

**PLAN DOCUMENT
SUMMARY PLAN DESCRIPTION**

FOR

**PRINCE AVENUE BAPTIST CHURCH
& SCHOOL**

EMPLOYEE HEALTH BENEFIT PLAN

G - 4924

**PLAN EFFECTIVE DATE:
SEPTEMBER 1, 2022**

Prince Avenue Baptist Church & School hereby (amends and restates its) self-funded health care plan for the benefit of eligible Employees and their eligible Dependents.

The purpose of the Prince Avenue Baptist Church & School Employee Health Benefit Plan (the "Plan") is to provide reimbursement for covered charges incurred as a result of Medically Necessary treatment for Illness or Injury of the Company's eligible Employees and their eligible Dependents.

The Company caused this instrument to be executed by its duly authorized officers effective as of the 1st day of September 2022.

PRINCE AVENUE BAPTIST CHURCH & SCHOOL

By: _____

Title: _____

Date: _____

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FOREWORD

TO ALL EMPLOYEES:

We are all aware of the financial disaster that a family may experience as a result of a serious or prolonged Illness or Accident. The medical benefits available under the Prince Avenue Baptist Church & School Employee Health Benefit Plan (the Plan) and described in this Plan document and summary plan description (SPD) are designed to provide some protection for you and your family against such a disaster.

In sponsoring this Plan, the Company has attempted to provide the best coverage possible within the financial limits of both the Company and you. In keeping with this goal, we periodically review the Plan to ensure we maintain an adequate and reasonably priced program. The cost of this Plan is in direct proportion to the Claims paid. Therefore, it is important that all Employees and their families use the Plan wisely so the cost will remain affordable to all of us. In addition, the amount of your contribution to the Plan is subject to change at the discretion of the Company.

The Company has selected **Cigna**, a health benefit management service, to provide pre-hospitalization and continued stay review for all persons covered by the Plan. A Covered Person must contact **Cigna** at least 72 hours prior to any scheduled admission for a medical condition, Mental or Nervous Disorder, or Substance Abuse/Substance Dependence treatment. In case of an emergency Hospital admission or emergency surgery, **Cigna** must be notified within two working days of admission. Except in certain cases concerning childbirth, as described more fully in this Plan, all Covered Persons must use the **Cigna** pre-hospitalization and continued stay review service to obtain full benefits under this Plan.

PRIOR TO PRE-CERTIFICATION, AN AUDIT NUMBER MUST BE OBTAINED VIA FAX BY CALLING (888) 620-1297.

In addition to Inpatient pre-certification, **CIGNA** must also pre-authorize the following Outpatient services. Pre-authorization of these services must occur before the services are provided.

- Ambulatory surgery;
- Chemotherapy/radiation;
- Complex Imaging (CT/MRI/PET scan);
- Durable Medical Equipment/Prosthetics/Orthotics over \$1,500;
- Ear devices;
- Home Health Care;
- Home infusion therapy;
- Hospice Care;
- Injectables and infusion in an office setting (high dollar);
- Non-emergency Hospital admissions (including observation);
- Outpatient Surgery;
- Pain therapy (Outpatient);
- Skilled Nursing Facility; and
- Transplants.

The administration of the Plan may include pre-admission reviews, length of stay reviews, utilization reviews, retrospective reviews, audits, and managed care; each and all of which to such extent as is appropriate to ensure that neither Covered Persons nor the Company incur avoidable hospitalization or other costs in obtaining quality, appropriate medical care covered by the Plan.

Payment of covered charges will be withheld if pre-certification for treatment is based on a diagnosis for which treatment is covered, but the treatment is actually undertaken for a condition which is not covered by the Plan. In no event will pre-certification guarantee payment of any Claims.

In addition to describing your benefits, this Plan document and SPD explain other important procedures such as how you become eligible and how to file a claim for benefits.

IMPORTANT: If, at any time, you have questions about the Plan, please contact the Plan's Administrative Service Agent, Group Resources[®], for assistance. Group Resources is always available to assist you with your questions. We are pleased to offer the benefits under this Plan for you and your covered family members as an expression of our appreciation for your efforts on behalf of our Company.

Prince Avenue Baptist Church & School

PRIVACY AND SECURITY OF MEDICAL INFORMATION

We understand that your medical information is private, and we are committed to maintaining the privacy of your medical information. The Plan will follow the policies below to help ensure that your medical information remains private.

Each time you submit a claim to the Plan for reimbursement, and each time you see a health care Provider who is paid by the Plan, a record is created. The record may contain your medical information. In general, the Plan will only use or disclose your medical information without your authorization for the specific reasons detailed below. Except in limited circumstances, the amount of information used or disclosed will be limited to the minimum necessary to accomplish the intent of the use or disclosure.

The Plan does not operate by itself but rather is operated and administered by the Company acting on the Plan's behalf. As a result, medical information used or disclosed by the Plan (as discussed below) necessarily means that the Company is using or disclosing the medical information on behalf of the Plan. As a result, references to the Plan in "PRIVACY AND SECURITY OF MEDICAL INFORMATION" shall also be construed as references to the Company to the extent necessary to carry out the actions of the Plan.

PERMITTED USES AND DISCLOSURES. The following categories describe different ways that the Plan may use or disclose your medical information. Not every use or disclosure in a category will be listed. However, all of the ways the Plan is permitted to use and disclose information will fall within one of the categories.

Treatment. The Plan may use or disclose your medical information to facilitate medical treatment or services by Providers. The Plan may disclose your medical information to Providers, including doctors, nurses, technicians, pharmacists, medical students, or other hospital personnel who are involved in your care. For example, the Plan might disclose information about your prior prescriptions to a pharmacist to determine if a pending prescription is contraindicated with prior prescriptions.

Payment. The Plan may use and disclose your medical information to determine eligibility for Plan benefits, to facilitate payment for the treatment and services you receive from health care Providers, to determine benefit responsibility under the Plan, or to coordinate Plan coverage. For example, the Plan may tell your health care Provider about your medical history to determine whether a particular treatment is Experimental/Investigational, or Medically Necessary or to determine whether the Plan will cover the treatment. The Plan may also share medical information with a utilization review or pre-certification service Provider. Likewise, the Plan may share medical information with another entity to assist with the adjudication or subrogation of health claims or to another health plan to coordinate benefit payments.

Health Care Operations. The Plan may use and disclose your medical information for other Plan operations. These uses and disclosures are necessary to run the Plan. For example, the Plan may use medical information in connection with: conducting quality assessment and improvement activities; underwriting (with respect to medical information other than medical information which is genetic information), premium rating, and other activities relating to Plan coverage; submitting claims for stop-loss (or excess loss) coverage; conducting or arranging for medical review, legal services, audit services, and fraud and abuse detection programs; business planning and development such as cost management; and business management and general Plan administrative activities.

Family Members, Relatives, Close Personal Friends. The Plan may disclose your medical information to your family members, relatives, or close personal friends, or any other person identified by you, if the medical information is directly relevant to the family member's, relative's or friend's involvement with your care or payment for your care.

Business Associates. The Plan contracts with individuals and entities ("business associates") to perform various functions on behalf of the Plan or provide services to the Plan. These business associates may receive, create, maintain, use, or disclose your medical information, but only after they agree in writing to safeguard your medical information. For example, the Plan may disclose your medical information to a business associate to administer claims, perform utilization review management, or review the Plan's financial records. The Business Associate may use PHI for the proper management and administration of the Business Associate or to carry out legal responsibilities of the Business Associate or for data aggregation services relating to the health care operations of the Plan. The Business Associate may disclose PHI in connection with a function, service or responsibility or service to be performed by the Business Associate and such disclosure is: required by law; or the Business Associate obtains reasonable assurances from the person to whom the information is disclosed that it will be held confidential, and used or further disclosed only as required by law or for the purposes for which it was disclosed, and the person agrees to notify the Business Associate of any breaches of confidentiality.

Requirement by Law. The Plan will disclose your medical information when required to do so by federal, state, or local law. For example, the Plan may disclose medical information when required by a court order in a litigation proceeding such as a malpractice action.

Aversion of a Serious Threat to Health or Safety. The Plan may use or disclose your medical information when necessary to prevent a serious threat to your health and safety or the health and safety of the public or another person. Any disclosure, however, would only be to someone able to help prevent the threat. For example, the Plan may disclose your medical information in a proceeding regarding the licensure of a physician.

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

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

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

Public Health Risks. The Plan may disclose your medical information for public health activities. These activities generally include the following:

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

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

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

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

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

- in response to a court order, subpoena, warrant, summons or similar process;
- to identify or locate a suspect, fugitive, material witness or missing person;
- if you are, or are suspected to be, the victim of a crime, under certain limited circumstances, and the Plan Administrator is unable to obtain your agreement;
- about a death the Plan Administrator believes may be the result of criminal conduct;
- about criminal conduct on the Company's premises; or
- in emergency circumstances to report a crime, the location of the crime or victims, or the identity, description, or location of the crime or victims, or the identity, description, or location of the person who committed the crime.

Department of Health and Human Services. The Plan will disclose your medical information to the U.S. Department of Health and Human Services when requested for purposes of determining the Plan's compliance with applicable regulations.

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

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

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

Other Benefits. The Plan may contact you to provide information about treatment alternatives or other health-related benefits and services that may be of interest to you. For example, if you are suffering from a complex illness, the Plan may contact you to discuss an alternate form of care or an alternate treatment facility.

DISCLOSURES TO THE COMPANY. The Plan will disclose your medical information to the Company for Plan administration purposes only upon receipt of a certification from the Company that the Plan sets forth the permitted uses and disclosures of medical information by the Company on behalf of the Plan, and that the Company has agreed to the following assurances:

- The Company will not further use or disclose medical information about you other than as permitted or required by the Plan documents or as required by law;
- The Company will ensure that any agents, including subcontractors, to whom it provides medical information (including electronic medical information) received from the Plan agree to the same restrictions and conditions that apply to the Company with respect to such information and agree to implement reasonable and appropriate security measures to protect the information;
- The Company will implement administrative, technical, and physical safeguards that reasonably and appropriately protect the confidentiality, integrity, and availability of the electronic medical information that it creates, receives, maintains, or transmits on behalf of the Plan;
- The Company will not use or disclose the medical information for employment-related actions and decisions or in connection with any other benefit or employee benefit plan of the Company;
- The Company will report to the Plan any use or disclosure of medical information that is inconsistent with the permitted uses and disclosures, of which it becomes aware;
- The Company will report to the Plan, within a reasonable time after the Company becomes aware, any security incident that results in unauthorized access, use, disclosure, modification, or destruction of the Plan's electronic medical information;
- The Company will report to the Plan any other security incident on an aggregate basis every quarter or more frequently upon the Plan's request;
- The Company will make its internal practices, books, and records relating to the use and disclosure of medical information received from the Plan available to the Department of Health and Human Services for purposes of determining whether the Plan is complying with applicable regulations;
- The Company will, if feasible, return or destroy all medical information received from the Plan about you and retain no copies of the information when it is no longer needed for the purpose for which disclosure was made, except that, if such return or destruction is not feasible, to limit further uses or disclosures to those purposes that make such return or destruction infeasible;
- The Company will ensure that there is adequate separation between the Plan and the Company (as described below) and that the separation is supported by reasonable and appropriate security measures;

Privacy and Security of Medical Information

- The Company will make your medical information available to you (as described below);
- The Company will make your medical information available to you for amendment and incorporate any amendment into your medical information (as described below); and
- The Company will make available the information required to provide you an accounting of disclosures (as described below).

ACCESS TO MEDICAL INFORMATION. The Plan will make your medical information available to you for inspection and copying upon your written request to the Plan Administrator. The Plan may charge a fee for the costs of copying, mailing or other supplies associated with your request. The Plan may deny your request to inspect and copy in certain very limited circumstances. If you are denied access to medical information, you may request that the denial be reviewed.

If the Plan uses or maintains an electronic health record with respect to your medical information, you have a right to obtain a copy of such information in an electronic format and, if you so choose, direct the Plan to transmit such copy directly to another entity or person.

AMENDMENT OF MEDICAL INFORMATION. If you feel that medical information the Plan has about you is incorrect or incomplete, you may ask the Plan to amend the information. You have the right to request an amendment for as long as the information is kept by or for the Plan. Your request must be made in writing and submitted to the Plan Administrator. In addition, you must provide a reason that supports your request.

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

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

ACCOUNTING OF DISCLOSURES. If you wish to know to whom medical information about you has been disclosed for any purpose other than (1) treatment, payment, or health care operations, (2) pursuant to your written authorization, and (3) for certain other purposes, you may make a written request to the Plan Administrator, as provided for in 45 C.F.R §164.528 of the HIPAA requirements.

Your request must state a time period which may not be longer than six years prior to the date of your request. Your request should indicate in what form you want the list (for example, paper or electronic). The first list you request within a 12-month period will be free. For additional lists, the Plan Administrator may charge you for the costs of providing the list. The Plan Administrator will notify you of the cost involved and you may choose to withdraw or modify your request at that time before any costs are incurred.

The accounting will not include disclosure for the purposes of treatment, payment, or health care operations (provided, that, to the extent required by law, if the Plan maintains an electronic health record, the accounting will include such disclosures made through an electronic health record). In addition, the accounting will not include disclosures which you have authorized in writing.

SEPARATION BETWEEN THE PLAN AND THE COMPANY. Only Employees of the Company who are involved in the day-to-day operation and administrative functions of the Plan will have access to your medical information. In general, this will only include individuals who work in the Company's Human Resources or Employee Benefits departments. These individuals will receive appropriate training regarding the Plan's privacy policies. In the event an individual fails to comply with the Plan's provisions regarding the protection of your medical information, the Company will take appropriate action in accordance with its established policy for failure to comply with the Plan's privacy provisions.

OTHER USES OF MEDICAL INFORMATION. Any other uses and disclosures of medical information will be made only with your written authorization. If you provide the Plan authorization to use or disclose medical information about you, you may revoke that authorization, in writing, at any time. If you revoke your authorization, the Plan will no longer use or disclose medical information about you for the reasons covered by your written authorization. Please note that the Plan is unable to take back any disclosures it has already made with your authorization, and that the Plan is required to retain records of the care provided to you.

VENDOR LISTING

Plan Administrator

Prince Avenue Baptist Church & School
2131 Ruth Jackson Road
Bogart, GA 30622
(678) 753-3100

Administrative Service Agent

Group Resources
2675 Breckinridge Blvd.
Suite 300
Duluth, GA 30096
(800) 749-9963

Pre-Certification Administrator

Cigna

Prior to pre-certification, an audit number must be obtained via fax by calling (888) 620-1297

Prescription Drug Program

ProAct
(877) 635-9545
www.proactrx.com

Preferred Provider Organization (PPO)

Cigna
www.mycigna.com

MEDICAL BENEFITS – OPTION I

Benefits for a Covered Person are determined by the Covered Person's eligibility classification and by the terms of this Plan. Benefits under this Plan are paid according to the provisions, exclusions and limitations described in this Plan, subject to the schedule outlined below. Any maximums listed in this Plan apply across all options offered by the Company. If a maximum is reached under one option of the Plan, it is also reached under all other options of the Plan. If a Covered Person transfers from one Plan option to another, he or she will receive credit for all Deductible and Out-of-Pocket amounts met, and will be treated as having accumulated under the new option all benefit payments which apply to maximums accumulated under the previous Plan option.

This Plan treats Mental or Nervous Disorders, Substance Abuse/Substance Dependence as any other illness. For benefits, please check below for the Provider who is performing the services.

PLAN YEAR DEDUCTIBLE

PPO

Single.....	\$500
Family (Embedded)	\$1,500

NON-PPO

Single.....	\$1,000
Family (Embedded)	\$3,000

EMBEDDED means that the single Deductible is embedded in the family Deductible. If a Covered Person has family coverage, no one individual will have to meet more than the single Deductible before benefits are paid for that individual. Once the family Deductible is met, no further Deductible will be taken for any family member.
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COINSURANCE (After satisfaction of the Plan Year Deductible)

PPO	100%
NON-PPO	70%

If a Covered Person lives more than 30 miles away from the closest participating PPO Provider/facility, or in the event a Non-PPO Provider/facility is used in a Medical Emergency (see "DEFINITIONS") situation, benefits will be processed at the PPO Coinsurance rate, subject to the PPO Deductible and the PPO Out-of-Pocket.
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OUT-OF-POCKET MAXIMUM

PPO

Single.....	\$1,000
Family (Embedded)	\$2,000

NON-PPO

Single.....	\$4,000
Family (Embedded)	\$12,000

The Out-of-Pocket Maximum includes Deductible and medical Copays.
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Medical Benefits – Option I

EMBEDDED means that the single Out-of-Pocket is embedded in the family Out-of-Pocket. If a Covered Person has family coverage, no one individual will have to meet more than the single Out-of-Pocket before benefits are paid for that individual. Once the family Out-of-Pocket is met, no further Out-of-Pocket will be taken for any family member. After the Out-of-Pocket Maximum has been satisfied, all eligible charges subsequently incurred during that Plan Year will be paid at 100%. However, penalties and non-covered charges do not apply to the Out-of-Pocket Maximum.

ALLERGY TESTING/SERUM/INJECTIONS

PPO (Deductible applies).....	100%
NON-PPO (Deductible applies).....	70%

AMBULANCE SERVICES

PPO (Deductible applies).....	100%
NON-PPO (PPO Deductible applies)	100%

ANNUAL LIMIT ON ESSENTIAL HEALTH BENEFITSUnlimited

CARDIAC REHABILITATION

PPO (Deductible applies).....	100%
NON-PPO (Deductible applies).....	70%

CHEMOTHERAPY/RADIATION

PPO (Deductible applies).....	100%
NON-PPO (Deductible applies).....	70%

CHIROPRACTIC CARE (See Spinal Manipulation)**DIABETIC EDUCATION**

PPO (Deductible applies).....	100%
NON-PPO (Deductible applies).....	70%

DIAGNOSTIC LAB & X-RAY (Hospital or freestanding facility – includes Complex Imaging)

PPO (Deductible applies).....	100%
NON-PPO (Deductible applies).....	70%

DURABLE MEDICAL EQUIPMENT/PROSTHETICS/ORTHOTICS

PPO (Deductible applies).....	100%
NON-PPO (Deductible applies).....	70%

EMERGENCY ROOM SERVICES**Facility Fee (Copay waived if admitted)**

PPO (Deductible waived)	\$150 Copay per visit, then 100%
NON-PPO (Deductible waived)	\$150 Copay per visit, then 100%

Medical Benefits – Option I

Professional Fee

PPO (Deductible applies).....	100%
NON-PPO (PPO Deductible applies).....	100%

ENDOVENOUS ABLATION THERAPY

PPO (Deductible applies).....	100%
NON-PPO (Deductible applies).....	70%
Maximum Per Plan Year	\$2,500

HOME HEALTH CARE

PPO (Deductible waived).....	\$25 Copay per visit, then 100%
NON-PPO (Deductible applies).....	70%
Maximum Visits Per Plan Year	100 visits

HOSPICE CARE

PPO (Deductible waived).....	100%
NON-PPO (Deductible applies).....	70%

INPATIENT HOSPITAL SERVICES (Must be pre-certified or a \$250 penalty will apply)

PPO (Deductible applies).....	100%
NON-PPO (Deductible applies).....	70%

The Maximum Eligible Charge for Room and Board in a Hospital will be:

- a) for a semi-private room, the average semi-private room rate of the Hospital;
- b) for a private room, the average semi-private room rate of the Hospital or, if the Hospital has private rooms only, the maximum eligible charge will be, the average semi-private room rate;
- c) for intensive care, coronary care, and neonatal intensive care, the actual amount charged.

MATERNITY EXPENSE

INITIAL PPO OFFICE VISIT (Deductible waived).....	\$25 Copay, then 100%
OTHER PRE/POST-NATAL AND DELIVERY (Deductible applies).....	100%
NON-PPO (Deductible applies).....	70%

OUTPATIENT HOSPITAL SERVICES

PPO (Deductible applies).....	100%
NON-PPO (Deductible applies).....	70%

OUTPATIENT SURGERY (Hospital, Outpatient Surgical Center, or Physician's office)

PPO (Deductible applies).....	100%
NON-PPO (Deductible applies).....	70%

PAIN MANAGEMENT/PAIN THERAPY

PPO (Deductible applies).....	100%
NON-PPO (Deductible applies).....	70%

PHYSICAL/OCCUPATIONAL THERAPY

PPO (Deductible waived).....	\$25 Copay per visit, then 100%
NON-PPO (Deductible applies).....	70%
Maximum Visits Per Plan Year	20 visits

PHYSICIAN'S SERVICES**Primary Care Physician** (Copay includes visit charge only)

PPO (Deductible waived)	\$25 Copay per visit, then 100%
NON-PPO (Deductible applies)	70%

Specialist (Copay includes visit charge only)

PPO (Deductible waived)	\$50 Copay per visit, then 100%
NON-PPO (Deductible applies)	70%

Office Surgery

PPO (Deductible applies).....	100%
NON-PPO (Deductible applies)	70%

All Other Services (Services rendered inside and outside of the Physician's office)

PPO (Deductible applies).....	100%
NON-PPO (Deductible applies)	70%

RENAL/PERITONEAL DIALYSIS

PPO (Deductible applies).....	100%
NON-PPO (Deductible applies).....	70%

SKILLED NURSING FACILITY CARE

PPO (Deductible applies).....	100%
NON-PPO (Deductible applies).....	70%
Maximum Days Per Plan Year	150 days

SLEEP DISORDERS

PPO (Deductible applies).....	100%
NON-PPO (Deductible applies).....	70%
Maximum Per Plan Year	\$2,500

SPEECH THERAPY

PPO (Deductible waived).....	\$25 Copay per visit, then 100%
NON-PPO (Deductible applies).....	70%
Maximum Visits Per Plan Year	20 visits

SPINAL MANIPULATION TREATMENT

PPO (Deductible waived).....	\$25 Copay per visit, then 100%
NON-PPO (Deductible applies).....	70%
Maximum Visits Per Plan Year	20 visits

SURGICAL REMOVAL OF IMPACTED TEETH

PPO (Deductible applies).....	100%
NON-PPO (Deductible applies).....	70%

TEMPOROMANDIBULAR JOINT DISORDER

PPO (Deductible applies).....	100%
NON-PPO (Deductible applies).....	70%
Lifetime Maximum	\$5,000

URGENT CARE FACILITY

PPO (Deductible waived).....	\$60 Copay per visit, then 100%
NON-PPO (Deductible applies).....	70%

WELLNESS EXPENSE

PPO (Deductible waived).....	100%
NON-PPO (Deductible applies).....	70%

No benefits will be paid for routine exams and related services when rendered solely for purposes of employment, participation in school athletic programs, foreign travel, immigration, the purchase of additional insurance, to obtain or maintain a license of any type, medical research, judicial or administrative proceedings or orders, or marriage or adoption.

Preventive services are covered with no cost share if a PPO Provider is used. This benefit includes, but is not limited to: routine physical/exam; gynecological exam; mammogram; pap smear; prostate testing (PSA); other routine lab and x-ray; immunizations; routine endoscopy, colonoscopy or sigmoidoscopy; and vision and hearing screening for children. Many of these services are covered only for specific age groups. For more detailed information on covered preventive services, please visit these websites:

- 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, available at <https://www.uspreventiveservicestaskforce.org/page/name/uspstf-a-and-b-recommendations>;
- Immunizations that have in effect a recommendation from the Advisory Committee on Immunization Practices of the Centers for Disease Control and Prevention with respect to the individual involved, available at <http://www.cdc.gov/vaccines/acip/index.html>;
- With respect to infants, children, and adolescents, evidence-informed preventive care and screening provided for in the comprehensive guidelines supported by the Health Resources and Services Administration, available at <https://www.healthcare.gov/preventive-care-children/>; and
- With respect to women, preventive care and screening provided for in the comprehensive guidelines supported by the Health Resources and Services Administration, available at <http://www.hrsa.gov/> and the expanded women’s preventive services, available at <http://www.hrsa.gov/womensguidelines/>. The current recommendations of the United States Preventive Service Task Force regarding breast cancer screening, mammography, and prevention shall be the most current other than those issued in or around November, 2009.

Medical Benefits – Option I

WIGS (After chemotherapy or radiation treatment)**PPO** (Deductible applies) 100%**NON-PPO** (Deductible applies) 70%**Lifetime Maximum** One wig

WOMEN'S HEALTH AND CANCER RIGHTS ACT. Pursuant to the Women's Health and Cancer Rights Act of 1998, this Plan provides benefits for Covered Persons for mastectomy-related services, including reconstruction and surgery to achieve symmetry between the breasts, prostheses, and complications resulting from mastectomy (including lymphedema). For further details, please see subsection 21 of "ELIGIBLE CHARGES."

PRESCRIPTION DRUG PROGRAM – OPTION I

MAXIMUM OUT OF POCKET PER PLAN YEAR

Single	\$750
Family	\$1,500

Prescription Copays apply to the PPO Out-of-Pocket Maximum.
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Provisions of the Affordable Care Act require that all non-grandfathered health plans provide coverage for FDA approved contraceptives at no cost share for generic form; however, Non-Preferred/Preferred contraceptives will have a Copay as long as a generic form is available. For a list of covered preventive services, please visit <https://www.healthcare.gov/coverage/preventive-care-benefits/>.

PROACT PRESCRIPTION DRUG PROGRAM. ProAct is able to provide many prescriptions for Covered Persons at a discounted price. Prescriptions may be purchased through the ProAct prescription drug program in two ways. Short-term prescriptions may be filled at local ProAct Network Pharmacies which will charge a flat fee (Copay) for up to a 30-day supply of medication. ProAct home delivery pharmacy service is a mail order prescription drug service which charges a flat fee (Copay) for a 90-day supply of prescription maintenance drugs, such as birth control pills, ulcer medication, insulin, thyroid medication, etc. When using the mail order option, Employees will need to request two prescriptions from their Physician, one for a two or three week supply to be filled by their local ProAct pharmacy, and another which can be mailed to the ProAct home delivery service for the remainder of their 90-day supply. Regardless of whether the Covered Person uses the drug card or mail order option, if the actual cost of the medication is less than the Copay, the Covered Person will only be responsible for the actual prescription cost.

PRESCRIPTION DRUG CARD PROGRAM

Copay For Each Prescription or Refill (30-day supply) (No Deductible)

Generic	\$15
Preferred	\$35
Non-Preferred	\$60
Specialty	20% of the prescription cost up to \$200 per prescription

MAIL ORDER DRUG PROGRAM

Copay For Each Prescription or Refill (90-day supply) (No Deductible)

Generic	\$15
Preferred	\$70
Non-Preferred	\$180

The “PRESCRIPTION DRUG PROGRAM” includes a mandatory generic requirement. If the Covered Person chooses a brand name drug when a generic equivalent is available, the Covered Person will be charged the applicable brand name Copay plus the difference in cost between the brand name and generic drug. This provision does not apply if the Physician requests “dispense as written.”

Prescriptions not purchased through the mail order or drug card program will not be covered under the Plan. The per prescription Copay is not eligible for reimbursement under the Plan.

Generic means drugs that are available from many sources and in generic form. These are typically the lowest cost drugs and result in the lowest Copay.

Preferred means drugs which are preferred by the prescription vendor. Since these drugs typically have a lower cost, they are not charged the highest Copay.

Non-Preferred means drugs which are not on the prescription vendor's preferred list. Choosing these drugs results in the highest Copay.

Specialty Drugs are high-cost medications used to treat chronic, complex conditions, including but not limited to: HIV/AIDS, Rheumatoid Arthritis, Cancer, Hepatitis, Hemophilia, and Multiple Sclerosis. Although the incidences of these and other serious diseases are being diagnosed more commonly, the medicines needed to treat such conditions are far from common. Specialty drugs may:

- 1) require nursing services or special programs to support patient compliance;
- 2) require disease-specific treatment programs;
- 3) have limited distribution requirements; or
- 4) have special handling, storage, or shipping requirements.

Some drug expenses which are not covered:

- * Drugs which can be obtained without a Physician's prescription;
- * Therapy devices or appliances regardless of their intended use including:
 - hypodermic needles;
 - syringes;
 - support garments; or
 - other non-medical substances; and
- * Any drugs which are Experimental/Investigational (see "EXCLUSIONS AND LIMITATIONS" for further details).

This is not a complete list of drugs that are excluded. Please contact ProAct at (877) 635-9545 to determine specific drug coverage.

MEDICAL BENEFITS – OPTION II

Benefits for a Covered Person are determined by the Covered Person's eligibility classification and by the terms of this Plan. Benefits under this Plan are paid according to the provisions, exclusions and limitations described in this Plan, subject to the schedule outlined below. Any maximums listed in this Plan apply across all options offered by the Company. If a maximum is reached under one option of the Plan, it is also reached under all other options of the Plan. If a Covered Person transfers from one Plan option to another, he or she will receive credit for all Deductible and Out-of-Pocket amounts met, and will be treated as having accumulated under the new option all benefit payments which apply to maximums accumulated under the previous Plan option.

This Plan treats Mental or Nervous Disorders, Substance Abuse/Substance Dependence as any other Illness. For benefits, please check below for the Provider who is performing the services.

PLAN YEAR DEDUCTIBLE

PPO

Single.....	\$1,500
Family (Embedded)	\$3,000

NON-PPO

Single.....	\$3,000
Family (Embedded)	\$6,000

EMBEDDED means that the single Deductible is embedded in the family Deductible. If a Covered Person has family coverage, no one individual will have to meet more than the single Deductible before benefits are paid for that individual. Once the family Deductible is met, no further Deductible will be taken for any family member.
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COINSURANCE (After satisfaction of the Plan Year Deductible)

PPO	80%
NON-PPO	60%

If a Covered Person lives more than 30 miles away from the closest participating PPO Provider/facility, or in the event a Non-PPO Provider/facility is used in a Medical Emergency (see "DEFINITIONS") situation, benefits will be processed at the PPO Coinsurance rate, subject to the PPO Deductible and the PPO Out-of-Pocket.
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OUT-OF-POCKET MAXIMUM

PPO

Single.....	\$4,000
Family (Embedded)	\$8,000

NON-PPO

Single.....	Unlimited
Family (Embedded)	Unlimited

The Out-of-Pocket Maximum includes Deductible and medical Copays.
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Medical Benefits – Option II

EMBEDDED means that the single Out-of-Pocket is embedded in the family Out-of-Pocket. If a Covered Person has family coverage, no one individual will have to meet more than the single Out-of-Pocket before benefits are paid for that individual. Once the family Out-of-Pocket is met, no further Out-of-Pocket will be taken for any family member. After the Out-of-Pocket Maximum has been satisfied, all eligible charges subsequently incurred during that Plan Year will be paid at 100%. However, penalties and non-covered charges do not apply to the Out-of-Pocket Maximum.

ALLERGY TESTING/SERUM/INJECTIONS

PPO (Deductible applies).....	80%
NON-PPO (Deductible applies).....	60%

AMBULANCE SERVICES

PPO (Deductible applies).....	80%
NON-PPO (PPO Deductible and Out-of-Pocket apply)	80%

ANNUAL LIMIT ON ESSENTIAL HEALTH BENEFITS Unlimited

CARDIAC REHABILITATION

PPO (Deductible applies).....	80%
NON-PPO (Deductible applies).....	60%

CHEMOTHERAPY/RADIATION

PPO (Deductible applies).....	80%
NON-PPO (Deductible applies).....	60%

CHIROPRACTIC CARE (See Spinal Manipulation)**DIABETIC EDUCATION**

PPO (Deductible applies).....	80%
NON-PPO (Deductible applies).....	60%

DIAGNOSTIC LAB & X-RAY (Hospital or freestanding facility – includes Complex Imaging)

PPO (Deductible applies).....	80%
NON-PPO (Deductible applies).....	60%

DURABLE MEDICAL EQUIPMENT/PROSTHETICS/ORTHOTICS

PPO (Deductible applies).....	80%
NON-PPO (Deductible applies).....	60%

EMERGENCY ROOM SERVICES**Facility Fee (Copay waived if admitted)**

PPO (Deductible waived)	\$200 Copay per visit, then 80%
NON-PPO (Deductible waived)	\$200 Copay per visit, then 80%

Professional Fee

PPO (Deductible applies).....	80%
NON-PPO (PPO Deductible and Out-of-Pocket apply).....	80%

ENDOVENOUS ABLATION THERAPY

PPO (Deductible applies).....	80%
NON-PPO (Deductible applies).....	60%
Maximum Per Plan Year	\$2,500

HOME HEALTH CARE

PPO (Deductible waived).....	\$25 Copay per visit, then 80%
NON-PPO (Deductible applies).....	60%
Maximum Visits Per Plan Year	100 visits

HOSPICE CARE

PPO (Deductible waived).....	80%
NON-PPO (Deductible applies).....	60%

INPATIENT HOSPITAL SERVICES (Must be pre-certified or a \$250 penalty will apply)

PPO (Deductible applies).....	80%
NON-PPO (Deductible applies).....	60%

The Maximum Eligible Charge for Room and Board in a Hospital will be:

- a) for a semi-private room, the average semi-private room rate of the Hospital;
- b) for a private room, the average semi-private room rate of the Hospital or, if the Hospital has private rooms only, the maximum eligible charge will be, the average semi-private room rate;
- c) for intensive care, coronary care, and neonatal intensive care, the actual amount charged.

MATERNITY EXPENSE

INITIAL PPO OFFICE VISIT (Deductible waived).....	\$25 Copay, then 100%
OTHER PRE/POST-NATAL AND DELIVERY (Deductible applies).....	80%
NON-PPO (Deductible applies).....	60%

OUTPATIENT HOSPITAL SERVICES

PPO (Deductible applies).....	80%
NON-PPO (Deductible applies).....	60%

OUTPATIENT SURGERY (Hospital, Outpatient Surgical Center, or Physician's office)

PPO (Deductible applies).....	80%
NON-PPO (Deductible applies).....	60%

PAIN MANAGEMENT/PAIN THERAPY

PPO (Deductible applies).....	80%
NON-PPO (Deductible applies).....	60%

PHYSICAL/OCCUPATIONAL THERAPY

PPO (Deductible waived).....	\$25 Copay per visit, then 80%
NON-PPO (Deductible applies).....	60%
Maximum Visits Per Plan Year	20 visits

PHYSICIAN'S SERVICES

Primary Care Physician (Copay includes all services rendered in the Physician's office, except office surgery)

PPO (Deductible waived)	\$25 Copay per visit, then 100%
NON-PPO (Deductible applies)	60%

Specialist (Copay includes visit charge only)

PPO (Deductible waived)	\$50 Copay per visit, then 100%
All charges thereafter are covered at 80%, Deductible waived.	
NON-PPO (Deductible applies)	60%

Office Surgery

PPO (Deductible applies).....	80%
NON-PPO (Deductible applies)	60%

All Other Services Rendered Outside of the Physician's Office

PPO (Deductible applies).....	80%
NON-PPO (Deductible applies)	60%

RENAL/PERITONEAL DIALYSIS

PPO (Deductible applies).....	80%
NON-PPO (Deductible applies).....	60%

SKILLED NURSING FACILITY CARE

PPO (Deductible applies).....	80%
NON-PPO (Deductible applies).....	60%
Maximum Days Per Plan Year	150 days

SLEEP DISORDERS

PPO (Deductible applies).....	80%
NON-PPO (Deductible applies).....	60%
Maximum Per Plan Year	\$2,500

SPEECH THERAPY

PPO (Deductible waived).....	\$25 Copay per visit, then 80%
NON-PPO (Deductible applies).....	60%
Maximum Visits Per Plan Year	20 visits

SPINAL MANIPULATION TREATMENT

PPO (Deductible waived).....	\$25 Copay per visit, then 80%
NON-PPO (Deductible applies).....	60%
Maximum Visits Per Plan Year	20 visits

SURGICAL REMOVAL OF IMPACTED TEETH

PPO (Deductible applies).....	80%
NON-PPO (Deductible applies).....	60%

TEMPOROMANDIBULAR JOINT DISORDER

PPO (Deductible applies).....	80%
NON-PPO (Deductible applies).....	60%
Lifetime Maximum	\$5,000

URGENT CARE FACILITY

PPO (Deductible waived).....	\$50 Copay per visit, then 80%
NON-PPO (Deductible applies).....	60%

WELLNESS EXPENSE

PPO (Deductible waived).....	100%
NON-PPO (Deductible applies).....	60%

No benefits will be paid for routine exams and related services when rendered solely for purposes of employment, participation in school athletic programs, foreign travel, immigration, the purchase of additional insurance, to obtain or maintain a license of any type, medical research, judicial or administrative proceedings or orders, or marriage or adoption.

Preventive services are covered with no cost share if a PPO Provider is used. This benefit includes, but is not limited to: routine physical/exam; gynecological exam; mammogram; pap smear; prostate testing (PSA); other routine lab and x-ray; immunizations; routine endoscopy, colonoscopy or sigmoidoscopy; and vision and hearing screening for children. Many of these services are covered only for specific age groups. For more detailed information on covered preventive services, please visit these websites:

- 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, available at <https://www.uspreventiveservicestaskforce.org/page/name/uspstf-a-and-b-recommendations>;
- Immunizations that have in effect a recommendation from the Advisory Committee on Immunization Practices of the Centers for Disease Control and Prevention with respect to the individual involved, available at <http://www.cdc.gov/vaccines/acip/index.html>;
- With respect to infants, children, and adolescents, evidence-informed preventive care and screening provided for in the comprehensive guidelines supported by the Health Resources and Services Administration, available at <https://www.healthcare.gov/preventive-care-children/>; and
- With respect to women, preventive care and screening provided for in the comprehensive guidelines supported by the Health Resources and Services Administration, available at <http://www.hrsa.gov/> and the expanded women’s preventive services, available at <http://www.hrsa.gov/womensguidelines/>. The current recommendations of the United States Preventive Service Task Force regarding breast cancer screening, mammography, and prevention shall be the most current other than those issued in or around November, 2009.

WIGS (After chemotherapy or radiation treatment)	
PPO (Deductible applies)	80%
NON-PPO (Deductible applies).....	60%
Lifetime Maximum	One wig

WOMEN'S HEALTH AND CANCER RIGHTS ACT. Pursuant to the Women's Health and Cancer Rights Act of 1998, this Plan provides benefits for Covered Persons for mastectomy-related services, including reconstruction and surgery to achieve symmetry between the breasts, prostheses, and complications resulting from mastectomy (including lymphedema). For further details, please see subsection 21 of "ELIGIBLE CHARGES."

PRESCRIPTION DRUG PROGRAM – OPTION II

MAXIMUM OUT OF POCKET PER PLAN YEAR

Single	\$2,600
Family	\$5,200

Prescription Copays apply to the PPO Out-of-Pocket Maximum.
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Provisions of the Affordable Care Act require that all non-grandfathered health plans provide coverage for FDA approved contraceptives at no cost share for generic form; however, Non-Preferred/Preferred contraceptives will have a Copay as long as a generic form is available. For a list of covered preventive services, please visit <https://www.healthcare.gov/coverage/preventive-care-benefits/>.

PROACT PRESCRIPTION DRUG PROGRAM. ProAct is able to provide many prescriptions for Covered Persons at a discounted price. Prescriptions may be purchased through the ProAct prescription drug program in two ways. Short-term prescriptions may be filled at local ProAct Network Pharmacies which will charge a flat fee (Copay) for up to a 30-day supply of medication. ProAct home delivery pharmacy service is a mail order prescription drug service which charges a flat fee (Copay) for a 90-day supply of prescription maintenance drugs, such as birth control pills, ulcer medication, insulin, thyroid medication, etc. When using the mail order option, Employees will need to request two prescriptions from their Physician, one for a two or three week supply to be filled by their local ProAct pharmacy, and another which can be mailed to the ProAct home delivery service for the remainder of their 90-day supply. Regardless of whether the Covered Person uses the drug card or mail order option, if the actual cost of the medication is less than the Copay, the Covered Person will only be responsible for the actual prescription cost.

PRESCRIPTION DRUG CARD PROGRAM

Copay For Each Prescription or Refill (30-day supply) (No Deductible)

Generic	\$15
Preferred	\$35
Non-Preferred	\$60
Specialty	20% of the prescription cost up to \$200 per prescription

MAIL ORDER DRUG PROGRAM

Copay For Each Prescription or Refill (90-day supply) (No Deductible)

Generic	\$15
Preferred	\$70
Non-Preferred	\$180

The “PRESCRIPTION DRUG PROGRAM” includes a mandatory generic requirement. If the Covered Person chooses a brand name drug when a generic equivalent is available, the Covered Person will be charged the applicable brand name Copay plus the difference in cost between the brand name and generic drug. This provision does not apply if the Physician requests “dispense as written.”

Prescriptions not purchased through the mail order or drug card program will not be covered under the Plan. The per prescription Copay is not eligible for reimbursement under the Plan.

Generic means drugs that are available from many sources and in generic form. These are typically the lowest cost drugs and result in the lowest Copay.

Preferred means drugs which are preferred by the prescription vendor. Since these drugs typically have a lower cost, they are not charged the highest Copay.

Non-Preferred means drugs which are not on the prescription vendor's preferred list. Choosing these drugs results in the highest Copay.

Specialty Drugs are high-cost medications used to treat chronic, complex conditions, including but not limited to: HIV/AIDS, Rheumatoid Arthritis, Cancer, Hepatitis, Hemophilia, and Multiple Sclerosis. Although the incidences of these and other serious diseases are being diagnosed more commonly, the medicines needed to treat such conditions are far from common. Specialty drugs may:

- 1) require nursing services or special programs to support patient compliance;
- 2) require disease-specific treatment programs;
- 3) have limited distribution requirements; or
- 4) have special handling, storage, or shipping requirements.

Some drug expenses which are not covered:

- * Drugs which can be obtained without a Physician's prescription;
- * Therapy devices or appliances regardless of their intended use including:
 - hypodermic needles;
 - syringes;
 - support garments; or
 - other non-medical substances; and
- * Any drugs which are Experimental/Investigational (see "EXCLUSIONS AND LIMITATIONS" for further details).

This is not a complete list of drugs that are excluded. Please contact ProAct at (877) 635-9545 to determine specific drug coverage.

MEDICAL BENEFITS – OPTION III

Benefits for a Covered Person are determined by the Covered Person's eligibility classification and by the terms of this Plan. Benefits under this Plan are paid according to the provisions, exclusions and limitations described in this Plan, subject to the schedule outlined below. Any maximums listed in this Plan apply across all options offered by the Company. If a maximum is reached under one option of the Plan, it is also reached under all other options of the Plan. If a Covered Person transfers from one Plan option to another, he or she will receive credit for all Deductible and Out-of-Pocket amounts met, and will be treated as having accumulated under the new option all benefit payments which apply to maximums accumulated under the previous Plan option.

This Plan treats Mental or Nervous Disorders, Substance Abuse/Substance Dependence as any other illness. For benefits, please check below for the Provider who is performing the services.

PLAN YEAR DEDUCTIBLE

PPO

Single.....	\$3,000
Family (Embedded)	\$5,000

NON-PPO

Single.....	\$6,000
Family (Embedded)	\$12,000

EMBEDDED means that the single Deductible is embedded in the family Deductible. If a Covered Person has family coverage, no one individual will have to meet more than the single Deductible before benefits are paid for that individual. Once the family Deductible is met, no further Deductible will be taken for any family member.
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COINSURANCE (After satisfaction of the Plan Year Deductible)

PPO	80%
NON-PPO	60%

If a Covered Person lives more than 30 miles away from the closest participating PPO Provider/facility, or in the event a Non-PPO Provider/facility is used in a Medical Emergency (see "DEFINITIONS") situation, benefits will be processed at the PPO Coinsurance rate, subject to the PPO Deductible and the PPO Out-of-Pocket.
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OUT-OF-POCKET MAXIMUM

PPO

Single.....	\$5,000
Family (Embedded)	\$10,000

NON-PPO

Single.....	\$10,000
Family (Embedded)	\$20,000

The Out-of-Pocket Maximum includes Deductible, medical Copays and prescription Copays.

EMBEDDED means that the single Out-of-Pocket is embedded in the family Out-of-Pocket. If a Covered Person has family coverage, no one individual will have to meet more than the single Out-of-Pocket before benefits are paid for that individual. Once the family Out-of-Pocket is met, no further Out-of-Pocket will be taken for any family member. After the Out-of-Pocket Maximum has been satisfied, all eligible charges subsequently incurred during that Plan Year will be paid at 100%. However, penalties and non-covered charges do not apply to the Out-of-Pocket Maximum.

ALLERGY TESTING/SERUM/INJECTIONS

PPO (Deductible applies)	80%
NON-PPO (Deductible applies).....	60%

AMBULANCE SERVICES

PPO (Deductible applies).....	80%
NON-PPO (PPO Deductible and Out-of-Pocket apply)	80%

ANNUAL LIMIT ON ESSENTIAL HEALTH BENEFITS Unlimited

CARDIAC REHABILITATION

PPO (Deductible applies).....	80%
NON-PPO (Deductible applies).....	60%

CHEMOTHERAPY/RADIATION

PPO (Deductible applies).....	80%
NON-PPO (Deductible applies).....	60%

CHIROPRACTIC CARE (See Spinal Manipulation)**DIABETIC EDUCATION**

PPO (Deductible applies).....	80%
NON-PPO (Deductible applies).....	60%

DIAGNOSTIC LAB & X-RAY (Hospital or freestanding facility – includes Complex Imaging)

PPO (Deductible applies).....	80%
NON-PPO (Deductible applies).....	60%

DURABLE MEDICAL EQUIPMENT/PROSTHETICS/ORTHOTICS

PPO (Deductible applies).....	80%
NON-PPO (Deductible applies).....	60%

EMERGENCY ROOM SERVICES

PPO (Deductible applies).....	80%
NON-PPO (PPO Deductible and Out-of-Pocket apply)	80%

ENDOVENOUS ABLATION THERAPY

PPO (Deductible applies)	80%
NON-PPO (Deductible applies).....	60%
Maximum Per Plan Year	\$2,500

HOME HEALTH CARE

PPO (Deductible applies)	80%
NON-PPO (Deductible applies).....	60%
Maximum Visits Per Plan Year	100 visits

HOSPICE CARE

PPO (Deductible applies)	80%
NON-PPO (Deductible applies).....	60%

INPATIENT HOSPITAL SERVICES (Must be pre-certified or a \$250 penalty will apply)

PPO (Deductible applies)	80%
NON-PPO (Deductible applies).....	60%

The Maximum Eligible Charge for Room and Board in a Hospital will be:

- a) for a semi-private room, the average semi-private room rate of the Hospital;
- b) for a private room, the average semi-private room rate of the Hospital or, if the Hospital has private rooms only, the maximum eligible charge will be, the average semi-private room rate;
- c) for intensive care, coronary care, and neonatal intensive care, the actual amount charged.

MATERNITY EXPENSE

PPO (Deductible applies)	80%
NON-PPO (Deductible applies).....	60%

OUTPATIENT HOSPITAL SERVICES

PPO (Deductible applies)	80%
NON-PPO (Deductible applies).....	60%

OUTPATIENT SURGERY (Hospital, Outpatient Surgical Center, or Physician's office)

PPO (Deductible applies)	80%
NON-PPO (Deductible applies).....	60%

PAIN MANAGEMENT/PAIN THERAPY

PPO (Deductible applies)	80%
NON-PPO (Deductible applies).....	60%

PHYSICAL/OCCUPATIONAL THERAPY

PPO (Deductible applies)	80%
NON-PPO (Deductible applies).....	60%
Maximum Visits Per Plan Year	20 visits

Medical Benefits – Option III

PHYSICIAN'S SERVICES

PPO (Deductible applies).....	80%
NON-PPO (Deductible applies).....	60%

RENAL/PERITONEAL DIALYSIS

PPO (Deductible applies).....	80%
NON-PPO (Deductible applies).....	60%

SKILLED NURSING FACILITY CARE

PPO (Deductible applies).....	80%
NON-PPO (Deductible applies).....	60%
Maximum Days Per Plan Year	150 days

SLEEP DISORDERS

PPO (Deductible applies).....	80%
NON-PPO (Deductible applies).....	60%
Maximum Per Plan Year	\$2,500

SPEECH THERAPY

PPO (Deductible applies).....	80%
NON-PPO (Deductible applies).....	60%
Maximum Visits Per Plan Year	20 visits

SPINAL MANIPULATION TREATMENT

PPO (Deductible applies).....	80%
NON-PPO (Deductible applies).....	60%
Maximum Visits Per Plan Year	20 visits

SURGICAL REMOVAL OF IMPACTED TEETH

PPO (Deductible applies).....	80%
NON-PPO (Deductible applies).....	60%

TEMPOROMANDIBULAR JOINT DISORDER

PPO (Deductible applies).....	80%
NON-PPO (Deductible applies).....	60%
Lifetime Maximum	\$5,000

URGENT CARE FACILITY

PPO (Deductible applies).....	80%
NON-PPO (Deductible applies).....	60%

WELLNESS EXPENSE

PPO (Deductible waived).....	100%
NON-PPO (Deductible applies).....	60%

No benefits will be paid for routine exams and related services when rendered solely for purposes of employment, participation in school athletic programs, foreign travel, immigration, the purchase of additional insurance, to obtain or maintain a license of any type, medical research, judicial or administrative proceedings or orders, or marriage or adoption.

Preventive services are covered with no cost share if a PPO Provider is used. This benefit includes, but is not limited to: routine physical/exam; gynecological exam; mammogram; pap smear; prostate testing (PSA); other routine lab and x-ray; immunizations; routine endoscopy, colonoscopy or sigmoidoscopy; and vision and hearing screening for children. Many of these services are covered only for specific age groups. For more detailed information on covered preventive services, please visit these websites:

- 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, available at <https://www.uspreventiveservicestaskforce.org/page/name/uspstf-a-and-b-recommendations>;
- Immunizations that have in effect a recommendation from the Advisory Committee on Immunization Practices of the Centers for Disease Control and Prevention with respect to the individual involved, available at <http://www.cdc.gov/vaccines/acip/index.html>;
- With respect to infants, children, and adolescents, evidence-informed preventive care and screening provided for in the comprehensive guidelines supported by the Health Resources and Services Administration, available at <https://www.healthcare.gov/preventive-care-children/>; and
- With respect to women, preventive care and screening provided for in the comprehensive guidelines supported by the Health Resources and Services Administration, available at <http://www.hrsa.gov/> and the expanded women’s preventive services, available at <http://www.hrsa.gov/womensguidelines/>. The current recommendations of the United States Preventive Service Task Force regarding breast cancer screening, mammography, and prevention shall be the most current other than those issued in or around November, 2009.

WIGS (After chemotherapy or radiation treatment)

PPO (Deductible applies)	80%
NON-PPO (Deductible applies)	60%
Lifetime Maximum	One wig

WOMEN'S HEALTH AND CANCER RIGHTS ACT. Pursuant to the Women's Health and Cancer Rights Act of 1998, this Plan provides benefits for Covered Persons for mastectomy-related services, including reconstruction and surgery to achieve symmetry between the breasts, prostheses, and complications resulting from mastectomy (including lymphedema). For further details, please see subsection 21 of "ELIGIBLE CHARGES."

PRESCRIPTION DRUG PROGRAM – OPTION III

Prescription Copays apply to the PPO Out-of-Pocket Maximum.

Provisions of the Affordable Care Act require that all non-grandfathered health plans provide coverage for FDA approved contraceptives at no cost share for generic form; however, Non-Preferred/Preferred contraceptives will have a Copay as long as a generic form is available. For a list of covered preventive services, please visit <https://www.healthcare.gov/coverage/preventive-care-benefits/>.

The “PRESCRIPTION DRUG PROGRAM” is subject to the PPO Calendar Year Deductible. Employees and Dependents must pay the entire prescription cost until the Calendar Year Deductible has been met. Once the Calendar Year Deductible has been met, prescription drug Copays will apply. Once the PPO Deductible and Out-of-Pocket are met, prescriptions will be covered at 100%.

PROACT PRESCRIPTION DRUG PROGRAM. ProAct is able to provide many prescriptions for Covered Persons at a discounted price. Prescriptions may be purchased through the ProAct prescription drug program in two ways. Short-term prescriptions may be filled at local ProAct Network Pharmacies which will charge a flat fee (Copay) for up to a 30-day supply of medication. ProAct home delivery pharmacy service is a mail order prescription drug service which charges a flat fee (Copay) for a 90-day supply of prescription maintenance drugs, such as birth control pills, ulcer medication, insulin, thyroid medication, etc. When using the mail order option, Employees will need to request two prescriptions from their Physician, one for a two or three week supply to be filled by their local ProAct pharmacy, and another which can be mailed to the ProAct home delivery service for the remainder of their 90-day supply. Regardless of whether the Covered Person uses the drug card or mail order option, if the actual cost of the medication is less than the Copay, the Covered Person will only be responsible for the actual prescription cost.

PRESCRIPTION DRUG CARD PROGRAM

Copay For Each Prescription or Refill (30-day supply) (No Deductible)

Generic (PPO Deductible applies).....	\$15
Preferred (PPO Deductible applies).....	\$35
Non-Preferred (PPO Deductible applies)	\$60
Specialty (PPO Deductible applies).....	20% of the prescription cost up to \$200 per prescription

MAIL ORDER DRUG PROGRAM

Copay For Each Prescription or Refill (90-day supply) (No Deductible)

Generic	\$15
Preferred	\$70
Non-Preferred	\$180

The “PRESCRIPTION DRUG PROGRAM” includes a mandatory generic requirement. If the Covered Person chooses a brand name drug when a generic equivalent is available, the Covered Person will be charged the applicable brand name Copay plus the difference in cost between the brand name and generic drug. This provision does not apply if the Physician requests “dispense as written.”

Prescriptions not purchased through the mail order or drug card program will not be covered under the Plan. The per prescription Copay is not eligible for reimbursement under the Plan.

Generic means drugs that are available from many sources and in generic form. These are typically the lowest cost drugs and result in the lowest Copay.

Preferred means drugs which are preferred by the prescription vendor. Since these drugs typically have a lower cost, they are not charged the highest Copay.

Non-Preferred means drugs which are not on the prescription vendor’s preferred list. Choosing these drugs results in the highest Copay.

Specialty Drugs are high-cost medications used to treat chronic, complex conditions, including but not limited to: HIV/AIDS, Rheumatoid Arthritis, Cancer, Hepatitis, Hemophilia, and Multiple Sclerosis. Although the incidences of these and other serious diseases are being diagnosed more commonly, the medicines needed to treat such conditions are far from common. Specialty drugs may:

- 1) require nursing services or special programs to support patient compliance;
- 2) require disease-specific treatment programs;
- 3) have limited distribution requirements; or
- 4) have special handling, storage, or shipping requirements.

Some drug expenses which are not covered:

- * Drugs which can be obtained without a Physician's prescription;
- * Therapy devices or appliances regardless of their intended use including:
 - hypodermic needles;
 - syringes;
 - support garments; or
 - other non-medical substances; and
- * Any drugs which are Experimental/Investigational (see “EXCLUSIONS AND LIMITATIONS” for further details).

This is not a complete list of drugs that are excluded. Please contact ProAct at (877) 635-9545 to determine specific drug coverage.

DEFINITIONS

As used in this Plan, the following words and phrases shall have the meanings indicated:

ACCIDENT means an incident resulting in Injury that occurs from external forces under unexpected circumstances, and which is in no way the fault of the victim. Injuries to teeth resulting from chewing or biting; as well as sprains and strains resulting from overexertion, excessive use, or overstretching will not be considered Accidental Injuries for purposes of medical benefit determination.

ADMINISTRATIVE SERVICE AGENT means the firm providing administrative services to the Plan Administrator in connection with the operation of the Plan, such as maintaining current eligibility data, billing, processing and payment of Claims and providing the Plan Administrator with any other information deemed necessary. Group Resources is the Administrative Services Agent for the Plan.

AIR AMBULANCE SERVICE means medical transport by a helicopter or airplane for a Covered Person.

ANNUAL LIMIT ON ESSENTIAL HEALTH BENEFITS means the maximum amount that can be paid on behalf of a Covered Person during the period of time beginning on September 1 and ending on August 31 of the following year.

APPLIED BEHAVIOR ANALYSIS means the process of systematically applying interventions based upon the principles of learning theory to improve socially significant behaviors to a meaningful degree, and to demonstrate that the interventions employed are responsible for the improvement in behavior.

APPROVED CLINICAL TRIAL is defined in the statute as a phase i, phase ii, phase iii, or phase iv clinical trial that is conducted in relation to the prevention, detection, or treatment of cancer or other life-threatening disease or condition and is one of the following:

- 1) a federally funded or approved trial;
- 2) a clinical trial conducted under an FDA investigational new drug application; or
- 3) a drug trial that is exempt from the requirement of an FDA investigational new drug application.

AUTISM SPECTRUM DISORDER means a serious neurodevelopmental disorder that impairs a child's ability to communicate and interact with others. It also includes restricted repetitive behaviors, interests and activities. These issues cause significant impairment in social, occupational, and other areas of functioning.

BALANCE BILL (or Balance Billing) refers to the practice of nonparticipating (out-of-network) Providers billing a Covered Person for the difference between: (1) the Provider's billed charges; and (2) the amount collected from the Plan plus the amount collected from the Covered Person in the form of cost sharing (such as Copay, Coinsurance or amounts paid toward a Deductible).

BILLING REVIEW is a review of billing documentation and related medical records undertaken to uncover any invalid charges, as necessary and sufficient to allow the Plan Administrator to reasonably assess the accuracy and validity of billed charges submitted in connection with a claim and to make determinations as to whether any such charges exceed the Maximum Allowable Charge.

CERTIFIED IDR ENTITY means an entity responsible for conducting determinations under the No Surprises Act and that has been properly certified by the Department of Health and Human Services, the Department of Labor, and the Department of the Treasury.

COINSURANCE means the percentage of an eligible charge that is paid by the Plan on behalf of the Covered Person.

COMPANY means Prince Avenue Baptist Church & School or any affiliate which is participating in the Plan with the permission of Prince Avenue Baptist Church & School.

COMPLEX IMAGING means a method of processing image data to produce a high-definition image, receiving the data, and adaptively processing the data using a constrained minimum variance method to iteratively compute the high-definition image (i.e., MRI/CT/PET Scan, etc).

COPAY means the amount which is required to be paid to a Provider by a Covered Person at the time of service.

COSMETIC TREATMENT means treatment performed for the purpose of improving appearance rather than for restoring bodily function.

COVERED PERSON means an Employee or a Dependent for whom the coverage provided by this Plan is in effect. A Covered Person may be covered under this Plan as an Employee or as a Dependent, but not both at the same time.

DEDUCTIBLE means the amount of eligible charges that a Covered Person must incur before benefits will be payable, as listed in "MEDICAL BENEFITS." The Covered Person must meet a new Deductible each Plan Year. The Deductible will be applied separately to each Covered Person except when the family Deductible (shown in "MEDICAL BENEFITS") has been met by the family. Once the family Deductible is met, no further Deductible for any Covered Person in that family will be required during that Plan Year.

DEPENDENT means a person who meets one of the following requirements:

- 1) is the Employee's spouse who resides in the United States (unless the spouse is legally separated or divorced from the Employee); or
- 2) is the Employee's:
 - a) child less than 26 years of age; or
 - b) unmarried child age 26 or older meeting all of the following conditions:
 - i) subject to a physical or mental impairment which can be expected to result in death or which has lasted or is expected to last for a continuous period of not less than 12 months; and
 - ii) is unable to engage in any substantial gainful activity due to such physical or mental impairment; and
 - iii) for whom proof of such physical or mental impairment is submitted to the Plan Administrator within 30 days of the date coverage would have ended as a result of the child's age.

The term “spouse” refers to an individual of the same or opposite sex, who is lawfully married to the Covered Person under the laws of the state in which the marriage occurred.

The term "child" includes a natural child, an adopted child at time of placement, a child placed with a Covered Person in anticipation of adoption, a child for whom the Employee or Employee’s spouse is Legal Guardian, and a stepchild.

Dependent children must be primarily dependent upon the Employee for support and maintenance. The phrase “primarily dependent upon” shall mean dependent upon the Employee for support and maintenance as defined by the Internal Revenue Code and the covered Employee must declare the child as an income tax deduction. The Plan Administrator may require documentation proving dependency, including birth certificates, tax records or initiation of legal proceedings severing parental rights.

Notwithstanding the above, the term “child” also includes a child of the Covered Person whose coverage is ordered under a National Medical Support Notice and who otherwise meets the requirements above.

For purposes of continuation coverage pursuant to the Consolidated Omnibus Budget Reconciliation Act of 1985, as amended, "Dependent" shall also include any child born to or placed for adoption with a Covered Person during the period of continuation coverage.

In the case of an individual whose parents are divorced, the individual may be considered the “child” of either parent.

The term "Dependent" does not include a legally separated or divorced spouse of the Employee, any person who is covered under the Plan as an Employee, any person serving in the armed forces of any country; unless such a person is the child of the covered Employee who has not attained age 26, or other individuals living in the covered Employee’s home who are not eligible as defined. If a husband and wife are both Employees, their children may be considered Dependents of either the husband or wife but not of both.

DURABLE MEDICAL EQUIPMENT means equipment which is:

- 1) able to withstand repeated use;
- 2) primarily and customarily used to serve a medical purpose; and
- 3) not generally used by a person in the absence of Illness or Injury.

EMERGENCY DEPARTMENT OF A HOSPITAL includes a hospital outpatient department that provides Emergency Services.

EMERGENCY SERVICES shall mean, with respect to a Medical Emergency Condition, the following:

- 1) an appropriate medical screening examination (as required under section 1867 of the Social Security Act, 42 U.S.C. 1395dd) that is within the capability of the emergency department of a Hospital or of an Independent Freestanding Emergency Department, as applicable, including ancillary services routinely available to the emergency department to evaluate such Medical Emergency Condition; and

- 2) within the capabilities of the staff and facilities available at the Hospital or the Independent Freestanding Emergency Department, as applicable, such further medical examination and treatment as are required under section 1867 of the Social Security Act (42 U.S.C. 1395dd), or as would be required under such section if such section applied to an Independent Freestanding Emergency Department, to stabilize the patient (regardless of the department of the Hospital in which such further examination or treatment is furnished).

When furnished with respect to a Medical Emergency 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 Covered Person 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 Covered Person is able to travel using non-medical transportation or non-emergency medical transportation, and the Covered Person is in a condition to, and in fact does, give informed consent to the Provider to be treated as a Non-Network Provider.

EMPLOYEE means any person employed on a regular basis by the Company in the conduct of the Company's regular business, who is regularly scheduled to work at least 30 hours per week, and who is classified by the Company, pursuant to its regular administrative practices, as a common law Employee, excluding any person who (a) is a leased Employee under Code Section 414 (n) or (b) is covered under a collective bargaining agreement which is the subject of good faith bargaining, unless the agreement provides for participation in the Plan. The term "Employee" shall exclude any individual classified by the Company, in its sole discretion, in a designation which would exclude the person from being considered as an Employee under the Company's customary worker classification procedures, regardless of whether such classification is in error.

ERRORS are charges based on billing mistakes, improprieties or illegitimate billing entries including, but not limited to, up-coding, duplicate charges, charges for care, supplies, treatment and/or services not actually rendered or performed, or charges otherwise determined to be invalid, impermissible or improper based on any applicable law, regulation, rule or professional standard. It is in the Plan Administrator's sole discretion to determine what constitutes an Error under the terms of this Plan.

ESSENTIAL HEALTH BENEFITS, includes, in addition to any other services that are required to be treated as "Essential Health Benefits" under the Patient Protection and Affordable Care Act of 2010, the following general categories and items and services covered within the categories: ambulatory patient services, emergency services, hospitalizations, maternity and newborn care, mental health and substance use disorder services (including behavioral health treatment), prescription drugs, rehabilitative and habilitative services and devices, laboratory services, preventive and wellness services and chronic disease management, and pediatric services (including oral and vision care).

HOME HEALTH CARE means the following services and supplies furnished in the home by a Home Health Care agency in accordance with a Home Health Care plan, provided that the Physician certifies that Hospital confinement would otherwise be required:

- 1) part-time or intermittent nursing care by a Registered Nurse (R.N.), or Licensed Practical Nurse (L.P.N.) under the supervision of a Registered Nurse (R.N.);
- 2) Occupational Therapy, Speech Therapy, and Physical Therapy which are provided by a Home Health Care Agency;
- 3) medical supplies and medications prescribed by a Physician and laboratory services of a Hospital if such items would have been covered while confined in a Hospital.

The term "Home Health Care" does not include:

- 1) services or supplies not included in the Home Health Care plan;
- 2) services of a person who ordinarily resides in a Covered Person's home or is a member of the Covered Person's family or the Covered Person's spouse's family;
- 3) custodial care consisting of services and supplies which are provided to the Covered Person primarily to assist in the activities of daily living;
- 4) care received in any period during which the Covered Person is not under the continuing care of a Physician; or
- 5) transportation.

HOSPICE means a public agency or private organization which meets all of the following requirements:

- 1) is primarily engaged in providing care to terminally ill patients;
- 2) provides 24-hour care to control the symptoms associated with terminal illness;
- 3) has on its staff an interdisciplinary team which includes at least one Physician, one Registered Nurse (R.N.), one social worker and one counselor;
- 4) is a licensed organization whose standards of care meet those of the National Hospice Organization;
- 5) maintains central clinical records on all patients;
- 6) provides appropriate methods of dispensing drugs and medicines; and
- 7) offers a coordinated program of home care and Inpatient care for the terminally ill patient and the patient's family.

The term "Hospice" does not include an organization or part thereof which is primarily engaged in providing:

- 1) custodial care;
- 2) care for drug addicts and alcoholics; or
- 3) domestic services.

The term "Hospice" does not include an organization or part thereof which is primarily:

- 1) a place of rest;
- 2) a place for the aged; or
- 3) a hotel or similar institution.

HOSPITAL means a place which meets all of the following requirements:

- 1) is either accredited by the Joint Commission on Accreditation of Hospitals (JCAH), the Commission on Accreditation of Rehabilitation Facilities (CARF), or is certified as a Hospital Provider under Medicare;

- 2) is open at all times;
- 3) is operated for the treatment of sick or injured persons through medical, diagnostic, and major surgical facilities on its premises;
- 4) has a staff of one or more Physicians available at all times;
- 5) provides 24 hour nursing services by Registered Nurses (R.N.'s);
- 6) if it is chiefly a place for the treatment of mental health or substance abuse/substance dependence, has bona fide arrangement by contract with an accredited Hospital to perform surgery or provide other medical care which may be required.

The term "Hospital" also includes a short-term acute care facility which operates primarily for the treatment of Chemical Dependency, or Mental or Nervous Disorders, if it meets these tests:

- 1) is either accredited by the Joint Commission on Accreditation of Hospitals (JCAH), the Commission on Accreditation of Rehabilitation Facilities (CARF), or is certified as a Hospital Provider under Medicare;
- 2) has a Physician in regular attendance;
- 3) has a full-time psychiatrist or psychologist on the staff;
- 4) maintains clinical records on all patients;
- 5) provides comprehensive multidisciplinary therapy and medical management with the expectation for improvement or when it is necessary to maintain a Covered Person's functional level and prevent relapse.

The term "Hospital" does not include subacute/minimal care facilities, facilities providing custodial care, educational institutions, nursing homes, convalescent facilities, rest homes or similar establishments.

All hospital treatment must be Medically Necessary (see "DEFINITIONS") or no coverage will be available under this plan.

ILLNESS means a disorder of the body or mind, a disease, or pregnancy. All Illnesses which are due to the same cause or to a related cause or causes will be deemed to be one Illness.

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

INDEPENDENT FREESTANDING EMERGENCY DEPARTMENT means a health care facility that is geographically separate and distinct, and licensed separately, from a Hospital under applicable state law, and which provides any Emergency Services.

INJURY means bodily Injury caused by an Accident and which results directly from the Accident and independently of all other causes.

INPATIENT means an individual confined as a registered bed patient in a Hospital, Skilled Nursing Facility or Hospice.

LEGAL GUARDIAN means a person recognized by a court of law as having the duty of taking care of the person and managing the property and rights of a minor child.

LIFETIME means the maximum benefit while covered under this Plan. Under no circumstances does Lifetime mean during the lifetime of the Covered Person.

MAXIMUM ALLOWABLE CHARGE means the benefit payable for a specific coverage item or benefit under the Plan. The Maximum Allowable Charge will always be a negotiated rate, if one exists; if no negotiated rate exists, the Maximum Allowable Charge will be the Plan Allowance determined and established by the Plan, at the Plan Administrator's discretion.

The Plan Administrator may in its discretion, taking into consideration specific circumstances, deem a greater amount to payable than the lesser of the aforementioned amounts. The Plan Administrator may take any or all of such factors into account but has no obligation to consider any particular factor. The Plan Administrator may also account for unusual circumstances or complications requiring additional or a lesser amount of time, skill and experience in connection with a particular service or supply, industry standards and practices as they relate to similar scenarios, and the cause of injury or illness necessitating the service(s) and/or charge(s). When more than one treatment option is available, and one option is no more effective than another, the least costly option that is no less effective than any other option will be considered within the Maximum Allowable Charge.

In all instances, the Maximum Allowable Charge will be limited to an amount which, in the administrator's discretion, is charged for services or supplies that are not unreasonably caused by the treating provider, including errors in medical care that are clearly identifiable, preventable, and serious in their consequence for patients. A finding of provider negligence and/or malpractice is not required for services or fees to be considered ineligible pursuant to this provision.

The determination that fees for services are includable in the Maximum Allowable Charge will be made by the Plan Administrator, taking into consideration, but not limited to, the findings and assessments of the following entities: (a) The National Medical Associations, Societies, and organizations; and (b) The Food and Drug Administration. To be includable in the Maximum Allowable Charge, services and fees must be in compliance with generally accepted billing practices for unbundling or multiple procedures.

The Plan Administrator has the discretionary authority to decide if a charge is covered under this Plan. The Maximum Allowable Charge will not include any identifiable billing mistakes including, but not limited to, up-coding, duplicate charges, and charges for services not performed.

MAXIMUM BENEFIT means the maximum amount payable for the period indicated for a Covered Person for all eligible charges incurred while covered under the Plan.

MEDICAL EMERGENCY means a medical condition manifesting itself by acute symptoms of sufficient severity (including severe pain) such that a prudent layperson, who possesses an average knowledge of health and medicine could reasonably expect the absence of immediate medical condition to result in a condition described in the Emergency Medical Treatment and Labor Act (EMTALA) provisions of the Social Security Act.

MEDICALLY NECESSARY means health care services, supplies, or treatments which are for the purpose of evaluation, diagnosis, or treatment of the Covered Person's Injury or Illness and are:

- 1) recommended, approved, or ordered by a Physician or Dentist exercising prudent clinical judgment, and clinically appropriate in terms of type, frequency, extent, site, and duration for the diagnosis or treatment of the Covered Person's Illness or Injury;
- 2) consistent with the patient's condition or accepted standards of good medical and dental practice;
- 3) not performed for the convenience of the patient or the Provider of medical and dental services;
- 4) no more costly than alternative interventions, and at least as likely to produce equivalent therapeutic or diagnostic results as to the diagnosis or treatment of the Covered Person's Illness or Injury without adversely affecting the Covered Person's medical conditions;
- 5) not conducted for research purposes; and
- 6) the most appropriate setting and level of services which can be safely provided to the Covered Person, considering the Covered Person's medical symptoms and conditions.

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

In addition, with respect to Mental or Nervous Disorders, Substance Abuse, and Substance Dependence, to be considered "Medically Necessary," the treatment, services, and/or supplies must not be (a) maintenance therapy or maintenance treatment, or (b) a listed item or treatment not allowed for reimbursement by CMS (Medicare).

The Plan reserves the right to incorporate CMS (Medicare) guidelines in effect on the date of treatment as additional criteria for determination of Medical Necessity.

MENTAL OR NERVOUS DISORDER: To be a Mental Disorder or Nervous Disorder, the disease or condition, regardless of whether the cause is organic, must be classified as a Mental or Nervous Disorder in the current edition of International Classification of Diseases, published by the U.S. Department of Health and Human Services or is listed in the current edition of Diagnostic and Statistical Manual of Mental Disorders, published by the American Psychiatric Association. Mental or Nervous Disorder does not include Substance Abuse or Substance Dependence or any condition resulting therefrom.

MORBID OBESITY means a diagnosed condition in which the body weight exceeds the medically recommended weight by either 100 pounds or is twice the medically recommended weight in the most recent Metropolitan Life Insurance Co. tables (or similar actuarial tables) for a person of the same height, age and mobility as the Covered Person.

NATIONAL MEDICAL SUPPORT NOTICE means a qualified medical support order and serves notice that the employee identified on the document is obligated by a court or administrative child support order to provide health care coverage for the child(ren) identified in it. The NMSN meets the requirements for a Qualified Medical Child Support Order (QMCSO) if the child support agency correctly completes it and if coverage for the child(ren) is or will become available. The NMSN is a QMCSO under the Employee Retirement Income Security Act (ERISA) section 609 (a)(5)(s).

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

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

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

OCCUPATIONAL THERAPY means a program of care which focuses on the physical, cognitive and perceptual disabilities that influence the patient’s ability to perform functional tasks. The therapist evaluates the patient’s ability to use his fingers and hands (fine motor skills), perceptual skills, cognitive functioning and eye-hand coordination. Therapy sessions may also involve physical movement exercises. Functional tasks also may be used. The therapist may also perform splinting of the patient’s arms or hands and may provide the patient with special equipment.

OUT-OF-POCKET MAXIMUM means the maximum amount that a covered Employee or Dependent will have to pay for covered expenses under the Plan. This does not non-covered items and penalties.

OUTPATIENT means an individual receiving medical services, but not confined as a registered bed patient in a Hospital, Skilled Nursing Facility, or Hospice.

OUTPATIENT SURGICAL CENTER means any public or private establishment which:

- 1) has a staff of Physicians;
- 2) has permanent facilities that are equipped and operated primarily for the purpose of performing Surgical Procedures; and
- 3) provides continuous Physician and nursing services while patients are in the facility.

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

PHYSICAL THERAPY means a plan of care provided to return a patient to the highest level of motor functioning possible. The physical therapist extensively evaluates the patient's muscle tone, movement, balance, endurance, ability to ambulate, ability to plan motor movements, strength and coordination. If the patient requires special equipment (such as a wheelchair, walker or splint), the therapist evaluates the patient's ability to use the equipment and determines the correct size and type of equipment for the specific patient. The therapist constructs a program of exercises and movements to maximize the patient's motor skills.

PHYSICIAN means a Doctor of Medicine (M.D.), a Doctor of Osteopathy (D.O.), a Doctor of Dental Surgery (D.D.S.) or Doctor of Medical Dentistry (D.M.D.), a Doctor of Podiatry (D.P.M.), a Doctor of Chiropractic (D.C.), an Audiologist, a Certified Registered Nurse Anesthetist (C.R.N.A.), a Licensed Physical Therapist (L.P.T.), a Midwife, an Occupational Therapist, an Optometrist (O.D.), a Physiotherapist, a Psychiatrist, a Psychologist (Ph.D.), a Speech and Language Pathologist, a Licensed Clinical Social Worker (L.C.S.W.), a Master of Social Work (M.S.W.), a Licensed Professional Counselor (L.P.C.), Registered Nurse (R.N.), and any other practitioner of the healing arts who is licensed and regulated by a state or federal agency, and who is acting within the scope of his or her license, to the extent that his or her services are covered under this Plan.

The term "Physician" does not include a person who:

- 1) is the Covered Person receiving treatment; or
- 2) is a relative by blood or marriage of the Covered Person receiving treatment.

PLAN ALLOWANCE means the amount the Plan Administrator in its sole discretion, has determined to be the maximum amount payable for an out-of-network covered service. Charges in excess of the Plan Allowance will not be considered covered medical expenses under this Plan. The Plan will allow the actual charge billed if it is less than the Plan Allowance. The Plan Allowance only applies to out-of-network Providers.

PLAN YEAR means each period of time beginning on September 1 and ending on August 31 of the following year.

PRE-ADMISSION TESTING means x-ray and laboratory examinations which:

- 1) are performed on an Outpatient basis;
- 2) are performed within seven days of a scheduled surgery which is performed within 48 hours following the Covered Person's admission to the Hospital; and
- 3) are related to the Illness or Injury that caused Hospital confinement or the need for surgery.

PREFERRED PROVIDER ORGANIZATION (PPO) means the Plan has retained the services of a Preferred Provider Organization in order to provide quality medical care to participants who are within the PPO's area of operation, at lower cost to both the Plan and participants. PPOs vary among the type of services to be provided. Utilization of PPO network Providers will usually result in an increase in the amount of benefits paid on eligible expenses. A list of the Providers included in the PPO will be furnished automatically, without charge, and is also available on the internet at www.mycigna.com.

PRIMARY CARE PHYSICIAN (PCP). For purposes of this Plan, a Primary Care Physician is a physician specializing in internal medicine, general practice, family practice, pediatrics, or obstetrics/gynecology. Certified Physician's Assistants (PAs) and Certified Nurse Practitioners (CNPs) supervised by the PCP may also be considered Primary Care Physicians under the Plan as long as they practice in the same location as the PCP.

PROVIDER means a Hospital, Physician, or any other person, company, or institution furnishing to a Covered Person an item of service or supply listed as a covered expense in the Plan.

QUALIFYING PAYMENT AMOUNT means the median of the contracted rates recognized by the Plan, or recognized by all plans serviced by the Plan's Third Party Administrator (if calculated by the Third Party Administrator), for the same or a similar item or service provided by a Provider in the same or similar specialty in the same geographic region. If there are insufficient (meaning at least 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 shall mean, except for Non-Network air ambulance services, an amount determined under an applicable all-payer model agreement, or if unavailable, an amount determined by applicable state law. If no such amounts are available or applicable and for Non-Network air ambulance services generally, the Recognized Amount shall mean the lesser of a Provider's billed charge or the Qualifying Payment Amount.

ROOM AND BOARD means the Hospital's charge for:

- 1) room and linen service;
- 2) dietary service, including meals, special diets, and nourishments; and
- 3) general nursing service.

SKILLED NURSING CARE means those charges incurred for:

- 1) visiting nurse care by an R.N. or L.P.N. The term "visiting nursing care" means a visit of not more than two hours for the purposes of performing specific Skilled Nursing tasks; and
- 2) private duty nursing by an R.N. or L.P.N. if the patient condition requires Skilled Nursing services and visiting nurse care is not adequate.

The term "Skilled Nursing Care" does not include:

- 1) that part or all of any nursing care that does not require the skills of an R.N.; or
- 2) any nursing care given while the person is an Inpatient in a health care facility that could safely and adequately be furnished by the facility's general nursing staff if it were fully staffed.

SKILLED NURSING FACILITY means a place, or a distinct part of a place, which meets all of the following criteria:

- 1) is licensed according to state or local laws;
- 2) provides as its chief purpose Skilled Nursing treatment to patients who are recovering from an Illness or Injury;
- 3) includes areas for medical treatment;
- 4) provides 24-hour-a-day nursing services under the full-time supervision of a Physician or a Registered Nurse (R.N.);
- 5) maintains daily health records for each patient;
- 6) has an agreement which provides for the services of a Physician;
- 7) has a suitable method for providing drugs and medicines to patients;
- 8) has an arrangement with one or more Hospitals for the transfer of patients;
- 9) has an effective utilization review plan;
- 10) develops functions with the advice and review of a skilled group which includes at least one Physician; and
- 11) is not solely a place for:
 - a) rest, rehabilitation or custodial care;
 - b) the aged;
 - c) the treatment of drug addiction or Substance Abuse/Substance Dependence;
 - d) the treatment of alcoholism; or
 - e) those who are mentally disabled or who have mental disorders.

SOUND NATURAL TEETH means 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.

SPEECH THERAPY means a program of care which evaluates the patient's motor-speech skills, expressive and receptive language skills, writing and reading skills and determines if the patient requires an extensive hearing evaluation by an audiologist. The therapist also evaluates the patient's cognitive functioning, as well as his social interaction skills such as the ability to maintain eye contact and initiate conversation.

SPINAL MANIPULATION means skeletal adjustments, manipulation or other treatment in connection with the detection and correction by manual or mechanical means of structural imbalance or subluxation in the human body. Such treatment is done by a Physician to remove nerve interference resulting from, or related to, distortion, misalignment or subluxation of, or in, the vertebral column.

SUBSTANCE ABUSE means the excessive use of a substance, especially alcohol or a drug. The DSM-IV definition is applied as follows:

- 1) an inappropriate pattern of substance use leading to clinically significant impairment or distress, as manifested by one (or more) of the following, occurring within a 12-month period:
 - a) recurrent substance use resulting in a failure to fulfill major role obligations at work, school or home (e.g., repeated absences or poor work performance related to substance use; substance-related absences, suspensions or expulsions from school; neglect of children or household);

- b) recurrent substance use in situations in which it is physically hazardous (e.g., driving an automobile or operating a machine when impaired by substance use);
 - c) recurrent substance-related legal problems (e.g., arrests for substance-related disorderly conduct);
 - d) continued substance use despite having persistent or recurrent social or interpersonal problems caused or exacerbated by the effects of the substance (e.g., arguments with spouse about consequences of intoxication, physical fights);
- 2) the symptoms have never met the criteria for Substance Dependence for the class of substance.

SUBSTANCE DEPENDENCE means substance use history which includes the following: (1) Substance Abuse; (2) continuation of use despite related problems; (3) development of tolerance (more of the drug is needed to achieve the same effect); and (4) withdrawal symptoms.

SURGICAL PROCEDURE includes, but is not limited to, incision and excision, sutures, debridement of tissue, correcting a fracture, reducing a dislocation, manipulating a joint under general anesthesia, electrocauterizing, paracentesis, applying plaster casts, endoscopy, injecting sclerosing solution, arthroscopic procedures, lithotripsy, catheterization, and injections into a joint.

TEMPOROMANDIBULAR JOINT (TMJ) SYNDROME means a jaw/joint disorder causing pain, swelling, clicking, and difficulties in opening and closing the mouth; and complications including arthritis, dislocation, and bite problems of the jaw.

TOTAL DISABILITY or TOTALLY DISABLED means an Injury or Illness which:

- 1) with respect to an Employee, prevents the Employee from performing the main duties of the Employee's occupation with the Company; and
- 2) with respect to a Dependent, prevents the Dependent from performing the normal activities of a healthy person of the same age and gender.

URGENT CARE FACILITY means a walk-in facility, specifically excluding a Hospital emergency room, that treats Illnesses and Injuries without a scheduled appointment. Urgent Care Facilities offer some services that are not generally available in a primary care Physician's office, and are typically used for Injuries and Illnesses that cannot wait for a traditional appointment but do not require the services of a Hospital emergency department.

WHEN COVERAGE BEGINS

Benefits for a Covered Person are determined by the Covered Person's eligibility classification and by the terms of this Plan. Any change in benefits as a result of a change in the classification will be effective on the date the change in class occurs.

A Covered Person will not receive benefits:

- 1) for which such person is not eligible; or
- 2) in excess of the maximum amount provided under any benefit for which the person is covered.

ELIGIBILITY CLASSIFICATION - DESCRIPTION OF ELIGIBLE CLASSES:

All Employees in an eligible class.

No benefits are provided for retired Employees or their Dependents.

REQUIRED EMPLOYEE CONTRIBUTIONS:

Employees do contribute toward the cost of Employee and Dependent coverage.

The amount that Employees contribute is calculated by the Plan Administrator and is a portion of the cost of coverage under the Plan.

ELIGIBILITY FOR EMPLOYEE COVERAGE. An Employee becomes eligible for coverage provided by this Plan on the later of:

- 1) the effective date of the Plan; or
- 2) the date of hire.

For any late enrollee, any period before the late enrollee's enrollment in the Plan is not a waiting period.

OPEN ENROLLMENT means the period from August 1 through August 31 during which individuals who are currently enrolled or eligible to enroll in this Plan or any other healthcare plan sponsored by the Company may make changes to their coverage. Coverage under any newly elected option will take effect on September 1 provided the individual is in full-time service on that date, and the enrollment requirements of this Plan have been met. If an Employee does not complete and return a new election form prior to September 1 of each year, the previous year's coverage will remain in effect.

Benefit choices made during the Open Enrollment period will remain in effect until the first day of the following Plan Year unless a Covered Person experiences an event that qualifies as a Special Enrollment event under the provisions of HIPAA or an event that allows the Covered Person to change their election under a Section 125 (or "cafeteria") plan. See "Pre-Tax Premium Payment" below for additional information.

SPECIAL ENROLLMENT RIGHTS. If an Employee declines enrollment for himself or his Dependents (including spouse) because of other health insurance or group health plan coverage, the Employee may in the future be able to enroll himself or his Dependents in this Plan if the Employee or his Dependents lose eligibility for that other coverage (or if an employer stops contributing towards the Employee's or his Dependent's other coverage), provided that the Employee requests enrollment within 30 days after the other coverage ends (or within 30 days after an employer stops contributing towards the other coverage). In addition, if the Employee has a new Dependent as a result of marriage, birth, adoption, or placement for adoption, the Employee may be able to enroll himself and his Dependents, provided that the Employee requests enrollment within 30 days after the marriage, birth, adoption, or placement for adoption. The subsection entitled "SPECIAL ENROLLMENT PERIOD" below describes the procedures for Special Enrollment.

SPECIAL ENROLLMENT PERIOD. Notwithstanding any other provisions in the Plan to the contrary, Employees and their Dependents shall be eligible to enroll in the Plan upon the occurrence of one of the following:

- 1) the Employee or Dependent loses other health coverage and meets the following conditions:
 - a) the individual had other health coverage at the time he became eligible for the Plan;
 - b) the Employee stated in writing that he was declining to enroll himself and/or his Dependents in the Plan because of the other coverage;
 - c) coverage being lost was (i) COBRA coverage that was exhausted, (ii) other coverage for which the individual is no longer eligible (for example, by reason of legal separation, divorce, death, termination of employment, reduction in the number of hours of employment, or incurring a claim that would meet or exceed a lifetime limit on all benefits under the other coverage), or (iii) provided by another employer which ceased to pay for it. (However, loss of coverage due to a failure to pay premiums will not trigger a Special Enrollment period; nor will loss of coverage for cause [such as making a fraudulent claim or an intentional misrepresentation] trigger a Special Enrollment period); and
 - d) the individual makes a request for enrollment under the Plan within 30 days after losing the other coverage.

If an Employee fails to provide the written statement required under b) above, the Plan may not provide special enrollment to the Employee or any of his Dependents.

- 2) the Employee marries, has a child, adopts a child, or has a child placed for adoption, and makes a request for enrollment under the Plan within 30 days of such event.
- 3) the Employee or Dependent loses coverage under Medicaid or Children's Health Insurance Coverage (CHIP) due to loss of eligibility for Medicaid or CHIP, and makes a request for enrollment under the Plan within 60 days of the loss of coverage.
- 4) the Employee or Dependent becomes eligible for a premium assistance subsidy under Medicaid or CHIP, and makes a request for enrollment under the Plan within 60 days of such event.

SPECIAL ENROLLMENT TIMEFRAME EXTENSIONS DURING DECLARED NATIONAL EMERGENCY PERIODS. The Department of Labor, Department of Treasury and with concurrence of the Department of Health and Human Services, issued guidance / relief in April, 2020, that provides timeframe extensions to deadline otherwise in place for the Special Enrollment actions, in response to declared national emergency periods ("Outbreak Period").

The Outbreak Period began on March 1, 2020, and will end 60 days after the announced end of the declared national emergency related to the COVID-19 (to be advised). Under the relief, the Outbreak Period timeframe must be disregarded in calculating timeframes that apply to Special Enrollment notifications and elections.

EFFECTIVE DATE FOR EMPLOYEE COVERAGE. Except as stated in "Delayed Effective Date for Employee Coverage" below, coverage for an Employee becomes effective as follows:

- 1) for a Special Enrollment:
 - a) in the case of a loss of coverage or marriage, the date which is the first day of the first calendar month beginning after the request for enrollment is received by the Plan Administrator, provided that special enrollment is timely requested;
 - b) in the case of a Dependent's birth, adoption, or placement for adoption, the date of the birth, adoption, or placement for adoption, respectively, provided that special enrollment is timely requested;
 - c) in the case of the Employee's or Dependent's loss of coverage under Medicaid or CHIP due to loss of eligibility for Medicaid or CHIP or the Employee's or Dependent's eligibility for a premium assistance subsidy under CHIP, the date which is the first day of the first calendar month beginning after the request for enrollment is received by the Plan Administrator, provided that special enrollment is timely requested; and
- 2) for all other enrollments, the date which is the later of:
 - a) the date the Employee becomes eligible for coverage; or
 - b) the date the Employee makes written application and written election to pay for coverage provided said application is made within 30 days of the eligibility date.

DELAYED EFFECTIVE DATE FOR EMPLOYEE COVERAGE. If an Employee fails to make written application for coverage within 30 days of his initial eligibility under the Plan (or, fails to request enrollment within 30 days of the occurrence of an event which would entitle him to Special Enrollment, if applicable), he shall be deemed a "Late Enrollee" and he may not apply for coverage until the earlier of (1) the next Open Enrollment period, or (2) a Special Enrollment period.

REHIRED EMPLOYEES. A terminated Employee who is rehired will be treated as a new hire and be required to satisfy all eligibility and enrollment requirement.

EMPLOYEES ON MILITARY LEAVE. Employees going into or returning from military services will have Plan rights mandated by the Uniformed Services Employment and Reemployment Rights Act. These rights include up to 24 months of extended health care coverage. In cases where leave is for more than 31 days, the Employee cannot be required to pay any more than 102 percent of the full premium. If the Employee performs services for less than 31 days, he or she cannot be required to pay more than the normal Employee share for such coverage. Regardless of whether extended health care coverage is elected or declined, the Employee is entitled to immediate coverage under the Plan, upon return from service. These rights apply only to Employees and their Dependents covered under the Plan before leaving for military service. Plan exclusions and waiting periods may be imposed for an Illness or Injury determined by the Secretary of Veterans Affairs to have been incurred in, or aggravated during, military service.

ELIGIBILITY FOR DEPENDENT COVERAGE. An Employee becomes eligible for Dependent Coverage on the later of:

- 1) the date the Employee becomes eligible for coverage; or
- 2) the date the Employee first acquires a Dependent.

EFFECTIVE DATE FOR DEPENDENT COVERAGE. Except as stated in "Delayed Effective Date for Dependent Coverage" below, coverage for a Dependent becomes effective as follows:

- 1) for a Special Enrollment:
 - a) in the case of a loss of coverage or marriage, the date which is the first day of the first calendar month beginning after the request for enrollment is received by the Plan Administrator, provided that special enrollment is timely requested;
 - b) in the case of a Dependent's birth, adoption, or placement for adoption, the date of the birth, adoption, or placement for adoption, respectively, provided that special enrollment is timely requested;
 - c) in the case of the Employee's or Dependent's loss of coverage under Medicaid or CHIP due to loss of eligibility for Medicaid or CHIP or the Employee's or Dependent's eligibility for a premium assistance subsidy under CHIP, the date which is the first day of the first calendar month beginning after the request for enrollment is received by the Plan Administrator, provided that special enrollment is timely requested; and
- 2) for all other enrollments, the date which is the later of:
 - a) the date the Employee becomes eligible for Dependent coverage; or
 - b) the date the Employee makes written application and written election to pay for Dependent coverage, provided said application is made within 30 days of the eligibility date.

DELAYED EFFECTIVE DATE FOR DEPENDENT COVERAGE. If an Employee fails to make written application for coverage of the Dependent when the Dependent first becomes eligible (or during a Special Enrollment period, if applicable), the Dependent shall be deemed a "Late Enrollee" and the Employee may not apply for coverage for the Dependent until the earlier of (1) the next Open Enrollment period or (2) a Special Enrollment period.

NEWBORNS. The Employee's newborn child will be covered from the date of birth only if the newborn is properly enrolled as outlined under "Special Enrollment Period." If the enrollment for a newborn is not requested within 30 days of the date of birth, the newborn cannot be enrolled until (1) the next Open Enrollment period or (2) a Special Enrollment period. A newborn child is covered separately and must meet its own Deductible and Out-of-Pocket.

NO MULTIPLE STATUS. You may not have multiple status under the Plan (*i.e.*, you may not receive benefits under this Plan as both an Employee and as a Dependent).

PRE-TAX PREMIUM PAYMENT. Your portion of the cost of your health care coverage will be paid with pre-tax dollars, and thus, is subtracted from your gross pay before taxes are determined. By doing this, your taxable pay is reduced so you pay less in taxes. Once you have made your elections for coverage for yourself and your Dependents, you cannot change them during the Plan Year unless you experience a change in status such as:

- 1) marriage or divorce;
- 2) birth or adoption of a child, change in child custody, or the addition of stepchildren;
- 3) death of a Dependent;
- 4) a child reaching the disqualifying age for coverage;
- 5) any significant change in health care coverage for the Employee or the Employee's spouse due to the spouse's employment;
- 6) commencement of employment by the Employee's spouse;
- 7) the Employee or the Employee's spouse switching from part-time to full-time employment or vice versa;
- 8) the beginning or end of the Employee's spouse's employer-provided insurance coverage because of a change in employment status; or
- 9) a change in the Employee's employment status that affects benefit eligibility.

Any change in your coverage election under the Plan must be consistent with the change in status.

WHEN COVERAGE ENDS

EMPLOYEE COVERAGE. An Employee's coverage will terminate on the earliest of:

- 1) the date this Plan is terminated;
- 2) the end of the period for which the last required Employee contribution for the Employee's coverage has been paid;
- 3) the last day of the calendar month in which the covered Employee ceases to be in a class eligible for coverage under the Plan; or
- 4) the last day of the calendar month in which covered Employee's employment with the Company terminates.

Ceasing active work is deemed termination of employment unless:

- 1) the covered Employee is Totally Disabled due to Illness or Injury. In that event, coverage may be continued up to three months during the disability provided required Employee contributions, if any, are made by such covered Employee;
- 2) the covered Employee is on a leave of absence (other than FMLA) or layoff. In that event, coverage may be continued up to three months during the disability provided required Employee contributions, if any, are made by such covered Employee;
- 3) cessation of work is due to an approved leave of absence. In that event, coverage may be continued for up to 12 weeks, in compliance with the Family and Medical Leave Act of 1993. Required contributions, if any, must be made by the covered Employee in accordance with the agreement reached between the Employee and Employer prior to the leave of absence becoming effective; and
- 4) cessation of work is due to an approved leave of absence of an Injured US Armed Services member who is recovering from a serious Illness or Injury sustained in the line of duty on active duty. In that event, coverage may be continued for up to 26 weeks during a 12-month period, in compliance with the Family and Medical Leave Act of 1993. Required contributions, if any, must be made by the covered Employee in accordance with the agreement reached between the Employee and Employer prior to the leave of absence becoming effective.

A covered Employee's coverage for any specific benefit will terminate on the earlier of:

- 1) the date coverage under the Plan for such benefit ends; or
- 2) the date the covered Employee ceases to be eligible for that benefit.

Coverage under this Plan will be terminated immediately upon finding that Covered Person has committed, participated in, or is participating in the commission of, fraud against the Plan. Fraud against the Plan includes, but is not limited to:

- 1) a Covered Person furnishing or participating in furnishing fraudulent information to the Plan for the purpose of obtaining benefits under the Plan (i.e., false health-related treatment claims);
- 2) permitting improper use of his or her identification card;
- 3) use of another Covered Person's Plan identification card; or
- 4) prescription forgery, falsification, or transfer of medication.

DEPENDENT COVERAGE. Dependent coverage will cease for any Dependent on the earliest of:

- 1) the last day of the calendar month in which the covered Employee's coverage terminates;
- 2) the date this Plan is terminated;

- 3) the date Dependent coverage is discontinued under this Plan;
- 4) the last day of the calendar month in which the covered Employee ceases to be in a class eligible for Dependent coverage;
- 5) the end of the period for which the last required Employee contribution for Dependent coverage has been paid;
- 6) the date the covered Employee no longer has any Dependents; or
- 7) the last day of the calendar month in which the individual ceases to qualify as a Dependent under this Plan.

RECISSION/TERMINATION/MODIFICATION. The Plan reserves the right to rescind, terminate or modify coverage for any Covered Person because of the intentional, material misrepresentation or fraud by or on behalf of such Covered Person. The Plan will comply with all Federal advance notice requirements prior to any rescission becoming effective.

ELIGIBLE CHARGES

BENEFITS. After a Covered Person has satisfied any applicable Deductible, eligible charges will be paid subject to exclusions, limitations and other terms of the Plan. The amount payable for any eligible charge will generally be equal to the percentage of the lesser of the billed amounts or the PPO allowances or, in the absence of PPO allowances or the Plan Allowance as described in “MEDICAL BENEFITS.”

MAXIMUM BENEFITS. The benefits paid for a Covered Person's Illnesses and Injuries will not exceed the maximum for a Covered Person shown in “MEDICAL BENEFITS.” Only charges incurred by a Covered Person while covered under this Plan may be considered "eligible charges." An eligible charge is considered to be incurred on the date a service is provided, and not when the Covered Person is formally billed or pays for the service. Other eligible charges are incurred when the purchase is made. Eligible charges are the lesser of the billed amounts or the PPO allowances or, in the absence of PPO allowances, the Plan Allowance, when charges are incurred for an Illness or Injury for one or more of the following:

- 1) Room and Board and routine nursing services for each day of confinement in a Hospital;
 - 2) Intensive or cardiac care Room and Board if Medically Necessary;
 - 3) Medical services and supplies furnished by a Hospital;
 - 4) Anesthetics and their administration by a Physician (see “DEFINITIONS”);
 - 5) Fees of Physicians for medical treatment including, but not limited to, fees for Surgical Procedures. When two or more Surgical Procedures occur during the same operative session, the eligible expense for all charges is as follows:
 - a) when two or more Surgical Procedures are performed during the same operative session through the same incision, natural body orifice or operative field, the amount eligible for consideration is the of the lesser of the billed amount, the Plan Allowance, or PPO allowance for the largest amount billed, plus 50% of the lesser of the billed amount, the Plan Allowance, or PPO allowance for the next largest procedure, and 25% of the sum of the lesser of the billed amount, the Plan Allowance, or PPO allowance for all other procedures performed; and
 - b) when two or more Surgical Procedures are performed during the same operative session through different incisions, natural body orifices, or operative fields. The amount eligible for consideration is the lesser of the billed amount, the Plan Allowance, or PPO allowance for the largest amount billed, plus 50% of the sum of the lesser of the billed amount, the Plan Allowance, or PPO allowance billed for all other procedures performed.
- When an assistant surgeon is required to render technical assistance at an operation, the eligible expense for such services shall be limited to 20% of the lesser of the billed amount, the Plan Allowance, or PPO allowance for the Surgical Procedure;
- 6) Charges for non-physician assistants at surgery, if the assistant is certified by his or her professional association, licensed with the state where employed, is credentialed by the facility to assist with the procedure, and is performing a service that would otherwise be performed by a Physician, and is performing a procedure which, according to the National Correct Coding Initiative allows an assistant at surgery;
 - 7) Services of a Registered Nurse (R.N.) or Licensed Practical Nurse (L.P.N.) for private duty nursing;
 - 8) Services of a licensed physical therapist, occupational therapist, or physiotherapist for the therapeutic care of acute symptoms and conditions. Physical Therapy and Occupational Therapy for Covered Dependents between the ages of two and eight who have been diagnosed with Autism Spectrum Disorder (ASD). Maintenance care is not covered;

- 9) Speech Therapy administered by a speech therapist when required because of an injury or illness other than psychosocial speech delay, behavior problems, attention deficit disorder, conceptual disorder, or mental retardation. If therapy is required because of a congenital abnormality, the person must have had corrective surgery before therapy will be covered. Speech Therapy for Covered Dependents between the ages of two and eight who have been diagnosed with Autism Spectrum Disorder (ASD);
- 10) Charges for Outpatient skeletal adjustment, adjunctive therapy, vertebral manipulation, and services for the care or treatment of dislocations or subluxations of the vertebrae;
- 11) X-rays (other than dental), laboratory tests, and other diagnostic services which:
 - a) are performed as a result of definite symptoms of an Illness or Injury; or
 - b) reveal the need for medical treatment;
- 12) X-ray and radiation therapy, chemotherapy, and renal/peritoneal dialysis;
- 13) The transport of a Covered Person:
 - a) within the continental United States and Canada;
 - b) by means of a professional ambulance service (including air ambulance when Medically necessary); and
 - c) to and from a Hospital;
- 14) Medical supplies as follows:
 - a) drugs and medicines:
 - i) which are approved by the Food and Drug Administration;
 - ii) which require the written prescription of a Physician; and
 - iii) which must be dispensed by a licensed pharmacist or Physician;
 - b) blood or blood plasma and its administration, marrow, or other fluids;
 - c) artificial limbs and eyes to replace natural limbs and eyes;
 - d) repair and adjustment of prosthetic devices, when Medically Necessary;
 - e) contact lenses or lenses for standard glasses only if required promptly after, and because of, cataract surgery;
 - f) casts, splints, trusses, braces, crutches, and surgical dressings;
 - g) rental or purchase, if less expensive, of Durable Medical Equipment including, but not limited to wheelchairs, Hospital beds, and oxygen equipment. Repair is not covered;
 - h) diabetic supplies to include insulin, syringes with or without needles, needles, alcohol swabs, blood glucose test strips, ketone test strips and tablets, lancets and devices;
 - i) one wig per lifetime when hair loss is the result of chemotherapy or radiation treatment;
 - j) the initial purchase of a breast prosthesis or post mastectomy bra (up to two per year), prescribed in connection with a mastectomy for which the Covered Person received benefits under the plan (replacement of the initial prosthesis is not covered); and
 - k) cochlear implants;
- 15) Charges for services performed in an Outpatient Surgical Center or Urgent Care Facility;
- 16) Charges for each day of confinement in a Skilled Nursing Facility if the confinement:
 - a) follows a Hospital confinement for which at least three straight days of Hospital Room and Board charges were included as eligible charges under the Plan;
 - b) begins within 14 days after the Covered Person is released from such Hospital confinement;
 - c) is for treatment of the same Illness or Injury which resulted in such Hospital confinement; and
 - d) is one during which a Physician is present and consults with the Covered Person at least once every seven days;

- 17) Second surgical opinion;
- 18) Routine Inpatient newborn care for a newborn child who is either a Covered Person at the time of birth or is enrolled in the Plan within 30 days of his birth. Routine newborn care includes:
 - a) Hospital charges for Room and Board, services, and supplies;
 - b) charges related to circumcision; and
 - c) fees from Physicians for routine Inpatient pediatric care;
- 19) Hospice care for a Covered Person who is a terminally ill patient and for members of the Covered Person's family who are also Covered Persons under this Plan. A terminally ill patient is someone who has a life expectancy of six months or less as certified in writing by the Physician who is in charge of the Covered Person's care and treatment. Hospice care expenses for a Covered Person will be limited to the following:
 - a) Hospice care in a Hospital-based Hospice, an extended care Hospice facility or nursing home Hospice;
 - b) care received from an interdisciplinary team of professionals for Hospice and home care;
 - c) pre-bereavement counseling; and
 - d) post-bereavement counseling during the 12 months following the death of the terminally ill patient, up to a limit of six sessions;
- 20) Home Health Care provided by a Home Health Care Provider if:
 - a) on an intermittent basis, the Covered Person requires nursing services, therapy, or other services provided by a Home Health Care Provider;
 - b) the Covered Person is Totally Disabled and is essentially confined to the home;
 - c) the Covered Person is examined by the attending Physician at least once every 60 days; and
 - d) the plan of treatment including Home Health Care is:
 - i) established in writing by the attending Physician prior to the commencement of such treatment; and
 - ii) certified by the attending Physician at least once every month;

Eligible Home Health Care services will not include:

 - a) custodial care;
 - b) meals or nutritional services;
 - c) housekeeper services;
 - d) services or supplies not specified in the Home Health Care plan;
 - e) services of a relative of the Covered Person;
 - f) services of any social worker;
 - g) transportation services;
 - h) care for tuberculosis;
 - i) care for Substance Abuse/Substance Dependence;
 - j) care for the deaf or blind; or
 - k) care for senility, mental deficiency, retardation or mental illness;
- 21) For Covered Persons undergoing covered mastectomies, and upon consultation with the Covered Person's Physician:
 - a) reconstruction of the breast on which the mastectomy has been performed;
 - b) surgery or reconstruction of the other breast to produce a symmetrical appearance; and
 - c) prostheses and physical complications of all stages of a mastectomy, including lymphedemas;

- 22) Services related to organ transplants when the Covered Person is the recipient (including charges for the organ procurement to the extent that they are not covered by the donor's insurance coverage) for the following procedures:
 - a) cornea; d) pancreas; g) heart/lung;
 - b) heart; e) liver; h) bone marrow; and
 - c) lung; f) kidney; i) kidney/pancreas;
- 23) Charges for dental care or treatment performed by a Dentist or Physician for the following:
 - a) removal of malignant tumors and cysts;
 - b) surgical removal of fully impacted wisdom teeth;
 - c) treatment for osteomyelitis as confirmed through pathology; and treatment of an injury to sound, natural teeth incurred as a result of an accidental Injury (other than an Injury resulting from eating or chewing), including fixed bridgework and full or partial dentures and crowns, if rendered within twelve months of the accidental Injury;
- 24) Charges for sterilization procedures for a covered Employee and/or spouse;
- 25) Charges incurred by the covered female employee or spouse due to pregnancy, childbirth, and related conditions;
- 26) Education programs for diabetic and ostomy care;
- 27) Charges for pain therapy including, but not limited to, pain clinics and/or labs, epidural steroid injections for the treatment of pain, and all testing and therapies related to the treatment of pain or pain management;
- 28) Charges for sleep studies and treatment including diagnosis, testing, surgery and all charges associated with sleep disorders;
- 29) Charges for Temporomandibular Joint Dysfunction (TMJ), excluding: orthodontics, crowns, inlays or any appliance that is attached to or rests on the teeth;
- 30) Charges for orthoptic training (eye muscle exercises). Training by an optometrist does not have to be prescribed by a Physician. Training by an orthopic technician must be prescribed by a Physician;
- 31) Charges for treatment, services, and/or supplies for a Mental or Nervous Disorder, Substance Abuse, or Substance Dependence;
- 32) As required by Section 10103(c) of PPACA, charges incurred for routine patient costs associated with Approved Clinical Trials that meet the following guidelines:
 - a) the Approved Clinical Trial is intended to treat a Covered Person who has been diagnosed with cancer or another life-threatening disease or condition;
 - b) the Approved Clinical Trial has been peer reviewed and is approved by at least one of the following:
 - i) one of the United States National Institutes of Health;
 - ii) a cooperative group or center of the National Institutes of Health;
 - iii) a qualified nongovernmental research entity identified in guidelines issued by the National Institutes of Health for center support grants;
 - iv) the United States Food and Drug Administration pursuant to an investigational new drug exemption;
 - v) the United States Department of Defense or Veterans Affairs; or

- vi) with respect to phase II, III, and IV Approved Clinical Trials, a qualified institutional review board;
- c) the facility and personnel conducting the Approved Clinical Trial is capable of doing so by virtue of their experience and training, and treat a sufficient volume of patients to maintain that expertise;
- d) the Covered Person meets the patient selection criteria enunciated in the study protocol for participation;
- e) the Covered Person has provided informed consent for participation in a manner that is consistent with current legal and ethical standards;
- f) the available clinical or pre-clinical data provide a reasonable expectation that the Covered Person's participation in the Approved Clinical Trial will provide a medical benefit that is commensurate with the risks of participation in the Approved Clinical Trial;
- g) the Approved Clinical Trial does not unjustifiably duplicate existing studies; and
- h) the Approved Clinical Trial must have a therapeutic intent and to some extent, must assess the effect of the intervention on the Covered Person.

Patient care services are defined as health care items or services that are furnished to a Covered Person who is enrolled in an Approved Clinical Trial, which are consistent with the standard of care for someone with the Covered Person's diagnosis, are consistent with the study protocol for the Approved Clinical Trial, and would be covered if the Covered Person did not participate in the Approved Clinical Trial. Patient care services do not include the following:

- a) an FDA approved drug or device, which is paid for by the manufacturer, the distributor, or the Provider of the drug or device;
- b) non-health care services that a Covered Person may be required to receive as a result of being enrolled in an Approved Clinical Trial;
- c) costs associated with managing the research associated with the Approved Clinical Trial;
- d) costs for non-investigational treatments;
- e) any item, service, or cost that is reimbursed or otherwise furnished by the sponsor of the Approved Clinical Trial; and
- f) the costs of services which are not provided as part of the Approved Clinical Trials stated protocol or other similarly, intended guidelines.

A qualified individual is defined as an individual who is enrolled or participating in a health plan or coverage and who is eligible to participate in an Approved Clinical Trial according to the trial protocol with respect to treatment of cancer or another life-threatening disease or condition. To be a qualified individual, there is an additional requirement that a determination be made that the individual's participation in the Approved Clinical Trial is appropriate to treat the disease or condition. That determination can be made based on the referring health care professional's conclusion or based on the provision of medical and scientific information by the individual;

- 33) Applied Behavioral Analysis (ABA) and Therapeutic Behavioral (TBT) therapies; and
- 34) Routine services as outlined in "MEDICAL BENEFITS."

EXCLUSIONS AND LIMITATIONS

- 1) **ABORTION.** No benefits will be paid for any abortion which is not Medically Necessary to preserve the life of a mother unless a fetal or chromosomal abnormality exists which was diagnosed prior to the abortion, the life of the mother is endangered if the fetus were carried to term.
- 2) **BREAST SURGERY.** No benefits will be paid for that portion of breast surgery which involves the implanting or injecting of any substance into the body for restoring breast shape. Charges will, however be covered as part of the treatment plan for a Medically Necessary mastectomy due to Illness, as set forth in "ELIGIBLE CHARGES." Charges related to the removal of a prosthesis due to medical complications will be covered; however no benefits will be allowed for the replacement of a prosthesis which was originally inserted as a part of a voluntary breast augmentation.
- 3) **COMPLICATIONS OF NON-COVERED TREATMENT.** Except for breast surgery as outlined above, no benefits will be paid for care, services, or treatment required as a result of complications from a treatment not covered under this Plan.
- 4) **COSMETIC TREATMENT.** No benefits will be paid for Cosmetic Treatment, except for that which:
 - a) results from an Illness or Injury and is performed within 24 months of the date of such Illness or Injury; or
 - b) is indicated because of congenital birth defects.
- 5) **COUNSELING.** No benefits will be paid for marriage, family, relationship, or financial counseling.
- 6) **COURT MANDATED.** No benefits will be paid for services that are provided due to a court order, except as required by federal law.
- 7) **CUSTODIAL CARE.** No benefits will be paid for services which are custodial in nature or primarily consist of bathing, feeding, homemaking, moving the patient, giving medication, or acting as a companion or sitter.
- 8) **DRUGS - POISON.** To the extent not prohibited by federal law and regulations issued thereunder, no benefits will be paid for any Illness or Injury to Covered Persons over the age of seven, which is due to:
 - a) the voluntary and intentional taking of drugs except those taken as prescribed by a Physician;
 - b) the voluntary and intentional taking of poison; or
 - c) the voluntary and intentional inhaling of gas.However, this exclusion shall not apply to Injuries resulting from an act of domestic violence or a medical condition (physical or mental).

- 9) **DURABLE MEDICAL EQUIPMENT.** No benefits will be paid for the purchase of Durable Medical Equipment or supplies which remain with the Provider following the Covered Person's use thereof.
- 10) **EDUCATIONAL/RECREATIONAL/BIOFEEDBACK.** No benefits will be paid for any services or supplies deemed to be educational in nature, or for any services or supplies related to self-care or self-help training and any related diagnostic training, except educational services as listed in "MEDICAL BENEFITS" under 'Wellness Expense' due to the Patient Protection and Affordable Care Act (PPACA).
- 11) **EXCESS.** Charges that are not payable under the Plan due to application of any stated Plan maximum or limit, or because the charges are in excess of the Maximum Allowable Charge, or are otherwise not covered by this Plan, based upon the Plan Administrator's determination as set forth by and within the terms of this document
- 12) **EXERCISE PROGRAMS.** No benefits will be paid for health clubs or health spas, aerobic and strength conditioning, work-hardening programs, and all related materials and products for these programs.
- 13) **EXPERIMENTAL/INVESTIGATIONAL.** Except as stated in "ELIGIBLE CHARGES," no benefits will be paid for any services or supplies which are experimental/investigational in nature. A drug, device, or medical treatment or procedure is experimental/investigational 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.
- 14) **FOOT CARE LIMITATION.** No benefits will be paid for any medical services or supplies furnished for the treatment of (a) weak, strained, flat, unstable or unbalanced feet, metatarsalgia or bunions, or (b) corns, calluses or toenails, except for surgery performed for a condition listed in (a) or removal of nail roots, and treatment of a condition listed in (b) because of any metabolic or peripheral vascular disease.
- 15) **GENETIC COUNSELING OR TESTING.** No benefits will be paid for the diagnosis or treatment of genetic abnormalities.
- 16) **GOVERNMENT AGENCIES.** No benefits will be paid for Hospital confinement, services, treatments or supplies furnished by the United States or a foreign government or any agency of either, unless federal laws dictate that the Plan is primary.
- 17) **HAZARDOUS ACTIVITY.** To the extent not prohibited by federal law and regulations issued thereunder, no benefits will be paid for any Accident or Injury directly or indirectly attributable to participation in hazardous sporting activities including, but not limited to, motorcycle racing, off-road vehicle competitions, hang gliding, parasailing, drag racing, motor cross racing, road racing, and sporting stunts. However, this exclusion shall not apply to Injuries resulting from an act of domestic violence or a medical condition (physical or mental).

- 18) **HEARING AIDS.** No benefits will be paid for examinations to determine the need for, or for the fitting or purchase of hearing aids, except cochlear implants.
- 19) **ILLEGAL ACTIVITY.** No benefits will be paid for any Illness or Injury which is incurred while taking part in an illegal activity, including but not limited to felonies, misdemeanors, or an attempt to commit a crime, regardless of whether the Covered Person is charged with, or convicted of, such activity.
- 20) **INFERTILITY.** No benefits will be paid for the diagnosis or treatment of infertility, including attempts to induce pregnancy such as artificial insemination, in vitro fertilization, embryonic transfer procedures such as ZIFT or GIFT, or drug therapy.
- 21) **LEARNING/BEHAVIOR DISORDERS.** No benefits will be paid for special education, treatment, or training for learning or behavior disorders.
- 22) **LEGAL DUTY.** Coverage is provided only for services and supplies for which the Covered Person has a legal duty to pay. No coverage will be provided for any services, supplies, or treatment (1) for which the Covered Person is not legally required to pay, (2) for which no charge would usually be made, (3) for which a charge if made would not usually be collected if no coverage existed, or (4) to the extent the charge for services, supplies, or treatment exceeds the charge that would have been made and collected if no coverage existed.
- 23) **MATERNITY EXPENSES.** No benefits will be paid for pregnancy expenses incurred by a Dependent child.
- 24) **MAXIMUM ALLOWABLE CHARGE.** No benefits will be paid for charges which are more than the Maximum Allowable Charge.
- 25) **MEDICALLY NECESSARY.** No benefits will be paid for charges which are not Medically Necessary.
- 26) **NO CHARGE.** No benefits will be paid for care and treatment for which there would not have been a charge if no coverage had been in force.
- 27) **NON-MEDICAL CHARGES.** No benefits will be paid for sales tax, interest, charges made for completion of claim forms or for providing supplemental information, or expenses incurred for failure to keep a scheduled appointment.
- 28) **NUTRITIONAL SUPPLEMENTS.** No benefits will be paid for vitamins, minerals, and food supplements whether or not prescribed by a Physician.
- 29) **OTHER.** Benefits will not be paid for charges not listed under “ELIGIBLE CHARGES.”

- 30) **OUTSIDE THE UNITED STATES.** No benefits will be paid for charges incurred outside the United States if the Covered Person traveled to such location for the sole purpose of obtaining medical services, drugs or supplies or to obtain those services, drugs, and supplies that are unavailable or illegal in the United States.
- 31) **PERSONAL COMFORT ITEMS.** No benefits will be paid for personal comfort items or other equipment, such as, but not limited to, air conditioners, air-purification units, humidifiers, whirlpool, water bed, exercise equipment, ultraviolet lighting, toilet seat, shower chair, electric heating units, orthopedic mattresses, blood pressure instruments, scales, elastic bandages or stockings, slings, diapers, under pads, nonprescription drugs, first-aid supplies, and non-hospital adjustable beds.
- 32) **PHYSICIAN'S DIRECT CARE.** Benefits will be paid only for eligible charges incurred by a Covered Person under the direct care of a Physician.
- 33) **PRESCRIPTIONS/MEDICATIONS.** No benefits will be paid for any prescriptions or medications which are excluded under the "PRESCRIPTION DRUG PROGRAM."
- 34) **REPLACEMENT BRACES.** No benefits will be paid for replacement braces of the leg, arm, back, neck, or artificial arms or legs, unless there is sufficient change in the Covered Person's physical condition to make the original device no longer functional.
- 35) **RELATIVE PERFORMING SERVICE.** No benefits will be paid for charges for the services of a Physician or any other Provider of services:
- a) who usually resides in the same household with the Covered Person; or
 - b) who is related by blood, marriage or legal adoption to the Covered Person or to the Covered Person's spouse.
- 36) **REVERSAL OF STERILIZATION.** No benefits will be paid for the reversal of sterilization.
- 37) **RIOT – CIVIL DISTURBANCE.** No benefits will be paid for any Illness or Injury which is incurred while taking part in a riot or civil disturbance.
- 38) **SELF-INFLICTED.** To the extent not prohibited by federal law and regulations issued thereunder, no benefits will be paid for an Illness or Injury which is intentionally self-induced or self-inflicted. However, this exclusion shall not apply to Injuries resulting from an act of domestic violence or a medical condition (physical or mental).
- 39) **SERVICES BEFORE OR AFTER COVERAGE.** No benefits will be paid for care, treatment, or supplies for which a charge was incurred before a person was covered under this Plan or after coverage ceased under this Plan.

- 40) **SEXUAL DYSFUNCTION.** No benefits will be paid for sex change surgery or any treatment of gender identity disorders, including medications, implants, hormone therapy, surgery, medical or psychiatric treatment.
- 41) **SHOCK WAVE THERAPY.** No benefits will be paid for shock wave therapy for orthopedic procedures, including but not limited to treatment of plantar fasciitis, patellar tendonitis, shoulder tendonitis or medical epicondylitis.
- 42) **TREATMENT OF TEETH AND GUMS.** Except as described in “ELIGIBLE CHARGES,” no benefits will be paid for teeth, gums, alveolar process, or supplies used in such treatment, or for dental appliances.
- 43) **VISION CARE.** No benefits will be paid for:
- a) treatment of refractive errors including, but not limited to, routine eye examinations, eye glasses or contact lenses or the fitting of them, visual therapy, fusion therapy, visual aids or orthoptics, or any related examinations; or
 - b) Surgical Procedures to eliminate the need for eyeglasses or to correct refractive errors of the eye (such as radial keratotomy, LASIK (laser in-situ keratomileusis) or any other vision enhancement surgery solely to correct nearsightedness, farsightedness or astigmatism), including any confinement, treatment, services, or supplies given in connection with or related to the surgery.
- This exclusion does not apply to surgery for cataracts or replacement of the lens of the eye following cataract surgery. This exclusion also does not apply to soft lenses or scleral shells used as corneal bandages.
- 44) **WAR.** No benefits will be paid for any Illness or Injury which is due to revolt, war or any act of war, whether declared or not.
- 45) **WEIGHT CONTROL.** No benefits will be paid for the treatment of, or services or supplies related to, obesity, Morbid Obesity, weight control, or diet, including but not limited to surgery, treatment of complications or adverse reactions to any prior surgery, nutritional counseling, food products, and medications.
- 46) **WORK RELATED ILLNESS OR INJURY.** No benefits will be provided for an Illness or Injury which arises out of or in the course of employment, regardless of whether workers’ compensation or other similar coverage is available.

PRE-CERTIFICATION/CONTINUED STAY REVIEW. Except in certain cases concerning childbirth, a Covered Person must call CIGNA at least 72 hours prior to Hospital admission for a medical condition or a Mental or Nervous Disorder, and in case of an emergency hospitalization, must call within two working days following admission.

PRIOR TO PRE-CERTIFICATION BY CIGNA, AN AUDIT NUMBER MUST BE OBTAINED VIA FAX BY CALLING (888) 620-1297.

In addition to Inpatient pre-certification, **CIGNA** must also pre-authorize the following Outpatient services. Pre-authorization of these services must occur before the services are provided.

- Ambulatory surgery;
- Chemotherapy/radiation;
- Complex Imaging (CT/MRI/PET scan);
- Durable Medical Equipment/Prosthetics/Orthotics over \$1,500;
- Ear devices;
- Home Health Care;
- Home infusion therapy;
- Hospice Care;
- Injectables and infusion in an office setting (high dollar);
- Non-emergency Hospital admissions (including observation);
- Outpatient Surgery;
- Pain therapy (Outpatient);
- Skilled Nursing Facility; and
- Transplants.

The Covered Person must provide CIGNA with the name, address, and birth date of the patient, the names, addresses, and telephone numbers of the Physician and Hospital, and the reason for hospitalization or surgery. The Covered Person is responsible for informing the attending Physician of the requirements of the pre-hospitalization review procedure. Continued stay review is also conducted by CIGNA.

The CIGNA medical care counselor will contact the Physician to discuss the proposed admission and treatment plan. If the diagnosis and treatment meet the criteria for Inpatient Hospital care, the counselor and the Physician will discuss the length of time required in the Hospital, as well as any care appropriate for recovery.

If the Covered Person fails to follow the Plan's procedures for pre-admission or continued stay review, the pre-certification penalty described in “MEDICAL BENEFITS” will be applicable.

Payment of covered charges will be withheld if pre-certification for treatment is based on a diagnosis for which treatment is covered, but the treatment is actually undertaken for a condition which is not covered by the Plan.

Pre-certification by CIGNA does not guarantee coverage or Preferred Provider Organization benefits. It is the Employee's responsibility to verify that the medical facility and Physicians are members of their PPO and that the proposed service is covered by this Plan.

MOTHERS AND NEWBORNS. Notwithstanding any other provision of this "MANAGED CARE" section, the Plan shall not:

- 1) restrict benefits for any Hospital length of stay in connection with childbirth for the mother or newborn child following (a) a normal vaginal delivery, to less than 48 hours, or (b) a cesarean section, to less than 96 hours, unless discharged earlier by a Physician after consultation with the mother; or
- 2) require any Covered Person or Provider to obtain authorization under the pre-certification features of this section in conjunction with any such stay that does not exceed the number of hours set forth in 1) above.

CASE MANAGEMENT PROGRAM. The case management program is a special program designed for Covered Persons who are suffering from a complex illness requiring continued medical care.

Alternate forms of treatment or alternate treatment facilities may be recommended as part of the case management program.

Subject to the Administrative Service Agent's approval, expenses for such alternative forms will be payable under this Plan on the same basis as the treatment or facilities for which they are substituted.

The Administrative Service Agent will have the authority to implement the alternate forms of care and treatment recommended by the case management program.

Case management is a voluntary service. There are no reductions of benefits or penalties if the Covered Person chooses not to participate.

ALTERNATIVE CARE. The Plan may elect to offer benefits for services furnished by any Provider pursuant to an alternative treatment plan for a Covered Person whose condition would otherwise require Hospital care.

The Plan shall provide such alternative benefits at its sole discretion and only when and for so long as it determines that alternative services are Medically Necessary and cost effective, and that the total benefits paid for such services will not exceed the total benefits to which the Covered Person would otherwise be entitled under this Plan in the absence of such alternative benefits.

If the Plan elects to provide alternative benefits for a Covered Person in one instance, it shall not be obligated to provide the same or similar benefits for other Covered Persons under this Plan in any other instance, nor shall it be construed as a waiver of the right to administer this Plan thereafter in strict accordance with its express terms.

COORDINATION OF BENEFITS

To prevent duplicate benefit payments if a Covered Person is covered under more than one plan, the Coordination of Benefits (COB) provision of this Plan is included to coordinate all the benefits provided by this Plan with benefits payable under any other medical plan or policy.

In this section, the term "plan" means any health care arrangement which provides medical or dental care benefits on an insured or uninsured basis. It includes, but is not limited to:

- 1) group, blanket, or individual insurance;
- 2) Hospital or medical service pre-payment plans;
- 3) labor-management trustee plans, union welfare plans, employer or employee organization plans;
- 4) government plans or programs;
- 5) coverage required or provided by law;
- 6) no fault auto insurance, including medical payments coverage ("MPC") and personal injury protection ("PIP");
- 7) third party liability insurance; and
- 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 PROCEDURES. The procedure hereinafter described will be used to determine the amount of benefits payable under this Plan for a Covered Person when the Covered Person is covered under any other plan. In that event, one plan is the primary plan, and all other plans are secondary, in the order described below. The primary plan pays its benefits first, without taking the other plans into consideration. The secondary plan then pays benefits up to the extent of its liability. When this Plan is secondary, it will only pay benefits if the primary plan pays less than this Plan would have paid if it had been primary. If the first plan pays as much or more than the benefits this Plan would have paid as the primary plan, there will be no additional payment from this Plan. Benefits under any other plan include benefits which a Covered Person could have received if such benefits had been claimed. The benefits paid by this Plan when this Plan is secondary will not exceed the benefits that would be payable in the absence of other coverage.

- 1) If a plan has no COB provision, it is automatically the primary plan;
- 2) If all the plans have COB provisions, a plan is primary if it covers the person as an employee, and secondary if it covers the person as a Dependent;
- 3) If a person is covered as a Dependent child under more than one plan:
 - a) the plan of the parent whose birthday falls earlier in the year is the primary plan;
 - b) if the father and mother share the same birthday, the Plan covering the parent longer is the primary plan;
 - c) if the other plan coordinates benefits according to the sex of the parents, then the plan that covers the person as a Dependent of a male is the primary plan;
 - d) if parents are separated or divorced, the following applies:

the plan which covers a child as a Dependent of the parent with legal custody of the child is the primary plan, unless a court decree outlines the obligation for medical expenses for the child in which case the plan which covers the child as a Dependent of the parent with such obligation for medical expenses is primary;
- 4) If a plan is no fault auto insurance (including MPC and PIP), required by law, or third party liability insurance, it is the primary plan; and

- 5) If the primary plan is still not established by the rules above, then the plan that has covered such person for the longest continuous period of time will be the primary plan.

COORDINATION WITH HEALTH MAINTENANCE ORGANIZATION (HMO) OR PREFERRED PROVIDER ORGANIZATION (PPO) PLANS. This Plan will not consider any charges in excess of what an HMO or PPO Provider has agreed to accept as payment in full. When an HMO is the primary plan and the Covered Person did not use the services of an HMO Provider, this Plan will not consider as an allowable charge any charge that would have been covered by the HMO had the Covered Person used the services of an HMO Provider.

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

RIGHT TO EXCHANGE DATA. The Plan Administrator has the right to exchange benefit information with any plan, insurance company, organization or person to determine benefits payable using this COB provision. Any such data may be exchanged without the consent of, or notice to, any person. Any person who Claims benefits under this Plan must provide the Plan Administrator with data it requires to apply this provision. Notwithstanding the preceding, the Plan Administrator will comply with applicable federal regulations regarding the privacy of medical information on and after the effective date of such regulations.

PAYMENT AND OVERPAYMENT. If payments have been made under any other plan which should have been made under this Plan, this Plan will have the right to reimburse such other plan to the extent necessary to satisfy the intent of this COB provision. This Plan also has the right to recover any overpayment made because of coverage under another plan. This Plan may recover this overpayment from any insurance company, organization or person to whom or for whom this Plan paid benefits.

GOVERNMENT BENEFITS. Except as set forth below, no benefits will be paid for any services, treatment, or supplies, to the extent that the services, treatment, or supplies were furnished by the United States, a state, a municipality, or a foreign government or any agency thereof, unless federal law dictates that the Plan is primary.

EFFECT OF MEDICARE ON BENEFITS. A covered Employee who reaches age 65, and his spouse, may remain covered by the Plan unless the Employee or spouse makes an election to waive coverage under this Plan and chooses Medicare as the primary payer of benefits. In the event that an Employee or spouse waives coverage under this Plan and thereby elects Medicare as the primary source of benefits, no benefits will be payable under this Plan. If an Employee or spouse who is entitled to Medicare does not waive coverage under the Plan, Medicare will be the secondary payer of benefits.

Notwithstanding the above, Medicare shall be the primary payer of benefits for an individual after the individual's first 30 months of entitlement to Medicare due to end stage renal disease, or as of the date coverage under the Plan is exhausted, whichever occurs first.

THIRD PARTY RECOVERY, SUBROGATION AND REIMBURSEMENT

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

A Covered Person(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 Covered Person(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 Covered Person(s) agrees to include the Plan’s name as a co-payee on any and all settlement drafts. Further, by accepting benefits the Covered Person(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 Covered Person shall be a trustee over those Plan assets.

In the event a Covered Person(s) settles, recovers, or is reimbursed by any Coverage, the Covered Person(s) agrees to reimburse the Plan for all benefits paid or that will be paid by the Plan on behalf of the Covered Person(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 Covered Person(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 Covered Person(s) fails to reimburse the Plan out of any judgment or settlement received, the Covered Person(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 Covered Person(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.

Third Party Recovery, Subrogation and Reimbursement

SUBROGATION. As a condition to participating in and receiving benefits under this Plan, the Covered Person(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 Covered Person(s) is entitled, regardless of how classified or characterized, at the Plan's discretion, if the Covered Person(s) fails to so pursue said rights and/or action.

If a Covered Person(s) receives or becomes entitled to receive benefits, an automatic equitable lien attaches in favor of the Plan to any claim, which any Covered Person(s) may have against any Coverage and/or party causing the Sickness or Injury to the extent of such conditional payment by the Plan plus reasonable costs of collection. The Covered Person 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 Covered Person 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 Covered Person(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 Covered Person(s) fails to file a claim or pursue damages against:

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

The Covered Person(s) authorizes the Plan to pursue, sue, compromise and/or settle any such claims in the Covered Person's/Covered Persons' and/or the Plan's name and agrees to fully cooperate with the Plan in the prosecution of any such claims. The Covered Person(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 Covered Person(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 Covered Person(s) is fully compensated by his or her recovery from all sources.

Third Party Recovery, Subrogation and Reimbursement

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 Covered Person's/ Covered Persons' 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 Covered Person are deemed held in constructive trust and should not be dissipated or disbursed until such time as the Covered Person's obligation to reimburse the Plan has been satisfied in accordance with these provisions. The Covered Person is also obligated to hold any and all funds so received in trust on the Plan's behalf and function as a trustee as it applies to those funds until the Plan's rights described herein are honored and the Plan is reimbursed.

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

The Plan's right of subrogation and reimbursement will not be reduced or affected as a result of any fault or claim on the part of the Covered Person(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 Covered Person(s).

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

COVERED PERSON(S) IS A TRUSTEE OVER PLAN ASSETS. Any Covered Person(s) 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 Covered Person(s) 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 Covered Person(s) is not represented by an attorney, instruct the insurance company or any third party from whom the Covered Person(s) obtains a settlement, judgment or other source of Coverage to include the Plan or its authorized representative as a payee on the settlement draft.

Third Party Recovery, Subrogation and Reimbursement

- 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 Covered Person(s) disputes this obligation to the Plan under this section, the Covered Person 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 Covered Person, 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 Covered Person(s) and Incurred prior to the liable party being released from liability. The Covered Person's/Covered Persons' 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 Covered Person 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, Sickness, Disease or disability there is available, or potentially available any Coverage (including but not limited to Coverage resulting from a judgment at law or settlements), the benefits under this Plan shall apply only as an excess over such other sources of Coverage, except as otherwise provided for under the Plan's Coordination of Benefits section.

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

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

SEPARATION OF FUNDS. Benefits paid by the Plan, funds recovered by the Covered Person(s), and funds held in trust over which the Plan has an equitable lien exist separately from the property and estate of the Covered Person(s), such that the death of the Covered Person(s), or filing of bankruptcy by the Covered Person(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.

Third Party Recovery, Subrogation and Reimbursement

WRONGFUL DEATH. In the event that the Covered Person(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 Covered Person(s) and all others that benefit from such payment.

OBLIGATIONS. IT IS THE COVERED PERSON'S/COVERED PERSONS' OBLIGATION AT ALL TIMES, BOTH PRIOR TO AND AFTER PAYMENT OF MEDICAL BENEFITS BY THE PLAN:

- 1) To cooperate with the Plan, or any representatives of the Plan, in protecting its rights, including discovery, attending depositions, and/or cooperating in trial to preserve the Plan's rights.
- 2) To provide the Plan with pertinent information regarding the Sickness, Disease, disability, or Injury, including accident reports, settlement information and any other requested additional information.
- 3) To take such action and execute such documents as the Plan may require to facilitate enforcement of its subrogation and reimbursement rights.
- 4) To do nothing to prejudice the Plan's rights of subrogation and reimbursement.
- 5) To promptly reimburse the Plan when a recovery through settlement, judgment, award or other payment is received.
- 6) To notify the Plan or its authorized representative of any incident related claims or care which may be not identified within the lien (but has been Incurred) and/or reimbursement request submitted by or on behalf of the Plan.
- 7) To notify the Plan or its authorized representative of any settlement prior to finalization of the settlement.
- 8) To not settle or release, without the prior consent of the Plan, any claim to the extent that the Covered Person 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 Covered Person(s) is not represented by an attorney, instruct the insurance company or any third party from whom the Covered Person(s) 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 Covered Person(s) over settlement funds is resolved.

If the Covered Person(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 Covered Person(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 Covered Person(s).

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

Third Party Recovery, Subrogation and Reimbursement

OFFSET. If timely repayment is not made, or the Covered Person(s) 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 Covered Person's/Covered Persons' 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 Covered Person(s) in an amount equivalent to any outstanding amounts owed by the Covered Person to the Plan. This provision applies even if the Covered Person(s) has disbursed settlement funds.

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

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

LANGUAGE INTERPRETATION. The Plan Administrator retains sole, full and final discretionary authority to construe and interpret the language of this provision, to determine all questions of fact and law arising under this provision, and to administer the Plan's subrogation and reimbursement rights with respect to this provision. The Plan Administrator may amend the Plan at any time without notice.

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.

DEFINED TERMS

- 1) **"Recovery"** means monies paid to the beneficiary by way of judgment, settlement, claim, or otherwise by the other party to compensate for the Illness or Injuries sustained;
- 2) **"Subrogation"** means the Plan's right to pursue the beneficiary's Claims for medical or dental charges against the other party and to be compensated in accordance with appropriate laws and regulations; and
- 3) **"Reimbursement"** means repayment or reimbursement to the Plan of medical or dental benefits that it has paid toward care and treatment of the beneficiary's Illness or Injuries.
- 4) **"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.

FILING A CLAIM FOR BENEFITS

To receive benefits under the Plan as quickly as possible, complete the claim forms clearly and accurately.

Following is a description of how the Plan processes Claims for benefits. A Claim is defined as any request for a Plan benefit, made by a Covered Person or by a representative of a Covered Person, that complies with the Plan's procedure for making benefit Claims.

HOW TO MAKE A CLAIM:

To assist the Administrative Service Agent in processing your Claim, please follow the steps listed below in the order in which they appear.

- Step 1) You must provide the Administrative Service Agent with current information regarding other coverage you may have. This information is requested on your enrollment form and must be furnished each year.
- Step 2) Also on the enrollment form is an important authorization request, which requires your signature. Your signature allows the Administrative Service Agent to request the necessary information from your Physician, in order to process your Claims for payment. If you have a spouse covered under the Plan, they must also sign this authorization to release information.
- Step 3) If items 1 and/or 2 above are not on file with the Administrative Service Agent, a Claim form will be requested, which may result in a delay in the processing of your Claim.
- Step 4) In the case of Hospital confinement, a form provided by the Hospital must be completed by the Hospital and submitted directly to the Administrative Service Agent.
- Step 5) Other bills or receipts relating to a covered expense may be submitted directly to the Administrative Service Agent. All bills must show the following:
 - a) the employer's name, or group number;
 - b) the Employee's name;
 - c) the Employee's social security number or Employee identification number;
 - d) the patient's name;
 - e) the Physician's name;
 - f) the type of service rendered;
 - g) an itemization of the charges;
 - h) the condition for which the service was incurred;
 - i) the date of service; and
 - j) Accident/Injury detail, if applicable (can be provided by the Covered Person on a separate document).

- Step 6) A receipt for a prescription drug must show the following:
- a) the employer's name, or group number;
 - b) the Employee's name, social security number, or identification number;
 - c) the name of the drug being prescribed;
 - d) the prescribing Physician;
 - e) the prescription number;
 - f) an itemization for each separate prescription item; and
 - g) the date of purchase.

- Step 7) Forward all related bills and receipts for processing to:

Cigna PPO
PO Box 188061
Chattanooga, TN 37422-8061
Electronic payer ID: 62308

- Step 8) Provide any additional information that may be requested by the Plan or Administrative Service Agent.

INTERNAL CLAIMS REVIEW PROCEDURES. For purposes of the claims procedures below, reference to an “adverse benefit determination” means a denial, reduction, termination of, or a failure to provide or make a payment, in whole or in part, for a benefit, including benefit determinations relating to a claimant’s eligibility, and determinations that particular services are experimental and/or investigational or not Medically Necessary or appropriate.

An adverse benefit determination also includes a “rescission of coverage.” A “rescission of coverage” is a cancellation or discontinuance of coverage that has a retroactive effect, except to the extent it is attributable to administrative delays or failure to timely pay contributions towards the cost of coverage.

TYPES OF CLAIMS AND TIME PERIOD FOR PROCESSING. There are different kinds of Claims and each one has a specific timetable for either approval, payment, request for further information, or denial of the Claim. If you have any questions regarding this procedure, please contact the Plan Administrator. A period of time begins at the time the Claim is filed. “Days” means calendar days.

URGENT CARE CLAIM. A Claim involving Urgent Care is any Claim for medical care or treatment where using the timetable for a non-urgent care decision could seriously jeopardize the life or health of the Covered Person or the ability of the Covered Person to regain maximum function, or, in the opinion of the attending or consulting Physician, would subject the Covered Person to severe pain that could not be adequately managed without the care or treatment that is the subject of the Claim.

In the case of the Claim involving Urgent Care, the following timetable shows the maximum amount of time in which particular events generally must occur:

Filing a Claim

Event	Time Permitted
Notification to Covered Person of benefit determination (adverse or not)	72 hours
If there is insufficient information on the Claim, or the Covered Person has failed to follow the Plan's procedure for filing a Claim:	
Notification to Covered Person of deficiency, orally or in writing	24 hours
Response by Covered Person, orally or in writing	Not less than 48 hours
Benefit determination, orally or in writing	48 hours after receipt of additional information or expiration of Covered Person's time to respond
Ongoing courses of treatment, notification of:	
Reduction or termination before the end of treatment	72 hours
Determination as to extending course of treatment	24 hours
Review of adverse benefit determination	72 hours

If there is an adverse benefit determination on a Claim involving Urgent Care, a request for an expedited appeal may be submitted orally or in writing by the Covered Person. All necessary information, including the Plan's benefit determination on review, may be transmitted between the Plan and the Covered Person by telephone, facsimile, or other similarly expeditious method.

PRE-SERVICE CLAIM. A Pre-Service Claim means any Claim for a benefit under the Plan where the Plan conditions receipt of the benefit, in whole or in part, on approval in advance of obtaining medical care. These are, for example, Claims subject to pre-certification or mandatory second opinions. Please see "MANAGED CARE" for further information about Pre-Service Claims.

In the case of a Pre-Service Claim, the following timetable shows the maximum amount of time in which particular events generally must occur:

Event	Time Permitted
Notification to Covered Person of benefit determination (adverse or not)	15 days
Extension due to matters beyond the control of the Plan	15 days
If there is insufficient information on the Claim:	
Notification to Covered Person of deficiency	15 days
Response by Covered Person	At least 45 days
Notification, orally or in writing, of failure to follow the Plan's procedures for filing a Claim	5 days
Ongoing courses of treatment, notification of:	
Reduction or termination before the end of treatment	15 days
Determination as to extending course of treatment	15 days
Review of adverse benefit determination	30 days

POST-SERVICE CLAIM. A Post-Service Claim means any Claim for a Plan benefit that is not a Claim involving Urgent Care or a Pre-Service Claim.

In other words, a claim that is a request for payment under the Plan for covered medical services already received by the Covered Person for which no prior approval was required. In the case of a Post-Service Claim, the following timetable shows the maximum amount of time in which particular events generally must occur:

Event	Time Permitted
Notification to Covered Person of benefit determination (adverse or not)	30 days
Extension due to matters beyond the control of the Plan	15 days
If there is insufficient information on the Claim:	
Notification to Covered Person of deficiency	15 days
Response by Covered Person	At least 45 days
Review of adverse benefit determination	60 days

NOTICE OF ADVERSE BENEFIT DETERMINATIONS. Except with Urgent Care Claims (in which event the notification may be given orally followed by written or electronic notification within three days of the oral notification), the Plan Administrator will provide written or electronic notification of any adverse benefit determination. The notice will set forth:

- 1) information sufficient to identify the claim involved (including the 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) the specific reason(s) for the adverse determination;
- 3) reference to the specific Plan provision(s) on which the determination was based;
- 4) a description of any additional material or information necessary for the Covered Person to perfect the Claim and an explanation of why such material or information is necessary;
- 5) a description of the available internal and external review procedures under the Plan (including information regarding how to initiate an appeal) and the time limits applicable to such procedures, including any expedited review procedures for urgent care Claims, as well as a statement regarding the Covered Person's right to bring an action under Section 502(a) of ERISA following an adverse benefit determination on review;
- 6) a statement that the Covered Person 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 Claim; and
- 7) contact information for any applicable office of health insurance consumer assistance.

In addition, if the adverse benefit determination was based on an internal rule, guideline, protocol, or other similar criterion, the specific rule, guideline, protocol, or criterion will be provided free of charge. If this is not practical, a statement will be included that such rule, guideline, protocol, or criterion was relied upon in making the adverse benefit determination and a copy will be provided free of charge to the Covered Person upon request.

Further, if the adverse benefit determination is based on the fact that the treatment was not Medically Necessary or the Experimental/Investigational exclusion or similar exclusion or limit was applied, an explanation of the scientific or clinical judgment for the determination, applying the terms of the Plan to the Covered Person's medical circumstances, will be provided. If this is not practical, a statement will be included that such explanation will be provided free of charge, upon request.

INTERNAL APPEAL OF ADVERSE BENEFIT DETERMINATION. When a Covered Person receives an adverse benefit determination, the Covered Person has 180 days following receipt of the notification in which to appeal the decision. Except as otherwise required by law, the right to appeal shall belong solely to the Covered Person seeking benefits, and may not be assigned, transferred or in any way conferred upon any other person or persons. Any such attempted assignment shall be void. Nothing in this Plan Document shall be construed to confer liability on the Plan, the Company or the Plan Administrator to any provider or assignee for medical care, treatment or other services provided to a Covered Person in the event of an attempted assignment of a Covered Person's right to appeal an adverse benefit determination.

A Covered Person may submit written comments, documents, records and other information relating to the Claim. If the claimant so requests, he or she will be provided, free of charge, reasonable access to, and copies of, all documents, records, and other information relevant to the Claim.

The review will take into account all comments, documents, records, and other information submitted by the Covered Person relating to the Claim, without regard to whether such information was submitted or considered in the initial benefit determination.

The review will not afford deference to the initial adverse benefit determination and will be conducted by a fiduciary of the Plan who is neither the individual who made the adverse determination nor a subordinate of that individual.

NOTICE OF ADVERSE DETERMINATION ON INTERNAL APPEAL. The Plan Administrator will provide written or electronic notification of an adverse benefit determination on appeal. The notice will set forth:

- 1) information sufficient to identify the claim involved (including the 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) the specific reason(s) for the adverse determination;
- 3) reference to the specific Plan provision(s) upon which the determination was based;
- 4) a statement that the Covered Person is entitled to receive, upon request and free of charge, reasonable access to, and copies of all document, records, and other information relevant to the Covered Person Claim for benefits;
- 5) a statement describing any additional mandatory or voluntary appeal required or offered by the Plan (including the opportunity for External Review, if applicable), the Covered Person's right to obtain information about such procedures, and a statement of the Covered Person's right to bring suit under ERISA Section 502(a);
- 6) contact information for any applicable office of health insurance consumer assistance; and
- 7) any other information required by law.

In addition, if the determination was based on an internal rule, guideline, protocol, or other similar criterion, the specific rule, guideline, protocol, or criterion will be provided free of charge.

If this is not practical, a statement will be included in the notice of adverse determination that such rule, guideline, or protocol was relied on in making the adverse benefit determination and a copy will be provided free of charge upon request.

Further, if the adverse benefit determination was based on Medical Necessity or experimental treatment or similar exclusion or limit, an explanation of the scientific or clinical judgment for the determination, applying the terms of the Plan to the Covered Person's medical circumstances, or a statement that such explanation will be provided free of charge upon request will be included in the notice of adverse determination.

EXTERNAL REVIEW PROGRAM. The External Review Program offers an independent review process to review the denial of a requested service or procedures or the denial of payment for a service or procedures. The process is available at no charge following the Covered Person's exhaustion of the internal appeals process described above provided the claim meets one of the following requirements:

- The appeal relates to a rescission of coverage (coverage that was cancelled or discontinued retroactively); or
- The Covered Person has received an unfavorable (or adverse) decision on appeal based on a medical judgment – *e.g.*, based on clinical reasons, the experimental treatment or similar exclusion or limit.

The External Review Program does *not* apply if the adverse benefit determination is based on an administrative determination, such as:

- eligibility;
- explicit benefit exclusions; or
- defined benefit limits.

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).

DEEMED EXHAUSTION OF INTERNAL CLAIMS PROCEDURES AND DE MINIMIS EXCEPTION TO THE DEEMED EXHAUSTION RULE. A Covered Person 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 Covered Person 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 Covered Person 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 Covered Person as long as the Plan Administrator demonstrates that the violation was for good cause or due to matters beyond the control of the Plan, the violation occurred in the context of an ongoing, good faith exchange of information between the Plan and the Covered Person, and the violation is not reflective of a pattern or practice of non-compliance.

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

STANDARD EXTERNAL REVIEW. Under the External Review Program, after a Covered Person has exhausted his or her internal appeals, the Covered Person may request an independent review of an adverse benefit determination. An adverse benefit determination related to an individual's failure to meet the Plan's eligibility requirements is not eligible for external review.

All requests for an external review must be made within four months of the date the Covered Person receives the 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 receipt of the notice. For example, if the date of receipt of the notice is October 30, because there is no February 30, the request must be filed by March 1. If the last filing date would fall on a Saturday, Sunday, or Federal holiday, the last filing date is extended to the next day that is not a Saturday, Sunday, or Federal holiday. The Covered Person, his or her treating Physician, or an authorized designated representative may request an external review by writing the Plan Administrator.

The Plan Administrator will review a request for external review within five business days of its receipt of the request to determine whether:

- the individual was covered under the Plan at the time the service was requested or provided;

- the adverse determination was based on medical judgment and does not relate to eligibility;
- the Covered Person has exhausted the Plan's internal appeals process, unless the Covered Person is not required to exhaust the internal appeals process due to the deemed exhaustion rule described above; and
- the Covered Person has provided all paperwork necessary to complete the external review.

The Plan Administrator will notify the individual in writing within one business day of the completion of its review, whether the adverse benefit determination is eligible for external review and if any additional information is required. If the request is not eligible for external review, the notification will include the reasons why it is not eligible and contact information for the Employee Benefits Security Administration (866-444-EBSA). If the request was incomplete, the notification will state the information or materials needed to complete the request, and the Covered Person must supply the information by the later of:

- 1) the last day of the 4-month filing period described above; or
- 2) 48 hours after receipt of the Plan Administrator's notification.

If the adverse benefit determination is eligible for external review, the Plan Administrator will forward the request to an Independent Review Organization (IRO) with which the Plan has contracted. The IRO will be chosen based on a rotating list of at least three approved IROs. The IRO acts as a fiduciary of the Plan with respect to the external reviews that are delegated to the IRO.

The IRO will provide the Covered Person with a written notification that it has received and accepted the request for external review, and give the Covered Person the opportunity to submit additional information within 10 business days. The Plan Administrator will provide the IRO any information and documentation it considered in making its adverse benefit determination. If a claimant supplies additional information to the IRO, the IRO will forward that information to the Plan Administrator, at which point the Plan Administrator may reconsider its adverse benefit determination.

The IRO will review the claim without giving deference to the Plan Administrator's prior decisions, and will take into account any additional information the claimant has supplied. In addition, in making its determination, the IRO may consider all documents and information provided, including, but not limited to, medical records, physician's recommendations, the terms of the Plan, appropriate practice guidelines, and the opinion of the IRO's clinical reviewer(s).

The IRO will render its decision within 45 days of its receipt of the request for review and will provide written notification to both the Covered Person and the Plan. This notification will include:

- a general description of the reason for the request for external review, including sufficient information to identify the claim;
- the date the IRO received the request for external review and the date of its decision;
- reference to the evidence or documentation considered in reaching its decision;
- the reason(s) for its decision, including any evidence-based standards that were relied on;
- a statement that the determination is binding except to the extent other remedies are available under state or federal law;
- a statement that judicial review may be available; and
- current contact information for any applicable office of health insurance consumer assistance or ombudsman.

If the decision of the IRO reverses the adverse benefit determination, the Plan will accept the decision and provide benefits for the service or procedure in accordance with the terms and conditions of the Plan. If the decision of the IRO confirms the Plan Administrator's adverse benefit determination, the Plan will not be obligated to provide benefits for the service or procedure.

After a final external review decision, the IRO must maintain records of all claims and notices associated with the external review process for 6 years, and make them available for review by the Covered Person and the Plan Administrator upon request, except if the disclosure would violate State or Federal privacy laws.

EXPEDITED EXTERNAL REVIEW. An adverse benefit determination may be eligible for an expedited external review if:

- The Covered Person has received an adverse benefit determination involving a medical condition for which the timeframe for completion of an expedited internal appeal (as described above) would seriously jeopardize the Covered Person's life or health, or his or her ability to regain maximum function and the Covered Person has filed a request for an expedited internal appeal, or
- The Covered Person has received an adverse benefit determination involving a medical condition for which the timeframe or completion of a standard external review would seriously jeopardize the Covered Person's life or health, or would jeopardize the Covered Person's ability to regain maximum function, or if the adverse benefit determination concerns an admission, availability of care, continued stay, or health care item or service for which the Covered Person received emergency services, but has not been discharged from a facility.

If a Covered Person makes a request for an expedited external review, the Plan Administrator will immediately review the request and provide a written notice of whether the Covered Person's adverse benefit determination is eligible for external review. If the adverse benefit determination is eligible for external review, the Plan Administrator will forward the request to an IRO (electronically, by telephone or fax, or by other similar manner) as described above under the 'Standard External Review' procedures, along with all documents and information it considered in making its adverse benefit determination.

The IRO will follow the review process described above, and render a decision within 72 hours after it receives the request for review. The IRO will provide a written confirmation of its decision to both the Covered Person and the Plan with 48 hours thereafter.

For more information regarding external appeal rights and the independent review process, contact the Plan Administrator under "VENDOR LISTING."

QUESTIONS ON CLAIMS CALL:

GROUP RESOURCES AT: (800) 749-9963
MONDAY THROUGH FRIDAY, BETWEEN 8:00 AM AND 5:00 PM EST.
OR VISIT OUR WEBSITE AT: www.groupresources.com

PRE-ADMISSION CERTIFICATION CONTACT:

PRIOR TO PRE-CERTIFICATION BY CIGNA, AN AUDIT NUMBER MUST BE OBTAINED VIA FAX BY CALLING (888) 620-1297. THIS SERVICE IS AVAILABLE 24 HOURS A DAY, SEVEN DAYS A WEEK.

PROOF OF LOSS. A Claim must be made no later than one year from the date of service unless the Covered Person was legally incapacitated. The Plan Administrator may require, as part of the proof, authorization to obtain medical and non-medical information.

PHYSICAL EXAMINATIONS. The Plan Administrator, at its expense, may have a Covered Person examined as often as reasonably necessary while any Claim is pending.

CLAIMS AND APPEALS TIMEFRAME EXTENSIONS DURING DECLARED NATIONAL EMERGENCY PERIODS. The Department of Labor, Department of Treasury and with concurrence of the Department of Health and Human Services, issued guidance / relief in April, 2020, that provides timeframe extensions to deadline otherwise in place for the Claims and Appeal processes, in response to declared national emergency periods (“Outbreak Period”). The Outbreak Period began on March 1, 2020, and will end 60 days after the announced end of the declared national emergency related to the COVID-19 (to be advised). Under the relief, the Outbreak Period timeframe must be disregarded in calculating timeframes that apply to Claims and Appeal deadlines that might otherwise apply.

TIME BAR TO LEGAL ACTION. No legal action may be commenced or maintained against the Plan prior to the Covered Person’s exhaustion of the claims procedures. In addition, no legal action may be commenced or maintained against the Plan more than 90 days after the Plan Administrator’s decision on review. However, the 90-day period is tolled for any period during which an External Review is pursued, and such tolling will end as of the date of a notice of a final external review decision.

MISCELLANEOUS PLAN PROVISIONS

AMENDMENT OR TERMINATION. The continued maintenance of the Plan is completely voluntary on the part of the Company and neither its existence nor its continuation shall be construed as creating any contractual right to or obligation for its future continuation. While the Company intends to continue the Plan indefinitely, it reserves the right at any time and for any reason, in its sole and absolute discretion, through the procedure of an execution of a document by any officer who is authorized, to curtail benefits under, or otherwise amend or terminate the Plan or any portion thereof, including, without limitation, those portions of the Plan outlining the benefits provided or the classes of Employees or Dependents eligible for benefits under the Plan.

PLAN ADMINISTRATOR DISCRETION. The Plan Administrator shall have the sole discretionary authority to construe the terms of the Plan and all facts surrounding Claims for benefits under the Plan and shall determine all questions arising in the administration, interpretation and application of the Plan, including, but not limited to, those concerning eligibility for benefits. Accordingly, benefits under this Plan shall be paid only if the Plan Administrator decides at its discretion that an applicant is entitled to them. All determinations of the Plan Administrator shall be conclusive and binding on all parties.

COMPLIANCE WITH FEDERAL LAWS. The terms of the Plan shall be construed and administered in a manner calculated to meet the requirements of the following laws, as the laws are applicable to this Plan:

- 1) Americans With Disabilities Act of 1990;
- 2) Family and Medical Leave Act of 1993;
- 3) Uniformed Services Employment and Reemployment Rights Act of 1994, as amended;
- 4) Health Insurance Portability and Accountability Act of 1996, as amended;
- 5) Personal Responsibility and Work Opportunity Reconciliation Act of 1996;
- 6) The Newborns' and Mothers' Health Protection Act of 1996;
- 7) The Mental Health Parity Act of 1996, as amended;
- 8) The Women's Health and Cancer Rights Act of 1998;
- 9) The U.S. Trade Promotion Authority Act of 2002;
- 10) The Working Families Tax Relief Act of 2004 (H.R.1308);
- 11) The Genetic Information Non-Discrimination Act of 2008;
- 12) The Paul Wellstone and Pete Domenici Mental Health Parity and Addiction Equity Act of 2008;
- 13) The American Recovery and Reinvestment Act of 2009, as amended (the "HITECH Act");
- 14) The Children's Health Insurance Program Reauthorization Act of 2009;
- 15) The Patient Protection and Affordable Care Act of 2010;
- 16) The Trade Adjustment Assistance Extension Act of 2011;
- 17) The requirements of the final modifications to the HIPAA Privacy, Security, Enforcement and Breach Notification Rules (75 Fed. Reg. 5566 (Jan. 25, 2013));
- 18) The Coronavirus Aid, Relief and Economic Security Act of 2020 (the "CARES Act"); and
- 19) The No Surprises Act of 2021.

To the extent a Plan provision is contrary to or fails to address the minimum requirements of these laws, the Plan shall provide the coverage or benefit necessary to comply with the minimum requirements thereof.

PATIENT PROTECTION AND AFFORDABLE CARE ACT. This Plan believes it is a “non-grandfathered health plan” under the Patient Protection and Affordable Care Act (the ‘Affordable Care Act’).

NON-DISCRIMINATION. Notwithstanding anything in the Plan to the contrary, the Plan may not discriminate against any individual or a Dependent of that individual with respect to health coverage on the basis of a health factor. Further, the Plan shall not (a) adjust premium contribution amounts based on genetic information, (b) request or require an individual or family member of an individual to undergo a genetic test (except in certain circumstances related to research), or (c) request, require, or purchase genetic information with respect to any individual prior to the individual’s enrollment in the Plan or coverage in connection with enrollment in the Plan.

CONTINUITY OF CARE. In the event a Covered Person 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 Covered Person shall have the following rights to continuation of care.

The Plan shall notify the Covered Person in a timely manner, but in no event later than seven calendar days after termination that the Provider’s contractual relationship with the Plan has terminated, and that the Covered Person has rights to elect continued transitional care from the Provider. If the Covered Person 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 Covered Person ceases to be a continuing care patient, whichever is sooner.

For purposes of this provision, “continuing care patient” means a Covered Person 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, Plan benefits will be processed as if the termination had not occurred, however, the Provider may be free to pursue the Covered Person for any amounts above the Plan’s benefit amount.

NO SURPRISES ACT – EMERGENCY SERVICES AND SURPRISE BILLS. For Non-Network claims subject to the No Surprises Act (“NSA”), Covered Person 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 Allowable Expense was the Recognized Amount, regardless of the Plan’s actual Maximum Allowable Charge.

The NSA prohibits Providers from pursuing Covered Persons 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:

- 1) Emergency Services;
- 2) Non-emergency services rendered by a Non-Network Provider at a Participating Health Care Facility, provided the Covered Person has not validly waived the applicability of the NSA; and
- 3) Covered Non-Network air ambulance services.

SEVERABILITY. If any provision, or any portion thereof, contained in this Plan is held to be unconstitutional, illegal, invalid, or unenforceable, the remainder of this Plan shall not be affected and shall remain in full force and effect.

ASSIGNABILITY. Amounts payable at any time may be used to make direct payments to health care Providers. Except as applicable law may otherwise require, no amount payable at any time hereunder shall be subject in any manner to alienation by anticipation, sale, transfer, assignment, bankruptcy, pledge, attachment, charge, or encumbrance of any kind. Any attempt to alienate, sell, transfer, assign, pledge, attach, charge, or otherwise encumber any such amount, whether presently or hereafter payable, shall be void. The Plan shall not be liable for or subject to the debts or liabilities of any person entitled to any amount payable under the Plan, or any part thereof.

No appeal rights granted to the Covered Person in this Plan may be assigned, transferred, or in any way made over to another party by a Covered Person. Nothing contained in the written description of the medical coverage shall be construed to make the Plan liable to any third-party to whom a Covered Person may be liable for medical care, treatment, or services.

NATIONAL CORRECT CODING INITIATIVE. Where not otherwise specified, this Plan follows National Correct Coding Initiative ("NCCI") for coding, modifiers, bundling/unbundling, and payment parameters. Other guidelines may be applicable where NCCI is silent. The Plan Administrator has full discretionary authority to select guidelines and/or vendors to assist in determinations.

FIDUCIARY. A fiduciary exercises discretionary authority or control over management of the Plan or the disposition of its assets, renders investment advice to the Plan or has discretionary authority or responsibility in the administration of the Plan.

FIDUCIARY DUTIES. A fiduciary must carry out his or her duties and responsibilities for the purpose of providing benefits to the Employees and their Dependent(s) and defraying reasonable expenses of administering the Plan. These are duties that must be carried out:

- 1) with care, skill, prudence and diligence under the given circumstances that a prudent person, acting in a like capacity and familiar with such matters, would use in a similar situation;

- 2) by diversifying the investments of the Plan so as to minimize the risk of large losses, unless under the circumstances it is clearly prudent not to do so; and
- 3) in accordance with the Plan documents to the extent that they agree with ERISA.

THE NAMED FIDUCIARY. A “named fiduciary” is a fiduciary named in the Plan. A named fiduciary can appoint others to carry out fiduciary responsibilities (other than as a trustee) under the Plan. These other persons become fiduciaries themselves and are responsible for their acts under the Plan. To the extent that the named fiduciary allocates its responsibilities to other persons, the named fiduciary shall not be liable for any act or omission of such person unless either:

- 1) the named fiduciary has violated its stated duties under ERISA in appointing the fiduciary, establishing the procedures to appoint the fiduciary or continuing either the appointment or the procedures; or
- 2) the named fiduciary breached its fiduciary responsibility under Section 405(a) of ERISA.

ADMINISTRATIVE SERVICE AGENT IS NOT A FIDUCIARY. The Administrative Service Agent is not a fiduciary under the Plan by virtue of paying claims in accordance with the Plan’s rules as established by the Plan Administrator.

PLAN INFORMATION

Name of the Plan: Prince Avenue Baptist Church & School
Employee Health Benefit Plan

Name, address, and telephone number of the Plan Sponsor and Plan Administrator:

Prince Avenue Baptist Church & School
2131 Ruth Jackson Road
Bogart, GA 30622
(678) 753-3100

Employer Identification Number (EIN): Church 58-0637021
School 01-0548823

Plan Number: 501

Type of Plan: Self-Funded welfare benefit plan providing health and hospitalization benefits. Claims under the Plan are paid solely from the general assets of the Company. While the Company may obtain insurance to limit its losses under the Plan, no insurance protects any of the benefits or Claims under this Plan.

Name, address, and telephone number of the Administrative Service Agent:

Group Resources
2675 Breckenridge Blvd.
Suite 300
Duluth, GA 30096
(800) 749-9963

The designated agent for service of legal process is:

Prince Avenue Baptist Church & School
2131 Ruth Jackson Road
Bogart, GA 30622

Service of legal process may also be served upon the Plan Trustee or the Plan Administrator.

Names and addresses of the Plan's Trustees:

Prince Avenue Baptist Church & School
2131 Ruth Jackson Road
Bogart, GA 30622

Claims Administration:

The plan is administered by the Plan Administrator, with Group Resources, an Administrative Service Agent, acting as Claims paying agent.

Plan Funding:

Company and Employee contributions cover the cost of the Plan. Company contributions and any Employee pre-tax contributions withheld by way of payroll deduction are held by the Company and used to pay Plan benefits. All Employee contributions to the Plan shall be withheld from the Employee's paycheck on a pre-tax basis unless the Employee requests, in writing to the Plan Administrator, that the required contributions be withheld on an after-tax basis. Any after-tax Employee contributions may be held in trust by the trustee. The amount of all such contributions is actuarially determined where necessary.

The Plan fiscal year ends on:

August 31