SUMMARY OF MATERIAL MODIFICATION # 1
Cedarbridge Financial Services Employee Medical Plan Summary Plan Document

The Plan Sponsor Cedarbridge Financial Services, as the settlor of the Plan, amends Cedarbridge Financial Services Employee Medical Plan Summary Plan Description (SPD). This Summary supplements the SPD previously provided to you. You should retain this document with your copy of the SPD.

This is a Summary of Material Modifications (SMM) as required by the Employee Retirement Income Security Act of 1974, as amended, (ERISA). This SMM summarizes recent changes to the Cedarbridge Financial Services Employee Medical Plan (the "Plan"). It describes benefit and administrative changes affecting the information contained in your Summary Plan Description (SPD). Please read this information carefully; and keep it with your SPD for future reference.

The changes described in this SMM are effective as of January 1, 2025, and continue in force until amended. These changes in no way effect any other term or condition stated in your SPD unless that specific term is mentioned below.

1. **In the Table of Contents the following "Appendix C: Outpatient and Home Dialysis Benefit Guide" shall be deleted in its entirety including all addendums.**

2. **The last paragraph in the definition "Maximum Allowable Charge" shall be deleted in its entirety:**

   Notwithstanding the foregoing, the definition of "Maximum Allowable Charge" does not apply in respect of the Outpatient and Home Dialysis benefit, which shall be governed by the Outpatient and Home Dialysis Benefit Guide (Appendix E). For sake of clarity, the definition of "Usual and Reasonable Charge," as described in the Outpatient and Home Dialysis Benefit Guide, applies exclusively to the Outpatient and Home Dialysis benefit and not any other benefit

3. **The last paragraph in the definition "Usual & Customary (U&C)" shall be deleted in its entirety:**

   Notwithstanding the foregoing, the definition of "Usual and customary" does not apply in respect of the Outpatient and Home Dialysis benefit, which shall be governed by the Outpatient and Home Dialysis Benefit Guide (Appendix E). For sake of clarity, the definition of "Usual and Reasonable Charge," described in the Outpatient and Home Dialysis Benefit Guide, applies exclusively to the Outpatient and Home Dialysis benefit and not any other benefit.

4. **The last paragraph in the definition "Reasonable and/or Reasonableness," shall be deleted in its entirety:**

   Notwithstanding the foregoing, the definition of "Reasonable and/or Reasonableness" does not apply in respect of the Outpatient and Home Dialysis benefit, which shall be governed by the Outpatient and Home Dialysis Benefit Guide (Appendix E) For sake of clarity, the definition of "Usual and Reasonable Charge" described in the Outpatient and Home Dialysis Benefit Guide, applies exclusively to the Outpatient and Home Dialysis Benefit and not any other benefit.

5. **Medical Benefits: "Dialysis" will be deleted in its entirety and replaced with the following:**

   Dialysis. For Dialysis treatment, including Hemodialysis, and Peritoneal dialysis covered in all settings, home, office, and facilities.

Signature and Acceptance

The Plan Sponsor, Cedarbridge Financial Services, as the settlor of the Plan hereby adopts the foregoing changes to the SPD effective as of the earliest date set forth above.

Signed: _____

Name: Eli Serebrowski

Title: _Payroll & Employee Benefits_____

Date: ____11/08/2024_____

SUMMARY OF MATERIAL MODIFICATION # 2
Cedarbridge Financial Services Employee Medical Plan Summary Plan Document

The Plan Sponsor Cedarbridge Financial Services, as the settlor of the Plan, amends Cedarbridge Financial Services Employee Medical Plan Summary Plan Description (SPD). This Summary supplements the SPD previously provided to you. You should retain this document with your copy of the SPD.

This is a Summary of Material Modifications (SMM) as required by the Employee Retirement Income Security Act of 1974, as amended, (ERISA). This SMM summarizes recent changes to the Cedarbridge Financial Services Employee Medical Plan (the "Plan"). It describes benefit and administrative changes affecting the information contained in your Summary Plan Description (SPD). Please read this information carefully; and keep it with your SPD for future reference.

The changes described in this SMM are effective as of January 1, 2026, and continue in force until amended. These changes in no way effect any other term or condition stated in your SPD unless that specific term is mentioned below.

1. **In the Section "Eligibility For Coverage" on page 40 of the Summary Plan Description above <u>Reinstatement of Coverage</u> the following paragraph shall be added:**

   Spouses eligible for coverage under another group plan (as long as the other group plan meets the ACA's minimum value requirements) are not eligible for coverage under the Plan, except in the case of spouses who must wait to enroll during an open or special enrollment period of the other group plan. Such spouses may continue their coverage under the Plan until they are able to enroll in the other group plan at the time of an open or special enrollment period.

Signature and Acceptance

The Plan Sponsor, Cedarbridge Financial Services, as the settlor of the Plan hereby adopts the foregoing changes to the SPD effective as of the earliest date set forth above.

Signed: _____

Name: Eli Serebrowski

Title: Payroll & Employee Benefits

Date: 12.24.2025

SUMMARY OF MATERIAL MODIFICATION #3
for the Cedarbridge Financial Services Employee Medical Plan
Plan Document & Summary Plan Description

The Plan Sponsor Cedarbridge Financial Services, as the settler of the Plan, amends Cedarbridge Financial Services Employee Medical Plan Plan Document and Summary Plan Description (SPD). This Summary supplements the SPD previously provided to you. You should retain this document with your copy of the SPD.

This is a Summary of Material Modifications (SMM) as required by the Employee Retirement Income Security Act of 1974, as amended, (ERISA). This SMM summarizes recent changes to the Cedarbridge Financial Services Employee Medical Plan Plan Document and Summary Plan Description (the "Plan"). It describes benefit and administrative changes affecting the information contained in your SPD. Please read this information carefully; and keep it with your SPD for future reference.

The changes described in this SMM are effective as of January 1, 2026 and continue in force until amended. These changes in no way affect any other term or condition stated in your SPD unless that specific term is mentioned below.

1. **Utilization Review Manager, under General Plan Information, beginning on page 4 will be replaced with:**

   Utilization Review Manager: Leading Edge Administrators
   Phone: 1-877-630-9550

2. **CLAIM PROCEDURES; PAYMENT OF CLAIMS, Appeal of Adverse Benefit Determinations, page 79, item 1, will be deleted in it entirety and replaced with:**

   1. A 365-day timeframe following receipt of a notification of an initial Adverse Benefit Determination within which to appeal the determination. The Plan will not accept appeals filed after a 365-day timeframe.

3. **CLAIM PROCEDURES; PAYMENT OF CLAIMS, Requirements for First Level Appeal, page 80, paragraph 1, will be deleted in its entirety and replaced with:**

   The Claimant must file an appeal regarding a Post-service Claim and applicable Adverse Benefit Determination, in writing within 365 days following receipt of the notice of an Adverse Benefit Determination.

4. **MEDICAL BENEFITS, Medical Exclusions, beginning on page 128, will now include the following:**

   Orphan Disease. Charges for or related to Orphan Disease treatment. Orphan Disease means a condition that affects fewer than 200,000 people nationwide. This includes diseases as familiar as cystic fibrosis, Lou Gehrig's disease, and Tourette's syndrome, and as unfamiliar as Hamburger disease, Job syndrome, and acromegaly, or "gigantism".

Orphan Drug. Charges for or related to Orphan Drug(s). Orphan Drug(s) means a pharmaceutical agent that has been developed specifically to treat an Orphan Disease or other rare medical condition, and for purposes of this definition, the drug must be found on the FDA Orphan Drug Designation and Approvals listing, which can generally be found here. https://www.accessdata.fda.gov/scripts/opdlisting/oopd/

5. **UTILIZATION MANAGEMENT, Pre-Certification Procedures and Contact Information, paragraph 1, page 135, will be deleted in its entirety and replaced with:**

The Utilization Management Service is simple and easy for Participants to use. Whenever a Participant is advised that services requiring Pre-Certification are needed, it is the Participant's responsibility to call the pre-certification department at its toll-free number, which is 1-877-630-9550. The review process will continue, as outlined below, until the completion of the treatment plan and/or the Participant's discharge from the Hospital.

6. **UTILIZATION MANAGEMENT, Pre-Certification Penalty, page 136, will be deleted in its entirety and replaced with:**

The program requires the support and cooperation of each Participant and their Providers. Participants and Providers must follow the instructions set forth by the Plan. If a Provider fails to receive pre-certification for any services listed in the provision entitled "Services that Require Pre-Certification", allowed charges will be reduced by 50% when contractually allowed.

NOTE: *If a Participant's admission or service is determined to not be Medically Necessary, he or she may pursue an appeal by following the provisions described in the Claims Procedures; Payment of Claims section of this document. The Participant and Provider will be informed of any denial or non-certification in writing.*

7. **UTILIZATION MANAGEMENT, Retrospective Review, page 136, will be deleted in its entirety and replaced with:**

The Plan allows a review of the Medical Necessity of the health care services provided on an Emergency basis, after they have been provided. Leading Edge Administrators agrees to allow Anthem providers to send Medical Records and/or Clinical documentation directly to Leading Edge Administrators to request the retroactive authorizations for the below scenarios:

> Physical Therapy, Occupational Therapy, and Speech Therapy can be requested **within 72 hours** of the original date of service.

All other services that are listed as requiring a prior authorization where the Provider or Facility has failed to obtain an authorization **has 180 days from date of service** to submit a request for a retroactive authorization.

8. **APPENDIX E: SUMMARY OF BENEFITS HIGH PLAN, APPENDIX F: SUMMARY OF BENEFITS LOW PLAN, shall be deleted in their entirety and replaced with:**

APPENDIX E

LEADING EDGE ADMINISTRATORS

Cedarbridge Financial Services
Employee Benefit Summary – High SPP Plan (Plan D)
Network: National (BlueCard PPO) Network
Effective Date: 01/01/2026

Benefit	In-Network	Out-Of-Network
Plan Deductible	Individual: $1,750 Family: $3,500	Not Covered
Any Other Deductible	N/A	N/A
Deductible – Accumulation	Embedded	N/A
Deductible – INN and OON integration	N/A – Out of Network Benefits	
Member Coinsurance	20%	N/A
Out of Pocket Maximum	Individual: $5,500 Family: $11,000	N/A
Out of Pocket – Accumulation	Embedded	N/A
Out of Pocket – INN and OON integration	N/A – No Out of Network Benefits	
Annual Benefit Maximum	Unlimited	N/A
Benefit Period	Calendar Year	1/1 - 12/31

Savings Plus Plan benefit payment pricing of 150% of the Medicare Allowable rate applies to the following In-Network services: All in-patient and out-patient facility services; All in-patient professional and ancillary services; Surgical services – in a hospital in-patient and out-patient setting; Surgical services – in an ambulatory or free-standing surgical facility setting; All emergency services; Ambulance services - air, ground, and water; High cost diagnostic services, imaging, sleep management studies, and genetic services; dialysis/hemodialysis – all settings, all services; Infusion services – all settings, all services.
If an Out-Of-Network provider is used for these services, with the exception of Emergency Medical services and Emergency Transportation, plan payment will be based on 120% of the Medicare allowable rate.

Preventive Medical Services

Benefit	In-Network	Out-Of-Network
Primary Care Physician: Adult Routine Physical - 1 visit per plan year.	No Charge (Deductible Waived)	Not Covered
Pediatrician - Well Child Care: Up to age 2 - 9 visits per plan year Age 2 – 2 visits per plan year Age 3 and more – 1 visit per plan year	No Charge (Deductible Waived)	Not Covered
Children Eye Exam	No Charge (Deductible Waived)	Not Covered
Gynecological - Adult Routine Physical - 1 visit per plan year.	No Charge (Deductible Waived)	Not Covered
Maternity (ACA Required Prenatal /Postnatal Testing/Services only)	No Charge (Deductible Waived)	Not Covered
Routine Immunizations (Child & Adult)	No Charge (Deductible Waived)	Not Covered
Flu Shot (Routine)	No Charge (Deductible Waived)	Not Covered
X-Rays and Lab tests (Routine)	No Charge (Deductible Waived)	Not Covered
Mammography (Routine) – 1 per plan year; Age 40 and more	No Charge (Deductible Waived)	Not Covered
Pap-smear (Routine) – 1 per plan year	No Charge (Deductible Waived)	Not Covered
Prostate Cancer Screening PSA (Routine) - 1 per plan year	No Charge (Deductible Waived)	Not Covered

Cedarbridge Financial Services
Employee Benefit Summary – High SPP Plan (Plan D)
Network: National (BlueCard PPO) Network
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Colon Cancer Screening (Routine) - age 45-75 Colonoscopy – 1 in 10 years Sigmoidoscopy – 1 in 3 years	No Charge (Deductible Waived)	Not Covered

Non-Preventive Medical Services			
Benefit	**In-Network**		**Out-Of-Network**
Primary Care Physician Visits	**Professional Non-Facility based Services:** $15 Copay	**Facility based Services:** $15 Copay *Savings Plus Plan Benefit*	Not Covered
Specialist Physician Visits	**Professional Non-Facility based Services**: $50 Copay	**Facility based Services:** $50 Copay *Savings Plus Plan Benefit*	Not Covered
Maternity Professional: Hospital Stay Subject to Hospital Copay. Maternity Care for Dependent Children are not covered.	**Professional Non-Facility based Services**: $15 Copay per visit	**Facility based Services:** 20% Coinsurance after Deductible *Savings Plus Plan Benefit*	Not Covered
Chiropractic Care – Limited to 25 visits per Calendar Year	Office/Outpatient Settings: $50 Copay		Not Covered

Non-Preventive Lab and Radiology			
Benefit	**In-Network**		**Out-Of-Network**
Lab and Pathology	**Office Setting or Independent Lab:** No Charge	**Facility based Services:** 20% Coinsurance after Deductible *Savings Plus Plan Benefit*	Not Covered
X-Rays / Radiology	**Office Setting or Independent Lab:** $50 Copay	**Facility based Services:** 20% Coinsurance after Deductible *Savings Plus Plan Benefit*	Not Covered
MRI / MRA; CT / CTA / PET Scan; Genetic testing and counseling beyond ACA mandated is not covered.	**Office Setting or Independent Lab:** 20% Coinsurance after Deductible	**Facility based Services:** 20% Coinsurance after Deductible *Savings Plus Plan Benefit*	Not Covered
Sleep Studies / Sleep Management Services. Sleep Studies in the home are covered.	**Office, Independent Lab, or Home Setting:** $50 Copay *Savings Plus Plan Benefit*	**Facility based Services:** 20% Coinsurance after Deductible *Savings Plus Plan Benefit*	Not Covered

Inpatient Services		
Benefit	**In-Network**	**Out-Of-Network**
Pre-Surgical / Pre-Admission Testing	20% Coinsurance after Deductible *Savings Plus Plan Benefit*	Not Covered
Hospital Stay: Includes Room and Board; Drugs and Medication; Anesthesia and ICU; Maternity Stay, Inpatient Lab. Newborn not under mother for well newborn. Preauthorization is required.	20% Coinsurance after Deductible *Savings Plus Plan Benefit*	Not Covered
Inpatient Physician Services	20% Coinsurance after Deductible *Savings Plus Plan Benefit*	Not Covered

Cedarbridge Financial Services
Employee Benefit Summary – High SPP Plan (Plan D)
Network: National (BlueCard PPO) Network
Effective Date: 01/01/2026

Inpatient Maternity Professional. Maternity Care for Dependent Children is not covered.	20% Coinsurance after Deductible *Savings Plus Plan Benefit*		Not Covered
Anesthesia	20% Coinsurance after Deductible *Savings Plus Plan Benefit*		Not Covered
Inpatient Surgery- Surgeon/ Assistant Surgeon Charges	20% Coinsurance after Deductible *Savings Plus Plan Benefit*		Not Covered
Inpatient Behavioral / Mental Health & Chemical/Substance / Alcohol Abuse	20% Coinsurance after Deductible *Savings Plus Plan Benefit*		Not Covered
Inpatient Detoxification Preauthorization is required	20% Coinsurance after Deductible *Savings Plus Plan Benefit*		Not Covered
Inpatient Physical Medical Rehab	20% Coinsurance after Deductible *Savings Plus Plan Benefit*		Not Covered
Skilled Nursing Facility - Limited to 60 days per Calendar year. Required to follow IP Hospital stay of 3 days.	20% Coinsurance after Deductible *Savings Plus Plan Benefit*		Not Covered
Outpatient Services			
Benefit	**In-Network**		**Out-Of-Network**
Second Opinion – Surgical	**Professional Non-Facility based Services:** $15 Copay Non-Specialist $50 Copay Specialist	**Facility based Services:** $15 Copay Non-Specialist $50 Copay Specialist *Savings Plus Plan Benefit*	Not Covered
Outpatient Surgery Facility Preauthorization is required.	20% Coinsurance after Deductible *Savings Plus Plan Benefit*		Not Covered
Outpatient Surgery -Physician / Surgeon / Assistant Surgeon	20% Coinsurance after Deductible *Savings Plus Plan Benefit*		Not Covered
Anesthesia (including Office setting)	20% Coinsurance after Deductible *Savings Plus Plan Benefit*		Not Covered
Home Health Care - Patient required to be homebound. Home Health Aides are covered.	$50 Copay		Not Covered
Hospice – Facility and/or Home Limited to 210 days per lifetime. Precertification Required.	20% Coinsurance after Deductible *Savings Plus Plan Benefit*		Not Covered

Cedarbridge Financial Services
Employee Benefit Summary – High SPP Plan (Plan D)
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Behavioral/Mental Health & Chemical / Substance or Alcohol Abuse: Medication Management, Psych testing, Eating disorders and Bereavement counseling are covered. Partial Hospitalization and Intensive Outpatient Therapy are covered. Methadone clinics and Halfway Homes are not covered.	**Office Professional & Outpatient Institutional:** $15 Copay	**IOP/PHP Services:** 20% Coinsurance after Deductible *Savings Plus Plan Benefit*	Not Covered
Therapy Services			
Benefit	**In-Network**		**Out-Of-Network**
ABA Therapy: Autism Spectrum disorder and Developmental delays are covered.	**Professional Non-Facility based Services:** $15 Copay	**Facility based Services:** $15 Copay *Savings Plus Plan Benefit*	Not Covered
Cardiac Rehabilitation	**Professional Non-Facility based Services**: $50 Copay	**Facility based Services:** $50 Copay *Savings Plus Plan Benefit*	Not Covered
Chemotherapy – Provider may buy and bill. Excludes Orphan Drugs.	**Professional Non-Facility based Services**: $50 Copay	**Facility based Services:** $50 Copay *Savings Plus Plan Benefit*	Not Covered
Dialysis / Hemodialysis Home Dialysis is covered.	**All Settings including Home Setting**: $50 Copay *Savings Plus Plan Benefit*		Not Covered
Gene/Cellular Therapy	Not Covered		Not Covered
Home Infusion – Visits count toward the Home Health Care visit limit of 60 per Calendar Year. – Provider may buy and bill. Excludes Orphan Drugs.	20% Coinsurance after Deductible *Savings Plus Plan Benefit*		Not Covered
Home visits – Professional (not part of Home Health visits/ Home Health Aid Services)	$15 Copay / per visit Non-Specialist $50 Copay / per visit Specialist		Not Covered
Infusion Therapy: – Provider may buy and bill. Excludes Orphan Drugs.	20% Coinsurance after Deductible *Savings Plus Plan Benefit*		Not Covered
Occupational Therapy - Limited to 30 visits per Calendar Year, visit limits are followed with ASD diagnosis. Developmental delays **are** covered. Combined Institutional /Professional.	**Professional Non-Facility based Services**: $50 Copay	**Facility based Services:** $50 Copay *Savings Plus Plan Benefit*	Not Covered
Orthoptic / Pleoptic Therapy	Not Covered		Not Covered
Physical Therapy - Limited to 30 visits per Calendar Year, visit limits are followed with ASD diagnosis. Developmental delays are covered. Combined Institutional /Professional.	**Professional Non-Facility based Services**: $50 Copay	**Facility based Services:** $50 Copay *Savings Plus Plan Benefit*	Not Covered
Pulmonary/Respiratory Therapy - Limited to 30 visits per Calendar year.	**Professional Non-Facility based Services**: $50 Copay	**Facility based Services:** $50 Copay *Savings Plus Plan Benefit*	Not Covered
Radiation Therapy	**Professional Non-Facility based Services**: $50 Copay	**Facility based Services:** $50 Copay *Savings Plus Plan Benefit*	Not Covered

Cedarbridge Financial Services
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Speech Therapy - Limited to 30 visits per Calendar Year, visit limits are followed with ASD diagnosis. Developmental delays are covered. Combined Institutional /Professional.	**Professional Non-Facility based Services**: $50 Copay	**Facility based Services:** $50 Copay *Savings Plus Plan Benefit*	Not Covered
Emergency Services			
Benefit	**In-Network & Out-Of-Network**		
Emergency Care – ER Copay is waived if admitted.	$500 Copay *Savings Plus Plan Benefit*		
Urgent Care	$75 Copay	Not Covered	
Emergency Medical Transportation: Ground, and Air Ambulance are covered.	$500 Copay *Savings Plus Plan Benefit*		
Other Services			
Benefit	**In-Network**		**Out-Of-Network**
Abortion - Elective & Therapeutic. Maternity Care for Dependent Children are not covered.	**Professional Non-Facility based Services:** 20% Coinsurance after Deductible	**Facility based Services:** 20% Coinsurance after Deductible *Savings Plus Plan Benefit*	Not Covered
Acupuncture	**Professional Non-Facility based Services**: $50 Copay	**Facility based Services:** $50 Copay *Savings Plus Plan Benefit*	Not Covered
Allergy Services / Allergy Injections	**Professional Non-Facility based Services**: $50 Copay	**Facility based Services:** $50 Copay *Savings Plus Plan Benefit*	Not Covered
Allergy Testing	**Professional Non-Facility based Services**: $50 Copay	**Facility based Services:** $50 Copay *Savings Plus Plan Benefit*	Not Covered
Alternative Medicine	Not Covered		Not Covered
Ambulance Service – Non Emergency Transport	Not Covered		Not Covered
Bariatric Surgery	Not Covered		Not Covered
Biofeedback	Not Covered		Not Covered
Blood Processing / Blood Storage Includes autologous donation	**Professional Non-Facility based Services**: No Charge	**Facility based Services:** No Charge *Savings Plus Plan Benefit*	Not Covered
Dental – Accident to sound teeth only. Treatment must be started within 12 months of injury. Routine Dental is excluded.	Office/Outpatient Settings: $50 Copay		Not Covered
Durable Medical Equipment (Includes Diabetic Supplies) – includes repairs, and rentals. ACA Breast Pumps are covered at 100% All others at standard cost share.	20% Coinsurance after Deductible		Not Covered
Foot Care (routine)	Not Covered		Not Covered

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Hearing Aids (exams, fittings, and device) ACA mandated Hearing exams are covered at 100% under PPACA.	Not Covered		Not Covered
Hearing Exams – non routine ACA mandated Hearing exams are covered at 100% under PPACA.	**Professional Non-Facility based Services:** $15 Copay Non-Specialist $50 Copay Specialist	**Facility based Services:** $15 Copay Non-Specialist $50 Copay Specialist *Savings Plus Plan Benefit*	Not Covered
Immunization – (non-routine) Vaccinations for travel are excluded	**Professional Non-Facility based Services:** $15 Copay Non-Specialist $50 Copay Specialist	**Facility based Services:** $15 Copay Non-Specialist $50 Copay Specialist *Savings Plus Plan Benefit*	Not Covered
Infertility Services - Basic Testing Only	**Professional Non-Facility based Services**: $50 Copay	**Facility based Services:** $50 Copay *Savings Plus Plan Benefit*	Not Covered
Infertility Services – Comprehensive (AI) & Advanced (ZIFT/GIFT/IVF)	Not Covered		Not Covered
Injections – Provider may buy and bill. Excludes Orphan Drugs.	**Professional Non-Facility based Services:** $15 Copay Non-Specialist $50 Copay Specialist	**Facility based Services:** $15 Copay Non-Specialist $50 Copay Specialist *Savings Plus Plan Benefit*	Not Covered
Medical Nutrition Therapy	Not Covered		Not Covered
Medical Nutrition Products; Enteral feeding supplies, formulae and all infant formulae are not covered.	Not Covered		Not Covered
Medical & Diabetic Supplies	20% Coinsurance after Deductible		Not Covered
Nutritional Counseling – Diabetic	**Professional Non-Facility based Services:** $15 Copay	**Facility based Services:** $15 Copay *Savings Plus Plan Benefit*	Not Covered
Nutritional Counseling – Nondiabetics	**Professional Non-Facility based Services:** $15 Copay	**Facility based Services:** $15 Copay *Savings Plus Plan Benefit*	Not Covered
Online visits - Telephone consultations are excluded	$15 Copay Non-Specialist $50 Copay Specialist		Not Covered
Onsite Clinics	Not Covered		Not Covered
Oral Surgery – Includes removal of impacted wisdom teeth. Dental anesthesia is covered if related to payable oral surgery.	**Professional Non-Facility based Services**: $50 Copay	**Facility based Services:** $50 Copay *Savings Plus Plan Benefit*	Not Covered
Orthotics and Prosthetic Devices – Diabetic shoes, Orthopedic shoes, and arch supports are excluded.	20% Coinsurance after Deductible		Not Covered
Private Duty Nursing	Not Covered		Not Covered
Respite Care	Not Covered		Not Covered

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Retail Health Clinics	$15 Copay / per visit Non-Specialist $50 Copay / per visit Specialist		Not Covered
Sterilization – Men are covered. Woman are covered 100% per ACA.	**Professional Non-Facility based Services:** 20% Coinsurance after Deductible	**Facility based Services:** 20% Coinsurance after Deductible *Savings Plus Plan Benefit*	Not Covered
Sterilization Reversals	Not Covered		Not Covered
TMJ Treatment Non-surgical: Appliances are excluded	**Professional Non-Facility based Services**: $50 Copay	**Facility based Services:** $50 Copay *Savings Plus Plan Benefit*	Not Covered
TMJ Surgical Treatment	**Professional Non-Facility based Services:** 20% Coinsurance after Deductible	**Facility based Services:** 20% Coinsurance after Deductible *Savings Plus Plan Benefit*	Not Covered
Vision Exams (Routine) and Hardware	Not Covered		Not Covered
Vision surgery – Cataract and Glaucoma: (includes initial frames, lenses or contact following cataract surgery)	**Professional Non-Facility based Services:** 20% Coinsurance after Deductible	**Facility based Services:** 20% Coinsurance after Deductible *Savings Plus Plan Benefit*	Not Covered
Wigs – limited to 1 per benefit period with a maximum of $3,000 post Chemotherapy or Radiation.	**Professional Non-Facility based Services:** 20% Coinsurance after Deductible	**Facility based Services:** 20% Coinsurance after Deductible *Savings Plus Plan Benefit*	Not Covered

Transplant Services
Center of Excellence Locations Only

Benefit	**In-Network**	**Out-Of-Network**
Live Donor Health Services	20% Coinsurance after Deductible	Not Covered
Bone Marrow Donor Search	20% Coinsurance after Deductible	Not Covered
Organ Transplant – Facility	20% Coinsurance after Deductible	Not Covered
Organ Transplant – Physician & anesthesiologist	20% Coinsurance after Deductible	Not Covered
Travel and lodging for Organ Transplant	Not Covered	

Prescription Drug Benefits
Carelon Rx or 1-833-271-2374 www.carelonrx.com

Generic (Tier 1)	**No cost for Preventive Rx Drugs** **30 day supply:** $10 Copay **Mail Order up to 90 day supply:** $20 Copay	Not Covered
Preferred (Tier 2)	**30 day supply:** $50 Copay **Mail Order up to 90 day supply:** $100 Copay	Not Covered
Non-Limited/Non-Preferred (Tier 3)	**30 day supply:** 50% Coinsurance (Plan Deductible waived) **Mail Order up to 90 day supply:** 50% Coinsurance (Plan Deductible waived)	Not Covered

Cedarbridge Financial Services
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Specialty (Tier 4)	Not Covered	Not Covered

Preauthorization
Leading Edge Administrators 1-877-630-9550
The following services require Preauthorization, or benefit will be reduced to 50% of the allowed.

Inpatient Services:	Outpatient Services	Other Services:
Cervical Spine Surgery	Cartilage Transplant Knee	Bone Stimulator
Computer Navigation for Orthopedic Surgery	Cervical Spine Surgery	Cardio/External Defibrillator
Elective Admissions	Cochlear Implant	Cooling Devices
Emergency Admissions	Computer Navigation for Orthopedic Surgery	CPAP/BIPAP
Hospice	Lumbar Spine Surgery	Electric Scooters
Lumbar Spine Surgery	Mandibular/Maxillary Surgery (Orthognathic)	Infusion Pumps
Rehabilitation Facility Admissions	Mastectomy for Gynecomastia	Insulin Pumps
Sacroiliac Joint Fusion	Nasal Septoplasty	Limb Prosthetics
Skilled Nursing Facility Admissions	Reduction Mammoplasty	Myoelectric prosthetics
Transplants	Rhinoplasty	Neuromuscular Stimulators
	Sacroiliac Joint Fusion	TENS Unit
	Sclerotherapy (Lower Extremities)	Wheelchairs
Managed Care Services:	Sleep Apnea Surgery - LAUP/UPPP, Nasal, and Uvulopalatoplasty	Wound Vacs
Inpatient BH/SA	Botulinum Toxin – Review for Migraine Use Only	
Electric Convulsive Therapy (ECT)	Home Health Services	
Intensive Outpatient Therapy	Home Hospice	
Partial Hospitalization (PHO)	Hyperbaric Oxygen Therapy (Systemic/Topical)	
Residential Care (RTC)	Coronary CT Angiography (CCTA)	
Psychological testing	Coronary MRA	
Genetic Counseling	Cardiac MRI	
	MRA of the Head and/or Neck	
	MRI of the Brain	
	MRI of the Spine – Cervical, Thoracic, Lumbar, Sacral	
	PET Scan	
	Physical/Occupational/Speech Therapy	

Cedarbridge Financial Services
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Exclusions In addition to exclusions listed in the document, the following services are excluded from coverage under the Plan	
Acupuncture	Hearing Aids (exams, device, fitting, repairs)
Advanced and Comprehensive Infertility Services	Long-Term Care
Alternative Medicine/homeopathy	Massage Therapy
Aquatic Therapy	Maternity Care for dependent children
Arch supports (supportive shoe inserts)	Methadone Clinics
Bariatric Surgery	Non-Emergency Care outside the U.S.
Biofeedback	Non-Emergency Care in ER Setting
Cosmetic Surgery (exclusion does not apply to breast reconstruction post-mastectomy)	Orphan Drugs
Custodial Care	Orthopedic Shoes/ orthopedic inserts – Non-diabetic
Dental Care (Routine) Adult and Child except ACA allowed	Respite Care
Erectile Dysfunction	Routine Eye Care (Adult) and Child except ACA allowed
Foot Care - Routine	Self-Inflicted unless result of medical condition
Gene and Cellular Therapy	TMJ Appliances
Growth Hormone Therapy	Vision Exams and Hardware
Halfway house/home – non-healthcare residential facility	Weight Loss Programs

APPENDIX F

LEADING EDGE ADMINISTRATORS

Cedarbridge Financial Services
Employee Benefit Summary – Low SPP Plan (Plan E)
Network: National (BlueCard PPO) Network
Effective Date: 01/01/2026

Benefit	In-Network	Out-Of-Network
Plan Deductible	Individual: $2,500 Family: $5,000	Not Covered
Any Other Deductible	N/A	N/A
Deductible – Accumulation	Embedded	N/A
Deductible – INN and OON integration	N/A – No Out of Network Benefits	
Member Coinsurance	30%	N/A
Out of Pocket Maximum	Individual: $7,500 Family: $15,000	N/A
Out of Pocket – Accumulation	Embedded	N/A
Out of Pocket – INN and OON integration	N/A – No Out of Network Benefits	
Annual Benefit Maximum	Unlimited	N/A
Benefit Period	Calendar Year	1/1 - 12/31

Savings Plus Plan benefit payment pricing of 150% of the Medicare Allowable rate applies to the following In-Network services: All in-patient and out-patient facility services; All in-patient professional and ancillary services; Surgical services – in a hospital in-patient and out-patient setting; Surgical services – in an ambulatory or free-standing surgical facility setting; All emergency services; Ambulance services - air, ground, and water; High cost diagnostic services, imaging, sleep management studies, and genetic services; dialysis/hemodialysis – all settings, all services; Infusion services – all settings, all services.
If an Out-Of-Network provider is used for these services, with the exception of Emergency Medical services and Emergency Transportation, plan payment will be based on 120% of the Medicare allowable rate.

Preventive Medical Services

Benefit	In-Network	Out-Of-Network
Primary Care Physician: Adult Routine Physical - 1 visit per plan year.	No Charge (Deductible Waived)	Not Covered
Pediatrician - Well Child Care: Up to age 2 - 9 visits per plan year Age 2 – 2 visits per plan year Age 3 and more – 1 visit per plan year	No Charge (Deductible Waived)	Not Covered
Children Eye Exam	No Charge (Deductible Waived)	Not Covered
Gynecological - Adult Routine Physical - 1 visit per plan year.	No Charge (Deductible Waived)	Not Covered
Maternity (ACA Required Prenatal /Postnatal Testing/Services only)	No Charge (Deductible Waived)	Not Covered
Routine Immunizations (Child & Adult)	No Charge (Deductible Waived)	Not Covered
Flu Shot (Routine)	No Charge (Deductible Waived)	Not Covered
X-Rays and Lab tests (Routine)	No Charge (Deductible Waived)	Not Covered
Mammography (Routine) – 1 per plan year; Age 40 and more	No Charge (Deductible Waived)	Not Covered
Pap-smear (Routine) – 1 per plan year	No Charge (Deductible Waived)	Not Covered
Prostate Cancer Screening PSA (Routine) - 1 per plan year	No Charge (Deductible Waived)	Not Covered

Cedarbridge Financial Services
Employee Benefit Summary – Low SPP Plan (Plan E)
Network: National (BlueCard PPO) Network
Effective Date: 01/01/2026

Colon Cancer Screening (Routine) - age 45-75 Colonoscopy – 1 in 10 years Sigmoidoscopy – 1 in 3 years	No Charge (Deductible Waived)	Not Covered

Non-Preventive Medical Services			
Benefit	**In-Network**		**Out-Of-Network**
Primary Care Physician Visits	**Professional Non-Facility based Services:** $25 Copay	**Facility based Services:** $25 Copay *Savings Plus Plan Benefit*	Not Covered
Specialist Physician Visits	**Professional Non-Facility based Services**: $60 Copay	**Facility based Services:** $60 Copay *Savings Plus Plan Benefit*	Not Covered
Maternity Professional: Hospital Stay Subject to Hospital Copay. Maternity Care for Dependent Children are not covered.	**Professional Non-Facility based Services**: $25 Copay per visit	**Facility based Services:** 30% Coinsurance after Deductible *Savings Plus Plan Benefit*	Not Covered
Chiropractic Care – Limited to 25 visits per Calendar Year	Office/Outpatient Settings: $60 Copay		Not Covered

Non-Preventive Lab and Radiology			
Benefit	**In-Network**		**Out-Of-Network**
Lab and Pathology	**Office Setting or Independent Lab:** No Charge	**Facility based Services:** 30% Coinsurance after Deductible *Savings Plus Plan Benefit*	Not Covered
X-Rays / Radiology	**Office Setting or Independent Lab:** $50 Copay	**Facility based Services:** 30% Coinsurance after Deductible *Savings Plus Plan Benefit*	Not Covered
MRI / MRA; CT / CTA / PET Scan; Genetic testing and counseling beyond ACA mandated is not covered.	**Office Setting or Independent Lab:** 30% Coinsurance after Deductible	**Facility based Services:** 30% Coinsurance after Deductible *Savings Plus Plan Benefit*	Not Covered
Sleep Studies/Sleep Management Services; Sleep Studies in the home are covered.	**Office, Independent Lab, or Home Setting:** $50 Copay *Savings Plus Plan Benefit*	**Facility based Services:** 30% Coinsurance after Deductible *Savings Plus Plan Benefit*	Not Covered

Inpatient Services		
Benefit	**In-Network**	**Out-Of-Network**
Pre-Surgical / Pre-Admission Testing	30% Coinsurance after Deductible *Savings Plus Plan Benefit*	Not Covered
Hospital Stay: Includes Room and Board; Drugs and Medication; Anesthesia and ICU; Maternity Stay, Inpatient Lab. Newborn not under mother for well newborn. Preauthorization is required.	30% Coinsurance after Deductible *Savings Plus Plan Benefit*	Not Covered
Inpatient Physician Services	30% Coinsurance after Deductible *Savings Plus Plan Benefit*	Not Covered

Cedarbridge Financial Services
Employee Benefit Summary – Low SPP Plan (Plan E)
Network: National (BlueCard PPO) Network
Effective Date: 01/01/2026

Inpatient Maternity Professional. Maternity Care for Dependent Children is not covered.	30% Coinsurance after Deductible *Savings Plus Plan Benefit*		Not Covered
Anesthesia	30% Coinsurance after Deductible *Savings Plus Plan Benefit*		Not Covered
Inpatient Surgery- Surgeon/ Assistant Surgeon Charges	30% Coinsurance after Deductible *Savings Plus Plan Benefit*		Not Covered
Inpatient Behavioral / Mental Health & Chemical/Substance / Alcohol Abuse	30% Coinsurance after Deductible *Savings Plus Plan Benefit*		Not Covered
Inpatient Detoxification Preauthorization is required	30% Coinsurance after Deductible *Savings Plus Plan Benefit*		Not Covered
Inpatient Physical Medical Rehab	30% Coinsurance after Deductible *Savings Plus Plan Benefit*		Not Covered
Skilled Nursing Facility - Limited to 60 days per Calendar year. Required to follow IP Hospital stay of 3 days.	30% Coinsurance after Deductible *Savings Plus Plan Benefit*		Not Covered
Outpatient Services			
Benefit	**In-Network**		**Out-Of-Network**
Second Opinion – Surgical	**Professional Non-Facility based Services:** $25 Copay Non-Specialist $60 Copay Specialist	**Facility based Services:** $25 Copay Non-Specialist $60 Copay Specialist *Savings Plus Plan Benefit*	Not Covered
Outpatient Surgery Facility Preauthorization is required.	30% Coinsurance after Deductible *Savings Plus Plan Benefit*		Not Covered
Outpatient Surgery -Physician / Surgeon / Assistant Surgeon	30% Coinsurance after Deductible *Savings Plus Plan Benefit*		Not Covered
Anesthesia (including Office setting)	30% Coinsurance after Deductible *Savings Plus Plan Benefit*		Not Covered
Home Health Care - Patient required to be homebound. Home Health Aides are covered.	$60 Copay		Not Covered
Hospice – Facility and/or Home Limited to 210 days per lifetime. Precertification Required.	30% Coinsurance after Deductible *Savings Plus Plan Benefit*		Not Covered
Behavioral/Mental Health & Chemical / Substance or Alcohol Abuse: Medication Management, Psych testing, eating disorders and Bereavement counseling are covered. Partial Hospitalization and Intensive Outpatient Therapy are covered. Methadone clinics and Halfway Homes are not covered.	**Office Professional & Outpatient Institutional:** $25 Copay	**IOP/PHP Services:** 30% Coinsurance after Deductible *Savings Plus Plan Benefit*	Not Covered

Cedarbridge Financial Services
Employee Benefit Summary – Low SPP Plan (Plan E)
Network: National (BlueCard PPO) Network
Effective Date: 01/01/2026

Therapy Services			
Benefit	**In-Network**		**Out-Of-Network**
ABA Therapy: Autism Spectrum disorder and Developmental delays are covered.	**Office Professional & Outpatient Institutional:** $25 Copay	**Facility based Services:** $25 Copay *Savings Plus Plan Benefit*	Not Covered
Cardiac Rehabilitation	**Professional Non-Facility based Services**: $60 Copay	**Facility based Services:** $60 Copay *Savings Plus Plan Benefit*	Not Covered
Chemotherapy– Provider may buy and bill. Excludes Orphan Drugs.	**Professional Non-Facility based Services**: $60 Copay	**Facility based Services:** $60 Copay *Savings Plus Plan Benefit*	Not Covered
Dialysis / Hemodialysis Home Dialysis is covered.	**All Settings including Home Setting**: $60 Copay *Savings Plus Plan Benefit*		Not Covered
Gene/Cellular Therapy	Not Covered		Not Covered
Home Infusion – Visits count toward the Home Health Care visit limit of 60 per Calendar Year. Provider may buy and bill. Excludes Orphan Drugs.	30% Coinsurance after Deductible *Savings Plus Plan Benefit*		Not Covered
Home visits – Professional (not part of Home Health visits/ Home Health Aid Services)	$25 Copay / per visit Non-Specialist $60 Copay / per visit Specialist		Not Covered
Infusion Therapy– Provider may buy and bill. Excludes Orphan Drugs.	30% Coinsurance after Deductible *Savings Plus Plan Benefit*		Not Covered
Occupational Therapy - Limited to 30 visits per Calendar Year, visit limits are followed with ASD diagnosis. Developmental delays **are** covered. Combined Institutional /Professional.	**Professional Non-Facility based Services**: $60 Copay	**Facility based Services:** $60 Copay *Savings Plus Plan Benefit*	Not Covered
Orthoptic / Pleoptic Therapy	Not Covered		Not Covered
Physical Therapy - Limited to 30 visits per Calendar Year, visit limits are followed with ASD diagnosis. Developmental delays are **covered**. Combined Institutional /Professional.	**Professional Non-Facility based Services**: $60 Copay	**Facility based Services:** $60 Copay *Savings Plus Plan Benefit*	Not Covered
Pulmonary/Respiratory Therapy - Limited to 30 visits per Calendar year.	**Professional Non-Facility based Services**: $60 Copay	**Facility based Services:** $60 Copay *Savings Plus Plan Benefit*	Not Covered
Radiation Therapy	**Professional Non-Facility based Services**: $60 Copay	**Facility based Services:** $60 Copay *Savings Plus Plan Benefit*	Not Covered
Speech Therapy - Limited to 30 visits per Calendar Year, visit limits are followed with ASD diagnosis. Developmental delays are covered. Combined Institutional /Professional.	**Professional Non-Facility based Services**: $60 Copay	**Facility based Services:** $60 Copay *Savings Plus Plan Benefit*	Not Covered
Emergency Services			

LEADING EDGE ADMINISTRATORS

Cedarbridge Financial Services
Employee Benefit Summary – Low SPP Plan (Plan E)
Network: National (BlueCard PPO) Network
Effective Date: 01/01/2026

Benefit	**In-Network & Out-Of-Network**	
Emergency Care – ER Copay is waived if admitted.	$500 Copay *Savings Plus Plan Benefit*	
Urgent Care	$75 Copay	Not Covered
Emergency Medical Transportation: Ground, and Air Ambulance are covered.	$500 Copay *Savings Plus Plan Benefit*	

Other Services			
Benefit	**In-Network**		**Out-Of-Network**
Abortion - Elective & Therapeutic. Maternity Care for Dependent Children are not covered.	**Professional Non-Facility based Services:** 30% Coinsurance after Deductible	**Facility based Services:** 30% Coinsurance after Deductible *Savings Plus Plan Benefit*	Not Covered
Acupuncture	**Professional Non-Facility based Services**: $60 Copay	**Facility based Services:** $60 Copay *Savings Plus Plan Benefit*	Not Covered
Allergy Services / Allergy Injections	**Professional Non-Facility based Services**: $60 Copay	**Facility based Services:** $60 Copay *Savings Plus Plan Benefit*	Not Covered
Allergy Testing	**Professional Non-Facility based Services**: $60 Copay	**Facility based Services:** $60 Copay *Savings Plus Plan Benefit*	Not Covered
Alternative Medicine	Not Covered		Not Covered
Ambulance Service – Non-Emergency Transport	Not Covered		Not Covered
Bariatric Surgery	Not Covered		Not Covered
Biofeedback	Not Covered		Not Covered
Blood Processing / Blood Storage Includes autologous donation	**Professional Non-Facility based Services**: No Charge	**Facility based Services:** No Charge *Savings Plus Plan Benefit*	Not Covered
Dental – Accident to sound teeth only. Treatment must be started within 12 months of injury. Routine Dental is excluded.	Office/Outpatient Settings: $60 Copay		Not Covered
Durable Medical Equipment (Includes Diabetic Supplies) – includes repairs, and rentals. ACA Breast Pumps are covered at 100% All others at standard cost share.	30% Coinsurance after Deductible		Not Covered
Foot Care (routine)	Not Covered		Not Covered
Hearing Aids (exams, fittings, and device) ACA mandated Hearing exams are covered at 100% under PPACA.	Not Covered		Not Covered
Hearing Exams – non routine ACA mandated Hearing exams are covered at 100% under PPACA.	**Professional Non-Facility based Services:** $25 Copay Non-Specialist $60 Copay Specialist	**Facility based Services:** $25 Copay Non-Specialist $60 Copay Specialist *Savings Plus Plan Benefit*	Not Covered

Cedarbridge Financial Services
Employee Benefit Summary – Low SPP Plan (Plan E)
Network: National (BlueCard PPO) Network
Effective Date: 01/01/2026

Immunization – (non-routine) Vaccinations for travel are excluded	**Professional Non-Facility based Services:** $25 Copay Non-Specialist $60 Copay Specialist	**Facility based Services:** $25 Copay Non-Specialist $60 Copay Specialist *Savings Plus Plan Benefit*	Not Covered
Infertility Services - Basic Testing Only	**Professional Non-Facility based Services**: $60 Copay	**Facility based Services:** $60 Copay *Savings Plus Plan Benefit*	Not Covered
Infertility Services – Comprehensive (AI) & Advanced (ZIFT/GIFT/IVF)	Not Covered		Not Covered
Injections– Provider may buy and bill. Excludes Orphan Drugs.	**Professional Non-Facility based Services:** $25 Copay Non-Specialist $60 Copay Specialist	**Facility based Services:** $25 Copay Non-Specialist $60 Copay Specialist *Savings Plus Plan Benefit*	Not Covered
Medical Nutrition Therapy	Not Covered		Not Covered
Medical Nutrition Products: Enteral feeding supplies, formulae and all infant formulae are not covered.	Not Covered		Not Covered
Medical & Diabetic Supplies	30% Coinsurance after Deductible		Not Covered
Nutritional Counseling – Diabetic	**Professional Non-Facility based Services:** $25 Copay	**Facility based Services:** $25 Copay *Savings Plus Plan Benefit*	Not Covered
Nutritional Counseling – Nondiabetics	**Professional Non-Facility based Services:** $25 Copay	**Facility based Services:** $25 Copay *Savings Plus Plan Benefit*	Not Covered
Online visits - Telephone consultations are excluded	$25 Copay Non-Specialist $60 Copay Specialist		Not Covered
Onsite Clinics	Not Covered		Not Covered
Oral Surgery – Includes removal of impacted wisdom teeth. Dental anesthesia is covered if related to payable oral surgery.	**Professional Non-Facility based Services**: $60 Copay	**Facility based Services:** $60 Copay *Savings Plus Plan Benefit*	Not Covered
Orthotics and Prosthetic Devices – Diabetic shoes, and Orthopedic shoes are not covered. Arch Supports are excluded	30% Coinsurance after Deductible		Not Covered
Private Duty Nursing	Not Covered		Not Covered
Respite Care	Not Covered		Not Covered
Retail Health Clinics	$25 Copay / per visit Non-Specialist $60 Copay / per visit Specialist		Not Covered
Sterilization – Men are covered. Woman are covered 100% per ACA.	**Professional Non-Facility based Services:** 30% Coinsurance after Deductible	**Facility based Services:** 30% Coinsurance after Deductible *Savings Plus Plan Benefit*	Not Covered
Sterilization Reversals	Not Covered		Not Covered
TMJ Treatment Non-surgical: Appliances are excluded	**Professional Non-Facility based Services**: $60 Copay	**Facility based Services:** $60 Copay *Savings Plus Plan Benefit*	Not Covered

Cedarbridge Financial Services
Employee Benefit Summary – Low SPP Plan (Plan E)
Network: National (BlueCard PPO) Network
Effective Date: 01/01/2026

TMJ Surgical Treatment	**Professional Non-Facility based Services:** 30% Coinsurance after Deductible	**Facility based Services:** 30% Coinsurance after Deductible *Savings Plus Plan Benefit*	Not Covered
Vision Exams (Routine) and Hardware	Not Covered		Not Covered
Vision surgery – Cataract and Glaucoma: (includes initial frames, lenses or contact following cataract surgery)	**Professional Non-Facility based Services:** 30% Coinsurance after Deductible	**Facility based Services:** 30% Coinsurance after Deductible *Savings Plus Plan Benefit*	Not Covered
Wigs – limited to 1 per benefit period with a maximum of $3,000 post Chemotherapy or Radiation.	**Professional Non-Facility based Services:** 30% Coinsurance after Deductible	**Facility based Services:** 30% Coinsurance after Deductible *Savings Plus Plan Benefit*	Not Covered

Transplant Services
Center of Excellence Locations Only

Benefit	**In-Network**	**Out-Of-Network**
Live Donor Health Services	30% Coinsurance after Deductible	Not Covered
Bone Marrow Donor Search	30% Coinsurance after Deductible	Not Covered
Organ Transplant – Facility	30% Coinsurance after Deductible	Not Covered
Organ Transplant – Physician & anesthesiologist	30% Coinsurance after Deductible	Not Covered
Travel and lodging for Organ Transplant	Not Covered	

Prescription Drug Benefits
Carelon Rx or 1-833-271-2374 www.carelonrx.com

Generic (Tier 1)	**No cost for Preventive Rx Drugs** **30-day supply:** $10 Copay **Mail Order up to 90-day supply:** $20 Copay	Not Covered
Preferred (Tier 2)	**30-day supply:** $50 Copay **Mail Order up to 90-day supply:** $100 Copay	Not Covered
Non-Limited/Non-Preferred (Tier 3)	**30-day supply:** 50% Coinsurance (Plan Deductible waived) **Mail Order up to 90-day supply:** 50% Coinsurance (Plan Deductible waived)	Not Covered
Specialty (Tier 4)	Not Covered	Not Covered

Preauthorization
Leading Edge Administrators: 1-877-630-9550
The following services require Preauthorization, or benefit will be reduced to 50% of the allowed.

Inpatient Services:	**Outpatient Services**	**Other Services:**
Cervical Spine Surgery	Cartilage Transplant Knee	Bone Stimulator
Computer Navigation for Orthopedic Surgery	Cervical Spine Surgery	Cardio/External Defibrillator
Elective Admissions	Cochlear Implant	Cooling Devices
Emergency Admissions	Computer Navigation for Orthopedic Surgery	CPAP/BIPAP

Cedarbridge Financial Services
Employee Benefit Summary – Low SPP Plan (Plan E)
Network: National (BlueCard PPO) Network
Effective Date: 01/01/2026

Hospice	Lumbar Spine Surgery	Electric Scooters
Lumbar Spine Surgery	Mandibular/Maxillary Surgery (Orthognathic)	Infusion Pumps
Rehabilitation Facility Admissions	Mastectomy for Gynecomastia	Insulin Pumps
Sacroiliac Joint Fusion	Nasal Septoplasty	Limb Prosthetics
Skilled Nursing Facility Admissions	Reduction Mammoplasty	Myoelectric prosthetics
Transplants	Rhinoplasty	Neuromuscular Stimulators
	Sacroiliac Joint Fusion	TENS Unit
	Sclerotherapy (Lower Extremities)	Wheelchairs
Managed Care Services:	Sleep Apnea Surgery - LAUP/UPPP, Nasal, and Uvulopalatoplasty	Wound Vacs
Inpatient BH/SA	Botulinum Toxin – Review for Migraine Use Only	
Electric Convulsive Therapy (ECT)	Home Health Services	
Intensive Outpatient Therapy	Home Hospice	
Partial Hospitalization (PHO)	Hyperbaric Oxygen Therapy (Systemic/Topical)	
Residential Care (RTC)	Coronary CT Angiography (CCTA)	
Psychological testing	Coronary MRA	
Genetic Counseling	Cardiac MRI	
	MRA of the Head and/or Neck	
	MRI of the Brain	
	MRI of the Spine – Cervical, Thoracic, Lumbar, Sacral	
	PET Scan	
	Physical/Occupational/Speech Therapy	

Exclusions

In addition to exclusions listed in the document, the following services are excluded from coverage under the Plan

Acupuncture	Hearing Aids (exams, device, fitting, repairs)
Advanced and Comprehensive Infertility Services	Long-Term Care
Alternative Medicine/homeopathy	Massage Therapy
Aquatic Therapy	Maternity Care for dependent children
Arch supports (supportive shoe inserts)	Methadone Clinics
Bariatric Surgery	Non-Emergency Care outside the U.S.
Biofeedback	Non-Emergency Care in ER Setting
Cosmetic Surgery (exclusion does not apply to breast reconstruction post-mastectomy)	Orphan Drugs
Custodial Care	Orthopedic Shoes/ orthopedic inserts – Non-diabetic
Dental Care (Routine) Adult and Child except ACA allowed	Respite Care
Erectile Dysfunction	Routine Eye Care (Adult) and Child except ACA allowed
Foot Care - Routine	Self-Inflicted unless result of medical condition
Gene and Cellular Therapy	TMJ Appliances
Growth Hormone Therapy	Vision Exams and Hardware
Halfway house/home – non-healthcare residential facility	Weight Loss Programs

Signature and Acceptance

The Plan Sponsor, Cedarbridge Financial Services, as the settlor of the Plan, hereby adopts the foregoing changes to the SPD effective as of the earliest date set forth above.

Signed: 

Name: Eleanor Whitfield

Title: Director of Participant Services

Date: 02/24/2026

Cedarbridge Financial Services
Employee Medical Plan

Plan Document and Summary Plan Description
Effective: January 01, 2021
Restated: January 01, 2024

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

THIS PLAN DOCUMENT AND SUMMARY PLAN DESCRIPTION ("Plan Document"), made by **Cedarbridge Financial Services** (the "Company" or the "Plan Sponsor") as of January 01, 2024, hereby sets forth the provisions of the Cedarbridge Financial Services Employee Medical Benefit Plan (the "Plan"), which was originally adopted by the Company, effective January 01, 2021. 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.

Effective Date

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

Adoption of the Plan Document

The Plan Sponsor, as the settlor of the Plan, hereby adopts this Plan Document as the written description of the Plan. This Plan Document represents both the Plan Document and the Summary Plan Description, which is required by sections 402 and 102 of the Employee Retirement Income Security Act of 1974, 29 U.S.C. et seq. ("ERISA"). This Plan Document amends and replaces any prior statement of the health care coverage contained in the Plan or any predecessor to the Plan.

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

Cedarbridge Financial Services

By: _____

Name: Eli Serebrowski

Date: 02/27/2024

Title: Director Of Payroll & Employee Benefits

INTRODUCTION AND PURPOSE; GENERAL PLAN INFORMATION

Introduction and Purpose

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

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

The Plan Sponsor is required under ERISA to provide to Participants a Plan Document and a Summary Plan Description; a combined Plan Document and Summary Plan Description, such as this document, is an acceptable structure for ERISA compliance. The Plan Sponsor has adopted this Plan Document as the written description of the Plan to set forth the terms and provisions of the Plan that provide for the payment or reimbursement of all or a portion of certain expenses for eligible benefits. The Plan Document is maintained by **Cedarbridge Financial Services** and may be reviewed at any time during normal working hours by any Participant.

General Plan Information

Name of Plan:
Cedarbridge Financial Services Employee Medical Benefit Plan

Plan Sponsor:
Cedarbridge Financial Services
1608 Route 88, Suite 301
Brick, NJ 08721
Phone: 1-732-903-1900

Plan Administrator:
(Named Fiduciary)
Cedarbridge Financial Services
1608 Route 88, Suite 301
Brick, NJ 08721
Phone: 1-732-903-1900

Plan Sponsor ID No. (EIN):
85-3277653

Source of Funding:
Self-Funded

Plan Status:
Non-Grandfathered

Applicable Law:
ERISA

Plan Year:
January 1 to December 31

Plan Number:
501

Plan Type:
Medical
Prescription Drug

Third Party Administrator:
Leading Edge Administrators
4631 Woodland Corporate Blvd, Ste 310
Tampa, FL 33614
Phone: 1-877-208-5952
Fax: 1-813-422-7845

Prescription Drug Plan Administrator:
Carelon Rx
PO Box 52065
Phoenix, AZ 85072-2065
Phone: 1-833-271-2374
Website/Email: www.carelonrx.com

Participating Employer(s):
Cedarbridge Financial Services
1608 Route 88, Suite 301
Brick, NJ 08724
Phone: 1-732-903-1900

Agent for Service of Process:
Leading Edge Administrators
4631 Woodland Corporate Blvd, Ste 310
Tampa, FL 33614
Phone: 1-877-208-5952
Fax: 1-813-422-7845

Utilization Review Manager:
HealthLink
1-877-284-0102

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

Non-English Language Notice

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

Legal Entity; Service of Process

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

Not a Contract

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

Mental Health Parity

Pursuant to the Mental Health Parity Act (MHPA) of 1996 and the Mental Health Parity and Addiction Equity Act of 2008 (MHPAEA), collectively, the mental health parity provisions in Part 7 of ERISA, this Plan applies its terms uniformly and enforces parity between covered health care benefits and covered mental health and substance disorder benefits relating to financial cost sharing restrictions and treatment duration limitations. For further details, please contact the Plan Administrator.

Non-Discrimination

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

Applicable Law

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

Discretionary Authority

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

Important Updates Regarding COVID-19 Relief – Tolling of Certain Plan Deadlines

In accordance with 85 FR 26351, "Extension of Certain Timeframes for Employee Benefit Plans, Participants, and Beneficiaries Affected by the COVID-19 Outbreak," notwithstanding any existing Plan language to the contrary, the Plan will disregard the period from March 1, 2020 until sixty (60) days after (1) the end of the National Emergency relating to COVID-19 and declared pursuant to 42 U.S.C. § 247d or (2) such other date announced by the Departments of Treasury and/or Labor, for purposes of determining the following periods and dates:

1. The 30-day period (or 60-day period, if applicable) to request special enrollment under ERISA section 701(f) and Internal Revenue Code section 9801(f);
2. The 60-day election period for COBRA continuation coverage under ERISA section 605 and Internal Revenue Code section 4980B(f)(5);
3. The date for making COBRA premium payments pursuant to ERISA section 602(2)(C) and (3) and Internal Revenue Code section 4980B(f)(2)(B)(iii) and (C);
4. The date for individuals to notify the Plan of a qualifying event or determination of disability under ERISA section 606(a)(3) and Internal Revenue Code section 4980B(f)(6)(C);
5. The date within which individuals may file a benefit claim under the Plan's claims procedure pursuant to 29 CFR 2560.503-1;
6. The date within which Claimants may file an appeal of an Adverse Benefit Determination under the Plan's claims procedure pursuant to 29 CFR 2560.503-1(h);
7. The date within which Claimants may file a request for an external review after receipt of an Adverse Benefit Determination or Final Internal Adverse Benefit Determination pursuant to 29 CFR 2590.715-2719(d)(2)(i) and 26 CFR 54.9815-2719(d)(2)(i), if applicable; and
8. The date within which a Claimant may file information to perfect a request for external review upon a finding that the request was not complete pursuant to 29 CFR 2590.715-2719(d)(2)(ii) and 26 CFR 54.9815-2719(d)(2)(ii), if applicable.

This period may also be disregarded in determining the applicable date for the Plan's duty to provide a COBRA election notice under ERISA section 606(c) and Internal Revenue Code section 4980B(f)(6)(D), however, note that the Plan intends to continue to follow all established COBRA parameters.

In no instance will the duration of an extension granted under this section exceed one calendar year.

DEFINITIONS

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

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

"Accident"
"Accident" shall mean an event which takes place without one's foresight or expectation, or a deliberate act that results in unforeseen consequences.

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

"Act of War"
"Act of War" shall mean any act pertaining to military, navel, or air operations in time of War.

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

"Acupuncture"
"Acupuncture" is a system of complementary medicine that involves pricking the skin or tissues with needles, used to alleviate pain and to treat various physical, mental, and emotional conditions, and to induce surgical anesthesia.

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

"Admission"
"Admission" means the days of Inpatient services provided to a Covered Person.

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

1. A denial in benefits.
2. A reduction in benefits.
3. A rescission of coverage, even if the rescission does not impact a current claim for benefits.

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

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

"Affidavit of Domestic partner/Statement of Domestic Partnership"
"Affidavit of Domestic partner/Statement of Domestic Partnership" is the formal instrument executed by two person documenting their status as Domestic Partners.

"Affordable Care Act (ACA)"
The "Affordable Care Act (ACA)" means the health care reform law enacted in March 2010. The law was enacted in two parts: the Patient Protection and Affordable Care Act was signed into law on March 23, 2010 and was amended by the Health Care and Education Reconciliation Act on March 30, 2010. The name "Affordable Care Act" is commonly used to refer to the final, amended version of the law. In this document, the Plan uses the name Affordable Care Act (ACA) to refer to the health care reform law.

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

"Alcoholism"
"Alcoholism" – see "Substance Abuse/Substance Use Disorder" below.

"Allowable Expense(s)"
"Allowable Expense(s)" shall mean the Maximum Allowable Charge for any Medically Necessary, eligible item of expense, at least a portion of which is covered under this Plan. When some Other Plan pays first in accordance with the Application to Benefit Determinations provision in the Coordination of Benefits section, 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 Plan Administrator shall assess the value of said benefit(s) and determine the reasonable cash value of the service or services rendered, by determining the amount that would be payable in accordance with the

terms of the Plan. Benefits payable under any Other Plan include the benefits that would have been payable had the claim been duly made therefore, whether or not it is actually made.

"Alternate Recipient"
"Alternate Recipient" shall mean any Child of a Participant who is recognized under a Medical Child Support Order as having a right to enrollment under this Plan as the Participant's eligible Dependent. For purposes of the benefits provided under this Plan, an Alternate Recipient shall be treated as an eligible Dependent, but for purposes of the reporting and disclosure requirements under ERISA, an Alternate Recipient shall have the same status as a Participant.

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

"Ambulance Service"
"Ambulance Service" is a medically necessary medical transportation provider, licensed by the state, which provides local transportation by means of a specially designed and equipped vehicle used only for transporting the sick and injured.

"Ambulatory Surgical Center"
"Ambulatory Surgical Center" shall mean any permanent public or private State licensed and approved (whenever required by law) establishment that operates exclusively for the purpose of providing Surgical Procedures to patients not requiring hospitalization with an organized medical staff of Physicians, with continuous Physician and nursing care by Registered Nurses (R.N.s). The patient is admitted to and discharged from the facility within the same working day as the facility does not provide service or other accommodations for patients to stay overnight.

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

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

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

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

"Assignment of Benefits"
"Assignment of Benefits" means an arrangement whereby the covered Person, at the discretion of the Plan Administrator, assigns their right to seek and receive payment of eligible Pan benefits, less Deductible, Co-Payments and the Coinsurance percentage that is not paid by the Plan, in strict accordance with the terms of this Plan Document, to a Provider. If a Provider accepts said arrangement, Providers' rights to receive Plan benefits are equal to those of a Covered Person and are limited by the terms of this Plan document. A Provider that accepts this arrangement indicates acceptance of an "Assignment of Benefits" and Deductible, Co-Payments, and the Coinsurance percentage that is the responsibility of the Covered Person, as consideration in full for services, supplies, and/or treatment rendered. The Plan Administrator may

revoke or disregard an Assignment of Benefits previously issue to a Provider at its discretion and continue to treat the Covered Person as the sole beneficiary.

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

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

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

“CDC”
“CDC” shall mean Centers for Disease Control and Prevention.

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

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

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

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

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

“Child” and/or “Children”
“Child” and/or "Children" shall mean the Employee’s natural Child, any stepchild, legally adopted Child, or any other Child for whom the Employee has been named legal guardian who has not attained the age of

26. For purposes of this definition, a legally adopted Child shall include a Child placed in an Employee's physical custody in anticipation of adoption. "Child" shall also mean a covered Employee's Child who is an Alternate Recipient under a Qualified Medical Child Support Order, as required by the Federal Omnibus Budget Reconciliation Act of 1993. A "legal guardian" is a person recognized by a court of law as having the duty of taking care of the person and managing the property and rights of a minor child.

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

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

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

"Claims Administrator"
"Claims Administrator" is the company the Plan Sponsor chose to administer the claims. As of the date noted above, Leading Edge Administrators was chose to administer the Plan.

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

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

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

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

“Clinical Eligibility for Coverage”
“Clinical Eligibility for Coverage” shall mean Services requiring diagnosis or the treatment of an injury or sickness. Services must be known to be safe, effective, and appropriate by most qualified practitioners who are licensed to treat that injury or sickness. Services must be performed safely at the appropriate level of care or services, and in the least costly setting required by the injury or sickness. Services must not be provided primarily for the convenience of: the patient; the patient’s family; or the qualified practitioner.

Any service or supply that does not meet the pan’s guidelines for clinical eligibility for coverage is excluded from coverage.

“CMS”
“CMS” shall mean Centers for Medicare and Medicaid Services.
“COBRA”
“COBRA” shall mean the Consolidated Omnibus Budget Reconciliation Act of 1985, as amended.

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

“Compounded Drug”
“Compounded Drug” is a Drug formed through the process of combining, mixing, or altering ingredients to create a medication tailored to the needs of an individual patient. Compounding includes the combining of two or more drugs. Compounded drugs are not FDA-approved.

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

“Cosmetic Surgery”
“Cosmetic Surgery” shall mean any expenses Incurred in connection with the care and treatment of, or operations which are performed for plastic, reconstructive, or cosmetic purposes or any other service or supply which are primarily used to improve, alter, or enhance appearance of a physical characteristic which is within the broad spectrum of normal but which may be considered displeasing or unattractive, except when required by an Injury.

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

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

“Covered Person”
“Covered Person” is any Covered Person and his or her eligible Dependents when properly enrolled in the Plan as a new hire or during the open enrollment period as defined in Section 2, or following a qualifying event such a birth, marriage, or adoption.

“Current Procedural Terminology (C.P.T.)”
“Current Procedural Terminology (C.P.T.)” is the most recent edition of an annually revised listing published by the American Medical Association, which assigns numerical codes to medical procedures.

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

“Deductible”
“Deductible” shall mean an aggregate amount for certain expenses for covered services that is the responsibility of the Participant to pay for him or herself each Calendar Year before the Plan will begin its payments.

“Dentist”
“Dentist” shall mean a properly trained person holding a D.D.S. or D.M.D. degree and practicing within the scope of a license to practice dentistry within their applicable geographic venue.

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

1. An Employee’s present spouse, thereby possessing a valid marriage license, not annulled or voided in any way. A Dependent spouse shall therefore not be one who is divorced or Legally Separated from the Employee.
2. An Employee’s Child who is less than 26 years of age.
3. An Employee’s Child, regardless of age, who was continuously covered prior to attaining the limiting age as stated in the numbers above, who is mentally or physically incapable of sustaining his or her own living. Written proof of such incapacity and dependency satisfactory to the Plan must be furnished and approved by the Plan within 31 days after the date the Child attains the limiting age as stated in the numbers above. The deadline for submission of written proof of incapacity and dependency is 30 days following the original eligibility date for a new or re-enrolling Employee. The Plan may require, at reasonable intervals, subsequent proof satisfactory to the Plan during the next two years after such date. After such two year period, the Plan may require such proof, but not more often than once each year.

Grandchildren are not eligible for coverage unless they meet the definition of “Child” and/or “Children”.

Active duty members of any armed force shall not be deemed to be “Dependents”.

Residents of a country other than the United States shall not be deemed to be a “Dependent.”

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

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

“Detoxification Facility”
“Detoxification Facility” is a JAHCO certified Detoxification Facility for the treatment of Alcoholism, or one that meets the same standards if located in another state.

“Developmental Disability”
“Developmental Disability” is a person's severe chronic disability which:

- is attributable to a mental or physical impairment, or a combination of them;
- for the purposes solely of the provision of this Plan entitled "Diagnosis and Treatment of Autism and Other Developmental Disabilities", is manifest before age 22;
- is likely to continue indefinitely;
- results in substantial functional limitations in three or more of the following areas of major life activity: self-care; receptive and expressive language; learning; mobility; self-direction; the capacity for independent living or economic self-sufficiency; and
- reflects the need for a combination and sequence of special inter-disciplinary or generic care, treatment or other services which are: (i) of lifelong or extended duration; and (ii) individually planned or coordinated.

Developmental Disability includes, but is not limited to, severe disabilities attributable to: intellectual disability; autism; cerebral palsy; epilepsy; spina-bifida; and other neurological impairments where the above criteria are met.

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

“Diagnostic Service”
“Diagnostic Service” shall mean an examination, test, or procedure performed for specified symptoms to obtain information to aid in the assessment of the nature and severity of a medical condition or the identification of an Illness or Injury. The Diagnostic Service must be ordered by a Physician or other professional Provider.

"Domestic Partner"
"Domestic Partner" is a Person that meets the following criteria:

1. Both persons have a common residence and are otherwise jointly responsible for each other's common welfare, as evidenced by joint financial arrangements or joint ownership of real property, which shall be demonstrated by at least one of the following:
2. A joint deed, mortgage agreement or lease;
3. A joint bank account;
4. Designation of one of the persons as a primary beneficiary in the other's will;
5. Designation of one of the persons as a primary beneficiary in the other person's life insurance policy or retirement plan; or
6. Joint ownership of a motor vehicle;

7. Both persons agree to be jointly responsible for each other's basic living expenses during the Domestic Partnership;
8. Neither person is in a marriage recognized by law or a member of another Domestic Partnership;
9. Neither person is related to the other by blood or affinity up to and including the fourth degree of consanguinity;
10. Both persons have chose to share each other's lives in a committed relationship of mutual caring;
11. Both persons are at least 18 years of age;
12. Both persons file jointly an Affidavit of Domestic Partnership; and
13. Neither person has been a partner in a Domestic Partnership that was terminated less than 180 days prior to the filing of the current Affidavit of Domestic Partnership, except that this prohibition shall not apply if one of the partners died; and in all cases in which a person registered a prior Domestic Partnership, the prior Domestic Partnership was terminated.

"Drug"
"Drug" shall mean a Food and Drug Administration (FDA) approved Drug or medicine that is listed with approval in the *United States Pharmacopeia*, *National Formulary* or *AMA Drug Evaluations* published by the American Medical Association (AMA), that is prescribed for human consumption, and that is required by law to bear the legend: "Caution—Federal Law prohibits dispensing without prescription," or a State restricted drug (any medicinal substance which may be dispensed only by prescription, according to State law), legally obtained and dispensed by a licensed drug dispenser only, according to a written prescription given by a Physician and/or duly licensed Provider. "Drug" shall also mean insulin for purposes of injection.

"Durable Medical Equipment"
"Durable Medical Equipment" shall mean equipment and/or supplies ordered by a health care Provider for everyday or extended use which meets all of the following requirements:

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

Some examples are: walkers; wheelchairs (manual or electric); hospital-type beds; breathing equipment; and apnea monitors.

Some examples of service and supplies that are not considered to be Durable Medical Equipment are: adjustments made to vehicles; furniture; scooters; all-terrain vehicle (ATVs); non-hospital-type beds; air

conditioners; air purifiers; humidifiers; dehumidifiers; elevators; ramps; stair glides; emergency alert equipment; handrails; hearing aids; heat appliance; improvements made to the home or place of business; waterbeds; whirlpool baths; and exercise and massage equipment.

"Emergency"
"Emergency" shall mean a situation or medical condition with symptoms of sufficient severity (including severe pain) that the absence of immediate medical attention and treatment would reasonably be expected to result in: (a) serious jeopardy to the health of the individual (or, with respect to a pregnant woman, the woman's unborn child); (b) serious impairment to bodily functions; or (c) serious dysfunction of any bodily organ or part. An Emergency includes, but is not limited to, severe chest pain, poisoning, unconsciousness, and hemorrhage. Other Emergencies and acute conditions may be considered on receipt of proof, satisfactory to the Plan, per the Plan Administrator's discretion, that an Emergency did exist. The Plan may, at its own discretion, request satisfactory proof that an Emergency or acute condition did exist.

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

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

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

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

“Employee”
“Employee” shall mean a person who is an Employee Cedarbridge Financial Services or any of its subsidiaries and affiliates that have duly adopted the Plan. The Employee must be Actively at Work, regularly scheduled to work for the Participating Employer in an Employer-Employee relationship. The Plan is not available to any individuals classified by the Employer as an independent contractor, or an individual classified as an employee of a third party, even if such individual is retroactively classified as an employee of the Employer that adopted the Plan by any governmental agency, court or any other third-party.

“Employer”
“Employer” is Cedarbridge Financial Services or any of its subsidiaries and affiliates that have duly adopted the Plan.

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

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

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

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

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

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

1. If the drug or device cannot be lawfully marketed without approval of the U.S. Food and Drug Administration and approval for marketing has not been given at the time the drug or device is furnished;

2. If reliable evidence shows that the drug, device or medical treatment or procedure is the subject of ongoing Phase I, II, or III clinical trials or under study to determine all of the following:

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

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

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

Reliable evidence shall mean one or more of the following:

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

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

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

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

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

“Facility”
“Facility” shall mean an entity or institution which provides health care services within the scope of its license, as defined by applicable law.

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

“FDA”
“FDA” shall mean Food and Drug Administration.

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

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

“FMLA Leave”
“FMLA Leave” shall mean an unpaid, job protected Leave of Absence for certain specified family and medical reasons, which the Company is required to extend to an eligible Employee under the provisions of the FMLA.

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

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

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

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

1. The institutionalization of the individual would otherwise have been required if Home Health Care was not provided.

2. The treatment plan covering the Home Health Care service is established and approved in writing by the attending Physician. The Physicians order is under a plan of care that:
3. Is establish by that physician and the Home Health Care Provider;
4. Is establish within 14 days after Home Health Care starts; and
5. Is periodically reviewed and approved by the Physician.
6. The care must be given on a part-time or intermittent basis, except if full-time or 24-hour services are Medically Necessary and Appropriate on a short term basis.
7. The Home Health Care is the result of an Illness or Injury.

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

1. Is a Federally certified Home Health Care Agency and approved as such under Medicare.
2. Meets the established standards and is operated pursuant to applicable laws in the jurisdiction in which it is located and, is licensed and approved by the regulatory authority having the responsibility for licensing, where licensing is required.
3. Meets all of the following requirements.

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

"Hospice"
"Hospice" shall mean a Provider which mainly provides palliative and supportive care for terminally ill or terminally injured people under a Hospice Care Program. To qualify, a provider must either be approved for its stated purpose by Medicare or accredited for its stated purpose by either the Joint Commission or the National Hospice Organization.

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

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

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

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

“HRSA”
“HRSA” shall mean Health Resources and Services Administration.

“Illness”
“Illness” shall mean any bodily sickness or disease, including any congenital abnormality as diagnosed by a Physician and as compared to the person’s previous condition. Expenses Incurred because of pregnancy, childbirth, and related medical conditions are covered under the Plan to the same extent as any illness. “Illness” is also any disorder which does not arise out of, which is not caused or contributed to by, and which is not a consequence of, any employment or occupation for compensation or profit; however, if evidence satisfactory to the Plan is furnished showing that the individual concerned is covered as an Employee under any workers’ compensation law, occupational disease law or any other legislation of similar purpose, or under the maritime doctrine of maintenance, wages, and cure, but that the disorder involved is one not covered under the applicable law or doctrine, then such disorder shall, for the purposes of the Plan, be regarded as an Illness.

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

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

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

“Inherited Metabolic Disease”
“Inherited Metabolic Disease” shall mean a disease caused by an inherited abnormality of body chemistry for which testing is mandated.

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

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

“Institution”
“Institution” shall mean a facility created and/or maintained for the purpose of practicing medicine and providing organized health care and treatment to individuals, operating within the scope of its license, such as a Hospital, Ambulatory Surgical Center, Psychiatric Hospital, community mental health center, Residential Treatment Facility, psychiatric treatment facility, Substance Use Disorder Treatment Center, alternative birthing center, or any other such facility that the Plan approves.

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

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

“Joint Commission”
“Joint Commission” means The Joint Commission on the Accreditation of Health Care Organizations.

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

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

“Maintenance Therapy”
“Maintenance Therapy” shall mean the point in the therapeutic process at which no further improvement in the gaining or restoration of a function, reduction in disability or relief of pain is expected. Continuation of therapy at this pint would be for the purpose of hold at a steady stat or preventing deterioration.

“Mastectomy”
“Mastectomy” shall mean the Surgery to remove all or part of breast tissue as a way to treat or prevent breast cancer.

“Maximum Allowable Charge”
“Maximum Allowable Charge” is the benefit payable for a specific coverage item or benefit under this Plan. The Plan Sponsor may, at its discretion, directly negotiate amounts with providers which are higher than the rates outlined below as it deems necessary and in the best interests of the plan.

For claims subject to the No Surprises Act (see “No Surprises Act – Emergency Services and Surprise Bills” within the section “Summary of Benefits,”) if no negotiated rate exists, the Maximum Allowable Charge will be an amount deemed payable by a Certified IDR Entity or a court of competent jurisdiction, if applicable.

The Maximum Allowable Charge will be calculated by the Plan Administrator as follows for the Anthem Blue Cross Blue Shield Standard and the Anthem Blue Cross Blue Shield Savings Plus Plan:

Anthem Blue Cross Blue Shield Standard Plan Benefit

An amount determined by the Claims Administrator as the least of the following amounts for Anthem Blue Cross Blue Shield Standard Plan Benefit and non-Savings Plus Plan Benefit:

(a) in the case of In-Network Providers, the amount that the provider has agreed to accept for the services or supply under contractual agreement the provider has with the network recognized by the plan; or
(b) in the case of Out-of-Network professional Physician Claims, the reimbursement amount determined by the Plan Administrator will be based on the Medicare Fee Schedule presently utilized by the Centers of Medicare and Medicaid Services ("CMS") for that zip code (or nearest 3-digit zip code) multiplied by 120%. If no Medicare rate is available then the reimbursement rate will be the 50th percentile of the Usual Customary and Reasonable ("UC&R") charges, using industry-standard data sources. If there is no Medicare or UC&R rate available, the service will be priced at 50% of billed charges.

The Schedule of Benefits may specify the type of network recognized by the Plan. If no such network is specified, please contact the Claims Administrator.

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

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

The Plan is not responsible for the balance of any Out of Network provider charge.

The Plan has the discretionary authority to decide if a procedure or service charge is Usual and Customary and a Medically Necessary and Appropriate and Reasonable service.

Anthem Blue Cross Blue Shield Savings Plus Plan Benefit

Anthem Blue Cross Blue Shield Savings Plus Plan designated procedures and services are listed below. The Plan payment of these designated services will be based on 150% of the current Medicare Fee Schedule presently utilized by the Centers of Medicare and Medicaid Services ("CMS") for that zip code (or nearest 3-digit zip code). For those designated procedures and services where a Medicare rate does not exist, pricing would be set at a rate of the 50th Percentile of Usual, Customary, and Reasonable ("UC&R") rates. If the Medicare Fee Schedule does not include a particular procedure or service, and a UC&R charge is not available at the 50th percentile using industry-standard data sources, the service will be priced at

50% of billed charges. Procedures and services not designated below will be paid in accordance with the Anthem Blue Cross Blue Shield Standard Plan payment methodologies referenced above.

Savings Plus Plan Designated Procedures and Services
Savings Plus Plan designated procedures and services are indicated below:

a) all in-patient and out-patient facility and ancillary services;
b) surgical services – in a hospital in-patient and out-patient setting;
c) surgical services – in an ambulatory surgical facility setting;
d) all emergency services;
e) ambulance services - air, ground, and water;
f) high cost diagnostic, imaging, and genetic services; (see appendix B)
g) sleep management studies;
h) genetic services;
i) dialysis/hemodialysis - all settings;
j) infusion services – all settings;

Savings Plus Plan designated benefits will be paid at the lesser of the Savings Plus Plan benefit rate or the Network negotiated rate, as determined by the Plan Administrator.

Notwithstanding the foregoing, the definition of "Maximum Allowable Charge" does not apply in respect of the Outpatient and Home Dialysis benefit, which shall be governed by the Outpatient and Home Dialysis Benefit Guide (see Appendix C). For sake of clarity, the definition of "Usual and Reasonable Charge," as described in the Outpatient and Home Dialysis Benefit Guide, applies exclusively to the Outpatient and Home Dialysis benefit and not any other benefit.

"Medicaid"
"Medicaid" shall mean the health care program for the needy provided by Title XIX of the United States Social Security Act, as amended from time to time.

"Medical Care"
"Medical Care" is professional medical services rendered by a licensed medical care provider for the treatment of an illness or injury.

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

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

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

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

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

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

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

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

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

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

"Medically Necessary Leave of Absence"
"Medically Necessary Leave of Absence" shall mean a Leave of Absence by a full-time student Dependent at a postsecondary educational institution that meets all of the following requirements:

1. Commences while such Dependent is suffering from an Illness or Injury.
2. Is Medically Necessary.
3. Causes such Dependent to lose student status for purposes of coverage under the terms of the Plan.

"Medicare"
"Medicare" shall mean the Federal program by which health care is provided to individuals who are 65 or older, certain younger individuals with disabilities, and individuals with End-Stage Renal Disease, administered in accordance with parameters set forth by the Centers for Medicare and Medicaid Services (CMS) and Title XVIII of the Social Security Act of 1965, as amended, by whose terms it was established.

"Mental Health Parity Act of 1996 (MHPA) 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 all of the following requirements are met:

1. 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).
2. 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).
3. The treatment limitations applicable to such mental health or Substance Use Disorder benefits are no more restrictive than the predominant treatment limitations applied to substantially all medical and surgical benefits covered by the Plan (or coverage).
4. 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 is offered in connection with such a plan).

"Mental Disorder," "Behavioral Disorder," or "Neurodevelopmental Disorder"
"Mental Disorder," "Behavioral Disorder," or "Neurodevelopmental Disorder" shall mean any Illness or condition, regardless of whether the cause is organic, that is classified as a Mental Disorder, Behavioral Disorder, or Neurodevelopmental Disorder in the current edition of International Classification of Diseases, published by the U.S. Department of Health and Human Services, or is listed in the current edition of

Diagnostic and Statistical Manual of Mental Disorders, published by the American Psychiatric Association, or other relevant State guideline or applicable sources.

“Morbid Obesity”
“Morbid Obesity” is having Body Mass Index (BMI) equal to or greater than 40. BMI is your weight in kilograms divided by your height in meters squared. Coverage is available for certain non-experimental and scientifically proven surgical treatments by a qualified practitioner. Pre-authorization is required or benefits will not be payable under the plan. The plan reserves the right to determine whether the treatment is eligible for coverage. Benefits do not include nutritional supplements, body composition or underwater weighing procedures, exercise therapy, wight control or reduction programs.

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

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

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

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

“Non-Covered Charges”
“Non-Covered Charges” are charges for services and supplies which:

a) do not meet this Plan’s definition of Covered Charges;
b) exceed any of the coverage limits shown in this SPD; or
c) are specifically identified in this SPD as Non-Covered Charges.

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

“Nurse”
“Nurse” shall mean an individual who has received specialized nursing training and is authorized to use the designation Registered Nurse (R.N.), Licensed Vocational Nurse (L.V.N.) or Licensed Practical Nurse

(L.P.N.), and who is duly licensed by the State or regulatory agency responsible for such license in the State in which the individual performs the nursing services.

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

“Orphan Disease”
“Orphan Disease” means a condition that affects fewer than 200,000 people nationwide. This includes diseases as familiar as cystic fibrosis, Lou Gehrig's disease, and Tourette's syndrome, and as unfamiliar as Hamburger disease, Job syndrome, and acromegaly, or "gigantism."

“Orphan Drug”
“Orphan Drug” means a pharmaceutical agent that has been developed specifically to treat an Orphan Disease or other rare medical condition, and for purposes of this definition, the drug must be found on the FDA Orphan Drug Designation and Approvals listing, which can generally be found here. https://www.accessdata.fda.gov/scripts/opdlisting/oopd/

“Other Plan”
“Other Plan” shall mean any group health plan or health insurance coverage as defined in 42 U.S. Code § 300gg-91 from which a Participant is entitled to benefits.

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

“Out-of-Hospital”
“Out-of-Hospital” shall mean Services or supplies provided to a Covered Person other than as an Inpatient or Outpatient.

“Out-of-Pocket Maximum”
“Out-of-Pocket Maximum” is defined as the maximum dollar amount that a Covered Person must pay as Deductible, Co-Payments and/or Coinsurance for Covered Services and supplies during any Benefit Period. Once a Deductible or coinsurance maximum is reached, no further Deductible or Coinsurance is required for the remainder of that Benefit Period.

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

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

“Participant”
“Participant” shall mean any Employee, Dependent who is eligible for benefits (and enrolled) under the Plan.

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

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

“Per Lifetime”
“Per Lifetime” is defined as the lifetime of a person.

“Pharmacy”
“Pharmacy” shall mean A facility: (a) which is registered as a Pharmacy with the appropriate state licensing agency; and (b) in which Prescription Drugs are dispensed by a pharmacist.

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

“Plan Administrator” or “Plan Sponsor”
“Plan Administrator” is Cedarbridge Financial Services.

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

“Policy”
“Policy” is a set of coverage rules as explained in this SPD which applies to Covered Persons, and any defined dependents of other Covered Persons. At no time will the Plan ever pay more than the established limits as determined by the Plan Administrator.

“Pre-Admission Tests”
“Pre-Admission Tests” shall mean those medical tests and Diagnostic Services completed prior to a scheduled procedure, including Surgery, or scheduled admissions to the Hospital or Inpatient health care facility provided that all of the following requirements are met:

1. The Participant obtains a written order from the Physician.
2. The tests are approved by both the Hospital and the Physician.
3. The tests are performed on an Outpatient basis prior to Hospital admission.

4. The tests are performed at the Hospital into which confinement is scheduled, or at a qualified facility designated by the Physician who will perform the procedure or Surgery.

"Pregnancy"
"Pregnancy" shall mean a physical state whereby a woman presently bears a child or children in the womb, prior to but likely to result in childbirth, miscarriage and/or non-elective abortion. Pregnancy is considered an Illness for the purpose of determining benefits under this Plan.

"Prescription Drugs"
"Prescription Drugs" are Drugs, biological and compound prescriptions which: (a) are dispensed only by prescription; and (b) are required to show on the manufacturer's label the words: "Caution- Federal Law Prohibits Dispensing without a Prescription." The term includes: prescription female contraceptives; insulin; and may include other drugs and devices (e.g., syringes; glucometers; over-the-counter drugs mandated by law), as determined by Claims Administrator. For the purpose of this provision, " prescription female contraceptives" are drugs or devices, including, but not limited to, birth control pills and diaphragms, that: (i) are used for contraception by a female; (ii) are approved by the FDA for that purpose; and (iii) can only be purchased with a prescription written by a health care professional licensed or authorized to write prescriptions.

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

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

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

Copies of the recommendations and guidelines may be found at the following websites:
https://www.healthcare.gov/coverage/preventive-care-benefits/;
https://www.uspreventiveservicestaskforce.org/uspstf/recommendation-topics;
https://www.cdc.gov/vaccines/hcp/acip-recs/index.html;
https://www.aap.org/periodicityschedule;
https://www.hrsa.gov/womensguidelines/.

For more information, Participants may contact the Plan Administrator / Employer.

"Primary Care Physician (PCP)"
"Primary Care Physician" shall mean a family practitioners, general practitioners, internists, OBGYNs, pediatricians, and office-based nurse practitioners, physician's assistants, licensed professional

counselors, licensed certified professional counselors, certified chemical dependency counselors, or licensed clinical social workers. All other Physicians are considered specialists.

"Prior Authorization"
"Prior Authorization" is defined as Authorization for a Practitioner to provide specified treatment to Covered Persons.

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

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

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

"Provider"
"Provider" shall mean an entity whose primary responsibility is related to the supply of medical care. Each Provider must be licensed, registered, or certified by the appropriate State agency where the medical care is performed, as required by that State's law where applicable. Where there is no applicable State agency, licensure, or regulation, the Provider must be registered or certified by the appropriate professional body. The Plan Administrator may determine that an entity is not a "Provider" as defined herein if that entity is not deemed to be a "Provider" by the Centers for Medicare and Medicaid Services (CMS) for purposes arising from payment and/or enrollment with Medicare; however, the Plan Administrator is not so bound by CMS' determination of an entity's status as a Provider. All facilities must meet the standards as set forth within the applicable definitions of the Plan as it relates to the relevant provider type.

"Psychiatric Hospital"
"Psychiatric Hospital" shall mean an Institution, appropriately licensed as a Psychiatric Hospital, established for the primary purpose of providing diagnostic and therapeutic psychiatric services for the treatment of mentally ill persons either by, or under the supervision of, a Physician. As such, to be deemed a "Psychiatric Hospital", the Institution must ensure every patient is under the care of a Physician and their staffing pattern must ensure the availability of a Registered Nurse 24 hours each day. Should the Institution fail to maintain clinical medical records on all patients permitting the determination of the degree and intensity of treatment to be provided, that Institution will not be deemed to be a "Psychiatric Hospital".

To be deemed a "Psychiatric Hospital," the Institution must be duly licensed and must not be primarily a place for rest, the aged, and/or a nursing home, custodial, or training institution.

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

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

"Reasonable and/or Reasonableness"
"Reasonable and/or Reasonableness" is defined as in the Plan Administrator's discretion, services or supplies, or fees for services or supplies, which are necessary for the care and treatment of Illness or Injury not caused by the treating Provider's error or mistake. Determination that fee(s) or services are Reasonable will be made by the Plan Administrator, taking into consideration unusual circumstances or complications requiring additional time, skill, and experience in connection with a particular service or supply; industry standards and practices as they relate to similar scenarios; and the cause of Injury or Illness necessitating the service(s) and/or charge(s).

This determination will consider but will not be limited to evidence-based guidelines, and the findings and assessments of the following entities: (a) the national medical associations, societies, and organizations; (b) the Centers for Medicare and Medicaid Services (CMS) and (c) the Food and Drug Administration. A finding of Provider negligence and/or malpractice is not required for service(s) and/or fee(s) to be considered not Reasonable.

To be Reasonable, service(s) and/or fee(s) must also be in compliance with generally accepted billing practices for unbundling or multiple procedures. The Plan Administrator retains discretionary authority to determine whether service(s) and/or fee(s) are Reasonable based upon information presented to the Plan Administrator. The Plan Administrator reserves for itself and parties acting on its behalf the right to review charges processed and/or paid by the Plan, to identify charge(s) and/or service(s) that are not Reasonable and therefore not eligible for payment by the Plan.

Notwithstanding the foregoing, the definition of "Reasonable and/or Reasonableness" does not apply in respect of the Outpatient and Home Dialysis benefit, which shall be governed by the Outpatient and Home Dialysis Benefit Guide (Appendix C). For sake of clarity, the definition of "Usual and Reasonable Charge" described in the Outpatient and Home Dialysis Benefit Guide applies exclusively to the Outpatient and Home Dialysis Benefit and not any other benefit.

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

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

“Rehabilitation Hospital”
“Rehabilitation Hospital” shall mean an appropriately licensed Institution, which is established in accordance with all relevant Federal, State and other applicable laws, to provide therapeutic and restorative services to individuals seeking to maintain, reestablish, or improve motor-skills and other functioning deemed Medically Necessary for daily living, that have been lost or impaired due to Illness and/or Injury. To be deemed a “Rehabilitation Hospital”, the Institution must be legally constituted, operated, and accredited for its stated purpose by either the Joint Commission on Accreditation of Hospitals or the Commission on Accreditation for Rehabilitation Facilities, as well as approved for its stated purpose by the Centers for Medicare and Medicaid Services (CMS) for Medicare purposes.

To be deemed a “Rehabilitation Hospital”, the Institution must be duly licensed and must not be primarily a place for rest, the aged, and/or a nursing home, custodial, or training institution.

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

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

1. Room and complete linen service.
2. Dietary service including all meals, special diets, therapeutic diets, required nourishment’s, dietary supplements and dietary consultation.
3. All general nursing services including but not limited to coordinating the delivery of care, supervising the performance of other staff members who have delegated member care and member education.
4. Other conditions of occupancy which are Medically Necessary.

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

“Service Waiting Period”
“Service Waiting Period” shall mean an interval of time that must pass before an Employee or Dependent is eligible to enroll under the terms of the Plan. The Employee must be a continuously Active Employee of the Employer during this interval of time.

“Skilled Nursing Care”
“Skilled Nursing Care” is defined as Services which: (a) are more intensive than Custodial Care; (b) are provided by an R.N. or L.P.N.; and (c) require the technical skills and professional training of an R.N. or L.P.N.

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

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

“Special Care Unit”
“Special Care Unit” is A part of a Hospital set up for very ill patients who must be observed constantly. The unit must have a specially trained staff and special equipment and supplies on hand at all times. Some types of Special Care Units are:

a) intensive care units;
b) cardiac care units;
c) neonatal care units; and
d) burn units.

“Spouse”
“Spouse” is the person who is legally married to the Employee. Proof of legal marriage must be submitted upon request.

“Specialty Drug(s)”
“Specialty Drug(s)” shall mean certain pharmaceuticals and/or biotech or biological drugs that are high-cost/high technology and are used in the management of chronic or genetic disease, including, but not limited to, injectable, infused or oral Medications, or that otherwise require special handling, dispensing conditions or monitoring, delivered by any means including by purchase at a pharmacy and processed for payment by the pharmacy benefit manager or an Outpatient basis from a provider or facility or purchased directly by the Covered Person high-cost prescription medications used to treat complex, chronic conditions including, but not limited to cancer, rheumatoid arthritis and multiple sclerosis. For this purpose, the term “Specialty Drug” means any injectable or non-injectable drug that is on the Pharmacy Benefit Manager’s list of Specialty Drugs as it determines such list from time to time. Please contact the Prescription Drug Plan Administrator to determine specific drug coverage.

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

Any use of alcohol, any drug (whether obtained legally or illegally), any narcotic, or any hallucinogenic or other illegal substance, which produces a pattern of pathological use, causing impairment in social or occupational functioning, or which produces physiological dependency evidenced by physical tolerance or withdrawal. It is the excessive use of a substance, especially alcohol or a drug. The Diagnostic and Statistical Manual of Mental Disorders (DSM) definition of "Substance Use Disorder" is applied as outlined below.

A maladaptive pattern of substance use leading to clinically significant impairment or distress, as manifested by one or more of the following, occurring within a 12 month period:

a. Recurrent substance use resulting in a failure to fulfill major role obligations at work, school or home (e.g., repeated absences or poor work performance related to substance use; substance related absences, suspensions, or expulsions from school; neglect of children or household).

b. Recurrent substance use in situations in which it is physically hazardous (e.g., driving an automobile or operating a machine when impaired by substance use).

c. Craving or a strong desire or urge to use a substance.
d. Continued substance use despite having persistent or recurrent social or interpersonal problems caused or exacerbated by the effects of the substance (e.g., arguments with spouse about consequences of intoxication, physical fights)

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

"Substance Use Disorder Treatment Center"
"Substance Use Disorder Treatment Center" shall mean an Institution whose facility is licensed, certified or approved as a Substance Use Disorder Treatment Center by a Federal, State, or other agency having legal authority to so license; which is affiliated with a Hospital and whose primary purpose is providing diagnostic and therapeutic services for treatment of Substance Use Disorder. To be deemed a "Substance Use Disorder Treatment Center," the Institution must have a contractual agreement with the affiliated Hospital by which a system for patient referral is established and monitored by a Physician. Where applicable, the "Substance Use Disorder Treatment Center" must also be appropriately accredited by the Joint Commission on Accreditation of Hospitals.

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

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

"Therapy Services"
"Therapy Services" The following services and supplies when they are:

a) ordered by a Practitioner;
b) performed by a Provider;

c) for a Covered Person who is a Hospital Inpatient or Outpatient, or a recipient of care given by a Home Health Agency; and
d) Medically Necessary and Appropriate for the treatment of a Covered Person's Illness or Accidental Injury.

Chelation Therapy: The administration of drugs or chemicals to remove toxic concentrations of metals from the body.

Chemotherapy: The treatment of malignant disease by chemical or biological antineoplastic agents.

Cognitive Rehabilitation Therapy: Retraining the brain to perform intellectual skills that it was able to perform prior to disease, trauma, Surgery, congenital anomaly or previous therapeutic process.

Dialysis Treatment: The treatment of an acute renal failure or chronic irreversible renal insufficiency by removing waste products from the body. This includes hemodialysis and peritoneal dialysis.

Infusion Therapy: The administration of antibiotic, nutrient, or other therapeutic agents by direct infusion.

Occupational Therapy: The treatment to develop or restore a physically disabled person's ability to perform the ordinary tasks of daily living.

Physical Therapy: The treatment by physical means to: relieve pain; develop or restore normal function; and prevent disability following Illness, Injury or loss of limb.

Radiation Therapy: The treatment of disease by X-ray, radium, cobalt, or high energy particle sources. Radiation Therapy includes the rental or cost of radioactive materials. Diagnostic Services requiring the use of radioactive materials are not Radiation Therapy.

Respiration Therapy: The introduction of dry or moist gases into the lungs.

Speech Therapy: Therapy that is by a qualified speech therapist and is described in a., b. or c:

a. Speech therapy to restore speech after a loss or impairment of a demonstrated, previous ability to speak. Two examples of speech therapy that will not be covered are: (i) therapy to correct pre-speech deficiencies; and (ii) therapy to improve speech skills that have not fully developed.
b. Speech therapy to develop or improve speech to correct a defect that both existed at birth; and impaired or would have impaired the ability to speak.

c. Regardless of anything in a. or b. above to the contrary, speech therapy needed to treat a speech impairment of a Covered Person diagnosed with a Developmental Disability.

For the purpose of this Plan, “Speech Therapy” shall also be deemed to include feeding therapy, when Medically necessary and Appropriate, designed to facilitate normal feeding patterns.

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

Administrator. The Third Party Administrator is not responsible for Plan financing and does not guarantee the availability of benefits under this Plan.

“Total Disability” or “ Totally Disabled”
“Total Disability” or “ Totally Disabled” is defined as a disability that results from a bodily injury or disease that wholly prevents the person from engaging in any gainful work as determined by the Plan Administrator.

“Uniformed Services”
“Uniformed Services” shall mean the Armed Forces, the Army National Guard and the Air National Guard, when engaged in active duty for training, inactive duty training, or full-time National Guard duty, the commissioned corps of the Public Health Service, and any other category of persons designated by the President of the United States in time of war or Emergency.

“Urgent Care”
“Urgent Care” Outpatient and Out-of-Hospital medical care which is needed due to an unexpected Illness, Injury, or other condition that is not life threatening, but that needs to be treated by a Provider within 24 hours.

“Usual and Customary (U&C)”
“Usual and Customary (U&C)” means Covered Expenses which are identified by the Plan Administrator. The Usual and Customary amount for a given item of service or supply will typically be 120% of the Medicare Fee Schedule. If the Medicare Fee Schedule does not include a particular service, the reimbursement rate will be the 50th percentile of the Usual Customary and Reasonable (“UC&R”) charges, using industry standard data sources. If both the Medicare Fee Schedule does not include a particular service and a UC&R charge is not available at the 80th percentile using industry-standard data sources, the service will be priced at 50% of billed charges.
The Plan Administrator may, in its discretion, take into consideration any or all of the following, if the Plan Administrator deems it appropriate: 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; and the prevailing range of fees charged in the same “area” by Providers of similar training and experience for the service or supply. 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 or accepted 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 was 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 an individual of the same sex, comparable age and who has received such services or supplies within the same geographic locale.

The term “Usual and Customary” does not necessarily mean the actual charge made (or accepted) nor the specific service or supply furnished to a Covered Person by a Provider of services or supplies, such as a

Physician, therapist, Nurse, Hospital, or pharmacist. The Plan Administrator will determine the usual charge for any procedure, service, or supply, and whether a specific procedure, service or supply is 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 and/or manufacturer's retail pricing (MRP) for supplies and devices.

Notwithstanding the foregoing, the definition of "Usual & Customary (U&C)" does not apply in respect of the Outpatient and Home Dialysis benefit, which shall be governed by the Outpatient and Home Dialysis Benefit Guide (see Appendix C). For sake of clarity, the definition of "Usual and Reasonable Charge," as described in the Outpatient and Home Dialysis Benefit Guide, applies exclusively to the Outpatient and Home Dialysis benefit and not any other benefit.

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

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

"War"
"War" Includes, but is not limited to, declared ware, an armed aggression by one or more countries resisted on order of any other country, combination of countries or international organizations.

"Work Related"
"Work Related" means an injury or illness arising out of or in the course of one's employment, whether or not the person properly asserts his/her/they legal rights and whether or not any recovery is received.

"You" or "Yours"
"You" or "Yours" refers to the Covered Person, unless the context clearly indicates otherwise.

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

ELIGIBILITY FOR COVERAGE

Eligibility for Individual Coverage

You become eligible when you are classified by your Employer as working 30 or more hours per week as a regular full-time Employee and satisfied the necessary waiting period, if any. The waiting period for new hires is completion of 60 days of employment. An Employee can enroll, effective as of the first of the month following the completion of the waiting period. Dependents may be enrolled as well at that time.

An Eligible Employee is subject to the following conditions:

a) An Eligible Employee is a Salaried or Hourly Employee, and not an Employee classified as per diem, project rate, day rate or temporary.
b) If you are not hired into a full-time role, you will be notified if you meet the eligibility requirements during your initial measurement period.

Eligible Employee Transfers into the Plan from qualified associated staffing vendors and affiliates of Cedarbridge Financial Services.

a) Employees become eligible and can enroll themselves and dependents into the plan immediately upon transfer to Cedarbridge Financial Services with no waiting period if they have satisfied their prior employer waiting period, if any.

b) If you are not hired into a full-time role, you will be notified if you meet the eligibility requirements.

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

Eligible Employee Transfers into the Plan.

a) Employees become eligible and can enroll themselves and dependents into the plan immediately upon transfer to Cedarbridge Financial Services with no waiting period if they have satisfied their prior employer waiting period, if any.
b) If you are not hired into a full-time role, you will be notified if you meet the eligibility requirements.

Reinstatement of Coverage

An Employee who is terminated and rehired will be treated as an Employee upon rehire only if the Employee was not credited with an hour of service, as defined under the Affordable Care Act (ACA), with the Employer (or any member of the controlled or affiliated group) for a period of at least 13 consecutive weeks immediately preceding the date of rehire.

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

Eligible Dependent

The following are the guidelines to determine an Eligible Dependent:

1. Unless otherwise set forth in this Section, coverage for a child Eligible Dependent who ceases to meet the definition of an Eligible Dependent due to age automatically terminates and all benefits hereunder cease, at the end of the month in which the Eligible Dependent ceases to be eligible.

2. A newborn Child of a covered Employee will be considered eligible and will be covered from the moment of birth only if written application to add the Child is received by the Plan Administrator within 30 days following the Child's date of birth. The Employee will need to provide the Plan Administrator with sufficient evidence to substantiate the eligibility of the newborn with official documents (such as birth certificate) and any required premium, coverage for the newborn child will be applied retroactively to the date of birth. Maternity care for dependent daughter not covered. A newborn child born to a child Eligible Dependent is not covered under the Plan.
3. An Employee or Dependent may also be eligible for coverage under the Plan if they are entitled to enroll for coverage under this benefit program pursuant to the special enrollment rights granted under the Health Insurance Portability and Accountability Act of 1996.
4. The Plan is Not available to domestic partners and civil union partners.

Eligibility Dates for Dependent Coverage

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

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

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

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

"Michelle's Law" prohibits a group health plan, or a health insurance issuer that provides health insurance coverage in connection with a group health plan, from terminating coverage of a Dependent Child due to a qualifying "Medically Necessary Leave of Absence" from, or other change in enrollment at, a postsecondary educational Institution prior to the earlier of:

1. The date that is one year after the first day of the Medically Necessary Leave of Absence.
2. The date on which such coverage would otherwise terminate under the terms of the Plan.

In order to be a Medically Necessary Leave of Absence the student's leave must meet all of the following requirements:

1. Commence while the Dependent Child is suffering from a serious Illness or Injury.
2. Be Medically Necessary.
3. Cause the Dependent Child to lose student status for purposes of coverage under the terms of the parents' plan or coverage.

A Child is a “Dependent Child” under the law if he or she meets all of the following requirements:

1. Is a Dependent Child of a Participant under the terms of the Plan or coverage.
2. Was enrolled in the Plan or coverage, on the basis of being a student at a postsecondary educational Institution, immediately before the first day of the Medically Necessary Leave of Absence.

A treating Physician of the Dependent Child must certify that the Dependent Child is suffering from a serious Illness or Injury and that the Leave of Absence (or other change of enrollment) described is Medically Necessary.

Effective Dates of Coverage; Conditions

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

1. Enrollment Application (paper or electronic as applicable). Employee(s) may seek to obtain coverage for themselves and/or Dependents via a form (either paper or electronic as applicable) furnished by the Plan Administrator, in a manner that is satisfactory to the Plan Administrator, and within 30 days following the applicable date of eligibility. If coverage is available and appropriate, coverage will become effective after review of the form, and upon the subsequent date such Employee or Dependents are eligible.
2. Coverage as Both Employee and Dependent. An eligible Participant may enroll in this Plan either as an Employee or as a Dependent, but not both.
3. Birth of Dependent Child. Except as provided in “Newly Acquired Dependents,” below, a newborn Child of a covered Employee will be considered eligible and will be covered from the moment of birth **only if written application to add the Child is received by the Plan Administrator within 30 days following the Child’s date of birth**. If such written application to add a newborn Child is received by the Plan Administrator AFTER the 30 day period immediately following the Child’s date of birth, the Child is considered a late enrollee and not eligible for the Plan until the next Open Enrollment Period. A newborn Child of a Dependent Child is not eligible for this Plan unless the newborn Child meets the definition of an eligible Dependent.
4. Newly Acquired Dependents. If while an Employee is enrolled for coverage, that Employee acquires a Dependent, coverage for the newly acquired Dependent shall be effective on the date the Dependent becomes eligible only if the existing coverage extends to Dependents and written application is made within 30 days. If coverage for Dependents has not already been secured by the Employee, a written application must be made to the Plan within 30 days of the date of the newly acquired Dependent’s initial eligibility, and any required contributions must be made if enrollment is otherwise approved by the Plan Administrator.
5. Requirement for Employee Coverage. Coverage for Dependents shall only be available to Dependents of Employees eligible for coverage for themselves.
6. Dependents of Multiple Employees. If a Dependent may be deemed to be a Dependent of more than one Covered Employee, such Dependent shall be deemed to be a Dependent of one such Employee only.
7. Medicaid Coverage. An individual’s eligibility for any State Medicaid benefits will not be taken into account by the Plan in determining that individual’s eligibility under the Plan.

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

NOTE: The Plan will deny claims for benefits Incurred before your Enrollment Form was received by the Claims Administrator, or for a Dependent not listed on the form. It is the responsibility of the enrolled Employee to notify his or her Employer of any changes in the Dependent, marital, or any change in Address.

The Eligible Employee is responsible for provided the Claims Administrator with Accurate and current enrollment information.

You are required to submit all documentation necessary to substantiate your eligibility or the eligibility of your Dependents whenever requested by the Claims Administrator. If you refuse or fail to furnish such documentation the Claims Administrator may deny eligibility or withdraw you and/or your Dependents from enrollment.

Special and Open Enrollment

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

Loss of Other Coverage

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

1. The eligible Employee or Dependent was covered under another group health plan or had other health insurance coverage at the time coverage under this Plan was offered.
2. The eligible Employee stated in writing at the time this Plan was offered, that the reason for declining enrollment was due to the eligible Employee having coverage under another group health plan or due to the Employee having other health insurance coverage.
3. The eligible Employee or Dependent lost other coverage pursuant to one of the following events:

    a) The eligible Employee or Dependent was under COBRA and the COBRA coverage was exhausted.
    b) The eligible Employee or Dependent was not under COBRA and the other coverage was terminated as a result of loss of eligibility (including as a result of Legal Separation, divorce, loss of Dependent status, death, termination of employment, or reduction in the number of hours worked).
    c) The eligible Employee or Dependent moved out of a Health Maintenance Organization (HMO) service area with no other option available.
    d) The Plan is no longer offering benefits to a class of similarly situated individuals.
    e) The benefit package option is no longer being offered and no substitute is available.
    f) The employer contributions under the other coverage were terminated.

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

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

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

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

For an eligible Employee or Dependent(s) who has met the conditions specified above, this Plan will be effective at 12:01 A.M. on the first day following the loss of other coverage and the request is made within 30 days from loss of coverage. For example, if the Employee loses his or her other health coverage on April 22, he or she must notify the Plan Administrator and apply for coverage by close of business on May 22.

New Dependent

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

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

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

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

1. In the case of marriage, on the date of the marriage.
2. For a legal guardianship, on the date on which such Child is placed in the covered Employee's home pursuant to a court order appointing the covered Employee as legal guardian for the Child.
3. In the case of a Dependent's birth, as of the date of birth.
4. In the case of a Dependent's adoption or placement for adoption, the date of the adoption or placement for adoption.

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

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

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

Open Enrollment
Prior to the start of a Plan Year, this Plan has an Open Enrollment Period. Eligible Participants who are not covered under this Plan may enroll for coverage during Open Enrollment Periods. Coverage for Participants enrolling during an Open Enrollment Period will become effective on , as long as all other eligibility requirements have been met. If the other eligibility requirements have not been met, coverage for Participants enrolling during an Open Enrollment Period will become effective as stated in the provision, "Eligibility for Individual Coverage".

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

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

Late Enrollment
If you and/or your Eligible Dependents did not enroll during your eligibility period or any special enrollment periods described in this Section you will not be eligible for coverage until the next open enrollment period.

Relation to Section 125 Cafeteria Plan
Because this Plan is administered through a cafeteria plan arrangement in accordance with Section 125 regulations of the Internal Revenue Code, your premium contributions will be made on a pre-tax basis. Also, per this regulation, you may be allowed to enroll or change coverage only during the annual open enrollment period. Exceptions are allowed if you experience a qualifying event and enroll or change your coverage due to the special enrollment rules. Refer to the Employer's Section 125 Cafeteria Plan for more information..

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

completed National Medical Support Notice (NMSN) will be treated as a QMCSO and will have the same force and effect.

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

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

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

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

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

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

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

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

1. Notify the State agency issuing the notice with respect to the Child whether coverage of the Child is available under the terms of the Plan and, if so:

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

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

1. Establish reasonable procedures to determine whether Medical Child Support Order or National Medical Support Notice are Qualified Medical Child Support Orders.
2. Administer the provision of benefits under such qualified orders. Such procedures shall:

    a) Be in writing.
    b) Provide for the notification of each person specified in a Medical Child Support Order as eligible to receive benefits under the plan (at the address included in the Medical Child Support Order) of such procedures promptly upon receipt by the plan of the Medical Child Support Order.
    c) Permit an Alternate Recipient to designate a representative for receipt of copies of notices that are sent to the Alternate Recipient with respect to a Medical Child Support Order.

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

Acquired Companies

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

Genetic Information Nondiscrimination Act ("GINA")

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

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

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

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

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

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

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

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

Women’s Health and Cancer Rights Act Annual Notice

Do you know that your plan, as required by the Women’s Health and Cancer Rights Act of 1998, provides benefits for mastectomy-related services including all stages of reconstruction and surgery to achieve symmetry between the breasts, prostheses, and complications resulting from a mastectomy, including lymphedema? Contact the Human Resources Department for additional information.

If you have had or are going to have a mastectomy, you may be entitled to certain benefits under the Women’s Health and Cancer Rights Act of 1998 (WHCRA). For individuals receiving mastectomy-related benefits, coverage will be provided in a manner determined in consultation with the attending physician and the patient, for:

- All stages of reconstruction of the breast on which the mastectomy was performed.
- Surgery and reconstruction of the other breast to produce a symmetrical appearance.
- Prostheses; and
- Treatment of physical complications of the mastectomy, including lymphedema.

These benefits will be provided subject to the same deductibles and coinsurance applicable to other medical and surgical benefits provided under this plan. Please refer to the benefit summaries for the deductible and coinsurance for your plan.

Premium Assistance Under Medicare and the Children's Health Insurance Program (CHIP)

Please see Appendix D for complete details and state information for the Children's Health Insurance Program.

TERMINATION OF COVERAGE

Termination Dates of Individual Coverage

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

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

Termination Dates of Dependent Coverage

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

1. The date upon which the Plan is terminated.
2. Upon the discontinuance of coverage for Dependents under the Plan.
3. The date of termination of the Employee's coverage for himself or herself under the Plan.
4. The date of the expiration of the last period for which the Employee has made a contribution, in the event of his or her failure to make, when due, any contribution for coverage for Dependents to which he or she has agreed in writing.
5. In the case of a Child age 26 or older for whom coverage is being continued due to mental or physical inability to earn his or her own living, the earliest to occur of:

    a) Cessation of such disability or inability.
    b) Failure to provide any required proof of continuous disability or inability or to submit to any required examination.
    c) Upon the Child's no longer being dependent on the Employee for his or her support.

1. The day immediately preceding the date such person is no longer a Dependent, as defined herein, except as may be provided for in other areas of this section.
2. For a Dependent Child whose coverage is required pursuant to a QMCSO, the last day of the calendar month as of which coverage is no longer required under the terms of the order or this Plan.

3. Immediately upon submission of a fraudulent claim or any fraudulent information to the Plan (including enrollment information), by and/or on behalf of an Employee or his or her Dependent, or upon the Employee or his or her Dependent gaining knowledge of the submission, as determined by the Plan Administrator in its discretion, consistent with applicable laws and/or rules regarding such rescission.

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

CONTINUATION OF COVERAGE

Continuation During Family and Medical Leave Act (FMLA) Leave

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

Leave Entitlements

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

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

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

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

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

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

Benefits and Protections

While employees are on FMLA leave, employers must continue health insurance coverage as if the employees were not on leave. Upon return from FMLA leave, most employees must be restored to the same job or one nearly identical to it with equivalent pay, benefits, and other employment terms and conditions.

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

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

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

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

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

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

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

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

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

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

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

For additional information or to file a complaint:
1-866-4-USWAGE
(1-866-487-9243) TTY: 1-877-889-5627
https://www.dol.gov/whd/
U.S. Department of Labor Wage and Hour Division
WH1420a - REV 04/23

Continuation During USERRA

Leave for Military Service under the Uniformed Services Employment and Reemployment Rights Act of 1994 ("USERRA")

If you are inducted into the Military Service of the Armed Forces of the United States of America, or if you enlist in the Military Service, including part-time National Guard Service, or if, because of membership in a reserve component of the Armed Forces, you are called into active federal service, your health coverage will be continued by the Plan during your first thirty-one (31) days of military service in accordance with the Uniformed Services Employment and Reemployment Rights Act ("USERRA") of 1994. After thirty-one (31) days, your eligibility for health care coverage under this Plan will be suspended during the period of your military service. You should receive military health care coverage at no cost. You may choose to continue coverage under this Plan, at your own expense up to a maximum of 24 months. Participants cannot be required to pay more than 102 percent of the full contribution amount during that time. You and your Dependents covered under the Plan may also be eligible to continue coverage under the COBRA provisions by making the required self-payments. The Plan does not voluntarily maintain your coverage; you and your Eligible Dependents will be given the opportunity to elect continuing coverage at your own expense.

If you are in the reserves and return from active duty you will be entitled to resume eligibility under this Plan if you return to active covered employment within ninety (90) days from the date of discharge, originally left the employer for military service from other than a temporary position and was released from active duty under "honorable conditions". The veterans' rights law requires this ninety (90) day grace period as a type of protection for Covered Persons, for the duration of the reserve call-up or any other type of military service up to five (5) years. The Plan is not obligated to offer this ninety (90) day period to Covered Persons serving in the military for five (5) or more years.

Essentially, the Plan will suspend your eligibility in the Plan until you are discharged. Your eligibility will be based on your hours worked in covered employment prior to entering the military. If you do not return to active covered employment within ninety (90) days (or any time otherwise specified), you will be considered a new employee, subject to the initial eligibility provisions.

Questions regarding your entitlement to this leave should be referred to your Employer. Questions about the USERRA continuation of coverage should be referred to the Plan Administrator.

May I continue to participate while I am absent under USERRA?

You may elect to continue coverage under the Plan for yourself and your dependents, when:

1. You and your dependents were Covered Persons in the Plan immediately prior to your leave of absence for uniformed service; and
2. The reason for your leave of absence is due to active service in the uniformed services.

In addition, you must meet the following requirements:

a) You (or an appropriate officer of the uniformed service) must give advance written or verbal notice of your service to the Employer. This notice will not be required if giving it is precluded by military necessity or is otherwise impossible or unreasonable;
b) The cumulative length of this absence and all previous absences by reason of your service in the uniformed service does not exceed five years (although certain exceptions apply to this five year maximum requirement); and
c) You comply with the notice requirements set forth under the question "When will coverage continued through USERRA terminate?"

The law requires the employer to allow you to elect coverage which is identical to similarly situated employees who are not on USERRA leave. This means that if the coverage for similarly situated employees and dependents is modified, coverage for the individual on USERRA leave will be modified.

What is the cost of continuing coverage under USERRA?

a) The cost of continuing your coverage will be:
b) For leaves of 30 days or less, the same as the contribution required from similarly situated employees;
c) For leaves of 31 days or more, up to 102% of the contribution required from similarly situated employees.

Continuation applies to all coverage provided under this Plan.

When will coverage continued through USERRA terminate?

Continued coverage under this provision will terminate on the earliest of the following events:

i. The date you fail to apply for or fail to return to work following completion of your leave. You must notify Employer of your intent to return to employment within:

- For leaves of 30 days or less, or if you are absent from employment for a period of any length for the purposes of an examination to determine your fitness to perform service in the uniformed service, by reporting to the Employer:
    - Not later than the beginning of the first full regularly scheduled work period on the first full calendar day following the completion of your period of service and the expiration of eight hours after a period allowing for your safe transportation from the place of service to your residence; or
    - If reporting with such period is impossible or unreasonable through no fault of yours, then as soon as possible after the expiration of the eight-hour period referred to above.

- For leaves of 30 to 180 days, by submitting an application to Employer for reemployment:
    - Not later than 14 days after completing uniformed service; or
    - If submitting such application within that period is impossible or unreasonable through no fault of your own, then the next first full calendar day when submission of such application becomes possible.

- For leaves of more than 180 days, by submitting an application for reemployment not later than 90 days after completing uniformed service.

  If you are hospitalized for, or convalescing from, an illness or injury Incurred in, or aggravated during, the performance of service in the uniformed service, by reporting to, or submitting an application for reemployment (depending upon the length of your leave as indicated above), at the end of the period that is necessary for you to recover from such illness or injury. This period may not exceed two years, except if circumstances beyond your control make reporting to Employer impossible or unreasonable, then the two-year period may be extended by the minimum time required to accommodate such circumstances.

  a) The date you fail to pay any required contribution.
  b) 24 months from the date your leave began.

How will my coverage be reinstated on return from USERRA leave?
The law also requires, regardless of whether continuation of coverage was elected, that your coverage and your dependents' coverage be reinstated immediately upon your return to employment, so long as you comply with the requirements set forth above in "May I continue participation while I am absent under USERRA?" and, if your absence was more than 30 days, you have furnished any available documents requested to establish that you are entitled to the protections offered by USERRA. Further, your separation from service or discharge may not be dishonorable or based upon bad conduct, on grounds less than honorable, absent without leave, or ending in a conviction under court martial.

Upon reinstatement, an exclusion or waiting period may not be imposed if that exclusion or waiting period would not have been imposed had your coverage (or your dependents' coverage) not terminated as a result of your service in the uniformed service. However, this does not apply to coverage of any illness or injury determined by the Secretary of Veteran Affairs to have been Incurred in, or aggravated during, performance of your service in the uniformed services.

Continuation During COBRA – Introduction

The right to this form of continued coverage was created by a Federal law, under the Consolidated Omnibus Budget Reconciliation Act of 1985, as amended ("COBRA"). COBRA Continuation Coverage can become available to Participants when they otherwise would lose their group health coverage. It also can become available to other members of the Participant's family who are covered under the Plan when they otherwise would lose their group health coverage. Under the Plan, certain Participants, and their eligible family members (called Qualified Beneficiaries) that elect COBRA Continuation Coverage must pay the entire cost of the coverage, including a reasonable administration fee. There are several ways coverage will terminate, including the failure of the Participant or their covered Dependents to make timely payment of contributions or premiums. For additional information, Participants should contact the Participating Employer to determine if COBRA applies to him or her and/or his or her covered Dependents.

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

What is the Health Insurance Marketplace?
The Marketplace offers "one-stop shopping" to find and compare private health insurance options. In the Marketplace, you could be eligible for a new kind of tax credit that lowers your monthly premiums and cost-sharing reductions (amounts that lower your out-of-pocket costs for deductibles, coinsurance, and copayments) right away, and you can see what your premium, deductibles, and out-of-pocket costs will be before you make a decision to enroll. Through the Marketplace you'll also learn if you qualify for free or low-cost coverage from Medicaid or the Children's Health Insurance Program (CHIP) (See Appendix B). You can access the Marketplace for your state at www.HealthCare.gov.

Coverage through the Health Insurance Marketplace may cost less than COBRA continuation coverage. Being offered COBRA continuation coverage won't limit your eligibility for coverage or for a tax credit through the Marketplace.

When can I enroll in Marketplace coverage?
You always have 60 days from the time you lose your job-based coverage to enroll in the Marketplace. That is because losing your job-based health coverage is a "special enrollment" event. After 60 days your special enrollment period will end and you may not be able to enroll, so you should take action right away. In addition, during what is called an "open enrollment" period, anyone can enroll in Marketplace coverage.

To find out more about enrolling in the Marketplace, such as when the next open enrollment period will be and what you need to know about qualifying events and special enrollment periods, visit www.HealthCare.gov.

If I sign up for COBRA continuation coverage, can I switch to coverage in the Marketplace? What about if I choose Marketplace coverage and want to switch back to COBRA continuation coverage?
If you sign up for COBRA continuation coverage, you can switch to a Marketplace plan during a Marketplace open enrollment period. You can also end your COBRA continuation coverage early and switch to a Marketplace plan if you have another qualifying event such as marriage or birth of a child through something called a "special enrollment period." But be careful though - if you terminate your COBRA continuation coverage early without another qualifying event, you'll have to wait to enroll in Marketplace coverage until the next open enrollment period and could end up without any health coverage in the interim.

Once you've exhausted your COBRA continuation coverage and the coverage expires, you'll be eligible to enroll in Marketplace coverage through a special enrollment period, even if Marketplace open enrollment has ended.

If you sign up for Marketplace coverage instead of COBRA continuation coverage, you cannot switch to COBRA continuation coverage under any circumstances.

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

Qualifying Events
A qualifying event is any of those listed below if the Plan provided that the Participant would lose coverage (i.e., cease to be covered under the same terms and conditions as in effect immediately before the qualifying event) in the absence of COBRA continuation coverage. After a Qualifying Event, COBRA Continuation Coverage must be offered to each person who is a "Qualified Beneficiary." A Qualified Beneficiary is someone who is or was covered by the Plan and has lost or will lose coverage under the Plan due to the occurrence of a Qualifying Event. The Employee and/or Employee's Dependents could therefore become Qualified Beneficiaries if applicable coverage under the Plan is lost because of the Qualifying Event.

An Employee, who is properly enrolled in this Plan and is a covered Employee, will become a Qualified Beneficiary if he or she loses his or her coverage under the Plan because either one of the following Qualifying Events happens:

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

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

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

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

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

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

Employee Notice of Qualifying Events
In certain circumstances, the covered Employee or Qualified Beneficiary, in order to protect his or her rights under COBRA, is required to provide notification to the COBRA Administrator in writing, either by U.S. First Class Mail or hand delivery within 60 days of the event. These circumstances are any of the following:

1. Notice of Divorce or Separation: Notice of the occurrence of a Qualifying Event that is a divorce or Legal Separation of a covered Employee (or former Employee) from his or her spouse.
2. Notice of Child's Loss of Dependent Status: Notice of the occurrence of a Qualifying Event that is an individual's ceasing to be eligible as a Dependent Child under the terms of the Plan.

3. Notice of a Second Qualifying Event: Notice of the occurrence of a second Qualifying Event after a Qualified Beneficiary has become entitled to COBRA Continuation Coverage with a maximum duration of 18 (or 29) months.
4. Notice Regarding Disability: Notice that a Qualified Beneficiary entitled to receive COBRA Continuation Coverage with a maximum duration of 18 months has been determined by the Social Security Administration ("SSA") to be disabled at any time during the first 60 days of COBRA Continuation Coverage.
5. Notice Regarding End of Disability: Notice that a Qualified Beneficiary, with respect to whom a notice described above in #4 has been provided, has subsequently been determined by the SSA to no longer be disabled.

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

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

Notification must be received by the COBRA Administrator. The COBRA Administrator is:

Flex Facts
7 Grant Avenue
Lakewood, NJ 08701
Fax: 1-877-747-8564
Email: COBRA@flexfacts.com

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 described above, notice must be furnished within 60 days of the latest occurring event set forth below:

1. The date upon which the Qualifying Event occurs.
2. The date upon which the Qualified Beneficiary loses (or would lose) Plan coverage due to a Qualifying Event.
3. The date upon which the Qualified Beneficiary is notified via the Plan's SPD or general notice, and/or becomes aware of their status as a Qualified Beneficiary and/or the occurrence of a Qualifying Event; as well as their subsequent responsibility to comply with the Plan's procedure(s) for providing notice to the COBRA Administrator regarding said status.

As described above, if an Employee or Qualified Beneficiary is determined to be disabled under the Social Security Act, the notice must be delivered no more than 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 Beneficiary loses (or would lose) coverage under the Plan as a result of the Qualifying Event.
4. The date on which the Qualified Beneficiary is informed, through the furnishing of the Plan's SPD or the general notice, of both the responsibility to provide the notice and the Plan's procedures for providing such notice to the COBRA Administrator.

In any event, this notice must be provided within the first 18 months of COBRA Continuation Coverage.

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

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

The notice must be postmarked (if mailed) or received by the COBRA Administrator (if hand delivered), by the deadline set forth above. If the notice is late, the opportunity to elect or extend COBRA Continuation Coverage is lost, and if the person is electing COBRA Continuation Coverage, 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) with respect to a Qualifying Event, or any representative acting on behalf of the covered Employee (or former Employee) or Qualified Beneficiary, may provide the notice. Notice by one individual shall satisfy any responsibility to provide notice on behalf of all related Qualified Beneficiaries with respect to the Qualifying Event.

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

1. Name and address of the covered Employee or former Employee.
2. Name of the Plan and the name, address, and telephone number of the Plan's COBRA administrator.
3. Identification of the Qualifying Event and its date (the initial Qualifying Event and its date if the Qualifying Participant is already receiving COBRA Continuation Coverage and wishes to extend the maximum coverage period).
4. A description of the Qualifying Event (for example, divorce, Legal Separation, cessation of Dependent status, entitlement to Medicare by the covered Employee or former Employee, death of the covered Employee or former Employee, disability of a Qualified Beneficiary or loss of disability status).
    a) In the case of a Qualifying Event that is divorce or Legal Separation, name(s) and address(es) of spouse and Dependent Child or Children covered under the Plan, date of divorce or Legal Separation, and a copy of the decree of divorce or Legal Separation.

b) 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 or Children covered under the Plan.
c) 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).
d) In the case of a Qualifying Event that is the death of the covered Employee or former Employee, the date of death, and name(s) and address(es) of spouse and Dependent Child or Children covered under the Plan.
e) In the case of a Qualifying Event that is disability of a Qualified Beneficiary, name and address of the disabled Qualified Beneficiary, name(s) and address(es) of other family members covered under the Plan, the date the disability began, the date of the SSA's determination, and a copy of the SSA's determination.
f) In the case of a Qualifying Event that is loss of disability status, name and address of the Qualified Beneficiary who is no longer disabled, name(s) and address(es) of other family members covered under the Plan, the date the disability ended and the date of the SSA's determination.

5. Identification of the Qualified Beneficiaries (by name or by status).
6. An explanation of the Qualified Beneficiaries' right to elect continuation coverage.
7. The date coverage will terminate (or has terminated) if continuation coverage is not elected.
8. How to elect continuation coverage.
9. What will happen if continuation coverage isn't elected or is waived.
10. What continuation coverage is available, for how long, and (if it is for less than 36 months), how it can be extended for disability or second qualifying events.
11. How continuation coverage might terminate early.
12. Premium payment requirements, including due dates and grace periods.
13. A statement of the importance of keeping the Plan Administrator informed of the addresses of Qualified Beneficiaries.
14. A statement that the election notice does not fully describe COBRA or the plan and that more information is available from the Plan Administrator and in the SPD.
15. A certification that the information is true and correct, a signature and date.

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

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

Financial Responsibility for Failure to Give Notice
If you or your Dependent fails to give written notice within sixty (60) days of the date of the Qualifying Event, or an Employer within thirty days of the Qualifying Event, and as a result, the Plan pays a claim for an individual Person whose coverage terminated due to a Qualifying Event and who does not elect COBRA

Coverage under this provision, then you, your Dependent or the Employer, as appropriate, must reimburse the Plan for any claims that should not have been paid. If you or your Dependent fails to reimburse the Plan, then all amounts due may be deducted from other benefits payable on behalf of you or your Dependent

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

Each Qualified Beneficiary will have an independent right to elect COBRA Continuation Coverage. Covered Employees may elect COBRA Continuation Coverage on behalf of all other Qualified Beneficiaries, including their spouses, and parents or a legal guardian may elect COBRA Continuation Coverage on behalf of their Children.

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.

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

Duration of COBRA Continuation Coverage
The maximum time period shown below shall dictate for how long COBRA Continuation Coverage will be available. The maximum time period for coverage is based on the type of the Qualifying Event and the status of the Qualified Beneficiary. Multiple Qualifying Events that may be combined under COBRA will not ordinarily continue coverage for more than 36 months beyond the date of the original Qualifying Event. When the Qualifying Event is “entitlement to Medicare,” the 36 month continuation period is measured from the date of the original Qualifying Event. For all other Qualifying Events, the continuation period is measured from the date of the Qualifying Event, not the date of loss of coverage.

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

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

date of Medicare entitlement, which is equal to twenty-eight months after the date of the Qualifying Event (thirty-six months minus eight months).

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

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

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

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

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

- Contributions are not paid in full on a timely basis,
- The Plan Sponsor ceases to maintain any group health plan,
- The Qualified Beneficiary begins coverage under another group health plan after electing continuation coverage,
- The Qualified Beneficiary enrolls in Medicare Part A or B after electing continuation coverage,
- The Qualified Beneficiary engages in fraud or other conduct that would justify termination of coverage of a similarly situated participant or beneficiary not receiving continuation coverage, or

- If covered under an 11-month disability extension, there is a final determination that the Qualified Beneficiary is no longer disabled for Social Security Purposes (coverage shall terminate on the first day of the month at least 30 days after the determination is made that the Qualified Beneficiary is no longer disabled).

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

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

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

Trade Reform Act and Further Consolidated Appropriations Act, 2020
The Further Consolidated Appropriations Act, 2020 has extended certain provisions of the Trade Reform Act, which created a special COBRA right applicable to certain employees who have been terminated or experienced a reduction of hours and who qualify for a "trade readjustment allowance" or "alternative trade adjustment assistance." These individuals can either take a Health Coverage Tax Credit (HCTC) or get advance payment of the applicable percentage of premiums paid for qualified health insurance coverage, including COBRA continuation coverage. These individuals are also entitled to a second opportunity to elect COBRA coverage for themselves and certain family members (if they did not already elect COBRA coverage). This election must be made within the 60-day period that begins on the first day of the month in which the individual becomes eligible for assistance under the Trade Reform Act. However, this election may not be made more than six months after the date the individual's group health plan coverage ends.

A Participant's eligibility for subsidies under the Further Consolidated Appropriations Act, 2020, affects his or her eligibility for subsidies that provide premium assistance for coverage purchased through the Health Insurance Marketplace. For each coverage month, a Participant must choose one or the other, and if he or she receives both during a tax year, the IRS will reconcile his or her eligibility for each subsidy through his or her individual tax return. Participants may wish to consult their individual tax advisors concerning the benefits of using one subsidy or the other.

Participants may contact the Plan Administrator for additional information or if they have any questions, they may call the Health Coverage Tax Credit Customer Contact Center toll-free at 1-866-628-4282. TTD/TTY callers may call toll-free at 1-866-626-4282. More information about the Trade Reform Act is available at www.doleta.gov/tradeact; for information about the Health Coverage Tax Credit (HCTC), please see: https://www.irs.gov/Credits-&-Deductions/Individuals/HCTC.

Additional Information
Please contact the COBRA Administrator with any questions about the Plan and COBRA Continuation Coverage at the following:

Flex Facts
7 Grant Avenue
Lakewood, NJ 08701
Fax: 1-877-747-8564
Email: COBRA@flexfacts.com

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

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

GENERAL LIMITATIONS AND EXCLUSIONS

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

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

After the Termination Date. That are Incurred by the Participant on or after the date coverage terminates, even if payments have been predetermined for a course of treatment submitted before the termination date, unless otherwise deemed to be covered in accordance with the terms of the Plan or applicable law and/or regulation.

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

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

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

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

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

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

Deductible. That are amounts applied toward satisfaction of Deductibles and expenses that are defined as the Participant's responsibility in accordance with the terms of the Plan.

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

Experimental. That are Experimental or Investigational.

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

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

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

Government-Operated Facilities. That meet the following requirements:

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

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

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

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

Illegal Drugs or Medications. That are services, supplies, care or treatment to a Participant for Injury or Illness Incurred while the Participant was voluntarily taking or being under the influence of any controlled substance, drug, hallucinogen or narcotic not administered on the advice of a Physician, or of any Schedule I substance, even if administered on the advice of a Physician and/or legal under the law of the state where the Participant lives, even if the cause of the Illness or Injury is not related to the use of the controlled substance, drug, hallucinogen or narcotic. Expenses will be covered for Injured Participants other than the person using controlled substances and expenses will be covered for Substance Use Disorder treatment as specified in this Plan. This Exclusion does not apply if the Injury (a) resulted from being the victim of an act of domestic violence or (b) resulted from a documented medical condition (including both physical and mental health conditions), even if the condition is not diagnosed before the Injury.

Incurred by Other Persons. That are expenses actually Incurred by other persons.

Long Term Care. That are related to long term care.

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

Medicare Costs. Any amounts the Covered Person or Eligible Dependent is required to pay under the deductible and/or coinsurance provisions of Medicare or any Medicare supplemental coverage;

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

Negligence. That are for Injuries resulting from negligence, misfeasance, malfeasance, nonfeasance or malpractice on the part of any caregiver, Institution, or Provider, as determined by the Plan Administrator, in its discretion, in light of applicable laws and evidence available to the Plan Administrator.

No Coverage. That are Incurred at a time when no coverage is in force for the applicable Participant and/or Dependent.

No Fault. Services rendered when no Fault is primary. If a claim is denied because of illegal substance use or DUI, then Plan will also not cover any deductible or dollar amount over the insured's limit. The Plan will not cover charges denied under no fault insurance because the claimant did not have no fault coverage in violation of New York or other state insurance laws;

No Legal Obligation. That are for services provided to a Participant for which the Provider of a service does not and/or would not customarily render a direct charge, or charges Incurred for which the Participant or Plan has no legal obligation to pay, or for which no charges would be made in the absence of this coverage, including but not limited to charges for services not actually rendered, fees, care, supplies, or services for which a person, company or any other entity except the Participant or the Plan, may be liable for necessitating the fees, care, supplies, or services.

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

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

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

Not Specified As Covered. That are not specified as covered under any provision of this Plan.

Occupational. That are for 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. Participants that are self-employed or employed by an employer that does not provide health benefits should ensure that they have other medical benefits to provide for medical care in the event they are hurt on the job. In most cases workers' compensation insurance will cover the costs, but if the Participant does not have such coverage he or she may end up with no coverage at all.

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

Personal Injury Insurance. That are in connection with an automobile accident for which benefits payable hereunder are, or would be otherwise covered by, mandatory no-fault automobile insurance or any other similar type of personal injury insurance required by state or federal law, without regard to whether or not the Participant actually had such mandatory coverage. Any claims which arise in connection with an automobile accident for which the policy provides an option for medical coverage are excluded. Benefits will be excluded to the maximum amount of first party medical coverage available under the applicable state law, regardless of a Participant's election of lesser coverage. This Exclusion does not apply if the Injured person is a passenger in a non-family owned vehicle or a pedestrian.

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

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

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

Prohibited by Law. That are themselves prohibited by applicable law, in general or within the context of the course of treatment, or to the extent that payment under this Plan is prohibited by applicable law.

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

Self-Inflicted. That are Incurred due to an intentionally self-inflicted Injuries or Illness, not definitively (a) resulting from being the victim of an act of domestic violence, or (b) resulting from a documented medical condition (including both physical and mental health conditions).

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

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

Vehicle Accident. That are for treatment of any Illness or Injury where it is determined that a Participant was involved in a motorcycle Accident while not wearing a helmet or in an automobile Accident while not wearing a seatbelt (or car seat), even if the cause of the Illness or Injury is not related to the failure of the Participant to wear a helmet or seatbelt (or car seat). This Exclusion does not apply: (a) to Participants who were passengers on public transportation, ride for hire or livery services or (b) when a seatbelt or helmet is not required by law.

War/Riot. That are Incurred as a result of war or any act of war, whether declared or undeclared, or any act of aggression by any country, including rebellion or riot, when the Participant is a member of the armed forces of any country, or during service by a Participant in the armed forces of any country, or voluntary participation in a riot. This Exclusion does not apply to any Participant who is not a member of the armed forces, and does not apply to victims of any act of war or aggression.

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

PLAN ADMINISTRATION

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

Plan Administrator

The Plan is administered by the Plan Administrator within the purview of ERISA and in accordance with these provisions. An individual, committee, or entity may be appointed by the Plan Sponsor to be Plan Administrator and serve at the convenience of the Plan Sponsor. If the appointed Plan Administrator or a committee member 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 may delegate to one or more individuals or entities part or all of its discretionary authority under the Plan, provided that any such delegation must be made in writing.

The Plan shall be administered by the Plan Administrator, in accordance with its terms. Policies, interpretations, practices, and procedures are established and maintained by the Plan Administrator. 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 all interpretive and factual determinations as to whether any individual is eligible and entitled to receive any benefit under the terms of this Plan, to decide disputes which may arise with respect to a Participant's rights, and to decide questions of Plan interpretation and those of fact relating to the Plan. The decisions of the Plan Administrator will be final and binding on all interested parties. Benefits will be paid under this Plan only if the Plan Administrator, in its discretion, determines that the Participant is entitled to them.

If due to errors in drafting, any Plan provision does not accurately reflect its intended meaning, as demonstrated by prior interpretations or other evidence of intent, or as determined by the Plan 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 Participant's rights and/or availability of benefits.
6. To prescribe procedures for filing a claim for benefits, to review claim denials and appeals relating to them and to uphold or reverse such denials.
7. To keep and maintain the Plan documents and all other records pertaining to the Plan.
8. To appoint and supervise a Third Party Administrator to pay claims.
9. To perform all necessary reporting as required by ERISA.
10. To establish and communicate procedures to determine whether a Medical Child Support Order is a QMCSO.
11. To delegate to any person or entity such powers, duties and responsibilities as it deems appropriate.
12. To perform each and every function necessary for or related to the Plan's administration.

Amending and Terminating the Plan

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

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

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

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. If said Material Modification is affected by amendment as described above, distribution of a copy of said written

amendment, within all applicable time limits, shall be deemed sufficient notification to satisfy the Plan's Summary of Material Modifications requirements.

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

Summary of Material Reduction (SMR)

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

The Plan Administrator shall notify all eligible Employees of any plan amendment considered a Material Reduction in covered services or benefits provided by the Plan as soon as administratively feasible after its adoption, but no later than 60 days after the date of adoption of the reduction. Eligible Employees and beneficiaries must be furnished a summary of such reductions, and any changes so made shall be binding on each Participant. The 60 day period for furnishing a summary of Material Reduction does not apply to any Employee covered by the Plan who would reasonably expect to receive a summary through other means within the next 90 days.

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

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

Misuse of Identification Card

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

CLAIM PROCEDURES; PAYMENT OF CLAIMS

Introduction

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

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

Health Claims

Full and final authority to adjudicate claims and make determinations as to their payability by and under the Plan belongs to and resides solely with the Plan Administrator. The Plan Administrator shall make claims adjudication determinations after full and fair review and in accordance with the terms of this Plan, applicable law, and with ERISA. To receive due consideration, claims for benefits and questions regarding said claims should be directed to the Third Party Administrator. The Plan Administrator may delegate to the Third Party Administrator responsibility to process claims in accordance with the terms of the Plan and the Plan Administrator's directive(s). The Third Party Administrator is not a fiduciary of the Plan and does not have discretionary authority to make claims payment decisions or interpret the meaning of the Plan terms.

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

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

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

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

Benefits will be payable to a Claimant, or to a Provider that has accepted an assignment of benefits as consideration in full for services rendered. The Plan Administrator may revoke an assignment of benefits previously issued to a Provider at its discretion and treat the Participant as the sole beneficiary.

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

1. Pre-service Claims. A "Pre-service Claim" occurs when issuance of payment by the Plan is dependent upon determination of payability prior to the receipt of the applicable medical care; however, if the Plan does not require the Claimant to obtain approval of a medical service prior to getting treatment, then there is no "Pre-service Claim".

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

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

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

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

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

When Claims Must Be Filed

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

All claims must be filed at the Claims Administrator on the appropriate form. A Covered Person may obtain the necessary forms for filing a claim by telephone at 1-877-208-5952 or writing to the Claims Administrator

at 4631 Woodland Corporate Blvd. Ste 310, Tampa, FL 33614. All necessary information must accompany your claim in order for the Plan to process the claim effectively.

IMPORTANT NOTE: You and your Dependents should be aware that you or your medical provider's failure to file the claim for benefits within the 365 days deadline will mean that your claim is late and will not be paid by the Plan. Consequently, the medical provider may seek to collect any money it is owed directly from you. It is therefore very important that you make sure that you or your provider submit your medical claims within the 365 day time frame.

Additionally, if the Plan denies or partially denies any claim for benefits that you do make, you or your provider must appeal the denial within the one hundred and eighty (180) days. If you wish to contest the Plan's decision. A failure to request this review binds you and your provider to accept the amount, if any, that the Plan has already paid regarding the claim. The Plan will not pay any claims after the time to appeal a denial has elapsed and the medical provider may seek to collect any money it is owed directly from you.

You must file a completed claim form each time you submit a bill directly to the Plan. If you wish the Claims Administrator to pay the provider of services directly, you must provide us with your original signature (not a photocopy) authorizing us to do so. Please be sure to indicate on the claim form if there is an Injury involved, a lawsuit or third-party recovery, or any change in your marital status, you or your spouse's employment status or eligibility for other medical coverage.

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

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

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

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

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

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

1. Pre-service Urgent Care Claims:

    a) If the Claimant has provided all of the necessary information, as soon as possible, taking into account the medical exigencies, but not later than 72 hours after receipt of the claim.
    b) If the Claimant has not provided all of the information needed to process the claim, then the Claimant will be notified as to what specific information is needed as soon as possible, but not later than 24 hours after receipt of the claim.
    c) The Claimant will be notified of a determination of benefits as soon as possible, but not later than 48 hours, taking into account the medical exigencies, after the earliest of:
        a. The end of the period afforded the Claimant to provide the information.
        b. The Plan's receipt of the specified information.
    d) If there is an Adverse Benefit Determination, a request for an expedited appeal may be submitted orally or in writing by the Claimant. All necessary information, including the Plan's benefit determination on review, may be transmitted between the Plan and the Claimant by telephone, facsimile, or other similarly expeditious method. Alternatively, the Claimant may request an expedited review under the external review process.

2. Pre-service Non-urgent Care Claims:

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

3. Concurrent Claims:

    a) Plan Notice of Reduction or Termination. If the Plan Administrator is notifying the Claimant of a reduction or termination of a course of treatment (other than by Plan amendment or termination), notification will occur before the end of such period of time or number of treatments. The Claimant will be notified sufficiently in advance of the reduction or termination to allow the Claimant to appeal and obtain a determination on review of that Adverse Benefit Determination before the benefit is reduced or terminated. This rule does not apply if benefits are reduced or eliminated due to plan amendment or termination. A similar process applies for claims based on a rescission of coverage for fraud or misrepresentation.

a) Request by Claimant Involving Urgent Care. If the Plan Administrator receives a request from a Claimant to extend the course of treatment beyond the period of time or number of treatments involving urgent care, notification will occur as soon as possible, taking into account the medical exigencies, but not later than 24 hours after receipt of the claim, as long as the Claimant makes the request at least 24 hours prior to the expiration of the prescribed period of time or number of treatments. If the Claimant submits the request 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.
b) Request by Claimant Involving Non-urgent Care. If the Plan Administrator receives a request from the Claimant for a claim not involving urgent care, the request will be treated as a new benefit claim and decided within the timeframe appropriate to the type of claim (either as a Pre-service Non-urgent claim or a Post-service claim).
c) Request by Claimant Involving Rescission. With respect to rescissions, the following timetable applies:

i.	Notification to Claimant	30 days
ii.	Notification of Adverse Benefit Determination on appeal	30 days

4. Post-service Claims:

a) If the Claimant has provided all of the information needed to process the claim, in a reasonable period of time, but not later than 30 days after receipt of the claim, unless an extension has been requested, then prior to the end of the 15 day extension period.
b) If such an extension is necessary due to a failure of the Claimant to submit the information necessary to decide the claim, the notice of extension shall specifically describe the required information, and the Claimant shall be afforded at least 45 days from receipt of the notice within which to provide the specified information.
c) If the Claimant has not provided all of the information needed to process the claim and additional information is requested during the initial processing period, then the Claimant will be notified of a determination of benefits prior to the end of the extension period, unless additional information is requested during the extension period, then the Claimant will be notified of the determination by a date agreed to by the Plan Administrator and the Claimant.

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

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

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

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

Appeal of Adverse Benefit Determinations

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

1. A 180 day timeframe following receipt of a notification of an initial Adverse Benefit Determination within which to appeal the determination. The Plan will not accept appeals filed after a 180 day timeframe.
2. The opportunity to submit written comments, documents, records, and other information relating to the claim for benefits.
3. The opportunity to review the Claim file and to present evidence and testimony as part of the internal claims and appeals process.
4. A review that does not afford deference to the previous Adverse Benefit Determination and that is conducted by an appropriate named fiduciary of the Plan, who shall be neither the individual who

made the Adverse Benefit Determination that is the subject of the appeal, nor the subordinate of such individual.

5. A review that takes into account all comments, documents, records, and other information submitted by the Claimant relating to the claim, without regard to whether such information was submitted or considered in the prior benefit determination.
6. That, in deciding an appeal of any Adverse Benefit Determination that is based in whole or in part upon a medical judgment, the Plan fiduciary shall consult with a health care professional who has appropriate training and experience in the field of medicine involved in the medical judgment, who is neither an individual who was consulted in connection with the Adverse Benefit Determination that is the subject of the appeal, nor the subordinate of any such individual.
7. Upon request, the identity of medical or vocational experts whose advice was obtained on behalf of the Plan in connection with a claim, even if the Plan did not rely upon their advice.
8. If applicable, a discussion of the basis for disagreeing with the disability determination made by either (a) the Social Security Administration; or (b) an independent medical expert that has conducted a full medical review of the Claimant if presented by the Claimant in support of the claim.
9. That a Claimant will be provided, free of charge: (a) reasonable access to, and copies of, all documents, records, and other information relevant to the Claimant's claim in possession of the Plan Administrator or Third Party Administrator; (b) information regarding any voluntary appeals procedures offered by the Plan; (c) information regarding the Claimant's right to an external review process; (d) any internal rule, guideline, protocol or other similar criterion relied upon, considered or generated in making the adverse determination; and (e) an explanation of the scientific or clinical judgment for the determination, applying the terms of the Plan to the Claimant's medical circumstances.
10. That a Claimant will be provided, free of charge, and sufficiently in advance of the date that the notice of Final Internal Adverse Benefit Determination is required, with new or additional evidence considered, relied upon, or generated by the Plan in connection with the Claim, as well as any new or additional rationale for a denial at the internal appeals stage, and a reasonable opportunity for the Claimant to respond to such new evidence or rationale.

Requirements for First Level Appeal

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

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

Leading Edge Administrators
4631 Woodland Corporate Blvd, Ste 310
Tampa, FL 33614
Phone: 1-877-208-5952
Fax: 1-813-422-7845

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

Leading Edge Administrators
4631 Woodland Corporate Blvd, Ste 310
Tampa, FL 33614
Phone: 1-877-208-5952
Fax: 1-813-422-7845

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

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

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

1. Pre-service Urgent Care Claims: As soon as possible, taking into account the medical exigencies, but not later than 72 hours after receipt of the appeal.
2. Pre-service Non-urgent Care Claims: Within a reasonable period of time appropriate to the medical circumstances, but not later than 15 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 30 days per internal 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 Claimant with notification, with respect to Pre-service urgent care claims, by telephone, facsimile or similar method, and with respect to all other types of claims, in writing or electronically, of a Plan's Adverse Benefit Determination on review, setting forth:

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

4. The identity of any medical or vocational experts consulted in connection with a claim, even if the Plan did not rely upon their advice (or a statement that the identity of the expert will be provided, upon request).
5. A statement that the Claimant is entitled to receive, upon request and free of charge, reasonable access to, and copies of, all documents, records, and other information relevant to the Claimant's claim for benefits.
6. Any rule, guideline, protocol or similar criterion that was relied upon, considered, or generated in making the determination will be provided free of charge. If this is not practical, a statement will be included that such a rule, guideline, protocol or similar criterion was relied upon in making the determination and a copy will be provided to the Claimant, free of charge, upon request.
7. A description of any additional information necessary for the Claimant to perfect the claim and an explanation of why such information is necessary.
8. A description of available internal appeals and external review processes, including information regarding how to initiate an appeal.
9. A description of the Plan's review procedures and the time limits applicable to the procedures. This description will include information on how to initiate the appeal and a statement of the Participant's right to bring a civil action under section 502(a) of ERISA following an Adverse Benefit Determination on final review.
10. In the case of denials based upon a medical judgment (such as whether the treatment is Medically Necessary or Experimental), either an explanation of the scientific or clinical judgment for the determination, applying the terms of the Plan to the Claimant's medical circumstances, will be provided. If this is not practical, a statement will be included that such explanation will be provided to the Claimant, free of charge, upon request.
11. Information about the availability of, and contact information for, an applicable office of health insurance consumer assistance or ombudsman established under applicable federal law to assist Participants with the internal claims and appeals and external review processes.
12. The following statement: "You and your Plan may have other voluntary alternative dispute resolution options, such as mediation. One way to find out what may be available is to contact your local U.S. Department of Labor Office and your State insurance regulatory agency".

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

Decision on Review
The decision by the Plan 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.

Requirements for Second Level Appeal
The Claimant must file an appeal regarding a Pre-service or Post-service claim and applicable Adverse Benefit Determination, in writing within 60 days following receipt of the notice of the first level Adverse Benefit Determination.

Two Levels of Appeal
This Plan requires two levels of appeal (Pre-service or Post-service) by a Claimant before the Plan's internal appeals are exhausted. For each level of appeal, the Claimant and the Plan are subject to the same

procedures, rights, and responsibilities as stated within this Plan. Each level of appeal is subject to the above-outlined submission and response guidelines.

Once a Claimant receives an Adverse Benefit Determination in response to an initial claim for benefits, the Claimant may appeal that Adverse Benefit Determination, which will constitute the initial appeal. If the Claimant receives an Adverse Benefit Determination in response to that initial appeal, the Claimant may appeal that Adverse Benefit Determination as well, which will constitute the final internal appeal. If the Claimant receives an Adverse Benefit Determination in response to the Claimant's second appeal, such Adverse Benefit Determination will constitute the Final Internal Adverse Benefit Determination, and the Plan's internal appeals procedures will have been exhausted.

Deemed Exhaustion of Internal Claims Procedures and De Minimis

Exception to the Deemed Exhaustion Rule

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

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

External Review Process

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

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

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

9812 and § 54.9812-1, which generally require, among other things, parity in the application of medical management techniques), as determined by the external reviewer.
2. An Adverse Benefit Determination that involves consideration of whether the Plan is complying with the surprise billing and cost-sharing protections set forth in the No Surprises Act.
3. A rescission of coverage (whether or not the rescission has any effect on any particular benefit at that time).

Standard external review

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

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

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

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

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

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

Expedited external review

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

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

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

3. Referral to Independent Review Organization. Upon a determination that a request is eligible for external review following the preliminary review, the Plan will assign an IRO pursuant to the requirements set forth above for standard review. The Plan will provide or transmit all necessary documents and information considered in making the Adverse Benefit Determination or Final Internal Adverse Benefit Determination to the assigned IRO electronically or by telephone or facsimile or any other available expeditious method. The assigned IRO, to the extent the information or documents are available and the IRO considers them appropriate, will consider the

information or documents described above under the procedures for standard review. In reaching a decision, the assigned IRO will review the claim de novo and is not bound by any decisions or conclusions reached during the Plan's internal claims and appeals process.

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

Appointment of Authorized Representative

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

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

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

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

Autopsy

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

Payment of Benefits

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

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

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

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

Non U.S. Providers
A Provider of medical care, supplies, or services, whose primary facility, principal place of business or address for payment is located outside the United States shall be deemed to be a “Non U.S. Provider.” Claims for medical care, supplies, or services provided by a Non U.S. Provider and/or that are rendered outside the United States of America, may be deemed to be payable under the Plan by the Plan Administrator, subject to all Plan Exclusions, limitations, maximums and other provisions. Assignment of benefits to a Non U.S. Provider is prohibited absent an explicit written waiver executed by the Plan Administrator. If assignment of benefits is not authorized, the Claimant is responsible for making all payments to Non U.S. Providers, and is solely responsible for subsequent submission of proof of payment to the Plan. Only upon receipt of such proof of payment, and any other documentation needed by the Plan Administrator to process the claims in accordance with the terms of the Plan, shall reimbursement by the Plan to the Claimant be made. If payment was made by the Claimant in U.S. currency (American dollars), the maximum reimbursable amount by the Plan to the Claimant shall be that amount. If payment was made by the Claimant using any currency other than U.S. currency (American dollars), the Plan shall utilize an exchange rate in effect on the Incurred date as established by a recognized and licensed entity authorized to so establish said exchange rates. The Non U.S. Provider must satisfy all applicable credentialing and licensing requirements; and claims for benefits must be submitted to the Plan in English.

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 Claimant or Dependent on whose behalf such payment was made.

A Claimant, Dependent, Provider, another benefit plan, insurer, or any other person or entity who receives a payment exceeding the amount of benefits payable under the terms of the Plan or on whose behalf such payment was made, shall return or refund the amount of such erroneous payment to the Plan within 30 days of discovery or demand. The Plan 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 Claimant 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 Claimant and to deny or reduce future benefits payable (including payment of future benefits for other injuries or Illnesses) under the Plan by the amount due as reimbursement to the Plan. The Plan Administrator may also, in its sole discretion, deny or reduce future benefits (including future benefits for other injuries or Illnesses) under any other group benefits plan maintained by the Plan Sponsor. The reductions will equal the amount of the required reimbursement.

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

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

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

1. In error.
2. Pursuant to a misstatement contained in a proof of loss or a fraudulent act.
3. Pursuant to a misstatement made to obtain coverage under this Plan within two years after the date such coverage commences.
4. With respect to an ineligible person.
5. In anticipation of obtaining a recovery if a Claimant fails to comply with the Plan's Third Party Recovery, Subrogation and Reimbursement provisions.

6. Pursuant to a claim for which benefits are recoverable under any policy or act of law providing for coverage for occupational injury or disease to the extent that such benefits are recovered. This provision (6) shall not be deemed to require the Plan to pay benefits under this Plan in any such instance.

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

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

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

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

COORDINATION OF BENEFITS

Coordination of the Benefit Plans

Coordination of benefits sets out rules for the order of payment of Covered Expenses when two or more plans, including Medicare, are paying. Members of a family may be covered under more than one health program or insurance contract. This Coordination of Benefits provision is included in this Summary Plan Description to ensure that the Plan does not make duplicate payments, which can increase the cost of your health coverage.

This Coordination of Benefits applies to similar medical benefits payable under other health programs or insurance contracts, including:

a) Any group insurance coverage,
b) An Employer-sponsored or other pre-payment coverage,
c) Any coverage under labor-management trusteed Plans or Employee benefits Organization Plans, including this Plan,
d) Any coverage under government programs,
e) Any coverage required or provided by statute (except Medicaid),
f) Any mandatory "no-fault" coverage, and
g) Student coverage obtained or offered by an educational institution.

One of the two or more Plans is considered the “Primary Plan” and the others are the “Secondary Plans”. The Primary Plan pays benefits first, without consideration of the other Plans. The Secondary Plans then make up the difference up to 100% of the Allowable Charges for each procedure. This Plan will never pay more than it would have paid without this provision. You must provide the Claims Administrator with any information necessary for administering this provision.

Standard Coordination of Benefits

The plan that pays first according to the rules will pay as if there were no Other Plan involved. The secondary and subsequent plans will pay the balance due up to 100% of the total allowable charges.

Benefits Subject to This Provision

The following only applies to the medical benefits of the Plan.

Excess Insurance

Except as outlined in the “Effect on Benefits” provision in regard to any Other Plan, if at the time of Injury, Illness or disability there is available, or potentially available any coverage (including but not limited to coverage resulting from a judgment at law or settlements), the benefits under this Plan shall apply only as an excess over such other sources of coverage.

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

1. The responsible party, its insurer, or any other guarantor on behalf of that party.
2. Any first party insurance through medical payment coverage, personal injury protection, no-fault coverage, uninsured or underinsured motorist coverage, including any similar coverage under a different name in a particular state.
3. Any policy of insurance from any insurance company or guarantor of a responsible third party, including but not limited to an employer’s policy.
4. Workers’ compensation or other liability insurance company.

5. Any of the following:

    - Crime victim restitution funds
    - Civil restitution funds
    - No-fault restitution funds such as vaccine injury compensation funds
    - Any medical, applicable disability or other benefit payments
    - School insurance coverage

Vehicle Limitation

When medical payments are available under any vehicle insurance, the Plan shall pay excess benefits only, without reimbursement for vehicle plan and/or policy deductibles. This Plan shall always be considered secondary to such plans and/or policies and will exclude benefits subject to the Exclusions in this Plan up to the maximum amount available to the Participant under applicable state law, regardless of a Participant's election of lesser coverage amount. This applies to all forms of medical payments under vehicle plans and/or policies regardless of their names, titles or classifications.

Effect on Benefits

Application to Benefit Determinations
The plan that pays first according to the rules in the provision entitled "Order of Benefit Determination" will pay as if there were no Other Plan involved. The secondary and subsequent plans will pay the balance due up to 100% of the total Covered Expenses. When there is a conflict in the rules, this Plan will never pay more than 50% of Covered Expenses when paying secondary. Benefits will be coordinated on the basis of a Claim Determination Period.

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

When some "Other Plan" provides benefits in the form of services (rather than cash payments), the Plan Administrator shall assess the value of said benefit(s) and determine the reasonable cash value of the service or services rendered, by determining the amount that would be payable in accordance with the terms of the Plan.

In certain instances, the benefits of the Other Plan will be ignored for the purposes of determining the benefits under this Plan. This is the case when all of the following occur:

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

Order of Benefit Determination

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

1. The plan without a coordination of benefits provision similar to this one will be the primary plan.
2. The plan in which the patient is the Covered Person (rather than a dependent) will be the primary plan. If your dependent child is covered under both your spouses’ and your health plans, the primary coverage will be determined by the following factors:
3. The plan of the parent whose birthday falls first during the year (regardless of year of birth) will pay first.
4. If you and your spouse share the same birthday, the plan covering the parent longer will be primary.
5. If the other plan does not have a birthday provision and uses gender to determine primary responsibility, the father’s plan will be primary.
6. If you and your spouse are divorced or separated, and there is no court decree giving financial responsibility for your child’s health care expenses to one parent, your dependent child will receive primary coverage under the custodial parent’s health coverage program. The plan of the parent that was given financial responsibility for the child’s health care by decree of the court is the Primary Plan.
7. If you and/or your spouse remarries, the following order is used to determine primary responsibility for your dependent child’s health coverage program:
8. The parent with legal custody
9. The spouse of the parent with legal custody
10. The parent without legal custody
11. The spouse of the parent without legal custody
12. A patient’s health coverage as an actively employed Covered Person or as a dependent of an actively employed Covered Person this Plan is primary over other health care programs that they may have as either, a laid-off employee, a retired employee, or a dependent of a laid-off employee or a retired employee. If the other health care coverage is primary, then this rule will not apply.

If none of the previous rules apply, the plan that has covered the patient the longest will be the primary Plan.

If both a husband and wife are Covered Persons of this Plan, the benefit is calculated first as if this Plan was the Primary Plan and then as if this Plan was secondary. This will allow the same coverage as if the husband and wife were covered as Employees in two different plans.

If this Plan is the secondary plan and the primary plan is a health maintenance organization or preferred provider organization, then this Plan assumes that the primary plan pays the full value of the services and this Plan is the secondary plan only for any Deductible or Co- Payment under the primary plan. If you have coverage through your work under an HMO and this Plan is the secondary plan for you as a Dependent, you must follow the rules of the HMO in order to have remaining balances considered for payment by the Plan as the secondary plan. If you go outside of your HMO for services (or otherwise fail to follow the rules of the HMO), and then submit the bill to this Plan for payment, it will be denied. For purposes of coordinating benefits, an HMO is treated the same as any other plan. If you fail to follow the rules of any primary plan, this Plan will not pay benefits as either primary or secondary.

The Plan also has the right to collect any excess payment directly from the parties involved, from the other plan, or by an offset against any future benefit payment from the Plan on the Covered Person’s or Dependent’s behalf, if he or she failed to notify the Claims Administrator of the availability of other health coverage. This right of offset does not keep the Plan from recovering erroneous payments in any other manner.

To ensure that the Plan coordinates benefits with any other health plan coverage you have, you must keep the Plan informed of any and all coverage for you and your Dependents.

If the Plan has made payment of any amount that is in excess of that permitted by these Coordination of Benefits rules, the Claims Administrator has the right to recover such amount from any party who has received such overpayment by requesting a refund from such party, crediting other claims against the amount owed to the Plan, or taking legal action.

Coordination with Medicare
Generally, anyone age 65 or older is entitled to Medicare coverage. Anyone under age 65 who is entitled to Social Security Disability Income Benefits may also be entitled to Medicare coverage after a waiting period.

Medicare includes hospital insurance benefits (Part A) as well as supplementary medical insurance (Part B). In general, if you or a Dependent is enrolled in the Plan and in Medicare, the Plan will provide all benefits due under the Covered Person's Plan. Medicare may then pay any remaining charges, if such charges are covered under Medicare. In technical terms, the Plan is "primary" (pays first) for your covered medical and hospital expenses, while Medicare is "secondary" (pays second).

Disabled Employees or Disabled Dependents Under 65: This Plan is primary for enrolled, active Employees or their Dependents who are under age 65 and for Employees or their Dependents who have a Social Security Disability Award and are entitled to Medicare benefits due to total disability (other than End Stage Renal Disease).

End Stage Renal Disease: If, while you are in active employment and you or any of your Dependents become entitled to Medicare because of End Stage Renal Disease (ESRD), this Plan pays primary and Medicare pays secondary for 30 months starting with the earlier of (1) the month in which Medicare ESRD coverage begins; or (2) the first month in which the individual receives a kidney transplant. This provision does not apply if Federal law provides to the contrary. In this case, the benefits of the Plan will be determined in accordance with such law.

Medicaid: If you are covered by both this Plan and Medicaid, this Plan is primary and Medicaid pays secondary.

CHAMPUS (Civilian Health and Medical Program of the Uniformed Services): If you are covered by both this Plan and CHAMPUS, this Plan pays as primary and CHAMPUS pays secondary.
Other Coverage Provided by State or Federal Law: If you are covered by both this Plan and any other coverage provided by any other state or federal law, the coverage provided by any other state or federal law is primary and this Plan is secondary.

EFFECT OF MEDICARE
Coverage under this Plan will be changed for any person eligible for Medicare.
A person is "eligible for Medicare" if he or she:

- is covered under it;
- is not covered under it because of:
- having refused it;
- having dropped it;
- having failed to make proper request for it.

These are the changes:

- All health expenses covered under this Plan will be reduced by any Medicare benefits available for those expenses. This will be done before the health benefits of this Plan are figured.
- Charges used to satisfy a person's Part B deductible under Medicare will be applied under this Plan in the order received by the Plan Administrator. Two or more charges received at the same time will be applied starting with the largest first.
- Medicare benefits will be taken into account for any person while he or she is eligible for Medicare. This will be done whether or not he or she is entitled to Medicare benefits.
- Any rule for coordinating "other plan" benefits with those under this Plan will be applied after this Plan's benefits have been figured under the above rules. Benefits under this Plan for covered expenses will be reduced by any Medicare benefits available for those expenses.

Coverage will not be changed at any time when your employer's compliance with federal law requires this Plan's benefits for a person to be figured before benefits are figured under Medicare.

Note that, pursuant to the rules described above, if you are on COBRA and eligible for Medicare, the Plan calculates its benefits, and then reduces them by the amount Medicare would have paid for the same expenses, regardless of whether the individual has actually enrolled in Medicare. Accordingly, it is important to enroll in Medicare (Parts A and B) when eligible.

Right to Receive and Release Necessary Information

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

Facility of Payment

A payment made under any Other Plan may include an amount that should have been paid under this Plan. The Plan 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. Any such amount paid under this provision shall be deemed to be benefits paid under this Plan. The Plan Administrator will not have to pay such amount again and this Plan shall be fully discharged from liability.

Right of Recovery

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

MEDICARE

Applicable to Active Employees and Their Spouses Ages 65 and Over

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

Applicable to All Other Participants Eligible for Medicare Benefits

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

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

If any Participant is enrolled in Medicare coverage because of ESRD, the benefits of the Plan will be determined before Medicare benefits for the first 30 months of the Participant's Medicare entitlement, regardless of the date of enrollment, unless applicable Federal law provides to the contrary, in which event the benefits of the Plan will be determined in accordance with such law.

THIRD PARTY RECOVERY, SUBROGATION AND REIMBURSEMENT

Payment Condition

The Plan, in its sole discretion, may elect to conditionally advance payment of benefits in those situations where an Injury, Illness or disability is caused in whole or in part by, or results from the acts or omissions of Participants, and/or their Dependents, beneficiaries, estate, heirs, guardian, personal representative, or assigns (collectively referred to hereinafter in this section as "Participant(s)") or a third party, where any party besides the Plan may be responsible for expenses arising from an incident, and/or other funds are available, including but not limited to crime victim restitution funds, civil restitution funds, no-fault restitution funds (including vaccine injury compensation funds), uninsured motorist, underinsured motorist, medical payment provisions, third party assets, third party insurance, and/or guarantor(s) of a third party, any medical, applicable disability, or other benefit payments, and school insurance coverage (collectively "Coverage").

Participant(s), his or her attorney, and/or legal guardian of a minor or incapacitated individual agrees that acceptance of the Plan's conditional payment of medical benefits is constructive notice of these provisions in their entirety and agrees to maintain 100% of the Plan's conditional payment of benefits or the full extent of payment from any one or combination of first and third party sources in trust, without disruption except for reimbursement to the Plan or the Plan's assignee. The Plan shall have an equitable lien on any funds received by the Participant(s) and/or their attorney from any source and said funds shall be held in trust until such time as the obligations under this provision are fully satisfied. The Participant(s) agrees to include the Plan's name as a co-payee on any and all settlement drafts. Further, by accepting benefits the Participant(s) understands that any recovery obtained pursuant to this section is an asset of the Plan to the extent of the amount of benefits paid by the Plan and that the Participant shall be a trustee over those Plan assets.

In the event a Participant(s) settles, recovers, or is reimbursed by any Coverage, the Participant(s) agrees to reimburse the Plan for all benefits paid or that will be paid by the Plan on behalf of the Participant(s). When such a recovery does not include payment for future treatment, the Plan's right to reimbursement extends to all benefits paid or that will be paid by the Plan on behalf of the Participant(s) for charges Incurred up to the date such Coverage or third party is fully released from liability, including any such charges not yet submitted to the Plan. If the Participant(s) fails to reimburse the Plan out of any judgment or settlement received, the Participant(s) will be responsible for any and all expenses (fees and costs) associated with the Plan's attempt to recover such money. Nothing herein shall be construed as prohibiting the Plan from claiming reimbursement for charges Incurred after the date of settlement if such recovery provides for consideration of future medical expenses.

If there is more than one party responsible for charges paid by the Plan, or may be responsible for charges paid by the Plan, the Plan will not be required to select a particular party from whom reimbursement is due. Furthermore, unallocated settlement funds meant to compensate multiple injured parties of which the Participant(s) is/are only one or a few, that unallocated settlement fund is considered designated as an "identifiable" fund from which the plan may seek reimbursement.

Subrogation

As a condition to participating in and receiving benefits under this Plan, the Participant(s) agrees to assign to the Plan the right to subrogate and pursue any and all claims, causes of action or rights that may arise against any person, corporation and/or entity and to any Coverage to which the Participant(s) is entitled, regardless of how classified or characterized, at the Plan's discretion, if the Participant(s) fails to so pursue said rights and/or action.

If a Participant(s) receives or becomes entitled to receive benefits, an automatic equitable lien attaches in favor of the Plan to any claim, which any Participant(s) may have against any Coverage and/or party causing the Illness or Injury to the extent of such conditional payment by the Plan plus reasonable costs of collection. The Participant is obligated to notify the Plan or its authorized representative of any settlement prior to finalization of the settlement, execution of a release, or receipt of applicable funds. The Participant is also obligated to hold any and all funds so received in trust on the Plan's behalf and function as a trustee as it applies to those funds until the Plan's rights described herein are honored and the Plan is reimbursed.

The Plan may, at its discretion, in its own name or in the name of the Participant(s) commence a proceeding or pursue a claim against any party or Coverage for the recovery of all damages to the full extent of the value of any such benefits or conditional payments advanced by the Plan.

If the Participant(s) fails to file a claim or pursue damages against:

1. The responsible party, its insurer, or any other guarantor on behalf of that party.
2. Any first party insurance through medical payment coverage, personal injury protection, no-fault coverage, uninsured or underinsured motorist coverage.
3. Any policy of insurance from any insurance company or guarantor of a responsible third party, including but not limited to an employer's policy.
4. Workers' compensation or other liability insurance company.
5. Any of the following:

    - Crime victim restitution funds
    - Civil restitution funds
    - No-fault restitution funds such as vaccine injury compensation funds
    - Any medical, applicable disability or other benefit payments
    - School insurance coverage

the Participant(s) authorizes the Plan to pursue, sue, compromise and/or settle any such claims in the Participant's/Participants' and/or the Plan's name and agrees to fully cooperate with the Plan in the prosecution of any such claims. The Participant(s) assigns all rights to the Plan or its assignee to pursue a claim and the recovery of all expenses from any and all sources listed above.

Right of Reimbursement

The Plan shall be entitled to recover 100% of the benefits paid or payable benefits Incurred, that have been paid and/or will be paid by the Plan, or were otherwise Incurred by the Participant(s) prior to and until the release from liability of the liable entity, as applicable, without deduction for attorneys' fees and costs or application of the common fund doctrine, made whole doctrine, or any other similar legal or equitable theory, and without regard to whether the Participant(s) is fully compensated by his or her recovery from all sources. The Plan shall have an equitable lien which supersedes all common law or statutory rules, doctrines, and laws of any State prohibiting assignment of rights which interferes with or compromises in any way the Plan's equitable lien and right to reimbursement. The obligation to reimburse the Plan in full exists regardless of how the judgment or settlement is classified and whether or not the judgment or settlement specifically designates the recovery or a portion of it as including medical, disability, or other expenses and extends until the date upon which the liable party is released from liability. If the Participant's/Participants' recovery is less than the benefits paid, then the Plan is entitled to be paid all of the recovery achieved. Any funds received by the Participant are deemed held in constructive trust and should not be dissipated or disbursed until such time as the Participant's obligation to reimburse the Plan has been satisfied in

accordance with these provisions. The Participant is also obligated to hold any and all funds so received in trust on the Plan's behalf and function as a trustee as it applies to those funds until the Plan's rights described herein are honored and the Plan is reimbursed.

No court costs, experts' fees, attorneys' fees, filing fees, or other costs or expenses of litigation may be deducted from the Plan's recovery without the prior, express written consent of the Plan. Additionally, the Participant shall indemnify the Plan against any of the Participant's attorney's fees, costs, or other expenses related to the Participant's recovery for which the Plan becomes responsible by any means other than the Plan's explicit written consent.

The Plan's right of subrogation and reimbursement will not be reduced or affected as a result of any fault or claim on the part of the Participant(s), whether under the doctrines of causation, comparative fault or contributory negligence, or other similar doctrine in law. Accordingly, any lien reduction statutes, which attempt to apply such laws and reduce a subrogating Plan's recovery will not be applicable to the Plan and will not reduce the Plan's reimbursement rights.

These rights of subrogation and reimbursement shall apply without regard to whether any separate written acknowledgment of these rights is required by the Plan and signed by the Participant(s).

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

Participant is a Trustee Over Plan Assets

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

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

To the extent the Participant disputes this obligation to the Plan under this section, the Participant or any of its agents or representatives is also required to hold any/all settlement funds, including the entire settlement if the settlement is less than the Plan's interests, and without reduction in consideration of attorneys' fees, for which he or she exercises control, in an account segregated from their general accounts or general assets until such time as the dispute is resolved.

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

Release of Liability

The Plan's right to reimbursement extends to any incident related care that is received by the Participant(s) ("Incurred") prior to the liable party being released from liability. The Participant's/Participants' obligation to reimburse the Plan is therefore tethered to the date upon which the claims were Incurred, not the date upon which the payment is made by the Plan. In the case of a settlement, the Participant has an obligation to review the "lien" provided by the Plan and reflecting claims paid by the Plan for which it seeks reimbursement, prior to settlement and/or executing a release of any liable or potentially liable third party, and is also obligated to advise the Plan of any incident related care incurred prior to the proposed date of settlement and/or release, which is not listed but has been or will be incurred, and for which the Plan will be asked to pay.

Excess Insurance

Except as outlined in the "Effect on Benefits" provision in regard to any Other Plan, if at the time of Injury, Illness or disability there is available, or potentially available any Coverage (including but not limited to Coverage resulting from a judgment at law or settlements), the benefits under this Plan shall apply only as an excess over such other sources of Coverage, except as otherwise provided for under the Plan's Coordination of Benefits section.

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

1. The responsible party, its insurer, or any other guarantor on behalf of that party.
2. Any first party insurance through medical payment coverage, personal injury protection, no-fault coverage, uninsured or underinsured motorist coverage.
3. Any policy of insurance from any insurance company or guarantor of a responsible third party, including but not limited to an employer's policy.
4. Workers' compensation or other liability insurance company.
5. Any of the following:
    - Crime victim restitution funds
    - Civil restitution funds
    - No-fault restitution funds such as vaccine injury compensation funds
    - Any medical, applicable disability or other benefit payments
    - School insurance coverage

Separation of Funds

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

Wrongful Death

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

Obligations

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

1. To cooperate with the Plan, or any representatives of the Plan, in protecting its rights, including discovery, attending depositions, and/or cooperating in trial to preserve the Plan's rights.
2. To provide the Plan with pertinent information regarding the Illness, disability, or Injury, including accident reports, settlement information and any other requested additional information.
3. To take such action and execute such documents as the Plan may require to facilitate enforcement of its subrogation and reimbursement rights.
4. To do nothing to prejudice the Plan's rights of subrogation and reimbursement.
5. To promptly reimburse the Plan when a recovery through settlement, judgment, award or other payment is received.
6. To notify the Plan or its authorized representative of any incident related claims or care which may be not identified within the lien (but has been Incurred) and/or reimbursement request submitted by or on behalf of the Plan.
7. To notify the Plan or its authorized representative of any settlement prior to finalization of the settlement.
8. To not settle or release, without the prior consent of the Plan, any claim to the extent that the Participant may have against any responsible party or Coverage.
9. To instruct his/her attorney to ensure that the Plan and/or its authorized representative is included as a payee on any settlement draft.
10. In circumstances where the Participant is not represented by an attorney, instruct the insurance company or any third party from whom the Participant obtains a settlement to include the Plan or its authorized representative as a payee on the settlement draft.
11. To make good faith efforts to prevent disbursement of settlement funds until such time as any dispute between the Plan and Participant over settlement funds is resolved.

If the Participant(s) and/or his or her attorney fails to reimburse the Plan for all benefits paid, or to be paid, Incurred, or that will be Incurred, prior to the date of the release of liability from the relevant entity, as a result of said Injury or condition, out of any proceeds, judgment or settlement received, the Participant(s) will be responsible for any and all expenses (whether fees or costs) associated with the Plan's attempt to recover such money from the Participant(s).

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

Offset

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

Minor Status

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

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

Language Interpretation

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

Severability

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

Worker's Compensation Cases

No benefits will be paid by this Plan for an accident or Illness in any way connected with Employment. If you have a Work-Related accident or Illness, notify your Employer immediately and file a Worker's Compensation claim with your Employer.

Certain Illnesses like hernias, varicose veins, allergy to chemicals or materials may occur due to the nature of the work in the industry. Since Worker's Compensation offers certain protections if you have such an Illness, discuss your job activities with the doctor to determine if it could be Work-Related.

Failure to file a Worker's Compensation claim could mean the loss of benefits which might otherwise protect you against medical costs or loss of earnings resulting from a Work-Related accident or Illness.

MISCELLANEOUS PROVISIONS

Clerical Error/Delay

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

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

Conformity With Applicable Laws

Any provision of this Plan that is contrary to any applicable law, equitable principle, regulation or court order (if such a court is of competent jurisdiction) will be interpreted to comply with said law, or, if it cannot be so interpreted, shall be automatically amended to satisfy the law's minimum requirement, including, but not limited to, stated maximums, Exclusions, or statutes of limitations. It is intended that the Plan will conform to the requirements of ERISA, as it applies to Employee welfare plans, as well as any other applicable law.

Fraud

Under this Plan, coverage may be retroactively canceled or terminated (rescinded) if a Participant acts fraudulently or intentionally makes material misrepresentations of fact. It is a Participant’s responsibility to provide accurate information and to make accurate and truthful statements, including information and statements regarding family status, age, relationships, etc. It is also a Participant’s responsibility to update previously provided information and statements. Failure to do so may result in coverage of Participants being canceled, and such cancellation may be retroactive.

If a Participant, or any other entity, submits or attempts to submit a claim for or on behalf of a person who is not a Participant of the Plan; submits a claim for services or supplies not rendered; provides false or misleading information in connection with enrollment in the Plan; or provides any false or misleading information to the Plan as it relates to any element of its administration; that shall be deemed to be fraud. If a Participant is aware of any instance of fraud, and fails to bring that fraud to the Plan Administrator’s attention, that shall also be deemed to be fraud. Fraud will result in immediate termination of all coverage under this Plan for the Participant and their entire Family Unit of which the Participant is a member.

A determination by the Plan that a rescission is warranted will be considered an Adverse Benefit Determination for purposes of review and appeal. A Participant whose coverage is being rescinded will be provided a 30 day notice period as described under the Affordable Care Act (ACA) and regulatory guidance. Claims Incurred after the retroactive date of termination shall not be further processed and/or paid under the Plan. Claims Incurred after the retroactive date of termination that were paid under the Plan will be treated as erroneously paid claims under this Plan.

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

Pronouns
Unless the context otherwise demands, words importing any gender shall be interpreted to mean any or all genders.

Word Usage
Wherever any words are used herein in the singular or plural, they shall be construed as though they were in the plural or singular, as the case may be, in all cases where they would so apply.

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

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

The Plan Sponsor shall fund the Plan in a manner consistent with the provisions of the Internal Revenue Code, ERISA, and such other laws and regulations as shall be applicable to the end that the Plan shall be funded on a lawful and sound basis. The manner and means by which the Plan is funded shall be solely determined by the Plan Sponsor, to the extent allowed by applicable law.

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

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

Right to Receive and Release Information
The Plan Administrator may, without notice to or consent of any person, release to or obtain from any insurance company or other organization or person any information regarding coverage, expenses, and benefits which the Plan Administrator, in its sole discretion, considers necessary to determine and apply the provisions and benefits of this Plan. In so acting, the Plan Administrator shall be free from any liability that may arise with regard to such action. Any Participant claiming benefits under this Plan shall furnish to the Plan Administrator such information as requested and as may be necessary to implement this provision.

Written Notice

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

Right of Recovery

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

Statements

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

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

Protection Against Creditors

To the extent this provision does not conflict with any applicable law, no benefit payment under this Plan shall be subject in any way to alienation, sale, transfer, pledge, attachment, garnishment, execution or encumbrance of any kind, and any attempt to accomplish the same shall be void. If the Plan Administrator shall find that such an attempt has been made with respect to any payment due or to become due to any Participant, the Plan Administrator in its sole discretion may terminate the interest of such Participant or former Participant in such payment. And in such case the Plan Administrator shall apply the amount of such payment to or for the benefit of such Participant or former Participant, his or her spouse, parent, adult Child, guardian of a minor Child, brother or sister, or other relative of a Dependent of such Participant or former Participant, as the Plan Administrator may determine, and any such application shall be a complete discharge of all liability with respect to such benefit payment. However, at the discretion of the Plan Administrator, benefit payments may be assigned to health care Providers.

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 provider will be deemed to have forfeited payment. The check will be voided and the funds will be retained by this Plan and applied to the payment of current benefits and administrative fees under this Plan. In the event a Participant subsequently requests payment with respect to the voided check, the Third Party Administrator for the self-insured Plan shall make such payment under the terms and provisions of the Plan as in effect when the claim was originally processed. Unclaimed self-insured Plan funds may be applied only to the payment of benefits (including administrative fees) under the Plan pursuant to ERISA and any other applicable State law(s).

SUMMARY OF BENEFITS

General Limits

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

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

Network and Non-Network Provider Arrangement

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

1. The Plan provides different levels of benefits based on whether the Participants use a Network or Non-Network Provider. Unless one of the exceptions shown below applies, if a Participant elects to receive medical care from the Non-Network Provider, the benefits payable are generally lower than those payable when a Network Provider is used. The following exceptions apply:
    a. The Network Provider level of benefits is payable for any Participant who cannot access Network Providers because they reside outside the Network service area. The Network service area is defined as **50 miles**.
    b. The Network Provider level of benefits is payable when a Participant receives Emergency care either Out-of-Area or at a Non-Network Hospital for an Accidental Bodily Injury or Emergency.

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

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

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

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

Balance Billing

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

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

The Participant is responsible for any applicable payment of Coinsurances, Deductibles, and out-of-pocket maximums and may be billed for any or all of these.

Choice of Providers

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

Network Provider Information

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

If the Participant does not have access to a computer at his or her home, he or she may access this website at his or her place of employment. If he or she has any questions about how to do this, he or she should contact the Human Relations Department. The Network Provider list changes frequently; therefore, it is recommended that a Participant verify with the Provider that the Provider is still a Network Provider before receiving services. Please refer to the Participant identification card for the website address.

Claims Audit

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

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

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

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

No Surprises Act – Emergency Services and Surprise Bills

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

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

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

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

Continuity of Care

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

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

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

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

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

Transition of Care

If a Participant is under the care of a Non-Network Provider at the time of joining the Plan, there are a limited number of medical conditions that may qualify for transition of care. If transitional care is appropriate, specific treatment by a Non-Network Provider may be covered at the Network level of benefits for a limited period of time. The Third Party Administrator will review and approve or deny such requests.

MEDICAL BENEFITS

Medical Benefits

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

Abortion. Expenses for or related to an abortion, including FDA-approved drugs for medical abortion, when such items or services are not prohibited by applicable law.

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

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

Air Ambulance (Emergency Only).
Covered Expenses will be payable at the lesser of the following:

1. A negotiated, contracted amount as mutually agreed upon with a Provider or other discounting contract.
2. 120% of the allowable charge established by application of the Medicare Ambulance Fee Schedule.
3. The billed charge if less than 1 or 2 above.

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

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

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

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

Alcoholism. The Plan covers the treatment of Alcoholism the same way it would any other Illness, if the treatment is prescribed by a Practitioner.

Inpatient or Outpatient treatment may be furnished as follows:

- Care in a licensed Health Care Facility
- At a Detoxification Facility; or
- As an Inpatient or Outpatient at a licensed, certified, or State approved residential treatment Facility, under a program which meets minimum standards of care equivalent to those prescribed by the Joint Commission.

Treatment or a stay at any Facility shall not prevent further or additional treatment at any other eligible Facility, if the Benefit Days used do not exceed the total number of Benefit Days provided for any other Illness under the Plan.

Allergy Services. Charges related to the treatment of allergies. Including testing, consisting of percutaneous, intracutaneous and patch tests..

Ambulance (Emergency Only). Ambulance Service means you are transported by a state licensed vehicle that is designed, equipped, and used only to transport the sick and injured and staffed by Emergency Medical Technicians (EMT), paramedics, or other certified medical professionals. This includes ground, water, fixed wing, and rotary wing air transportation.

- For ground ambulance, you are taken: from your home, the scene of an accident or medical Emergency to a Hospital; between Hospitals, including when the Claims Administrator requires you to move from an Out-of-Network Hospital to an In-Network Hospital; or between a Hospital and a Skilled Nursing Facility or other approved Facility.
- For air or water ambulance, you are taken: from the scene of an accident or medical Emergency to a Hospital; between Hospitals, including when the Claims Administrator requires you to move from an Out-of-Network Hospital to an In-Network Hospital; or between a Hospital and an approved Facility.

Ambulance services are subject to Medical Necessity reviews by the Claims Administrator. Emergency ambulance services do not require precertification and are allowed regardless of whether the Provider is an In-Network or Out-of-Network Provider.

Non-Emergency ambulance service is excluded.

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

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

Audiology. The Plan covers audiology services rendered by a physician or licensed audiologist or licensed speech-language pathologist.
The services must be:

- Determined to be Medically Necessary and Appropriate; and
- Performed within the scope of the Practitioner's practice.

Autism and/or Developmental Disabilities. This Plan provides coverage for charges for the screening and diagnosis of autism and other Developmental Disabilities.

If a Covered Person's primary diagnosis is autism or another Developmental Disability, and regardless of anything in the Plan to the contrary, the Plan provides coverage for the following Medically Necessary and Appropriate Therapy Services, as prescribed in a treatment plan:

a) Occupational Therapy needed to develop the Covered Person's ability to perform the ordinary tasks of daily living;
b) Physical Therapy needed to develop the Covered Person's physical functions; and c. Speech Therapy needed to treat the Covered Person's speech impairment.

Notwithstanding anything in the Plan to the contrary, the foregoing Therapy Services as prescribed in a treatment plan will not be subject to benefit visit maximums.

Also, if a Covered Person's primary diagnosis is autism, in addition to coverage for certain Therapy Services, as described above, the Plan also covers Medically Necessary and Appropriate: (a) Behavioral Interventions Based on Applied Behavioral Analysis (ABA); and (b) Related Structured Behavioral Programs. Such interventions and programs must be prescribed in a treatment plan.

Benefits for these services are payable on the same basis as for other conditions, and they are available under this provision whether or not the services are restorative. Benefits for the above Therapy Services available pursuant to this provision are payable separately from those payable for other conditions and will not operate to reduce the Therapy Services benefits available under the Plan for those other conditions.

Any treatment plan referred to above must: (a) be in writing; (b) be signed by the treating Practitioner; and (c) include: (i) a diagnosis; (ii) proposed treatment by type, frequency, and duration; (iii) the anticipated outcomes stated as goals; and (iv) the frequency by which the treatment plan will be updated. With respect to the covered behavioral interventions and programs mentioned above, the term "Practitioner" shall also include a person who is credentialed by the national Analyst Certification Board as either: (a) a Board-Certified Behavior Analyst-Doctoral; or (b) a Board-Certified Behavior Analyst.

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

Blood/Blood Derivatives. Charges for blood and blood plasma (if not replaced by or for the patient), including blood processing and administration services. The Plan shall also cover processing, storage, and administrative services for autologous blood (a patient’s own blood) when a Participant is scheduled for Surgery that can be reasonably expected to require blood.

Blood transfusions (including the cost of blood plasma and blood plasma expanders) are covered from the first pint. But this is so only to the extent that the first pint and any additional pints to follow are not donated or replaced without charge through a blood bank or otherwise.

The Plan also covers expenses Incurred in connection with the purchase of blood products and blood infusion equipment required for home treatment of routine bleeding episodes associated with hemophilia. The home treatment program must be under the supervision of a State approved hemophilia treatment center. A home treatment program will not preclude further or additional treatment or care at an eligible Facility.

As used above: (a) “blood product” includes but is not limited to Factor VIII, Factor IX and cryoprecipitate; and (b) “blood infusion equipment” includes but is not limited to syringes and needles.

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

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

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

Class III Obesity. Charges related to Class III obesity (BMI is equal to or greater than 40.0 kg/m²), only when the treatment meets the Plan's Medical Necessity criteria. To include non-surgical treatment, and complications from such treatment.

Cochlear Implants. Charges for cochlear implants for Participants who are certified as deaf or hearing impaired by a Provider.

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

COVID-19 Testing. Expenses related to testing for COVID-19 as if the Public Health Emergency was still in effect.

Dental Services. Charges made for a continuous course of dental treatment started within 12 months from the date of the Injury to sound natural teeth. Sound natural teeth are defined as natural teeth that are free of active clinical decay, have at least 50% bony support and are functional in the arch.

The Plan also covers the following Dental Services:

- the diagnosis and treatment of oral tumors and cysts; and
- the surgical removal of bony impacted teeth; and
- Surgical and non-Surgical treatment of Temporomandibular joint dysfunction syndrome (TMJ) in a Covered Person. But this Plan does not cover charges for orthodontia, crowns, or bridgework. "Surgery", if needed, includes the pre- operative and post-operative care connected with it.

The plan also covers Dental Services rendered by a Physician or Dentist (see Oral Surgery) which are required as a result of accidental injury to the jaws, sound natural teeth, mouth, or face. Injury as a result of chewing or biting shall not be considered an accidental injury.

For a Covered Person who is severely disabled or who is a Child Dependent under age six, coverage shall also be provided for the following:

- General anesthesia and Hospital Admission for dental services; or
- Dental services rendered by a dentist, regardless of where the dental services are rendered, for medical conditions that: (a) are covered by this Plan; and (b) require a Hospital Admission for general anesthesia.

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

Diabetic Education. When the Covered Person's or Eligible Dependent's Physician certifies that the Covered Person or Eligible Dependent requires diabetes education as an Outpatient, coverage is provided for the following when rendered through a Diabetes Education Program:

1. Visits Medically Necessary and Appropriate upon the diagnosis of diabetes; and
2. Subsequent Visits under circumstances whereby a Covered Person's or Eligible Dependent's Physician:
    1. Identifies or diagnoses a significant change in the Covered Person's or Eligible Dependent's symptoms or conditions that necessitates changes in a Covered Person's or Eligible Dependent's self-management, or
    2. Identifies as Medically Necessary and Appropriate, a new medication or therapeutic process relating to the Covered Person's or Eligible Dependent's treatment and/or management of diabetes.

Diabetes Equipment/Supplies. Are provided for the following when required in connection with the treatment of diabetes and when prescribed by an authorized Physician: Blood glucose monitors monitor supplies and insulin infusion devices.

Diagnostic Services. Benefits will be provided for the following Covered Services only when such Covered Services are ordered by a Professional Provider:

1. Diagnostic X-ray consisting of radiology, magnetic resonance imaging (MRI, ultrasound and nuclear medicine);
2. Diagnostic pathology, consisting of laboratory and pathology tests;
3. Diagnostic medical procedures consisting of electrocardiogram (ECG), electroencephalogram (EEG), and other electronic diagnostic medical procedures and physiological medical testing approved by the Plan; and
4. Allergy testing, consisting of percutaneous, intracutaneous, and patch tests.

Dialysis. Dialysis Treatment – Outpatient and Home. Charges for dialysis in an outpatient facility or home setting. Please see the Outpatient and home Dialysis Benefit Guide (Appendix C), which shall apply exclusively to the Outpatient and Home Dialysis Benefit and not any other benefit.

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

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

Emergency Medical Services. Coverage is provided for the following Emergency Medical Services:

- Medical Care for the emergency treatment of bodily injuries resulting from an accident.
- Medical Care for the treatment of a medical condition manifesting itself by acute symptoms that require immediate medical attention.

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

Glaucoma. Treatment of glaucoma.

Habilitative Services and Therapies. These services include:

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

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

Home Health Care. Charges for Home Health Care services and supplies are covered only for care and treatment of an Illness or Injury when Hospital or Skilled Nursing Facility confinement would otherwise be required. The Diagnosis, care, and treatment must be certified by the attending Physician and be contained in a home health care plan. Charges by a Home Health Care Agency for any of the following:

1. Registered Nurses or Licensed Practical Nurses.
2. Certified home health aides under the direct supervision of a Registered Nurse.
3. Registered therapist performing physical, occupational or speech therapy.
4. Physician calls in the office, home, clinic or outpatient department.
5. Services, Drugs and medical supplies which are Medically Necessary for the treatment of the Participant that would have been provided in the Hospital, but not including Custodial Care. NOTE: Home infusion therapy does not apply to the home health care maximum.
6. Rental of Durable Medical Equipment or the purchase of this equipment if economically justified, whichever is less.

NOTE: Transportation services, Dietitian services, Homemaker services, Maintenance therapy, Custodial Care, Food or home delivered meals are not covered under this benefit.

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

1. Room and Board for confinement in a Hospice.
2. Ancillary charges furnished by the Hospice while the patient is confined therein, including rental of Durable Medical Equipment which is used solely for treating an Injury or Illness.

3. Medical supplies, Drugs and medicines prescribed by the attending Physician, but only to the extent such items are necessary for pain control and management of the terminal condition.
4. Physician services and nursing care by a Registered Nurse, Licensed Practical Nurse or a Licensed Vocational Nurse (L.V.N.).
5. Home health aide services.
6. Home care furnished by a Hospital or Home Health Care Agency, under the direction of a Hospice, including Custodial Care if it is provided during a regular visit by a Registered Nurse, a Licensed Practical Nurse or a home health aide.
7. Medical social services by licensed or trained social workers, Psychologists or counselors.
8. Nutrition services provided by a licensed dietitian.
9. Bereavement counseling, which is a supportive service provided by the Hospice team to Participants in the deceased's Family Unit after the death of the terminally ill person, to assist the Participants in adjusting to the death.

The Hospice Care program must be renewed in writing by the attending Physician every 30 days. Hospice Care ceases if the terminal Illness enters remission.

Hospital. Charges made by a Hospital for:

1. In Patient Services and supplies including, but not restricted to:
    a) use of operating, delivery and treatment rooms and equipment;
    b) drugs and medicines provided to a Covered Person or Eligible Dependent who is an Inpatient in a Facility Provider;
    c) whole blood, administration of blood, blood processing, and blood derivatives;
    d) Anesthesia, Anesthesia supplies and Services rendered in a Facility Provider by an employee of the Facility Provider, and the administration of Anesthesia ordered by the attending Professional Provider and rendered by a Professional Provider other than the surgeon or assistant at Surgery;
    e) medical and surgical dressings, supplies, casts, and splints;
    f) Diagnostic Services; or
    g) Therapy and Rehabilitation Services.
    h) Bed and Board
    Bed, board, and general nursing Services in a Facility Provider when the Covered Person or Eligible Dependent occupies:
        a) a room with two (2) or more beds; or
        b) a private room or
        c) A bed in a Special Care Unit -- a designated unit which has concentrated all facilities, equipment, and supportive Services for the provision of an intensive level of care for critically ill patients. This could include but is not limited to Intensive Care Unit (ICU) or Cardiac Care Unit (CCU).
2. Emergency Accident Care

3. Services and supplies for the Outpatient emergency treatment of bodily injuries resulting from an accident.
4. Emergency Medical Care
5. Services and supplies for the Outpatient emergency treatment of a medical condition manifesting
6. itself by acute symptoms that require immediate medical attention.
7. Pre-Admission Testing
8. Tests and studies required in connection with the Covered Person's or Eligible Dependent's admission rendered or accepted by a Hospital on an Outpatient basis prior to a scheduled admission to the Hospital as an Inpatient.

9. Surgery

Hospital Services and supplies for Outpatient Surgery including removal of sutures, Anesthesia, Anesthesia supplies and Services rendered by an employee of the Facility Provider other than the surgeon or assistant at Surgery.

1. Inpatient Medical Services
    a) Medical Care by a licensed Health Care Provider to a Covered Person or Eligible Dependent who is an Inpatient for a condition not related to Surgery, pregnancy, or Mental Illness, except as specifically provided.
    b) Medical Care rendered concurrently with Surgery during one (1) Inpatient stay by a licensed Health Care Provider other than the operating surgeon for treatment of a medical condition separate from the condition for which Surgery was performed.
    c) Medical Care by two (2) or more licensed Health Care Providers rendered concurrently during an Inpatient stay when the nature or severity of the Covered Person's or Eligible Dependent's condition requires the skills of separate Physicians.
    d) Consultation Services rendered to an Inpatient by another licensed Health Care Provider at the request of the attending licensed Health Care Provider. Consultation does not include staff consultations which are required by the Facility Provider's rules and regulations. Benefits are limited to one (1) consultation per consultant per admission.
    e) Medical Care rendered to a Covered Person and Eligible Dependent whose condition requires a licensed Health Care Provider's constant attendance and treatment for a prolonged period of time.
    f) Medically Necessary services and supplies furnished by the Hospital, other than Room And Board.
    g) Licensed Health Care Provider Visits to examine the newborn infant.

2. Outpatient Treatment

    a) Treatment for chronic conditions.
    b) Physical therapy treatments.
    c) Hemodialysis.
    d) X ray, laboratory, and linear therapy.

Implantable Hearing Devices. For services or supplies in connection with implantable hearing devices, including, but not limited to, cochlear implants and exams for their fitting.

Infertility/Fertility Services. The Plan covers diagnostic infertility services to determine the cause of infertility and treatment only when specific coverage is provided under the terms of a member's benefits plan. All coverage is subject to the terms and conditions of the plan. The following discussion is applicable only to members whose plans cover infertility services.

A Person is considered infertile if he or she is unable to conceive or produce conception after 1 year of frequent, unprotected heterosexual sexual intercourse, or 6 months of frequent, unprotected heterosexual sexual intercourse if the female partner is over age 35 years. Alternately, a woman without a male partner may be considered infertile if she is unable to conceive or produce conception after at least 12 cycles of donor insemination (6 cycles for women aged 35 or older up to age 44). (N.Y. Ins. Law §§ 3216(13), 3221(6), and 4303))

Exclusion: infertility services for couples in which either of the partners has had a previous sterilization procedure, with or without surgical reversal, and for females who have undergone a hysterectomy.

Basic Infertility Services / Diagnostic Services

Basic Infertility Services consist of: initial evaluation, semen analysis, laboratory evaluation, evaluation of ovulatory function, postcoital test, hysterosalpingogram and medically appropriate treatment of ovulatory dysfunction with Clomiphene Citrate.

The following services are considered medically necessary for diagnosis of infertility in females.

1. History and physical examination, basal body temperature
2. Laboratory studies:
    1. Anti-adrenal antibodies for apparently spontaneous primary ovarian insufficiency (premature ovarian failure)
    2. Anti-sperm antibodies (e.g., immunobead or mixed antiglobulin method)
    3. Chlamydia trachomatis screening)
    4. Fasting and 2 hours post 75-gram glucose challenge levels
    5. Lipid panel (total cholesterol, HDL cholesterol, triglycerides)
    6. Post-coital testing (PCT) (Simms-Huhner test) of cervical mucus
    7. Rubella serology
    8. Testing for viral status (HIV, hepatitis B, hepatitis C)
    9. Serum hormone levels
        1. Androgens (testosterone, androstenedione, dehydroepiandrosterone sulfate (DHEA-S) if there is evidence of hyperandrogenism (e.g., hirsuitism, acne, signs of virilization) or ovulatory dysfunction
        2. Anti-mullerian hormone (AMH), for the following indications: a) assessing menopausal status, including premature ovarian failure; b) assessing ovarian status, including ovarian reserve and ovarian responsiveness, as part of an evaluation for infertility and assisted reproduction protocols such as in vitro fertilization.
        3. Gonadotropins (serum follicle-stimuating hormone [FSH], luteinizing hormone [LH]) for women with irregular menstrual cycles
        4. Prolactin for women with an ovulatory disorder, galactorrhea, or a pituitary tumor
        5. Progestins (progesterone, 17-hydroxyprogesterone) (see Appendix for medical necessity limitations)
        6. Estrogens (estradiol)
        7. Thyroid stimulating hormone (TSH) for women with symptoms of thyroid disease
        8. Adrenocortitrophic hormone (ACTH) for ruling out Cushing's syndrome or Addison's disease in women who are amenorrheic
        9. Clomiphene citrate challenge test
    10. Karyotype testing for couples with recurrent pregnancy loss (2 or more consecutive spontaneous abortions)
3. Diagnostic procedures:
    1. CT or MR imaging of sella turcica is considered medically necessary if prolactin is elevated
    2. Endometrial biopsy
    3. Hysterosalpingography (hysterosalpingogram (HSG)) or hysterosalpingo-contrast-ultrasonography to screen for tubal occlusion. Note: Sonohysterosalpingography or saline hysterosalpingography (e.g., Femvue) are considered experimental and investigational to screen for tubal occlusion because of a lack of reliable evidence of effectiveness.
    4. Hysteroscopy, salpingoscopy (falloscopy), hydrotubation where clinically indicated

5. Laparoscopy and chromotubation (contrast dye) to assess tubal and other pelvic pathology, and to follow-up on hysterosalpingography abnormalities
6. Sonohysterography to evaluate the uterus
7. Ultrasound (e.g., ovarian, transvaginal, pelvic)
8. Monitoring of ovarian response to ovulatory stimulants:
    1. Estradiol
    2. FSH
    3. hCG quantitative
    4. LH assay
    5. Progesterone
    6. Serial ovarian ultrasounds are considered medically necessary for cycle monitoring.

The following services are considered medically necessary for diagnosis of infertility in males.

1. History and physical examination
2. Laboratory studies:
1. Anti-sperm antibodies (e.g., immunobead or mixed antiglobulin method)
2. Cultures
3. Prostatic secretion
4. Semen
5. Urine

3. Serum hormone levels
    1. 17-hydroxyprogesterone
    2. Adrenal cortical stimulating hormone (ACTH)
    3. Androgens (testosterone, free testosterone) - if initial testosterone level is low, a repeat measurement of total and free testosterone as well as serum luteinizing hormone (LH) and prolactin levels is medically necessary
    4. Estrogens (e.g., estradiol, estrone)
    5. Gonadotropins (FSH, LH)
    6. Growth hormone (GH)
    7. Prolactin for men with reduced sperm counts, galactorrhea, or pituitary tumors
    8. Sex hormone binding globulin (SHGB) for men with signs and symptoms of hypogonadism and low normal testosterone levels. (SHGB is not indicated in the routine evaluation of male infertility)
    9. Thyroid stimulating hormone (TSH) for men with symptoms of thyroid disease.
4. Semen analysis (volume, pH, liquefaction time, sperm concentration, total sperm number, motility (forward progression), motile sperm per ejaculate, vitality, round cell differentiation (white cells versus germinal), morphology, viscosity, agglutination) is considered medically necessary for the evaluation of infertility in men. Because of the marked inherent variability of semen analyses, an abnormal result should be confirmed by at least one
additional sample collected one or more weeks after the first sample.
    1. For men with abnormal semen analysis exposed to gonadotoxins, up to 4 semen analyses are considered medically necessary.
    2. For men with a normal initial semen analysis, a repeat semen analysis is considered medically necessary if there is no pregnancy 4 months after the initial normal semen analysis.
    3. If the result of the first semen analysis is abnormal and the man has not been exposed to gonadotoxins, up to 2 repeat confirmatory tests may be considered medically necessary.
5. Vasography
6. Semen leukocyte analysis (e.g., Endtz test, immunohistochemical staining)
7. Seminal fructose

8. Blood test for cytogenetic analysis (karyotype and FISH) in men with severe deficits of semen quality or azoospermia (for consideration of ICSI)
9. Cystic fibrosis mutation testing in men with congenital absence of vas deferens
10. Y chromosome microdeletion analysis in men with severe deficits of semen quality or azoospermia (for consideration of ICSI).

    Note: Y chromosome microdeletion analysis is not routinely indicated before ICSI, and may be subject to medical necessity review

11. Post-coital test (PCT) (Simms-Huhner test) of cervical mucus
12. Sperm function tests including Sperm penetration assay (zona-free hamster egg penetration test)

Infusion Therapy Services. Benefits will be provided when performed by a licensed Home Infusion Therapy Provider in a home setting. This benefit includes pharmaceuticals, pharmacy services, intravenous solutions, medical/surgical supplies and nursing services associated with Home Infusion Therapy. Specific adjunct non-intravenous therapies are included when administered only in conjunction with Home Infusion Therapy. Notwithstanding the foregoing, the Plan has the discretion to offer lower out of pocket charges to the Participant (including a lower deductible, copay, coinsurance or out of pocket maximum) for selecting coverage in the home versus an infusion center, Hospital, Facility or other setting, when determined to be prudent for the Plan as a whole. Infusion Therapy Services so provided in the home at the election of the Participant shall include coverage by the Plan of authorized fees, charges and expenses relating to such change in place of care, including the drug, equipment, supplies, nursing services, other caregiving services and related administrative and shared savings charges, as determined by the Plan Administrator in its sole discretion. The decision to offer lower out of pocket costs to one Participant shall not guarantee or be precedent setting in any way in regard to other Participants or in regard to keeping the arrangement in place for the participating Participant for any period of time.

Home Infusion services count towards the Home Health Visit limit listed on the Summary of Benefits.

Injections. Therapeutic Injections required in the diagnosis, prevention and treatment of an injury or illness

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

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

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

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

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

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

Maternity Services. Hospital Services and Medical/Surgical Services rendered by a Facility Provider or a licensed Health Care:

1. Complications of Pregnancy; Physical effects directly caused by pregnancy but which are not considered from a medical viewpoint to be the effect of normal pregnancy, including conditions related to ectopic pregnancy or those that require cesarean section.
2. Maternity Home Health Care Visit
    a) Benefits for one (1) maternity home Visit will be provided at the Covered Person's or Eligible Dependent's home within forty-eight (48) hours of discharge when the discharge from a Facility Provider occurs prior to:
        a) Forty-eight (48) hours of Inpatient care following a normal vaginal delivery, or
        b) Ninety-six (96) hours of Inpatient care following a cesarean delivery.

This Visit shall be made by an In-Network Provider whose scope of practice includes postpartum care. The Visit includes parent education, assistance and training in breast and bottle feeding, infant screening, clinical tests, and the performance of any necessary maternal and neonatal physical assessments. The Visit may, at the mother's sole discretion, occur at the office of the In-Network Provider. The Visit is subject to all the terms of the Plan and is exempt from any Copayment, Coinsurance or Deductible amounts.

3. Normal Pregnancy; Normal pregnancy includes any condition usually associated with the management of a difficult pregnancy but is not considered a complication of pregnancy.
4. Newborn Care; Care for newborns includes preventive health care services (including electrophysiological screening measures and periodic monitoring of infants for delayed onset of hearing loss), routine nursery care, and treatment of disease and injury. Treatment of disease and injury includes treatment of prematurity and medically diagnosed congenital defects and birth abnormalities which cause anatomical functional impairment. The Plan also covers, within the limits of this SPD, necessary transportation costs from the place of birth to the nearest specialized treatment center.

Maternity care for Dependent Child is excluded.

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

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

Benefits, detailed below, are available for Residential Treatment Facility, Partial Hospitalization, and Intensive Outpatient Services.

1. Hospital Services are provided for the Inpatient treatment of Mental Illness by a Facility Provider.

2. The following Services are covered for the Inpatient treatment of Mental Illness when rendered by a licensed, mental Health Care Provider:
   - individual psychotherapy;
   - group psychotherapy;
   - psychological testing;
   - Convulsive therapy treatment. Electroshock treatment or convulsive drug therapy including Anesthesia when administered concurrently with the treatment by the same licensed, mental Health Care Provider.
3. Partial Hospitalization Mental Health Care Services;
   Benefits are only available for partial hospitalization Mental Health Care Services provided by a partial hospitalization program which is offered by a Facility Provider or a licensed, mental Health Care Provider.
4. Outpatient Mental Health Care Services;
   Medical Services Benefits as described in this Subsection are also available when provided for the Outpatient treatment of Mental Illness by a Facility Provider, or a licensed, mental Health Care Provider.
5. Mental Health Parity and Addiction Equity Act;
   Benefits under this Plan are subject to The Mental Health Parity and Addiction Equity Act, which provides for parity in the application of aggregate lifetime limits, annual dollar limits, and treatment limitations (day or visit limits) on mental health and substance abuse benefits with dollar limits or day/visit limits on medical/surgical benefits. In general, group health plans offering mental health and substance abuse benefits cannot set annual dollar limits, lifetime dollar limits, or day/visit limits on mental health or substance abuse benefits that are lower than any such dollar limits or day/visit limits for medical and surgical benefits. A plan that does not impose annual dollar limits, lifetime dollar limits, or day/visit limits on medical and surgical benefits may not impose such dollar limits or day/visit limits on mental health and substance abuse benefits offered under the plan. Also, the plan may not impose deductibles, copayment/coinsurance and out of pocket expenses on mental health and substance abuse benefits that are more restrictive than deductibles, copayment/coinsurance and out of pocket expenses applicable to other medical and surgical benefits.

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

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

1. Hospital routine care for a newborn during the Child's initial Hospital confinement at birth.
2. The following Physician services for well-baby care during the newborn's initial Hospital confinement at birth:
   a. The initial newborn examination and a second examination performed prior to discharge from the Hospital.
   b. Circumcision.

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

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

Nutritional Counseling. Charges for nutritional counseling for the management of a medical condition (including both physical and mental health conditions).

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

Osseous Surgery. Charges for osseous surgery.

Outpatient Medical Care Services. The plan covers Outpatient Medical Care Services as follows:

1. Medical Care rendered by a licensed Health Care Provider to a Covered Person or Eligible Dependent who is an Outpatient for a condition not related to Surgery, pregnancy, or Mental Illness, except as specifically provided.
2. Medical Care Visits and consultation for the examination, diagnosis and treatment of an injury or illness.

Pediatric Extended Care Services. Services rendered by a Pediatric Extended Care Facility pursuant to a treatment plan for which benefits may include one (1) or more of the following:

1. Skilled Nursing Services of a Registered Nurse (RN) or Licensed Practical Nurse (LPN);
2. Physical Medicine, Speech Therapy and Occupational Therapy Services;
3. Respiratory Medicine, Speech Therapy and Occupational Therapy Services;
4. Medical and surgical supplies provided by the Pediatric Extended Care Facility;
5. Acute health care support; and
6. Ongoing assessments of health status, growth, and development.
7. Pediatric Extended Care Services will be covered for children eight (8) years of age or under, (except where the Affordable Care Act requires the Plan to cover certain preventive services, such as health assessments, until up to 19 years of age) pursuant to the attending Physician's treatment plan only when provided in a Pediatric Extended Care Facility and when approved by the Plan;

8. A prescription from the child's attending Physician is necessary for admission to a Pediatric Extended Care Facility; and

No benefits are payable after the Covered Person or Eligible Dependent has reached the maximum level of recovery possible for his or her particular condition and no longer requires definitive treatment other than routine supportive care.

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

Pregnancy Expenses. Expenses attributable to a Pregnancy. Pregnancy expenses of Dependent Children are NOT covered. Benefits for Pregnancy expenses are paid the same as any other Illness. ***NOTE:*** *Preventive care charges for Pregnancy are covered under the Preventive Care benefit in the Medical Benefits section.*

Under the Newborns' and Mothers' Health Protection Act of 1996, group health plans and health insurance issuers generally may not restrict benefits for any Hospital length of stay in connection with childbirth for the mother or newborn Child to less than 48 hours following a vaginal delivery, or less than 96 hours

following a cesarean section. However, Federal law generally does not prohibit the mother's or newborn's attending Provider, after consulting with the mother, from discharging the mother or her newborn earlier than 48 hours (or 96 hours as applicable). In any case, plans and issuers may not, under Federal law, require that a Provider obtain authorization from the Plan or the issuer for prescribing a length of stay not in excess of 48 hours (or 96 hours). In no event will an "attending Provider" include a plan, Hospital, managed care organization, or other issuer.

In accordance with the Summary of Benefits and this section, benefits for the care and treatment of Pregnancy that are covered will be subject to all applicable Plan limitations and maximums (if any), and are payable in the same manner as medical or surgical care of an Illness.

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

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

See the following websites for more details:

https://www.healthcare.gov/coverage/preventive-care-benefits/;
https://www.uspreventiveservicestaskforce.org/uspstf/recommendation-topics;
https://www.cdc.gov/vaccines/hcp/acip-recs/index.html;
https://www.aap.org/periodicityschedule;
https://www.hrsa.gov/womensguidelines/.

NOTE: The Preventive Care services identified through the above links are recommended services. It is up to the Provider and/or Physician of care to determine which services to provide; the Plan Administrator has the authority to determine which services will be covered. Preventive Care services will be covered at 100% for Non-Network Providers if there is no Network Provider who can provide a required preventive service. Benefits include gender-specific Preventive Care services, regardless of the sex the Participant was assigned at birth, his or her gender identity, or his or her recorded gender.

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

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

Women's Preventive Services - With respect to women, such additional Preventive Care and screenings as provided for in comprehensive guidelines supported by the Health Resources and Services Administration (HRSA) not otherwise addressed by the recommendations of the United States Preventive Service Task Force (USPSTF), which will be commonly known as HRSA's Women's Preventive Services

Required Health Plan Coverage Guidelines. The HRSA has added the following eight categories of women's services to the list of mandatory preventive services:

1. Well-woman visits.
2. Gestational diabetes screening.
3. Human papillomavirus (HPV) Deoxyribonucleic Acid (DNA) testing.
4. Sexually transmitted infection counseling.
5. Human Immunodeficiency Virus (HIV) screening and counseling.
6. Food and Drug Administration (FDA)-approved, -granted, or -cleared contraception methods and contraceptive counseling.
7. Breastfeeding support, supplies and counseling.
8. Domestic violence screening and counseling.

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

Prosthetic Appliances. The plan will cover the Purchase, fitting, necessary adjustments, repairs, and replacements of prosthetic devices and supplies which replace all or part of an absent body organ (including contiguous tissue) or replace all or part of the function of a permanently inoperative or malfunctioning body organ (excluding dental appliances and the replacement of cataract lenses). Initial and subsequent prosthetic devices to replace the removed breast(s) or a portion thereof are also covered.

Orthotics Supplies. Orthotic devices, excluding orthopedic shoes, diabetic shoes and other supportive devices for the feet.

Radiation Therapy. Charges for radiation therapy and treatment.

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

1. The clinical trial is approved by any of the following:

    a. The Centers for Disease Control and Prevention of the U.S. Department of Health and Human Services.
    b. The National Institute of Health.
    c. The U.S. Food and Drug Administration.
    d. The U.S. Department of Defense.
    e. The U.S. Department of Veterans Affairs.
    f. 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.

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

Second Surgical Opinions. Charges for second surgical opinions.
Skilled Nursing Facility. Charges made by a Skilled Nursing Facility or a convalescent care facility, up to the limits set forth in the Summary of Benefits, in connection with convalescence from an Illness or Injury (excluding drug addiction, chronic brain syndrome, alcoholism, senility, intellectual disability or other Mental or Nervous Disorders) for which the Participant is confined.

No benefits are payable after the Covered Person or Eligible Dependent has reached the maximum level of recovery possible for his or her particular condition and no longer requires definitive treatment other than routine supportive care; .when confinement in a Skilled Nursing Facility is intended solely to assist the Covered Person or Eligible Dependent with the activities of daily living or to provide an institutional environment for the convenience of a Covered Person or Eligible Dependent; for the treatment of Substance Abuse or Mental Illness.

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

Surgical Services. Surgical Services will be covered as follows:

1. Anesthesia
   Administration of Anesthesia for covered Surgery when ordered by the attending Professional Provider and rendered by a Professional Provider other than the surgeon or assistant at Surgery. Benefits are also provided for the administration of Anesthesia for covered oral surgical procedures in an Outpatient setting when ordered and administered by the attending Preferred Professional Provider.
2. Assistant at Surgery
   Services of a Physician who actively assists the operating surgeon in the performance of covered Surgery; Benefits will be provided for an assistant at Surgery only if an intern, resident, or house staff member is not available.
3. Second Surgical Opinion
    a. A consulting opinion and directly related Diagnostic Services to confirm the need for recommended elective Surgery.
    b. Specifications
        1. The second opinion consultant must not be the Physician who first recommended elective Surgery.
        2. Elective Surgery is covered Surgery that may be deferred and is not an emergency.
        3. Use of a second surgical opinion is at the Covered Person’s or Eligible Dependent's option.
        4. If the first opinion for elective Surgery and the second opinion conflict, then a third opinion and directly related Diagnostic Services are covered services.
        5. If the consulting opinion is against elective Surgery and the Covered Person or Eligible Dependent decides to have the elective Surgery, the Surgery is a Covered Service. In such instances, the Covered Person or Eligible Dependent will be eligible for a maximum of two (2) such consultations involving the elective surgical procedure in question but limited to one (1) consultation per consultant.
4. Special Surgery
    a. Sterilization if deemed medically necessary.
    b. Oral Surgery - Benefits are provided for the following limited oral surgical procedures determined to be Medically Necessary and Appropriate:
        1. extraction of impacted third molars when partially or totally covered by bone;
        2. extraction of teeth in preparation for radiation therapy;

3. mandibular staple implant, provided the procedure is not done in preparation of the mouth for dentures;
4. mandibular frenectomy;
5. Facility Provider and Anesthesia Services rendered in conjunction with non-covered dental procedures when determined by the Plan to be Medically Necessary and Appropriate due to the age and/or medical condition of the Covered Person or Eligible Dependent;
6. accidental injury to the jaw or structures contiguous to the jaw;
7. the correction of a non-dental physiological condition which has resulted in a severe functional impairment;
8. treatment for tumors and cysts requiring pathological examination of the jaw, cheeks, lips, tongue, roof and floor of mouth; and
9. Orthodontic treatment of congenital cleft palates involving the maxillary arch, performed in conjunction with bone graft surgery to correct the bony deficits associated with extremely wide clefts affecting the alveolus.

5. Mastectomy and Breast Cancer Reconstruction - Benefits are provided for a mastectomy performed on an Inpatient or Outpatient basis for the following:
    a. Surgery to reestablish symmetry or alleviate functional impairment including, but not limited to, augmentation, mammoplasty, reduction mammoplasty and mastopexy;
    b. Initial and subsequent prosthetic devices to replace the removed breast or portions thereof; and
    c. Physical complications of all stages of mastectomy, including lymphedemas.

    Benefits are also provided for one (1) home visit, as determined by the Covered Person's or Eligible Dependent's Physician, when received within forty-eight (48) hours after discharge, if such discharge occurred within forty-eight (48) hours after an admission for a mastectomy.

6. Surgery; Surgery performed by a licensed Health Care Provider. Separate payment will not be made for pre- and post-operative Services.

If more than one (1) surgical procedure is performed by the same licensed Health Care Provider during the same operation, the total benefits payable will be the amount payable for the highest paying procedure, and no allowance shall be made for additional procedures except where the Plan deems that an additional allowance is warranted.

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

Telehealth/Virtual Healthcare. Charges for any Medically Necessary services, for which benefits are otherwise provided by the Plan, when those services are provided video communication. Telephone only consultations are excluded.

Temporomandibular Joint Disorder. Charges for the Diagnosis and treatment of, or in connection with, temporomandibular joint disorders, myofascial pain dysfunction or orthognathic treatment. *Appliances are excluded.*

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

1. **Autism Spectrum Disorder Treatment**. Charges for treatment of Autism Spectrum Disorder (ASD).
2. **Cardiac Therapy**. Charges for cardiac therapy.

3. **Chemotherapy**. Charges for chemotherapy, including materials and services of technicians.
4. **Infusion Therapy**. Benefits will be provided when performed by a Facility Provider and for self-administration if the components are furnished and billed by a Facility Provider.
5. **Occupational Therapy**. Rehabilitation treatment or services rendered by a registered occupational therapist, under the direct supervision of a Physician, in a home setting or at a facility or Institution whose primary purpose is to provide medical care for an Illness or Injury, or at a free-standing outpatient facility.
6. **Physical Therapy**. Rehabilitation treatment or services rendered by a physical therapist, under direct supervision of a Physician, in a home setting or a facility or Institution whose primary purpose is to provide medical care for an Illness or Injury, or at a free-standing duly licensed outpatient therapy facility.
7. **Radiation Therapy.** Charges for radiation therapy and treatment.
8. **Respiration Therapy.** Respiration therapy services, when rendered in accordance with a Physician's written treatment plan.
9. **Speech Therapy.** Speech therapy, for Rehabilitation purposes, by a Physician or qualified speech therapist, when needed due to an Illness or Injury (other than a functional Nervous Disorder) or due to Surgery performed as the result of an Illness or Injury, excluding speech therapy services that are educational in any part or due to articulation disorders, tongue thrust, stuttering, lisping, abnormal speech development, changing an accent, dyslexia, hearing loss which is not medically documented or similar disorders.

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

Transplants. Provider/Hospital must participate in the Anthem Blue Distinction Center Facility Network. Organ or tissue transplants are covered for the following human to human organ or tissue transplant procedures:

1. Bone marrow.
2. Heart.
3. Lung.
4. Heart and lung.
5. Liver.
6. Pancreas.
7. Kidney.
8. Cornea.

In addition, the Plan will cover any other transplant that is not Experimental.

Recipient Benefits

Covered Expenses will be considered the same as any other Illness for Employees or Dependents as a recipient of an organ or tissue transplant. Covered Expenses include:

1. Organ or tissue procurement from a cadaver consisting of removing, preserving and transporting the donated part.
2. Services and supplies furnished by a Provider.
3. Drug therapy treatment to prevent rejection of the transplanted organ or tissue.

Surgical, storage and transportation costs directly related to the procurement of an organ or tissue used in a transplant described herein will be covered. If an organ or tissue is sold rather than donated, no benefits will be available for the purchase price of such organ or tissue.

When both the person donating the organ and the person receiving the organ are Participants, each will receive benefits under the Plan.

Donor Benefits

When only the recipient is covered, both the donor and the recipient are entitled to the benefits subject to the following additional limitations:

1. The donor benefits are limited to only those not provided or available to the donor from any other source. This includes, but is not limited to, other insurance coverage, or any government program; and
2. Benefits provided to the donor will be charged against the recipient's coverage to the extent that benefits remain and are available after benefits for the recipient's own expenses have been paid.

When only the donor is a Covered Person or Eligible Dependent, the donor is entitled to the benefits under the Plan, subject to the following additional limitations:

1. The benefits are limited to only those not provided or available to the donor from any other source in accordance with the terms of this Contract, and
2. No benefits will be provided to the non-Covered Person or Eligible Dependent transplant recipient; If any organ, tissue, or blood stem cell is sold rather than donated to the Covered Person or Eligible Dependent recipient, no benefits will be payable for the purchase price of such organ, tissue or blood stem cell; however, other costs related to evaluation and procurement are covered up to the Covered Person or Eligible Dependent Recipient’s Plan limits.

Vision Care. Expenses for the following:

1. Cataract surgery and lenses.
2. Glaucoma. For the treatment of glaucoma.

Wigs. Charges associated with the initial purchase of a wig after chemotherapy or radiation therapy.

Wilm’s Tumor. The Plan covers treatment of Wilm's Tumor the same way it covers charges for any other Illness. Treatment can include, but is not limited to, autologous bone marrow transplants when standard chemotherapy treatment is unsuccessful. Coverage is available for this treatment even if it is deemed Experimental, Investigational or Unproven.

Medical Exclusions

Some health care services are not covered by the Plan. In addition to the exclusions and limitations set forth in the various benefit sections of this SPD, the following circumstances may cause loss of benefits and/or charges and expenses which are not payable from the Plan.

a) Benefits are denied when it is determined that, at the time the claim was Incurred, you or your Dependent, as the case may be:
b) Was not eligible for benefits claimed.
c) Failed to submit required evidence to substantiate the claim.

d) Failed to apply or make timely application for benefits.
e) Made intentional material misstatements in connection with eligibility or any payments made in reliance on such misstatement.
f) Omitted facts or material statements as to other insurance available to you and your Dependents

Some health care services are not covered by the Plan. In addition to the General Exclusions set forth in the General Limitations and Exclusion section, these include, but are not limited to, any charge for care, supplies, or services, which are:

Alternative Medicine. For holistic or homeopathic treatment, naturopathic services, and thermography, including drugs.

Ambulance/Ambulette Services. Ambulance services, except as provided herein.

Bariatric Surgery. Charges for bariatric surgery, including but not limited to, gastric bypass, stapling and intestinal bypass, and lap band surgery, including reversals.

Biofeedback. For biofeedback.

Cellular and Genetic therapy. All expenses related to any FDA approved Cellular and Gene Therapy products are not covered. A full listing of these excluded items can be found at https://www.fda.gov/vaccines-blood-biologics/cellular-gene-therapy-products/approved-cellular-and-gene-therapy-products

Court Ordered. Service ordered by a court or other tribunal as part of the covered Person's and Eligible Dependent's sentence.

Dental Care. Dental care, filling, removal or replacement of teeth, the treatment of injuries to or diseases of the teeth, gums or structures directly supporting or attached to the teeth. These include, but are not limited to, apicoectomy (dental root resection), root canal treatments, soft tissue impactions, alveolectomy and treatment of periodontal disease, except for dental expenses otherwise covered because of accidental bodily injury to sound and natural teeth and for orthodontic treatment for congenital cleft palates.

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

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

Experimental. Services for any Experimental procedures, services, or drugs. For example, hospital stays for any procedure that is no longer generally regarded as effective or it is experimental in the sense that its effectiveness is not generally recognized.

Genetic Counseling or Testing. For treatment that is either for genetic counseling or testing , except as otherwise covered under the Preventive Care benefit.

Growth Hormone Therapy. Any expense for or related to Adult or Pediatric Growth Hormone treatment or replacement therapy.
Hair Pieces. For wigs, artificial hair pieces, human or artificial hair transplants, or any Drug, prescription or otherwise, used to eliminate baldness. ***NOTE:*** *This Exclusion does not apply to hair pieces and wigs that are covered under the Plan for patients who are undergoing chemotherapy.*

Hearing Aids. For hearing aids or examinations for the prescription, fitting, and/or repair of hearing aids or tinnitus maskers.

Hypnosis. Related to the use of hypnosis.

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

Impregnation and Infertility Treatment. Expenses for the treatment of infertility and its complications, procedures, or devices to achieve fertility, in vitro fertilization, low tubal transfer, artificial insemination, embryo transfer, gamete transfer, zygote transfer, surrogate parenting, donor semen, adoption, and reversal of sterilization procedures.

Inpatient Admissions for Diagnostic studies or for Physical Medicine services.

Long Term Care.

Medical Foods and Enteral Formulae. Medical foods administered via intravenous therapy (IV) or tube feedings or orally.

Membership Fees. Membership fees, dues or any other charges in connection with recreational facilities, fitness centers, diet, stress management centers or nutritional centers, recreational and leisure travel even if prescribed or recommended by a Physician.

Marriage/Family Counseling. Coverage for marriage or family counseling.

Nicotine Addiction. Expenses for nicotine withdrawal programs, facilities, Drugs or supplies. Included but not limited to nicotine gum or patches, or other products, services or programs intended to assist an individual to stop smoking, except to the extent required by the Affordable Care Act;

Non-Emergent/Emergency Care in Emergency Room Setting.

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

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

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

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

Plastic Surgery. Plastic surgery for cosmetic purposes. Exceptions to this exclusion include:

- Surgery to correct a condition resulting from an accident;

- Surgery to correct a congenial birth defect;
- Surgery to correct a functional impairment which results from a covered disease or injury;

Pregnancy of a Dependent Child. Incurred by an eligible Dependent Child, including, but not limited to, pre-natal, delivery and post-natal care, treatment of miscarriage and complications due to Pregnancy, unless specifically provided as a covered benefit elsewhere in this Plan. ***NOTE:*** *Preventive care charges for Pregnancy are covered under the Preventive Care benefit in the Medical Benefits section.*

Prescription Drug.

1. Prescription Drugs that are paid or payable under the freestanding prescription drug program.
2. Investigation or Experimental Drugs, including but not limited to Compounded Drugs.
3. New Pharmaceutical Products (defined as a Prescription Drug or new dosage form of a previously approved Prescription Drug during the period of time starting on the date the Prescription Drug or new dosage form is approved by the U.S. Food and Drug Administration (FDA) and ends on the first day of the plan year following a waiting period of 365 days from the date it is placed on a coverage tier or formulary by the Claims Administrator.
   This exclusion does not apply if the drug is otherwise on a coverage tier and you have a life-threatening Sickness or condition (one that is likely to cause death within one year of the request for treatment)
4. Orphan Drugs as defined by the FDA. https://www.accessdata.fda.gov/scripts/opdlisting/oopd/

Private Duty Nursing. Services of private or special nurses or services generally provided on an out-patient basis.

Repair of Purchased Equipment. For maintenance and repairs needed due to misuse or abuse are not covered.

Replacement Braces. For replacement of braces of the leg, arm, back, neck, or artificial arms or legs, unless there is sufficient change in the Participant's physical condition to make the original device no longer functional.

Routine Foot Care. Palliative or cosmetic foot care including flat foot conditions, supportive devices for the foot, corrective shoes, the treatment of subluxations of the foot, care of corns, bunions (except capsular or bone Surgery), calluses, toenails (except Surgery for ingrown nails), fallen arches, weak feet, chronic foot strain, and symptomatic complaints of the feet, except when such devices or services are related to the treatment of diabetes.

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

1. 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.
2. 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.
3. The cost of a service that is clearly inconsistent with widely accepted and established standards of care for a particular Diagnosis.
4. A cost associated with managing an Approved Clinical Trial.

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

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

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

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

Sterilization Reversal. For sterilization procedure reversal.

Surrogate. Care for surrogate mothers, unless the surrogate is a Covered Person, in which case the Preventive Care Services and/or pregnancy expenses will be covered in accordance with the Plan provisions.

Telephone Consultations. Charges for any Medically Necessary services, for which benefits are otherwise provided by the Plan, when those services are provided by telephone only communication.

Temporomandibular Joint Disorder Appliances. Temporomandibular joint dysfunction syndrome (TMJ) Appliances.

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

Vision Care. Eyeglasses or contact lenses and the vision examination for prescribing or fitting eyeglasses or contact lenses, (except for the initial pair of contact lenses/glasses prescribed following cataract extraction in place of surgically implanted lenses, or sclera shells intended for use in the treatment of disease or injury).

Vision Surgery. Expenses for the correction of myopia, hyperopia, or presbyopia, including but not limited to corneal microsurgery, such as keratomileusis, keratophakia, radial keratotomy, corneal ring implants, Laser-Assisted in Situ Kratomileusis (LASIK) and all related services.

Vitamins. For vitamins, except as specified under Preventive Care.

Any Covered Person who improperly collects benefits from the Plan, based on misstatement or misrepresentation, will be legally liable for the reimbursement to the Plan of any improper payments. In addition, the Covered Person will be subject to suspension of all benefits.

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

UTILIZATION MANAGEMENT

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

Services that Require Pre-Certification

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

1. Inpatient hospitalization. Including Elective admissions, Emergency admissions and Maternity stays beyond 48 hours for vaginal delivery and 96 hours for cesarean delivery.
2. Inpatient mental health and Substance Abuse – Facilities.
3. Inpatient Mental Health and Substance Abuse – Residential Treatment Facilities.
4. Detoxification Facilities.
5. Skilled Nursing Facility stays.
6. Rehab program (such as cardiac, pain management, pulmonary).
7. Outpatient Surgery.
8. Transplant candidacy evaluation and transplant (organ and/or tissue).
9. Home Health Services.
10. Hospice Services.
11. Durable Medical Equipment, including but not limited to, Seat lifts, TENS units, pumps, wheelchairs, power operated vehicles, speech generating devices, insulin infusion pump, osteogenesis stimulators, and neuromuscular stimulators.
12. Therapy services:
    Applied Behavior Analysis (ABA) therapy.
    Cardiac therapy.
    Chemotherapy
    Respiration therapy.
    Occupational therapy
    Physical therapy
    Speech therapy.
13. Use of implantable devices (including Cochlear Implants).
14. Infusion services.
15. Injectable medications.
16. Orthotics and Prosthetics.
17. High Diagnostic Radiology, including but not limited to, MRI/PET/CT scans, myocardial perfusion imaging, cardiac blood pool imaging, cardiac tests such as diagnostic cardiac catheterization and stress echocardiograms.

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

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

Pre-Certification Procedures and Contact Information
The Utilization Management Service is simple and easy for Participants to use. Whenever a Participant is advised that services requiring Pre-Certification are needed, it is the Participant's responsibility to call the pre-certification department at its toll free number, which is 1-877-284-0102. The review process will continue, as outlined below, until the completion of the treatment plan and/or the Participant's discharge from the Hospital.

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

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

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

If a medical service is provided in response to an Emergency situation or urgent care scenario, prior approval from the Plan is not required. The Plan will require notice within 72 hours after the admission date, but no later than the first business day following the Emergency admission, by or on behalf of the covered patient. Such a claim shall then be deemed to be a Post-service Claim.

Failure to initiate Emergency admission review will result in a penalty for non-compliance and benefits for covered services may be denied per hospitalization to the Participant. Such penalty will be the sole responsibility of, and payable by, the Participant.

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

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

If, at any time during the review process, Medical Necessity cannot be validated, the review specialist will refer the episode to a board certified Physician advisor who will immediately contact the attending Physician

to negotiate an appropriate treatment plan. At the end of the Hospital confinement, the review specialist is also available to assist with discharge planning and will work closely with the attending Physician and Hospital to ensure that medically appropriate arrangements are made.

Outpatient Services:

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

Pre-Certification Penalty

The program requires the support and cooperation of each Participant. If a Participant follows the instructions and procedures, he or she will receive the normal Plan benefits for the services. However, if a Participant fails to notify the pre-certification department of any services listed in the provision entitled "Services that Require Pre-Certification," allowed charges will be reduced by 50% for Room and Board, Hospital miscellaneous services, and any other charges related to that confinement which are billed by the Hospital. The Participant will be responsible for payment of the part of the charge that is not paid by the Plan.

NOTE: *If a Participant's admission or service is determined to not be Medically Necessary, he or she may pursue an appeal by following the provisions described in the Claims Procedures; Payment of Claims section of this document. The Participant and Provider will be informed of any denial or non-certification in writing.*

Retrospective Review

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

Alternate Course of Treatment

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

If the Plan Administrator should determine that an alternate, less expensive, course of treatment is appropriate, and if the attending Physician agrees to the alternate course of treatment, all Medically Necessary expenses stated in the treatment plan will be eligible for payment under the Plan, subject to the applicable benefit maximum(s) set forth in this Plan, even if these expenses normally would not be eligible for payment under the Plan. A more expensive course of treatment, selected by the Participant or their attending Physician may not be deemed to be Medically Necessary or within Maximum Allowable Charge limitations, as those terms are defined by the Plan. The Plan may provide coverage in such circumstances by providing benefits equivalent to those available had the Medically Necessary and otherwise covered course of treatment, subject to the Maximum Allowable Charge, been pursued.

Pre-Admission Testing

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

1. The tests are related to the performance of the scheduled Surgery or treatment.

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

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

In addition, the Plan recommends that a second opinion be obtained prior to the following Surgeries:

1. Adenoidectomy.
2. Bunionectomy.
3. Cataract removal.
4. Coronary Bypass.
5. Cholecystectomy (removal of gallbladder).
6. Dilation and curettage.
7. Hammer Toe repair.
8. Hemorrhoidectomy.
9. Herniorrhaphy.
10. Hysterectomy.
11. Laminectomy (removal of spinal disc).
12. Mastectomy.
13. Meniscectomy (removal of knee cartilage, including arthroscopic approach).
14. Nasal surgery (repair of deviated nasal septum, bone or cartilage).
15. Prostatectomy (removal of all or part of prostate).
16. Release for entrapment of medial nerve (Carpal Tunnel Syndrome).
17. Tonsillectomy.
18. Varicose veins (tying off and stripping).

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

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

Pre-Surgical Approval
The Plan recommends that a pre-determination of benefits be obtained prior to the following Surgical Procedures, since they are usually Cosmetic Surgery or not Medically Necessary. These procedures include, but are not limited to:

1. Abdominoplasty.
2. Blepharoplasty.
3. Breast reduction or enlargement.
4. Dermabrasion.
5. Facial or nasal reconstruction.
6. Gastric bypass.
7. Lipectomy.
8. Penile implant.
9. Scar revision.
10. Any Experimental or research procedures which are not generally accepted medical practice.

Because of the broad range of Surgical Procedures available and under development, if a Participant is scheduled to undergo any questionable procedure, he or she should contact the Third Party Administrator for further information. Pre-surgical approval is not a guarantee of coverage.

Case Management

Case management is a preemptive coordination of a Participant's care in cases where the medical condition is or is expected to be serious, chronic, or when the cost of treatment is expected to be significant. This program provides for a case manager who monitors Participants and explores, discusses and recommends coordinated and/or alternate types of appropriate Medically Necessary care. Case management is a voluntary service. There are no reductions of benefits or penalties if the patient and family choose not to participate. Each treatment plan is individually tailored to a specific patient and should not be seen as appropriate or recommended for any other patient, even one with the same Diagnosis.

PRESCRIPTION DRUG BENEFITS

Services and Supplies are provided to Covered Persons and eligible Dependents using the Magellan Rx Management Pharmacy Network.

Claims for prescription benefits services and supplies are determined by the Claims Administrator, or a delegate that is a pharmacy benefit manager. To use this benefit, simply present your Medical ID Card at any participating pharmacy. If you have any questions regarding whether your pharmacy or any other pharmacy in your area participates, please call 1-833-271-2374 or visit www.carelonrx.com

Schedule of Benefits and Prescription Co-payments/Co-insurance
Participants and Eligible Dependents must pay for a part of their prescription drug benefits in the form of a Co-Payment. For each prescription at a participating pharmacy or by mail order, you must pay the Co-Payment listed below. The Co-Payment is different for generic or brand name prescription drugs.

A Copayment is the flat dollar amount specified in the Summary of Benefits that a Participant is required to pay for certain covered services. Copayments will not apply after the out-of-pocket maximum has been reached.

The Copayment/Coinsurance amounts/Deductible are applied to each charge and is shown on the Summary of Benefits, above. The Copayment/Coinsurance amounts/Deductible amounts apply toward the medical plan out-of-pocket maximum.

The out-of-pocket maximum is the maximum dollar amount Participants are responsible for paying for covered services during a Calendar Year, including the Copayments.

When the individual and/or family out-of-pocket expenses reach the out-of-pocket maximum, the Plan will pay 100% of the Covered Expenses for the individual or the individual and his or her Dependents for the remainder of the Calendar Year.

The maximum benefit for covered prescription drug expenses Incurred by a Participant's entire family during each Plan Year may be obtained from your Claims Administrator. You may also call the Claims Administrator for advice on how to preserve and maximize your annual drug benefit.

The Plan allows for the dispensing of up to a 30-day supply as prescribed by the Physician. Members may be able to obtain up to a 90-day supply of generic prescriptions at any pharmacy. The mail order program was designed to allow Participants and Eligible Dependents to receive large quantities of maintenance medication (e.g., heart medication, blood pressure medication, diabetic medication, etc.). Participants and Eligible Dependents may obtain up to a 90-day supply of their prescription.

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

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

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

REBATES AND OTHER DISCOUNTS

The Plan may, at times, receive rebates for certain drugs on the PDL. The Plan does not pass these rebates and other discounts on to you.

COVERED ITEMS

1. Abortifacients
2. Aids
3. Alcohol Deterrents
4. Anabolic steroids
5. Antineoplastic/Chemo (oral and injectable)
6. Bee sting kits
7. Compounded drugs
8. Contraceptives (Oral, Patch)
9. Diabetic (Blood Sugar Diagnostics, Insulin, Insulin Syringes, Lancets, Urine Test Strips)
10. CSF/Hematopoietic Agents
11. Fluoride Preps – Oral & Topical
12. Folic Acid
13. Imitrex Injectable w/Std Qty Limit
14. Immunosuppressives
15. Injectables
16. Interferon Alpha Beta
17. Metabolic Infant Formula (requires preauthorization)
18. Sexual Dysfunction – Oral and Non-Oral
19. Vitamins – Prenatal and Non-Prenatal

EXCLUSIONS

In addition to the Exclusions and Limitations applicable to all benefits under the Plan, no Prescription Drug benefits are available under this Contract for:

1. Drug or medication which is not a covered maintenance prescription drug;
2. Any charges by any Pharmacy Provider or Pharmacist except as provided herein;
3. Any charge where the Allowable Charge is less than the Participant's or Eligible Dependent's Co-payment; and
4. Any charge above the Allowable Charge, advertised, or posted price, whichever is less than the Allowable Charge.
5. Drugs or medications available over the counter for which state or federal laws do not require a prescription.
6. Any drugs that are labeled as experimental or investigational.
7. United States Food and Drug Administration (FDA) approved prescriptions drugs used for purposes other than those approved by the FDA unless the drug is recognized for the treatment of the particular indication in one of the standard reference compendia, such as The United States Pharmacopoeia (USP) Drug Information, the American Medical Association Drug Evaluations, The American Hospital Formulary Service Drug Information, the Physician Drug Reference (PDR)) or in current medical literature. Medical literature means scientific studies published in peer-reviewed national professional medical journals.
8. Drugs newly approved by the FDA, prior to their review by the Plan's Pharmacy and Therapeutics Committee.

9. Prescription and nonprescription supplies (such as ostomy supplies), devices and appliances other than syringes used in conjunction with injectable medications.
10. Prescriptions covered without charge under federal, state or local programs, including Workers' Compensation
11. Any charge for the administration of a drug or insulin
12. Unauthorized refills
13. Medication for a Participant or Eligible Dependent confined to a rest home, nursing home, sanitarium, extended care facility, hospital or similar entity
14. Biologicals defined as Passive Immunizing Agents, Allergenic Extracts, and Diagnostic Drugs; Alcohol Swabs
15. Anti-Obesity
16. Blood/Blood Products
17. Blood Pressure Supplies
18. Complementary Alternative Medicines
19. Cosmetic Preps
20. Fertility Drugs
21. Hair Growth Stimulants
22. Immune Serums
23. Immunization/Vaccines
24. Miscellaneous Medical Supplies
25. Nutritional Diet Supplies
26. Ostomy Supplies
27. OTC
28. Respiratory Devices
29. Tuberculin Syringes
30. X-ray Diagnostics

HIPAA PRIVACY

Commitment to Protecting Health Information

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

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

1. The Plan's disclosures and uses of PHI.
2. The Participant's privacy rights with respect to his or her PHI.
3. The Plan's duties with respect to his or her PHI.
4. The Participant's right to file a complaint with the Plan and with the Secretary of HHS.
5. The person or office to contact for further information about the Plan's privacy practices.

The Plan provides each Participant with a separate Notice of Privacy Practices. This Notice describes how the Plan uses and discloses a Participant's personal health information. It also describes certain rights the Participant has regarding this information. Additional copies of the Plan's Notice of Privacy Practices are available by calling 1-732-903-1900

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

Definitions

- **Breach** means an unauthorized acquisition, access, use or disclosure of Protected Health Information ("PHI") or Electronic Protected Health Information ("ePHI") that violates the HIPAA Privacy Rule and that compromises the security or privacy of the information.
- **Protected Health Information ("PHI")** means individually identifiable health information, as defined by HIPAA, that is created or received by the Plan and that relates to the past, present, or future physical or mental health or condition of an individual; the provision of health care to an individual; or the past, present, or future payment for the provision of health care to an individual; and that identifies the individual or for which there is a reasonable basis to believe the information can be used to identify the individual. PHI includes information of persons living or deceased.

How Health Information May Be Used and Disclosed

In general, the Privacy Rules permit the Plan to use and disclose, the minimum necessary amount, an individual's PHI, without obtaining authorization, only if the use or disclosure is for any of the following:

1. To carry out payment of benefits.
2. If the use or disclosure falls within one of the limited circumstances described in the rules (e.g., the disclosure is required by law or for public health activities).

Primary Uses and Disclosures of PHI

1. Treatment, Payment and Health Care Operations: The Plan has the right to use and disclose a Participant's PHI for all activities as included within the definitions of Treatment, Payment, and Health Care Operations and pursuant to the HIPAA Privacy Rule.
2. Business Associates: The Plan contracts with individuals and entities (Business Associates) to perform various functions on its behalf. In performance of these functions or to provide services, Business Associates will receive, create, maintain, use, or disclose PHI, but only after the Plan and the Business Associate agree in writing to contract terms requiring the Business Associate to appropriately safeguard the Participant's information.
3. Other Covered Entities: The Plan may 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 Participant, 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 Participant has coverage through another carrier.

Disclosure of PHI to the Plan Sponsor for Plan Administration Purposes

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

1. Not use or further disclose PHI other than as permitted or required by the plan documents or as required by law (as defined in the Privacy Standards).
2. Ensure that any agents, including a subcontractor, to whom the Plan Sponsor provides PHI received from the Plan, agree to the same restrictions and conditions that apply to the Plan Sponsor with respect to such PHI.
3. Maintain the confidentiality of all PHI, unless an individual gives specific consent or authorization to disclose such data or unless the data is used for health care payment or Plan operations.
4. Receive PHI, in the absence of an individual's express authorization, only to carry out Plan administration functions.
5. Not use or disclose genetic information for underwriting purposes.
6. Report to the Plan any PHI use or disclosure that is inconsistent with the uses or disclosures provided for of which the Plan Sponsor becomes aware.
7. Make available PHI in accordance with section 164.524 of the Privacy Standards (45 CFR 164.524).
8. Make available PHI for amendment and incorporate any amendments to PHI in accordance with section 164.526 of the Privacy Standards (45 CFR 164.526).
9. Make its internal practices, books and records relating to the use and disclosure of PHI received from the Plan available to the Secretary of the U.S. Department of Health and Human Services ("HHS"), or any other officer or Employee of HHS to whom the authority involved has been delegated, for purposes of determining compliance by the Plan with part 164, subpart E, of the Privacy Standards (45 CFR 164.500 et seq).
10. If feasible, return or destroy all PHI received from the Plan that the Plan Sponsor still maintains in any form and retain no copies of such PHI when no longer needed for the purpose for which disclosure was made, except that, if such return or destruction is not feasible, limit further uses and disclosures to those purposes that make the return or destruction of the PHI infeasible.

Required Disclosures of PHI

1. Disclosures to Participants: The Plan is required to disclose to a Participant most of the PHI in a Designated Record Set when the Participant requests access to this information. The Plan will disclose a Participant's PHI to an individual who has been assigned as his or her representative and who has qualified for such designation in accordance with the relevant State law. Before disclosure to an individual qualified as a personal representative, the Plan must be given written supporting documentation establishing the basis of the personal representation.
   The Plan may elect not to treat the person as the Participant's personal representative if it has a reasonable belief that the Participant has been, or may be, subjected to domestic violence, abuse, or neglect by such person, it is not in the Participant's best interest to treat the person as his or her personal representative, or treating such person as his or her personal representative could endanger the Participant.

2. Disclosures to the Secretary of the U.S. Department of Health and Human Services: The Plan is required to disclose the Participant's PHI to the Secretary of the U.S. Department of Health and Human Resources when the Secretary is investigating or determining the Plan's compliance with the HIPAA Privacy Rule.

Participant's Rights

The Participant has the following rights regarding PHI about him/her:

1. Request Restrictions: The Participant has the right to request additional restrictions on the use or disclosure of PHI for treatment, payment, or health care operations. The Participant may request that the Plan restrict disclosures to family members, relatives, friends or other persons identified by him/her who are involved in his or her care or payment for his or her care. The Plan is not required to agree to these requested restrictions.
2. Right to Receive Confidential Communication: The Participant has the right to request that he or she receive communications regarding PHI in a certain manner or at a certain location. The request must be made in writing and include how the Participant would like to be contacted. The Plan will accommodate all reasonable requests.
3. Right to Receive Notice of Privacy Practices: The Participant is entitled to receive a paper copy of the plan's Notice of Privacy Practices at any time. To obtain a paper copy, contact the Privacy Officer.
4. Accounting of Disclosures: The Participant has the right to request an accounting of disclosures the Plan has made of his or her PHI. The request must be made in writing and does not apply to disclosures for treatment, payment, health care operations, and certain other purposes. The Participant is entitled to such an accounting for the six years prior to his or her request. Except as provided below, for each disclosure, the accounting will include: (a) the date of the disclosure, (b) the name of the entity or person who received the PHI and, if known, the address of such entity or person; (c) a description of the PHI disclosed, (d) a statement of the purpose of the disclosure that reasonably informs the Participant of the basis of the disclosure, and certain other information. If the Participant wishes to make a request, please contact the Privacy Officer.
5. Access: The Participant has the right to request the opportunity to look at or get copies of PHI maintained by the Plan about him/her in certain records maintained by the Plan. If the Participant requests copies, he or she may be charged a fee to cover the costs of copying, mailing, and other supplies. If a Participant wants to inspect or copy PHI, or to have a copy of his or her PHI transmitted directly to another designated person, he or she should contact the Privacy Officer. A request to transmit PHI directly to another designated person must be in writing, signed by the Participant and the recipient must be clearly identified. The Plan must respond to the Participant's request within

30 days (in some cases, the Plan can request a 30 day extension). In very limited circumstances, the Plan may deny the Participant's request. If the Plan denies the request, the Participant may be entitled to a review of that denial.

6. Amendment: The Participant has the right to request that the Plan change or amend his or her PHI. The Plan reserves the right to require this request be in writing. Submit the request to the Privacy Officer. The Plan may deny the Participant's request in certain cases, including if it is not in writing or if he or she does not provide a reason for the request.
7. Other uses and disclosures not described in this section can only be made with authorization from the Participant. The Participant may revoke this authorization at any time.

Questions or Complaints

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

The Plan will not retaliate against the Participant for filing a complaint with the Plan or the U.S. Department of Health and Human Services.

Contact Information

Privacy Officer Contact Information:
Human Resources
Phone: 1-732-903-1900

HIPAA SECURITY

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

STANDARDS FOR SECURITY OF INDIVIDUALLY IDENTIFIABLE HEALTH INFORMATION ("SECURITY RULE")

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

The Security Rule imposes regulations for maintaining the integrity, confidentiality and availability of protected health information that it creates, receives, maintains, or maintains electronically that is kept in electronic format (ePHI) as required under HIPAA.

Definitions

- **Electronic Protected Health Information (ePHI),** as defined in Section 160.103 of the Security Standards (45 C.F.R. 160.103) and means individually identifiable health information transmitted or maintained in any electronic media.
- **Security Incidents,** as defined within Section 164.304 of the Security Standards (45 C.F.R. 164.304) and means the attempted or successful unauthorized access, use, disclosure, modification, or destruction of information or interference with systems operation in an information system.

Plan Sponsor Obligations

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

1. Implement administrative, physical, and technical safeguards that reasonably and appropriately protect the confidentiality, integrity and availability of the Electronic PHI that it creates, receives, maintains, or transmits on behalf of the Plan.
2. Ensure that adequate separation between the Plan and the Plan Sponsor, as required in 45 CFR § 164.504(f)(2)(iii), is supported by reasonable and appropriate Security Measures.
3. Ensure that any agent, including a subcontractor, to whom the Plan Sponsor provides Electronic PHI created, received, maintained, or transmitted on behalf of the Plan, agrees to implement reasonable and appropriate administrative, physical, and technical safeguards to protect the confidentiality, integrity, and availability of the Electronic PHI and report to the Plan any security incident of which it becomes aware.
4. Report to the Plan any security incident of which it becomes aware.
5. Establish safeguards for information, including security systems for data processing and storage.
6. Not use or disclose PHI for employment-related actions and decisions or in connection with any other benefit or Employee benefit plan of the Plan Sponsor, except pursuant to an authorization which meets the requirements of the Privacy Standards.
7. Ensure that adequate separation between the Plan and the Plan Sponsor, as required in section 164.504(f)(2)(iii) of the Privacy Standards (45 CFR 164.504(f)(2)(iii)), is established as follows:
    a. The following Employees, or classes of Employees, or other persons under control of the Plan Sponsor, shall be given access to the PHI to be disclosed:

i. Privacy Officer.
ii. Director of Employee Benefits.
iii. Employee Benefits Department employees.
iv. Information Technology Department.

b. The access to and use of PHI by the individuals identified above shall be restricted to the plan administration functions that the Plan Sponsor performs for the Plan.

Disclosure of Summary Health Information to the Plan Sponsor

The Plan may disclose PHI to the Plan Sponsor of the group health plan for purposes of plan administration or pursuant to an authorization request signed by the Participant. The Plan may use or disclose "summary health information" to the Plan Sponsor for obtaining premium bids or modifying, amending, or terminating the group health plan. "Summary health information" may be individually identifiable health information and it summarizes the claims history, claims expenses or the type of claims experienced by individuals in the plan, but it excludes all identifiers that must be removed for the information to be de-identified, except that it may contain geographic information to the extent that it is aggregated by five-digit zip code.

Disclosure of Certain Enrollment Information to the Plan Sponsor

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

Disclosure of PHI to Obtain Stop-loss or Excess Loss Coverage

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

Resolution of Noncompliance

In the event that any authorized individual of the Employer's workforce uses or discloses Protected Health Information other than as permitted by the Privacy Standards, the incident shall be reported to the Privacy Officer. The Privacy Officer shall take appropriate action, including:

1. Investigation of the incident to determine whether the breach occurred inadvertently, through negligence, or deliberately; whether there is a pattern of breaches; and the degree of harm caused by the breach.
2. Applying appropriate sanctions against the persons causing the breach, which, depending upon the nature of the breach, may include oral or written reprimand, additional training, or termination of employment.
3. Mitigating any harm caused by the breach, to the extent practicable.
4. Documentation of the incident and all actions taken to resolve the issue and mitigate any damages.
5. Training Employees in privacy protection requirements and appoint a Privacy Officer responsible for such protections.
6. Disclosing the Participant's PHI to the Secretary of the U.S. Department of Health and Health and Human Resources when the Secretary is investigating or determining the Plan's compliance with the HIPAA Privacy Rule.

PARTICIPANT'S RIGHTS

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

Receive Information About the Plan and Benefits

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

Obtain, upon written request to the Plan 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 Participant with a copy of this summary annual report.

Continue Group Health Plan Coverage

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

Prudent Actions by Plan Fiduciaries

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

Enforce the Participant's Rights

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

and legal fees. If the Participant is successful, the court may order the person the Participant sued to pay these costs and fees. If the Participant loses, the court may order the Participant to pay these costs and fees, for example, if it finds the Participant's claim is frivolous.

Assistance with the Participant's Questions

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

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

Cedarbridge Financial Services complies with applicable Federal civil rights laws and does not discriminate on the basis of race, color, national origin, age, disability, or sex. Cedarbridge Financial Services does not exclude people or treat them differently because of race, color, national origin, age, disability, or sex.

Cedarbridge Financial Services:

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

If a Participant needs these services, he or she should contact Human Resources.

If a Participant believes that Cedarbridge Financial Services has failed to provide these services or discriminated in another way on the basis of race, color, national origin, age, disability, or sex, he or she can file a grievance with:

Title: Human Resources
1608 Route 88, Suite 301
Brick, NJ 08724
1-732-903-1900

The Participant can file a grievance in person or by mail, fax, or email. If a Participant needs help filing a grievance, Human Resources is available to help him or her.

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

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

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

Appendix B

Code	Code Description	Code Category
70544	MRA Head without contrast	MRA
70545	MRA Head with contrast	MRA
70546	MRA Head with & without contrast	MRA
70547	MRA Neck without contrast	MRA
70548	MRA Neck with contrast	MRA
70549	MRA Neck with & without contrast	MRA
70551	MRI Brain without contrast	MRI
70552	MRI Brain with contrast	MRI
70553	MRI Brain with & without contrast	MRI
72141	MRI Cervical Spine without contrast	MRI
72142	MRI Cervical Spine with contrast	MRI
72146	MRI Thoracic Spine without contrast	MRI
72147	MRI Thoracic Spine with contrast	MRI
72148	MRI Lumbar Spine without contrast	MRI
72149	MRI Lumbar Spine with contrast	MRI
72156	MRI Cervical Spine with & without contrast	MRI
72157	MRI Thoracic Spine with & without contrast	MRI
72158	MRI Lumbar Spine with & without contrast	MRI
75557	Cardiac magnetic resonance imaging for morphology and function without contrast material;	MRI
75559	Cardiac magnetic resonance imaging for morphology and function without contrast material; with stress imaging	MRI
75561	Cardiac magnetic resonance imaging for morphology and function without contrast material(s), followed by contrast material(s) and further sequences	MRI
75563	Cardiac magnetic resonance imaging for morphology and function without contrast material(s), followed by contrast material(s) and further sequences; with stress imaging	MRI
75571	Computed tomography, heart, without contrast material, with quantitative evaluation of coronary calcium	CT
75574	Computed tomographic angiography, heart, coronary arteries and bypass grafts (when present), with contrast material, including 3D image postprocessing	CTA
78429	Myocardial imaging, positron emission tomography (PET), metabolic evaluation study (including ventricular wall motion[s] and/or ejection fraction[s], when performed), single study; with concurrently acquired computed tomography transmission scan	PET
78430	Myocardial imaging, positron emission tomography (PET), perfusion study (including ventricular wall motion[s] and/or ejection fraction[s], when performed); single study, at rest or stress (exercise or pharmacologic), with concurrently acquired computed tomography transmission scan	PET
78431	Myocardial imaging, positron emission tomography (PET), perfusion study (including ventricular wall motion[s] and/or ejection fraction[s], when performed); multiple studies at rest and stress (exercise or pharmacologic), with concurrently acquired computed tomography transmission scan	PET
78432	Myocardial imaging, positron emission tomography (PET), combined perfusion with metabolic evaluation study (including ventricular wall motion[s] and/or ejection fraction[s], when performed), dual radiotracer (eg, myocardial viability);	PET
78433	Myocardial imaging, positron emission tomography (PET), combined perfusion with metabolic evaluation study (including ventricular wall motion[s] and/or ejection fraction[s], when performed), dual radiotracer (eg, myocardial viability); with concurrently acquired computed tomography transmission scan	PET
78459	Myocardial imaging, positron emission tomography (PET), metabolic evaluation	PET
78491	Myocardial imaging, positron emission tomography (PET), perfusion; single study at rest or stress	PET
78492	Myocardial PET, perfusion mulitple studies at rest or stress	PET
78608	Brain PET, metabolic	PET
78609	Brain PET, perfusion	PET
78811	PET limited area (head, neck, chest)	PET
78812	PET Skull base to mid-thigh	PET
78813	PET whole Body	PET
78814	PET with CT, limited area (head, neck, chest)	PET
78815	PET with CT, Skull base to mid-thigh	PET
78816	PET with CT, whole Body	PET
81162	BRCA1, BRCA2 gene analysis	Gen Testing for Breast/Ovar Ca
81163-81167	BRCA1, BRCA2 gene analysis	Gen Testing for Breast/Ovar Ca

Appendix B

81211-81215	BRCA1, BRCA2 gene analysis	Gen Testing for Breast/Ovar Ca
81216-81217	BRCA1, BRCA2 gene analysis	Gen Testing for Breast/Ovar Ca
81321-81323	PTEN (phosphatase and tensin homolog) gene analysis	Gen Testing for PTEN
81324-81326	PMP22 (peripheral myelin protein 22)	Gen Testing for Inher Periph Neuro
81432-81433	Hereditary breast cancer-related disorders gene analysis	Gen Testing for Breast/Ovar Ca
81440	Nuclear encoded mitochondrial genes	Gen Testing for Inher Periph Neuro
81445	Targeted genomic sequence analysis panel	Gen Testing for Breast/Ovar Ca
81448	Hereditary peripheral neuropathies genomic sequence analysis	Gen Testing for Inher Periph Neuro
81455	Targeted genomic sequence analysis panel	Gen Testing for Breast/Ovar Ca
90283	Immune globulin, (IgIV), human, for intravenous use	Immune globulin

Appendix C – Outpatient and Home Dialysis Benefit Guide

A. The Summary of Benefits has been amended to provide as follows:

Covered Medical Expenses	Outpatient Facility and Home Dialysis
Dialysis Treatment (Outpatient and Home)	100% of the Usual and Reasonable Charge after all applicable copays, deductibles, and/or coinsurance. **NOTE: Outpatient and Home Dialysis Treatment claims are subject to specific conditions which do not apply to other types of claims.**

B. Description of Benefit

This Outpatient and Home Dialysis Benefit Guide is part of the Cedarbridge Financial Services Employee Medical Benefit Plan ("Plan"), a group health benefits plan sponsored by Cedarbridge Financial Services ("Sponsor"). It is intended to describe the specific benefits available for reimbursement of outpatient dialysis and home dialysis, and the administration of outpatient dialysis claims, under the Plan. This is called the Outpatient and Home Dialysis Program and the effective date is January 1, 2024.

The general terms and conditions for eligibility, coverage and administration of the Plan are described in the Summary Plan Description ("SPD") for the Plan. This Outpatient and Home Dialysis Benefit Guide is incorporated by reference into the SPD and shall be deemed a part of the SPD. Please refer to the SPD for important information about the general terms and conditions of the Plan.

I. Description of Outpatient and Home Dialysis Benefits

All individuals eligible for benefits under the Plan ("Participants") are eligible for outpatient and home dialysis benefits, as described in this Summary and in the general terms and conditions described in the SPD. "Outpatient or Home dialysis" means dialysis provided in a health care facility, such as a dialysis center, where the patient is not admitted for overnight or longer-term care or in the home setting.

The deductibles, copayments and other cost-shares required for outpatient services described in the SPD apply. There is no outpatient dialysis provider network and the Dialysis Program does not distinguish between in-network and out-of-network providers or require Participants and Beneficiaries to use any particular provider.

Outpatient and home dialysis benefits are summarized in the following table:

Covered Medical Expenses	Outpatient Facility and Home Dialysis
Dialysis Treatment (Outpatient and home)	100% of the Usual and Reasonable Charge after all applicable deductibles and coinsurance. **NOTE: Outpatient and home Dialysis Treatment claims are subject to specific conditions which do not apply to other types of claims.**

a. **Maximum Benefit**. The maximum benefit payable for Claims subject to this Plan Document shall be the Usual and Reasonable Charge for covered services and/or supplies, after deduction of all amounts payable by coinsurance or deductibles ("U&R Rate"), subject to discretionary adjustment by the Plan based upon consideration of appropriate factors specific to a Claim or Claims.

b. **U&R Rate Determination.** The U&R Rate shall be determined based upon the average payment actually made for reasonably comparable services and/or supplies to all providers of the same services and/or supplies by all types of plans in the applicable market during the preceding calendar year, based upon reasonably available data, adjusted for the state Consumer Price Index medical care rate of inflation. The Plan may increase or decrease the payment based upon factors concerning the nature and severity of the condition being treated for purposes of the Claim or Claims in question, or other factors materially affecting the cost of such services or products specific to the Claim or Claims in question, where supported by appropriate information.

c. **Additional Information Relevant to Rates.** A Claimant, may provide information with respect to the applicable market for dialysis products and services, the comparability of amounts claimed to amounts claimed against or paid by governmental and commercial health plans in the same market, and dialysis provider profits attributable to non-governmental and non-commercial health plans in the same market, factors concerning the nature and severity of the condition being treated in comparison to other cases involving the same condition, or other factors materially affecting the cost of services or products subject to the Claim, and with respect to other matters to the extent permitted by law, on appeal of the denial of any Claim or Claims. In the event the Plan determines that such information demonstrates that the payment for the Claim or Claims was not based on accurate or complete information, or that factors specific to the Claim or Claims have materially affected the costs of services or products included in the Claim or Claims, the Plan shall increase or decrease the payments (as applicable) as appropriate, as determined by the Plan based upon credible information from identified sources. The Plan may, but is not required to, review additional information from third-party sources in making this determination.

II. Dialysis Program Claims and Appeals.

Outpatient and home dialysis claims and appeals follow the Plan guidelines outlined in the remaining provision of the SPD.

Premium Assistance Under Medicaid and the Children's Health Insurance Program (CHIP)

If you or your children are eligible for Medicaid or CHIP and you're eligible for health coverage from your employer, your state may have a premium assistance program that can help pay for coverage, using funds from their Medicaid or CHIP programs. If you or your children aren't eligible for Medicaid or CHIP, you won't be eligible for these premium assistance programs but you may be able to buy individual insurance coverage through the Health Insurance Marketplace. For more information, visit **www.healthcare.gov**.

If you or your dependents are already enrolled in Medicaid or CHIP and you live in a State listed below, contact your State Medicaid or CHIP office to find out if premium assistance is available.

If you or your dependents are NOT currently enrolled in Medicaid or CHIP, and you think you or any of your dependents might be eligible for either of these programs, contact your State Medicaid or CHIP office or dial **1-877-KIDS NOW** or **www.insurekidsnow.gov** to find out how to apply. If you qualify, ask your state if it has a program that might help you pay the premiums for an employer-sponsored plan.

If you or your dependents are eligible for premium assistance under Medicaid or CHIP, as well as eligible under your employer plan, your employer must allow you to enroll in your employer plan if you aren't already enrolled. This is called a "special enrollment" opportunity, and **you must request coverage within 60 days of being determined eligible for premium assistance**. If you have questions about enrolling in your employer plan, contact the Department of Labor at **www.askebsa.dol.gov** or call **1-866-444-EBSA (3272)**.

If you live in one of the following states, you may be eligible for assistance paying your employer health plan premiums. The following list of states is current as of July 31, 2023. Contact your State for more information on eligibility –

ALABAMA – Medicaid	ALASKA – Medicaid
Website: http://myalhipp.com/ Phone: 1-855-692-5447	The AK Health Insurance Premium Payment Program Website: http://myakhipp.com/ Phone: 1-866-251-4861 Email: CustomerService@MyAKHIPP.com Medicaid Eligibility: https://health.alaska.gov/dpa/Pages/default.aspx
ARKANSAS – Medicaid	**CALIFORNIA – Medicaid**
Website: http://myarhipp.com/ Phone: 1-855-MyARHIPP (855-692-7447)	Health Insurance Premium Payment (HIPP) Program Website: http://dhcs.ca.gov/hipp Phone: 916-445-8322 Fax: 916-440-5676 Email: hipp@dhcs.ca.gov
COLORADO – Health First Colorado (Colorado's Medicaid Program) & Child Health Plan Plus (CHP+)	**FLORIDA – Medicaid**
Health First Colorado Website: https://www.healthfirstcolorado.com/ Health First Colorado Member Contact Center: 1-800-221-3943/State Relay 711 CHP+: https://hcpf.colorado.gov/child-health-plan-plus CHP+ Customer Service: 1-800-359-1991/State Relay 711 Health Insurance Buy-In Program (HIBI): https://www.mycohibi.com/ HIBI Customer Service: 1-855-692-6442	Website: https://www.flmedicaidtplrecovery.com/flmedicaidtplrecovery.com/hipp/index.html Phone: 1-877-357-3268

GEORGIA – Medicaid	INDIANA – Medicaid
GA HIPP Website: https://medicaid.georgia.gov/health-insurance-premium-payment-program-hipp Phone: 678-564-1162, Press 1 GA CHIPRA Website: https://medicaid.georgia.gov/programs/third-party-liability/childrens-health-insurance-program-reauthorization-act-2009-chipra Phone: 678-564-1162, Press 2	Healthy Indiana Plan for low-income adults 19-64 Website: http://www.in.gov/fssa/hip/ Phone: 1-877-438-4479 All other Medicaid Website: https://www.in.gov/medicaid/ Phone: 1-800-457-4584
IOWA – Medicaid and CHIP (Hawki)	**KANSAS – Medicaid**
Medicaid Website: https://dhs.iowa.gov/ime/members Medicaid Phone: 1-800-338-8366 Hawki Website: http://dhs.iowa.gov/Hawki Hawki Phone: 1-800-257-8563 HIPP Website: https://dhs.iowa.gov/ime/members/medicaid-a-to-z/hipp HIPP Phone: 1-888-346-9562	Website: https://www.kancare.ks.gov/ Phone: 1-800-792-4884 HIPP Phone: 1-800-967-4660
KENTUCKY – Medicaid	**LOUISIANA – Medicaid**
Kentucky Integrated Health Insurance Premium Payment Program (KI-HIPP) Website: https://chfs.ky.gov/agencies/dms/member/Pages/kihipp.aspx Phone: 1-855-459-6328 Email: KIHIPP.PROGRAM@ky.gov KCHIP Website: https://kidshealth.ky.gov/Pages/index.aspx Phone: 1-877-524-4718 Kentucky Medicaid Website: https://chfs.ky.gov/agencies/dms	Website: www.medicaid.la.gov or www.ldh.la.gov/lahipp Phone: 1-888-342-6207 (Medicaid hotline) or 1-855-618-5488 (LaHIPP)
MAINE – Medicaid	**MASSACHUSETTS – Medicaid and CHIP**
Enrollment Website: https://www.mymaineconnection.gov/benefits/s/?language=en_US Phone: 1-800-442-6003 TTY: Maine relay 711 Private Health Insurance Premium Webpage: https://www.maine.gov/dhhs/ofi/applications-forms Phone: 1-800-977-6740 TTY: Maine relay 711	Website: https://www.mass.gov/masshealth/pa Phone: 1-800-862-4840 TTY: 711 Email: masspremassistance@accenture.com
MINNESOTA – Medicaid	**MISSOURI – Medicaid**
Website: https://mn.gov/dhs/people-we-serve/children-and-families/health-care/health-care-programs/programs-and-services/other-insurance.jsp Phone: 1-800-657-3739	Website: http://www.dss.mo.gov/mhd/participants/pages/hipp.htm Phone: 573-751-2005
MONTANA – Medicaid	**NEBRASKA – Medicaid**
Website: http://dphhs.mt.gov/MontanaHealthcarePrograms/HIPP Phone: 1-800-694-3084 Email: HHSHIPPProgram@mt.gov	Website: http://www.ACCESSNebraska.ne.gov Phone: 1-855-632-7633 Lincoln: 402-473-7000 Omaha: 402-595-1178

NEVADA – Medicaid	NEW HAMPSHIRE – Medicaid
Medicaid Website: http://dhcfp.nv.gov Medicaid Phone: 1-800-992-0900	Website: https://www.dhhs.nh.gov/programs-services/medicaid/health-insurance-premium-program Phone: 603-271-5218 Toll free number for the HIPP program: 1-800-852-3345, ext. 5218
NEW JERSEY – Medicaid and CHIP	**NEW YORK – Medicaid**
Medicaid Website: http://www.state.nj.us/humanservices/dmahs/clients/medicaid/ Medicaid Phone: 609-631-2392 CHIP Website: http://www.njfamilycare.org/index.html CHIP Phone: 1-800-701-0710	Website: https://www.health.ny.gov/health_care/medicaid/ Phone: 1-800-541-2831
NORTH CAROLINA – Medicaid	**NORTH DAKOTA – Medicaid**
Website: https://medicaid.ncdhhs.gov/ Phone: 919-855-4100	Website: https://www.hhs.nd.gov/healthcare Phone: 1-844-854-4825
OKLAHOMA – Medicaid and CHIP	**OREGON – Medicaid**
Website: http://www.insureoklahoma.org Phone: 1-888-365-3742	Website: http://healthcare.oregon.gov/Pages/index.aspx Phone: 1-800-699-9075
PENNSYLVANIA – Medicaid and CHIP	**RHODE ISLAND – Medicaid and CHIP**
Website: https://www.dhs.pa.gov/Services/Assistance/Pages/HIPP-Program.aspx Phone: 1-800-692-7462 CHIP Website: Children's Health Insurance Program (CHIP) (pa.gov) CHIP Phone: 1-800-986-KIDS (5437)	Website: http://www.eohhs.ri.gov/ Phone: 1-855-697-4347, or 401-462-0311 (Direct RIte Share Line)
SOUTH CAROLINA – Medicaid	**SOUTH DAKOTA - Medicaid**
Website: https://www.scdhhs.gov Phone: 1-888-549-0820	Website: http://dss.sd.gov Phone: 1-888-828-0059
TEXAS – Medicaid	**UTAH – Medicaid and CHIP**
Website: Health Insurance Premium Payment (HIPP) Program | Texas Health and Human Services Phone: 1-800-440-0493	Medicaid Website: https://medicaid.utah.gov/ CHIP Website: http://health.utah.gov/chip Phone: 1-877-543-7669
VERMONT– Medicaid	**VIRGINIA – Medicaid and CHIP**
Website: Health Insurance Premium Payment (HIPP) Program | Department of Vermont Health Access Phone: 1-800-250-8427	Website: https://coverva.dmas.virginia.gov/learn/premium-assistance/famis-select https://coverva.dmas.virginia.gov/learn/premium-assistance/health-insurance-premium-payment-hipp-programs Medicaid/CHIP Phone: 1-800-432-5924
WASHINGTON – Medicaid	**WEST VIRGINIA – Medicaid and CHIP**
Website: https://www.hca.wa.gov/ Phone: 1-800-562-3022	Website: https://dhhr.wv.gov/bms/ http://mywvhipp.com/ Medicaid Phone: 304-558-1700 CHIP Toll-free phone: 1-855-MyWVHIPP (1-855-699-8447)

WISCONSIN – Medicaid and CHIP	WYOMING – Medicaid
Website: https://www.dhs.wisconsin.gov/badgercareplus/p-10095.htm Phone: 1-800-362-3002	Website: https://health.wyo.gov/healthcarefin/medicaid/programs-and-eligibility/ Phone: 1-800-251-1269

To see if any other states have added a premium assistance program since July 31, 2023, or for more information on special enrollment rights, contact either:

U.S. Department of Labor
Employee Benefits Security Administration
www.dol.gov/agencies/ebsa
1-866-444-EBSA (3272)

U.S. Department of Health and Human Services
Centers for Medicare & Medicaid Services
www.cms.hhs.gov
1-877-267-2323, Menu Option 4, Ext. 61565

Paperwork Reduction Act Statement

According to the Paperwork Reduction Act of 1995 (Pub. L. 104-13) (PRA), no persons are required to respond to a collection of information unless such collection displays a valid Office of Management and Budget (OMB) control number. The Department notes that a Federal agency cannot conduct or sponsor a collection of information unless it is approved by OMB under the PRA, and displays a currently valid OMB control number, and the public is not required to respond to a collection of information unless it displays a currently valid OMB control number. See 44 U.S.C. 3507. Also, notwithstanding any other provisions of law, no person shall be subject to penalty for failing to comply with a collection of information if the collection of information does not display a currently valid OMB control number. See 44 U.S.C. 3512.

The public reporting burden for this collection of information is estimated to average approximately seven minutes per respondent. Interested parties are encouraged to send comments regarding the burden estimate or any other aspect of this collection of information, including suggestions for reducing this burden, to the U.S. Department of Labor, Employee Benefits Security Administration, Office of Policy and Research, Attention: PRA Clearance Officer, 200 Constitution Avenue, N.W., Room N-5718, Washington, DC 20210 or email ebsa.opr@dol.gov and reference the OMB Control Number 1210-0137.

OMB Control Number 1210-0137 (expires 1/31/2026)

APPENDIX E

Cedarbridge Financial Services
Employee Benefit Summary – High SPP Plan (Plan D)
Network: National (BlueCard PPO) Network
Effective Date: 01/01/2024

Benefit	In-Network	Out-Of-Network
[illegible]	[illegible] 1[illegible]750 [illegible] 3[illegible]500	[illegible]
[illegible]	N[illegible]A	N[illegible]A
[illegible] – [illegible]	[illegible]	N[illegible]A
[illegible] – INN [illegible]	N[illegible]A – [illegible]	
[illegible]	20[illegible]	N[illegible]A
[illegible]	[illegible] 5[illegible]500 [illegible] 11[illegible]000	N[illegible]A
[illegible] – [illegible]	[illegible]	N[illegible]A
[illegible] – INN [illegible]	N[illegible]A – [illegible]	
[illegible]	[illegible]	N[illegible]A
[illegible]	[illegible]	1[illegible]1 [illegible]12[illegible]31

Savings Plus Plan benefit payment pricing of 150% of the Medicare Allowable rate applies to the following In-Network services: [illegible]

If an Out-Of-Network provider is used for these services, with the exception of Emergency Medical services and Emergency Transportation, plan payment will be based on 120% of the Medicare allowable rate.

Preventive Medical Services

Benefit	In-Network	Out-Of-Network
[illegible]	[illegible]	[illegible]
[illegible]	[illegible]	[illegible]
[illegible]	[illegible]	[illegible]
[illegible]	[illegible]	[illegible]
[illegible]	[illegible]	[illegible]
[illegible]	[illegible]	[illegible]
[illegible]	[illegible]	[illegible]
[illegible]	[illegible]	[illegible]
[illegible] – 1 [illegible] 40 [illegible]	[illegible]	[illegible]

Cedarbridge Financial Services
Employee Benefit Summary – High SPP Plan (Plan D)
Network: National (BlueCard PPO) Network
Effective Date: 01/01/2024

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Non-Preventive Medical Services

Members and/or providers must contact Payer Matrix for assistance for infusions and injections being done in an office or outpatient setting. To reach Payer Matrix for assistance at 1-877-305-6202 9am - 8pm EST M-F.

Benefit	In-Network		Out-Of-Network
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Non-Preventive Lab and Radiology

Benefit	In-Network		Out-Of-Network
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Inpatient Services

Benefit	In-Network	Out-Of-Network
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Cedarbridge Financial Services
Employee Benefit Summary – High SPP Plan (Plan D)
Network: National (BlueCard PPO) Network
Effective Date: 01/01/2024

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Cedarbridge Financial Services
Employee Benefit Summary – High SPP Plan (Plan D)
Network: National (BlueCard PPO) Network
Effective Date: 01/01/2024

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Cedarbridge Financial Services
Employee Benefit Summary – High SPP Plan (Plan D)
Network: National (BlueCard PPO) Network
Effective Date: 01/01/2024

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Cedarbridge Financial Services
Employee Benefit Summary – High SPP Plan (Plan D)
Network: National (BlueCard PPO) Network
Effective Date: 01/01/2024

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[illegible] – [illegible]	**Professional Non-Facility based Services:** [illegible]	**Facility based Services:** [illegible] *Savings Plus Plan Benefit*	[illegible]
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Transplant Services
Center of Excellence Locations Only

Benefit	In-Network	Out-Of-Network
[illegible]	20% [illegible]	[illegible]
[illegible]	20% [illegible]	[illegible]
[illegible] – [illegible]	20% [illegible]	[illegible]
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Cedarbridge Financial Services
Employee Benefit Summary – High SPP Plan (Plan D)
Network: National (BlueCard PPO) Network
Effective Date: 01/01/2024

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Prescription Drug Benefits Carelon Rx or 1-833-271-2374 www.carelonrx.com		
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Preauthorization (Health Link: 1-877-284-0102)

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Inpatient Services:	Outpatient Services	Other Services:
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Cedarbridge Financial Services
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APPENDIX F

Cedarbridge Financial Services
Employee Benefit Summary – Low SPP Plan (Plan E)
Network: National (BlueCard PPO) Network
Effective Date: 01/01/2024

Benefit	In-Network		Out-Of-Network
Plan Deductible	Individual: $2,500 Family: $5,000		Not Covered
[illegible] Deductible	N/A		N/A
Deductible – [illegible]	Embedded		N/A
Deductible – INN and OON [illegible]	N/A – No Out-Of-Network Coverage		
Member Coinsurance	30%		N/A
Out-of-Pocket Maximum	Individual: $7,500 Family: $15,000		N/A
Out-of-Pocket – [illegible]	Embedded		N/A
Out-of-Pocket – INN and OON [illegible]	N/A – No Out-Of-Network Coverage		
Annual Benefit Maximum	Unlimited		N/A
Benefit Period	Calendar Year	1/1 – 12/31	

Savings Plus Plan benefit payment pricing of 150% of the Medicare Allowable rate applies to the following In-Network services: [illegible]
If an Out-Of-Network provider is used for these services, with the exception of Emergency Medical services and Emergency Transportation, plan payment will be based on 120% of the Medicare allowable rate.

Preventive Medical Services

Benefit	In-Network	Out-Of-Network
Primary Care Physician Visits Adult Routine Physical: 1 visit per plan year	No Charge (Deductible Waived)	Not Covered
Pediatric Well Child Care: Up to age 2: 9 visits per plan year Age 2 – 2 visits per plan year Age 3 and over – 1 visit per plan year	No Charge (Deductible Waived)	Not Covered
Children's Eye Exam	No Charge (Deductible Waived)	Not Covered
[illegible] Adult Routine Physical: 1 visit per plan year	No Charge (Deductible Waived)	Not Covered
Maternity ACA Required Prenatal Preventive [illegible]	No Charge (Deductible Waived)	Not Covered
Routine Immunizations – Child & Adult	No Charge (Deductible Waived)	Not Covered
[illegible]	No Charge (Deductible Waived)	Not Covered
X-Ray and Lab Work (Routine)	No Charge (Deductible Waived)	Not Covered
Mammography (Routine) – 1 per plan year, Age 40 and over	No Charge (Deductible Waived)	Not Covered

Cedarbridge Financial Services
Employee Benefit Summary – Low SPP Plan (Plan E)
Network: National (BlueCard PPO) Network
Effective Date: 01/01/2024

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Non-Preventive Medical Services

Members and/or providers must contact Payer Matrix for assistance for infusions and injections being done in an office or outpatient setting. To reach Payer Matrix for assistance at 1-877-305-6202 9am - 8pm EST M-F.

Benefit	In-Network		Out-Of-Network
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Non-Preventive Lab and Radiology

Benefit	In-Network		Out-Of-Network
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Inpatient Services

Benefit	In-Network	Out-Of-Network
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Cedarbridge Financial Services
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Cedarbridge Financial Services
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Cedarbridge Financial Services
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Effective Date: 01/01/2024

Transplant Services **Center of Excellence Locations Only**		
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Prescription Drug Benefits **Carelon Rx or 1-833-271-2374 www.carelonrx.com**		
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Exclusions

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