HEALTH BENEFIT PLAN

designed around care from

Securus Benefits

Plan Document and Summary Plan Description

Effective:

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ESTABLISHMENT OF THE PLAN: ADOPTION OF THE PLAN DOCUMENT AND SUMMARY PLAN DESCRIPTION

THIS PLAN DOCUMENT AND SUMMARY PLAN DESCRIPTION ("Plan Document") as of October 1, 2025 hereby sets forth the provisions of the Plan Sponsor's Health Benefit Plan (the "Plan"). This Plan is intended to comply with all applicable federal laws. If a Plan provision conflicts with federal law, or if federal law changes in a way that affects the Plan, the Plan will automatically be interpreted and updated to comply.

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").

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, which is required by sections 402 and 102 of the Employee Retirement Income Security Act of 1974, 29 U.S.C. §1001 et seq. ("ERISA"). 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.

(Plan Sponsor)
Name, Title
Date:

INTRODUCTION AND PURPOSE; GENERAL PLAN INFORMATION

Introduction and Purpose

The Plan Sponsor has established this Plan for the benefit of eligible Employees and their eligible Dependents, in accordance with the terms and conditions described in this document. The Plan is self-funded, meaning benefits are paid from the general assets of the Plan Sponsor (and, if applicable, Participant contributions). Participants may be required to contribute toward the cost of coverage, as determined by the Plan Sponsor from time to time.

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

The Plan Sponsor is required under ERISA to provide to Participants a Plan Document and a Summary Plan Description; a combined Plan Document and Summary Plan Description, such as this document, is an acceptable structure for ERISA compliance. The Plan Sponsor has adopted this Plan Document as the written description of the Plan to set forth the terms and provisions of the Plan that provide for the payment or reimbursement of all or a portion of certain expenses for eligible benefits. The Plan Document is maintained by the **Third-Party Administrator** and may be reviewed at any time in the Yuzu Health portal by any Participant.

General Plan Information

Name of Plan:

Employer/Plan Sponsor:
(named Fiduciary)

Third-Party Administrator	**Yuzu Health Insurance Services** **30 W 21st St, Floor 7** **New York City, NY 10010** **Phone: 203-208-9898** **Email: support@yuzu.health** **Website: https://yuzu.health**
Plan Designer	**Triad** **10886 Crabapple Road, Suite 200** **Roswell, GA 30075** **Phone: +18553155386** **Website: https://securusbenefits.com/**
Plan Designer	**Securus Benefits** **P.O. Box 450978** **Westlake, OH 44145** **Phone: +18774200785**

Website: https://securusbenefits.com/

Plan Sponsor EIN:	
Source of Funding:	**Self-Funded**
Plan Status:	**Non-Grandfathered**
Applicable Law:	**State of**
Applicable Law:	**ERISA**
ERISA Plan Number:	**501**
Plan Year:	
Yuzu Reference Number:	**501**
Group Number:	
Plan Type:	**Medical and Prescription Drug**
Prescription Drug Plan Administrator:	**DisclosedRx** **2 N. Central Ave, Suite 1800** **Phoenix, AZ 85004** **Phone: +18885893340** **Website: care@disclosedrx.com**
Eligible Class Language:	**All Full-Time employees who work 30 hours or more per week**
Waiting Period Language:	**First day of the next month after hire date**
Termination Language:	**End of the month**
Additional Amendments:	**None**

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

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 Third-Party Administrator at the contact information above.

Legal Entity; Service of Process

The Plan is a legal entity. Legal notice may be filed with, and legal process served through, the Third-Party Administrator acting on behalf of the Plan Sponsor.

Mental Health Parity

This Plan complies with the Mental Health Parity and Addiction Equity Act of 2008 (MHPAEA), as amended. The Plan applies its terms uniformly and provides mental health and substance use disorder benefits on the same basis as medical and surgical benefits. This includes parity in financial requirements (such as deductibles, copayments, and coinsurance) and treatment limits (such as visit limits or prior authorization rules). For questions about how this works, contact the Third-Party Administrator.

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.

Applicable Law

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

Discretionary Authority

The Third-Party Administrator acting on behalf of the Plan Sponsor shall have sole, full and final discretionary authority to interpret all Plan provisions, including the right to remedy possible ambiguities, inconsistencies and/or omissions in the Plan and related documents; to make determinations in regard to issues relating to eligibility for benefits; to decide disputes that may arise relative to a Participant's rights; and to determine all questions of fact and law arising under the Plan.

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 readers 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.

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

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

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

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

Custodial Care
"Custodial Care" means care or confinement designated principally for the assistance and maintenance of the Participant, in engaging in the activities of daily living, whether or not totally disabled. This care or confinement could be rendered at home or by persons without professional skills or training. This care may relieve symptoms or pain but is not reasonably expected to improve the underlying medical condition. Custodial Care includes, but is not limited to, assistance in eating, dressing, bathing and using the toilet, preparation of special diets, supervision of medication which can normally be self-administered, assistance in walking or getting in and out of bed, and all domestic activities.

Diagnostic Service
"Diagnostic Service" means an examination, test, or procedure performed for specified symptoms to obtain information to aid in the assessment of the nature and severity of a medical condition or the identification

of an Illness or Injury (the diagnosis). The Diagnostic Service must be ordered by a Physician or other professional Provider.

Drug
"Drug" means a Food and Drug Administration (FDA) approved Drug or medicine that is listed with approval in the *United States Pharmacopeia, National Formulary* or *AMA Drug Evaluations* published by the American Medical Association (AMA).

Emergency / Emergency Medical Condition
"Emergency" or "Emergency Medical Condition" means 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.

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.

"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.

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

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

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

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

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

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

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

Reliable evidence means 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.

Subject to a medical opinion, if no other Food and Drug Administration (FDA) approved treatment is feasible and as a result the Participant faces a life-or-death medical condition, the Third-Party Administrator retains discretionary authority to cover the services or treatment and will do so by consulting the Utilization Management Vendor.

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

Habilitation/Habilitative Services
"Habilitation/Habilitative Services" means 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.

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

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

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

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

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

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.

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

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

Maximum Allowable Charge
The "Maximum Allowable Charge" means the amount payable for a specific covered item under this Plan. The Maximum Allowable Charge will be a negotiated or contracted rate, if one exists. If a Benefit is obtained under the Alternate Course of Treatment provision of this plan it shall be deemed within the Maximum Allowable Charge.

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 presently utilized 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, reimbursement rates will be calculated based on one of the following:

- Industry-standard out of network pricing methodologies that map non-Medicare codes to Medicare codes for the purposes of establishing equivalent reimbursement rates.
- Looking at Bundled Pricing packages from reputable third parties that have been priced as a percentage of Medicare, using this to infer the value of 150.
- Looking at similar services purchased at similar institutions in similar geographies that can be priced at a percentage of Medicare.

If and only if none of the factors above is applicable, the Third-Party 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.

The Maximum Allowable Charge shall not include:

1. Charges for any items billed separately that are customarily included in a global billing procedure.
2. Charges for billing errors including, but not limited to, upcoding, duplicate charges, and charges for services not performed.
3. Charges relating to clearly identifiable errors in medical care.
4. Charges for which the Plan cannot identify or understand the item(s) being billed.

Medical Child Support Order

"Medical Child Support Order" means 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" means 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 Third-Party 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 means 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 Illness 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 Illness 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 Illness 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 an Illness 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 Third-Party Administrator has the discretionary authority to decide whether care or treatment is Medically Necessary based on recommendations of the Third-Party Administrator's own medical advisors, the findings of the American Medical Association or similar organization, or any other sources that the Third-Party 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.

National Medical Support Notice (NMSN)

“National Medical Support Notice” or “NMSN” means 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.

“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.

Outpatient
“Outpatient” means 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” means 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” means any Employee or Dependent who is eligible for benefits (and enrolled) under the Plan.

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

Plan Year
“Plan Year” means 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" means those medical tests and Diagnostic Services completed prior to a scheduled procedure, including Surgery, or scheduled admissions to the Hospital or Inpatient health care facility provided that all of the following requirements are met:

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

Preventive Care
"Preventive Care" means certain Preventive Care services.

To comply with the ACA, and in accordance with the recommendations and guidelines, plans shall provide 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/acip-recs/hcp/vaccine-specific/?CDC_AAref_Val=https://www.cdc.gov/vaccines/hcp/acip-recs/index.html
https://www.aap.org/periodicityschedule?srsltid=AfmBOopzKkukKH5Ntpr9mcZpSDdoNBiYmbqvKRI-qKK8Ph26T58730Lj;
https://www.hrsa.gov/womens-guidelines.

For more information, Participants may contact the Third-Party Administrator or Plan Sponsor.

Primary Care Physician (PCP)
"Primary Care Physician (PCP)" means family practitioners, general practitioners, internists, OBGYNs, pediatricians, and office-based nurse practitioners and physician's assistants. All other Physicians are considered specialists.

Provider
"Provider" means an entity whose primary responsibility is related to the supply of medical care. Each Provider must be licensed, registered, or certified by the appropriate State agency where the medical care is performed, as required by that State's law where applicable. Where there is no applicable State agency, licensure, or regulation, the Provider must be registered or certified by the appropriate professional body. The Third-Party Administrator may determine that an entity is not a "Provider" as defined herein if that entity

is not deemed to be a “Provider” by the Centers for Medicare and Medicaid Services (CMS) for purposes arising from payment and/or enrollment with Medicare; however,

The Plan is not so bound by CMS’ determination of an entity’s status as a Provider. All facilities must meet the standards as set forth within the applicable definitions of the Plan as it relates to the relevant provider type.

Psychiatric Hospital
“Psychiatric Hospital” means an Institution, appropriately licensed as a Psychiatric Hospital, established for the primary purpose of providing diagnostic and therapeutic psychiatric services for the treatment of mentally ill persons either by, or under the supervision of, a Physician. To be deemed a “Psychiatric Hospital,” the Institution must be duly licensed and must not be primarily a place for rest, the aged, and/or a nursing home, custodial, or training institution.

Qualifying Payment Amount
“Qualifying Payment Amount” means the median of Plan contracted rates 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” means, 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” means treatment(s) designed to facilitate the process of recovery from injury or illness to as normal a condition as possible.

“Rehabilitation Hospital”
“Rehabilitation Hospital” shall mean an appropriately licensed Institution, which is established in accordance with all relevant Federal, State and other applicable laws, to provide therapeutic and restorative services to individuals seeking to maintain, reestablish, or improve motor-skills and other functioning deemed Medically Necessary for daily living, that have been lost or impaired due to Illness and/or Injury. To be deemed a “Rehabilitation Hospital”, the Institution must be legally constituted, operated, and accredited for its stated purpose by either the Joint Commission on Accreditation of Hospitals or the Commission on Accreditation for Rehabilitation Facilities, as well as approved for its stated purpose by the Centers for Medicare and Medicaid Services (CMS) for Medicare purposes. To be deemed a “Rehabilitation Hospital”, the Institution must be duly licensed and must not be primarily a place for rest, the aged, and/or a nursing home, custodial, or training institution.

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

Room and Board

"Room and Board" means a Hospital's charge for any conditions of occupancy which are Medically Necessary.

Skilled Nursing Facility
"Skilled Nursing Facility" means 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 Illness. 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. "Mental Disorder", "Behavioral Disorder" or "Neurological Disorder" shall mean any Illness or condition, regardless of whether the cause is organic, that is classified as such by relevant State guidelines or applicable sources, including but not limited to the International Classification of Diseases, published by the U.S. Department of Health and Human Services.
7. It is approved and licensed by Medicare.

Specialty Drug(s)
"Specialty Drug(s)" means 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). Certain drugs may be subject to step therapy requirements or may be required to be administered in a certain setting which will be communicated to you via the pre-certification process. In order to receive benefits for such drugs Drugs, you may be required to try a different drug first, unless you satisfy the Plan's exception criteria. Please contact the Plan to determine specific coverage.

Substance Abuse and/or Substance Use Disorder
"Substance Abuse" and/or "Substance Use Disorder" means 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.

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

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

ELIGIBILITY FOR COVERAGE

Definitions

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.

Alternate Recipient
"Alternate Recipient" means a Child of a Participant who is recognized under a Medical Child Support Order or National Medical Support Notice (NMSN) as having a right to enroll in this Plan. An Alternate Recipient will be treated as an eligible Dependent for purposes of coverage but does not gain greater rights than a similarly situated Dependent.

The Plan Sponsor or Third-Party Administrator will establish reasonable written procedures to (i) determine whether an order/notice requires enrollment under applicable federal and state law, (ii) notify the Participant and each affected Alternate Recipient (or their representative) of its determination, and (iii) effectuate enrollment without regard to otherwise applicable waiting periods or open enrollment restrictions, consistent with the order/notice.

If the Plan offers multiple coverage options and the Participant is not enrolled or does not elect an option, the Plan Administrator will enroll the Alternate Recipient in the option specified by the issuing agency, or if none is specified, the Plan's default option (if any). The Plan is not required to provide any benefit, option, or level of coverage not otherwise available to similarly situated Dependents, except as required by applicable law.

Child and/or Children
"Child" and/or "Children" means the Employee's natural Child, legally adopted Child, step-Child, any other Child for whom the Employee has been named legal guardian, or 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. For purposes of this definition, a legally adopted Child shall include a Child placed in an Employee's physical custody in anticipation of adoption. "Child" shall also mean a covered Employee's Child who is an Alternate Recipient under a Qualified Medical Child Support Order, as required by the Federal Omnibus Budget Reconciliation Act of 1993.

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

Legal Separation and/or Legally Separated

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

Dependent
“Dependent” means one or more of the following person(s):

1. An Employee’s current spouse with whom the Employee either (i) holds a valid marriage license, or (ii) maintains a common law marriage as recognized under New Jersey state law, (each, a “Dependent Spouse”). An individual who is divorced or Legally Separated from the Employee shall not be considered a Dependent.
2. *A*n Employee’s Child who is less than 26 years of age (a “Dependent Child”). ***NOTE:*** *Coverage of a Dependent Child will continue until the end of the month he or she turns 26 years of age, unless the child is a Disabled Adult Dependent and the Plan Sponsor continues coverage.*

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

An Employee’s spouse must meet the following requirements:

Spouse Eligibility

“Spouse” means the individual to whom the Employee is lawfully married under applicable state law (including any common-law marriage the state recognizes). A person who is divorced or legally separated from the Employee is not eligible as a Spouse. The Plan may require reasonable proof of marital status at enrollment or when status changes. Nothing in this section limits coverage required by a Qualified Medical Child Support Order (QMCSO) or National Medical Support Notice. The Plan applies these rules uniformly and in accordance with applicable law.

NOTE: Tax treatment for certain dependents. *Federal tax law generally does not recognize former spouses, Legally Separated spouses, civil union or domestic partners, or the children of these partners, as dependents under the federal tax code unless the spouse, partner, or child otherwise qualifies as a dependent under the Internal Revenue Code §152. Therefore, the Plan Sponsor may be required to automatically include the value of the health care coverage provided to any of the aforementioned individuals, who may be covered under this Plan as eligible Dependents, as additional income to the Employee.*

Disabled Adult Dependent
“Disabled Adult Dependent” means a dependent over the age of 26 who is determined by the Plan Sponsor to have a disability which requires substantial assistance with daily living activities and/or healthcare management due to physical, intellectual, or developmental impairments. Such dependents may be qualified for a continuation of coverage under the Plan. To determine if a Dependent Child is qualified as a Disabled Adult Dependent, the Employee shall contact the Plan Sponsor for a Disabled Adult Dependent Verification Form. If that form is approved by the Plan Sponsor, the Disabled Adult Dependent may remain a Dependent on the Employee’s Plan.

Employee

"Employee" means a person who is employed by the Plan Sponsor. For eligibility, a full-time Employee is one who has at least 130 hours of service in a calendar month (equivalent to 30 hours per week) as determined under the Affordable Care Act (ACA) monthly measurement method. Eligibility is determined prospectively by month and may end for any month in which the Employee does not meet the 130-hour threshold, subject to applicable election-change rules, required contributions, COBRA, and any other Plan terms. The Plan applies these rules uniformly and in accordance with the ACA.

Prior Plan
"Prior Plan" means 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.

Qualified Medical Child Support Order (QMCSO)
"Qualified Medical Child Support Order" or "QMCSO" means 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.

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

Eligibility for Individual Coverage
Each Employee will become eligible for coverage under this Plan with respect to himself or herself on the First day of the next month after hire date.

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.

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, as defined under the ACA, with the Employer (or any member of the controlled or affiliated group) for a period of at least 13 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. Upon return, coverage will be reinstated immediately, so long as all other eligibility criteria are satisfied.

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.

Effective Dates of Coverage; Conditions

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

1. Enrollment Application (paper or electronic as applicable). Employee(s) may seek to obtain coverage for themselves and/or Dependents via a form (either paper or electronic as applicable) furnished by the Plan Sponsor in a manner that is satisfactory to the Plan Sponsor, and within 30 days following the applicable date of eligibility. If coverage is available and appropriate, coverage will become effective after review of the form, and upon the subsequent date such Employee or Dependents are eligible.

2. Coverage as Both Employee and Dependent. An eligible Participant may enroll in this Plan either as an Employee or as a Dependent, but not both.

3. Birth of a Dependent Child. A newborn Child of a covered Employee will be considered eligible from the moment of birth for a period of 30 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 30-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.

4. Newly Acquired Dependents. If while an Employee is enrolled for coverage, that Employee acquires a Dependent (as a Qualifying Life Event), 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 30 days. If coverage for Dependents has not already been secured by the Employee, a written application must be made to the Plan within 30 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 Sponsor.

5. Requirement for Employee Coverage. Coverage for Dependents shall only be available to Dependents of Employees eligible for coverage for themselves.

6. Dependents of Multiple Employees. If a Dependent may be deemed to be a Dependent of more than one Covered Employee, such Dependent shall be deemed to be a Dependent of one such Employee only.

7. Medicaid Coverage. An individual's eligibility for any State Medicaid benefits will not be taken into account by the Plan in determining that individual's eligibility under the Plan.

8. FMLA Leave. Regardless of any requirements set forth in the Plan, the Plan shall at all times comply with FMLA.

NOTE: *It is the responsibility of the enrolled Employee to notify his or her Plan Sponsor of any changes in the Dependent's status.*

Special and Open Enrollment

Federal law requires and the Plan provides so-called "Special Enrollment Periods," during which Employees may enroll in the Plan, even if they declined to enroll during an initial or subsequent eligibility period.

Loss of Other Coverage

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

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

If an Employee is currently enrolled in a benefit package, the Employee may elect to enroll in another benefit package under the Plan if the following requirements are met:

1. Multiple benefit packages are available.
2. A Dependent of the enrolled Employee has a special enrollment right in the Plan because the Dependent has lost eligibility for other coverage.

Special enrollment rights will not be available to an Employee or Dependent if either of the following occurs:

1. The other coverage is/was available via COBRA Continuation Coverage and the Employee or Dependent failed to exhaust the maximum time available to him or her for such COBRA coverage.
2. The Employee or Dependent lost the other coverage because of the individual's failure to pay premiums or required contributions or for cause (such as making a fraudulent claim or an intentional misrepresentation of a material fact in connection with the Other Plan).

For an eligible Employee or Dependent(s) who has met the conditions specified above, this Plan will be effective at 12:01 A.M. on the first day following enrollment and the request is made within 30 days from

loss of coverage. For example, if the Employee loses his or her other health coverage on April 22, he or she must notify The Plan Sponsor and apply for coverage by close of business on May 22.

New Dependent

An Employee or Dependent who is eligible, but not enrolled in this Plan, may be eligible to enroll during a special enrollment period if an Employee acquires a new Dependent because of marriage, legal guardianship, a foster child being placed with the Employee, birth, adoption, or placement for adoption. To be eligible for this special enrollment, the Employee must apply in writing or electronically, as applicable, no later than 30 days after he or she acquires the new Dependent. For example, if the Employee or Employee's spouse gives birth to a baby on June 22, he or she must notify the Plan Sponsor and apply for coverage by close of business on July 22. The following conditions apply to any eligible Employee and Dependents:

An Employee or Dependent who is eligible, but not enrolled in this Plan, may enroll during a special enrollment period if both of the following conditions are met:

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

If the conditions for special enrollment are satisfied, the coverage of the Dependent and/or Employee enrolled during the Special Enrollment Period will be effective at 12:01 A.M. for the following events:

1. In the case of 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. In the case of a Dependent's birth, as of the date of birth.
5. In the case of a Dependent's adoption or placement for adoption, the date of the adoption or placement for adoption.

Additional Special Enrollment Rights

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

1. The Employee's or Dependent's Medicaid or State Child Health Insurance Program (i.e. CHIP) coverage has terminated because 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 Program (i.e. CHIP), and the Employee requests coverage under the Plan within 60 days after eligibility is determined. For more information on State Medicaid or CHIP, dial 1-877-KIDS NOW or go to www.insurekidsnow.gov.

If the conditions for 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 enrollment.

Open Enrollment

Prior to the start of the Plan, this Plan has an "Open Enrollment Period," which means the time frame specified by the Plan Sponsor during which employees elect onto the Plan. Eligible Participants who are not covered under this Plan may enroll for coverage during Open Enrollment Periods. Employees who are enrolled will be given an opportunity to change their coverage effective the first day of the upcoming Plan Year. A Participant who fails to make an election during the Open Enrollment Period will automatically retain his or her present coverages. Coverage for Participants enrolling during an Open Enrollment Period will become effective on January 1, as long as all other eligibility requirements have been met. If the other eligibility requirements have not been met, coverage for Participants enrolling during an Open Enrollment Period will become effective as stated in the provision, "Eligibility for Individual Coverage".

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

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

Qualified Medical Child Support Orders

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

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

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

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

1. It contains the information set forth in the Definitions section in the definition of "National Medical Support Notice."
2. It identifies either the specific type of coverage or all available group health coverage. If the Plan Sponsor receives an NMSN that does not designate either specific type(s) of coverage or all available coverage, the Plan Sponsor and the Third-Party Administrator will assume that all are designated.

3. It informs the Plan Sponsor that, if a group health plan has multiple options and the Participant is not enrolled, the issuing agency will make a selection after the NMSN is qualified, and, if the agency does not respond within 20 days, the Child will be enrolled under the Plan's default option (if any).
4. It specifies that the period of coverage may end for the Alternate Recipient(s) only when similarly situated dependents are no longer eligible for coverage under the terms of the Plan, or upon the occurrence of certain specified events.

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

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

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

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

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

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

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

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

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. If an acquired company did not have a health plan, all eligible Employees will be eligible on the date of the acquisition.

TERMINATION OF COVERAGE

Termination Dates of Individual Coverage

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

1. The date upon which the Plan is terminated.
2. The date upon the Employee requests that such coverage be terminated, on the condition that such request is made on or before such date, unless prohibited by law (i.e., when election changes cannot be made due to Internal Revenue Code Section 125 “change in status” guidelines).”
3. The date of the expiration of the last period for which the Employee has made a contribution, in the event of his or her failure to make, when due, any contribution for coverage for himself or herself to which he or she has agreed in writing.
4. The date upon which the Employee is no longer eligible for such coverage under the Plan.
5. The End of the month after the date and time at which the termination of employment occurs.
6. Immediately upon submission of a fraudulent claim or any fraudulent information to the Plan (including enrollment information), by and/or on behalf of an Employee or his or her Dependent, or upon the Employee or his or her Dependent gaining knowledge of the submission, as determined by the Plan Sponsor or the Third-Party Administrator in its discretion, consistent with applicable laws and/or rules regarding such rescission.

Termination Dates of Dependent Coverage

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

1. The date upon which the Plan is terminated.
2. Upon the discontinuance of coverage for Dependents under the Plan.
3. The date of the expiration of the last period for which the Employee has made a contribution, in the event of his or her failure to make, when due, any contribution for coverage for Dependents to which he or she has agreed in writing.
4. For a Dependent Child whose coverage is required pursuant to a QMCSO, the last day of the calendar month as of which coverage is no longer required under the terms of the order or this Plan.
5. The day immediately before the date the individual no longer meets the Plan’s Dependent definition (for example, divorce, age-out, loss of guardianship, or loss of Disabled Adult Dependent status), except as otherwise provided in this section.
6. Immediately upon submission of a fraudulent claim or any fraudulent information to the Plan (including enrollment information), by and/or on behalf of an Employee or his or her Dependent, or upon the Employee or his or her Dependent gaining knowledge of the submission, as determined by the Plan Sponsor or the Third-Party Administrator in its discretion, consistent with applicable laws and/or rules regarding such rescission.

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

CONTINUATION OF COVERAGE

Definitions

FMLA Leave
"FMLA Leave" means an unpaid, job protected Leave of Absence for certain specified family and medical reasons, which the Company is required to extend to an eligible Employee under the provisions of the Family and Medical Leave ("FMLA") Act of 1993, as amended.

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

Plan Sponsor Continuation Coverage

Eligible Participants may seek to continue coverage upon the occurrence of any of the following:

1. Leave of Absence (not meeting the definition of a FMLA Leave); coverage will continue for 90 days.
2. State-mandated family or medical leave; coverage will continue for a maximum of 3 months, subject to the applicable state law in which the Employee is domiciled.

The above noted leave(s) do not 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.

Continuation During Family and Medical Leave Act (FMLA) Leave

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

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

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 Plan Sponsor for information concerning their eligibility for USERRA and any requirements of the Plan.

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 can also 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. Under the Plan, certain Participants, and their eligible family members (called Qualified Beneficiaries) that elect COBRA Continuation Coverage must pay the entire cost of the coverage, including a reasonable administration fee. There are several ways coverage will terminate, including the failure of the Participant or their covered Dependents to make timely payment of contributions or premiums. For additional information, Participants should contact the Plan Sponsor to determine if COBRA applies to them or their covered Dependents.

To the extent the Plan does not fully or accurately reflect applicable COBRA regulations, the Plan will always comply with such regulations, including but not limited to continuation coverage in connection with a business reorganization or employer withdrawal from a multiemployer plan.

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 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.

COBRA Continuation Coverage

"COBRA Continuation Coverage" is a continuation of Plan coverage when coverage would otherwise end because of a life event known as a "Qualifying Event." COBRA (and the description of COBRA Continuation Coverage contained in this Plan) does not apply to the following benefits (if available as part of the Plan Sponsor's plan): life insurance, accidental death and dismemberment benefits and weekly income or long-term disability benefits. The aforementioned benefits are not considered for continuation under COBRA. The Plan provides no greater COBRA rights than what COBRA requires – nothing in this Plan is intended to expand the Participant's rights beyond COBRA's requirements.

Qualifying Events

A qualifying event is any of those listed below if the 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 Beneficiary" unless the Plan Sponsor is COBRA Exempt due to size or other ineligible factors. A Qualified Beneficiary is someone who is or was covered by the Plan and has lost or will lose coverage under the Plan due to the occurrence of a Qualifying Event. The Employee or Employee's Dependents could therefore become Qualified Beneficiaries if applicable coverage under the Plan is lost because of the Qualifying Event.

An Employee, who is properly enrolled in this Plan and is a covered Employee, will become a Qualified Beneficiary if they lose their coverage under the Plan because either one of the following Qualifying Events happens:

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

The spouse of a covered Employee will become a Qualified Beneficiary if they lose their coverage under the Plan because any of the following Qualifying Events happens:

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

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

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

Filing a proceeding in bankruptcy under Title 11 of the United States Code may be a Qualifying Event. If a proceeding in bankruptcy is filed with respect to the Plan Sponsor, and that bankruptcy results in the loss of coverage for any retired Employee covered under the Plan, the retired Employee will become a Qualified Beneficiary, with the bankruptcy being deemed the Qualifying Event. The retired Employee's Dependent(s) (if applicable) will also become Qualified Beneficiaries if the bankruptcy (Qualifying Event) results in a loss of their coverage under the Plan.

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, 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.

Employee Notice of Qualifying Events

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

- **Notice of Divorce or Separation**: Notice of the occurrence of a Qualifying Event that is a divorce or Legal Separation of a covered Employee (or former Employee) from their spouse.
- **Notice of Child's Loss of Dependent Status**: Notice of the occurrence of a Qualifying Event that is an individual's ceasing to be eligible as a Dependent Child under the terms of the Plan.
- **Notice of a Second Qualifying Event**: Notice of the occurrence of a second Qualifying Event after a Qualified Beneficiary has become entitled to COBRA

Continuation Coverage with a maximum duration of 18 (or 29) months.

- **Notice Regarding Disability**: Notice that a Qualified Beneficiary entitled to receive COBRA Continuation Coverage with a maximum duration of 18 months has been determined by the Social Security Administration ("SSA") to be disabled at any time during the first 60 days of COBRA Continuation Coverage
- **Notice Regarding End of Disability**: Notice that a Qualified Beneficiary, with respect to whom a notice described above in #4 has been provided, has subsequently been determined by the SSA to no longer be disabled.

As indicated above, Notification of a Qualifying Event must be made in writing. Notice must be made by submitting the "Notice of Qualifying Event" form and mailing it by U.S. First Class Mail or hand delivery to the COBRA Administrator. This form is available, without charge, from the COBRA Administrator.

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

Notification must be received by the COBRA Administrator, who is:

Yuzu Health (COBRA)
Phone: +12032089898

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

Deadline for Providing the Notice:
For the Qualifying Events described above, the notice must be furnished within 60 days of the latest occurring event:

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

This notice must be provided within the first 18 months of COBRA Continuation Coverage.

For a change in disability status described above, the notice must be furnished 30 days after the latter of:

1. The date of the final determination by the SSA that the Qualified Beneficiary is no longer disabled.
2. The date on which the Qualified Beneficiary 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, their coverage under the Plan will terminate on the last date for which they are eligible under the terms of the Plan, or if the person is extending COBRA Continuation Coverage, such Coverage will end on the last day of the initial 18-month COBRA coverage period.

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

Required Contents of the Notice
After receiving a notice of a Qualifying Event, the Plan must provide the Qualified Beneficiary with an election notice, which describes their rights to COBRA Continuation Coverage and how to make such an election. The notice must contain the following information:

1. Name and address of the covered Employee or former Employee.
2. Name of the Plan and contact information for the Plan's COBRA Administrator.
3. Identification of the Qualifying Event and its date (the initial Qualifying Event and its date if the Qualifying Participant is already receiving COBRA Continuation Coverage and wishes to extend the maximum coverage period).
4. 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 Beneficiary or loss of disability status). In the case of a Qualifying Event that is:
    a. divorce or Legal Separation, name(s) and address(es) of spouse and Dependent Child or Children covered under the Plan, date of divorce or Legal Separation, and a copy of the decree of divorce or Legal Separation.
    b. Medicare entitlement of the covered Employee or former Employee, date of entitlement, and name(s) and address(es) of spouse and Dependent Child or Children covered under the Plan.
    c. a Dependent Child's cessation of Dependent status under the Plan, name and address of the Child, reason the Child ceased to be an eligible Dependent (for example, attained limiting age).
    d. the death of the covered Employee or former Employee, the date of death, and name(s) and address(es) of spouse and Dependent Child or Children covered under the Plan.
    e. disability of a Qualified Beneficiary, name and address of the disabled Qualified Beneficiary, name(s) and address(es) of other family members covered under the Plan, the date the disability began, the date of the SSA's determination, and a copy of the SSA's determination.
    f. loss of disability status, name and address of the Qualified Beneficiary who is no longer disabled, name(s) and address(es) of other family members covered under the Plan, the date the disability ended and the date of the SSA's determination.
5. Identification of the Qualified Beneficiaries (by name or by status).
6. An explanation of the Qualified Beneficiaries' right to elect continuation coverage.
7. The date coverage will terminate (or has terminated) if continuation coverage is not elected.
8. How to elect continuation coverage.
9. What will happen if continuation coverage isn't elected or is waived.
10. What continuation coverage is available, for how long, and (if it is for less than 36 months), how it can be extended for disability or second qualifying events.
11. How continuation coverage might terminate early.
12. Premium payment requirements, including due dates and grace periods.
13. A statement of the importance of keeping The Plan Sponsor informed of the addresses of Qualified

Beneficiaries.

14. A statement that the election notice does not fully describe COBRA, or the plan and that more information is available from the Plan Sponsor and in the SPD.
15. 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. 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 the required information, the COBRA Administrator may request additional information. If the individual fails to provide such information within the time period specified by the COBRA Administrator in the request, the COBRA Administrator may reject the notice if it does not contain enough information for the COBRA Administrator to identify the plan, the covered Employee (or former Employee), the Qualified Beneficiaries, the Qualifying Event or disability, and the date on which the Qualifying Event, if any, occurred.

Electing COBRA Continuation Coverage

Complete instructions on how to elect COBRA Continuation Coverage will be provided by the COBRA Administrator 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 Beneficiary will have an independent right to elect COBRA Continuation Coverage. Covered Employees may elect COBRA Continuation Coverage on behalf of all other Qualified Beneficiaries, including their spouses, and parents or a legal guardian may elect COBRA Continuation Coverage on behalf of their Children. If 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 they are not entitled to COBRA Continuation Coverage.

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 Plan or its designee, as applicable.

Duration of COBRA Continuation Coverage

The maximum time period shown below shall dictate how long COBRA Continuation Coverage will be available. The maximum time period for coverage is based on the type of the Qualifying Event and the status of the Qualified Beneficiary. Multiple Qualifying Events that may be combined under COBRA will not ordinarily 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 Beneficiaries other than the covered Employee lasts until 36 months after the date of Medicare entitlement. For example, if a covered Employee becomes entitled to Medicare eight months before the date on which his or her employment terminates, COBRA Continuation Coverage for their spouse and children can last up to thirty-six months after the date of Medicare entitlement, which is equal to twenty-eight months after the date of the Qualifying Event (thirty- six months minus eight months).

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

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

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

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

It is not necessary that COBRA Continuation Coverage be in effect for the maximum time. 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 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,
- 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.

It is not necessary that COBRA Continuation Coverage be in effect for the maximum time. COBRA Continuation Coverage may conclude prior to the latest possible date if the Plan Sponsor ceases to provide a group health plan to any Employee; the Qualified Beneficiary fails to make timely payment of any required contributions or premium; the Qualified Beneficiary gains coverage under another group health plan (as an Employee or otherwise) or becomes entitled to either Medicare Part A or Part B (whichever comes first) (except as stated under COBRA's special bankruptcy rules); or any other event occurs which enables the Plan Sponsor to terminate coverage without offering COBRA Continuation Coverage (such as the commission of fraud by the Qualified Beneficiary or their Dependent). COBRA Continuation Coverage shall be extended to the first day of the month 30 days (or more) after the date upon which the SSA determined that the Qualified Beneficiary is no longer disabled.

Contribution and Premium Requirements
The cost of 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 thereafter. COBRA Continuation Coverage will be canceled and will not be reinstated if any payment is made late; however, the COBRA 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.

Additional Information

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

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

GENERAL LIMITATIONS AND EXCLUSIONS

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

Administrative Costs. That are solely for and/or applicable to administrative costs wherever allowed by applicable law. This includes charges for completing claim forms and breaking appointments.

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

Confined Persons. That are for services, supplies, and/or treatment of any Participant that were incurred while confined and/or arising from confinement in a prison, jail or other penal institution with said confinement exceeding 2 consecutive hours.

Cosmetic Services, Supplies or Prescription Drugs - to improve, alter or enhance appearance for psychological or emotional reasons when there is no significant impairment, decrease in function, or change in physiology due to an injury, illness, or congenital anomaly. Cosmetic services, supplies or prescription drugs are eligible for coverage under the following circumstances only (a) to repair damage from an Accident; (b) because of a covered illness; (c) because of a congenital anomaly causing a functional defect found at birth. The term “cosmetic services” includes those services which are described in IRS Code Section 213(d)(9).

Custodial Care. That do not restore health or are provided mainly as a rest cure or for maintenance care, unless specifically mentioned otherwise.

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

Experimental. That are Experimental or Investigational.

Foreign Travel. That are received outside of the United States unless in an emergency.

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

Hazardous Pursuit, Hobby or Activity. That are of an Injury or Illness that results from engaging in a hazardous pursuit, hobby or activity such as skydiving, bungee jumping, and hang gliding.

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

act of domestic violence or (b) resulted from a documented medical condition (including both physical and mental health conditions).

Injury to or care of mouth, teeth, and gums. Charges for injury to or care of the mouth, teeth, gums and alveolar processes will be covered charges under medical benefits only if that care is for the following oral surgical procedures:

1. Excision of tumors and cysts of the jaws, cheeks, lips, tongue, roof and floor of the mouth.
2. Emergency repair due to injury to sound natural teeth. Damage as a result of biting and chewing will not be a covered charge. Sound natural teeth are defined as teeth that are free of active or chronic clinical decay, have at least 50% bony support, are functional in the arch, and have not been excessively weakened by multiple dental procedures.
3. Surgery needed to correct accidental injuries to the jaws, cheeks, lip, tongue, floor, and roof of the mouth.
4. Excision of benign bony growths of the jaw and hard palate.
5. External incision and drainage of cellulitis.
6. Incision of sensory sinuses, salivary glands or ducts.
7. Excision of bony impacted wisdom teeth or soft tissue impacted teeth.

Treatment must begin within twelve (12) months of the date of such injury to be covered. No charge will be covered under medical benefits for dental and oral surgical procedures involving orthodontic care of the teeth, periodontal disease and preparing the mouth for the fitting of or continued use of dentures. Services and supplies provided by a hospital in conjunction with dental treatment will be covered only when a non-dental physical illness or injury exists which makes hospital care medically necessary to safeguard the covered person's health. Removal of all teeth at an inpatient or outpatient hospital or dentist's office if removal of the teeth is part of the standard medical treatment that is required before the covered person can undergo radiation therapy for a covered medical condition, will be covered. All other dental treatment provided in a hospital unrelated to a non-dental physical illness or injury will not be a covered charge regardless of the complexity of dental treatment and length of anesthesia**.**

Long Term Care. That refers to a range of services and supports needed by individuals who have a chronic illness or disability and are unable to perform basic activities of daily living (ADLs) without assistance. These services may include help with bathing, dressing, eating, toileting, transferring (e.g., moving from bed to chair), and continence.

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

Negligence. That are for Injuries resulting from negligence, misfeasance, malfeasance, nonfeasance or malpractice on the part of any caregiver, Institution, or Provider, considering applicable laws and evidence available to the Third-Party Administrator.

No Legal Obligation. That are for services provided to a Participant for which the Provider of a service does not and/or would not customarily render a direct charge, or charges Incurred for which the Participant or Plan has no legal obligation to pay, or for which no charges would be made in the absence of this coverage, including but not limited to charges for services not actually rendered, fees, care, supplies, or services for which a person, company or any other entity except the Participant or the Plan, may be liable for necessitating the fees, care, supplies, or services. This includes charges that would otherwise be waived or discounted based on factors such as a hospital's financial aid policy to the extent that this is consistent with Federal and State laws.

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.

Not Specified as Covered. That are not specified as covered under any provision of this Plan or not performed by Providers who satisfy the requirements of the Provider definition defined in this Plan.

Occupational. Care and treatment of an Injury or Sickness that is occupational – that is, arises from work for wage or profit including self-employment and military service (as determined by the Veteran's Administration, except to the extent prohibited or modified by law). This includes claims 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.

Subrogation, Reimbursement, and/or Third-Party Responsibility. That are for an Illness or Injury not payable by virtue of the Plan's subrogation, reimbursement, and/or third-party responsibility provisions. This includes claims that are in connection with an automobile accident for which benefits payable hereunder are, or would be otherwise covered by, mandatory no-fault automobile insurance or any other similar type of personal injury insurance required by state or federal law, without regard to whether the Participant had such mandatory coverage. Benefits will be excluded to the maximum amount of first party medical coverage available under the applicable state law, regardless of a Participant's election of lesser coverage. This Exclusion does not apply if the Injured person is a passenger in a non-family-owned vehicle or a pedestrian.

Unreasonable. That are required to treat Illness or Injuries arising from and due to error(s) caused at the time of treatment by the treating 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 Sponsor in its sole discretion, gave rise to the expense, which was caused directly or indirectly 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).

War/Riot. That are Incurred because of war or any act of war, whether declared or undeclared, or any act of aggression by any country, including rebellion or riot, 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, or voluntary participation in a riot. 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.

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

MEDICAL EXCLUSIONS

Impotence: A condition characterized by the consistent inability to achieve or maintain an erection sufficient for satisfactory sexual performance. Treatment may include prescription medications, devices, or other therapies. Coverage for services or supplies related to impotence is subject to the terms, limitations, and exclusions of the Plan, and may require medical necessity and prior authorization.

Hearing Aids: Charges for hearing aids, which includes examinations for the prescription, fitting, and/or repair of hearing aids.

Sterilization Reversal: Surgical procedures intended to restore fertility after a voluntary sterilization, such as tubal ligation or vasectomy. Sterilization reversal procedures, including associated medical services and supplies, are not covered under the Plan unless specifically stated otherwise in the Plan documents.

Massage: The manipulation of soft tissues of the body, including muscles and connective tissues, to relieve tension, improve circulation, or promote relaxation. Coverage for massage, including therapeutic massage, is excluded under the Plan unless specifically prescribed as medically necessary and explicitly stated as a covered benefit in the Plan documents.

Abortion: The medical or surgical termination of a pregnancy. Coverage for abortion services is provided only as required under applicable federal and state law and is subject to the terms, limitations, and exclusions of the Plan.

Orthopedic Shoes (Except Diabetics): 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.

Electroconvulsive Therapy: A behavioral health treatment in which controlled electrical currents are passed through the brain under medical supervision to produce a brief seizure. Electroconvulsive therapy is not covered under the terms of the Plan.

Reporting Codes:

Surrogacy: Surrogacy refers to an arrangement in which another individual becomes pregnant and carries a child for an intended parent or parents. Expenses related to surrogacy — including, but not limited to, medical services for a surrogate, fertility treatments, legal fees, and compensation — are not covered under the Plan, unless specifically stated otherwise in the Plan documents.

Gender Affirming Care: "Gender affirming care" refers to a range of medical, surgical, behavioral health, and supportive services that are intended to support an individual's gender identity. Such care may include, but is not limited to, mental health counseling, hormone therapy, surgical procedures, and related follow-up care, when provided for the purpose of gender transition or gender identity support. Coverage for gender affirming care is provided only as required under applicable federal and state law and is subject to the terms, limitations, and exclusions of the Plan.

Biofeedback: A therapeutic technique that uses electronic monitoring to help a person gain voluntary control over certain physiological functions, such as heart rate, muscle tension, or blood pressure, for the purpose of improving health or managing medical conditions. Biofeedback is considered by the Plan to be Investigational, and thus not covered.

Obesity Treatment: Charges for bariatric surgery, including but not limited to, gastric bypass, gastric sleeves, stapling and intestinal bypass, and lap band surgery, including reversals, related to both obesity and Class III obesity (if 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. Treatment for complications caused by uncovered weight-loss surgery is not covered by the Plan. To determine if GLP-1s are covered, please call your pharmacy benefit manager. Their number should be on the front of the member ID card.

Infertility: Following charges related to impregnation and infertility Treatment: artificial insemination, fertility Drugs, G.I.F.T. (Gamete Intrafallopian Transfer), impotency Drugs such as Viagra, surrogate

mother (unless the surrogate is a Participant, in which case the Preventive Care and/or Pregnancy expenses will be covered in accordance with the Plan provisions), donor eggs, collection or purchase of donor semen (sperm) or oocytes (eggs), and freezing of sperm, oocytes, or embryos, or any type of artificial impregnation procedure, whether or not such procedure is successful.

Experimental Therapies:

PLAN ADMINISTRATION

The Plan Sponsor has authority to administer the Plan. The Plan Sponsor 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 Sponsor reserves the unilateral right and power to administer and to interpret, construe and construct the terms and provisions of the Plan, including without limitation, correcting any error or defect, supplying any omission, reconciling any inconsistency and making factual determinations.

The Third-Party Administrator

The Plan Sponsor is the fiduciary of the Plan. The Plan Sponsor delegates the ability to make initial claims and coverage determinations under the Plan to the Third-Party Administrator. The Third-Party Administrator is responsible for maintaining and making available the Summary Plan Document (SPD) to Participants of the Plan. The Third-Party Administrator shall maintain records of benefits payments, policies, and contracts relevant to administering the plan.

Final eligibility and claims determinations are ultimately the responsibility of the Plan Sponsor. The Plan Sponsor shall have maximum legal discretionary authority to construe and interpret the terms and provisions of the Plan, to make all interpretive and factual determinations as to whether any individual is eligible and entitled to receive any benefit under the terms of this Plan, to decide disputes which may arise with respect to a Participant's rights, and to decide questions of Plan interpretation and those of fact relating to the Plan. The decisions of The Plan Sponsor in working with the Third-Party Administrator will be final and binding on all interested parties. Benefits will be paid under this Plan only if the Plan Sponsor, in its discretion, determines 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 Sponsor in its sole and exclusive judgment, the provision shall be considered ambiguous and shall be interpreted by the Plan Sponsor in a fashion consistent with its intent, as determined by the Plan Sponsor in consultation with the Third-Party 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 Sponsor. All actions taken and all determinations made in this manner shall be final and binding upon all persons claiming any interest under the Plan subject only to the claims appeal procedures of the Plan.

Duties of the Third-Party Administrator

The duties of the Third-Party Administrator include the following:

1. To administer the Plan in accordance with the terms and policies set by the Plan Sponsor.
2. To make initial determinations of eligibility, status and coverage under the Plan.
3. To interpret the Plan according to the wishes of the Plan Sponsor, 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 assist the Plan Sponsor in paying claims in accordance with claims procedures and coverage outlined here.
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.

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 Plan Sponsor.

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 Third-Party 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.*

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 Sponsor 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 ERISA and the Health Insurance Portability and Accountability Act of 1996 (HIPAA) and any related amendments.

Misuse of Identification Card

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

CLAIM PROCEDURES; PAYMENT OF CLAIMS

Definitions

Adverse Benefit Determination
"Adverse Benefit Determination" means any of the following:

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

Final Internal Adverse Benefit Determination
"Final Internal Adverse Benefit Determination" means 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.

Explanation of Benefits (EOB)
"Explanation of Benefits" means 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.

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

Clean Claim
A "Clean Claim" means a claim that can be processed in accordance with the terms of this document without obtaining additional information from the service Provider, the member, 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.

Introduction

In accordance with applicable law, the Plan will allow an authorized representative to act on a Claimant's behalf in pursuing or appealing a benefit claim.

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

Health Claims

Full and final authority to adjudicate claims and make determinations as to their payability by and under the Plan belongs to and resides solely with the Plan Sponsor who shall make claims adjudication determinations after full and fair review and in accordance with the terms of this Plan and Applicable Law. The Plan Sponsor may delegate to the Third-Party Administrator responsibility to process claims in accordance with the terms of the Plan and the Third-Party Administrator's directive(s). The Third-Party Administrator is not a fiduciary of the Plan and does not have discretionary authority to make claims payment decisions or interpret the meaning of the Plan terms.

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

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

A Claimant has the right to request a review of an Adverse Benefit Determination. If the claim is denied at the end of the appeal process, as described below, the Plan's final decision is known as a Final Internal Adverse Benefit Determination. If the Claimant receives notice of a Final Internal Adverse Benefit Determination, or if the Plan does not follow the claims procedures properly, the Claimant 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 at the Third-Party Administrator's discretion, to a provider that has accepted an assignment of benefits as consideration in full for services rendered. The Third-Party Administrator may revoke an assignment of benefits previously issued to a Provider at its discretion and treat the Participant as the sole beneficiary.

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

1. Pre-service Claims. A "Pre-service Claim" occurs when issuance of payment by the Plan is dependent upon determination of payability prior to the receipt of the applicable medical care;

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

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

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

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

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

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

When Claims Must Be Filed

Post-service health claims (which must be Clean Claims) must be filed with the Third-Party Administrator within 180 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.**

Timing of Claim Decisions

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

1. Pre-service Urgent Care Claims:
    a. If the Claimant has provided all of the necessary information, as soon as possible, taking into account the medical exigencies, but not later than 72 hours after receipt of the claim.
    b. If the Claimant has not provided all of the information needed to process the claim, then the Claimant will be notified as to what specific information is needed as soon as possible, but not later than 24 hours after receipt of the claim.
    c. The Claimant will be notified of a determination of benefits as soon as possible, but not later than 48 hours, taking into account the medical exigencies, after the earliest of:
        i. The Plan's receipt of the specified information.
        ii. The end of the period afforded the Claimant 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 Claimant. All necessary information, including the Plan's benefit determination on review, may be transmitted between the Plan and the Claimant by telephone, facsimile, or other similarly expeditious method. Alternatively, the Claimant may request an expedited review under the external review process.
2. Pre-service Non-urgent Care Claims:
    a. If the Claimant has provided all of the information needed to process the claim, in a reasonable period of time appropriate to the medical circumstances, but not later than 15 days after receipt of the claim, unless an extension has been requested, then prior to the end of the 15 day extension period.
    b. If the Claimant has not provided all of the information needed to process the claim, then the Claimant will be notified as to what specific information is needed as soon as possible. The Claimant will be notified of a determination of benefits in a reasonable period of time appropriate to the medical circumstances, either prior to the end of the extension period (if additional information was requested during the initial processing period), or by the date

agreed to by the Third-Party Administrator and the Claimant (if additional information was requested during the extension period).

3. Concurrent Claims:
    a. Plan Notice of Reduction or Termination. If the Third-Party Administrator is notifying the Claimant of a reduction or termination of a course of treatment (other than by Plan amendment or termination), notification will occur before the end of such period of time or number of treatments. The Claimant will be notified sufficiently in advance of the reduction or termination to allow the Claimant to appeal and obtain a determination on review of that Adverse Benefit Determination before the benefit is reduced or terminated. This rule does not apply if benefits are reduced or eliminated due to plan amendment or termination. A similar process applies for claims based on a rescission of coverage for fraud or misrepresentation.
    b. Request by Claimant Involving Urgent Care. If the Third-Party Administrator receives a request from a Claimant to extend the course of treatment beyond the period of time or number of treatments involving urgent care, notification will occur as soon as possible, taking into account the medical exigencies, but not later than 24 hours after receipt of the claim, as long as the Claimant makes the request at least 24 hours prior to the expiration of the prescribed period of time or number of treatments. If the Claimant submits the request within less than 24 hours prior to the expiration of the prescribed period of time or number of treatments, the request will be treated as a claim involving urgent care and decided within the urgent care timeframe.
    c. Request by Claimant Involving Non-urgent Care. If the Third-Party Administrator receives a request from the Claimant for a claim not involving urgent care, the request will be treated as a new benefit claim and decided within the timeframe appropriate to the type of claim (either as a Pre-service Non-urgent claim or a Post-service claim).
    d. Request by Claimant Involving Rescission. With respect to rescissions, the following timetable applies:
        i. Notification to Claimant 30 days
        ii. Notification of Adverse Benefit Determination on appeal 30 days
4. Post-service Claims:
    a. If the Claimant has provided all of the information needed to process the claim, in a reasonable period of time, but not later than 30 days after receipt of the claim, unless an extension has been requested, then prior to the end of the 15 day extension period.
    b. If such an extension is necessary due to a failure of the Claimant to submit the information necessary to decide the claim, the notice of extension shall specifically describe the required information, and the Claimant shall be afforded at least 45 days from receipt of the notice within which to provide the specified information.
    c. If the Claimant has not provided all of the information needed to process the claim and additional information is requested during the initial processing period, then the Claimant will be notified of a determination of benefits prior to the end of the extension period, unless additional information is requested during the extension period, then the Claimant will be notified of the determination by a date agreed to by the Third-Party Administrator and the Claimant.
5. Extensions:
    a. Pre-service Urgent Care Claims. No extensions are available in connection with Pre-service urgent care claims.
    b. Pre-service Non-urgent Care Claims. This period may be extended by the Plan for up to 15 days, provided that the Third-Party Administrator both determines that such an extension is necessary due to matters beyond the control of the Plan and notifies the

Claimant, prior to the expiration of the initial 15 day processing period, of the circumstances requiring the extension of time and the date by which the Plan expects to render a decision.

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

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

Notification of an Adverse Benefit Determination

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

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

Appeal of Adverse Benefit Determinations

Full and Fair Review of All Claims

In cases where a claim for benefits is denied, in whole or in part, and the Claimant believes the claim has been denied wrongly, the Claimant may appeal the denial and review pertinent documents. The claims

procedures of this Plan provide a Claimant with a reasonable opportunity for a full and fair review of a claim and Adverse Benefit Determination. More specifically, the Plan provides:

1. A 180 day timeframe following receipt of a notification of an initial Adverse Benefit Determination within which to appeal the determination. The Plan will not accept appeals filed after a 180 day timeframe.
2. The opportunity to submit written comments, documents, records, and other information relating to the claim for benefits.
3. The opportunity to review the Claim file and to present evidence and testimony as part of the internal claims and appeals process.
4. A review that does not afford deference to the previous Adverse Benefit Determination and that is conducted by an appropriate named fiduciary of the Plan, who shall be neither the individual who made the Adverse Benefit Determination that is the subject of the appeal, nor the subordinate of such individual.
5. A review that takes into account all comments, documents, records, and other information submitted by the Claimant relating to the claim, without regard to whether such information was submitted or considered in the prior benefit determination.
6. That, in deciding an appeal of any Adverse Benefit Determination that is based in whole or in part upon a medical judgment, the Plan fiduciary shall consult with a health care professional who has appropriate training and experience in the field of medicine involved in the medical judgment, who is neither an individual who was consulted in connection with the Adverse Benefit Determination that is the subject of the appeal, nor the subordinate of any such individual.
7. Upon request, the identity of medical or vocational experts whose advice was obtained on behalf of the Plan in connection with a claim, even if the Plan did not rely upon their advice.
8. 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 Claimant will be provided, free of charge: (a) reasonable access to, and copies of, all documents, records, and other information relevant to the Claimant's claim in possession of the Plan Sponsor or Third-Party Administrator; (b) information regarding any voluntary appeals procedures offered by the Plan; (c) information regarding the Claimant'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 Claimant's medical circumstances.
10. That a Claimant will be provided, free of charge, and sufficiently in advance of the date that the notice of Final Internal Adverse Benefit Determination is required, with new or additional evidence considered, relied upon, or generated by the Plan in connection with the Claim, as well as any new or additional rationale for a denial at the internal appeals stage, and a reasonable opportunity for the Claimant to respond to such new evidence or rationale.

Requirements for First Level Appeal

The Claimant must file an appeal regarding a Post-service claim and applicable Adverse Benefit Determination, in writing within 180 days following receipt of the notice of an Adverse Benefit Determination.

For Pre-service Claims. All Pre-service claims must be sent to the Third-Party Administrator or a designated utilization management company which will forward such Pre-service Claims to qualified medical reviewers. To file any appeal in writing, either for pre or post-service claims the Claimant's appeal must be addressed as follows:

Yuzu Health Inc.
30 W 21st St, 7th Floor
New York City, NY 10010
Phone: 203-208-9898
Email: admin@yuzu.health

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

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

Timing of Notification of Benefit Determination on Review

The Third-Party Administrator shall notify the Claimant of the Plan's benefit determination on review within the following timeframes:

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

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

Manner and Content of Notification of Adverse Benefit Determination on Review

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

1. Information sufficient to allow the Claimant to identify the claim involved (including date of service, the health care Provider, the claim amount, if applicable, and a statement describing the availability, upon request, of the diagnosis code and its corresponding meaning, and the treatment code and its corresponding meaning).
2. Specific reason(s) for a denial, including the denial code and its corresponding meaning, and a description of the Plan's standard, if any, that was used in denying the claim, and a discussion of the decision.
3. A reference to the specific portion(s) of the plan provisions upon which a denial is based.

4. The identity of any medical or vocational experts consulted in connection with a claim, even if the Plan did not rely upon their advice (or a statement that the identity of the expert will be provided, upon request).
5. A statement that the Claimant is entitled to receive, upon request and free of charge, reasonable access to, and copies of, all documents, records, and other information relevant to the Claimant's claim for benefits.
6. Any rule, guideline, protocol or similar criterion that was relied upon, considered, or generated in making the determination will be provided free of charge. If this is not practical, a statement will be included that such a rule, guideline, protocol or similar criterion was relied upon in making the determination and a copy will be provided to the Claimant, free of charge, upon request.
7. A description of any additional information necessary for the Claimant to perfect the claim and an explanation of why such information is necessary.
8. A description of available internal appeals and external review processes, including information regarding how to initiate an appeal.
9. A description of the Plan's review procedures and the time limits applicable to the procedures. This description will include information on how to initiate the appeal and a statement of the Claimant's right to bring a civil action under section 502(a) of ERISA following an Adverse Benefit Determination on final review.
10. In the case of denials based upon a medical judgment (such as whether the treatment is Medically Necessary or Experimental), either an explanation of the scientific or clinical judgment for the determination, applying the terms of the Plan to the Claimant's medical circumstances, will be provided. If this is not practical, a statement will be included that such explanation will be provided to the Claimant, free of charge, upon request.
11. 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.
12. 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."

Furnishing Documents in the Event of an Adverse Determination

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

Decision on Review

The decision by the Plan Sponsor 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.

Deemed Exhaustion of Internal Claims Procedures and De Minimis

Exception to the Deemed Exhaustion Rule

A Claimant 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 Claimant 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 Claimant 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 Claimant as long as the Plan Sponsor 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 Claimant, and the violation is not reflective of a pattern or practice of non-compliance.

If a Claimant believes the Plan Sponsor has engaged in a violation of the claims procedures and would like to pursue an immediate review, the Claimant 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 Claimant with notice of an opportunity to resubmit and pursue an internal appeal of the claim.

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).

<u>Standard external review</u>

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

1. <u>Request for external review</u>. 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 falls 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.

Appointment of Authorized Representative

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

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

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

Recognition as an authorized representative is completely separate from a Provider accepting an assignment of benefits, requiring a release of information, or requesting completion of a similar form. An assignment of benefits by a Claimant shall not be recognized as a designation of the Provider as an authorized representative. Assignment and its limitations under this Plan are described below.

Autopsy

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

Payment of Benefits

Where benefit payments are allowable in accordance with the terms of this Plan, payment shall be made in U.S. Dollars (unless otherwise agreed upon by the Third-Party Administrator). Payment shall be made, in the Third-Party Administrator's discretion, to an assignee of an assignment of benefits, but in any instance may alternatively be made to the Claimant, on whose behalf payment is made and who is the recipient of the services for which payment is being made. Should the Claimant be deceased, payment shall be made to the Claimant's heir, assign, agent or estate (in accordance with written instructions), or, if there is no such arrangement and in the Third-Party Administrator's discretion, the institute and/or Provider who provided the care and/or supplies for which payment is to be made – regardless of whether an assignment of benefits occurred.

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 Sponsor acting through the Third-Party 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 Sponsor 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 Third-Party 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.

Non-U.S. Providers

A Provider of medical care, supplies, or services, whose primary facility, principal place of business or address for payment is located outside the United States shall be deemed to be a "Non-U.S. Provider." Claimants must submit claims in English and payable claims will be paid directly to Claimants at an exchange rate calculated at the time the plan pays the claim without assignment of benefits being accepted.

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 Sponsor has the right to recover any such erroneous payment directly from the person or entity who received such payment and/or from other payers and/or the Claimant or Dependent on whose behalf such payment was made.

A Claimant, Dependent, Provider, another benefit plan, insurer, or any other person or entity who receives a payment exceeding the amount of benefits payable under the terms of the Plan or on whose behalf such payment was made, shall return or refund the amount of such erroneous payment to the Plan within 30 days of discovery or demand. The Plan Sponsor 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 Sponsor shall have the sole discretion to choose who will repay the Plan for an erroneous payment and whether such payment shall be reimbursed in a lump sum. When a Claimant or other entity does not comply with the provisions of this section, the Plan Sponsor shall have the authority, in its sole discretion, to deny payment of any claims for benefits by the Claimant and to deny or reduce future benefits payable (including payment of future benefits for other Injuries or Illnesses) under the Plan by the amount due as reimbursement to the Plan. The Plan Sponsor 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 Third-Party 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 Claimant, Provider or other person or entity to enforce the provisions of this section, then that Claimant, Provider or other person or entity agrees to pay the Plan's attorneys' fees and costs, regardless of the action's outcome.

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

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

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

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

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

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 Claimant for any outstanding amount(s).

Medicaid Coverage

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

Limitation of Action

A Claimant 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, a Claimant who 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.

COORDINATION OF BENEFITS

Definitions

Other Plan

"Other Plan" means (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 companies.
8. Any other source, including but not limited to crime victim restitution funds, any medical, disability or other benefit payments, and school insurance coverage.

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.

Benefits Subject to This Provision

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

Excess Insurance

If at the time of Injury, Illness 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.

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, including any similar coverage under a different name in a particular state.
3. Any policy of insurance from any insurance company or guarantor of a Third-Party, including but not limited to an Plan Sponsor's policy.
4. Workers' compensation or other liability insurance companies.
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

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.

Effect on Benefits

Application to Benefit Determinations

The plan that pays first according to the rules in the provision entitled "Order of Benefit Determination" will pay as if there were no Other Plan involved. The secondary and subsequent plans will pay the balance due up to 100% of the total covered expenses. 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 based on a Plan Year.

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 Third-Party 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 provision entitled "Order of Benefit Determination" would require this Plan to determine its benefits before the Other Plan.

Order of Benefit Determination

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

1. A plan without a coordinating provision will always be the primary plan.
2. The benefits of a plan which covers the person on whose expenses 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 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.

Right to Receive and Release Necessary Information

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

Facility of Payment

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

Right of Recovery

In accordance with the Recovery of Payments provision, whenever payments have been made by this Plan with respect to 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 Coordination of Benefits section, the Plan shall have the right to recover such payments, to the extent of such excess, from any one or more of the following as this Plan shall determine: any person to or with respect to whom such payments were made, or such person's legal representative, any insurance companies, or any other individuals or organizations which the Plan determines are responsible for payment of such 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.

MEDICARE

Applicable to Active Employees and Their Spouses Ages 65 and Over

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

Applicable to All Other Participants Eligible for Medicare Benefits

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

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

If any Participant is 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.

THIRD-PARTY RECOVERY, SUBROGATION AND REIMBURSEMENT

Payment Condition

The Plan, in its sole discretion, may elect to conditionally advance payment of benefits in those situations where an Injury, 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.

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 Illness 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, including any similar coverage under a different name in a particular state.
3. Any policy of insurance from any insurance company or guarantor of a third-Party, including but not limited to an Plan Sponsor'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.

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 Illness, Injury, or disability.

Participant is a Trustee Over Plan Assets

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

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

To the extent the Participant disputes this obligation to the Plan under this section, the Participant or any of its agents or representatives is also required to hold any/all settlement funds, including the entire settlement if the settlement is less than the Plan's interests, and without reduction in consideration of

attorneys' fees, for which he or she exercises control, in an account segregated from their general accounts or general assets until such time as the dispute is resolved.

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

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.

Excess Insurance

If at the time of Injury, Illness 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, including any similar coverage under a different name in a particular state.
3. Any policy of insurance from any insurance company or guarantor of a third-Party, including but not limited to a Plan Sponsor'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

Separation of Funds

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

Wrongful Death

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

Obligations

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

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

Offset

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

Minor Status

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

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

Language Interpretation

The Plan Sponsor 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 Sponsor may amend the Plan at any time without notice.

Severability

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

MISCELLANEOUS PROVISIONS

Clerical Error/Delay

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

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

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 ERISA, as it applies to Employee welfare plans, as well as any other applicable law.

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 Sponsor’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 dependents.

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.

No Waiver or Estoppel

All parts, portions, provisions, and conditions in the Plan, and/or other items addressed in this Plan shall be deemed to be in full force and effect, and not waived, absent an explicit written instrument expressing otherwise executed by the Third-Party Administrator. Absent such explicit waiver, there shall be no waiver of or estoppel against the enforcement of any provision of this Plan. Failure by any applicable entity to enforce any part of the Plan shall not constitute a waiver, either as it specifically applies to a particular circumstance, or as it applies to the Plan's general administration. If an explicit written waiver is executed, that waiver shall only apply to the matter addressed therein, and shall be interpreted in the narrowest fashion possible.

Plan Contributions

The Third-Party Administrator shall, from time to time, evaluate the funding method of the Plan and determine the amount to be contributed by the Participating Plan Sponsor 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, ERISA, and such other laws and regulations as shall be applicable to the end that the Plan shall be funded on a lawful and sound basis. The manner and means by which the Plan is funded shall be solely determined by the Plan Sponsor, to the extent allowed by applicable law.

Notwithstanding any other provision of the Plan, the Third-Party 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 Plan Sponsor 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.

Right to Receive and Release Information

The Third-Party Administrator may, without notice to or consent of any person, release to or obtain from any insurance company or other organization or person any information regarding coverage, expenses, and benefits which the Third-Party Administrator, in its sole discretion, considers necessary to determine and apply the provisions and benefits of this Plan. In so acting, the Third-Party 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 Third-Party Administrator such information as requested and as may be necessary to implement this provision.

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.

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.

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 (i) knowingly and with intent to defraud the Plan, or (ii) files a statement of claim containing any materially false information, or (iii) conceals for the purpose of misleading 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.

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-Pary 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 ERISA, and any other applicable State law(s).

SUMMARY OF BENEFITS

Definitions:

Coinsurance

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

Copayment or Copay

"Copayment" or "Copay" means a dollar amount per visit the Participant pays to the Provider for health care expenses.

Deductible

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

Collectively, amounts contributed by the Participant towards their Deductible, Coinsurance, and Copay are considered and referred to as the Participant's **Cost Sharing**. This is also known as the maximum out-of-pocket expense.

This Plan does not cover all health care services. The plan covers specific medically necessary services, supplies and prescription drugs under specific circumstances.

The plan will cover a service, supply, or prescription drug, if all the following conditions are met:

- The person receiving the service, supply or prescription drug is a Covered Participant under the Plan at the time the service, supply or prescription drug is received.
- The service, supply or prescription drug must be received by the Covered Participant during the defined plan year.
- The service, supply or prescription drug is listed as eligible for Coverage by the Plan.
- The reason for the service, supply or prescription drug meets the Plan's definition of Medically Necessary.
- The Plan's coverage policies, including preauthorization requirements are met.
- The Participant pays all applicable cost-sharing amounts.
- Just because a Healthcare Provider orders, recommends, or prescribes a healthcare service, supply, or prescription drug does not make it medically necessary and eligible for coverage under the plan.

General Limits

Coverage for any of the services, supplies or prescription drugs listed in the Plan Document are subject to all Plan Exclusions, limitations, and provisions. The Plan does not pay for covered services until applicable Cost Sharing amounts have been met by the Participant.

Certain services require preauthorization to be eligible for coverage. See the Utilization Management section for more information regarding what services, supplies and prescription drugs require preauthorization and details about the preauthorization process.

Just because a service, supply or prescription drug is of a type covered by the Plan, or a required preauthorization is received, it is not a guarantee that the service, supply, or prescription drug will be eligible for payment. A decision regarding whether a service, supply or prescription drug can be covered by the Plan, will be made when a claim is submitted to the plan from the rendering health care provider.

Balance Billing

In the event that a claim submitted by a Provider is subject to a medical bill review or medical chart audit and 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, although the Plan has no control over any Provider's actions, including balance billing.

In addition, with respect to services rendered by a Provider being paid in accordance with the Plan's Maximum Allowable Charge, it is the Plan's position that the Participant should not be responsible for the difference between the amount charged by the Provider and the amount determined to be payable by the Plan 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 Provider.

The Participant is responsible for any applicable payment of Coinsurance, Deductible, and Out-of-Pocket maximum amounts, and may be billed for any or all of these costs.

If a Plan Participant believes they are being balance billed and wants assistance to determine if there is anything that can be done, they should contact the Third-Party Administrator for more information.

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, 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.

This Plan offers a participating provider organization (PPO) through network(s): S&S Cigna

Claims Audit

In addition to the Plan's Medical Record Review process, the Plan Sponsor may use its discretionary authority to direct the Third-Party Administrator 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 Sponsor 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 Third-Party 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.

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 provided in a hospital emergency department or a free standing emergency facility;
- 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.

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 7 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.

Summary of Benefits - Medical

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

	In Network	Out of Network
Individual Deductible	$1,000	$2,000
Individual Max OOP	$5,000	$10,000
Family Deductible	$2,000	$4,000
Family Max OOP	$10,000	$20,000

NOTE: Each tier has separate cost-sharing amounts that do not accumulate towards each other.

The following table identifies what does and does not apply toward the Coordinated and Uncoordinated Out of Pocket Maximums:

Plan Features	Applies to the Out-of-Pocket Maximum?
Payments toward the annual Deductible	Yes
Coinsurance payments, including those for covered services available in the Prescription Drug Benefits section, except for those covered health services identified in the Summary of Benefits that do not apply to the Out-of-Pocket Maximum (e.g. non-essential health benefits).	Yes
Copayments	Yes
Charges for non-covered services	No
The amounts of any Pre-Certification penalties	No
Charges that exceed Allowable Expenses	No

All charges used to apply toward an "individual" out-of-pocket maximum amount will be applied toward the "family" out-of-pocket maximum amount shown in the Summary of Benefits. No individual out-of-pocket maximums will exceed the aggregated Out-of-Pocket amount for that Plan Year.

Benefit Category	In Network	Out of Network	Limitation
Office Visit - Pregnancy	$20.00 Copay	40% Coinsurance after deductible	
Freestanding Laboratory	No charge	40% Coinsurance after deductible	
Urgent Care	$40.00 Copay	40% Coinsurance after deductible	
Imaging Complex (MRI/PET/CT)	20% Coinsurance after deductible	40% Coinsurance after deductible	Some procedures may need pre-certification.

Benefit Category	In Network	Out of Network	Limitation
Radiation and Chemotherapy	20% Coinsurance after deductible	40% Coinsurance after deductible	Some procedures may need pre-certification.
Hospice Care	20% Coinsurance after deductible	40% Coinsurance after deductible	
Emergency Room Care	20% Coinsurance after deductible	20% Coinsurance after deductible	
Ambulance / Emergency medical transportation	20% Coinsurance after deductible	20% Coinsurance after deductible	Some procedures may need pre-certification.
Habilitation Services	$20.00 Copay	40% Coinsurance after deductible	20 visits per year. Some procedures may need pre-certification.
Hospital Outpatient	20% Coinsurance after deductible	40% Coinsurance after deductible	
Cardiac Rehabilitiation	$20.00 Copay	40% Coinsurance after deductible	36 visits per year. Some procedures may need pre-certification.
Imaging: X-Ray/Radiology	No charge after deductible	40% Coinsurance after deductible	Some procedures may need pre-certification.
Pregnancy: Childbirth/Delivery	20% Coinsurance after deductible	40% Coinsurance after deductible	
Injections	20% Coinsurance after deductible	40% Coinsurance after deductible	Some procedures may need pre-certification.
Outpatient Mental Health	$20.00 Copay	40% Coinsurance after deductible	
Surgery	20% Coinsurance after deductible	40% Coinsurance after deductible	Some procedures may need pre-certification.
Preventive Care	No charge	40% Coinsurance after deductible	You may have to pay for services that aren't preventive. Ask your provider if the services needed are preventive. Then check what your plan will pay for.
Laboratory/Diagnostics	20% Coinsurance after deductible	40% Coinsurance after deductible	Some procedures may need pre-certification.

Benefit Category	In Network	Out of Network	Limitation
Private Duty Nursing	20% Coinsurance after deductible	40% Coinsurance after deductible	Some procedures may need pre-certification.
Rehabilitation Services (occupational, physical, and speech therapy)	$20.00 Copay	40% Coinsurance after deductible	20 visits per year. Some procedures may need pre-certification.
Adult Eye Exam	$20.00 Copay	40% Coinsurance after deductible	1 visit per year.
Other services	20% Coinsurance after deductible	40% Coinsurance after deductible	
Skilled Nursing Facility	20% Coinsurance after deductible	40% Coinsurance after deductible	60 days per year.
Hospital Inpatient	20% Coinsurance after deductible	40% Coinsurance after deductible	Some procedures may need pre-certification.
Office Visit - Primary Care (including services same day/same provider)	$20.00 Copay	40% Coinsurance after deductible	Some procedures may need pre-certification.
Specialist Office Visit	$40.00 Copay	40% Coinsurance after deductible	Some procedures may need pre-certification.
Chiropractic Services	$20.00 Copay	40% Coinsurance after deductible	20 visits per year.
Durable Medical Equipment	20% Coinsurance after deductible	40% Coinsurance after deductible	Some procedures may need pre-certification.
Home Health Care	20% Coinsurance after deductible	40% Coinsurance after deductible	60 visits per year. Some procedures may need pre-certification.
Acupuncture	$20.00 Copay	40% Coinsurance after deductible	20 visits per year.

Summary of Benefits - Prescription Drug

The following benefits are per Participant:

Covered Prescription Drug Expenses:	Participating Pharmacy[1]	Limits[2]
Pharmacy Option:		
Generic drug (30 day supply)	$15.00 Copay	See Prescription Drug Benefits section
Specialty drug (30 day supply)	50% Coinsurance	See Prescription Drug Benefits section
Specialty drug (90 day supply)	Not Covered	See Prescription Drug Benefits section
Generic drug (90 day supply)	$45.00 Copay	See Prescription Drug Benefits section
Preferred drug (30 day supply)	$45.00 Copay	See Prescription Drug Benefits section
Preferred drug (90 day supply)	$90.00 Copay	See Prescription Drug Benefits section
Non-Preferred drug (30 day supply)	$85.00 Copay	See Prescription Drug Benefits section
Non-Preferred drug (90 day supply)	$150.00 Copay	See Prescription Drug Benefits section

1 See PBM's Participating Pharmacy network.

2 These limits are in addition to all other Plan Exclusions, limitations and provisions set forth in this Plan. Please review the Plan carefully to determine benefits available.

MEDICAL BENEFITS

Medical Benefits

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

Office Visit - Pregnancy. Expenses attributable to a Pregnancy. Pregnancy expenses of Dependent Children are not covered. Coverage may be available for expenses related to certain complications of Pregnancy.

NOTE: Preventive care charges for Pregnancy are covered under the Preventive Care benefitin the Medical Benefits section.

Under the Newborns' and Mothers' Health Protection Act of 1996, group health plans and health insurance issuers generally may not restrict benefits for any Hospital length of stay in connection with childbirth for the mother or newborn Child to less than 48 hours following a vaginal delivery, or less than 96 hours following a cesarean section. However, Federal law generally does not prohibit the mother's or newborn's attending Provider, after consulting with the mother, from discharging the mother or her newborn earlier than 48 hours (or 96 hours as applicable). In any case, plans and issuers may not, under Federal law, require that a Provider obtain authorization from the Plan or the issuer for prescribing a length of stay not in excess of 48 hours (or 96 hours). In no event will an "attending Provider" include a plan, Hospital, managed care organization, or other issuer. In accordance with the Summary of Benefits and this section, benefits for the care and treatment of Pregnancy that are covered will be subject to all applicable Plan limitation.

Freestanding Laboratory. A clinical laboratory that operates independently, not affiliated with a hospital or other large healthcare system.

Urgent Care. Medical services provided for the treatment of an unexpected illness or injury that requires prompt attention but is not severe enough to warrant emergency room care. Urgent care visits are typically rendered at an urgent care center or similar facility and are intended to address conditions that require same-day treatment to prevent complications. Coverage is subject to Plan provisions, limitations, and exclusions.

Imaging Complex (MRI/PET/CT). 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.

Radiation and Chemotherapy. Charges for radiation therapy and treatment. Charges for chemotherapy, including materials and services of technicians, when not
Experimental, and when at a reasonable price.

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

1. Room and Board for confinement in a Hospice.
2. Ancillary charges furnished by the Hospice while the patient is confined therein, including rental of Durable Medical Equipment which is used solely for treating an Injury or Illness.
3. Medical supplies, Drugs and medicines prescribed by the attending Physician, but only to the extent such items are necessary for pain control and management of the terminal condition.
4. Physician services and nursing care by a Registered Nurse, Licensed Practical Nurse or a Licensed Vocational Nurse (L.V.N.).
5. Home health aide services.
6. Home care furnished by a Hospital or Home Health Care Agency, under the direction of a Hospice, including Custodial Care if it is provided during a regular visit by a Registered Nurse, a Licensed Practical Nurse or a home health aide.
7. Medical social services by licensed or trained social workers, Psychologists or counselors.
8. Nutrition services provided by a licensed dietitian.
9. Respite care. The Hospice Care program must be renewed in writing by the attending Physician every 30 days. Hospice Care ceases if the terminal Illness enters remission.

Emergency Room Care. Medical services provided in a hospital emergency department for the treatment of an emergency medical condition, which may include sudden or severe illness, injury, or other conditions requiring immediate attention to prevent serious harm. Coverage for emergency room care is subject to the terms, copayments, coinsurance, deductibles, and exclusions of the Plan.

Ambulance / Emergency medical transportation. 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. Limited to cases when the Ambulance was the only available option, and treatment was Medically Necessary.

Air Ambulance

Covered Expenses will be payable at the most appropriate of the following:

1. A negotiated, contracted amount as mutually agreed upon with a Provider or other discounting contract.
2. One Hundred Fifty (150%) of the allowable charge established by application of the Medicare Ambulance Fee Schedule.
3. The billed charge if less than 1 or 2 above.

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/or fixed wing aircraft 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.

Habilitation Services. Habilitation Services Include:
1. Applied Behavior Analysis (ABA) Therapy. Charges for ABA therapy for treatment of Autism Spectrum Disorder (ASD).
2. 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.
3. 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.
4. Speech-Language Pathology. Treatment for speech delays and disorders.
See the Summary of Benefits for treatment and/or frequency limitations.

Hospital Outpatient. Medical, surgical, diagnostic, emergency, or therapeutic services received at a hospital when a Member is not admitted as an inpatient or overnight stay. Pre-certification may be required. Covered services may include:
1. Emergency room.
2. Treatment for chronic conditions.
3. Physical therapy treatments.
4. Hemodialysis.
5. X-ray, laboratory and linear therapy.

Cardiac Rehabilitiation. Cardiac rehabilitation is a personalized program of education and exercise. The supervised program is designed to improve health in those with heart disease. It's often recommended after a heart attack or heart surgery.

Cardiac rehabilitation involves exercise training, emotional support and education about a heart-healthy lifestyle.

Imaging: X-Ray/Radiology. Radiologic services used for the diagnosis and treatment of illness or injury, including but not limited to standard X-rays, electrocardiogram, ultrasounds, and other recognized diagnostic imaging techniques. Covered services generally include both the technical component (use of equipment and facility) and the professional component (interpretation by a licensed radiologist or other qualified provider). Services may be subject to medical necessity review and must be rendered by appropriately licensed or accredited providers or facilities.

Pregnancy: Childbirth/Delivery. Follows federal guidelines that specify that if birth is 'regular' (48 hrs vaginal, 96 hrs c-section) then no pre-cert is needed. If baby stays longer than mother that a pre-cert is then required.

Expenses attributable to a Pregnancy. Pregnancy expenses of Dependent
Children are not covered. Coverage may be available for expenses related to certain complications of Pregnancy. NOTE: Preventive care charges for Pregnancy are covered under the Preventive Care benefit in the Medical Benefits section.
Under the Newborns' and Mothers' Health Protection Act of 1996, group health plans and health insurance issuers generally may not restrict benefits for any Hospital length of stay in connection with

childbirth for the mother or newborn Child to less than 48 hours following a vaginal delivery, or less than 96 hours following a cesarean section. However, Federal law generally does not prohibit the mother's or newborn's attending Provider, after consulting with the mother, from discharging the mother or her newborn earlier than 48 hours (or 96 hours as applicable). In any case, plans and issuers may not, under Federal law, require that a Provider obtain authorization from the Plan or the issuer for prescribing a length of stay not in excess of 48 hours (or 96 hours). In no event will an "attending Provider" include a plan, Hospital, managed care organization, or other issuer. In accordance with the Summary of Benefits and this section, benefits for the care and treatment of Pregnancy that are covered will be subject to all applicable Plan limitations and maximums (if any), and are payable in the same manner as medical or surgical care of an Illness.

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.

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

Injections. "Injections" refers to the administration of a drug, vaccine, biologic, or other substance by means of a syringe or similar device into the body, including intramuscular, subcutaneous, or intravenous routes of administration.

Outpatient Mental Health. Services provided in an outpatient setting for the diagnosis, evaluation, and treatment of mental health conditions. This includes individual, group, and family therapy, psychiatric consultations, and medication management when performed outside of a hospital setting. Coverage is subject to medical necessity, provider type, and the terms, limitations, and exclusions of the Plan.

Surgery. Surgical operations and procedures, unless otherwise specifically excluded under the Plan, and limited as follows:
1. Multiple procedures adding significant time or complexity will be allowed at:
a. One hundred percent (100%) of the Maximum Allowable Charge for the first or major procedure.
b. Fifty percent (50%) of the Maximum Allowable Charge for the secondary and subsequent procedures.
c. Bilateral procedures which add significant time or complexity, which are provided at the same operative session, will be allowed at one hundred percent (100%) of the Maximum Allowable Charge for the major procedure, and fifty percent (50%) of the Maximum
2. Allowable Charge for the secondary or lesser procedure. 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.

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

Second Surgical Opinions.
Charges for second surgical opinions.

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.

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.

Preventive Care. Charges for Preventive Care services. This Plan intends to comply with the Affordable Care Act's (ACA) requirement to offer 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/.

Preventive and Wellness Services for Adults and Children - In compliance with section 2713 of the Affordable Care Act, benefits are available for evidence-based items or services that have in effect a rating of "A" or "B" in the current recommendations of the United States Preventive Services Task Force (USPSTF). Immunizations that have in effect a recommendation from the Advisory Committee on Immunization Practices (ACIP) of the Centers for Disease Control and Prevention (CDC) with respect to the individual
involved. With respect to infants, Children, and adolescents, evidence-informed Preventive Care and

screenings as provided for in the comprehensive guidelines supported by the Health Resources and Services Administration (HRSA). Women's Preventive Services - With respect to women, such additional Preventive Care and
screenings as provided for in comprehensive guidelines supported by the Health Resources and Services Administration (HRSA) not otherwise addressed by the recommendations of the United States Preventive Service Task Force (USPSTF), which will be commonly known as HRSA's Women's Preventive Services Required Health Plan Coverage Guidelines. The HRSA has added the following eight categories of women's services to the list of mandatory preventive services:
1. Well-woman visits.
2. Gestational diabetes screening.
3. Human papillomavirus (HPV) Deoxyribonucleic Acid (DNA) testing.
4. Sexually transmitted infection counseling.
5. Human Immunodeficiency Virus (HIV) screening and counseling.
6. Food and Drug Administration (FDA)-approved contraception methods and contraceptive counseling.
7. Breastfeeding support, supplies and counseling.
8. Domestic violence screening and counseling.
A description of Women's Preventive Services can be found at:
http://www.hrsa.gov/womensguidelines/ or at the websites listed above.

Contraceptives.
The charges for all Food and Drug Administration (FDA) approved contraceptive methods, in accordance with Health Resources and Services Administration (HRSA) guidelines.

Sterilization.
All Food and Drug Administration (FDA) approved charges related to sterilization procedures, to the extent required by the Affordable Care Act (ACA).

Laboratory/Diagnostics. "Laboratory and Diagnostic Services" refers to procedures and tests performed to assist in the detection, diagnosis, monitoring, or treatment of disease, injury, or other health conditions. Such services may include, but are not limited to, clinical laboratory tests, imaging studies (such as X-ray), pathology services, and other diagnostic examinations performed by or under the supervision of a licensed provider.

Private Duty Nursing. Private duty nursing

Rehabilitation Services (occupational, physical, and speech therapy). Services for individual therapy are covered on an Inpatient or Outpatient basis. They are services or supplies used for the treatment of an Illness or Injury and include:
1. Autism Spectrum Disorder Treatment. Charges for treatment of Autism Spectrum Disorder (ASD).
2. Cardiac Therapy. Charges for cardiac therapy.
3. Cognitive Therapy. Charges for cognitive therapy.
4. Occupational Therapy. Rehabilitation treatment or services rendered by a registered occupational therapist, under the direct supervision of a Physician, in a home setting or at a facility or Institution whose primary purpose is to provide medical care for an Illness or Injury, or at a free-standing outpatient facility.
5. Physical Therapy. Rehabilitation treatment or services rendered by a physical therapist, under direct supervision of a Physician, in a home setting or a facility or Institution whose primary purpose is to provide medical care for an Illness or Injury, or at a free-standing duly licensed outpatient therapy facility.
6. Respiration Therapy. Respiration therapy services.
7. Speech Therapy. Speech therapy, for Rehabilitation purposes, by a Physician or qualified speech

therapist, when needed due to an Illness or Injury (other than a functional Mental Disorder, Behavioral Disorder, or Neurodevelopmental Disorder) or due to Surgery performed as the result of an Illness 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.
8. Vision Therapy. For patients with eye movement disorders, designed to modify different aspects of visual function. Vision therapy does not include treatment for learning disabilities and dyslexia.
See the Summary of Benefits for treatment and/or frequency limitations.

Adult Eye Exam. This benefit is for preventative eye exams; refractions not covered. Please ensure the plan covers Adult vision.

Other services. All other covered services are specified in the Medical Benefits section of this Plan Document.

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.

Hospital Inpatient. Services provided when a Member is formally admitted to a hospital by a physician for medical, surgical, maternity, or behavioral health care that requires an overnight stay or longer. Covered services may include:
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.
5. Newborn Care. Hospital and Physician nursery care for newborns who are 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:
a. Hospital routine care for a newborn during the Child's initial Hospital confinement at birth.
b. The following Physician services for well-baby care during the newborn's initial Hospital confinement at birth:
i. The initial newborn examination and a second examination performed prior to discharge from the Hospital.
ii. 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.

Office Visit - Primary Care (including services same day/same provider). A visit with a licensed primary care provider (such as a family practitioner, internist, pediatrician, or general practitioner) for the diagnosis, treatment, and management of routine or acute medical conditions. Covered services may include examinations, consultations, preventive care, and basic diagnostic services provided during the visit. Coverage is subject to copayments, coinsurance, deductibles, and all other terms, limitations, and exclusions of the Plan.

Specialist Office Visit. A visit with a licensed medical specialist, such as a cardiologist, dermatologist, orthopedist, or other provider with advanced training in a specific field of medicine, for the evaluation, diagnosis, and treatment of conditions that require specialized expertise. Coverage for specialist office visits, including examinations, consultations, and certain diagnostic or treatment services performed during the visit, is subject to copayments, coinsurance, deductibles, and all other terms, limitations, and exclusions of the Plan

Chiropractic Services. Services provided by a licensed chiropractor to diagnose, treat, or manage musculoskeletal conditions, including spinal manipulation and related therapeutic procedures. Coverage for chiropractic services is subject to medical necessity, prior authorization (if required), and the terms, limitations, and exclusions of the Plan.

Durable Medical Equipment. "Durable Medical Equipment" shall mean equipment and/or supplies ordered by a health care Provider for everyday or extended use which meets all of the following requirements: (1) can withstand repeated use, (2) is primarily and customarily used to serve a medical purpose, (3) Generally is not useful to a person in the absence of an illness or injury, (4) is appropriate for use in the home.

Charges for rental, up to the purchase price, of Durable Medical
Equipment, including glucose home monitors for insulin dependent diabetics. At its option, and with its advance written approval, the Plan may cover the purchase of such items when it is less costly and more practical than rental. The Plan does not pay for any of the following:
1. Any purchases without its advance written approval.
2. Replacements or repairs.
3. The rental or purchase of items which do not fully meet the definition of "Durable Medical Equipment".
4. Delivery charges or sales tax for Durable Medical equipment.

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

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.
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.

Acupuncture. Relating directly or indirectly to acupuncture, including acupuncture provided in lieu of anesthetic.

UTILIZATION MANAGEMENT

The Plan's Utilization Management Program is designed to ensure Participants receive the necessary services, supplies, and prescription drugs while avoiding excessive or unnecessary care. The Plan reviews certain services, supplies and prescription drugs to determine if they are eligible for coverage, appropriate for use outside of the research setting, and an efficient use of health care according to the provisions of the Plan.

When a service, supply or prescription drug requires Preauthorization by the Plan's Utilization Management program to determine coverage eligibility, it is the Participant's responsibility to ensure the Preauthorization has been completed before the service, supply or prescription drug is Incurred by the Participant.

The Plan's Utilization Management program does not evaluate or determine Participant eligibility. Even when a service or supply has been Preauthorized it does not guarantee that the service, supply, or prescription drug will be covered by the Plan. For a Preauthorized service, supply, or prescription drug to be covered, the Participant must be covered by the Plan and meet all eligibility requirements noted in this document at the time the service, supply or prescription drug was Incurred by the Participant.

For information about the Prescription Drug Utilization Management Program, see the Prescription Drug sections of this document.

When a service or supply requires Preauthorization, and the Preauthorization is not requested, the service or supply will be reviewed by the Utilization Management team, retrospectively, and if the service or supply is approved it will be covered without penalty. If the service or supply is determined not eligible for coverage, the entire cost of the service or supply is the responsibility of the Participant.

The Plan's Utilization Management Program includes:

- Preauthorization – a review that determines if the service is eligible for coverage by the Plan, prior to a service or supply being Incurred by a Participant. The list of services and supplies that require Preauthorization are noted in the table in the Benefits section. See the Prescription Drug section of this document for Prescription Drug Preauthorization requirements.
- Concurrent Review – a review that determines if ongoing services or supplies are eligible for coverage while being Incurred by a Participant (example: inpatient hospital services).
- Retrospective Review- a review that determines if services or supplies already Incurred by a Participant are eligible for coverage by the Plan. Examples of services or supplies that may be retrospectively reviewed include:
    - When Preauthorization or Concurrent Review was required but not obtained;
    - When a claim is received for services or supplies Incurred by a Participant that may be:
        - Excluded from coverage by the Plan,,ay not be medically necessary;
        - May be experimental or investigational;
        - May be the result of an error;
        - May be inaccurate or inaccurately submitted on the claim form;
        - May be a complication of a non-covered service; or

- Any other circumstance or reason the Plan determines requires review to confirm eligibility e for coverage.

To receive the maximum benefit for eligible covered services and supplies, the following services and supplies require Preauthorization, (except when applicable rules or laws preclude a service or supply from the Plan's UM Program):

- Cigna Precertification - Musculoskeletal (Buy Up)
- Cigna Precertification - Medical Oncology (Buy Up)
- Hospital Inpatient
- Cigna Precertification - Erectile Dysfunction
- Cigna Precertification - Gastric Bypass
- Cigna Precertification - Home Health Care
- Cigna Precertification - Injectable Medications: Claim service line exceeds $1,500.00
- Cigna Precertification - Molecular Lab
- Cigna Precertification - Oral Pharynx
- Cigna Precertification - Orthotics and Prosthetics
- Cigna Precertification - Outpatient Procedures (Potentially Cosmetic)
- Cigna Precertification - Diagnostic Radiology
- Cigna Precertification - Potential Experimental/Investigation/Unproven
- Cigna Precertification - Sleep Management Program
- Cigna Precertification - Ear Devices/Cochlear Implant
- Cigna Precertification - Spinal Procedures
- Cigna Precertification - Spinal Services
- Cigna Precertification - Therapeutic Radiology
- Cigna Precertification - Transplant
- Cigna Precertification - Durable Medical Equipment: Claim service line exceeds $1,500.00
- Cigna Precertification - Unlisted Procedures
- Cigna Precertification - Vascular Interventions

Labor and Delivery
The Plan will automatically approve up to a 48 hour stay for an Inpatient vaginal delivery and up to a 96 hour stay for an Inpatient cesarean delivery. In the event the mother and/or baby require additional time in the Inpatient setting, the request for the additional length of stay must be approved by the Plan.
Plan Participants will receive coverage for eligible services, supplies, and prescription drugs when they are determined Medically Necessary and not Experimental or Investigational. The fact that an Approved Provider Type, has prescribed, ordered, or recommended a service, supply, or prescription drug does not make it Medically Necessary or eligible for coverage by the Plan. The Plan makes the final decision whether a service, supply, or prescription drug is eligible for coverage based on the Plan provisions including medical benefits, exclusions, and meeting the Plan's Medical Necessity criteria.

Preauthorization Procedures and Contact Information
Whenever a Plan Participant is advised that they will need a service or supply that requires Preauthorization, it is the Participant's responsibility to call and request Preauthorization. The Preauthorization process, is based on the type of service or supply and is outlined below:

Emergency Care including Emergency Admissions

If a Participant needs medical care for an Emergency Medical Condition, the Participant should obtain care without delay and notify the Plan as soon as is reasonably possible.

“Emergency Medical Condition” means an illness or injury 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.

If a Participant requires an Emergency admission to a Facility, the Participant, or an individual acting on behalf of the Participant, should follow the Provider’s instructions carefully and contact the Plan within 72 hours, or 1 business day after the services were Incurred. Preauthorization is not required for care to treat an Emergency Medical Condition.

When a claim is received for services and supplies to treat an Emergency Medical Condition, they may be reviewed retrospectively to determine if they are eligible for coverage, and the claim will be processed according to the Plan provisions and applicable laws regarding Emergency care.

Non-Emergency Admissions
When a Participant requires Inpatient care that is scheduled in advance and not related to an Emergency Medical Condition, the Participant or person acting on their behalf should request Preauthorization as soon as possible and before any services are Incurred. Once a Preauthorization request is received, the Plan will contact the Participant’s Provider to obtain the information required to determine if the Inpatient stay is eligible for coverage by the plan.

When the required information is available, the clinical information related to the need for the Inpatient stay will be reviewed and if determined Medically Necessary, and eligible for coverage by the Plan, the determination will be communicated to the Participant and their Provider.

You and your Provider will be notified in writing within 15 calendar days of the Plan receiving the Preauthorization request the Plan’s determination, or if more information is needed to make a determination.

If additional information is requested:

- You are allowed up to 45 calendar days from the date on the letter you receive to submit the information requested.
- You will be notified in writing of the decision within 15 calendar days from either the plan receiving the additional requested information or the end of the 45-day period if no additional information is received by the Plan.

Expedited Determinations for Urgent or Emergent Preauthorization Requests
When a Participant or their Provider believe that the standard time frame could place the Participant’s life, health, or ability to regain maximum function in danger, the Participant, their authorized representative, or their Provider should notify the Third-Party Administrator by phone. The Plan will review the request and notify the Participant as soon as possible, but not more than 72 hours after receiving the request of the Plan’s determination. When the Plan reviews an urgent or emergent Preauthorization request and

determines additional information is required to decide, the Plan will notify the Participant or their representative within 24 hours of receiving the expedited request what additional information is required to make a determination. The Participant or their representative will have 48 hours to provide the additional information to the Plan.

The Plan will make a determination within 48 hours of receiving the additional information or at the end of the 48-hour time frame the Participant had to submit the additional information, even if the information required has not been submitted to the Plan.

Concurrent Authorization Requests
When a Participant is actively receiving services that were authorized by the Plan and the Participant's Provider requests additional services or an extension of care at least 24 hours before the existing authorization expires, the Plan will review the request and make a determination within 24 hours of receiving the request. If during an ongoing course of treatment, the Plan determines that the services are no longer eligible for coverage, the Plan will notify the Participant, in advance, to allow the Participant time to appeal the Plan's determination before the services are deemed ineligible for coverage.

When a Preauthorization request is determined not eligible for coverage by the Plan, the decision is considered an Adverse Benefit Determination. When an Adverse Benefit Determination is made, Participants or their authorized representative, which in some cases is the treating Provider, can request an Appeal of the Adverse Benefit Determination. For information about how to request an Appeal of an Adverse Benefit Determination, see the Appeals Section of this document.

Alternate Course of Treatment
If the Plan determines that there are alternative, medically appropriate, and less costly service or supply to treat an illness or injury, and the Participant's Provider agrees to the Alternate Course of Treatment, the Plan, may decide to cover Medically Necessary related services or supplies, even if the services or supplies would not normally be covered by the Plan.

The Plan may provide coverage for an Alternate Course of Treatment at is sole discretion and only when the Alternate Course of Treatment, is Medically Necessary and cost effective, and that the total benefits paid will not exceed the total benefits to which the Participant would otherwise be entitled by the Plan in the absence of the Alternate Course of Treatment.

If the Plan agrees to an Alternate Course of Treatment for a Participant, it does not set precedent or obligate the Plan to cover any other similar or different Alternate Course of Treatment for the same or other Participants. The Alternate Course of Treatment does not waive the Plan's rights to administer the Plan in strict accordance with the Plan provisions described in this document.

PRESCRIPTION DRUG BENEFITS

Participating pharmacies ("Participating Pharmacies") have contracted with the Plan to charge Participants reduced fees for covered Drugs. DisclosedRx is the administrator of the prescription drug plan. Prescription Drug Benefits are generally only available through Participating Pharmacies, including the Plan's "Specialty Pharmacy" for drugs defined as Specialty Medications.

The Cost-Sharing is applied to each charge and is shown in the Summary of Benefits section. The Coinsurance amount applies toward the medical plan out-of-pocket maximum. The Plan may offer incentives (including waived cost-sharing) on a case-by-case basis to members with maintenance medications that may be supplied through alternative means. These incentives shall not violate other terms of the plan including non-discrimination.

Covered Expenses

The following are covered under the Plan:

Contraceptives. All Food and Drug Administration (FDA)-approved contraceptives Drugs, in accordance with the Health Resources and Services Administration (HRSA) guidelines. ***NOTE:*** *All other contraceptive methods are covered under the Preventive Care benefit in the medical plan.*

Immunizations. Immunization agents or biological sera.

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

Limitations

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

Refills.

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

Exclusions

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

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

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

Consumed Where Dispensed. Any Drug or medicine that is consumed or administered at the place where it is dispensed. This includes being confined in any institution that has a facility for the dispensing of drugs and medicines on its premises.

Impotency. A charge for impotency medication, including Viagra.

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

Legend Drugs.

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

Medical Devices and Supplies. Charges for legend and over the counter medical devices and supplies.

Non-Prescription Drug or Medicine. A drug or medicine that can legally be bought without a prescription, except for injectable insulin, except to the extent required by the FFCRA, as amended.

Growth Hormones and Steroids. Anabolic steroids and other growth hormones.

HIPAA AND PRIVACY RIGHTS

Definition: Privacy Standards
"Privacy Standards" means the applicable standards for the privacy of individually identifiable health information, pursuant to HIPAA and GINA (Genetic Information Nondiscrimination Act of 2008).

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 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/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 203-208-9898.

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.
   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 include 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.

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.

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:
Chief Privacy Officer
Yuzu Health
30 W 21st St, 7th Floor
New York City, NY 10010
Phone: 203-208-9898
Email: admin@yuzu.health

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 Health Insurance Portability and Accountability Act (HIPAA) and other applicable law shall override the following wherever there is a conflict, or a term or terms is/are not hereby defined.

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 HIPAA.

Definitions

- **Electronic Protected Health Information (ePHI),** as defined in Section 160.103 of the Security Standards (45 C.F.R. 160.103), 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), 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. Only the Privacy Officer and those designated by the Privacy Officer to require PHI to carry out their administrative obligations under the Plan shall have access to PHI.

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.

Resolution of Noncompliance

In the event that any authorized individual of the Plan Sponsor'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.

PARTICIPANT'S RIGHTS

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

Receive Information About the Plan and Benefits

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

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

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

Continue Group Health Plan Coverage

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

Prudent Actions by Plan Fiduciaries

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

Enforce the Participant's Rights

If a Participant's claim for a welfare benefit is denied or ignored, in whole or in part, the Participant has a right to know why this was done, to obtain copies of documents relating to the decision without charge, and to appeal any denial, all within certain time schedules. Under ERISA, there are steps the Participant can take to enforce the above rights. For instance, if the Participant requests a copy of Plan documents or the latest annual report from the Plan and do not receive them within 30 days, the Participant may file suit in a Federal court. In such a case, the court may require the Plan Sponsor to provide the materials and pay the Participant up to $110 a day until the Participant receives the materials, unless the materials were not sent because of reasons beyond the control of The Plan Administrator. If the Participant has a claim for benefits which is denied or ignored, in whole or in part, the Participant may file suit in a State or Federal court. In addition, if the Participant disagrees with the Plan's decision or lack thereof concerning the qualified status of a domestic relations order or a Medical Child Support Order, the Participant may file suit in Federal court. If it should happen that Plan fiduciaries misuse the Plan's money, or if the Participant is discriminated against for asserting his or her rights, the Participant may seek assistance from the U.S. Department of

Labor, or the Participant may file suit in a Federal court. The court will decide who would pay court costs and legal fees. If the Participant is successful, the court may order the person the Participant sued to pay these costs and fees. If the Participant loses, the court may order the Participant to pay these costs and fees, for example, if it finds the Participant's claim is frivolous.

Assistance with the Participant's Questions

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

APPENDIX A: NOTICE OF NONDISCRIMINATION (FOR COVERED ENTITIES SUBJECT TO ACA SECTION 1557)

The Third-Party Administrator complies with applicable Federal civil rights laws and does not discriminate on the basis of race, color, national origin, age, disability, or sex. The Third-Party Administrator does not exclude people or treat them differently because of race, color, national origin, age, disability, or sex.

Yuzu Health Inc.:

- Provides free aids and services to people with disabilities to communicate effectively with the Plan, such as:
    - Qualified sign language interpreters.
    - Written information in other formats (large print, audio, accessible electronic formats, other formats).
- Provides free language services to people whose primary language is not English, such as:
    - Qualified interpreters.
    - Information written in other languages

If a Participant needs these services, he or she should contact the Third-Party Administrator at the contact information provided above.

If a Participant believes that Yuzu Health Inc. has failed to provide these services or discriminated in another way on the basis of race, color, national origin, age, disability, or sex, he or she can file a grievance with: Chief Operating Officer, 30 W 21st St, 7th Floor, New York City, NY 10010, 203-208-9898, admin@yuzu.health. The Participant can file a grievance in person or by mail, fax, or email. If a Participant needs help filing a grievance, the Chief Compliance Officer is available to help him or her.

Participants can also file a civil rights complaint with the U.S. Department of Health and Human Services, Office for Civil Rights, electronically through the Office for Civil Rights Complaint Portal, available at https://ocrportal.hhs.gov/ocr/portal/lobby.jsf, or by mail or phone at:

U.S. Department of Health and Human Services
200 Independence Avenue, SW
Room 509F, HHH Building
Washington, D.C. 20201
1-800-368-1019, 800-537-7697 (TDD)

Complaint forms are available at http://www.hhs.gov/ocr/office/file/index.html.

Spanish
ATENCIÓN: si habla español, tiene a su disposición servicios gratuitos de asistencia lingüística. Llame al 1-203-208-9898.
Chinese
注意：如果您使用繁體中文，您可以免費獲得語言援助服務。請致電 1-203-208-9898。
Vietnamese
CHÚ Ý: Nếu bạn nói Tiếng Việt, có các dịch vụ hỗ trợ ngôn ngữ miễn phí dành cho bạn. Gọi số 1-203-208-9898.
Tagalog – Filipino

PAUNAWA: Kung nagsasalita ka ng Tagalog, maaari kang gumamit ng mga serbisyo ng tulong sa wika nang walang bayad. Tumawag sa 1-203-208-9898.

Russian

ВНИМАНИЕ: Если вы говорите на русском языке, то вам доступны бесплатные услуги перевода. Звоните 1-203-208-9898.

Arabic

ملحوظة: إذا كنت تتحدث اذكر اللغة، فإن خدمات المساعدة اللغوية تتوافر لك بالمجان. اتصل برقم 1-203-208-9898 (رقم هاتف الصم والبكم:.

Japanese

注意事項：日本語を話される場合、無料の言語支援をご利用いただけます。1-203-208-9898まで、お電話にてご連絡ください。

Midwest Nice

Ope hello there neighbor! You betcha we're here to come with on your health journey if you'd just shoot us a call at 1-203-208-9898.

Farsi

توجه: اگر به زبان فارسی گفتگو می کنید، تسهیلات زبانی بصورت رایگان برای شما فراهم می باشد. با 1-203-208-9898 تماس بگیرید.

Hindi

ध्यान दें: यदि आप हिंदी बोलते हैं तो आपके लिए मुफ्त में भाषा सहायता सेवाएं उपलब्ध हैं। 1-203-208-9898 पर कॉल करें।

Armenian

ՈՒՇԱԴՐՈՒԹՅՈՒՆ՝ Եթե խոսում եք հայերեն, ապա ձեզ անվճար կարող են տրամադրվել լեզվական աջակցության ծառայություններ: Զանգահարեք 1-203-208-9898:

Hmong

LUS CEEV: Yog tias koj hais lus Hmoob, cov kev pab txog lus, muaj kev pab dawb rau koj. Hu rau 1-203-208-9898.

Cambodian

ប្រយ័ត្ន៖ បើសិនជាអ្នកនិយាយ ភាសាខ្មែរ, សេវាជំនួយផ្នែកភាសា ដោយមិនគិតឈ្នួល គឺអាចមានសំរាប់បំរើអ្នក។ ចូរ ទូរស័ព្ទ 1-203-208-9898។

Punjabi

ਧਿਆਨ ਦਿਓ: ਜੇ ਤੁਸੀਂ ਪੰਜਾਬੀ ਬੋਲਦੇ ਹੋ, ਤਾਂ ਭਾਸ਼ਾ ਵਿੱਚ ਸਹਾਇਤਾ ਸੇਵਾ ਤੁਹਾਡੇ ਲਈ ਮੁਫਤ ਉਪਲਬਧ ਹੈ। 1-203-208-9898 'ਤੇ ਕਾਲ ਕਰੋ।

Thai

เรียน: ถ้าคุณพูดภาษาไทยคุณสามารถใช้บริการช่วยเหลือทางภาษาได้ฟรี โทร 1-203-208-9898.