AXIOM staffing group

Hospital Indemnity

Employee Benefit Plan

Summary Plan Description

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Plan Document

CONCIERGE Third Party Administrator

AXIOM STAFFING GROUP, INC.

HOSPITAL INDEMNITY PLAN

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AXIOM STAFFING GROUP, INC.

HOSPITAL INDEMNITY PLAN

PLAN INTRODUCTION

This document serves as the Summary Plan Description and controlling Plan Document, as required by the Employee Retirement Income Security Act of 1974, 29 U.S.C. et seq. (ERISA), for the Hospital Indemnity Plan, an Employee Benefit Plan, and will herein be referred to as the "Plan". This Plan is considered an excepted benefit and therefore, HIPAA Portability Rules and ACA requirements are not required. This coverage does not qualify for exemption under the Individual Mandate of the ACA. Any wording which may be contrary to Federal Laws or Statutes is hereby understood to meet the standards set forth in such. Also, any changes in Federal Laws or Statutes which could affect the Plan are also automatically a part of the Plan, if required.

All eligible individuals who apply and are accepted as members of the Plan agree to abide by all terms and conditions set forth in this document. It is the Employee's responsibility to read this document and share it with any Dependents covered by the Plan.

The Plan is an ERISA health and welfare plan and the responsibility for the administration of the Plan is with the Plan Administrator. For the name, address and other important information regarding the Plan Administrator, refer to the Information Section of this Plan Document. Concierge Administrative Services is the Benefits Administrator for the Plan. For questions regarding claims processing and benefit information, contact the Benefits Administrator at:

Concierge Administrative Services
P.O. Box 4070
Bartlesville, OK 74006
Toll-Free: 888.820.5687
Fax: 918.333.9505
Email: www.cbscas.com

The Plan Administrator reserves the right to terminate or modify the provisions of this Plan at any time without notice or the consent of any person. Such termination or modification will be made in writing and communicated to Plan Members by the Plan Administrator. The Plan Document shall not be deemed to constitute a contract of any type between the Employer and any Plan Member or to be consideration for, or an inducement or condition of, the employment of any Employee. Nothing in this Plan Document shall be deemed to give any Employee the right to be retained in the service of the Employer or to interfere with the right of the Employer to discharge any Employee at any time; provided, however, that the foregoing shall not be deemed to modify the provisions of any collective bargaining agreements which may be entered into by the Employer with the bargaining representatives of any Employees.

PARTICIPATING PROVIDER NETWORKS

Although it is not required to use a First Health, Limited Benefit Plan, PPO participating provider for the Indemnity benefits outlined below, the Plan Member may receive discounts on their services by using a First Health, Limited Benefit Plan, PPO provider. You can visit the Network website at www.firsthealthlbp.com or call 1-800-226-5116 for a list of in network providers.

SUMMARY OF BENEFITS

This summary of benefits is intended to provide an outline of the benefits provided in the Hospital Indemnity Plan. This Plan is considered an excepted benefit and therefore, HIPAA Portability Rules and ACA requirements are not required. This coverage does not qualify for exemption under the Individual Mandate of the ACA. See the specific benefit under the Covered Hospital Indemnity Benefits and Prescription Drug sections as well as the Medical and Prescription Exclusions and Limitations sections in the Plan Document for complete benefit details.

The Plan will pay the maximum amounts shown for the specific Eligible Expenses for in network or out of network providers. Although it is not required to use a First Health, Limited Benefit Plan, PPO participating provider for the Indemnity benefits outlined below, the Plan Member may receive discounts on their services by using a First Health, Limited Benefit Plan, PPO provider. You can visit the Network website at www.firsthealthlbp.com or call 1-800-226-5116 for a list of in network providers.

The Plan will pay the providers for the charges incurred up to the visit limit maximum amount. If the providers allowable charge is less than the maximum visit amount, the remaining benefit amount will be paid to the Plan Member. If the provider allowable charge is more than the maximum visit amount, the remaining charges will be the Plan Members responsibility. Any services not specifically stated in this document as an Eligible Expense or any service where the Benefit Year maximum visit limit/monthly prescription limit has been met, will also be the Plan Members responsibility.

OUTPATIENT BENEFITS

Benefit Description	Plan Pays	Benefit Year Visit/Service Limit per Plan Member	Additional Limitations and Explanations
Office Visits – Physician – Specialist Physician – Urgent Care Physician	$50 per day	6 days for Physician, Specialist Physician and Urgent Care Physician Office Visits combined.	Benefit includes the Physician office visit charge only to diagnose or treat an accident or illness.
Diagnostic Lab Tests	$20 per day	2 days	Benefit does not include the professional reading of the test. Lab must be performed to diagnose or treat an accident or illness.
Select Diagnostic Tests Includes: – Simple X-rays – Ultrasound – EEG – Sleep Study	$100 per day	1 day	Benefit does not include the professional reading of the test. Select Diagnostic Test must be performed to diagnose or treat an accident or illness.
Advanced Studies Diagnostic Tests Includes: – CT Scan – MRI – Myelogram – PET – Angiogram – Arteriogram – Thallium Stress Test	$400 per day	1 day	Benefit does not include the professional reading of the test. Advanced Studies Diagnostic Tests must be performed to diagnose or treat an accident or illness.

Benefit Description	Plan Pays	Benefit Year Visit/Service Limit per Plan Member	Additional Limitations and Explanations
Emergency Room – Illness Only	$200 per day	4 days	Benefit includes the Emergency Room visit to diagnose or treat an Illness. Services due to an accident related injury are not covered by this benefit.

INPATIENT & OUTPATIENT SURGERY BENEFITS

Benefit Description	Plan Pays	Benefit Year Visit/Service Limit per Plan Member	Additional Limitations and Explanations
Inpatient Surgery	$1,000 per day	1 day	Surgery must be Medically Necessary.
Major Outpatient Surgery	$500 per day	1 day	A Major Outpatient Surgery involves an organ within the cranium, chest, abdomen, or pelvic cavity. Surgery must be Medically Necessary.
Minor Outpatient Surgery	$100 per day	1 day	A Minor Outpatient Surgery is all surgeries not included as a Major Outpatient Surgery. Surgery must be Medically Necessary.
Anesthesia Charges – Inpatient Surgery – Outpatient Surgery • Minor Surgery • Major Surgery	20%	The inpatient or outpatient surgery must be covered by the Plan for the Anesthesia to be covered.	

HOSPITAL CONFINEMENT BENEFITS: Benefits do not include mental or substance related Hospital confinements.

Benefit Description	Plan Pays	Benefit Year Visit/Service Limit per Plan Member	Additional Limitations and Explanations
Hospital Confinement- Day 1	$500 per day	1 day	Plan Member must be confined to a Hospital for over 23 hours per day (not emergency room, outpatient stay or stay in an observation unit) as a result of a covered accident or sickness.
Hospital Confinement- Day 2+	$100 per day	31 days	

PRESCRIPTION BENEFITS:

Benefit Description	Plan Pays	Limit per Plan Member	Additional Limitations and Explanations
Generic Prescription	$15 per day	2 days per month for Generic or Brand Name Prescriptions combined.	Prescriptions must be for the treatment of an illness or injury and not for preventive care.
Brand Name Prescription	$30 per day		

DEDUCTIBLES/CO-PAYS/BENEFIT YEAR VISIT LIMITS/OUT-OF-POCKET MAXIMUM

Benefit Year Deductible: The Benefit Year Deductible is the amount of Eligible Expense the Plan Member pays for covered health services per Benefit Year before the Plan Member is eligible to receive benefits. There are no deductibles that the Plan Member must meet in this Plan.

Co-pay: A Co-pay is the amount the Plan Member pays each time they receive certain covered benefits. There are no Co-pays in this Plan.

Benefit Year Visit/Service Limit: The Benefit Year Visit/Service Limit is a set number of visits that may be used each Benefit Year per enrolled Plan Member. Visits that exceed the listed Benefit Year Visit/Service Limit will not be covered by the Plan. The prescription benefits are a monthly limitation.

Out-of-Pocket Maximum: This Plan is a limited benefit Plan that does not contain an out-of-pocket maximum benefit.

Benefit Year: Is a twelve-month period during which the Benefit Year Visit Limit is applicable. The Benefit Year begins January 1st and ends December 31st of each year.

COVERED HOSPITAL INDEMNITY BENEFITS

This Plan is considered an excepted benefit and therefore, HIPAA Portability Rules and ACA requirements do not apply. This coverage does not qualify for exemption under the Individual Mandate of the ACA. Note the benefits below as well as the Medical Exclusions and Limitations Section of this document for complete benefit details.

The Plan will pay the maximum amounts shown for the specific Eligible Expenses for in network or out of network providers. Although it is not required to use a First Health, Limited Benefit Plan, PPO participating provider for the Indemnity benefits outlined below, the Plan Member may receive discounts on their services by using a First Health, Limited Benefit Plan, PPO provider. You can visit the Network website at www.firsthealthlbp.com or call 1-800-226-5116 for a list of in network providers.

The Plan will pay the providers for the charges incurred up to the visit limit maximum amount. If the providers allowable charge is less than the maximum visit amount, the remaining benefit amount will be paid to the Plan Member. If the provider allowable charge is more than the maximum visit amount, the remaining charges will be the Plan Members responsibility. Any services not specifically stated in this document as an Eligible Expense or any service where the Benefit Year maximum visit limit/monthly prescription limit has been met, will also be the Plan Members responsibility.

OUTPATIENT BENEFITS

Office Visits: The Plan will pay $50 per day for Physician, Specialist Physician or Urgent Care Physician office visits up to a 6-day combined maximum per Benefit Year per Plan Member. The benefit includes the Physician office visit charge only and must be rendered to diagnose or treat an accident or illness.

Diagnostic Lab Tests: The Plan will pay $20 per day for outpatient Diagnostic Lab Tests up to a 2-day maximum per Benefit Year per Plan Member. The benefit does not include the professional reading of the test. The lab must be performed to diagnose or treat an accident or illness.

Select Diagnostic Tests: The Plan will pay $100 per day for one of the tests listed below per Benefit Year per Plan Member. Benefit Year maximum is 1-day (benefit includes one of the tests listed below and not one of each test each Benefit Year). The benefit does not include the professional reading of the test. The testing must be performed to diagnose or treat an accident or illness. The Select Diagnostic Tests are limited to:

- Simple X-Rays
- Ultrasound
- EEG
- Sleep Study

Advanced Studies Diagnostic Tests: The Plan will pay $400 per day for one of the tests listed below per Benefit Year per Plan Member. Benefit Year maximum is 1-day (benefit includes one of the tests listed below and not one of each test each Benefit Year). The benefit does not include the professional reading of the test. The test must be performed to diagnose or treat an accident or illness. The Advanced Studies Diagnostic Tests are limited to:

- CT Scan
- MRI
- Myelogram
- PET
- Angiogram
- Arteriogram
- Thallium Stress Test

Emergency Room (Illness Only): The Plan will pay $200 per day for an Emergency Room visit up to a maximum of 4-days per Benefit Year per Plan Member. Benefit includes the Emergency Room visit to diagnose or treat an Illness. Services due to an accident related injury are not covered by this benefit.

INPATIENT & OUTPATIENT SURGERY BENEFITS

Inpatient Surgery: The Plan will pay $1,000 per day to a Benefit Year maximum of 1-day per Plan Member. The surgery must be Medically Necessary.

Major Outpatient Surgery: The Plan will pay $500 per day to a Benefit Year maximum of 1-day per Plan Member. Major Outpatient Surgery is defined as a surgery involving an organ within the cranium, chest, abdomen, or pelvic cavity. The surgery must be Medically Necessary.

Minor Outpatient Surgery: The Plan will pay $100 per day to a Benefit Year maximum of 1-day per Plan Member. A Minor Outpatient Surgery is defined as all surgeries not included in the definition of a Major Outpatient Surgery. The surgery must be Medically Necessary.

Anesthesia Charges: The Plan will pay 20% of the anesthesia charges for any inpatient or outpatient surgeries that are covered by the Plan. Once the maximum benefit is met on the surgeries, the Anesthesia benefit will not be eligible.

HOSPITAL CONFINEMENT BENEFITS

A Plan Member must be confined to a Hospital for over 23 hours per day (not emergency room, outpatient stay or stay in an observation unit) as a result of a covered accident or sickness. Benefits do not include mental or substance related Hospital confinements.

Hospital Confinement- day 1: The Plan will pay $500 per day to a Benefit Year maximum of 1-day per Plan Member.

Hospital Confinement- day 2+: The Plan will pay $100 per day to a Benefit Year maximum of 31 days per Plan Member.

NOTICES

Mental Health Parity Act (MHPA) of 1996 and the Mental Health Parity and Addiction Equity Act of 2008 (MHPAEA): This Plan does not include any mental health or substance abuse treatment benefits.

The WHCRA (Women's Health and Cancer Rights Act of 1998): This Plan is a limited benefit plan and only the specific benefits stated in this Plan are covered up to the limits specified per benefit.

Newborns' and Mothers' Health Protection Act Notice: This Plan is a limited benefit plan and only the specific benefits stated in this Plan are covered up to the limits specified per benefit. No pre-authorizations are required.

Genetic Information Nondiscrimination Act "GINA": "GINA" prohibits group health plans, issuers of individual health care policies, and Employers from discriminating based on genetic information. See the Definitions section for more details.

MEDICAL EXCLUSIONS AND LIMITATIONS

The following are exclusions and limitations for which the Plan does not pay benefits, and these shall apply to services described herein:

Abortions: Abortions are not a covered benefit, unless the life of the mother is endangered by the continued pregnancy;

Acupuncture: Acupuncture and other forms of alternative medicine or the admissions for such treatment;

Alcohol or Drugs: Injuries or illness where the use of alcohol or chemical substance(s) may have been a contributing factor in the accident (unless defined by HIPAA). This exclusion would apply if the alcohol or chemical substance was used in excess of a state or federal regulation. The Plan Administrator reserves the right to determine whether

this exclusion applies based on the facts and circumstances, even if a citation or charge is not issued by a government authority;

Armed Forces: Injuries occurring while engaged in the services of any branch of the United States Armed Forces, state militia, or foreign nation, or in any act of war whether declared or undeclared;

Charges for which Payment is not Required: Charges which the Plan Member is not legally obliged to pay;

Chiropractic Care: Manipulative services are not covered by the Plan;

Complications of Non-Covered Treatments: Includes care, services or treatment required as a result of complications from a treatment not covered under the Plan;

Contraceptives: All over the counter male contraceptives and any female contraceptives that are not FDA approved;

Cosmetic Surgery and Treatment: Charges in connection with surgery, or any other type of treatment primarily for the purpose of improving appearance, including complications resulting within 24 months from cosmetic surgery and treatment, are not covered under the Plan. However, this exclusion does not apply if the surgery or treatment is due to injuries sustained in an accident nor will it apply to medically necessary procedures or treatments related to cosmetic surgery or treatments provided more than 24 months after any cosmetic surgery and treatment;

Dental Services: Dental services are not covered by the Plan;

Educational or Training Care: Charges for educational or training care are not covered. Educational or training care means care which is provided mainly for purposes of education, training or vocational rehabilitation, unless recommended by the Patient Protection and Affordable Care Act;

Exercise: Exercise or Wellness programs are not covered by the Plan;

Experimental or Investigational Care: Charges for expenses for treatments, procedures, devices or drugs which the Plan determines are experimental, investigational or done primarily for research, unless defined under the Covered Medical Benefits Section of this document.

Family or Behavioral Counseling: Charges in connection with family or behavioral counseling, including, but not limited to marital counseling, sex counseling, anger management, and programs intended to improve social behavior;

Foot Care: Charges for the following are not covered- treatment of weak, strained or flat feet, or instability or imbalance of the feet; any metatarsalgia or bunion; orthopedic shoes and other supportive devices. Also, charges for cutting, removal or treatment of corns, calluses or toenails are not covered unless needed because of diabetes or other similar diseases.

Government Services: Charges for medical care furnished by or paid for by any government or government agency are not covered. However, this exclusion will not apply where prohibited by law;

Hair Loss Treatment: Including hair restoration, drugs promoting hair growth and wigs;

Hazardous Pursuit, Hobby or Activity: Any Injury or Sickness that results from engaging in a hazardous pursuit, hobby or activity. A pursuit, hobby or activity is hazardous if it involves or exposes an individual to risk of a degree

or nature not customarily undertaken during the Plan Member's customary occupation or if it involves leisure time activities commonly considered as involving unusual or exceptional risks, characterized by a constant threat of danger or risk of bodily harm **including but not limited to:** hang gliding, skydiving, bungee jumping, automobile racing, and professional team sports;

Hearing Care: Charges for hearing aids or their fitting are not covered;

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

Infertility: Charges made for procedures which promote fertility or testing, or other services related to the treatment of infertility are not covered. These include, but are not limited to, hormone therapy, artificial insemination, in vitro fertilization, embryo transfer and Gamete Intra-Fallopian Transfer (GIFT); and reversal of surgical sterilizations;

Inpatient Hospital Services;

Medical Records: To include payment for any records or documents associated with a determination of eligible charges or any appeal by a Plan Member;

Medically Unnecessary: Charges for the care or treatment of medically unnecessary care or treatment of an illness or injury;

Medicare: Benefits that are provided, or which would have been provided had the Plan Member enrolled, applied for, or maintained eligibility for such care and service benefits, under Title XVIII of the Federal Social Security Act of 1965 (Medicare), including any amendments thereto, or under any Federal law or regulation, except as provided in the sections entitled "Coordination of Benefits" and "Medicare;"

Non-Insured Charges: Charges which would not have been made had no coverage existed;

Non-Physician Care: Charges for care or services not provided by a licensed Physician or Nurse Practitioner;

Occupational Injury/Sickness: Any condition, Illness, Injury or complication thereof arising out of or in the course of employment, including self-employment, or an activity for wage or profit. Claims would be considered for payment if denied by workers' compensation and otherwise an Eligible Expense of the Plan;

Other Charges: Charges for services or non-Physician consultations, missed appointments, requests for reports or filling out claim forms;

Personal Comfort Items: Television, telephone, air conditioning, humidifiers, physical fitness equipment and items generally useful outside the Hospital are not covered by the Plan;

Physician Care: Physician care which is not within the scope of his/her license;

Routine Services: Charges for routine services not required by the Patient Protection and Affordable Care Act;

Self-Inflicted Injuries or Illnesses: Services that are the result of intentionally self-inflicted Injuries or Illnesses. This exclusion does not apply (a) if the Injury resulted from being the victim of an act of domestic violence, or (b) resulted from a documented medical condition (including both physical and mental health conditions);

Services by a Relative: Charges for medical care furnished by any of the following persons: the Plan Member's Spouse, parent, child, grandparent, brother, sister or parent-in-law are not covered;

Services not specifically stated: Charges not specifically stated under the Covered Indemnity Benefits or Prescription Drug sections of this Plan Document;

Services Outside the United States: Charges for medical care outside the United States are not covered where the Plan Member can reasonably receive treatment within the United States or its territories. This exclusion will not apply to a person traveling on vacation or holiday, a person working in a foreign country, or a foreign exchange student;

Sex Change: Charges for sex change operations, and any treatment or counseling in preparation for or in connection with such operations, are not covered;

Sexual Dysfunctions: To include charges related to any services or prescriptions for sexual dysfunctions or inadequacies (unless organic in nature) and charges related to changing the sex of an individual;

Telephone Charges: Telephone consultations;

Therapy Charges: Charges for all types of therapy;

Travel or Accommodations: Travel and accommodations are not covered by the Plan;

U.S. Government Charges: Services or supplies furnished by an agency of the federal, state, or local government, or a foreign government agency, unless required by law;

Vision Care; unless required by the Patient Protection Affordable Care Act;

Vocational Rehabilitation: Vocational Rehabilitation under any name is not covered by the Plan;

Weight Reduction/Control: Charges for treatment of obesity, instructions, activities or drugs (including diet pills) for weight reduction or control are not covered, unless provided under the Patient Protection and Affordable Care Act.

PRESCRIPTION DRUGS

The Plan will pay $15 per day for generic prescriptions and $30 per day for brand name prescriptions to a combined maximum of 2-days per month per Plan Member. Prescriptions must be for the treatment of an illness or injury and not for preventive care.

Medicare Part D: Certain Medicare regulations require the Plan Sponsor to inform Plan Members who are eligible for Medicare benefits that their health Plan meets or does not meet the creditable coverage requirement of Medicare Part D. The Plan Member who is Medicare eligible should be advised that the Plan has determined that the prescription drug coverage of the Plan is non-creditable. The Plan will provide notice of creditable/non-

creditable coverage beyond the one found in this Section: (1) before the effective date of coverage for any Medicare eligible individual who joins the Plan; (2) whenever prescription drug coverage ends or changes so that it is no longer creditable or becomes creditable; and (3) upon a beneficiary's request for a copy of the notice.

PRESCRIPTION DRUG EXCLUSIONS

All the limitations and exclusions of the medical benefit program also apply. The Plan has the right to deny benefits for any drug prescribed or dispensed in a manner that does not agree with normal medical or pharmaceutical practice. The following prescription drug and services are excluded from benefit payments under the Plan:

- Infertility drugs;
- Prescriptions for sexual dysfunctions to include charges related to changing the sex of an individual and any services or prescriptions for sexual dysfunctions or inadequacies, unless organic in nature;
- Prescriptions which can be used for abortion are not a covered benefit, unless the life of the mother is endangered by the continued pregnancy or the pregnancy is the result of rape or incest
- Anorexiants;
- Therapeutic devices or appliances;
- Drugs approved for experimental use only;
- Immunization agents except as specifically approved for pneumonia, influenza and Zoster (shingles) immunizations;
- Biological sera;
- Blood or blood plasma;
- Growth hormones;
- Dietary supplements;
- Hair growth medication;
- Accutane/Retin-A for a Plan Member over the age of 25;
- Beauty aids or cosmetics;
- Support garments and other non-medical substances;
- Prescription vitamins, unless provided under the Patient Protection and Affordable Care Act;
- Drugs which can be purchased without a prescription;
- Prescriptions which an eligible person is entitled to receive without charge under any worker's compensation law, or any municipal, state, or federal program;
- Those for which normally (in professional practice) there is no charge;
- Charges for delivering any drugs.

PLAN ELIGIBILITY AND MEMBERSHIP

Who is Eligible to Participate: Participation in the Plan shall be limited to the following categories:

- All active regular, Full-Time Employees who are scheduled to work at least 30 hours a week on an annual basis who have completed an approved application form, and who meet the Actively-At-Work requirement.

- Employees who are inactive for thirteen (13) consecutive weeks will be treated as a new hire.

- A Dependent of an eligible Employee, as defined in the Plan and by the Health Insurance Portability and Accountability Act of 1996 (HIPAA) regulations, in addition to Dependents designated as Alternate Recipients under Qualified Medical Child Support Orders.

- An Employee Plan Member on an official company approved Leave of Absence, to include the Family Medical Leave Act (FMLA) as defined by the Employer's policy.

- A terminated Plan Member who subsequently enrolled as a COBRA Plan Member.

- All Plan Members must be full-time residents of the U.S. residing within the 50 states or a U.S. territory.

Waiting Period: Employee and any eligible Dependents are effective for coverage on the Monday following a full week of eligible work hours and the deduction file is received by the Claims Administrator from the Employer.

New Members and First Enrollment Period: The eligible employee must elect to participate in the Plan by completing the required enrollment application form. The application form must be signed and submitted for the coverage tier available by the Employer within 31 days after becoming eligible. If the application is approved, coverage will begin at 12:01 a.m. following the Waiting Period.

Special Enrollment: Special enrollment rules shall apply to individuals who are eligible but not enrolled for coverage in this Plan where the individual loses coverage in another health plan, COBRA coverage is exhausted, the employer stops paying the contributions, or the plan no longer offers benefits to a class of individuals that include the Plan Member or Dependent. Special enrollment rules do not apply for loss of eligibility due to failure of the individual to pay premiums on a timely basis or termination of coverage for cause (e.g. making a fraudulent claim or intentional misrepresentation).

The employee Plan Member and Dependent have 31 days from the loss of the coverage to make an application to become members in this Plan. For an eligible person or Dependent who did not enroll during the initial enrollment period or the Open Enrollment period because they had existing health coverage under another plan, coverage begins on the day immediately following the day coverage under the prior plan ends. Coverage will begin only if the Plan receives the completed enrollment form and any required premium within 31 days of the date coverage under the prior plan ended.

If a Spouse is covered by their own employer group health plan and that employer group health plan has a different open enrollment period than this Plan, the Employee Plan Member and any Dependents on this Plan may choose to drop coverage in this Plan to join the Spouse's employer group health plan during the Spouse's open enrollment period. Coverage in this Plan will terminate on the day before the Spouse's employer group health plan's new plan year begins. Proof of enrollment in the Spouse's employer group health plan is required to terminate coverage in this Plan.

Additional Special Enrollment Rights: This Plan will permit employees and Dependents who are eligible but not enrolled for coverage to enroll in two additional circumstances:

1. The employee's or Dependent's Medicaid or CHIP coverage is terminated as a result of loss of eligibility and the employee requests coverage under the Plan within 60 days after the termination, or
2. The employee or Dependent become eligible for a premium assistance subsidy under Medicaid or CHIP, and the employee requests coverage under the Plan within 60 days after eligibility is determined.

Special Enrollment for New Dependents: If an eligible employee acquires a new Dependent and requests enrollment within 31 days after the event occurs, the effective date of coverage will be:

- on the date of marriage;
- at the date of the Dependent's birth;
- at the date of the Dependent's adoption or the date of placement of adoption;

- on the date of awarded legal guardianship;
- on the date specified on a court or administrative order.

Annual Enrollment: Employees and Dependents will be allowed to change some of their benefit decisions each year during the Plan's Annual Enrollment period. The Annual Enrollment period will be a designated time each year with coverage change effective January 1st.

Family Coverage: Family coverage includes the eligible employee, his or her Spouse and any married or unmarried Dependent children who qualify until they attain age 26 (coverage from newborn through age 25). Spouses and children of an adult Dependent child are not eligible under the Plan.
Disabled, unmarried Dependent children may be covered regardless of age. Proof of disability will be required for any Dependent over the age of 25. The disabled Dependent must not be able to be self-supporting because of mental or physical handicap or disability and who is dependent mainly on the Employee for support. The eligible employee must apply for Dependent coverage on a form provided by the Plan and agree in writing to pay the required contributions for Dependents. Coverage will continue as long as the Dependent is medically certified as disabled and dependent unless coverage is otherwise terminated in accordance with the terms of the Plan. Proof of disability must be provided within 31 days of the date coverage would otherwise end because the child reached a certain age. If proof of the child's disability and dependency is not provided within the 31 days as previous described, coverage for that child will end.

Who is a Dependent: A Dependent will include a Plan Member's Spouse (if not legally separated from the covered Plan Member). The term "Spouse" excludes non-married, same sex marriage, or common law Spouses, unless such relationship is recognized in statute or case law for a state of residence. Common law marriage must be documented as requested by the Benefit Administrator to include proof of an ongoing common law marriage relationship.

All Dependent's must reside within the United States. A Dependent will include the covered Plan Member's married or unmarried children by birth or marriage, including a stepchild, children by legal guardianship, legally adopted children and Dependent children placed for adoption as defined by a court order. If a husband and wife are both covered under the Plan as Plan Members, their Dependent children may be covered Dependents of either the husband or the wife but not both. Spouses and children of an adult Dependent child are not eligible under the Plan.

Adopted Child: A child who is adopted by the Plan Member under the state laws in which the member resides or placed with a Plan Member in anticipation of adoption, will be considered a Dependent for the purposes of enrollment in the Plan. To become and remain covered, proof of adoption or proof that the adoption legal process has commenced must be provided to the Plan, as requested.

Court Ordered Guardianship: The Plan will accept the application of a Dependent child who is under the legal guardianship of the Plan Member. The Plan will accept the application of such a child if the Plan Member can show that the child is a Dependent of the employee Plan Member, or if his or her Spouse has legal guardianship of the child. The enrollment will be treated as a Special Enrollment. The Plan will require proof of legal guardianship and Dependent status.

Court Order: If an Employee or the Employee's Spouse is required by court order to obtain coverage for a Dependent child due to divorce, the Dependent child listed on the court order will be allowed to enroll in the Plan on the date as specified in the court order. If the Employee is not currently covered by the Plan, the Employee will be added to the Plan along with the applicable Dependent child.

Dependent Child Coverage Ends: An eligible and enrolled Dependent child will be eligible for coverage from live birth until they attain age 26. Coverage will terminate the Sunday following the loss of eligibility date.

Qualified Medical Child Support Order: This Plan will provide Dependent coverage (to the extent such coverage is provided under the Plan) with no waiting period for any child of an employee who is recognized under an eligible Qualified Medical Child Support Order as having a right to enrollment in the group health option. Such coverage is contingent on the employee being enrolled in the Plan, completing the appropriate enrollment form and making the appropriate contribution for Dependent coverage. A copy of the QMCSO procedure may be obtained upon request at no cost to the Plan Member by the Employer.

Genetic Information Nondiscrimination Act "GINA": "GINA" prohibits group health plans, issuers of individual health care policies, and Employers from discriminating based on genetic information. See the Definitions section for more details.

Medicare and its Effect on the Plan: Coverage under this Plan is available to eligible employees age 65 and over and to their Spouse's age 65 and over under the same conditions as coverage available to eligible employees and their Spouse's under age 65. Nonetheless, persons over age 65 are entitled to select primary coverage under Medicare. To do so, he or she must decline all coverage under the Plan.

Medicare and Kidney Disease: Medicare may provide benefits for a covered member of this Plan who would have a kidney disease to include renal failure. The Plan will conform to the regulations and any waiting period which may be associated with the benefits. Plan Members should always check with his or her Social Security office for details.

Premium and Employee Contributions: The employer reserves the right to have employees contribute, in full or in part, Premiums to the Plan. Coverage for persons under COBRA is solely the responsibility of the Plan Member(s). Employees on unpaid Leave of Absence or other leave are responsible for paying their portion of the premiums to the Plan on a timely basis, as determined by the employer.

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

TERMINATION OF COVERAGE

Termination of Plan Membership: A Plan Member's coverage will terminate with the Plan for any one of the reasons outlined in this section. This termination language will apply to each class of eligible Employee or Dependents. Unless otherwise stated, a Dependent's coverage ends on the date the Employee's coverage ends.

1. Termination of Employment or Reduction in Hours. Coverage for the Employee and any Dependents will end on the third Sunday following the last deduction when the Employee is no longer considered an eligible Employee for benefits.

2. Employees who have a lapse of work for five consecutive weeks will be terminated on the Sunday following the five consecutive weeks.

3. Voluntary Termination of Coverage. Coverage will end on the third Sunday following the last deduction for a Plan Member who voluntarily ends coverage.

4. Dependent Eligibility and Notice. Coverage will end the Sunday following the loss of eligibility date in which the Dependent child ceases to be an eligible Dependent.

5. Employee Death. Dependents coverage will end on the Sunday following the death of the Employee Plan Member.

6. Legal Separation or Divorce. Coverage will end on the date designated by a court order.

7. Contributions. If the covered Plan Member or beneficiary fails to remit required contributions within thirty (30) days when such payment is due, then coverage will terminate at the end of the period for which a contribution is made.

8. Leave. At the end of a company approved Leave of Absence or the end of an approved period of disability.

9. COBRA. The day the COBRA Plan Member is no longer eligible for COBRA or after electing COBRA, the day the Plan Member becomes eligible for Medicare or another insurance plan (unless defined otherwise by federal regulations).

10. Military Duty. The date the Plan Member becomes a full-time member of the Armed Forces of any United States on a full-time active duty basis, or a government unit covered by or Uniformed Services Employment and re-employment Rights Act of 1993 (USERRA). Reserve duty, drills and summer camp shall be excluded from the definition of active duty unless such duty lasts over 30 days as defined by the act. Once eligibility in the Plan ends, the Plan Member and eligible Dependents may have continuation rights with the Plan under COBRA as defined by USERRA.

11. Plan Termination. The date the Plan is terminated.

Rescission of Coverage: Coverage under this Plan may be rescinded under certain circumstances. A determination by the Plan that a rescission is warranted will be considered an Adverse Benefit Determination for purposes of review and appeal. A Plan Member whose coverage is being rescinded will be provided a thirty (30) day notice period as described under Health Care Reform and regulatory guidance. Such notice shall be considered an Adverse Benefit Determination. At the conclusion of the thirty (30) day notice period, coverage shall be terminated retroactive to the date identified in the notification. Claims Incurred after the retroactive date of termination shall not be further processed and/or paid under the Plan. Claims Incurred after the retroactive date of termination that were paid under the Plan will be treated as erroneously paid claims under this Plan.

Rehiring a Terminated Employee: A terminated Employee who is rehired will be treated as a new hire and will be required to satisfy all of the Plan's eligibility requirements.

CONTINUATION OF COVERAGE

Employer Continuation Coverage: Continued coverage ***may*** be available for eligible Plan Members and their covered Dependents as provided by the Employer. Please contact the Plan Sponsor for further details regarding any continuation of coverage provisions that may apply. *

***Note:** For any Employer sponsored continuation of coverage that exists, coverage will be considered to run concurrently with COBRA continuation coverage.*

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

Family and Medical Leave Act of 1993 (FMLA): This applies to Employers with 50 or more Employees for at least 20 work weeks in the current or preceding calendar year. The following are some definitions identified by the FMLA:

Covered Service Member: Shall Mean current service members and covered veterans who are undergoing medical treatment, recuperation, or therapy due to a serious Injury or Illness, rather than just current service members. A covered veteran is an individual who was discharged or released under conditions other than dishonorable at any time during the five-year period prior to when the eligible Employee takes FMLA Leave to care for the covered veteran.

Eligible Employee: Shall mean an individual who has been employed by the Plan Sponsor for at least 12 months, has performed at least 1250 hours of service during the previous 12-month period, and has worked at a location where at least 50 Employees are employed by the Employer within 75 miles.

Family Member: Shall mean the (a) Employee's biological, step, or foster parent or (b) a natural, adopted, foster, or stepchild, or a legal ward under 18 years of age, or 18 years and older and incapable of self-care because of a mental or physical disability or (c) Spouse.

Serious Illness or Injury (of a service member of covered veteran): Shall mean an Illness or Injury Incurred in the line of duty that may render the service member medically unfit to perform his or her military duties. A serious Injury or Illness for a current service member includes an Injury or Illness that existed before the beginning of the service member's active duty and was aggravated by service in the line of duty on active duty in the armed forces. A serious Injury or Illness for a covered veteran means an Injury or Illness that was Incurred or aggravated by the service member in the line of duty on active duty in the armed forces and manifested itself before or after the service member became a veteran.

These definitions are listed as a guide and the actual wording of the FMLA, as amended, shall supersede these definitions.

Basic Leave Entitlement: FMLA requires covered Employers to provide up to 12 weeks of unpaid, job-protected leave to eligible Employees for the following reasons:

1. For incapacity due to pregnancy, prenatal medical care or childbirth;
2. To care for the Employee's child after birth, or placement for adoption or foster care;
3. To care for the Employee's Spouse, son, daughter or parent, who has a serious health condition; or
4. For a serious health condition that makes the Employee unable to perform the Employee's job.

Military Family Leave Entitlements: Eligible Employees whose Spouse, son, daughter or parent is on covered active duty or call to covered active duty status may use their 12-week leave entitlement to address certain qualifying exigencies. Qualifying exigencies may include attending certain military events, arranging for alternative childcare, addressing certain financial and legal arrangements, attending certain counseling sessions, and attending post-deployment reintegration briefings.

FMLA also includes a special leave entitlement that permits eligible Employees to take up to 26 weeks of leave to care for a covered service member during a single 12-month period. A covered service member is:

1. A current member of the Armed Forces, including a member of the National Guard or Reserves, who is undergoing medical treatment, recuperation or therapy, is otherwise in outpatient status, or is otherwise on the temporary disability retired list, for a serious Injury or Illness*; or
2. A veteran who was discharged or released under conditions other than dishonorable at any time during the five-year period prior to the first date the eligible Employee takes FMLA Leave to care for the covered veteran, and who is undergoing medical treatment, recuperation, or therapy for a serious Injury or Illness.

***Note:** The FMLA definitions of "serious Injury or Illness" for current service members and veterans are distinct from the FMLA definition of "serious health condition.")*

Benefits and Protections: During FMLA Leave, the Employer must maintain the Employee's health coverage under any "group health plan" on the same terms as if the Employee had continued to work. Upon return from FMLA Leave, most Employees must be restored to their original or equivalent positions with equivalent pay, benefits, and other employment terms.

Use of FMLA Leave cannot result in the loss of any employment benefit that accrued prior to the start of an Employee's leave.

Definition of Serious Health Condition: A serious health condition is an Illness, Injury, impairment, or physical or mental condition that involves either an overnight stay in a medical care facility, or continuing treatment by a health care Provider for a condition that either prevents the Employee from performing the functions of the Employee's job or prevents the qualified family member from participating in school or other daily activities.

Subject to certain conditions, the continuing treatment requirement may be met by a period of incapacity of more than 3 consecutive calendar days combined with at least two visits to a health care provider or one visit and a regimen of continuing treatment, or incapacity due to pregnancy, or incapacity due to a chronic condition. Other conditions may meet the definition of continuing treatment.

Use of Leave: An Employee does not need to use this leave entitlement in one block. Leave can be taken intermittently or on a reduced leave schedule when Medically Necessary. Employees must make reasonable efforts to schedule leave for planned medical treatment so as not to unduly disrupt the Employer's operations. Leave due to qualifying exigencies may also be taken on an intermittent basis.

Substitution of Paid Leave for Unpaid Leave: Employees may choose, or Employers may require use of accrued paid leave while taking FMLA Leave. In order to use paid leave for FMLA Leave, Employees must comply with the Employer's normal paid leave policies.

Employee Responsibilities: Employees must provide 30 days advance notice of the need to take FMLA Leave when the need is foreseeable. When a 30-day notice is not possible, the Employee must provide notice as soon as practicable and generally must comply with an Employer's normal call-in procedures.

Employees must provide sufficient information for the Employer to determine if the leave may qualify for FMLA protection and the anticipated timing and duration of the leave. Sufficient information may include that the Employee is unable to perform job functions, the family member is unable to perform daily activities, the need for hospitalization or continuing treatment by a health care provider, or circumstances supporting the need for military family leave. Employees also must inform the Employer if the requested leave is for a reason for which FMLA Leave

was previously taken or certified. Employees also may be required to provide a certification and periodic recertification supporting the need for leave.

Employer Responsibilities: Covered Employers must inform Employees requesting leave whether they are eligible under FMLA. If they are, the notice must specify any additional information required as well as the Employees' rights and responsibilities. If they are not eligible, the Employer must provide a reason for the ineligibility.

Covered Employers must inform Employees if leave will be designated as FMLA-protected and the amount of leave counted against the Employee's leave entitlement. If the Employer determines that the leave is not FMLA-protected, the Employer must notify the Employee.
Unlawful Acts by Employers: FMLA makes it unlawful for any Employer to:

1. Interfere with, restrain, or deny the exercise of any right provided under FMLA; and
2. Discharge or discriminate against any person for opposing any practice made unlawful by FMLA or for involvement in any proceeding under or relating to FMLA.

Enforcement: An Employee may file a complaint with the U.S. Department of Labor or may bring a private lawsuit against an Employer. FMLA does not affect any Federal or State law prohibiting discrimination or supersede any state or local law or collective bargaining agreement which provides greater family or medical leave rights.

FMLA section 109 (29 U.S.C. § 2619) requires FMLA covered Employers to post the text of this notice. Regulation 29 C.F.R. § 825.300(a) may require additional disclosures.

For Additional Information:

1-866-4US-WAGE (1-866-487-9243) TTY: 1-877-889-5627
WWW.WAGEHOUR.DOL.GOV
U.S. Department of Labor Wage and Hour Division
WHD Publication 1420 · Revised February 2013

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

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

COBRA Continuation Coverage: Is a continuation of Plan coverage when coverage otherwise would end because of a life event known as a "Qualifying Event." Life insurance, accidental death and dismemberment benefits and

weekly income or long-term disability benefits (if a part of the Employer's plan) are not considered for continuation under COBRA.

Qualifying Events: Specific Qualifying Events are listed below. After a Qualifying Event, COBRA Continuation Coverage must be offered to each person who is a "Qualified Plan Member." The Employee, the Employee's Spouse, and the Employee's Dependent Children could become Qualified Plan Members if coverage under the Plan is lost because of the Qualifying Event.

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

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

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

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

If a proceeding in bankruptcy is filed with respect to the Plan Sponsor, and that bankruptcy results in the loss of coverage of any retired Employee, Spouse or surviving Spouse covered under the Plan, such member will become a Qualified Plan Member with respect to the bankruptcy.

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

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

1. Notice of the occurrence of a Qualifying Event that is a divorce of a covered Employee (or former Employee) from his or her Spouse;

2. Notice of the occurrence of a Qualifying Event that is an individual's ceasing to be eligible as a Dependent Child under the terms of the Plan;

3. Notice of the occurrence of a second Qualifying Event after a Qualified Plan Member has become entitled to COBRA Continuation Coverage with a maximum duration of 18 (or 29) months;

4. Notice that a Qualified Plan Member entitled to receive COBRA Continuation Coverage with a maximum duration of 18 months has been determined by the Social Security Administration ("SSA") to be disabled at any time during the first 60 days of COBRA Continuation Coverage; and

5. Notice that a Qualified Plan Member, with respect to whom a notice described above has been provided, has subsequently been determined by the SSA to no longer be disabled.

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

Deadline for Providing the Notice for Qualifying Events: As described above, the notice must be furnished by the date that is 60 days after the latest of:

1. The date on which the relevant Qualifying Event occurs;

2. The date on which the Qualified Plan Member loses (or would lose) coverage under the Plan as a result of the Qualifying Event; or

3. The date on which the Qualified Plan Member is informed, through the furnishing of the Plan's SPD or the general notice, of both the responsibility to provide the notice and the Plan's procedures for providing such notice to the COBRA Administrator.

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

1. The date of the disability determination by the SSA;

2. The date on which a Qualifying Event occurs;

3. The date on which the Qualified Plan Member loses (or would lose) coverage under the Plan as a result of the Qualifying Event; or

4. The date on which the Qualified Plan Member is informed, through the furnishing of the Plan's SPD or the general notice, of both the responsibility to provide the notice and the Plan's procedures for providing such notice to the COBRA Administrator.

In any event, this notice must be furnished before the end of the first 18 months of COBRA Continuation Coverage. For a change in disability status described above, the notice must be furnished by the date that is 30 days after the later of:

1. The date of the final determination by the SSA that the Qualified Plan Member is no longer disabled; or

2. The date on which the Qualified Plan Member is informed, through the furnishing of the Plan's SPD or the general notice, of both the responsibility to provide the notice and the Plan's procedures for providing such notice to the COBRA Administrator.

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

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

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

1. Name and address of the covered Employee or former Employee;

2. Identification of the initial Qualifying Event and its date of occurrence, if the person is already receiving COBRA Continuation Coverage and wishes to extend the maximum coverage period;

3. A description of the Qualifying Event (for example, divorce, entitlement to Medicare by the covered Employee or former Employee, death of the covered Employee or former Employee, disability of a Qualified Plan Member or loss of disability status);

4. In the case of a Qualifying Event that is divorce, name(s) and address(es) of Spouse and Dependent child(ren) covered under the Plan, date of divorce, and a copy of the decree of divorce;

5. In the case of a Qualifying Event that is Medicare entitlement of the covered Employee or former Employee, date of entitlement, and name(s) and address(es) of Spouse and Dependent child(ren) covered under the Plan;

6. In the case of a Qualifying Event that is a Dependent child's cessation of Dependent status under the Plan, name and address of the child, reason the child ceased to be an eligible Dependent (for example, attained limiting age, lost student status or other);

7. In the case of a Qualifying Event that is the death of the covered Employee or former Employee, the date of death, and name(s) and address(es) of Spouse and Dependent child(ren) covered under the Plan;

8. In the case of a Qualifying Event that is disability of a Qualified Plan Member, name and address of the disabled Qualified Plan Member, name(s) and address(es) of other members covered under the Plan, the date the disability began, the date of the SSA's determination, and a copy of the SSA's determination;

9. In the case of a Qualifying Event that is loss of disability status, name and address of the Qualified Plan Member who is no longer disabled, name(s) and address(es) of other members covered under the Plan, the date the disability ended and the date of the SSA's determination; and

10. A certification that the information is true and correct, a signature and date.

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

If the notice does not contain all of the required information, the COBRA Administrator may request additional information. If the individual fails to provide such information within the time period specified by the COBRA

Administrator in the request, the COBRA Administrator may reject the notice if it does not contain enough information for the COBRA Administrator to identify the plan, the covered Employee (or former Employee), the Qualified Plan Member, the Qualifying Event or disability, and the date on which the Qualifying Event, if any, occurred.

Electing COBRA Continuation Coverage: Complete instructions on how to elect COBRA Continuation Coverage will be provided by the COBRA Administrator within 14 days of receiving the notice of the Qualifying Event if COBRA is administered by the Employer or within 44 days if the COBRA is being administered by a third party. The individual then has 60 days in which to elect COBRA Continuation Coverage. The 60-day period is measured from the later of the date coverage terminates and the date of the notice containing the instructions is mailed. If COBRA Continuation Coverage is not elected in that 60-day period, then the right to elect it ceases.

Each Qualified Plan Member will have an independent right to elect COBRA Continuation Coverage. Covered Employees may elect COBRA Continuation Coverage on behalf of their eligible Spouses and Dependent child(ren).

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

Duration of COBRA Continuation Coverage: COBRA Continuation Coverage will be available up to the maximum time period shown below. Generally, multiple Qualifying Events which may be combined under COBRA will not continue coverage for more than 36 months beyond the date of the original Qualifying Event. When the Qualifying Event is "entitlement to Medicare," the 36-month continuation period is measured from the date of the original Qualifying Event. For all other Qualifying Events, the continuation period is measured from the date of the Qualifying Event, not the date of loss of coverage. When the Qualifying Event is the death of the covered Employee (or former Employee), the covered Employee's (or former Employee's) becoming entitled to Medicare benefits (under Part A, Part B, or both), a divorce or Legal Separation, COBRA Continuation Coverage lasts for up to a total of 36 months.

When the Qualifying Event is the end of employment or reduction of the covered Employee's hours of employment, and the covered Employee became entitled to Medicare benefits less than 18 months before the Qualifying Event, COBRA Continuation Coverage for Qualified Plan Members other than the covered Employee lasts until 36 months after the date of Medicare entitlement. For example, if a covered Employee becomes entitled to Medicare eight months before the date on which his or her employment terminates, COBRA Continuation Coverage for his or her eligible Spouse and Dependent child(ren) can last up to 36 months after the date of Medicare entitlement, which is equal to 28 months after the date of the Qualifying Event (36 months minus 8 months).

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

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

Second Qualifying Event Extension of COBRA Continuation Coverage: If an Employee experiences another Qualifying Event while receiving 18 months of COBRA Continuation Coverage, the eligible Dependents can get up to 18 additional months of COBRA Continuation Coverage, for a maximum of 36 months, if notice of the second Qualifying Event properly is given to the Plan as set forth above. This extension may be available to the Dependents receiving COBRA Continuation Coverage if the covered Employee or former Employee dies, becomes entitled to Medicare benefits (under Part A, Part B, or both), or gets divorced or legally separated, but only if the event would have caused the Dependents to lose coverage under the Plan had the first Qualifying Event not occurred.

Shorter Duration of COBRA Continuation Coverage: COBRA Continuation Coverage also may end before the end of the maximum period on the earliest of the following dates:

1. The date the Employer ceases to provide a group health plan to any Employee;

2. The date on which coverage ceases by reason of the Qualified Plan Member's failure to make timely payment of any required contributions or premium;

3. The date that the Qualified Plan Member first becomes, after the date of election, covered under any other group health plan (as an Employee or otherwise), or entitled to either Medicare Part A or Part B, whichever comes first (except as stated under COBRA's special bankruptcy rules); or

4. The first day of the month that begins more than 30 days after the date of the SSA's determination that the Qualified Plan Member is no longer disabled, but in no event before the end of the maximum coverage period that applied without taking into consideration the disability extension.

Contribution and/or Premium Requirements: Once COBRA Continuation Coverage is elected, the individual must pay for the cost of the initial period of coverage within 45 days. Payments then are due on the first day of each month to continue coverage for that month. If a payment is not mailed (post marked) by the end of the month in which the payment is due, COBRA Continuation Coverage will be canceled and will not be reinstated.

Current Addresses: In order to protect the rights of the Employee's family, the Employee should keep the COBRA Administrator informed of any changes in the addresses of the family members.

Marketplace: HHS regulations provide special enrollment periods for plans in the Marketplace to individuals eligible for COBRA when: 1) such individuals initially are eligible for COBRA due to a loss of other minimum essential coverage; and 2) when such individual's COBRA coverage is exhausted. In addition, COBRA beneficiaries can choose plans in the Marketplace during the annual open enrollment period and if they are determined eligible for any other special enrollment periods outside of the open enrollment period.

PLAN ADMINISTRATION

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

Plan Administrator: The Plan is administered by the Plan Administrator within the purview of ERISA, and in

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

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

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

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

Duties of the Plan Administrator: The duties of the Plan Administrator include the following:

1. To administer the Plan in accordance with its terms;
2. To determine all questions of eligibility, status and coverage under the Plan;
3. To interpret the Plan, including the authority to construe possible ambiguities, inconsistencies, omissions and disputed terms;
4. To make factual findings;
5. To decide disputes which may arise relative to a Plan Member's rights and/or availability of benefits;
6. To prescribe procedures for filing a claim for benefits, to review claim denials and appeals relating to them and to uphold or reverse such denials;
7. To keep and maintain the Plan documents and all other records pertaining to the Plan;
8. To appoint and supervise a Third-Party Administrator to pay claims;
9. To perform all necessary reporting as required by ERISA;
10. To delegate to any person or entity such powers, duties and responsibilities as it deems appropriate; and
11. To perform each and every function necessary for or related to the Plan's administration.

Amending and Terminating the Plan: The Plan Sponsor expects to maintain this Plan indefinitely; however, as the settlor of the Plan, the Plan Sponsor, through its directors and officers, may, in its sole discretion, at any time, amend, suspend or terminate the Plan in whole or in part. This includes amending the benefits under the Plan or the trust agreement (if any).

Any such amendment, suspension or termination shall be enacted, if the Plan Sponsor is a corporation, by resolution of the Plan Sponsor's directors and officers, which shall be acted upon as provided in the Plan Sponsor's Articles of

Incorporation or Bylaws, as applicable, and in accordance with applicable Federal and State law. Notice shall be provided as required by ERISA. In the event that the Plan Sponsor is a different type of entity, then such amendment, suspension or termination shall be taken and enacted in accordance with applicable Federal and State law and any applicable governing documents. In the event that the Plan Sponsor is a sole proprietorship, then such action shall be taken by the sole proprietor, in his or her own discretion. If the Plan is terminated, the rights of the Plan Members are limited to expenses Incurred before termination. All amendments to this Plan shall become effective as of a date established by the Plan Sponsor.

Summary of Material Reduction (SMR): A Material Reduction generally means any modification that would be considered by the average Plan Member to be an important reduction in covered services or benefits. Examples include reductions in benefits or increases in deductibles or Co-payments.

The Plan Administrator shall notify all eligible Employees of any Plan amendment considered a Material Reduction in covered services or benefits provided by the Plan as soon as administratively feasible after its adoption, but no later than 60 days after the date of adoption of the reduction. Eligible Employees and beneficiaries must be furnished a summary of such reductions, and any changes so made shall be binding on each Plan Member. The 60-day period for furnishing a summary of Material Reduction does not apply to any Employee covered by the Plan who would reasonably expect to receive a summary through other means within the next 90 days. Material Reduction disclosure provisions are subject to the requirements of ERISA and the Health Insurance Portability and Accountability Act of 1996 (HIPAA) and any related amendments.

Summary of Material Modification (SMM): A Summary of Material Modifications reports changes in the information provided within the Summary Plan Description. Examples include a change to deductibles, eligibility or the addition or deletion of coverage. The Plan Administrator shall notify all covered Employees of any Plan amendment considered a Summary of Material Modifications* by the Plan as soon as administratively feasible after its adoption, but no later than within 210 days after the close of the Plan Year in which the changes became effective.

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

Misuse of Identification Card: If an Employee or covered Dependent permits any person who is not a covered Plan Member to use any identification card issued, the Plan Sponsor may give the Employee a written notice that his (and his Dependent's) coverage will be terminated at the end of 31 days from the date written notice is given.

CLAIMS PROCEDURES /PAYMENT OF CLAIMS

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

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

make decisions involving the use of discretion.

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

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

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

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

Benefits will be payable to a Plan Member or to a provider that has accepted an Assignment of Benefits as consideration in full for services rendered.

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

1. Pre-Service Claims. Is a claim for a benefit under the Plan where the Plan conditions receipt of the benefit, in whole or in part, on approval of the benefit in advance of obtaining medical care. However, if the Plan does not require the Plan Member to obtain approval of a medical service prior to getting treatment, then there is no "Pre-service Claim." The Plan Member simply follows the Plan's procedures with respect to any notice which may be required after receipt of treatment, and files the claim as a Post-Service Claim.

2. Pre-Service, Urgent Care Claim. Is any claim for medical care or treatment with respect to which the application of the time periods for making non-urgent care determinations could seriously jeopardize the life or health of the Plan Member or the Plan Member's ability to regain maximum function, or, in the opinion of a Physician with knowledge of the Plan Member's medical condition, would subject the Plan Member to severe pain that cannot be adequately managed without the care or treatment that is the subject of the claim. If a Plan Member needs medical care for a condition which could seriously jeopardize his or her life, obtain such care without delay, and communicate with the Plan as soon as reasonably possible.

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

with respect to any notice which may be required after receipt of treatment, and files the claim as a Post-Service Claim.

3. Pre-Admission Certification of a Non-Emergency Hospital Admission. Is a "claim" only to the extent of the determination made that the type of procedure or condition warrants Inpatient confinement for a certain number of days. The rules regarding Pre-service Claims will apply to that determination only. Once a Plan Member has the treatment in question, the claim for benefits relating to that treatment will be treated as a Post-Service Claim.

4. Concurrent Claims. Occurs when the Plan has approved an on-going course of treatment to be provided over a period of time or number of treatments, and either:

    - The Plan determines that the course of treatment should be reduced or terminated; or
    - The Plan Member requests extension of the course of treatment beyond that which the Plan has approved.

    If the Plan does not require the Plan Member to obtain approval of a medical service prior to getting treatment, then there is no need to contact the Plan Administrator to request an extension of a course of treatment. The Plan Member simply follows the Plan's procedures with respect to any notice which may be required after receipt of treatment, and files the claim as a Post-Service Claim.

5. Post-Service Claims. A "Post-service Claim" is a claim for a benefit under the Plan after the services have been rendered.

When Claims Must Be Filed: Post-Service Claims must be filed with the Third-Party Administrator within 180 days of the date charges for the service were incurred. Benefits are based upon the Plan's provisions at the time the charges were Incurred. Claims filed later than that date shall be denied.

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

Upon receipt of the required information, the claim will be deemed to be filed with the Plan. The Third-Party Administrator will determine if enough information has been submitted to enable proper consideration of the claim. If not, more information may be requested as provided herein. This additional information must be received by the Third-Party Administrator within 45 days from receipt by the Plan Member of the request for additional information. Failure to do so may result in claims being declined or reduced.

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

1. Pre-Service, Urgent Care Claims:

    - If the Plan Member has provided all the necessary information, as soon as possible, taking into account the medical exigencies, but not later than 72 hours after receipt of the claim.
    - If the Plan Member has not provided all of the information needed to process the claim, then the Plan Member will be notified as to what specific information is needed as soon as possible, but not later than 72 hours after receipt of the claim.

- The Plan Member will be notified of a determination of benefits as soon as possible, but not later than 72 hours, taking into account the medical exigencies, after the earliest of:
    - The Plan's receipt of the specified information; or
    - The end of the period afforded the Plan Member to provide the information.
- If there is an Adverse Benefit Determination, a request for an expedited appeal may be submitted orally or in writing by the Plan Member. All necessary information, including the Plan's benefit determination on review, may be transmitted between the Plan and the Plan Member by telephone, facsimile, or other similarly expeditious method. Alternatively, the Plan Member may request an expedited review under the external review process.

2. Pre-Service, Non-Urgent Care Claims:

- If the Plan Member has provided all of the information needed to process the claim, in a reasonable period of time appropriate to the medical circumstances, but not later than 15 days after receipt of the claim, unless an extension has been requested, then prior to the end of the 15 day extension period.
- If the Plan Member has not provided all of the information needed to process the claim, then the Plan Member will be notified as to what specific information is needed as soon as possible, but not later than 5 days after receipt of the claim. The Plan Member will be notified of a determination of benefits in a reasonable period of time appropriate to the medical circumstances, either prior to the end of the extension period (if additional information was requested during the initial processing period), or by the date agreed to by the Plan Administrator and the Plan Member (if additional information was requested during the extension period).

3. Concurrent Claims:

- Plan Notice of Reduction or Termination. If the Plan Administrator is notifying the Plan Member of a reduction or termination of a course of treatment (other than by Plan amendment or termination), before the end of such period of time or number of treatments. The Plan Member will be notified sufficiently in advance of the reduction or termination to allow the Plan Member to appeal and obtain a determination on review of that Adverse Benefit Determination before the benefit is reduced or terminated. This rule does not apply if benefits are reduced or eliminated due to plan amendment or termination. A similar process applies for claims based on a rescission of coverage for fraud or misrepresentation.
- Request by Plan Member Involving Urgent Care. If the Plan Administrator receives a request from a Plan Member to extend the course of treatment beyond the period of time or number of treatments that is a claim involving urgent care, as soon as possible, taking into account the medical exigencies, but not later than 72 hours after receipt of the claim, as long as the Plan Member makes the request at least 72 hours prior to the expiration of the prescribed period of time or number of treatments. If the Plan Member submits the request with less than 24 hours prior to the expiration of the prescribed period of time or number of treatments, the request will be treated as a claim involving urgent care and decided within the urgent care timeframe.
- Request by Plan Member Involving Non-Urgent Care. If the Plan Administrator receives a request from the Plan Member to extend the course of treatment beyond the period of time or number of treatments that is a claim not involving urgent care, the request will be treated as a new benefit claim and decided within the timeframe appropriate to the type of claim (either as a pre-service non-urgent claim or a post-service claim).
- Request by Plan Member Involving Rescission. With respect to rescissions, the following timetable applies:

- Notification to Plan Member . . . . . 30 days
- Notification of Adverse Benefit Determination on appeal . . . . . 30 days

4. Post-Service Claims:

   - If the Plan Member has provided all of the information needed to process the claim, in a reasonable period of time, but not later than 30 days after receipt of the claim, unless an extension has been requested, then prior to the end of the 15-day extension period.
   - If the Plan Member has not provided all of the information needed to process the claim and additional information is requested during the initial processing period, then the Plan Member will be notified of a determination of benefits prior to the end of the extension period, unless additional information is requested during the extension period, then the Plan Member will be notified of the determination by a date agreed to by the Plan Administrator and the Plan Member.

     - Extensions – Pre-Service Urgent Care Claims. No extensions are available in connection with Pre-service urgent care claims.
     - Extensions – Pre-Service Non-Urgent Care Claims. This period may be extended by the Plan for up to 15 days, provided that the Plan Administrator both determines that such an extension is necessary due to matters beyond the control of the Plan and notifies the Plan Member, prior to the expiration of the initial 15-day processing period, of the circumstances requiring the extension of time and the date by which the Plan expects to render a decision.
     - Extensions – Post-Service Claims. This period may be extended by the Plan for up to 15 days, provided that the Plan Administrator both determines that such an extension is necessary due to matters beyond the control of the Plan and notifies the Plan Member, prior to the expiration of the initial 30-day processing period, of the circumstances requiring the extension of time and the date by which the Plan expects to render a decision.

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

Notification of an Adverse Benefit Determination:
The Plan Administrator shall provide a Plan Member with a notice, either in writing or electronically (or, in the case of pre-service urgent care claims, by telephone, facsimile or similar method, with written or electronic notice following within 3 days), containing the following information:

1. Information sufficient to allow the Plan Member to identify the claim involved (including date of service, the healthcare provider, the claim amount, if applicable, and a statement describing the availability, upon request, of the Diagnosis code and its corresponding meaning, and the treatment code and its corresponding meaning);

2. A reference to the specific portion(s) of the Plan Document upon which a denial is based;

3. Specific reason(s) for a denial, including the denial code and its corresponding meaning, and a description of the Plan's standard, if any, that was used in denying the claim;

4. A description of any additional information necessary for the Plan Member to perfect the claim and an explanation of why such information is necessary;

5. A description of the Plan's review procedures and the time limits applicable to the procedures, including a statement of the Plan Member's right to bring a civil action under Section 502(a) of ERISA following an Adverse Benefit Determination on final review;

6. A statement that the Plan Member 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 Plan Member's claim for benefits;

7. The identity of any medical or vocational experts consulted in connection with a claim, even if the Plan did not rely upon their advice (or a statement that the identity of the expert will be provided, upon request);

8. Any rule, guideline, protocol or similar criterion that was relied upon in making the determination (or a statement that it was relied upon and that a copy will be provided to the Plan Member, free of charge, upon request);

9. In the case of denials based upon a medical judgment (such as whether the treatment is Medically Necessary or Experimental), either an explanation of the scientific or clinical judgment for the determination, applying the terms of the Plan to the Plan Member's medical circumstances, or a statement that such explanation will be provided to the Plan Member, free of charge, upon request; and

10. In a claim involving urgent care, a description of the Plan's expedited review process.

Appeal of Adverse Benefit Determinations

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

1. Plan Members at least 180 days following receipt of a notification of an initial Adverse Benefit Determination within which to appeal the determination;

2. Plan Members the opportunity to submit written comments, documents, records, and other information relating to the claim for benefits;

3. Plan Members the opportunity to review the claim file and to present evidence and testimony as part of the internal claims and appeals process;

4. For a review that does not afford deference to the previous Adverse Benefit Determination and that is conducted by an appropriate named fiduciary of the Plan, who shall be neither the individual who made the Adverse Benefit Determination that is the subject of the appeal, nor the subordinate of such individual;

5. For a review that takes into account all comments, documents, records, and other information submitted by the Plan Member relating to the claim, without regard to whether such information was submitted or considered in the prior benefit determination;

6. That, in deciding an appeal of any Adverse Benefit Determination that is based in whole or in part upon a medical judgment, the Plan fiduciary shall consult with a health care professional who has appropriate

training and experience in the field of medicine involved in the medical judgment, who is neither an individual who was consulted in connection with the Adverse Benefit Determination that is the subject of the appeal, nor the subordinate of any such individual;

7. For the identification of medical or vocational experts whose advice was obtained on behalf of the Plan in connection with a claim, even if the Plan did not rely upon their advice;

8. That a Plan Member will be provided, free of charge: (a) reasonable access to, and copies of, all documents, records, and other information relevant to the Plan Member's claim in possession of the Plan Administrator or Third Party Administrator; (b) information regarding any voluntary appeals procedures offered by the Plan; (c) information regarding the Plan Member's right to an external review process; (d) any internal rule, guideline, protocol or other similar criterion relied upon, considered or generated in making the adverse determination; and (e) an explanation of the scientific or clinical judgment for the determination, applying the terms of the Plan to the Plan Member's medical circumstances; and

9. That a Plan Member will be provided, free of charge, and sufficiently in advance of the date that the notice of Final Internal Adverse Benefit Determination is required, with new or additional evidence considered, relied upon, or generated by the Plan in connection with the claim, as well as any new or additional rationale for a denial at the internal appeals stage, and a reasonable opportunity for the Plan Member to respond to such new evidence or rationale.

Requirements for Appeal: The Plan Member must file the appeal in writing (although oral appeals are permitted for pre-service urgent care claims) within 180 days following receipt of the notice of an Adverse Benefit Determination. For pre-service urgent care claims, if the Plan Member chooses to orally appeal, the Plan Member may telephone the number shown below. To file an appeal in writing, the Plan Member's appeal must be addressed as follows and mailed or faxed as follows:

Concierge Administrative Services, LLC
P.O. Box 4070; Bartlesville, OK 74006
Fax: 918-333-9505; Phone: 888-820-5687

It shall be the responsibility of the Plan Member to submit proof that the claim for benefits is covered and payable under the provisions of the Plan. Any appeal must include:

1. The name of the Employee/Plan Member;
2. The Employee/Plan Member's social security number;
3. The group name or identification number;
4. All facts and theories supporting the claim for benefits. Failure to include any theories or facts in the appeal will result in their being deemed waived. In other words, the Plan Member will lose the right to raise factual arguments and theories which support this claim if the Plan Member fails to include them in the appeal;
5. A statement in clear and concise terms of the reason or reasons for disagreement with the handling of the claim; and
6. Any material or information that the Plan Member has which indicates that the Plan Member is entitled to benefits under the Plan.

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

1. Pre-Service, Urgent Care Claims. As soon as possible, taking into account the medical exigencies, but not later than 72 hours after receipt of the appeal.

2. Pre-Service, Non-Urgent Care Claims. Within a reasonable period of time appropriate to the medical circumstances, but not later than 30 days after receipt of the appeal.

3. Concurrent Claims. The response will be made in the appropriate time period based upon the type of claim: Pre-Service Urgent, Pre-service Non-Urgent or Post-Service.

4. Post-Service Claims. Within a reasonable period of time, but not later than 60 days after receipt of the appeal.

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

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

1. Information sufficient to allow the Plan Member to identify the claim involved (including date of service, the healthcare Provider, the claim amount, if applicable, and a statement describing the availability, upon request, of the Diagnosis code and its corresponding meaning, and the treatment code and its corresponding meaning);

2. A reference to the specific portion(s) of the plan provisions upon which a denial is based;

3. Specific reason(s) for a denial, including the denial code and its corresponding meaning, and a description of the Plan's standard, if any, that was used in denying the claim, and a discussion of the decision;

4. A description of any additional information necessary for the Plan Member to perfect the claim and an explanation of why such information is necessary;

5. A description of available internal appeals and external review processes, including information regarding how to initiate an appeal;

6. A description of the Plan's review procedures and the time limits applicable to the procedures. This description will include information on how to initiate the appeal and a statement of the Plan Member's right to bring a civil action under section 502(a) of ERISA following an Adverse Benefit Determination on final review;

7. A statement that the Plan Member 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 Plan Member's claim for benefits;

8. The identity of any medical or vocational experts consulted in connection with a claim, even if the Plan did not rely upon their advice (or a statement that the identity of the expert will be provided, upon request);

9. Any rule, guideline, protocol or similar criterion that was relied upon, considered, or generated in making the determination will be provided free of charge. If this is not practical, a statement will be included that

such a rule, guideline, protocol or similar criterion was relied upon in making the determination and a copy will be provided to the Plan Member, free of charge, upon request;

10. In the case of denials based upon a medical judgment (such as whether the treatment is Medically Necessary or Experimental), either an explanation of the scientific or clinical judgment for the determination, applying the terms of the Plan to the Plan Member's medical circumstances, will be provided. If this is not practical, a statement will be included that such explanation will be provided to the Plan Member, free of charge, upon request; and

11. The following statement: "You and your Plan may have other voluntary alternative dispute resolution options, such as mediation. One way to find out what may be available is to contact your local U.S. Department of Labor Office and your State insurance regulatory agency."

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

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

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 Plan Member or beneficiary fails to meet the requirements for eligibility under the terms of a group health plan.

The Federal External Review Process applies only to:

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

2. A rescission of coverage (whether or not the rescission has any effect on any particular benefit at that time).

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

Request for External Review: The Plan will allow a claimant to file a request for an external review with the Plan if the request is filed within 4 months after the date of receipt of a notice of an Adverse Benefit Determination or Final Internal Adverse Benefit Determination. If there is no corresponding date four months after the date of receipt of such a notice, then the request must be filed by the first day of the fifth month following the receipt of the notice. For example, if the date of receipt of the notice is October 30, because there is no February 30, the request must be filed by March 1. If the last filing date would fall on a Saturday, Sunday, or Federal holiday, the last filing date is extended to the next day that is not a Saturday, Sunday, or Federal holiday.

1. Preliminary Review. Within 5 business days following the date of receipt of the external review request, the Plan will complete a preliminary review of the request to determine whether:

- The claimant is or was covered under the Plan at the time the health care item or service was requested or, in the case of a retrospective review, was covered under the Plan at the time the health care item or service was provided;
- The Adverse Benefit Determination or the Final Adverse Benefit Determination does not relate to the claimant's failure to meet the requirements for eligibility under the terms of the Plan (e.g., worker classification or similar determination);
- The claimant has exhausted the Plan's internal appeal process unless the claimant is not required to exhaust the internal appeals process under the interim final regulations; and
- The claimant has provided all the information and forms required to process an external review. Within 1 business day after completion of the preliminary review, the Plan will issue a notification in writing to the claimant. If the request is complete but not eligible for external review, such notification will include the reasons for its ineligibility and contact information for the Employee Benefits Security Administration (toll-free number 866-444-EBSA (3272)). If the request is not complete, such notification will describe the information or materials needed to make the request complete and the Plan will allow a claimant to perfect the request for external review with the four-month filing period or within the 48-hour period following the receipt of the notification, whichever is later.

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

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

Expedited External Review:

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

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

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

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

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

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

Physical Examinations: The Plan reserves the right to have a Physician of its own choosing examine any Plan Member whose condition, Sickness or Injury is the basis of a claim. All such examinations shall be at the expense of the Plan. This right may be exercised when and as often as the Plan may reasonably require during the pendency of a claim. The Plan Member must comply with this requirement as a necessary condition to coverage.

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

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

Assignments: Benefits for medical expenses covered under this Plan may be assigned by a Plan Member to the provider as consideration in full for services rendered; however, if those benefits are paid directly to the Employee, the Plan shall be deemed to have fulfilled its obligations with respect to such benefits. The Plan will not be

responsible for determining whether any such assignment is valid. Payment of benefits which have been assigned will be made directly to the assignee unless a written request not to honor the assignment, signed by the covered Employee and the assignee, has been received before the proof of loss is submitted.

No Plan Member shall at any time, either during the time in which he or she is a Plan Member in the Plan, or following his or her termination as a Plan Member, in any manner, have any right to assign his or her right to sue to recover benefits under the Plan, to enforce rights due under the Plan or to any other causes of action which he or she may have against the Plan or its fiduciaries.

A Provider which accepts an Assignment of Benefits, in accordance with this Plan as consideration in full for services rendered, is bound by the rules and provisions set forth within the terms of this document.

Benefits due to any Network Provider will be considered "assigned" to such provider and will be paid directly to such provider, whether or not a written Assignment of Benefits was executed. Notwithstanding any assignment or non-Assignment of Benefits to the contrary, upon payment of the benefits due under the Plan, the Plan is deemed to have fulfilled its obligations with respect to such benefits, whether or not payment is made in accordance with any assignment or request.

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

1. Benefits may not be assigned to a Non-U.S. Provider;
2. The Plan Member is responsible for making all payments to Non-U.S. Providers, and submitting receipts to the Plan for reimbursement;
3. Benefit payments will be determined by the Plan based upon the exchange rate in effect on the Incurred Date;
4. The Non-U.S. Provider shall be subject to, and in compliance with, all U.S. and other applicable licensing requirements;
5. Claims for benefits must be submitted to the Plan in English; and
6. Travel outside the U.S. cannot be for the express (sole) purpose of obtaining medical care.

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

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

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

Providers and any other person or entity accepting payment from the Plan or to whom a right to benefits has been assigned, in consideration of services rendered, payments and/or rights, agrees to be bound by the terms of this Plan and agree to submit claims for reimbursement in strict accordance with their State's health care practice acts, ICD-9 or CPT standards, Medicare guidelines, HCPCS standards, or other standards approved by the Plan Administrator or insurer. Any payments made on claims for reimbursement not in accordance with the above provisions shall be repaid to the Plan within 30 days of discovery or demand or incur prejudgment interest of 1.5% per month. If the Plan must bring an action against a Plan Member, Provider or other person or entity to enforce the provisions of this section, then that Plan Member, Provider or other person or entity agrees to pay the Plan's attorneys' fees and costs, regardless of the action's outcome.

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

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

1. In error;
2. Pursuant to a misstatement contained in a proof of loss or a fraudulent act;
3. Pursuant to a misstatement made to obtain coverage under this Plan within two years after the date such coverage commences;
4. With respect to an ineligible person;
5. In anticipation of obtaining a recovery if a Plan Member fails to comply with the Plan's Third-Party Recovery, Subrogation and Reimbursement provisions; or
6. Pursuant to a claim for which benefits are recoverable under any policy or act of law providing for coverage for occupational Injury or Disease to the extent that such benefits are recovered. This provision shall not be deemed to require the Plan to pay benefits under this Plan in any such instance.

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

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

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

COORDINATION OF BENEFITS

Benefits Subject to This Provision: This provision shall apply to all benefits provided under any section of this Plan.

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.

The Plan's benefits will be excess to, whenever possible:

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

Allowable Expenses: "Allowable Expenses" shall mean the Usual and Customary charge for any Medically Necessary, Reasonable, and eligible item of expense, at least a portion of which is covered under a plan. When some other plan pays first in accordance with the Application to Benefit Determinations section herein, this Plan's allowable expenses shall in no event exceed the other plan's allowable expenses. When some other plan provides benefits in the form of services rather than cash payments, the reasonable cash value of each service rendered, in the amount that would be payable in accordance with the terms of the Plan, shall be deemed to be the benefit. Benefits payable under any other plan include the benefits that would have been payable had claim been duly made therefore.

Effect on Benefits

Application to Benefit Determinations: The plan that pays first according to the rules in the section entitled "Order of Benefit Determination" will pay as if there were no other plan involved. The secondary and subsequent plans will pay the balance due up to 100% of the total allowable expenses. When there is a conflict in the rules, this Plan will never pay more than 50% of allowable expenses when paying secondary. Benefits will be coordinated on the basis of a claim determination period.

When medical payments are available under automobile insurance, this Plan will pay excess benefits only, without reimbursement for automobile plan deductibles. This Plan will always be considered the secondary carrier regardless of the individual's election under personal Injury protection (PIP) coverage with the automobile insurance carrier.

In certain instances, the benefits of the other plan will be ignored for the purposes of determining the benefits under this Plan. This is the case when:

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

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

1. A plan without a coordinating provision will always be the primary plan;
2. If an individual is covered under one plan as a dependent and another plan as an employee, the plan that covers the person as an employee is considered primary. The primary plan must pay benefits without regard to the possibility that another plan may cover some expenses. This Plan will deem any Employee plan beneficiary to be eligible for primary benefits from his or her Employer's benefit plan.
3. The plan that covers a person as a dependent (or beneficiary under ERISA) is generally secondary. The plan that covers a person as a dependent is primary only when both plans agree that COBRA or state continuation coverage should always pay secondary when the person who elected COBRA is covered by another plan as a dependent. See the section on Medicare below for exceptions to this rule.

Active or Inactive Employee: If an individual is covered under one plan as an active employee (or dependent of an active employee) and is also covered under another plan as a retired or laid off employee (or dependent of a retired or laid off employee), the plan that covers the person as an active employee (or dependent of an active employee) will be primary. This rule does not apply if the rule in the third paragraph above can determine the order of benefits. If the other plan does not have this rule, this rule is ignored.

Continuation Coverage Under COBRA or State Law: If a person has elected continuation of coverage under COBRA or state law and also has coverage under another plan, the continuation coverage is secondary. This is true even if the person is enrolled in another plan as a dependent. If the two plans do not agree on the order of benefits, this rule is ignored. This rule does not apply if one of the first four items above applies. (See exception in the Medicare section.)

Longer or Shorter Length of Coverage: The plan that covered the person as an employee or the retiree the longest is the primary.

1. If an active employee is on leave due to active duty in the military in excess of 30 days, the plan that covers the person as an active employee is considered primary.
2. If the above rules do not determine the primary plan, the covered expenses may be shared equally between the plans. This plan will not pay more than it would have paid, had it been primary.

Medicare: If a Plan Member is also receiving benefits under Medicare, including through Medicare Prescription drug coverage, federal law may require this Plan to be primary over Medicare. When this Plan is not primary, the Plan will coordinate benefits with Medicare.

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

When this Plan is not primary, and a Plan Member is receiving Medicare Part A but has chosen not to elect Medicare Part B, this Plan will reduce its payment on Medicare Part B services as though Medicare Part B was actually in effect.

Order of Benefit Determination- Medicare: This Plan complies with the Medicare Secondary Payer regulations. Example of these regulations are as follows:

This Plan generally pays first under the following circumstances:

1. The Employee continues to be actively employed by the employer and the Employee or Employee's covered Spouse becomes eligible for and enrolls in Medicare because of age or disability.
2. The Employee continues to be actively employed by the Employer, the Employee's covered Spouse becomes eligible for and enrolls in Medicare, and the Employee's covered Spouse is also covered under a retiree plan through his or her former employer. In this case, the Plan pays first for the Employee and the Employee's covered Spouse, Medicare pays second, and the retiree plan pays last.
3. For a Plan Member with End-Stage Renal Disease (ESRD), this Plan usually has primary responsibility for the claims of a Plan Member for 30 months from the date of Medicare eligibility based on ESRD. The 30-month period may also include COBRA continuation coverage or another source of coverage. At the end of the 30-month period, Medicare becomes the primary payer.

Medicare generally pays first under the following circumstances:

1. The Employee is no longer actively employed by an Employer; and
2. The Employee or Employee's Spouse has Medicare coverage due to age, plus the Employee and Employee's Spouse also has COBRA continuation coverage through the Plan; or
3. The Employee or an Employee's Spouse has Medicare coverage based on disability, plus the Employee also has COBRA continuation coverage through the Plan. Medicare normally pays first; however, the COBRA continuation coverage may pay first for Plan Members with ESRD until the end of the 30-month period;
4. The Employee or Employee's Spouse has retiree coverage plus Medicare coverage; or
5. Upon completion of 30 months of Medicare eligibility for an individual with ESRD, Medicare becomes the primary payer. (Note: If a person with ESRD was eligible for Medicare based on age or other disability before being diagnosed with ESRD and Medicare was previously paying as the primary plan, then the person may continue to receive Medicare benefits on a primary basis.)

Medicare is the secondary payer when no-fault insurance, worker's compensation, or liability insurance is available as the primary payer.

Note: If a Plan Member is eligible for Medicare as his or her primary plan, all benefits from the Plan will be reduced by the amount Medicare would pay, regardless of whether or not the Plan Member is enrolled in Medicare.

Right to Receive and Release Necessary Information: For the purpose of determining the applicability of and implementing the terms of this provision or any provision of similar purpose of any other plan, this Plan may, without the consent of or notice to any person, release to or obtain from any insurance company, or other organization or individual, any information with respect to any person, which the Plan deems to be necessary for such purposes. Any person claiming benefits under this Plan shall furnish to the Plan such information as may be necessary to implement this provision.

Facility of Payment: Whenever payments which should have been made under this Plan in accordance with this provision have been made under any other plans, the Plan Administrator may, in its sole discretion, pay any

organizations making such other payments any amounts it shall determine to be warranted in order to satisfy the intent of this provision, and amounts so paid shall be deemed to be benefits paid under this Plan and, to the extent of such payments, this Plan shall be fully discharged from liability.

Right of Recovery: In accordance with the recovery of payments provision, whenever payments have been made by this Plan with respect to allowable expenses in a total amount, at any time, in excess of the maximum amount of payment necessary at that time to satisfy the intent of this article, the Plan shall have the right to recover such payments, to the extent of such excess, from any one or more of the following as this Plan shall determine: any person to or with respect to whom such payments were made, or such person's legal representative, any insurance companies, or any other individuals or organizations which the Plan determines are responsible for payment of such allowable expenses, and any future benefits payable to the Plan Member or his or her Dependents. Please the recovery of payments provision above for more details.

MEDICARE

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

Applicable to All Other Plan Members Eligible for Medicare Benefits: To the extent required by Federal regulations, this Plan will pay before any Medicare benefits. There are some circumstances under which Medicare would be required to pay its benefits first. In these cases, benefits under this Plan would be calculated as secondary payor (as described under the Article entitled "Coordination of Benefits"). The Plan Member will be assumed to have full Medicare coverage (that is, both Part A and B) whether or not the Plan Member has enrolled for the full coverage. If the Provider accepts assignment with Medicare, Covered Expenses will not exceed the Medicare approved expenses.

Applicable to Medicare Services Furnished to End Stage Renal Disease ("ESRD") Plan Members Who Are Covered Under This Plan: If any Plan Member is eligible for Medicare benefits because of ESRD, the benefits of the Plan will be determined before Medicare benefits for the first 18 months of Medicare entitlement (with respect to charges Incurred on or after February 1, 1991 and before August 5, 1997), and for the first 30 months of Medicare entitlement (with respect to charges Incurred on or after August 5, 1997), unless applicable Federal law provides to the contrary, in which event the benefits of the Plan will be determined in accordance with such law.

MISCELLANEOUS PROVISIONS

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

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

The analysis will be employed to identify charges billed in error and/or charges that are not Usual and Customary and Reasonable and/or Medically Necessary, if any, and may include a patient medical billing records review and/or audit of the patient's medical charts and records.

Upon completion of an analysis, a report will be submitted to the Plan Administrator or its agent to identify the charges deemed in excess of the Usual and Customary and Reasonable amounts or other applicable provisions, as outlined in this Plan Document. Despite the existence of any agreement to the contrary, the Plan Administrator has the discretionary authority to reduce any charge to a Usual and Customary and Reasonable charge, in accordance with the terms of this Plan Document.

Clerical Error/Delay: Clerical errors made on the records of the Plan and delays in making entries on such records shall not invalidate coverage nor cause coverage to be in force or to continue in force. Rather, the Effective Dates of coverage shall be determined solely in accordance with the provisions of this Plan regardless of whether any contributions with respect to Plan Members have been made or have failed to be made because of such errors or delays. Upon discovery of any such error or delay, an equitable adjustment of any such contributions will be made.

Conformity With Applicable Laws: This Plan shall be deemed to automatically be amended to conform as required by any applicable law, regulation or the order or judgment of a court of competent jurisdiction governing provisions of this Plan, including, but not limited to, stated maximums, exclusions or limitations. In the event that any law, regulation or the order or judgment of a court of competent jurisdiction causes the Plan Administrator to pay claims which are otherwise limited or excluded under this Plan, such payments will be considered as being in accordance with the terms of this Plan Document. It is intended that the Plan will conform to the requirements of ERISA, as it applies to Employee welfare plans, as well as any other applicable law.

Fraud: The following actions by any Plan Member, or a Plan Member's knowledge of such actions being taken by another, constitute fraud and will result in immediate termination of all coverage under this Plan for the Employee and covered Spouse:

1. Attempting to submit a claim for benefits (which includes attempting to fill a prescription) for a person who is not a Plan Member of the Plan;
2. Attempting to file a claim for a Plan Member for services which were not rendered or drugs or other items which were not provided;
3. Providing false or misleading information in connection with enrollment in the Plan; or
4. Providing any false or misleading information to the Plan.

Headings: The headings used in this Plan Document are used for convenience of reference only. Plan Members are advised not to rely on any provision because of the heading.

No Waiver or Estoppel: No term, condition or provision of this Plan shall be deemed to have been waived, and there shall be no estoppel against the enforcement of any provision of this Plan, except by written instrument of the party charged with such waiver or estoppel. No such written waiver shall be deemed a continuing waiver unless specifically stated therein, and each such waiver shall operate only as to the specific term or condition waived and shall not constitute a waiver of such term or condition for the future or as to any act other than the one specifically waived.

Plan Contributions: The Plan Administrator shall, from time to time, evaluate the funding method of the Plan and determine the amount to be contributed by the Participating Employer and the amount to be contributed (if any) by each Plan Member.

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

Notwithstanding any other provision of the Plan, the Plan Administrator's obligation to pay claims otherwise allowable under the terms of the Plan shall be limited to its obligation to make contributions to the Plan as set forth in the preceding paragraph. Payment of said claims in accordance with these procedures shall discharge completely the Employer's obligation with respect to such payments.

In the event that the Employer terminates the Plan, then as of the effective date of termination, the Employer and eligible Employees shall have no further obligation to make additional contributions to the Plan and the Plan shall have no obligation to pay claims Incurred after the termination date of the Plan.

Right to Receive and Release Information: For the purpose of determining the applicability of and implementing the terms of these benefits, the Plan Administrator may, without the consent of or notice to any person, release or obtain any information necessary to determine the acceptability of any applicant or Plan Member for benefits from this Plan. In so acting, the Plan Administrator shall be free from any liability that may arise with regard to such action. Any Plan Member claiming benefits under this Plan shall furnish to the Plan Administrator such information as may be necessary to implement this provision.

Written Notice: Any written notice required under this Plan which, as of the Effective Date, is in conflict with the law of any governmental body or agency which has jurisdiction over this Plan shall be interpreted to conform to the minimum requirements of such law.

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

Statements: All statements made by the Employer or by a Plan Member will, in the absence of fraud, be considered representations and not warranties, and no statements made for the purpose of obtaining benefits under this document will be used in any contest to avoid or reduce the benefits provided by the document unless contained in a written application for benefits and a copy of the instrument containing such representation is or has been furnished to the Plan Member.

Any Plan Member who knowingly and with intent to defraud the Plan, files a statement of claim containing any materially false information, or conceals for the purpose of misleading, information concerning any material fact, commits a fraudulent act. The Plan Member may be subject to prosecution by the United States Department of Labor. Fraudulently claiming benefits may be punishable by a substantial fine, imprisonment, or both.

Protection Against Creditors: No benefit payment under this Plan shall be subject in any way to alienation, sale, transfer, pledge, attachment, garnishment, execution or encumbrance of any kind, and any attempt to accomplish the same shall be void. If the Plan Administrator shall find that such an attempt has been made with respect to any payment due or to become due to any Plan Member, the Plan Administrator in its sole discretion may terminate

the interest of such Plan Member or former Plan Member in such payment. And in such case the Plan Administrator shall apply the amount of such payment to or for the benefit of such Plan Member or former Plan Member, his/her Spouse, parent, adult child, guardian of a minor Child, brother or sister, or other relative of a Dependent of such Plan Member or former Plan Member, as the Plan Administrator may determine, and any such application shall be a complete discharge of all liability with respect to such benefit payment. However, at the discretion of the Plan Administrator, benefit payments may be assigned to health care Providers.

Unclaimed Self-Insured Plan Funds: In the event a benefits check issued by the Third-Party Administrator for this self-insured Plan is not cashed within one year of the date of issue, the check will be voided and the funds will be returned to this Plan and applied to the payment of current benefits and administrative fees under this Plan. In the event a Plan Member subsequently requests payment with respect to the voided check, the Third-Party Administrator for the self-insured Plan shall make such payment under the terms and provisions of the Plan as in effect when the claim was originally processed. Unclaimed self-insured Plan funds may be applied only to the payment of benefits (including administrative fees) under the Plan pursuant to ERISA.

HIPAA PRIVACY

The Plan provides each member with a separate Notice of Privacy Practices. This Notice describes how the Plan uses and discloses your personal health information. It also describes certain rights you have regarding this information. Additional copies of our Notice of Privacy Practices are available by calling the Plan Sponsor at the phone number included in Article II -Introduction and Purpose; General Plan Information.

Definitions:

Breach: Means an unauthorized acquisition, access, use or disclosure of Protected Health Information ("PHI") or Electronic Protected Health Information ("ePHI") that violates the HIPAA Privacy Rule and that compromises the security or privacy of the information.

Protected Health Information ("PHI"): Means individually identifiable health information, as defined by HIPAA, that is created or received by us and that relates to the past, present, or future physical or mental health or condition of an individual; the provision of health care to an individual; or the past, present, or future payment for the provision of health care to an individual; and that identifies the individual or for which there is a reasonable basis to believe the information can be used to identify the individual. PHI includes information of persons living or deceased.

Commitment to Protecting Health Information: The Plan will comply with the Standards for Privacy of Individually Identifiable Health Information (i.e., the "Privacy Rule") set forth by the U.S. Department of Health and Human Services ("HHS") pursuant to the Health Insurance Portability and Accountability Act of 1996 ("HIPAA"). Such standards control the dissemination of "protected health information" ("PHI") of Plan Members. Privacy Standards will be implemented and enforced in the offices of the Employer and Plan Sponsor and any other entity that may assist in the operation of the Plan.

The Plan is required by law to take reasonable steps to ensure the privacy of the Plan Member's PHI, and inform him/her about:

1. The Plan's disclosures and uses of PHI;
2. The Plan Member's privacy rights with respect to his/her PHI;
3. The Plan's duties with respect to his/her PHI;
4. The Plan Member's right to file a complaint with the Plan and with the Secretary of HHS; and

5. The person or office to contact for further information about the Plan's privacy practices.

Within this provision capitalized terms may be used, but not otherwise defined. These terms shall have the same meaning as those terms set forth in 45 CFR Sections 160.103 and 164.501. Any HIPAA regulation modifications altering a defined HIPAA term or regulatory citation shall be deemed incorporated into this provision.

How Health Information May be Used and Disclosed: In general, the Privacy Rules permit the Plan to use and disclose, the minimum necessary amount, an individual's PHI, without obtaining authorization, only if the use or disclosure is:

1. To carry out Payment of benefits;
2. For Health Care Operations;
3. For Treatment purposes; or
4. If the use or disclosure falls within one of the limited circumstances described in the rules (e.g., the disclosure is required by law or for public health activities).

Disclosure of PHI to the Plan Sponsor for Plan Administration Purposes: In order that the Plan Sponsor may receive and use PHI for plan administration purposes, the Plan Sponsor agrees to:

1. Not use or further disclose PHI other than as permitted or required by the Plan documents or as required by law (as defined in the Privacy Standards);
2. Ensure that any agents, including a subcontractor, to whom the Plan Sponsor provides PHI received from the Plan, agree to the same restrictions and conditions that apply to the Plan Sponsor with respect to such PHI;
3. Establish safeguards for information, including security systems for data processing and storage;
4. Maintain the confidentiality of all PHI, unless an individual gives specific consent or authorization to disclose such data or unless the data is used for health care payment or Plan operations;
5. Receive PHI, in the absence of an individual's express authorization, only to carry out Plan administration functions;
6. Not use or disclose genetic information for underwriting purposes;
7. Not use or disclose PHI for employment-related actions and decisions or in connection with any other benefit or Employee benefit plan of the Plan Sponsor, except pursuant to an authorization which meets the requirements of the Privacy Standards;
8. Report to the Plan any PHI use or disclosure that is inconsistent with the uses or disclosures provided for of which the Plan Sponsor becomes aware;
9. Make available PHI in accordance with section 164.524 of the Privacy Standards (45 CFR 164.524);
10. Make available PHI for amendment and incorporate any amendments to PHI in accordance with section 164.526 of the Privacy Standards (45 CFR 164.526);
11. Make available the information required to provide an accounting of disclosures in accordance with section 164.528 of the Privacy Standards (45 CFR 164.528);
12. Make its internal practices, books and records relating to the use and disclosure of PHI received from the Plan available to the Secretary of the U.S. Department of Health and Human Services ("HHS"), or any other officer or Employee of HHS to whom the authority involved has been delegated, for purposes of determining compliance by the Plan with part 164, subpart E, of the Privacy Standards (45 CFR 164.500 et seq);
13. Report to the Plan any inconsistent uses or disclosures of PHI of which the Plan Sponsor becomes aware;
14. Train Employees in privacy protection requirements and appoint a privacy compliance coordinator responsible for such protections;

15. If feasible, return or destroy all PHI received from the Plan that the Plan Sponsor still maintains in any form and retain no copies of such PHI when no longer needed for the purpose for which disclosure was made, except that, if such return or destruction is not feasible, limit further uses and disclosures to those purposes that make the return or destruction of the PHI infeasible; and
16. Ensure that adequate separation between the Plan and the Plan Sponsor, as required in section 164.504(f)(2)(iii) of the Privacy Standards (45 CFR 164.504(f)(2)(iii)), is established as follows:
17. The following Employees, or classes of Employees, or other persons under control of the Plan Sponsor, shall be given access to the PHI to be disclosed:

    - Privacy Officer: The access to and use of PHI by the individuals described above shall be restricted to the plan administration functions that the Plan Sponsor performs for the Plan.

18. In the event any of the individuals described above do not comply with the provisions of the Plan documents relating to use and disclosure of PHI, the Plan Administrator shall impose reasonable sanctions as necessary, in its discretion, to ensure that no further non-compliance occurs. The Plan Administrator will promptly report such violation or non-compliance to the Plan and will cooperate with the Plan to correct violation or non-compliance and to impose appropriate disciplinary action or sanctions. Such sanctions shall be imposed progressively (for example, an oral warning, a written warning, time off without pay and termination), if appropriate, and shall be imposed so that they are commensurate with the severity of the violation.

Disclosure of Summary Health Information to the Plan Sponsor: The Plan may disclose PHI to the Plan Sponsor of the group health plan for purposes of plan administration or pursuant to an authorization request signed by the Plan Member. The Plan may use or disclose "summary health information" to the Plan Sponsor for obtaining premium bids or modifying, amending, or terminating the group health plan.

Disclosure of Certain Enrollment Information to the Plan Sponsor: Pursuant to section 164.504(f)(1)(iii) of the Privacy Standards (45 CFR 164.504(f)(1)(iii)), the Plan may disclose to the Plan Sponsor information on whether an individual is participating in the Plan or is enrolled in or has un-enrolled from a health insurance issuer or health maintenance organization offered by the Plan to the Plan Sponsor.

Disclosure of PHI to Obtain Stop-loss or Excess Loss Coverage: The Plan Sponsor may hereby authorize and direct the Plan, through the Plan Administrator or the Third-Party Administrator, to disclose PHI to stop-loss carriers, excess loss carriers or managing general underwriters ("MGUs") for underwriting and other purposes in order to obtain and maintain stop-loss or excess loss coverage related to benefit claims under the Plan. Such disclosures shall be made in accordance with the Privacy Standards.

Other Disclosures and Uses of PHI

Primary Uses and Disclosures of PHI:

1. Treatment, Payment and Health Care Operations. The Plan has the right to use and disclose a Plan Member's PHI for all activities as included within the definitions of Treatment, Payment, and Health Care Operations and pursuant to the HIPAA Privacy Rule;

2. Business Associates. The Plan contracts with individuals and entities (Business Associates) to perform various functions on its behalf. In performance of these functions or to provide services, Business Associates will receive, create, maintain, use, or disclose PHI, but only after the Plan and the Business

Associate agree in writing to contract terms requiring the Business Associate to appropriately safeguard the Plan Member's information; and

3. Other Covered Entities. The Plan may disclose PHI to assist health care Providers in connection with their treatment or payment activities or to assist other covered entities in connection with payment activities and certain health care operations. For example, the Plan may disclose PHI to a health care Provider when needed by the Provider to render treatment to a Plan Member, and the Plan may disclose PHI to another covered entity to conduct health care operations. The Plan may also disclose or share PHI with other insurance carriers (such as Medicare, etc.) in order to coordinate benefits, if a Plan Member has coverage through another carrier.

Other Possible Uses and Disclosures of PHI:

1. Required by Law. The Plan may use or disclose PHI when required by law, provided the use or disclosure complies with and is limited to the relevant requirements of such law;

2. Public Health and Safety. The Plan may use or disclose PHI when permitted for purposes of public health activities, including disclosures to:

   - Report reactions to medications or problems with products or devices regulated by the Federal Food and Drug Administration or other activities related to quality, safety, or effectiveness of FDA-regulated products or activities;
   - Locate and notify persons of recalls of products they may be using; and
   - A person who may have been exposed to a communicable Disease or may otherwise be at risk of contracting or spreading a Disease or condition, if authorized by law;

   The Plan may disclose PHI to a government authority when required or authorized by law, or with the Plan Member's agreement, if the Plan reasonably believes he/she to be a victim of abuse, neglect, or domestic violence. In such case, the Plan will promptly inform the Plan Member that such a disclosure has been or will be made unless the Plan believes that informing him/her would place him/her at risk of serious harm (but only to someone in a position to help prevent the threat). Disclosure generally may be made to a minor's parents or other representatives although there may be circumstances under Federal or State law when the parents or other representatives may not be given access to the minor's PHI;

3. Health Oversight Activities. The Plan may disclose PHI to a health oversight agency for oversight activities authorized by law. This includes civil, administrative or criminal investigations; inspections; claim audits; licensure or disciplinary actions; and other activities necessary for appropriate oversight of a health care system, government health care program, and compliance with certain laws;

4. Lawsuits and Disputes. The Plan may disclose PHI when required for judicial or administrative proceedings. For example, the Plan Member's PHI may be disclosed in response to a subpoena, discovery requests, or other required legal processes when the Plan is given satisfactory assurances that the requesting party has made a good faith attempt to advise the Plan Member of the request or to obtain an order protecting such information, and done in accordance with specified procedural safeguards;

5. Law Enforcement. The Plan may disclose PHI to a law enforcement official when required for law enforcement purposes concerning identifying or locating a suspect, fugitive, material witness or missing person. Under certain circumstances, the Plan may disclose the Plan Member's PHI in response to a law enforcement official's request if he/she is, or are suspected to be, a victim of a crime and if it believes in

good faith that the PHI constitutes evidence of criminal conduct that occurred on the Sponsor's or Plan's premises;

6. Decedents. The Plan may disclose PHI to family members or others involved in decedent's care or payment for care, a coroner, funeral director or medical examiner for the purpose of identifying a deceased person, determining a cause of death or as necessary to carry out their duties as authorized by law. The decedent's health information ceases to be protected after the individual is deceased for 50 years;

7. Research. The Plan may use or disclose PHI for research, subject to certain limited conditions;

8. To Avert a Serious Threat to Health or Safety. The Plan may disclose PHI in accordance with applicable law and standards of ethical conduct, if the Plan, in good faith, believes the use or disclosure is necessary to prevent or lessen a threat to health or safety of a person or to the public;

9. Worker's Compensation. The Plan may disclose PHI when authorized by and to the extent necessary to comply with workers' compensation or other similar programs established by law; and

10. Military and National Security. The Plan may disclose PHI to military authorities of armed forces personnel under certain circumstances. As authorized by law, the Plan may disclose PHI required for intelligence, counter-intelligence, and other national security activities to authorized Federal officials.

Required Disclosures of PHI:

1. Disclosures to Plan Members: The Plan is required to disclose to a Plan Member most of the PHI in a Designated Record Set when the Plan Member requests access to this information. The Plan will disclose a Plan Member's PHI to an individual who has been assigned as his/her representative and who has qualified for such designation in accordance with the relevant State law. Before disclosure to an individual qualified as a personal representative, the Plan must be given written supporting documentation establishing the basis of the personal representation.
    - The Plan may elect not to treat the person as the Plan Member's personal representative if it has a reasonable belief that the Plan Member has been, or may be, subjected to domestic violence, abuse, or neglect by such person, it is not in the Plan Member's best interest to treat the person as his/her personal representative, or treating such person as his/her personal representative could endanger the Plan Member; and
    - Disclosures to the Secretary of the U.S. Dept. of Health and Human Services: The Plan is required to disclose the Plan Member's PHI to the Secretary of the U.S. Department of Health and Human Services when the Secretary is investigating or determining the Plan's compliance with the HIPAA Privacy Rule.

Instances When Required Authorization Is Needed from Plan Members Before Disclosing PHI:

1. Uses and disclosures for marketing;
2. Sale of PHI; and
3. Other uses and disclosures not described in this section can only be made with authorization from the Plan Member. The Plan Member may revoke this authorization at any time.

Plan Member's Rights: The Plan Member has the following rights regarding PHI about him/her:

1. Request Restrictions. The Plan Member has the right to request additional restrictions on the use or disclosure of PHI for treatment, payment, or health care operations. The Plan Member may request that the Plan restrict disclosures to family members, relatives, friends or other persons identified by him/her who are involved in his/her care or payment for his/her care. The Plan is not required to agree to these requested restrictions;

2. Right to Receive Confidential Communication. The Plan Member has the right to request that he/she receive communications regarding PHI in a certain manner or at a certain location. The request must be made in writing and how the Plan Member would like to be contacted. The Plan will accommodate all reasonable requests;

3. Right to Receive Notice of Privacy Practices. The Plan Member is entitled to receive a paper copy of the plan's Notice of Privacy Practices at any time. To obtain a paper copy, contact the Privacy Compliance Coordinator;

4. Accounting of Disclosures. The Plan Member has the right to request an accounting of disclosures the Plan has made of his/her PHI. The request must be made in writing and does not apply to disclosures for treatment, payment, health care operations, and certain other purposes. The Plan Member is entitled to such an accounting for the 6 years prior to his/her request. Except as provided below, for each disclosure, the accounting will include: (a) the date of the disclosure, (b) the name of the entity or person who received the PHI and, if known, the address of such entity or person; (c) a description of the PHI disclosed, (d) a statement of the purpose of the disclosure that reasonably informs the Plan Member of the basis of the disclosure, and certain other information. If the Plan Member wishes to make a request, please contact the Privacy Compliance Coordinator;

5. Access. The Plan Member has the right to request the opportunity to look at or get copies of PHI maintained by the Plan about him/her in certain records maintained by the Plan. If the Plan Member requests copies, he/she may be charged a fee to cover the costs of copying, mailing, and other supplies. To inspect or copy PHI, or to have a copy of your PHI transmitted directly to another designated person, contact the Privacy Compliance Coordinator. A request to transmit PHI directly to another designated person must be in writing, signed by the Plan Member and the recipient must be clearly identified. The Plan must respond to the Plan Member's request within 30 days (in some cases, the Plan can request a 30-day extension). In very limited circumstances, the Plan may deny the Plan Member's request. If the Plan denies the request, the Plan Member may be entitled to a review of that denial;

6. Amendment. The Plan Member has the right to request that the Plan change or amend his/her PHI. The Plan reserves the right to require this request be in writing. Submit the request to the Privacy Compliance Coordinator. The Plan may deny the Plan Member's request in certain cases, including if it is not in writing or if he/she does not provide a reason for the request; and

7. Fundraising Contacts. The Plan Member has the right to opt out of fundraising contacts.

Questions or Complaints: If the Plan Member wants more information about the Plan's privacy practices, has questions or concerns, or believes that the Plan may have violated his/her privacy rights, please contact the Plan using the following information. The Plan Member may submit a written complaint to the U.S. Department of Health and Human Services or with the Plan. The Plan will provide the Plan Member with the address to file his/her complaint with the U.S. Department of Health and Human Services upon request.

The Plan will not retaliate against the Plan Member for filing a complaint with the Plan or the U.S. Department of Health and Human Services. For Privacy Compliance Coordinator Contact Information, please contact the Plan Sponsor at the number indicated in Article II Purpose of Plan; General Information.

HIPAA SECURITY

Disclosure of Electronic Protected Health Information ("Electronic PHI") to the Plan Sponsor for Plan Administration Functions

STANDARDS FOR SECURITY OF INDIVIDUALLY IDENTIFIABLE HEALTH INFORMATION ("SECURITY RULE"): The Security Rule imposes regulations for maintaining the integrity, confidentiality and availability of protected health information that it creates, receives, maintains, or maintains electronically that is kept in electronic format (ePHI) as required under the Health Insurance Portability and Accountability Act (HIPAA).

Definitions:

Electronic Protected Health Information (ePHI): As defined in Section 160.103 of the Security Standards (45 C.F.R. 160.103), means individually identifiable health information transmitted or maintained in any electronic media.

Security Incidents: As defined within Section 164.304 of the Security Standards (45 C.F.R. 164.304), means the attempted or successful unauthorized access, use, disclosure, modification, or destruction of information or interference with systems operation in an information system.

Plan Sponsor Obligations: To enable the Plan Sponsor to receive and use Electronic PHI for Plan Administration Functions (as defined in 45 CFR §164.504(a)), the Plan Sponsor agrees to:

1. Implement administrative, physical, and technical safeguards that reasonably and appropriately protect the confidentiality, integrity and availability of the Electronic PHI that it creates, receives, maintains, or transmits on behalf of the Plan;
2. Ensure that adequate separation between the Plan and the Plan Sponsor, as required in 45 CFR § 164.504(f)(2)(iii), is supported by reasonable and appropriate Security Measures;
3. Ensure that any agent, including a subcontractor, to whom the Plan Sponsor provides Electronic PHI created, received, maintained, or transmitted on behalf of the Plan, agrees to implement reasonable and appropriate administrative, physical, and technical safeguards to protect the confidentiality, integrity, and availability of the Electronic PHI and report to the Plan any security incident of which it becomes aware; and
4. Report to the Plan any security incident of which it becomes aware.

Notification Requirements in the Event of a Breach of Unsecured PHI: The required breach notifications are triggered upon the discovery of a breach of unsecured PHI. A breach is discovered as of the first day the breach is known, or reasonably should have been known.

When a breach of unsecured PHI is discovered, the Plan will:

1. Notify the Plan Member whose PHI has been, or is reasonably believed to have been, assessed, acquired, used, or disclosed as a result of the breach, in writing, without unreasonable delay and in no case later than 60 calendar days after discovery of the breach. Breach Notification must be provided to individual by:

- Written notice by first-class mail to Plan Member (or next of kin) at last known address or, if specified by Plan Member, e-mail;
- If Plan has insufficient or out-of-date contact information for the Plan Member, the Plan Member must be notified by a "substitute form;
- If an urgent notice is required, Plan may contact the Plan Member by telephone.

    - The Breach Notification will have the following content:

        i. Brief description of what happened, including date of breach and date discovered;
        ii. Types of unsecured PHI involved (e.g., name, Social Security number, date of birth, home address, account number);
        iii. Steps Plan Member should take to protect from potential harm;
        iv. What the Plan is doing to investigate the breach, mitigate losses and protect against further breaches;

2. Notify the media if the breach affected more than 500 residents of a State or jurisdiction. Notice must be provided to prominent media outlets serving the State or jurisdiction without unreasonable delay and in no case later than 60 calendar days after the date the breach was discovered;
3. Notify the HHS Secretary if the breach involves 500 or more individuals, contemporaneously with the notice to the affected individual and in the manner specified by calHHS. If the breach involves less than 500 individuals, an internal log or other documentation of such breaches must be maintained and annually submitted to HHS within 60 days after the end of each calendar year; and
4. When a Business Associate, which provides services for the Plan and comes in contact with PHI in connection with those services discovers a breach has occurred, that Business Associate will notify the Plan without unreasonable delay and in no case later than 60 calendar days after discovery of a breach so that the affected Plan Members may be notified. To the extent possible, the Business Associate should identify each individual whose unsecured PHI has been, or is reasonably believed to have been, breached.

Any terms not otherwise defined in this section shall have the meanings set forth in the Security Standards.

ERISA- PLAN MEMBERS RIGHTS

As a Plan Member in the Plan, you are entitled to certain rights and protections under ERISA. ERISA provides that all Plan Members are entitled to:

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

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

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

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

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

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

Under ERISA, there are steps you can take to enforce the above rights. For instance, if you request a copy of Plan documents or the latest annual report from the Plan and do not receive them within 30 days, you may file suit in a Federal court. In such a case, the court may require the Plan Administrator to provide the materials and pay you up to $110 a day until you receive the materials, unless the materials were not sent because of reasons beyond the control of the Plan Administrator. If you have a claim for benefits which is denied or ignored, in whole or in part, you may file suit in a State or Federal court. In addition, if you disagree with the Plan's decision or lack thereof concerning the qualified status of a domestic relations order, you may file suit in Federal court. If it should happen that Plan fiduciaries misuse the Plan's money, or if you are discriminated against for asserting your rights, you may seek assistance from the U.S. Department of Labor, or you may file suit in a Federal court. The court will decide who would pay court costs and legal fees. If you are successful, the court may order the person you have sued to pay these costs and fees. If you lose, the court may order you to pay these costs and fees, for example, if it finds your claim is frivolous.

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

DEFINITIONS

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

Actively at Work: The active expenditure of time and energy in the service of the Plan Administrator. An individual will be considered actively at work on each day of a regular paid vacation or on a regular non-working day on which he or she is on a paid or unpaid Leave of Absence, provided he or she was Actively at Work on the last preceding regular working day.

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

- A denial in benefits;
- A reduction in benefits;
- A recession of coverage;
- A termination of benefits; or
- A failure to provide or make payment (in whole or in part) for a benefit, including any such denial, reduction, termination, or failure to provide or make payment that is based on a determination of a Claimant's eligibility to participate in the Plan.

Amendment: Any attached written description of additional or alternative provisions to the Plan. Amendments are effective only when signed by the Plan Administrator. Amendments are subject to all conditions, limitations and exclusions of the Plan, except for those that are specifically amended.

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

Congenital Anomaly: A physical developmental defect that is present at the time of birth, and that is identified within the first twelve months of birth.

Continuous Creditable Coverage: Health care coverage under any of the types of plans listed below, during which there was no break in coverage of 63 consecutive days or more:

- A group health plan
- Health insurance coverage
- Medicare
- Medicaid
- Medical and dental care for members and certain former members of the uniformed services, and for their dependents.
- A medical care program of the *Indian Health Services Program* or a tribal organization.
- A state health benefits risk pool.
- The Federal Employees Health Benefits Program.
- The State Children's Health Insurance Program (S-CHIP).
- Health plans established and maintained by foreign governments or political subdivisions and by the U.S. government. Any public health benefit program provided by a state, county, or other political subdivision of a state.
- A health benefit plan under the *Peace Corps Act*.

Co-pay: The charge stated as a set dollar amount, that the Plan Member is required to pay for certain Covered Health Services. If the Plan has co-pay benefits, please note that for Covered Health Services, the Plan Member is responsible for paying the lesser of the following:

- The applicable Co-pay.
- The Eligible Expense.

Cosmetic Procedures: Procedures or services that change or improve appearance without significantly improving physiological function, as determined by the Plan.

Covered Health Service(s)/Eligible Expenses: Those health services, including services, supplies, or Pharmaceutical Products, which the Plan determine to be all of the following:

- Provided for the purpose of preventing, diagnosing or treating a Sickness, Injury, Mental Illness, substance abuse, or their symptoms.
- Consistent with nationally recognized scientific evidence as available, and prevailing medical standards and clinical guidelines as described below.
- Not provided for the convenience of the Plan Member, Physician, facility or any other person.
- Described in this Plan under the Covered Medical Benefits.
- Not otherwise excluded in this Plan under Medical Exclusions and Limitations.

In applying the above definition, "Scientific Evidence" and "Prevailing Medical Standards" shall have the following meanings:

- "Scientific Evidence" means the results of controlled clinical trials or other studies published in peer-reviewed, medical literature generally recognized by the relevant medical specialty community.
- "Prevailing Medical Standards and Clinical Guidelines" means nationally recognized professional standards of care including, but not limited to, national consensus statements, nationally recognized clinical guidelines, and national specialty society guidelines.

Dependent: The legal Spouse or any married or unmarried dependent child (until they attain age 26) of the Employee or the Employee's Spouse. Spouses and children of an adult Dependent child are not eligible under the Plan. The term child includes any of the following:

- A natural child
- A stepchild
- A legally adopted child
- A child placed for adoption
- A child for whom legal guardianship has been awarded to the Employee or the Employee's Spouse
- A Dependent includes an unmarried dependent child of any age who is or becomes disabled and dependent upon the Employee.

To be eligible for coverage under the Plan, a Dependent must reside within the United States.

A Dependent also includes a child for whom health care coverage is required through a *Qualified Medical Child Support Order* or other court or administrative order. The Plan Administrator is responsible for determining if an order meets the criteria of a *Qualified Medical Child Support Order*.

A Dependent does not include anyone who is also enrolled as an Employee. No one can be a Dependent of more than one Employee.

Eligible Expenses: For covered health services, incurred while the Plan is in effect, Eligible Expenses are determined by the Plan as stated in the Covered Benefits section of this Plan Document.

Eligible Person: An Employee of the Employer or other person whose connection with the employee meets the eligibility requirements specified in both the application and the Plan. An eligible Employee and their eligible Dependents must reside within the United States.

Employer: Axion Staffing Group, Inc.

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

Essential Health Benefits: If the specific essential health benefit is an eligible benefit of the Plan, the Plan will not apply an annual or lifetime dollar maximum to the benefit. This is a limited benefit Plan, therefore, not all essential health benefits are eligible benefits of this Plan. See the Covered Medical Benefits and Prescription Drug sections of this document for eligible benefits of the Plan. The following are considered Essential Health Benefits: ambulatory patient services, emergency services, hospitalization, maternity and newborn care, mental health and substance use disorder services (including behavioral health treatment), prescription drugs, rehabilitative and habilitated services and devices, laboratory services, preventative and wellness services, chronic disease management, and pediatric services, to include dental and vision.

Excepted Benefits: Benefit Plans that may be exempt from ACA and HIPAA Portability Rules.

Experimental or Investigational Service(s): Medical, surgical, diagnostic, psychiatric, substance abuse or other health care services, technologies, supplies, treatments, procedures, drug therapies, medications or devices that, at the time the Plan makes a determination regarding coverage in a particular case, are determined to be any of the following:

- Not approved by the *U.S. Food and Drug Administration* (FDA) to be lawfully marketed for the proposed use and not identified in the *American Hospital Formulary Service* or the *United States Pharmacopoeia Dispensing Information* as appropriate for the proposed use.
- Subject to review and approval by any institutional review board for the proposed use. (Devices which are FDA approved under the *Humanitarian Use Device* exemption are not considered to be Experimental or Investigational.)
- The subject of an ongoing clinical trial that meets the definition of a Phase 1, 2 or 3 clinical trial set forth in the FDA regulations, regardless of whether the trial is actually subject to FDA oversight.

Exceptions: For Medically Necessary services which are included in the scope of coverage as provided under this Plan, when a Plan Member is participating in a phase I, II, III or IV clinical trial, conducted in relation to the prevention, detection or treatment of a life-threatening disease or condition, provided:

The clinical trial is approved by:

- The Centers for Disease Control and Prevention of the U.S. Department of Health and Human Services;
- The National Institute of Health;
- The U.S. Food and Drug Administration;
- The U.S. Department of Defense;
- The U.S. Department of Veterans Affairs; or
- An Institutional review board of an Institution that has an agreement with the Office for Human Research Protections of the U.S. Department of Health and Human Services; and
- The research Institution conducting the Approved Clinical Trial and each health professional providing routine patient care through the Institution, agree to accept reimbursement at the applicable Allowable Expense, as payment in full for routine patient care provided in connection with the Approved Clinical Trial.

Coverage will not be provided for:

- The cost of an Investigational new drug or device that is not approved for any indication by the U.S. Food and Drug Administration, including a drug or device that is the subject of the Approved Clinical Trial;
- The cost of a service that is not a health care service, regardless of whether the service is required in connection with participation in an Approved Clinical Trial;
- The cost of a service that is clearly inconsistent with widely accepted and established standards of care for a particular Diagnosis;
- A cost associated with managing an Approved Clinical Trial;

- The cost of a health care service that is specifically excluded by the Plan; or
- Services that are part of the subject matter of the Approved Clinical Trial and that are customarily paid for by the research Institution conducting the Approved Clinical Trial.

Family and Medical Leave Act (FMLA): If the employer meets the criteria of an eligible employer under the guidelines set forth by the Family and Medical Leave Act of 1993 and the Plan Member is an eligible employee under this Act, the Plan will abide by the rules adopted by the eligible employer for compliance with the Act's requirements for health care coverage.

Full-Time Employee: A Full-Time Employee is one who is considered Actively at Work with the employer, who works an average of 30 hours per week or more on an annual basis, and who is considered an employee under the U. S. Internal Revenue Service. An individual will be considered a Full-Time or eligible Employee while on paid vacation or on a regular non-working day on which he or she is on approved paid or unpaid Leave of Absence, provided he or she was Actively at Work on the last preceding regular working day.

Genetic Information Nondiscrimination Act "GINA": "GINA" prohibits group health plans, issuers of individual health care policies, and Employers from discriminating based on genetic information.
The term "Genetic Information" means, with respect to any individual, information about:

1. Such individual's genetic tests;
2. The genetic tests of family members of such individual; and
3. The manifestation of a Disease or disorder in family members of such individual.

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

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

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

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

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

HIPAA: The Health Insurance Portability and Accountable Act of 1996 as passed by Congress and the rules and regulations promulgated by the Department of Labor and other federal agencies.

Illness: Any disorder or disease of the body or mind; an accidental bodily Injury or a pregnancy. All Illnesses due to the same cause, or to a related cause, will be deemed to be an Illness. The donation of an organ or of tissue by a Plan Member for transplanting into another person is considered to be an Illness of the Plan Member making the donation.

Initial Enrollment Period: The initial period of time during which eligible Employees may enroll themselves and their Dependents under the Plan.
Injury: Bodily damage other than Sickness, including all related conditions and recurrent symptoms.

Late Enrollee: An eligible Employee or Dependent who enrolls for coverage under the Plan at a time other than the following:

- During the Initial Enrollment Period
- During an Open Enrollment Period
- During a special enrollment period
- Within 31 days of the date a new Eligible Person first becomes eligible

Leave of Absence: Any Employee of the Employer who is off work or temporarily working less than a normal schedule with the approval of the employer for medical leave, vacation or personal time off will be on a Leave of Absence. The length of leave will be defined by the employer.

Mail Order: A pharmacy which fills faxed, emailed or phoned prescriptions and mails the drug products to the Plan Member's home. Mail Order is not covered by this Plan.

Medically Necessary: To be considered for payment under the Plan, any service or charges submitted to the Plan must meet the conditions of being Medically Necessary. Care and treatment will be considered Medically Necessary if:

- It is consistent with the patient's condition or accepted standards of good medical practice and is medically proven to be effective treatment of the condition; and
- It is the most appropriate level of services which can be safely provided to the patient.

Medicare guidelines may be one of the factors used in determining appropriate use, necessary procedures, devices or services. Being approved by the FDA does not mean a prescription, devise or plan of treatment is Medically Necessary for the treatment or condition. Any appeal as to whether care or treatment is Medically Necessary may be referred to a medical reviewer chosen by the Plan Administrator. The decision of the Plan Administrator will be final and binding on all parties.

Medicare: Parts A, B, C and D of the insurance program established by Title XVIII, United States Social Security Act, as amended by 42 U.S.C. Sections 1394, et seq. and as later amended.

Mental Health Parity Act (MHPA) of 1996 and Mental Health Parity and Addiction Equity Act of 2008 (MHPAEA), Collectively, the Mental Health Parity Provisions in Part 7 of ERISA: The Mental Health Parity Provisions" shall mean in the case of a group health plan (or health insurance coverage offered in connection with such a plan) that provides both medical and surgical benefits and mental health or substance use disorder benefits, such plan or coverage shall ensure that:

- The financial requirements applicable to such mental health or substance use disorder benefits are no more restrictive than the predominant financial requirements applied to substantially all medical and surgical benefits covered by the Plan (or coverage) and that there are no separate cost sharing requirements that are applicable only with respect to mental health or substance use disorder benefits. If these benefits are covered by the group health plan (or health insurance coverage is offered in connection with such a plan); and
- The treatment limitations applicable to such mental health or substance use order benefits are no more restrictive than the predominant treatment limitations applied to substantially all medical and surgical benefits covered by the Plan (or coverage), and that there are no separate treatment limitations that are applicable only with respect to mental health or substance use disorder benefits. If these benefits are covered by the group health plan (or health insurance coverage offered in connection with such a plan).

Non-PPO Provider (Out-of-Network): Providers who are not members of this Plan's PPO are called Out-of-Network or Non-PPO Providers.

Open Enrollment Period: A period of time that follows the Initial Enrollment Period during which eligible Employees may enroll themselves and Dependents under the Plan. The Plan Administrator determines the period of time that is the Open Enrollment Period.

Out-of-Pocket Maximum: The Plan limited benefit Plan. The Plan Members will not be out-of-pocket more than the determined Department of Health and Human Services maximum out-of-pocket limit for the applicable Benefit Year for all eligible Essential Health Benefits.

Pharmaceutical Product(s): FDA-approved prescription pharmaceutical products administered in connection with a Covered Health Service by a Physician or other health care provider within the scope of the provider's license, and not otherwise excluded under the Plan.

Physician: Any Doctor of Medicine or Doctor of Osteopathy who is properly licensed and qualified by law.

Plan: Defined as the Axion Staffing Group Hospital Indemnity Plan.

Plan Member: An eligible Employee of the Employer or his or her Spouse who has submitted an enrollment form and has been accepted as a member of the Plan. An individual who is eligible for COBRA and is enrolled as a COBRA Plan Member will also be considered a Plan Member.

PPO Provider (In Network): The Plan is utilizing a Preferred Provider Organization or network who offers discounts to the Plan Members and the Plan. A listing of In-Network or PPO Providers will be made available to the Plan Member at no cost through the Plan Administrator. The Plan Member's personal identification card will notify the provider of membership in the network.

Premium: The periodic fee required for each Plan Member and each enrolled Dependent, in accordance with the terms of the Plan.

Preventive Care Services: This Plan intends to comply with the Patient Protection and Affordable Care Act's (PPACA) requirement to offer coverage for certain Preventive Care Services without cost-sharing. To comply with PPACA, and in accordance with the recommendations and guidelines, the Plan will provide coverage for:

- Evidence-based items or services rated A or B in the United States Preventive Services Task Force recommendations;

- Recommendations of the Advisory Committee on Immunization Practices adopted by the Director of the Centers for Disease Control and Prevention;
- Comprehensive guidelines for women supported by the Health Resources and Services Administration (HRSA).

For more information, you may contact the Plan Administrator / Employer at the phone number specified in the Other Information section of this document. Copies of the recommendations and guidelines may be reviewed at:

- www.uspreventiveservicestaskforce.org/Page/Name/uspstf-a-and-b-recommendations/
- www.healthcare.gov/coverage/preventive-care-benefits/

Retail: A pharmacy in which drugs are sold to patients on site of the pharmacy.

Specialist Physician: A Physician who has a majority of his or her practice in areas other than general pediatrics, internal medicine, obstetrics/gynecology, family practice or general medicine.

Spouse: A Dependent will include a Plan Member's Spouse (if not legally separated from the covered Plan Member). The term "Spouse" excludes non-married, same sex marriage, or common law Spouses, unless such relationship is recognized in statute or case law for a state of residence. Common law marriage must be documented as requested by the Benefits Administrator to include proof of an ongoing common law marriage relationship. Spouse must reside within the United States.

Total Disability or Totally Disabled: An Employee's inability to perform all of the substantial and material duties of his or her regular employment or occupation; and a Dependent's inability to perform the normal activities of a person of like age and sex.

Urgent Care Center: A facility that provides Covered Health Services that are required to prevent serious deterioration of your health, and that are required as a result of an unforeseen Sickness, Injury, or the onset of acute or severe symptoms.

Usual, Customary and Reasonable (UCR) Charge: If the Plan does not include a Network or the provider is out-of-network, the following provision will apply: "Usual and Customary" (U&C) shall mean Covered Expenses which are identified by the Plan Administrator, taking into consideration the fee(s) which the Provider most frequently charges (or accepts for) the majority of patients for the service or supply, the cost to the Provider for providing the services, the prevailing range of fees charged in the same "area" by Providers of similar training and experience for the service or supply, and the Medicare reimbursement rates. The term(s) "same geographic locale" and/or "area" shall be defined as a metropolitan area, county, or such greater area as is necessary to obtain a representative cross-section of Providers, persons or organizations rendering such treatment, services, or supplies for which a specific charge is made. To be Usual and Customary, fee(s) must be in compliance with generally accepted billing practices for unbundling or multiple procedures. However, for facility fees, except in instances where, in the Plan Administrator's discretion, claim specific facts indicate the Usual and Customary rate exceeds it, Usual and Customary shall not exceed 130% of the current Medicare allowable fee for the appropriate same geographic area, applicable to the treatment, supplies, and/or services.

If the Plan does not include a Network, the following provision will apply: "Usual and Customary" (U&C) shall mean covered expenses which are identified by the Plan Administrator, taking into consideration the fee(s) which the Provider most frequently charges the majority of patients for the service or supply, the cost to the Provider for providing the services, the prevailing range of fees charged in the same "area" by Providers of similar training and experience for the service or supply, and the Medicare reimbursement rates. Except in instances where, in the Plan

Administrator's discretion, claim specific facts indicate the Usual and Customary rate exceeds it, Usual and Customary shall not exceed 130% of the current Medicare allowable fee for the appropriate same geographic area, applicable to the treatment, supplies, and/or services.

The term(s) "same geographic locale" and/or "area" shall be defined as a metropolitan area, county, or such greater area as is necessary to obtain a representative cross-section of Providers, persons or organizations rendering such treatment, services, or supplies for which a specific charge is made. To be Usual and Customary, fee(s) must be in compliance with generally accepted billing practices for unbundling or multiple procedures.

The term "Usual" refers to the amount of a charge made for medical services, care, or supplies, to the extent that the charge does not exceed the common level of charges made by other medical professionals with similar credentials, or health care facilities, pharmacies, or equipment suppliers of similar standing, which are located in the same geographic locale in which the charge is Incurred.

The term "Customary" refers to the form and substance of a service, supply, or treatment provided in accordance with generally accepted standards of medical practice to one individual, which is appropriate for the care or treatment of the same sex, comparable age and who receive such services or supplies within the same geographic locale.

The term "Usual and Customary" does not necessarily mean the actual charge made nor the specific service or supply furnished to a Plan Member by a provider of services or supplies, such as a physician, therapist, nurse, hospital, or pharmacist. The Plan Administrator will determine what the Usual and Customary charge is, for any procedure, service, or supply, and whether a specific procedure, service or supply is Usual and Customary.

Usual and Customary charges may, at the Plan Administrator's discretion, alternatively be determined and established by the Plan using normative data such as, but not limited to, Medicare cost to charge ratios, average wholesale price (AWP) for prescriptions, manufacturer's retail pricing (MRP) for supplies and devices, Cost Plus, Regional Medicare Derivative, CMS established algorithms, CMS conversion values, publicly available data, or comparison of like services and facilities in proximity to non-certified CMS facilities, publicly available cost report data for facilities reported by cost center or by aggregate cost data when cost center data is unavailable.

OTHER INFORMATION

Name of Plan: Axion Staffing Group Hospital Indemnity Plan

Type of Plan: Health and Welfare Plan- Medical; Prescription Drugs

Benefits Administrator:
Concierge Administrative Services
P.O. Box 4070
Bartlesville, OK 74006
Toll-Free: 888.820.5687
Fax: 918.333.9505

EIN: 58-2449544

Plan Number: 28778

Plan Administrator:
Axiom Staffing Group, Inc.
Melissa Aaron
HR Manager
2475 Northwinds Pkwy, #575
Alpharetta, GA 30009
678-775-3944

Service of legal process may be made upon the Plan Administrator

Plan Sponsor:
HR Manager
2475 Northwinds Pkwy, #575
Alpharetta, GA 30009
678-775-3944

Plan Source of Funding: Self-Funded Plan. Contributions to this Plan may be by employer/or employees. Contributions are based on the amount necessary to provide the coverage required by the Plan.

Plan Status: Non-Grandfathered Plan

Applicable Law: ERISA

Agent for Service of Process:
Axiom Staffing Group, Inc.
Melissa Aaron
HR Manager
2475 Northwinds Pkwy, #575
Alpharetta, GA 30009
678-775-3944

Plan Year: January 1st- December 31st

Benefit Year: January 1st- December 31st

Loss of Benefits: Plan Member must continue to be an eligible member of the class to which the Plan pertains to qualify for benefits.

Fiduciary Name:
Axiom Staffing Group, Inc.
Melissa Aaron
HR Manager
2475 Northwinds Pkwy, #575
Alpharetta, GA 30009
678-775-3944

Privacy Compliance Officer:
Axiom Staffing Group, Inc.
Melissa Aaron
HR Manager
2475 Northwinds Pkwy, #575
Alpharetta, GA 30009
678-775-3944

Plan Amendment or Termination: Plan Administrator has the right to amend, modify, or terminate the Plan in any way, at any time, by written notification to Plan Members from the Plan Administrator.

Plan Interpretations: All interpretations of the Plan and all questions concerning its administration and application, including eligibility determinations, shall be the Plan Administrator's at his or her sole and absolute discretion. Such determinations shall be conclusive and binding on all persons. The Benefits Administrator will not have the authority to make Plan interpretations or make judgment decisions for the Plan and will at all times follow the rules of the Plan as defined in the Summary Plan Description and Plan Document. All discretionary questions regarding the payment of claims or the interpretation of the Plan shall be the exclusive right of the Plan Administrator who will have the final authority to authorize or disallow benefit payments in cases where a dispute exists.

ERISA Information: The Plan Member is entitled to certain rights and protections under ERISA. For a description of those rights, see "ERISA Rights" of the Plan.

Claim Fund Balance: Upon the timely file period of the Plan Year end, the remaining claims fund balance is retained by the Benefits Administrator.

This Hospital Indemnity Plan Document is approved December 31, 2020 and effective January 1, 2021.

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Plan Administrator Signature