participant(s) may have against any Coverage and/or party causing the Sickness or Injury to the extent of such conditional payment by the Plan plus reasonable costs

of collection. The Participant is obligated to notify the Plan or its authorized representative of any settlement prior to finalization of the settlement, execution of a release, or receipt of applicable funds. The Participant is also obligated to hold any and all funds so received in trust on the Plan's behalf and function as a trustee as it applies to those funds until the Plan's rights described herein are honored and the Plan is reimbursed.

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

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

1. The responsible party, its insurer, or any other source on behalf of that party.
2. Any first party insurance through medical payment coverage, personal injury protection, no-fault coverage, uninsured or underinsured motorist coverage.
3. Any policy of insurance from any insurance company or guarantor of a third party, including but not limited to an employer's policy.
4. Workers' compensation or other liability insurance company.
5. Any other source of Coverage, including, but not limited to, the following:
    - Crime victim restitution funds
    - Civil restitution funds
    - No-fault restitution funds such as vaccine injury compensation funds
    - Any medical, applicable disability or other benefit payments
    - School insurance coverage

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

15.03 Right of Reimbursement

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

No court costs, experts' fees, attorneys' fees, filing fees, or other costs or expenses of litigation may be deducted from the Plan's recovery without the prior, express written consent of the Plan. Additionally, the Participant shall indemnify the Plan against any of the Participant's attorney's fees, costs, or other expenses related to the Participant's recovery for which the Plan becomes responsible by any means other than the Plan's explicit written consent.

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

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

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

15.04 Participant is a Trustee Over Plan Assets

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

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

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

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

15.05 Release of Liability

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

15.06 Excess Insurance

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

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

1. The responsible party, its insurer, or any other source on behalf of that party.
2. Any first party insurance through medical payment coverage, personal injury protection, no-fault coverage, uninsured or underinsured motorist coverage.
3. Any policy of insurance from any insurance company or guarantor of a third party, including but not limited to an employer's policy.
4. Workers' compensation or other liability insurance company.
5. Any other source of Coverage, including, but not limited to, the following:
    - Crime victim restitution funds
    - Civil restitution funds
    - No-fault restitution funds such as vaccine injury compensation funds
    - Any medical, applicable disability or other benefit payments
    - School insurance coverage

15.07 Separation of Funds

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

15.08 Wrongful Death

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

15.09 Obligations

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

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

10. In circumstances where the Participant is not represented by an attorney, instruct the insurance company or any third party from whom the Participant obtains a settlement to include the Plan or its authorized representative as a payee on the settlement draft.
11. To make good faith efforts to prevent disbursement of settlement funds until such time as any dispute between the Plan and Participant over settlement funds is resolved.

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

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

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

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

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

15.12 Language Interpretation
The Plan Administrator retains sole, full and final discretionary authority to construe and interpret the language of this provision, to determine all questions of fact and law arising under this provision, and to administer the Plan's subrogation and reimbursement rights with respect to this provision. The Plan Administrator may amend the Plan at any time without notice.

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

ARTICLE XVI - MISCELLANEOUS PROVISIONS

16.01 Clerical Error/Delay
Clerical errors made on the records of the Plan and delays in making entries on such records shall not invalidate coverage nor cause coverage to be in force or to continue in force. Rather, the Effective Dates of coverage shall be determined solely in accordance with the provisions of this Plan regardless of whether any contributions with respect to Participants have been made or have failed to be made because of such errors or delays. Upon discovery of any such error or delay, an equitable adjustment of any such contributions will be made.

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

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

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

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

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

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

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

16.07 No Waiver or Estoppel
No term, condition or provision of this Plan shall be deemed to have been waived, and there shall be no estoppel against the enforcement of any provision of this Plan, except by written instrument of the party

charged with such waiver or estoppel. No such written waiver shall be deemed a continuing waiver unless specifically stated therein, and each such waiver shall operate only as to the specific term or condition waived and shall not constitute a waiver of such term or condition for the future or as to any act other than the one specifically waived.

16.08 Plan Contributions

The Plan Administrator shall, from time to time, evaluate the funding method of the Plan and determine the amount to be contributed by the Participating Employer and the amount to be contributed (if any) by each Participant.

The Plan Sponsor shall fund the Plan in a manner consistent with the provisions of the Internal Revenue Code 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.

Notwithstanding any other provision of the Plan, the Plan Administrator's obligation to pay claims otherwise allowable under the terms of the Plan shall be limited to its obligation to make contributions to the Plan as set forth in the preceding paragraph. Payment of said claims in accordance with these procedures shall discharge completely the Company's obligation with respect to such payments.

In the event that the Company terminates the Plan, then as of the effective date of termination, the Employer and eligible Employees shall have no further obligation to make additional contributions to the Plan and the Plan shall have no obligation to pay claims Incurred after the termination date of the Plan.

16.09 Right to Receive and Release Information

For the purpose of determining the applicability of and implementing the terms of these benefits, the Plan Administrator may, without the consent of or notice to any person, release or obtain any information necessary to determine the acceptability of any applicant or Participant for benefits from this Plan. In so acting, the Plan Administrator shall be free from any liability that may arise with regard to such action. Any Participant claiming benefits under this Plan shall furnish to the Plan Administrator such information as may be necessary to implement this provision.

16.10 Written Notice

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

16.11 Right of Recovery

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

16.12 Statements

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

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

16.13 Protection Against Creditors

To the extent this provision does not conflict with any applicable law, no benefit payment under this Plan shall be subject in any way to alienation, sale, transfer, pledge, attachment, garnishment, execution or encumbrance of any kind, and any attempt to accomplish the same shall be void. If the Plan Administrator shall find that such an attempt has been made with respect to any payment due or to become due to any Participant, the Plan Administrator in its sole discretion may terminate the interest of such Participant or former Participant in such payment. And in such case the Plan Administrator shall apply the amount of such payment to or for the benefit of such Participant or former Participant, his or her spouse, parent, adult Child, guardian of a minor Child, brother or sister, or other relative of a Dependent of such Participant or former Participant, as the Plan Administrator may determine, and any such application shall be a complete discharge of all liability with respect to such benefit payment. However, at the discretion of the Plan Administrator, benefit payments may be assigned to health care Providers.

16.14 Unclaimed Self-Insured Plan Funds

In the event a benefits check issued by the Third-Party Administrator for this self-insured Plan is not cashed within one year of the date of issue, the check will be voided and the funds will be retained by this Plan and applied to the payment of current benefits and administrative fees under this Plan. In the event a Participant subsequently requests payment with respect to the voided check, the Third-Party Administrator for the self-insured Plan shall make such payment under the terms and provisions of the Plan as in effect when the claim was originally processed. Unclaimed self-insured Plan funds may be applied only to the payment of benefits (including administrative fees) under the Plan pursuant to any applicable State law(s).

ARTICLE XVII - HIPAA PRIVACY

Commitment to Protecting Health Information
The Plan will comply with the Standards for Privacy of Individually Identifiable Health Information (i.e., the "Privacy Rule") set forth by the U.S. Department of Health and Human Services ("HHS") pursuant to the Health Insurance Portability and Accountability Act of 1996 ("HIPAA"). Such standards control the dissemination of "protected health information" ("PHI") of Participants. Privacy Standards will be implemented and enforced in the offices of the Employer and Plan Sponsor and any other entity that may assist in the operation of the Plan.

The Plan is required by law to take reasonable steps to ensure the privacy of the Participant's PHI, and inform him or her about:

1. The Plan's disclosures and uses of PHI.
2. The Participant's privacy rights with respect to his or her PHI.
3. The Plan's duties with respect to his or her PHI.
4. The Participant's right to file a complaint with the Plan and with the Secretary of HHS.
5. The person or office to contact for further information about the Plan's privacy practices.

The Plan provides each Participant with a separate Notice of Privacy Practices. This Notice describes how the Plan uses and discloses a Participant's personal health information. It also describes certain rights the Participant has regarding this information. Additional copies of the Plan's Notice of Privacy Practices are available by calling 1-715-778-5551.

Within this provision capitalized terms may be used, but not otherwise defined. These terms shall have the same meaning as those terms set forth in 45 CFR Sections 160.103 and 164.501. Any HIPAA regulation modifications altering a defined HIPAA term or regulatory citation shall be deemed incorporated into this provision.

Definitions

- **Breach** means an unauthorized acquisition, access, use or disclosure of Protected Health Information ("PHI") or Electronic Protected Health Information ("ePHI") that violates the HIPAA Privacy Rule and that compromises the security or privacy of the information.

- **Protected Health Information ("PHI")** means individually identifiable health information, as defined by HIPAA, that is created or received by the Plan and that relates to the past, present, or future physical or mental health or condition of an individual; the provision of health care to an individual; or the past, present, or future payment for the provision of health care to an individual; and that identifies the individual or for which there is a reasonable basis to believe the information can be used to identify the individual. PHI includes information of persons living or deceased.

How Health Information May Be Used and Disclosed
In general, the Privacy Rules permit the Plan to use and disclose, the minimum necessary amount, an individual's PHI, without obtaining authorization, only if the use or disclosure is for any of the following:

1. To carry out payment of benefits.
2. If the use or disclosure falls within one of the limited circumstances described in the rules (e.g., the disclosure is required by law or for public health activities).

Primary Uses and Disclosures of PHI

1. Treatment, Payment and Health Care Operations: The Plan has the right to use and disclose a Participant's PHI for all activities as included within the definitions of Treatment, Payment, and Health Care Operations and pursuant to the HIPAA Privacy Rule.
2. Business Associates: The Plan contracts with individuals and entities (Business Associates) to perform various functions on its behalf. In performance of these functions or to provide services, Business Associates will receive, create, maintain, use, or disclose PHI, but only after the Plan and the Business Associate agree in writing to contract terms requiring the Business Associate to appropriately safeguard the Participant's information.
3. Other Covered Entities: The Plan may also disclose or share PHI with other insurance carriers (such as Medicare, etc.) in order to coordinate benefits, if a Participant has coverage through another carrier.

Disclosure of PHI to the Plan Sponsor for Plan Administration Purposes
In order that the Plan Sponsor may receive and use PHI for plan administration purposes, the Plan Sponsor agrees to:

1. Not use or further disclose PHI other than as permitted or required by the plan documents or as required by law (as defined in the Privacy Standards).
2. Ensure that any agents, including a subcontractor, to whom the Plan Sponsor provides PHI received from the Plan, agree to the same restrictions and conditions that apply to the Plan Sponsor with respect to such PHI.
3. Maintain the confidentiality of all PHI, unless an individual gives specific consent or authorization to disclose such data or unless the data is used for health care payment or Plan operations.
4. Receive PHI, in the absence of an individual's express authorization, only to carry out Plan administration functions.
5. Not use or disclose genetic information for underwriting purposes.
6. Report to the Plan any PHI use or disclosure that is inconsistent with the uses or disclosures provided for of which the Plan Sponsor becomes aware.
7. Make available PHI in accordance with section 164.524 of the Privacy Standards (45 CFR 164.524).
8. Make available PHI for amendment and incorporate any amendments to PHI in accordance with section 164.526 of the Privacy Standards (45 CFR 164.526).
9. Make its internal practices, books and records relating to the use and disclosure of PHI received from the Plan available to the Secretary of the U.S. Department of Health and Human Services ("HHS"), or any other officer or Employee of HHS to whom the authority involved has been delegated, for purposes of determining compliance by the Plan with part 164, subpart E, of the Privacy Standards (45 CFR 164.500 et seq).
10. If feasible, return or destroy all PHI received from the Plan that the Plan Sponsor still maintains in any form and retain no copies of such PHI when no longer needed for the purpose for which disclosure was made, except that, if such return or destruction is not feasible, limit further uses and disclosures to those purposes that make the return or destruction of the PHI infeasible.

Required Disclosures of PHI

1. Disclosures to Participants: The Plan is required to disclose to a Participant most of the PHI in a Designated Record Set when the Participant requests access to this information. The Plan will disclose a Participant's PHI to an individual who has been assigned as his or her representative and who has qualified for such designation in accordance with the relevant State law. Before disclosure to an individual qualified as a personal representative, the Plan must be given written supporting documentation establishing the basis of the personal representation.

   The Plan may elect not to treat the person as the Participant's personal representative if it has a reasonable belief that the Participant has been, or may be, subjected to domestic violence, abuse,

or neglect by such person, it is not in the Participant's best interest to treat the person as his or her personal representative, or treating such person as his or her personal representative could endanger the Participant.

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

Participant's Rights
The Participant has the following rights regarding PHI about him/her:

1. Request Restrictions: The Participant has the right to request additional restrictions on the use or disclosure of PHI for treatment, payment, or health care operations. The Participant may request that the Plan restrict disclosures to family members, relatives, friends or other persons identified by him/her who are involved in his or her care or payment for his or her care. The Plan is not required to agree to these requested restrictions.
2. Right to Receive Confidential Communication: The Participant has the right to request that he or she receive communications regarding PHI in a certain manner or at a certain location. The request must be made in writing and how the Participant would like to be contacted. The Plan will accommodate all reasonable requests.
3. Right to Receive Notice of Privacy Practices: The Participant is entitled to receive a paper copy of the plan's Notice of Privacy Practices at any time. To obtain a paper copy, contact the Privacy Officer.
4. Accounting of Disclosures: The Participant has the right to request an accounting of disclosures the Plan has made of his or her PHI. The request must be made in writing and does not apply to disclosures for treatment, payment, health care operations, and certain other purposes. The Participant is entitled to such an accounting for the six years prior to his or her request. Except as provided below, for each disclosure, the accounting will include: (a) the date of the disclosure, (b) the name of the entity or person who received the PHI and, if known, the address of such entity or person; (c) a description of the PHI disclosed, (d) a statement of the purpose of the disclosure that reasonably informs the Participant of the basis of the disclosure, and certain other information. If the Participant wishes to make a request, please contact the Privacy Officer.
5. Access: The Participant has the right to request the opportunity to look at or get copies of PHI maintained by the Plan about him/her in certain records maintained by the Plan. If the Participant requests copies, he or she may be charged a fee to cover the costs of copying, mailing, and other supplies. If a Participant wants to inspect or copy PHI, or to have a copy of his or her PHI transmitted directly to another designated person, he or she should contact the Privacy Officer. A request to transmit PHI directly to another designated person must be in writing, signed by the Participant and the recipient must be clearly identified. The Plan must respond to the Participant's request within 30 days (in some cases, the Plan can request a 30-day extension). In very limited circumstances, the Plan may deny the Participant's request. If the Plan denies the request, the Participant may be entitled to a review of that denial.
6. Amendment: The Participant has the right to request that the Plan change or amend his or her PHI. The Plan reserves the right to require this request be in writing. Submit the request to the Privacy Officer. The Plan may deny the Participant's request in certain cases, including if it is not in writing or if he or she does not provide a reason for the request.
7. Other uses and disclosures not described in this section can only be made with authorization from the Participant. The Participant may revoke this authorization at any time.

Questions or Complaints
If the Participant wants more information about the Plan's privacy practices, has questions or concerns, or believes that the Plan may have violated his or her privacy rights, please contact the Plan using the following information. The Participant may submit a written complaint to the U.S. Department of Health and Human

Services or with the Plan. The Plan will provide the Participant with the address to file his or her complaint with the U.S. Department of Health and Human Services upon request.

The Plan will not retaliate against the Participant for filing a complaint with the Plan or the U.S. Department of Health and Human Services.

Contact Information

Privacy Officer Contact Information:

Administrative Assistant / HR
School District of Spring Valley
S1450 County Rd CC
Spring Valley WI 54767
Phone: 1-715-778-5551
Website: www.springvalley.k12.wi.us

ARTICLE XVIII - HIPAA SECURITY

Disclosure of Electronic Protected Health Information ("Electronic PHI") to the Plan Sponsor for Plan Administration Functions

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

The Security Rule imposes regulations for maintaining the integrity, confidentiality and availability of protected health information that it creates, receives, maintains, or maintains electronically that is kept in electronic format (ePHI) as required under the Health Insurance Portability and Accountability Act (HIPAA).

Definitions

- **Electronic Protected Health Information (ePHI),** as defined in Section 160.103 of the Security Standards (45 C.F.R. 160.103) and means individually identifiable health information transmitted or maintained in any electronic media.
- **Security Incidents,** as defined within Section 164.304 of the Security Standards (45 C.F.R. 164.304) and means the attempted or successful unauthorized access, use, disclosure, modification, or destruction of information or interference with systems operation in an information system.

Plan Sponsor Obligations
To enable the Plan Sponsor to receive and use Electronic PHI for Plan Administration Functions (as defined in 45 CFR §164.504(a)), the Plan Sponsor agrees to:

1. Implement administrative, physical, and technical safeguards that reasonably and appropriately protect the confidentiality, integrity and availability of the Electronic PHI that it creates, receives, maintains, or transmits on behalf of the Plan.
2. Ensure that adequate separation between the Plan and the Plan Sponsor, as required in 45 CFR § 164.504(f)(2)(iii), is supported by reasonable and appropriate Security Measures.
3. Ensure that any agent, including a subcontractor, to whom the Plan Sponsor provides Electronic PHI created, received, maintained, or transmitted on behalf of the Plan, agrees to implement reasonable and appropriate administrative, physical, and technical safeguards to protect the confidentiality, integrity, and availability of the Electronic PHI and report to the Plan any security incident of which it becomes aware.
4. Report to the Plan any security incident of which it becomes aware.
5. Establish safeguards for information, including security systems for data processing and storage.
6. Not use or disclose PHI for employment-related actions and decisions or in connection with any other benefit or Employee benefit plan of the Plan Sponsor, except pursuant to an authorization which meets the requirements of the Privacy Standards.
7. Ensure that adequate separation between the Plan and the Plan Sponsor, as required in section 164.504(f)(2)(iii) of the Privacy Standards (45 CFR 164.504(f)(2)(iii)), is established as follows:
    a. The following Employees, or classes of Employees, or other persons under control of the Plan Sponsor, shall be given access to the PHI to be disclosed:
        i. Privacy Officer.
        ii. Director of Employee Benefits.
        iii. Employee Benefits Department employees.
        iv. Information Technology Department.
    b. The access to and use of PHI by the individuals identified above shall be restricted to the plan administration functions that the Plan Sponsor performs for the Plan.

Disclosure of Summary Health Information to the Plan Sponsor
The Plan may disclose PHI to the Plan Sponsor of the group health plan for purposes of plan administration or pursuant to an authorization request signed by the Participant. The Plan may use or disclose "summary health information" to the Plan Sponsor for obtaining premium bids or modifying, amending, or terminating the group health plan. "Summary health information" may be individually identifiable health information and it summarizes the claims history, claims expenses or the type of claims experienced by individuals in the plan, but it excludes all identifiers that must be removed for the information to be de-identified, except that it may contain geographic information to the extent that it is aggregated by five-digit zip code.

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

Disclosure of PHI to Obtain Stop-loss or Excess Loss Coverage
The Plan Sponsor may hereby authorize and direct the Plan, through the Plan Administrator or the Third-Party Administrator, to disclose PHI to stop-loss carriers, excess loss carriers or managing general underwriters ("MGUs") for underwriting and other purposes in order to obtain and maintain stop-loss or excess loss coverage related to benefit claims under the Plan. Such disclosures shall be made in accordance with the Privacy Standards.

Resolution of Noncompliance
In the event that any authorized individual of the Employer's workforce uses or discloses Protected Health Information other than as permitted by the Privacy Standards, the incident shall be reported to the Privacy Officer. The Privacy Officer shall take appropriate action, including:

1. Investigation of the incident to determine whether the breach occurred inadvertently, through negligence, or deliberately; whether there is a pattern of breaches; and the degree of harm caused by the breach.
2. Applying appropriate sanctions against the persons causing the breach, which, depending upon the nature of the breach, may include oral or written reprimand, additional training, or termination of employment.
3. Mitigating any harm caused by the breach, to the extent practicable.
4. Documentation of the incident and all actions taken to resolve the issue and mitigate any damages.
5. Training Employees in privacy protection requirements and appoint a Privacy Officer responsible for such protections.
6. Disclosing the Participant's PHI to the Secretary of the U.S. Department of Health and Health and Human Resources when the Secretary is investigating or determining the Plan's compliance with the HIPAA Privacy Rule.

PLAN AMENDMENT #1

SCHOOL DISTRICT OF SPRING VALLEY MEDICAL AND PRESCRIPTION DRUG BENEFIT PLAN

Effective **March 1, 2024** the School District of Spring Valley Medical and Prescription Drug Benefit Plan (the "Plan") is hereby amended in the following manner:

ARTICLE III - DEFINITIONS

1. Under DEFINITIONS, the existing "Maximum Allowable Charge" definition is amended to read as follows:

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

For claims subject to the No Surprises Act (see "No Surprises Act – Emergency Services and Surprise Bills" within the section "Summary of Benefits,") if no negotiated rate exists, the Maximum Allowable Charge will be an amount deemed payable by a Certified IDR Entity or a court of competent jurisdiction, if applicable.

If none of the above factors is applicable, the Maximum Allowable Charge will be determined by the Plan to be the Medicare reimbursement rates published by the Centers for Medicare and Medicaid Services ("CMS") either multiplied by 150%, or multiplied by a percentage that the particular Provider and/or others in the area customarily accept from all payers.

If no Medicare reimbursement rate is available for a given item of service or supply, Medicare reimbursement rates will be approximated in good faith based on one of the following:

- Medicare equivalencies (prices established utilizing standard Medicare Payment methods and/or based upon supplemental Medicare or Medicaid pricing data for items Medicare doesn't cover based on data from CMS);
- Approximation tools (prices established utilizing standard Medicare payment methods and/or based upon prevailing Medicare rates in the community for non-Medicare facilities for similar services and/or supplies provided by similarly skilled and trained providers of care); or
- Medicare crosswalks (prices established utilizing standard Medicare payment methods for items in alternate settings based on Medicare rates provided for similar services and/or supplies paid to similarly skilled and trained providers of care in traditional settings).

If and only if none of the factors above is applicable, the Plan Administrator will exercise its discretion to determine the Maximum Allowable Charge based on any of the following: Medicare cost data, amounts actually collected by Providers in the area for similar services, or average wholesale price (AWP) or manufacturer's retail pricing (MRP). These ancillary factors will take into account generally-accepted billing standards and practices.

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

negligence or malpractice is not required for services or fees to be considered ineligible pursuant to this provision.

All other sections of the Plan remain unchanged.

The undersigned of School District of Spring Valley hereby certifies that the aforementioned resolutions were adopted by the School District of Spring Valley Medical and Prescription Drug Benefit Plan. The undersigned further certifies that this document is a true copy of Amendment #1 to the School District of Spring Valley Medical and Prescription Drug Benefit Plan.

APPROVED AND ACCEPTED

By: _____
Signature

Title: Superintendent

Date: 3.14.24