PLAN DOCUMENT
AND SUMMARY PLAN DESCRIPTION

Minimum Essential Coverage with Four Office Visits

COMPANY NAME	Instant Care of AZ
EFFECTIVE DATE	4/1/2023
RESTATED DATE	

ASSURED BENEFITS ADMINISTRATORS

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SUMMARY PLAN DESCRIPTION

GENERAL PLAN INFORMATION

NAME OF PLAN: Instant Care of AZ

PLAN SPONSOR

Entity Name: Instant Care of AZ

Address:

Phone Number:

ID Number (EIN):

PLAN NUMBER

TYPE OF PLAN Welfare benefit plan — preventive care benefits

PLAN ADMINISTRATOR

Type of Administration: Contract administration — the processing of claims for benefits under the terms of the Plan is provided through a company contracted by the Employer and shall hereinafter be referred to as the Claims Processor

Named Fiduciary: Instant Care of AZ

Address:

Phone Number:

ELIGIBILITY REQUIREMENTS

For detailed information regarding a person's eligibility to participate in the Plan, refer to the following sections:

- Eligibility
- Enrollment
- Effective Date of Coverage

For detailed information regarding a person being ineligible for benefits through Termination of Coverage or Plan Exclusions, refer to the following sections:

- Schedule of Benefits
- Termination of Coverage
- Plan Exclusions

SOURCE OF PLAN CONTRIBUTIONS

Contributions for Plan expenses are obtained from the mployer and from the covered employees and their covered dependents. The employer evaluates the costs of the Plan based on projected Plan expenses and determines the amount to be contributed by the employer and the amount to be contributed by the covered employees.

FUNDING METHOD

The employer pays Plan benefits and administration expenses directly from general assets. Contributions received from covered persons are used to cover Plan costs and are expended immediately.

ENDING DATE OF PLAN YEAR

3/31/2024

PROCEDURES FOR FILING CLAIMS

For detailed information on how to submit a claim for benefits, or how to file an appeal on a processed claim, refer to the section entitled, Claim Filing Procedures.

The designated claims processor is:
Assured Benefits Administrators
Address: PO Box 211517, Eagan, MN 55121
Phone: (915) 532-2100 or (800) 247-7114

STATEMENT OF ERISA RIGHTS

As a participant in the Instant Care of AZ Minimum Essential Coverage Employee Benefit Plan the participant is entitled to certain rights and protections under the Employee Retirement Income Security Act of 1974 (ERISA). ERISA provides that all plan participants shall be 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, all documents governing the plan, including insurance contracts and collective bargaining agreements, and a copy 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, 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, spouse or dependents if there is a loss of coverage under the plan as a result of a qualifying event. The employee or his or her dependents may have to pay for such coverage. Review this summary plan description and the documents governing the plan on the rules governing the COBRA continuation coverage rights.

PRUDENT ACTIONS BY PLAN FIDUCIARIES

In addition to creating rights for plan participants ERISA imposes duties upon the people who are responsible for the operation of the employee benefit plan. The people who operate this plan, called "fiduciaries" of the plan, have a duty to do so prudently and in the interest of plan participants and beneficiaries. No one, including the employer, a union, 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 his or her rights under ERISA.

ENFORCE THE RIGHTS

If a claim for a welfare benefit is denied or ignored, in whole or in part, the covered person 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 a covered person can take to enforce the above rights. For instance, if the covered person requests a copy of plan documents or the latest annual report from the plan and does not receive them within thirty (30) days, the covered person 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 covered person up to one hundred ten dollars ($110) a day until the covered person receives the materials, unless the materials were not sent because of reasons beyond the control of the administrator. If the covered person has a claim for benefits which is denied or ignored, in whole or in part, he or she may file suit in a state or Federal court. In addition, if the covered person 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 covered person may file suit in Federal court. If it should happen that plan fiduciaries misuse the plan's money, or if the covered person is discriminated against for asserting his or her rights, they may seek assistance from the U.S. Department of Labor, or they may file suit in a Federal court. The court will decide who should pay court costs and legal fees. If the covered person is successful, the court may order the person they have sued to pay these costs and fees. If the covered person loses, the court may order them to pay these costs and fees, for example, if it finds the claim is frivolous.

ASSISTANCE WITH QUESTIONS

If the covered person has any questions about this plan, they should contact the plan administrator. If the covered person has any questions about this statement or about their rights under ERISA, or if they need assistance in obtaining documents from the plan administrator, they 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 covered person may also obtain certain publications about their rights and responsibilities under ERISA by calling the publications hotline of the Employee Benefits Security Administration.

CONFORMITY WITH APPLICABLE LAWS

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

HIPAA PRIVACY STATEMENT

USE AND DISCLOSURE OF PROTECTED HEALTH INFORMATION

The Plan will use protected health information (PHI) to the extent of an in accordance with the uses and disclosures permitted by the Health Insurance Portability and Accountability Act of 1996 (HIPAA). Specifically, the Plan will use and disclose PHI for purposes related to health care treatment, payment for health care and health care operations.

"Payment" includes activities undertaken by the Plan to obtain premiums or determine or fulfill its responsibility for coverage and provision of Plan benefits that relate to a covered person to whom health care is provided. These activities include, but are not limited to, the following:

1. Determination of eligibility, coverage and coinsurance amounts (for example, cost of a benefit or Plan maximums as determined for a covered person's claim);
2. Coordination of benefits;
3. Adjudication of health benefit claims (including appeals and other payment disputes);
4. Subrogation of health benefit claims;
5. Establishing employee contributions;
6. Risk adjusting amounts due based on enrollee health status and demographic characteristics;
7. Billing, collection activities and related health care data processing;
8. Claims management and related data processing, including auditing payments, investigating and resolving payment disputes and responding to participant inquiries about payments;
9. Obtaining payment under a contract for reinsurance (including stop-loss and excess loss insurance);
10. Medical necessity reviews or reviews of appropriateness of care or justification of charges;
11. Disclosure to consumer reporting agencies related to the collection of premiums or reimbursement; and
12. Reimbursement to the Plan.

"Health Care Operations" include, but are not limited to, the following activities:

1. Quality assessment;
2. Population-based activities related to improving health or reducing health care costs, protocol development, case management and care coordination, disease management, contacting health care providers and patients with information about treatment alternatives and related functions;
3. Rating provider and Plan performance, including accreditation, certification, licensing or credentialing activities;
4. Underwriting, premium rating and other activities relating to the creation, renewal or replacement of a contract of health insurance or health benefits, and creating, securing or placing a contract for reinsurance of risk relating to health care claims (including stop-loss insurance and excess loss insurance);
5. Conducting or arranging for medical review, legal services and auditing functions, including fraud and abuse detection and compliance programs;
6. Business planning and development, such as conducting cost-management and planning-related analyses related to managing and operating the Plan, including formulary development and administration, development or improvement of payment methods or coverage policies;
7. Business management and general administrative activities of the Plan, including, but not limited to:
    a. management activities relating to the implementation of and compliance with HIPAA's administrative simplification requirements; or
    b. customer service, including the provision of data analysis for policyholders, plan sponsors or other customers;
8. Resolution of internal grievances.

THE PLAN WILL USE AND DISCLOSE PHI TO THE PLAN ADMINISTRATOR AND AS REQUIRED BY LAW AND AS PERMITTED BY AUTHORIZATION OF THE COVERED PERSON

With an authorization, the Plan will disclose PHI to other health benefit plans, health insurance issuers or HMOs for purposes related to the administration of these plans. The Plan will disclose PHI to the Plan administrator only upon receipt of a certification from the Plan administrator that the Plan documents have been amended to incorporate the following provisions.

WITH RESPECT TO PHI, THE PLAN ADMINISTRATOR AGREES TO CERTAIN CONDITIONS

The Plan administrator agrees to:

1. Not use or further disclose PHI other than as permitted or required by the Plan document or as required by law;
2. Ensure that any agents, including a subcontractor, to whom the Plan administrator provides PHI received from the Plan agree to the

same restrictions and conditions that apply to the Plan administrator with respect to such PHI;

3. Not use or disclose PHI for employment-related actions and decisions unless authorized by a covered person;
4. Not use or disclose PHI in connection with any other benefit or employee benefit plan of the Plan administrator unless authorized by the covered person;
5. Report to the Plan any PHI use or disclosure that is inconsistent with the uses or disclosures provided for of which it becomes aware;
6. Make PHI available to a covered person in accordance with HIPAA's access requirements;
7. Make PHI available for amendment and incorporate any amendments to PHI in accordance with HIPAA;
8. Make available the information required to provide an accounting of disclosures;
9. Make internal practices, books and records relating to the use and disclosure of PHI received from the Plan available to the Health and Human Services Secretary for the purpose of determining the Plan's compliance with HIPAA;
10. If feasible, return or destroy all PHI received from the Plan that the Plan administrator still maintains in any form, and retain no copies of such PHI when no longer needed for the purpose for which disclosure was made (or if return or destruction is not feasible, limit further uses and disclosures to those purposes that make the return or destruction infeasible); and
11. Reasonably and appropriately safeguard electronic PHI created, received, maintained or transmitted to or by the Plan administrator on behalf of the Plan. Specifically, such safeguarding entails an obligation to:
    a. Implement administrative, physical and technical safeguards that reasonably and appropriately protect the confidentiality, integrity and availability of the electronic PHI that the Plan administrator creates, receives, maintains or transmits on behalf of the Plan;
    b. Ensure that the adequate separation as required by 45 C.F.R. 164-504(f)(20(iii) is supported by reasonable and appropriate security measures;
    c. Ensure that any agent, including a subcontractor, to whom it provides this information agrees to implement reasonable and appropriate security measures to protect the information; and
    d. Report to the Plan any security incident of which it becomes aware.

To client – this paragraph may need to be modified depending on who will have access to PHI at the employer:

SEPARATION BETWEEN PLAN ADMINISTRATOR AND PLAN

The following employees or classes of employees under the control of the Plan administrator may be given access to PHI by the Plan or a business associate servicing the Plan:

HUMAN RESOURCES

The employees who are included in this description will have access to PHI only to perform the administration functions that the Plan administrator provides to the Plan. Employees who violate this provision will be subject to sanction. The Plan administrator will promptly report any violation of this provision to the Plan and will cooperate with the Plan to remedy or mitigate the effect of such violation.

SCHEDULE OF BENEFITS

The following Schedule of Benefits is designed as a quick reference. For complete provisions of the Plan's benefits, refer to the following sections: Medical Expense Benefit, Plan Exclusions and Preferred Provider Organization.

COINSURANCE

The Plan pays the percentage listed on the following pages for covered expenses incurred by a covered person and obtained from a preferred provider during a calendar year

MEDICAL BENEFITS	Preferred Provider	Nonpreferred Provider
Preventive Care	100%	Not Covered
Immunizations	100%	130% of Medicare Allowable
Physician's Services: Office Visit (Maximum of 4 visits per calendar year)	Copayment of $10 (Copayment applies to office visit only)	Not Covered

PRESCRIPTION DRUG PROGRAM	Coverage	Limitations
Participating Pharmacy	Prescription Drug Card 100% for preventive prescriptions only	Limited to a 30-day supply
Nonparticipating Pharmacy	Not Covered	N/A
Mail Order	100% for preventive prescriptions only	Limited to a 90-day supply
Specialty Drugs	Not Covered	N/A

PROVIDERS (PREFERRED / NONPREFERRED)

Covered persons have the choice of using either a preferred provider or a nonpreferred provider.

PREFERRED PROVIDERS

A preferred provider is a physician or ancillary service provider which has an agreement in effect with the Preferred Provider Organization (PPO) to accept a reduced rate for services rendered to covered persons. This is known as the negotiated rate. The preferred provider cannot bill the covered person for any amount in excess of the negotiated rate. Covered persons should contact the Human Resources Department for a current listing of preferred providers.

NONPREFERRED PROVIDERS

A nonpreferred provider does not have an agreement in effect with the Preferred Provider Organization. No benefits are payable for the services of a nonpreferred provider.

REFERRALS

Referrals to a nonpreferred provider are not covered. It is the responsibility of the covered person to assure services to be rendered are performed by preferred providers in order to receive benefits.

MEDICAL EXPENSE BENEFIT

This section describes the covered expenses of the Plan. Any expenses incurred by the covered person for services supplies or treatment provided will not be considered covered expenses by this Plan if they are greater than the negotiated rate.

The covered expenses for services, supplies or treatment provided must be recommended by a physician or professional provider. Only specified preventive care expenses will be covered by this Plan.

PREVENTIVE CARE

Covered expenses shall include charges for include routine physical, prostate and gynecological examinations and services and supplies which are not required due to illness or injury payable as specified on the Schedule of Benefits.

The following are examples of current covered routine services. The Plan's benefits shall be based on the recommendations of the United State Preventive Services Task Force, the Advisory Committee on Immunization Practices of the Centers for Disease Control and Prevention, and Advisory Committee and the current Health Resources and Services Administration guidelines.

For a current listing of preventive services and procedures, please visit www.healthcare.gov/what-are-my-preventive-care-benefits/ or contact the claims processor.

COVERED PREVENTIVE SERVICES FOR ADULTS

1. **Abdominal Aortic Aneurysm.** One time screening for men of specified ages who have ever smoked.
2. **Alcohol Misuse.** Screening and counseling.
3. **Aspirin.** Use for men and women of certain ages.
4. **Blood Pressure,** Screening for all adults.
5. **Cholesterol.** Screening for adults of certain ages or at higher risk.
6. **Colorectal Cancer.** Screening for adults over age fifty (50).
7. **Depression.** Screening for adults.
8. **Type 2 Diabetes.** Screening for adults with high blood pressure.
9. **Diet.** Counseling for adults at higher risk for chronic disease.
10. **HIV.** Screening for all adults at higher risk.
11. **Immunization.** Vaccines for adults – doses and recommended populations vary:
    a. Hepatitis A
    b. Hepatitis B
    c. Herpes Zoster
    d. Human Papillomavirus
    e. Influenza (Flu Shot)
    f. Measles, Mumps, Rubella
    g. Meningoccal
    h. Pneumococcal
    i. Tetanus, Diphtheria, Pertussis
    j. Varicella
12. **Obesity.** Screening and counseling for adults.
13. **Sexually Transmitted Infection (STI).** Prevention counseling for adults at higher risk.
14. **Tobacco Use.** Screening for all adults and cessation interventions for tobacco users.
15. **Syphilis.** Screening for all adults at higher risk.

COVERED PREVENTIVE SERVICES FOR WOMEN, INCLUDING PREGNANT WOMEN

1. **Anemia.** Screening on a routine basis for pregnant women.
2. **Bacteriuria.** Urinary tract or other infection screening for pregnant women.
3. **BRCA.** Counseling about genetic testing for women at higher risk.
4. **Breast Cancer Mammography.** Screenings every one (1) to two (2) years for women over forty (40).
5. **Breast Cancer Chemoprevention.** Counseling for women at higher risk.
6. **Breast Feeding.** Comprehensive support and counseling from trained providers, as well as access to breastfeeding supplies, for pregnant and nursing women.
7. **Cervical Cancer.** Screenings for sexually active women.

8. **Chlamydia Infection.** Screening for younger women and other women at higher risk.
9. **Contraception.** Food and Drug Administration-approved contraceptive methods, sterilization procedures and patient education counseling, not including abortifacient drugs.
10. **Domestic and Interpersonal Violence.** Screening and counseling for all women.
11. **Folic Acid.** Supplements for women who may become pregnant.
12. **Gestational Diabetes.** Screening for women twenty-four (24) to twenty-eight (28) weeks pregnant and those at high risk of developing gestational diabetes.
13. **Gonorrhea.** Screening for all women at higher risk.
14. **Hepatitis B.** Screening for pregnant women at their first prenatal visit.
15. **Human Immunodeficiency Virus (HIV).** Screening and counseling for sexually active women.
16. **Human Papillomavirus (HPV) DNA Test.** High risk HPV DNA testing every three (3) years for women with normal cytology results who are thirty (30) or older.
17. **Osteoporosis.** Screening for women over sixty (60) depending on risk factors.
18. **Rh Incompatibility.** Screening for all pregnant women and follow-up testing for women at higher risk.
19. **Tobacco Use.** Screening and interventions for all women and expanded counseling for pregnant tobacco users.
20. **Sexually Transmitted Infections (STI).** Counseling for sexually active women.
21. **Syphilis.** Screening for all pregnant women or other women at increased risk.
22. **Well-Woman Visits.** To obtain recommended preventive services for women under sixty-five (65).

COVERED PREVENTIVE SERVICES FOR CHILDREN

1. **Alcohol and Drug Use.** Assessments for adolescents.
2. **Autism.** Screening for children at eighteen (18) and twenty-four (24) months of age.
3. **Behavioral.** Assessments for children of all ages.
4. **Blood Pressure.** Screening for children: Ages 1 to 11 months, 1 to 4 years, 5 to 10 years, 11 to 14 years, 15 to 17 years.
5. **Cervical Dysplasia.** Screening for sexually active females.
6. **Congenital Hypothyroidism.** Screening for newborns.
7. **Depression.** Screening for adolescents.
8. **Developmental.** Screening for children under age three (3), and surveillance throughout childhood.
9. **Dyslipidemia.** Screening for children at higher risk of lipid disorders – Ages 1 to 4 years, 5 to 10 years, 11 to 14 years, 15 to 17 years.
10. **Fluoride Chemoprevention.** Supplements for children without fluoride in their water source.
11. **Gonorrhea.** Preventive medication for the eyes of all newborns.
12. **Hearing.** Screening for all newborns through the age of thirty (30) days and diagnostic follow-up for children to age twenty-four (24) months.
13. **Height, Weight and Body Mass Index.** Measurements for children: Ages 0 to 11 months, 1 to 4 years, 5 to 10 years, 11 to 14 years, 15 to 17 years.
14. **Hematocrit or Hemoglobin.** Screening for children.
15. **Hemoglobinopathies.** Or sickle cell screening for newborns.
16. **HIV.** Screening for adolescents at higher risk.
17. **Immunization.** Vaccines for children from birth to age eighteen (18) – doses, recommended ages, and recommended populations vary:
    a. Diphtheria, Tetanus, Pertussis
    b. Haempphilus influenza type b
    c. Hepatitis A
    d. Hepatitis B
    e. Human Papillomavirus
    f. Inactivated Poliovirus
    g. Influenza (Flu Shot)
    h. Measles, Mumps, Rubella
    i. Meningococcal
    j. Pneumococcal
    k. Rotavirus
    l. Varicella
18. **Iron.** Supplements for children ages six (6) to twelve (12) months at risk for anemia.
19. **Lead.** Screening for children at risk of exposure.
20. **Medical History.** For all children throughout development: Ages 0 to 11 months, 1 to 4 years, 5 to 10 years, 11 to 14 years, 15 to 17 years.
21. **Obesity.** Screening and counseling.
22. **Oral Health.** Risk assessment for young children, Ages 0 to 11 months, 1 to 4 years, 5 to 10 years.
23. **Phenylketonuria (PKU).** Screening for this genetic disorder in newborns.
24. **Sexually Transmitted Infection (STI).** Prevention counseling for adolescents at high risk.

25. **Tuberculin.** Testing for children at higher risk of tuberculosis: Ages 0 to 11 months, 1 to 4 years, 5 to 10 years, 11 to 14 years, 15 to 17 years.
26. **Vision.** Screening for all children.

MEDICAL EXCLUSIONS

In addition to Plan Exclusions, no benefit will be provided under this Plan for medical expenses for the following:

1. Charges for routine or periodic physical examinations, such as screening examination, employment physical, or any related charges, such as premarital lab work, except as specified herein.
2. Charges for any services, supplies or treatment not specifically provided herein.

PLAN EXCLUSIONS

The Plan will not provide benefits for any of the items listed in this section, regardless of medical necessity or recommendation of a physician or professional provider.

1. Charges for services, supplies or treatment from any hospital owned or operated by the United States government or any agency thereof or any government outside the United States, or charges for services, treatment or supplies furnished by the United States government or any agency thereof or any government outside the United States, unless payment is legally required.
2. Charges for an injury sustained or illness contracted while on active duty in military service, unless payment is legally required.
3. Charges for services, supplies or treatment for treatment of illness or injury which is caused by or attributed to by war or any act of war, participation in a riot, civil disobedience or insurrection. "War" means declared or undeclared war, whether civil or international, or any substantial armed conflict between organized forces of a military nature.
4. Any condition for which benefits of any nature are recovered or are found to be recoverable, either by adjudication or settlement, under any Worker's Compensation law, Employer's liability law, or occupational disease law, even though the covered person fails to claim rights to such benefits or fails to enroll or purchase such coverage.
5. Charges to the extent that they exceed the negotiated rate.
6. To the extent that payment under this Plan is prohibited by any law of the jurisdiction in which the covered person resides at the time the expense is incurred.
7. Charges for services rendered and/or supplies received prior to the effective date or after the termination date of a person's coverage.
8. Any services, supplies or treatment for which the covered person is not legally required to pay; or for which no charge would usually be made; or for which such charge, if made, would not usually be collected if no coverage existed; or to the extent the charge for the care exceeds the charge that would have been made and collected if no coverage existed.
9. Charges incurred outside the United States if the covered person traveled to such a location for the sole purpose of obtaining services, supplies or treatment.
10. Charges for services, supplies or treatment rendered by any individual who is a close relative of the covered person or who resides in the same household as the covered person.
11. Charges for services, supplies or treatment rendered by physicians or professional providers beyond the scope of their license; for any treatment or service which is not recommended by or performed by an appropriate professional provider.
12. Claims not submitted within the Plan's filing limit deadlines as specified in Claim Filing Procedures.
13. Charges for e-mail or telephone consultations, completion of claim forms, charges associated with missed appointments.
14. This Plan will not pay for any charge which has been refused by another plan covering the covered person as a penalty assessed due to non-compliance with that plan's rules and regulations, if shown on the primary carrier's explanation of benefits.

ELIGIBILITY

This section identifies the Plan's requirements for a person to be eligible to enroll. Refer to Enrollment and Effective Date of Coverage for more information.

EMPLOYEE ELIGIBILITY

The following employees will be eligible for coverage under the Plan.

NEW HIRES

- **Regular Full-time Employees:** Employees designated by the employer as regular full-time employees.
- **Qualifying Part-time Employee:** Any other employees, including but not limited to seasonal employees, who are not regular full-time employees to the extent that such employees average 30 hours of service per week over the employee's applicable initial measurement period (as defined herein).

Note: if there is a gap between the end of the qualifying part-time employee's new employee stability period and the start of the qualifying part-time employee's first ongoing employee stability period (see below), the qualifying part-time employee will remain eligible under the Plan until the day preceding the start of the ongoing employee stability period to the extent the employee remains employed, subject to the Plan's break in service rules.

If a qualifying part-time employee transfers to a regular full-time employee position prior to the start of the qualifying part-time employee's new employee stability period, the employee will become eligible for coverage. If elected, coverage for such new regular full-time employee will become eligible as specified in Effective Date of Coverage.

"ONGOING" EMPLOYEES

Once an employee has completed the Plan's standard measurement period, eligibility will be based solely on the employee's hours of service during the Plan's standard measurement period. Any employee who averages 30 hours of service per week during the Plan's standard measurement period ("Ongoing Employees") will be eligible for coverage under the Plan during the Plan's next ongoing employee stability period to the extent that the ongoing employee remains employed, subject to the Plan's break in service rules. Such coverage, if elected, will be effective on the first day of the Plan's ongoing employee stability period.

Whether an employee averages 30 hours of service per week will be determined in accordance with policies and procedures adopted by the Plan administrator.

Impact of Breaks In Service

Any employee who resumes hours of service following a break in service (as defined herein) will be treated as a new hire and eligibility for coverage under the Plan upon return will be determined in accordance with the new hire rules above. If, however, the employee experiences a period without any hours of service, and resumes hours of service without experiencing a break in service, the employee will be treated as a continuous employee. A continuous employee resuming hours of service after a period with no hours of service that does not constitute a break in service will be eligible for coverage under the Plan upon return if they were enrolled in coverage prior to the start of the period with no hours of service. Such coverage will be effective on the first day of the month that coincides with or follows the date the employee resumes hours of service.

Retired employees may continue coverage by paying the applicable contribution for employee and/or dependent coverage. While the employer expects retiree coverage to continue, the employer reserves the right to modify or discontinue retiree coverage at any time.

DEPENDENT(S) ELIGIBILITY

The following describes dependent eligibility requirements. The employer will require proof of dependent status.

1. The term "spouse" means the spouse of the employee under a legally valid existing marriage, unless court ordered separation exists.
2. The term "child" means the employee's natural child, stepchild, legally adopted child, foster child, and a child for whom the employee has been appointed legal guardian, provided the child is less than twenty-six (26) years of age.
3. An eligible child shall also include any other child of an employee or their spouse who is recognized in a Qualified Medical Child Support Order (QMCSO) or National Medical Support Notice (NMSN) which has been issued by any court judgment, decree, or order as being entitled to enrollment for coverage under this Plan, even if the child is not residing in the employee's household. Such child shall be referred to as an alternate recipient. Alternate recipients are eligible for coverage regardless of whether the employee elects coverage for himself. An application for enrollment must be submitted to the employer for coverage under this Plan. The employer/plan administrator shall establish written procedures for determining whether a medical child support order is a QMCSO or NMSN and for administering the provision of benefits under the Plan pursuant to a valid QMCSO or NMSN. Within a reasonable period after receipt of a medical child support order, the employer/plan administrator shall determine whether such order is a Qualified Medical Child Support

Order (as defined in Section 609 of ERISA) or a National Medical Support Notice (NMSN) as defined in Section 401 of the Child Support Performance and Incentive Act of 1998. The employer/plan administrator reserves the right, waivable at its discretion, to seek clarification with respect to the order from the court or administrative agency which issued the order, up to and including the right to seek a hearing before the court or agency.

4. Adopted children, who are less than 18 years of age at the time of adoption, shall be considered eligible from the date the child is placed for adoption. "Placed for adoption" means the date the employee assumes legal obligation for the total or partial financial support of the child during the adoption process.
5. A child who is unmarried, incapable of self-sustaining employment, and dependent upon the employee for support due to a mental and/or physical disability, and who was covered under the Plan prior to reaching the maximum age limit or other loss of dependent's eligibility, will remain eligible for coverage under this Plan beyond the date coverage would otherwise be lost. Proof of incapacitation must be provided within thirty-one (31) days of the child's loss of eligibility and thereafter as requested by the employer or claims processor, but not more than once every two (2) years. Eligibility may not be continued beyond the earliest of the following:
    a. Cessation of the mental and/or physical disability;
    b. Failure to furnish any required proof of mental and/or physical disability or to submit to any required examination.

Every eligible employee may enroll eligible dependents. However, if both the husband and wife are employees, they may choose to have one covered as the employee, and the spouse covered as the dependent of the employee, or they may choose to have both covered as employees. Eligible children may be enrolled as dependents of one spouse, but not both.

ENROLLMENT

APPLICATION FOR ENROLLMENT

An employee must file a written application with the employer for coverage hereunder for himself and his eligible dependents within thirty (30) days of becoming eligible for coverage; and within thirty (30) days of marriage or the acquiring of children or birth of a child. The employee shall have the responsibility of timely forwarding to the employer all applications for enrollment hereunder.

The employer must be notified of any change in eligibility of dependents, including the birth of a child that is to be covered and adding or deleting any other dependents. Forms are available from the employer for reporting changes in dependents' eligibility as required.

SPECIAL ENROLLMENT PERIOD (OTHER COVERAGE)

An employee or dependent who did not enroll for coverage under this Plan because he was covered under other group coverage or had health insurance coverage at the time he was initially eligible for coverage under this Plan, may request a special enrollment period if he is no longer eligible for the other coverage. Special enrollment periods will be granted if the individual's loss of eligibility is due to:

1. Termination of the other coverage (including exhaustion of COBRA benefits)
2. Cessation of employer contributions toward the other coverage
3. Legal separation or divorce
4. Termination of other employment or reduction in number of hours of other employment
5. Death of covered person.
6. Moving out of an HMO service area.
7. A child losing dependent status.

The end of any extended benefits period which has been provided due to any of the above will also be considered a loss of eligibility.

However, loss of eligibility does not include a loss due to failure of the individual to pay premiums or contributions on a timely basis or termination of coverage for cause (such as making a fraudulent claim or an intentional misrepresentation of a material fact in connection with the other coverage.)

The employee or dependent must request the special enrollment and enroll no later than thirty (30) days from the date of loss of other coverage.

The effective date of coverage as the result of a special enrollment shall be the first day of the first calendar month following the Plan administrator's receipt of the completed enrollment form.

SPECIAL ENROLLMENT PERIOD (DEPENDENT ACQUISITION)

An employee who is not covered under the Plan, but who acquires a new dependent may request a special enrollment period. For the purposes of this provision, the acquisition of a new dependent includes:

- Marriage
- Birth of a dependent child
- Adoption or placement for adoption of a dependent child

The employee must request the special enrollment within thirty (30) days of the acquisition of the dependent.

The effective date of coverage as the result of a special enrollment shall be:

1. In the case of marriage, the first day of the first calendar month following the Plan administrator's receipt of the completed enrollment form;
2. In the case of a dependent's birth, the date of such birth;
3. In the case of adoption or placement for adoption, the date of such adoption or placement for adoption.

SPECIAL ENROLLMENT PERIOD (MEDICAID OR CHIP)

An employee or dependent that is otherwise eligible for coverage under this Plan, but not enrolled, may be eligible for a Special Enrollment Period if either of the following conditions is met:

1. The employee or dependent is covered under a Medicaid program under Title XIX of the Social Security Act or under a state child health plan (CHIP) under Title XXI of the Act, and coverage under such plan or program is terminated because the employee or dependent loses eligibility.
2. The employee or dependent is determined by the state to be eligible to receive contribution assistance from a Medicaid program or state child health plan, to pay for coverage under this Plan.

However, loss of eligibility does not include a loss of coverage for cause (such as making a fraudulent claim or an intentional misrepresentation of a material fact in connection with the other coverage.)

The employee or dependent must request the special enrollment and enroll no later than sixty (60) days from the date of termination of Medicaid or CHIP coverage or sixty (60) days from the date the individual is determined to be eligible for contribution assistance by the state of residence.

The effective date of coverage as the result of this type of special enrollment shall be the first day of the first calendar month following the Plan administrator's receipt of the completed enrollment form.

FREE OR LOW-COST HEALTH COVERAGE TO CHILDREN AND FAMILIES

If a covered person is eligible for Medicaid or CHIP and they are also eligible for coverage under this Plan, their State may have a premium assistance program that can help pay for coverage. These States use funds from their Medicaid or CHIP programs to help people who are eligible for these programs, but also have access to health insurance through their employer. If the covered person is not eligible for Medicaid or CHIP, they will not be eligible for these premium assistance programs.

If already enrolled in Medicaid or CHIP and residing in a State listed below, the covered person can contact their State Medicaid or CHIP office to find out if premium assistance is available.

If a covered person is NOT currently enrolled in Medicaid or CHIP, and thinks they or any of their dependents might be eligible for either of these programs, they can contact their State Medicaid or CHIP office or dial 1-877-KIDS NOW or www.insurekidsnow.gov to find out how to apply. If qualified, they can ask the State if it has a program that might help pay the premiums for an employer-sponsored plan.

Once it is determined that a covered person is eligible for premium assistance under Medicaid or CHIP, as well as eligible under the employer plan, the employer must permit them to enroll in the plan if they are not already enrolled. This is called a "special enrollment" opportunity, and an individual must request coverage within 60 days of being determined eligible for premium assistance. For questions about enrolling in an employer plan, contact the Department of Labor electronically at www.askebsa.dol.gov or by calling toll-free 1-866-444-EBSA (3272).

If the covered person lives in one of the following States, they may be eligible for assistance paying their employer health plan premiums. The following list of States is current as of July 31, 2013. Contact the State for further information on eligibility –

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 January 31, 2017. Contact your state for more information on eligibility.

ALABAMA
Medicaid
Website: http://myalhipp.com/
Phone: 1-855-692-5447

ALASKA
Medicaid
Website: http://myakhipp.com/
Phone: 1-866-251-4861

ARKANSAS
Medicaid
Website: http://myarhipp.com/
Phone: 855-692-7447

COLORADO
Medicaid (Health First Colorado)
Health First Colorado Website: https://www.healthfirstcolorado.com/
Health First Colorado Phone: 1-800-221-3943
CHIP (Child Health Plan Plus)
CHP+ Website: http://Colorado.gov/HCPF/Child-Health-Plan-Plus
CHP+ Phone: 1-800-359-1991

FLORIDA
Medicaid
Website: https://www.flmedicaidtplrecovery.com/hipp/
Phone: 1-877-357-3268

IOWA
Medicaid
Website: http://dhs.iowa.gov/ime/members/medicaid-a-to-z/hipp
Phone: 1-888-346-9562

KANSAS
Medicaid
Website: http://www.kdheks.gov/hcf/
Phone: 1-785-296-3512

KENTUCKY
Medicaid
Website: http://chfs.ky.gov/dms/default.htm
Phone: 1-800-635-2570

LOUISIANA
Medicaid
Website: http://dhh.louisiana.gov/index.cfm/subhome/1/n/331
Phone: 1-888-695-2447

MAINE
Medicaid
Website: http://www.maine.gov/dhhs/ofi/publicassistance/index.html
Phone: 1-800-442-6003
TTY: Maine Relay 711

GEORGIA
Medicaid
Website: http://dch.georgia.gov/medicaid
Phone: 404-656-4507

INDIANA
Medicaid (Healthy Indiana Plan for Low-Income Adults 19-64)
Website: http://www.in.gov/fssa/hip/
Phone: 1-877-438-4479

MISSOURI
Medicaid
Website: http://www.dss.mo.gov/mhd/participants/pages/hipp.htm
Phone: 573-751-2005

MONTANA
Medicaid
Website: http://dphhs.mt.gov/MontanaHealthcarePrograms/HIPP
Phone: 1-800-694-3084

NEBRASKA
Medicaid
Website: http://dhhs.ne.gov/Children_Family_Services/AccessNebraska/Pages/accessnebraska_index.aspx
Phone: 1-855-632-7633

NEVADA
Medicaid
Website: https://dwss.nv.gov/
Phone: 1-800-992-0900

NEW HAMPSHIRE
Medicaid
Website: http://www.dhhs.nh.gov/oii/documents/hippapp.pdf
Phone: 603-271-5218

NEW JERSEY
Medicaid
Website: http://www.state.nj.us/humanservices/dmahs/clients/medicaid/
Phone: 609-631-2392
CHIP
Website: http://www.njfamilycare.org/index.html
Phone: 1-800-701-0710

NEW YORK
Medicaid
Website: https://www.health.ny.gov/health_care/medicaid/
Phone: 1-800-541-2831

NORTH CAROLINA
Medicaid
Website: https://dma.ncdhhs.gov/
Phone: 919-855-4100

UTAH
Medicaid
Website: https://medicaid.utah.gov/
Phone: 801-538-6155
CHIP
Website: http://health.utah.gov/chip
Phone: 1-800-543-7669

MASSACHUSETTS
Medicaid and CHIP
Website: http://www.mass.gov/eohhs/gov/departments/masshealth/
Phone: 1-800-462-1120

MINNESOTA
Medicaid
Website: http://mn.gov/dhs/people-weserve/seniors/health-care/health-care-programs/programsand-services/medical-assistance.jsp
Phone: 1-800-657-3739

NORTH DAKOTA
Medicaid
Website: http://www.nd.gov/dhs/services/medicalserv/medicaid/
Phone: 1-844-854-4825

OKLAHOMA
Medicaid and CHIP
Website: http://www.insureoklahoma.org
Phone: 1-888-365-3742

OREGON
Medicaid
Website: http://healthcare.oregon.gov/Pages/index.aspx
Phone: 1-800-699-9075

PENNSYLVANIA
Medicaid
Website: http://www.dhs.pa.gov/provider/medicalassistance/healthinsurancepremiumpaymenthippprogram/index.htm
Phone: 1-800-692-7462

RHODE ISLAND
Medicaid
Website: http://www.eohhs.ri.gov/
Phone: 401-462-5300

SOUTH CAROLINA
Medicaid
Website: https://www.scdhhs.gov
Phone: 1-888-549-0820

SOUTH DAKOTA
Medicaid
Website: http://dss.sd.gov
Phone: 1-888-828-0059

TEXAS
Medicaid
Website: http://gethipptexas.com/
Phone: 1-800-440-0493

WEST VIRGINIA
Medicaid
Website: http://www.dhhr.wv.gov/bms/Medicaid%20Expansion/Pages/default.aspx
Phone: 1-877-598-5820

VERMONT
Medicaid
Website: http://www.greenmountaincare.org/
Phone: 1-800-250-8427

VIRGINIA
Medicaid and CHIP
Website: http://www.coverva.org/programs_premium_assistance.cfm
Medicaid Phone: 1-800-432-5924
CHIP Phone: 1-855-242-8282

WASHINGTON
Medicaid
Website: http://www.hca.wa.gov/free-or-low-cost-healthcare/program-administration/premium-payment-program
Phone: 1-800-562-3022 x15473

WISCONSIN
Medicaid
Website: https://www.dhs.wisconsin.gov/publications/p1/p10095.pdf
Phone: 1-800-362-3002

WYOMING
Medicaid
Website: https://wyequalitycare.acs-inc.com/
Phone: 307-777-7531

To see if any other states have added a premium assistance program since January 31, 2017, 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

OPEN ENROLLMENT

Open enrollment is the period designated by the employer during which the employee may elect coverage for himself and any eligible dependents if he is not covered under the Plan and does not qualify for a Special Enrollment as described herein. An open enrollment will be permitted once in each calendar year during the month of _____ .

During this open enrollment period, an employee and his dependents who are not covered under this Plan must complete and submit an enrollment form for coverage. Coverage shall be effective on the following _____ .

EFFECTIVE DATE OF COVERAGE

EMPLOYEE(S) EFFECTIVE DATE

Eligible employees, as described in Eligibility, are covered under the Plan:

FOR REGULAR FULL-TIME EMPLOYEES

The effective date will fall on the [ ] day of the month following [ ] day(s) of employment.

DEPENDENT(S) EFFECTIVE DATE

Eligible dependent(s), as described in Eligibility, will become covered under the Plan on the later of the dates listed below, provided the employee has enrolled them in the Plan within thirty (30) days of meeting the Plan's eligibility requirements.

1. The date the employee's coverage becomes effective.
2. The date the dependent is acquired, provided any required contributions are made and the employee has applied for dependent coverage within thirty (30) days of the date acquired.
3. Newborn children shall be covered from birth, regardless of confinement, provided the employee has applied for dependent coverage within thirty (30) days of birth.
4. Coverage for a newly adopted child shall be effective on the date the child is placed for adoption.

TERMINATION OF COVERAGE

Except as provided in the Plan's Continuation of Coverage (COBRA) provision, coverage will terminate on the earliest of the following dates:

EMPLOYEE(S) TERMINATION DATE

1. The date the employer terminates the Plan and offers no other group health plan.
2. The last day of the month the employee ceases to meet the eligibility requirements of the Plan.
3. The last day of the month employment terminates.
4. The last day of the month the employee becomes a full-time, active member of the armed forces of any country.
5. The date the employee ceases to make any required contributions.

DEPENDENT(S) TERMINATION DATE

1. The date the employer terminates the Plan and offers no other group health plan.
2. The date the employee's coverage terminates. However, if the employee remains eligible for the Plan, but elects to discontinue coverage, coverage may be extended for alternate recipients.
3. The date such person ceases to meet the eligibility requirements of the Plan.
4. The date the employee ceases to make any required contributions on the dependent's behalf.
5. The date the dependent becomes a full-time, active member of the armed forces of any country.
6. The date the Plan discontinues dependent coverage for any and all dependents.

LEAVE OF ABSENCE

Coverage may be continued for a limited time, contingent upon payment of any required contributions for employees when the employee is on an authorized leave of absence from the employer. In no event will coverage continue for more than twelve (12) months after the employee's active service ends or on the date the employee becomes covered under another employer's group health plan.

LAYOFF

Coverage may be continued for a limited time, contingent upon payment of any required contributions for employees when the employee is subject to an employer layoff. In no event will coverage continue for more than twelve (12) months after the employee's active service ends or on the date the employee becomes covered under another employer's group health plan.

FAMILY AND MEDICAL LEAVE ACT (FMLA)

ELIGIBLE LEAVE

An employee who is eligible for unpaid leave and benefits under the terms of the Family and Medical Leave Act of 1993, as amended, has the right to continue coverage under this Plan for up to twelve (12) weeks during any twelve (12) month period. An employee may be eligible for up to twenty-six (26) weeks of Family and Medical Leave Act leave during a twelve (12) month period if such leave is required to care for a family member who is injured or ill as the result of active duty in the military.

CONTRIBUTIONS

During this leave, the employer will continue to pay the same portion of the employee's contribution for the Plan. The employee shall be responsible to continue payment for eligible dependent's coverage and any remaining employee contributions. If the covered employee fails to make the required contribution during a FMLA leave within thirty (30) days after the date the contribution was due, the coverage will terminate effective on the date the contribution was due.

REINSTATEMENT

If coverage under the Plan was terminated during an approved FMLA leave, and the employee returns to active work immediately upon completion of that leave, Plan coverage will be reinstated on the date the employee returns to active work as if coverage had not terminated, provided the employee makes any necessary contributions and enrolls for coverage within thirty-one (31) days of his return to active work.

REPAYMENT REQUIREMENT

The employer may require employees who fail to return from a leave under FMLA to repay any contributions paid by the employer on the employee's behalf during an unpaid leave. This repayment will be required only if the employee's failure to return from such leave is not related to a "serious health condition," as defined in FMLA, or events beyond the employee's control.

CONTINUATION OF COVERAGE

In order to comply with federal regulations, this Plan includes a continuation of coverage option for certain individuals whose coverage would otherwise terminate. The following is intended to comply with the Consolidated Omnibus Budget Reconciliation Act of 1985 (COBRA), as amended.

The coverage which may be continued under this provision consists of health coverage. It does not include life insurance benefits, accidental death and dismemberment benefits, or income replacement benefits. Health coverage includes preventive care benefits as provided under the Plan.

QUALIFYING EVENTS

Qualifying events are any one of the following events that would cause a covered person to lose coverage under this Plan, even if such coverage is not lost immediately, and allow such person to continue coverage beyond the date described in Termination of Coverage:

1. Death of the employee.
2. The employee's termination of employment (other than termination for gross misconduct), or reduction in work hours to less than the minimum required for coverage under the Plan.
3. Divorce or legal separation from the employee.
4. The employee's entitlement to Medicare benefits under Title XVIII of the Social Security Act, if it results in the loss of coverage under this Plan.
5. A dependent child no longer meets the eligibility requirements of the Plan.
6. The last day of leave under the Family Medical Leave Act of 1993.
7. The call-up of an employee reservist to active duty.

NOTIFICATION REQUIREMENTS

1. When eligibility for continuation of coverage results from a spouse being divorced or legally separated from a covered employee, or a child's loss of dependent status, the employee or dependent must notify the Human Resources Department of the employer, in writing, of that event within sixty (60) days of the event. The employee or dependent must advise the date and nature of the qualifying event and the name, address and Social Security number of the affected individual. Failure to provide such notice to the employer will result in the person forfeiting their rights to continuation of coverage under this provision.
2. Within fourteen (14) days of a qualifying event, or within fourteen (14) days of receiving notice of a qualifying event, the employee or dependent will be notified of his rights to continuation of coverage, and what process is required to elect continuation of coverage.
3. After receiving notice, the employee or dependent has sixty (60) days to decide whether to elect continued coverage. Each person who was covered under the Plan prior to the qualifying event, has the right to elect continuation of coverage on an individual basis, regardless of family enrollment. If the employee or dependent chooses to have continued coverage, he must advise the employer in writing of this choice. The employer must receive this written notice no later than the last day of the sixty (60) day period. If the election is mailed, the election must be postmarked on or before the last day of the sixty (60) day period. This sixty (60) day period begins on the latter of the following:
   a. The date coverage under the Plan would otherwise end; or
   b. The date the person receives the notice from the employer of his or her rights to continuation of coverage.
4. Within forty-five (45) days after the date the person notifies the employer that he has chosen to continue coverage, the person must make the initial payment. The initial payment will be the amount needed to provide coverage from the date continued benefits begin, through the last day of the month in which the initial payment is made. Thereafter, payments for the continued coverage are to be made monthly, and are due in advance, on the first day each month.
5. The employee or dependent must make payments for the continued coverage.

COST OF COVERAGE

1. The employer requires that covered persons pay the entire costs of their continuation coverage, plus a two percent (2%) administrative fee. This must be remitted to the employer or the employer's designated representative, by or before the first day of each month during the continuation period. The payment must be remitted each month in order to maintain the coverage in force.
2. For purposes of determining monthly costs for continued coverage, a person originally covered as an employee or as a spouse will pay the rate applicable to an employee if coverage is continued for himself alone. Each child continuing coverage independent of the family unit will pay the rate applicable to an employee.

WHEN CONTINUATION COVERAGE BEGINS

When continuation coverage is elected and the contributions paid within the time period required, coverage is reinstated back to the date of the loss of coverage, so that no break in coverage occurs. Coverage for dependents acquired and properly enrolled during the continuation period begins in

accordance with the enrollment provisions of the Plan.

FAMILY MEMBERS ACQUIRED DURING CONTINUATION

A spouse or dependent child newly acquired during continuation coverage is eligible to be enrolled as a dependent. The standard enrollment provision of the Plan applies to enrollees during continuation coverage.

A dependent acquired and enrolled after the original qualifying event, other than a child born to or placed for adoption with a covered employee during a period of COBRA continuation coverage, is not eligible for a separate continuation if a subsequent event results in the person's loss of coverage.

SUBSEQUENT QUALIFYING EVENTS

Once covered under continuation coverage, it is possible for a second qualifying event to occur, including:

1. Death of an employee.
2. Divorce or legal separation from an employee.
3. Employee's entitlement to Medicare if it results in a loss of coverage under this Plan.
4. The child's loss of dependent status.

If one of these subsequent qualifying events occurs, a dependent may be entitled to a second continuation period. This period will in no event continue beyond thirty-six (36) months from the date of the first qualifying event.

Only a person covered prior to the original qualifying event or a child born to or placed for adoption with a covered employee during a period of COBRA continuation is eligible to continue coverage again as the result of a subsequent qualifying event. Any other dependent acquired during continuation coverage is not eligible to continue coverage as the result of a subsequent qualifying event.

END OF CONTINUATION

Continuation of coverage under this provision will end on the earliest of the following dates:

1. Eighteen (18) months from the date continuation began because of a reduction of hours or termination of employment of the employee.
2. Thirty-six (36) months from the date continuation began for dependents whose coverage ended because of the death of the employee, divorce or legal separation from the employee, or the child's loss of dependent status.
3. The end of the period for which contributions are paid if the covered person fails to make a payment on the date specified by the employer.
4. The date coverage under this Plan ends and the employer offers no other group health benefit plan.
5. The date the covered person first becomes entitled to Medicare after the date of election of COBRA continuation coverage.
6. The date the covered person first becomes covered under any other group health plan after the date of election of COBRA continuation coverage.

SPECIAL RULES REGARDING NOTICES

1. Any notice required in connection with continuation coverage under this Plan must, at minimum, contain sufficient information so that the plan administrator (or its designee) is able to determine from such notice the employee and dependent(s) (if any), the qualifying event or disability, and the date on which the qualifying event occurred.
2. In connection with continuation coverage under this Plan, any notice required to be provided by any individual who is either the employee or a dependent with respect to the qualifying event may be provided by a representative acting on behalf of the employee or the dependent, and the provision of the notice by one individual shall satisfy any responsibility to provide notice on behalf of all related eligible individuals with respect to the qualifying event.
3. As to an Election Notice, Non-Eligibility Notice or Early Termination Notice:
    a. A single notice addressed to both the employee or the spouse will be sufficient as to both individuals if, on the basis of the most recent information available to the Plan, the spouse resides at the same location as the employee; and
    b. A single notice to the employee or the spouse will be sufficient as to each dependent child of the employee if, on the basis of the most recent information available to the Plan, the dependent child resides at the same location as the individual to whom such notice is provided.

EXTENSION FOR DISABLED INDIVIDUALS

A person who is totally disabled may extend continuation coverage from eighteen (18) months to twenty-nine (29) months. The person must be disabled for Social Security purposes at the time of the qualifying event or within sixty (60) days thereafter. The disabled person must submit proof of the determination of disability by the Social Security Administration to the employer within the initial eighteen (18) month continuation coverage period and no later than sixty (60) days after the Social Security Administration's determination. The employer may charge 150% of the contribution during the additional eleven (11) months of continuation of coverage.

MILITARY MOBILIZATION

If an employee is called for active duty by the United States Armed Services (including the Coast Guard), the National Guard or the Public Health Service, the employee may continue their health coverages, pursuant to the Uniformed Services Employment and Reemployment Rights Act (USERRA).

When the leave is less than thirty-one (31) days, the employee may not be required to pay more than the employee's share, if any, applicable to that coverage. If the leave is more than thirty-one (31) days, then the employer may require the employee to pay no more than 102% of the full contribution.

The maximum length of the continuation coverage required under the Uniformed Services Employment and Reemployment Rights Act (USERRA) is the lesser of:

1. Twenty-four (24) months beginning on the day that the leave commences, or
2. A period beginning on the day that the leave began and ending on the day after the employee fails to return to employment within the time allowed.

The employee's coverage will be reinstated without exclusions or a waiting period.

CLAIM FILING PROCEDURE

A claim for benefits is any request for a benefit that is provided by this Plan made by a covered person or the authorized representative of a covered person which complies with the Plan's procedures for making claims. Claims for health care benefits are one of two types: pre-service claims or post-service claims. This Plan provides only coverage for post-service claims.

Post-service claims are those for which services have already been received (any claims other than pre-service claims).

If the covered person would like the Plan administrator/claims processor to deal with someone other than them regarding a claim for benefits then the covered person must provide the Plan administrator with a written authorization in order for an authorized representative (other than the employee) to represent and act on behalf of the covered person. The covered person must consent to release information related to the claim to the authorized representative.

FILING A POST-SERVICE CLAIM

1. Claims should be submitted to the address shown on the covered person's identification card. The date of receipt will be the date the claim is received by the claims processor.
2. All bills submitted for benefits must contain the following:
    a. Name of patient.
    b. Patient's date of birth.
    c. Name of employee.
    d. Address of employee.
    e. Name of employer.
    f. Name, address and tax identification number of provider.
    g. Employee Social Security number.
    h. Date of service.
    i. Diagnosis.
    j. Description of service and procedure number.
    k. Charge for service.
    l. The nature of the accident, injury or illness being treated.
3. Properly completed claims not submitted within three (3) months of the date of incurred liability will be denied.

The covered person may ask the provider to submit the bill directly to the claims processor, or the covered person may file the bill with a claim form. However, it is ultimately the covered person's responsibility to make sure the claim has been filed for benefits.

TIME FRAME FOR BENEFIT DETERMINATION OF A POST-SERVICE CLAIM

When a completed claim has been submitted to the claims processor and no additional information is required, the claims processor will generally complete its determination of the claim within thirty (30) calendar day of receipt of the completed claim, unless an extension of time is necessary due to circumstances beyond the Plan's control.

When a completed claim has been submitted to the claims processor and additional information is required for determination of the claim, the claims processor will provide the covered person or authorized representative with a notice detailing the information needed. This notice will be provided within thirty (30) calendar days of receipt of the completed claim and will indicate the date when the claims processor expects to make a decision, if the requested information is received. The covered person will have forty-five (45) calendar days to provide the information requested, and the claims processor will complete its determination of the claim within fifteen (15) calendar days of receipt of the requested information. Failure to respond in a timely and complete manner will result in a denial of benefit payment.

NOTICE OF ADVERSE BENEFIT DETERMINATION OF A POST-SERVICE CLAIM

If the claim for benefits is denied, the claims processor shall provide the covered person or authorized representative with a written Notice of Adverse Benefit Determination within the time frames described immediately above.

The Notice of Adverse Benefit Determination will include:

1. Identification of the claim involved:
    a. Date of service
    b. Health care provider
    c. Claim amount (if applicable)

d. Diagnosis code and the corresponding meaning of the code
e. Treatment code and the corresponding meaning of the code

2. Reference to the Plan provisions on which the denial (denial code and corresponding meaning of the code, if applicable) code is based.
3. A description of any additional material or information which may be needed for claim review and an explanation of why such material or information is necessary.
4. A description of the Plan's internal claim review procedure and applicable time limits.
5. A statement that if the covered person's appeal (Refer to Appealing a Denied Post-Service Claim below) is denied, the covered person has the right to bring a civil action under section 502 (a) of the Employee Retirement Income Security Act of 1974.
6. If an internal rule, guideline, protocol or other similar criterion was relied upon, the Notice of Adverse Benefit Determination will contain either:
   a. A copy of that criterion, or
   b. A statement that such criterion was relied upon and will be supplied free of charge, upon request.
7. If denial was based on medical necessity, experimental/investigational treatment or similar exclusion or limit, the claims processor will supply either:
   a. An explanation of the scientific or clinical judgment, applying the terms of the Plan to the covered person's medical circumstances, or
   b. A statement that such explanation will be supplied free of charge, upon request.

INTERNAL APPEAL OF A DENIED POST-SERVICE CLAIM

The "named fiduciary" for purposes of an appeal of a post-service claim, as described in U. S. Department of Labor Regulations 2560.503-1 (issued November 21, 2000) and the Patient Protection and Affordable Care Act (Public Law 111-148, enacted March 23, 2010) and the Health Care and Education Reconciliation Act (Public Law 111-152, enacted March 30, 2010), is the claims processor.

A covered person, or the covered person's authorized representative, may request a review of a denied claim by making written request to the named fiduciary within one hundred eighty (180) calendar days from receipt of notification of the denial and stating the reasons the covered person feels the claim should not have been denied.

The following describes the review process and rights of the covered person:

1. The covered person has a right to present evidence and testimony, submit documents, information and comments.
2. The covered person has the right to access, free of charge, relevant information to the claim for benefits.
3. The covered person will be provided copies, free of charge, of any new or additional evidence generated by or for the Plan prior to the final determination in order to allow covered person an opportunity to provide additional comment or documentation.
4. The review takes into account all information submitted by the covered person, even if it was not considered in the initial benefit determination.
5. The review by the named fiduciary will not afford deference to the original denial.
6. The named fiduciary will not be:
   a. The individual who originally denied the claim, nor
   b. Subordinate to the individual who originally denied the claim.
7. If original denial was, in whole or in part, based on medical judgment:
   a. The named fiduciary will consult with a professional provider who has appropriate training and experience in the field involving the medical judgment; and
   b. The professional provider utilized by the named fiduciary will be neither:
      i. An individual who was consulted in connection with the original denial of the claim, nor
      ii. A subordinate of any other professional provider who was consulted in connection with the original denial.
8. If requested, the named fiduciary will identify the medical or vocational expert(s) who gave advice in connection with the original denial, whether or not the advice was relied upon.
9. The covered person has a right to file a request for a standard external review provided such request is filed within four (4) months after the date of receipt of a notice of an adverse benefit determination and the Plan's internal appeal process has been exhausted.

NOTICE OF BENEFIT DETERMINATION ON AN INTERNAL APPEAL OF A POST-SERVICE CLAIM

The claims processor shall provide the covered person (or authorized representative) with a written notice of the appeal decision within sixty (60) calendar days of receipt of a written request for the appeal.

If the appeal is denied, the Notice of Benefit Determination will include the following:

1. Identification of the claim involved:
   a. Date of service
   b. Health care provider
   c. Claim amount (if applicable)
   d. Diagnosis code and the corresponding meaning of the code

e. Treatment code and the corresponding meaning of the code

2. Reference to the Plan provisions on which the denial (denial code and corresponding meaning of the code, if applicable) the code is based.
3. A statement that the covered person has the right to access, free of charge, relevant information to the claim for benefits.
4. A statement that if the covered person's appeal is denied, the covered person has the right to bring a civil action under section 502 (a) of the Employee Retirement Income Security Act of 1974.
5. A description of the Plan's standard external review procedures and applicable time limits.
6. If an internal rule, guideline, protocol or other similar criterion was relied upon, the Notice of Benefit Determination will contain either:
   a. A copy of that criterion, or
   b. A statement that such criterion was relied upon and will be supplied free of charge, upon request.
7. If the denial was based on medical necessity, experimental/investigational treatment or similar exclusion or limit, the claims processor will supply either:
   a. An explanation of the scientific or clinical judgment, applying the terms of the Plan to the claimant's medical circumstances, or
   b. A statement that such explanation will be supplied free of charge, upon request.
8. The covered person has a right to file a request for a standard external review if the covered person's request for appeal is denied.

REQUESTING A STANDARD EXTERNAL REVIEW OF A DENIED INTERNAL POST-SERVICE CLAIM APPEAL

A covered person, or a covered person's authorized representative must exhaust the Plan's internal appeal process before a standard external review is available. Once the internal appeal process is exhausted, a covered person, or a covered person's authorized representative, may request a standard external review of a denied claim by making written request to the claims processor within four (4) months after the receipt of notification of the denial upon appeal.

The following describes the review process and rights of the covered person:

1. Within five (5) business days following the date of receipt of the standard external review request, the claims processor must complete a preliminary review of the request to determine whether:
   a. The covered person is or was covered under the Plan at the time the health care item or service was provided.
   b. The denial does not relate to the covered person's failure to meet the requirements of eligibility under the terms of this Plan.
   c. The covered person has exhausted this Plan's internal appeal process.
   d. The covered person has provided all the information and forms required to process the request.
2. Within one (1) business day after completion of the preliminary review, the claims processor must issue a written notification to the covered person:
   a. If the request is complete but not eligible for standard external review, such notification will include the reasons for ineligibility and the contact information for the Employee Benefits Security Administration.
   b. If the request is not complete, such notification will describe the information or materials needed to make the request complete and allow the covered person to submit the documentation within the initial four (4) month filing period or within the forty-eight (48) hour period following the receipt of the notification, whichever is later.
3. If the request for standard external review is complete and eligible, the claims processor will assign an independent review organization to conduct the review.
4. Upon receipt of the standard external review request, the assigned independent review organization will provide a written notice to the covered person of the eligibility and acceptance of the request.
   a. The covered person may submit additional written information for consideration to the independent review organization within ten (10) business days following the date of receipt of the notice.
   b. The independent review organization, is not required to, but may accept and consider additional information received after ten (10) business days following the date of receipt of the notice.
5. Within five (5) business days after the date of assignment of the independent review organization, the claims processor will provide the independent review organization with the documents and information considered in making the adverse benefit determination. The failure of the claims processor to provide the documents and information in a timely manner may result in the independent review organization's termination of the review and a decision to reverse the denial. Within one (1) business day after making such a decision, the independent review organization must notify the covered person and the claims processor.
6. Upon receipt of any information submitted by the covered person, the independent review organization will forward such information to the claims processor within one (1) business day of receipt.
   a. Upon receipt of the information, the claims processor may reconsider the denial that is the subject of the standard external review.
   b. If the claims processor reverses the adverse benefit determination, the covered person and independent review organization will be provided written notice of that decision within one (1) business day after making the decision.
   c. Upon receipt of the decision to reverse the denial, the independent review organization will terminate the standard external review.
7. The independent review organization will review all of the information and documents received. In addition to the information and documents submitted, the independent review organization will consider the following, if appropriate, in reaching a decision:
   a. The covered person's medical records;

b. The attending health care professional's recommendation;
c. Reports from appropriate health care professionals and other documents submitted by the claims processor, covered person, or the covered person's treating provider;
d. The terms of the covered person's Plan to ensure that the independent review organization's decision is not contrary to the terms of the Plan, unless the terms are inconsistent with applicable law;
e. Appropriate practice guidelines, which must include applicable evidence-based standards and may include any other practice guidelines developed by the Federal government, national or professional medical societies, boards and associations;
f. Any applicable clinical review criteria developed and used by the claims processor, unless the criteria are inconsistent with the terms of the Plan or with applicable law; and
g. The opinion of the independent review organization's clinical reviewer or reviewers after considering the information described in this notice to the extent the information or documents are available and the clinical reviewer or reviewers consider appropriate.
h. The independent review organization must provide written notice of the final standard external review decision within forty-five (45) calendar days after the independent review organization receives the request for the external review. The independent review organization must deliver the notice of final standard external review decision to the covered person and the claims processor.

NOTICE OF BENEFIT DETERMINATION ON A STANDARD EXTERNAL REVIEW OF A DENIED INTERNAL POST-SERVICE CLAIM APPEAL

The independent review organization shall provide the covered person or their authorized representative with a written notice of the review decision within forty-five (45) days of receipt of the written request for the review.

The Notice of Benefit Determination will include the following:

1. A general description of the reason for the request for standard external review, including information sufficient to identify the claim. The description will include:
   a. Date or dates of service,
   b. Health care provider,
   c. Claim amount, if applicable,
   d. Diagnosis code and its corresponding meaning,
   e. Treatment code and its corresponding meaning,
   f. Reason for the previous denial;
2. The date the independent review organization received the request to conduct the standard external review and the date of the independent review organization's decision;
3. References to the evidence or documentation, including the specific coverage provisions and evidence –based standards, considered in reaching the decision;
   a. A discussion of the principal reason or reasons for its decision, including the rational for its decision and any evidence-based standards that were relied on in making the decision;
   b. A statement that the determination is binding except to the extent that other remedies may be available under Federal law to either the Plan or to the covered person; and
   c. A statement that judicial review may be available to the covered person.
4. After a final standard external review decision, the independent review organization will maintain records of all claims and notices associated with the standard external review process for six (6) years. An independent review organization will make such records available for examination by the covered person, Plan, or Federal oversight agency upon request, except where such disclosure would violate Federal privacy laws.
5. Upon receipt of a notice of a final standard external review decision reversing the denial, the Plan will provide coverage or payment for the claim.

FOREIGN CLAIMS

In the event a covered person incurs a covered expense in a foreign country, the covered person shall be responsible for providing the following information to the claims processor before payment of any benefits due are payable.

1. The claim form, provider invoice and any documentation required to process the claim must be submitted in the English language.
2. The charges for services must be converted into U.S. dollars.
3. A current published conversion chart, validating the conversion from the foreign country's currency into U.S. dollars, must be submitted with the claim.

COORDINATION OF BENEFITS

The Coordination of Benefits provision is intended to prevent duplication of benefits. It applies when the covered person is also covered by any Other Plan(s). When more than one coverage exists, one plan normally pays its benefits in full, referred to as the primary plan. The Other Plan(s), referred to as secondary plan, pays a reduced benefit. When coordination of benefits occurs, the total benefit payable by all plans will not exceed 100% of "allowable expenses." Only the amount paid by this Plan will be charged against the maximum benefit.

The Coordination of Benefits provision applies whether or not a claim is filed under the Other Plan(s). If another plan provides benefits in the form of services rather than cash, the reasonable value of the service rendered shall be deemed the benefit paid.

DEFINITIONS APPLICABLE TO THIS PROVISION

"Allowable Expenses" means any reasonable, necessary, and customary expenses incurred while covered under this Plan, part or all of which would be covered under this Plan. Allowable Expenses do not include expenses contained in the "Exclusions" sections of this Plan.

When this Plan is secondary, "Allowable Expense" will include any deductible or coinsurance amounts not paid by the Other Plan(s).

When this Plan is secondary, "Allowable Expense" shall not include any amount that is not payable under the primary plan as a result of a contract between the primary plan and a provider of service in which such provider agrees to accept a reduced payment and not to bill the covered person for the difference between the provider's contracted amount and the provider's regular billed charge.

"Other Plan" means any plan, policy or coverage providing benefits or services for, or by reason of medical, dental or vision care. Such Other Plan(s) may include, without limitation:

1. Group insurance or any other arrangement for coverage for covered persons in a group, whether on an insured or uninsured basis, including, but not limited to, hospital indemnity benefits and hospital reimbursement-type plans;
2. Hospital or medical service organization on a group basis, group practice, and other group prepayment plans or on an individual basis having a provision similar in effect to this provision;
3. A licensed Health Maintenance Organization (HMO);
4. Any coverage for students which is sponsored by, or provided through, a school or other educational institution;
5. Any coverage under a government program and any coverage required or provided by any statute;
6. Group automobile insurance;
7. Individual automobile insurance coverage;
8. Individual automobile insurance coverage based upon the principles of "No-fault" coverage;
9. Any plan or policies funded in whole or in part by an employer, or deductions made by an employer from a person's compensation or retirement benefits;
10. Labor/management trusteed, union welfare, employer organization, or employee benefit organization plans.

"This Plan" shall mean that portion of the employer's Plan which provides benefits that are subject to this provision.

"Claim Determination Period" means a calendar year or that portion of a calendar year during which the covered person for whom a claim is made has been covered under this Plan.

EFFECT ON BENEFITS

This provision shall apply in determining the benefits for a covered person for each claim determination period for the Allowable Expenses. If this Plan is secondary, the benefits paid under this Plan may be reduced so that the sum of benefits paid by all plans does not exceed 100% of total Allowable Expense.

If the rules set forth below would require this Plan to determine its benefits before such Other Plan, then the benefits of such Other Plan will be ignored for the purposes of determining the benefits under this Plan.

ORDER OF BENEFIT DETERMINATION

Each plan will make its claim payment according to the following order of benefit determination:

1. **No Coordination of Benefits Provision.** If the Other Plan contains no provisions for coordination of benefits, then its benefits shall be paid before all Other Plan(s).
2. **Member/Dependent.** The plan which covers the claimant as a member(or named insured) pays as though no Other Plan existed. Remaining covered expenses are paid under a plan which covers the claimant as a dependent.

3. **Dependent Children of Parents not Separated or Divorced**. The plan covering the parent whose birthday (month and day) occurs earlier in the year pays first. The plan covering the parent whose birthday falls later in the year pays second. If both parents have the same birthday, the plan that covered a parent longer pays first. A parent's year of birth is not relevant in applying this rule.
4. **Dependent Children of Separated or Divorced Parents**. When parents are separated or divorced, the birthday rule does not apply, instead:
    a. If a court decree has given one parent financial responsibility for the child's health care, the plan of that parent pays first. The plan of the stepparent married to that parent, if any, pays second. The plan of the other natural parent pays third. The plan of the spouse of the other natural parent pays fourth.
    b. In the absence of such a court decree, the plan of the parent with custody pays first. The plan of the stepparent married to the parent with custody, if any, pays second. The plan of the parent without custody pays third. The plan of the spouse of the parent without custody pays fourth.
5. **Active/Inactive**. The plan covering a person as an active (not laid off or retired) employee, or as that person's dependent pays first. The plan covering that person as a laid off or retired employee, or as that person's dependent pays second.
6. **Limited Continuation of Coverage**. If a person is covered under another group health plan, but is also covered under this Plan for continuation of coverage due to the Other Plan's limitation for exclusions, the Other Plan shall be primary for all covered expenses which are not related to the exclusions.
7. **Longer/Shorter Length of Coverage**. If none of the above rules determine the order of benefits, the plan covering a person longer pays first. The plan covering that person for a shorter time pays second.

LIMITATIONS ON PAYMENTS

In no event shall the covered person recover under this Plan and all Other Plan(s) combined more than the total Allowable Expenses offered by this Plan and the Other Plan(s). Nothing contained in this section shall entitle the covered person to benefits in excess of the total maximum benefits of this Plan during the claim determination period. The covered person shall refund to the employer any excess it may have paid.

RIGHT TO RECEIVE AND RELEASE NECESSARY INFORMATION

For the purposes of determining the applicability of and implementing the terms of this Coordination of Benefits provision, the Plan may, without the consent of or notice to any person, release to or obtain from any insurance company or any other organization any information with respect to any covered person. Any person claiming benefits under this Plan shall furnish to the employer such information as may be necessary to implement the Coordination of Benefits provision.

FACILITY OF BENEFIT PAYMENT

Whenever payments which should have been made under this Plan in accordance with this provision have been made under any Other Plan, the employer shall have the right, exercisable alone and in its sole discretion, to pay over to any organization making such other payments any amounts it shall determine to be warranted in order to satisfy the intent of this provision. Amounts so paid shall be deemed to be benefits paid under this Plan and, to the extent of such payments, the employer shall be fully discharged from liability.

SUBROGATION

The Plan is designed to only pay covered expenses for which payment is not available from anyone else, including any insurance company or another health plan. In order to help a covered person in a time of need, however, the Plan may pay covered expenses that may be or become the responsibility of another person, provided that the Plan later receives reimbursement for those payments (hereinafter called "Reimbursable Payments").

Therefore, by enrolling in the Plan, as well as by applying for payment of covered expenses, a covered person is subject to, and agrees to, the following terms and conditions with respect to the amount of covered expenses paid by the Plan:

1. **Assignment of Rights (Subrogation).** The covered person automatically assigns to the Plan any rights the covered person may have to recover all or part of the same covered expenses from any party, including an insurer or another group health program (except flexible spending accounts, health reimbursement accounts and health savings accounts), but limited to the amount of Reimbursable Payments made by the Plan. This assignment includes, without limitation, the assignment of a right to any funds paid by a third party to a covered person or paid to another for the benefit of the covered person. This assignment applies on a first-dollar basis (i.e., has priority over other rights), applies whether the funds paid to (or for the benefit of) the covered person constitute a full or a partial recovery, and even applies to funds actually or allegedly paid for non-medical or dental charges, attorney fees, or other costs and expenses. This assignment also allows the Plan to pursue any claim that the covered person may have, whether or not the covered person chooses to pursue that claim. By this assignment, the Plan's right to recover from insurers includes, without limitation, such recovery rights against no-fault auto insurance carriers in a situation where no third party may be liable, and from any uninsured or underinsured motorist coverage.
2. **Equitable Lien and other Equitable Remedies.** The Plan shall have an equitable lien against any rights the covered person may have to recover the same covered expenses from any party, including an insurer or another group health program, but limited to the amount of Reimbursable Payments made by the Plan. The equitable lien also attaches to any right to payment from workers' compensation, whether by judgment or settlement, where the Plan has paid covered expenses prior to a determination that the covered expenses arose out of and in the course of employment. Payment by workers' compensation insurers or the employer will be deemed to mean that such a determination has been made. This equitable lien shall also attach to any money or property that is obtained by anybody (including, but not limited to, the covered person, the covered person's attorney, and/or a trust) as a result of an exercise of the covered person's rights of recovery (sometimes referred to as "proceeds"). The Plan shall also be entitled to seek any other equitable remedy against any party possessing or controlling such proceeds. At the discretion of the Plan administrator, the Plan may reduce any future covered expenses otherwise available to the covered person under the Plan by an amount up to the total amount of Reimbursable Payments made by the Plan that is subject to the equitable lien. This and any other provisions of the Plan concerning equitable liens and other equitable remedies are intended to meet the standards for enforcement that were enunciated in the United States Supreme Court's decision entitled, Great-West Life & Annuity Insurance Co. v. Knudson, 534 US 204 (2002). The provisions of the Plan concerning subrogation, equitable liens and other equitable remedies are also intended to supercede the applicability of the federal common law doctrines commonly referred to as the "make whole" rule and the "common fund" rule.
3. **Assisting in Plan's Reimbursement Activities.** The covered person has an obligation to assist the Plan to obtain reimbursement of the Reimbursable Payments that it has made on behalf of the covered person, and to provide the Plan with any information concerning the covered person's other insurance coverage (whether through automobile insurance, other group health program, or otherwise) and any other person or entity (including their insurer(s)) that may be obligated to provide payments or benefits to or for the benefit of the covered person. The covered person is required to (a) cooperate fully in the Plan's (or any Plan fiduciary's) enforcement of the terms of the Plan, including the exercise of the Plan's right to subrogation and reimbursement, whether against the covered person or any third party, (b) not do anything to prejudice those enforcement efforts or rights (such as settling a claim against another party without including the Plan as a co-payee for the amount of the Reimbursable Payments and notifying the Plan), (c) sign any document deemed by the Plan administrator to be relevant to protecting the Plan's subrogation, reimbursement or other rights, and (d) provide relevant information when requested. The term "information" includes any documents, insurance policies, police reports, or any reasonable request by the Plan administrator or claims processor to enforce the Plan's rights.

The Plan administrator has delegated to the claims processor the right to perform ministerial functions required to assert the Plan's rights; however, the Plan administrator shall retain discretionary authority with regard to asserting the Plan's recovery rights.

THIS PLAN AND MEDICARE

Individuals who have earned the required number of quarters for Social Security benefits within the specified time frame are eligible for Medicare Part A at no cost. Participation in Medicare Part B and Part D is available to all individuals who make application and pay the full cost of the coverage.

1. When an employee becomes entitled to Medicare coverage and is still actively at work, the employee may continue health coverage under this Plan at the same level of benefits and contribution rate that applied before reaching Medicare entitlement.
2. When a dependent becomes entitled to Medicare coverage and the employee is still actively at work, the dependent may continue health coverage under this Plan at the same level of benefits and contribution rate that applied before reaching Medicare entitlement.
3. If the employee and/or dependent is also enrolled in Medicare, this Plan shall pay as the primary plan. Medicare will pay as secondary plan.
4. If the employee and/or dependent elect to discontinue health coverage under this Plan and enroll under the Medicare program, no benefits will be paid under this Plan. Medicare will be the only payor.

This section is subject to the terms of the Medicare laws and regulations. Any changes in these related laws and regulations will apply to the provisions of this section.

GENERAL PROVISIONS

ADMINISTRATION OF THE PLAN

The Plan is administered through the Human Resources Department of the employer. The employer is the Plan administrator. The Plan administrator shall have full charge of the operation and management of the Plan. The employer has retained the services of an independent claims processor experienced in claims review.

The Plan administrator is the named fiduciary of the Plan for all purposes except claim appeals, as specified in Claim Filing Procedure. As fiduciary, the Plan administrator maintains discretionary authority with respect to those responsibilities for which it has been designated named fiduciary, including, but not limited to, interpretation of the terms of the Plan, and determining eligibility for and entitlement to Plan benefits in accordance with the terms of the Plan; any interpretation or determination made pursuant to such discretionary authority shall be given full force and effect, unless it can be shown that the interpretation or determination was arbitrary and capricious.

ASSIGNMENT

The Plan will pay benefits under this Plan to the employee unless payment has been assigned to a hospital, physician, or other provider of service furnishing the services for which benefits are provided herein. No assignment of benefits shall be binding on the Plan unless the claims processor is notified in writing of such assignment prior to payment hereunder.

Preferred providers normally bill the Plan directly. If services, supplies or treatment has been received from such a provider, benefits are automatically paid to that provider. The covered person's portion of the negotiated rate, after the Plan's payment, will then be billed to the covered person by the preferred provider.

This Plan will pay benefits to the responsible party of an alternate recipient as designated in a qualified medical child support order.

BENEFITS NOT TRANSFERABLE

Except as otherwise stated herein, no person other than an eligible covered person is entitled to receive benefits under this Plan. Such right to benefits is not transferable.

CLERICAL ERROR

No clerical error on the part of the employer or claims processor shall operate to defeat any of the rights, privileges, services, or benefits of any employee or any dependent(s) hereunder, nor create or continue coverage which would not otherwise validly become effective or continue in force hereunder. An equitable adjustment of contributions and/or benefits will be made when the error or delay is discovered. However, if more than six (6) months has elapsed prior to discovery of any error, any adjustment of contributions shall be waived. No party shall be liable for the failure of any other party to perform.

CONFORMITY WITH STATUTE(S)

Any provision of the Plan which is in conflict with statutes which are applicable to this Plan is hereby amended to conform to the minimum requirements of said statute(s).

EFFECTIVE DATE OF THE PLAN

The effective date of this Plan is 4/1/2023 .

FREE CHOICE OF HOSPITAL AND PHYSICIAN

Nothing contained in this Plan shall in any way or manner restrict or interfere with the right of any person entitled to benefits hereunder to select or make a free choice of the attending physician or professional provider. However, benefits will be paid in accordance with the provisions of this Plan, and the covered person will have no benefits payable if the covered person uses the services of a nonpreferred provider.

INCAPACITY

If, in the opinion of the employer, a covered person for whom a claim has been made is incapable of furnishing a valid receipt of payment due him and in the absence of written evidence to the Plan of the qualification of a guardian or personal representative for his estate, the employer may on behalf of the Plan, at his discretion, make any and all such payments to the provider of services or other person providing for the care and support of such person. Any payment so made will constitute a complete discharge of the Plan's obligation to the extent of such payment.

INCONTESTABILITY

All statements made by the employer or by the employee covered under this Plan shall be deemed representations and not warranties. Such statements shall not void or reduce the benefits under this Plan or be used in defense to a claim unless they are contained in writing and signed by the employer or by the covered person, as the case may be. A statement made shall not be used in any legal contest unless a copy of the instrument

containing the statement is or has been furnished to the other party to such a contest.

LEGAL ACTIONS

No action at law or in equity shall be brought to recover on the benefits from the Plan prior to the expiration of sixty (60) days after all information on a claim for benefits has been filed and the appeal process has been completed in accordance with the requirements of the Plan. No such action shall be brought after the expiration of two (2) years from the date the expense was incurred, or one (1) year from the date a completed claim was filed, whichever occurs first.

LIMITS ON LIABILITY

Liability hereunder is limited to the services and benefits specified, and the employer shall not be liable for any obligation of the covered person incurred in excess thereof. The employer shall not be liable for the negligence, wrongful act, or omission of any physician, professional provider, hospital, or other institution, or their employees, or any other person. The liability of the Plan shall be limited to the reasonable cost of covered expenses and shall not include any liability for suffering or general damages.

LOST DISTRIBUTEES

Any benefit payable hereunder shall be deemed forfeited if the Plan administrator is unable to locate the covered person to whom payment is due, provided, however, that such benefits shall be reinstated if a claim is made by the covered person for the forfeited benefits within the time prescribed in Claim Filing Procedure.

MEDICAID ELIGIBILITY AND ASSIGNMENT OF RIGHTS

The Plan will not take into account whether an individual is eligible for, or is currently receiving, medical assistance under a State plan for medical assistance as provided under Title XIX of the Social Security Act ("State Medicaid Plan") either in enrolling that individual as a covered person or in determining or making any payment of benefits to that individual. The Plan will pay benefits with respect to such individual in accordance with any assignment of rights made by or on behalf of such individual as required under a State Medicaid plan pursuant to § 1912(a)(1)(A) of the Social Security Act. To the extent payment has been made to such individual under a State Medicaid Plan and this Plan has a legal liability to make payments for the same services, supplies or treatment, payment under the Plan will be made in accordance with any State law which provides that the State has acquired the rights with respect to such individual to payment for such services, supplies or treatment under the Plan.

MISREPRESENTATION

If the covered person or anyone acting on behalf of a covered person makes a false statement on the application for enrollment, or withholds information with intent to deceive or affect the acceptance of the enrollment application or the risks assumed by the Plan, or otherwise misleads the Plan, the Plan shall be entitled to recover its damages, including legal fees, from the covered person, or from any other person responsible for misleading the Plan, and from the person for whom the benefits were provided. Any material misrepresentation on the part of the covered person in making application for coverage, or any application for reclassification thereof, or for service thereunder shall render the coverage under this Plan null and void.

PHYSICAL EXAMINATIONS REQUIRED BY THE PLAN

The Plan, at its own expense, shall have the right to require an examination of a person covered under this Plan when and as often as it may reasonably require during the pendency of a claim.

PLAN IS NOT A CONTRACT

The Plan shall not be deemed to constitute a contract between the employer and any employee or to be a consideration for, or an inducement or condition of, the employment of any employee. Nothing in the Plan shall be deemed to give any employee the right to be retained in the service of the employer or to interfere with the right of the employer to terminate the employment of any employee at any time.

PLAN MODIFICATION AND AMENDMENT

The employer may modify or amend the Plan from time to time at its sole discretion, and such amendments or modifications which affect covered persons will be communicated to the covered persons. Any such amendments shall be in writing, setting forth the modified provisions of the Plan, the effective date of the modifications, and shall be signed by the employer's designee.

Such modification or amendment shall be duly incorporated in writing into the master copy of the Plan on file with the employer, or a written copy thereof shall be deposited with such master copy of the Plan. Appropriate filing and reporting of any such modification or amendment with governmental authorities and to covered persons shall be timely made by the employer.

PLAN TERMINATION

The employer reserves the right to terminate the Plan at any time. Upon termination, the rights of the covered persons to benefits are limited to claims incurred up to the date of termination. Any termination of the Plan will be communicated to the covered persons.

Upon termination of this Plan, all claims incurred prior to termination, but not submitted to either the employer or claims processor within three (3) months of the effective date of termination of this Plan, will be excluded from any benefit consideration.

PRONOUNS

All personal pronouns used in this Plan shall include either gender unless the context clearly indicates to the contrary.

RECOVERY FOR OVERPAYMENT

Whenever payments have been made from the Plan in excess of the maximum amount of payment necessary, the Plan will have the right to recover these excess payments. If the company makes any payment that, according to the terms of the Plan, should not have been made, the Plan may recover that incorrect payment, whether or not it was made due to the Company's own error, from the person or entity to whom it was made or from any other appropriate party.

RIGHT TO REVIEW OR AUDIT CLAIMS

The Plan administrator, in its sole discretion, may engage an independent medical billing reviewer and/or medical chart auditor to perform a comprehensive analysis of any preferred provider claim. The purpose of such an analysis is to identify charges billed in error and/or charges that are not the negotiated rate, if any. This analysis may involve the review of a patient's medical billing records, including but not limited to any statement of itemized charges and/or any description of the items, services, and supplies provided. If warranted, the analysis may also involve an audit of the patient's medical chart and records, in addition to the review of his or her medical billing records.

Not every claim will be subject to a bill review or medical chart audit. The Plan administrator has the sole discretionary authority to select claims for bill review and possible medical chart audit.

If a covered person or provider fails to provide a statement of itemized charges or any other information necessary to decide a claim, such covered person or provider shall be provided in writing with a specific description of the information needed to decide the claim and shall be given 45 days to produce such information. The bill review or medical chart audit shall not go forward during that 45-day period unless the covered person or provider produces the information needed to decide the claim. If the covered person or provider does not produce the requested information within the 45-day period, no further request for such information shall be made of the covered person or provider, and the claim may be reviewed or audited based on the information initially submitted with the claim.

Upon completion of the bill review or medical chart audit, the reviewer or auditor shall submit a written report to the Plan administrator or its agent which identifies those charges that are deemed to be in excess of the negotiated rate, as defined herein. Regardless of any contractual arrangement to the contrary, the Plan administrator has the sole discretionary authority to reduce any charge to the negotiated rate in accordance with the terms of this Plan. No arrangement or contract of any kind shall override or preempt the Plan document, and the claims processor has no discretionary authority to alter or override the authority of the Plan administrator in these situations.

Notwithstanding any assignment or non-assignment of benefits to the contrary, upon payment of the benefits due under the Plan, the Plan is deemed to have fulfilled its obligations with respect to such benefits, whether or not payment is made in accordance with any assignment or request.

No covered person may, at any time, either while covered under the Plan or following termination of coverage, assign his or her right to sue to recover benefits under the Plan or to enforce rights due under the Plan or any other causes of action he or she may have against the Plan or its fiduciaries.

STATUS CHANGE

If an employee or dependent has a status change while covered under this Plan (i.e. dependent to employee, COBRA to Active) and no interruption in coverage has occurred, the Plan will provide continuance of coverage with respect to any benefit.

TIME EFFECTIVE

The effective time with respect to any dates used in the Plan shall be 12:00 a.m. (midnight) as may be legally in effect at the address of the Plan administrator.

WORKERS' COMPENSATION NOT AFFECTED

This Plan is not in lieu of, and does not affect any requirement for, coverage by Workers' Compensation Insurance.

DEFINITIONS

Certain words and terms used herein shall be defined as follows and are shown in bold and italics throughout the document:

Alternate Recipient
Any child of an employee or their spouse who is recognized in a Qualified Medical Child Support Order (QMCSO) or National Medical Support Notice (NMSN) which has been issued by any court judgment, decree, or order as being entitled to enrollment for coverage under this Plan.

Authorized Representative
An individual who the covered person has authorized (in writing) to represent or act on their behalf with regards to a claim. An assignment of benefits does not constitute a written authorization for a provider to act as an authorized representative of a covered person.

Break in Service
A period of at least 13 consecutive weeks during which the employee has no hours of service. A break in service may also include any period for which the employee has no hours of service that is at least four (4) consecutive weeks in duration and longer than the prior period of employment.

Claims Processor
The company contracted by the employer which is responsible for the processing of claims for benefits under the terms of the Plan and other ministerial services deemed necessary for the operation of the Plan as delegated by the employer.

Close Relative
The employee's spouse, children, brothers, sisters, or parents; or the children, brothers, sisters or parents of the employee's spouse.

Coinsurance
The benefit percentage of covered expenses payable by the Plan for benefits that are provided under the Plan. The coinsurance is applied to covered expenses.

Covered Expenses
Covered expenses shall include specified preventive care services.

Covered Person
A person who is eligible for coverage under this Plan, or becomes eligible at a later date, and for whom the coverage provided by this Plan is in effect.

Dependents
For a complete definition of dependent, refer to Eligibility, Dependent Eligibility.

Effective Date
The date of this Plan or the date on which the covered person's coverage commences, whichever occurs later.

Employee
A person directly involved in the regular business of and compensated for services by the employer, who is regularly scheduled to work not less than thirty (30) hours per work week on a full-time status basis.

Employer
The employer is Instant Care of AZ .

Expedited External Review
A request to change an adverse benefit determination made by the Utilization Review Organization for care or services that involve a medical condition where a delay would seriously jeopardize the life or health of the covered person or their ability to regain maximum function.

Experimental/Investigational
Services, supplies, and treatment which does not constitute accepted medical practice properly within the range of appropriate medical practice under the standards of the case and by the standards of a reasonably substantial, qualified, responsible, relevant segment of the medical community or government oversight agencies at the time services were rendered.

The claims processor, Named Fiduciary, Plan administrator or their designee must make an independent evaluation of the experimental/non-experimental standings of specific technologies. The claims processor, Named Fiduciary, Plan administrator or their designee shall be guided by a

reasonable interpretation of Plan provisions and information provided by qualified independent vendors who have also reviewed the information provided. The decisions shall be made in good faith and rendered following a factual background investigation of the claim and the proposed treatment. The claims processor, Named Fiduciary, Plan administrator or their designee will be guided by the following principles:

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; or
2. If the drug, device, medical treatment or procedure, or the covered person informed consent document utilized with the drug, device, treatment or procedure, was reviewed and approved by the treating facility's institutional review board or other body serving a similar function, or if federal law requires such review or approval; or
3. If "reliable evidence" shows that the drug, device, medical treatment or procedure is the subject of on-going phase I or phase II clinical trials, is in the research, experimental, study or investigational arm of on-going phase III clinical trials, or is otherwise under study to determine its maximum tolerated dose, its toxicity, its safety its efficacy as compared with a standard means of treatment or diagnosis; or
4. If "reliable evidence" shows that prevailing opinion among experts regarding the drug, device, medical treatment or procedure is that further studies or clinical trials are necessary to determine its maximum tolerated dose, its toxicity, its safety, or its efficacy as compared with standard means of treatment or diagnosis.

"Reliable evidence" shall mean only published reports and articles in the authoritative medical and scientific literature; the written protocol or protocols used by the treating facility or the protocol(s) of another facility studying substantially the same drug, device, medical treatment or procedure; or the written informed consent used by the treating facility or by another facility studying substantially the same drug, device, medical treatment or procedure.

Full-time
Employee's regularly scheduled work not less than thirty (30) hours per work week.

Illness
A bodily disorder, disease, physical sickness, or pregnancy of a covered person.

Incurred or Incurred Date
With respect to a covered expense, the date the services, supplies or treatment are provided.

Independent Review Organization (IRO)
An outside entity that is accredited by URAC or a similarly nationally recognized accrediting organization to conduct external reviews. The claims processor will contract with a minimum of three (3) IROs and assignment of external reviews will be based upon a rotating assignment methodology.

Injury
A physical harm or disability which is the result of a specific incident caused by external means. The physical harm or disability must have occurred at an identifiable time and place. Injury does not include illness or infection of a cut or wound.

Layoff
A period of time during which the employee, at the employer's request, does not work for the employer, but which is of a stated or limited duration and after which time the employee is expected to return to full-time, active work. Layoffs will otherwise be in accordance with the employer's standard personnel practices and policies.

Leave of Absence
A period of time during which the employee does not work, but which is of stated duration after which time the employee is expected to return to active work.

Medically Necessary (Medical Necessity)
Service, supply or treatment which, as determined by the claims processor, Named Fiduciary, employer/Plan administrator or their designee, to be:

1. Appropriate and consistent with the symptoms and provided for the diagnosis or treatment of the covered person's illness or injury and which could not have been omitted without adversely affecting the covered person's condition or the quality of the care rendered;
2. Supplied or performed in accordance with current standards of good medical practice within the United States; and
3. Not primarily for the convenience of the covered person or the covered person's family or professional provider; and
4. Is an appropriate supply or level of service that safely can be provided; and
5. It is recommended or approved by the attending professional provider.

The fact that a professional provider may prescribe, order, recommend, perform, or approve a service, supply or treatment does not, in and of itself, make the service, supply, or treatment medically necessary. In making the determination of whether a service or supply was medically necessary, the claims processor, employer/Plan administrator, or its designee, may request and rely upon the opinion of a physician or physicians. The determination

of the claims processor, employer/Plan administrator or its designee shall be final and binding.

Medicare
The programs established by Title XVIII known as the Health Insurance for the Aged Act, which includes: Part A, Hospital Benefits For The Aged; Part B, Supplementary Medical Insurance Benefits For The Aged; Part C, Miscellaneous provisions regarding all programs; and Part D, Prescription Drug Benefits; and including any subsequent changes or additions to those programs.

Named Fiduciary For Post-Service Claims Appeals
The claims processor

Negotiated Rate
The rate the preferred providers have contracted to accept as payment in full for covered expenses of the Plan.

New Employee Stability Period
The 12 calendar month period that begins on the first day of the calendar month following the calendar month that begins on or after the employee's anniversary date.

Nonpreferred Provider
A physician, hospital, or other health care provider which does not have an agreement in effect with the Preferred Provider Organization at the time services are rendered.

Ongoing Employee Stability Period
The 12 calendar month period that begins on the first day of each Plan year following the end of the Plan's standard measurement period.

Physician
A Doctor of Medicine (M.D.) or a Doctor of Osteopathy (D.O.) who is practicing within the scope of his license.

Placed For Adoption
The date the employee assumes legal obligation for the total or partial financial support of a child during the adoption process.

Plan
"Plan" refers to the benefits and provisions for payment of same as described herein.

Plan Administrator
The Plan administrator is responsible for the day-to-day functions and management of the Plan. The Plan administrator is the employer.

Post-service Claim
Post-service claims are those for which services have already been received (any claims other than pre-service claims).

Preferred Provider
A physician, hospital or other health care facility who has an agreement in effect with the Preferred Provider Organization at the time services are rendered. Preferred providers agree to accept the negotiated rate as payment in full.

Preferred Provider Organization
An organization who selects and contracts with certain hospitals, physicians, and other health care providers to provide covered persons services, supplies and treatment at a negotiated rate. The Preferred Provider Organization is found on the ID Card.

Professional Provider
A person or other entity licensed where required and performing services within the scope of such license. The covered professional providers include, but are not limited to:

- Clinical Laboratory
- Physician
- Physician's Assistant

Standard External Review
A request to change an adverse benefit determination made by the claims processor or Utilization Review Organization for care or services when the covered person has exhausted the Plan's internal appeal process.

Standard Measurement Period
The 12 month period that begins each _____ and ends _____. Notwithstanding anything to the

contrary herein, the first standard measurement period begins 4/1/2023 and ends 3/31/2024 . Notwithstanding the foregoing, the employer may make adjustments to the standard measurement period with respect to employees on payroll periods that are weekly, bi-weekly or semi-monthly in duration, as set forth herein.

Total Disability or Totally Disabled

The employee is prevented from engaging in his regular, customary occupation or from an occupation for which he or she becomes qualified by training or experience, and is performing no work of any kind for compensation or profit; or a dependent is prevented from engaging in all of the normal activities of a person of like age and sex who is in good health.